UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

TALLAHASSEE DIVISION

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

AUGUST DEKKER, et al.,

Plaintiffs,

vs.

JASON WEIDA,

Defendant.

_____/

DEPOSITION OF: ANN DALTON

DATE: TUESDAY, JANUARY 24, 2023

TIME: 10:04 A.M. - 6:05 P.M.

PLACE: AGENCY FOR HEALTH CARE ADMINISTRATION
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S T I P U L A T I O N S

It is hereby stipulated and agreed by and between the counsel for the respective parties and the deponent that the reading and signing of the deposition transcript be reserved.

P R O C E E D I N G S

THE COURT REPORTER: Do you swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes.

ANN DALTON,

having first been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. DEBRIERE:

Q. Ms. Dalton, have you ever had your deposition taken before?

A. Yes.

Q. Okay. So I'm just going to walk through some preliminary issues and go over some basic instructions that you've probably heard a million times, and then I'll get started with the questioning.

A. Okay.

MS. DUNN: Sorry. Before we start, can we introduce everybody who is on the phone.

MS. DEBRIERE: Absolutely. Thank you, Chelsea.

Before we start, we want to introduces folks on the phone.

MS. DUNN: I think there's one person who is currently muted. Someone just joined.

Shani, are you there?

MS. RIVAUX: Good morning. This is Shani Rivaux.

MS. DEBRIERE: Anyone else, Chelsea?

MS. DUNN: There is one person. I just don't know who it is.

MS. DEBRIERE: Is anybody else there?

MS. DUNN: It's a 305 number. So it's Miami.

MS. CHRISS: That's Jennifer.

MS. DEBRIERE: Okay. Jennifer Altman is the other person.

MS. DUNN: If folks on the line could mute their phones just so we don't have any background noise, that would be helpful. Thanks.

MS. DEBRIERE: So we're just going to mark exhibits as they're discussed. I'll be showing you papers to read off, and we'll just mark them as we move through. As I mark those exhibits, I'm going to read something called a Bates number; that just helps us track what pages we're on when we discuss things. If there's a Bates number, it's probably going to start with "DEF," then underscore, then the Bates number.

I'd like to go ahead and mark the notice of deposition as Exhibit 1. There's no Bates number on

that one.

MS. DUNN: And Catherine McKee just joined the line as well.

MS. DEBRIERE: It's just the notice that brings you here today.

(Plaintiff's Exhibit No. 1 was marked for identification.)

BY MS. DEBRIERE:

Q. So I'm going to be using the acronym GAPMS quite a bit. Do you know what that stands for?

A. Yes.

MS. DEBRIERE: And, Court Reporter, it's G-A-P-M-S.

BY MS. DEBRIERE:

Q. And it stands for generally accepted professional medical standards; which is set forth in 59G-1.035. You probably don't have that memorized. That's okay.

I will use the term "gender dysphoria," which is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth and the associated gender role and/or primary and secondary sex characteristics. When I use that term, can we just agree that's the definition I'm using?

A. Okay.

Q. I'm also going to be using the phrase "categorical exclusion of gender affirming care." And that's just the exclusion set out in 59G-1.050, Subpart 7. That's why we're here for today, for that exclusion of gender affirming care. Do you understand what I mean when I say that?

MR. PERKO: I'm going to object to the form. You can answer.

THE WITNESS: Yes.

BY MS. DEBRIERE:

Q. Well, I do want to make sure you understand what I'm talking about. Would you like to see a copy of the rule before we can agree on use of that phrase? Because as I use it, I do want to make sure we're talking the same thing.

A. Yeah.

MS. DEBRIERE: So we'll mark this as Exhibit 2. It's a copy of 59G-1.050.

(Plaintiff's Exhibit No. 2 was marked for identification.)

BY MS. DEBRIERE:

Q. If you scroll down to Subpart 7 -- scroll down; you're not a computer. If you follow down to Subpart 7 --

MR. PERKO: It's on the back of the page.
BY MS. DEBRIERE:
Q. So when I'm using the phrase "categorical exclusion of gender affirming care," I'm referring to that Subpart 7. Can we agree that that's the phrase that encompasses that portion of the rule?
MR. PERKO: I'm going to object to form.
But you can answer.
MS. DEBRIERE: Well, I think we do need -- Gary, I understand where you're coming from. But I think we just need to figure out a way to shorthand --
MR. PERKO: That's fine.
MS. DEBRIERE: -- that reference.
MR. PERKO: I'm just objecting to the use of "gender affirming care."
MS. DEBRIERE: Okay. How about "treatment for just gender dysphoria"? Would you --
MR. PERKO: That's fine.
BY MS. DEBRIERE:
Q. So we're going to use "categorical exclusion of treatment for gender dysphoria." And when I use that phrase -- categorical exclusion of treatment for gender dysphoria -- I'm referring to that Subpart 7. Can we agree to that?

A. Okay.

Q. I'm also going to use the term "EPSDT services"; which is an acronym for early and periodic screening, diagnostic, and treatment services. When I say "EPSDT," do you know what I mean when I say that?

A. Yes.

Q. So my name is Katy DeBriere. And I represent the plaintiffs August Dekker, Brit Rothstein, and Susan Doe and K.F.

I know you've been deposed before. I'm just going to go over some very brief instructions, just as a refresher.

If I ask a question ask and you don't understand it, don't try to, you know, understand what I'm saying and try to answer the question. Instead, just stop me and tell me to rephrase so that you understand the question. That's no problem at all.

A. Yes.

Q. And speaking one at a time -- I have a horrible habit of speaking over people. But we need to try and do our best to speak one at a time, so the court reporter can get down everything we say. I don't think you're going to have that problem, but I will. So please just let me finish my question before you answer. And I will do my best to do the same when you're

providing an answer back to me; okay?
A. Yes.
Q. Verbal answers -- again, it's clear that you understand. But as we move through, the court reporter can't record things like "uh-huh," or "huh-uh." So if you could just use "yes," or "no," or words whenever you are responding to a question; okay?
A. Yes.
Q. If you need to take a break for any reason, please feel free to ask me. Stop me; tell me you need to take a break. That's not going to be a problem at all. The only thing I ask is that you finish answering your question before we do.
A. Yes.
Q. Okay. Are you on any medications or other substances that can impact your memory today?
A. No.
Q. Can you state your name.
A. Ann Dalton.
Q. And, Ms. Dalton, what did you do to prepare for today?
A. I met with my attorneys.
Q. Okay. And how long did you meet with them for?
A. 45 minutes.
Q. Okay. Did you review any documents?

A. No.
Q. Okay. Can you describe your educational background for me.
A. I have master's degree in music from Florida State University and a bachelor's degree in music from Northern Kentucky University.
Q. What's your current position at the Agency for Health Care Administration?
MS. DEBRIERE: And, Court Reporter, probably throughout the deposition we'll be using "AHCA"; which is the acronym -- AHCA. Or I might reference "the agency" at times. And when I reference "the agency," I mean the Agency for Health Care Administration.
BY MS. DEBRIERE:
Q. So what is your current position at AHCA?
A. I'm the bureau chief of the Bureau of Medicaid Policy.
Q. How long have you worked in that role?
A. Since -- officially, since August 2021.
Q. Okay. What did you do prior to that role?
A. I was an AHCA administrator in the Bureau of Medicaid Policy.
Q. What does that mean to be an AHCA administrator?

A. I was a manager of a team -- the Program Authority Section in the Bureau of Medicaid Policy.

Q. What kind of responsibilities does that entail?

A. The Program Authorities Section was responsible for submitting and maintaining the Medicaid waivers, the Medicaid state plan with the federal partners at CMS; the promulgation of administrative rules; and the PACE program.

Q. And how long were you in that role for?

A. Since August 2018.

Q. What did you do prior to that?

A. I was a program administrator over a section in the Bureau of Medicaid Policy.

Q. And what responsibilities does that entail?

A. That section was titled Program Policy. And it was responsible for the Children's Health Insurance Program or CHIP Program; the provider enrollment policy; the eligibility rule; and a few other rule areas that I can't remember.

Q. What do you mean by eligibility rule? What's that?

A. The -- I don't remember the exact rule number. But it is the rule that outlines the eligibility criteria for recipients in the Medicaid program.

Q. Okay. Is that related to what category of

Medicaid someone would fall under in order to be eligible for Medicaid?

A. I believe so.

Q. Okay. And how long were you in that position for?

A. From January 2018 to August of 2018.

Q. And what did you do prior to that?

A. I worked at the Department of Elder Affairs as a senior management analyst in the Long Term Services and Supports Bureau.

Q. And how long were you in that role for?

A. From August 2017 to January 2018.

Q. Did that role require any knowledge about Medicaid?

A. Yes.

Q. And did that role require any knowledge about rulemaking?

A. Not the promulgation process itself, per Chapter 120; but the development of rule language, yes.

Q. Okay. And when did you start at DOEA?

A. June 2012.

Q. Okay. And so what other positions did you hold there between June 2012 and when you became the senior program management analyst?

A. I held various analyst positions within the

same unit.

Q. Okay. And did those other positions require knowledge of Medicaid?

A. Yes.

Q. And did those other positions require knowledge about rule promulgation?

A. The same as the senior management analyst would have.

Q. In your current role at AHCA, who is your direct supervisor?

A. Currently Brian Meyer is my direct supervisor.

Q. And who is that person's supervisor?

A. Jason Weida.

Q. And what is Brian Meyer's position at the agency?

A. These changes are recent. And I'm not sure of the exact title of his position.

Q. How is his position in relation to Tom Wallace? Or I should ask: What is Tom Wallace's position at the agency?

A. He's a deputy secretary at the agency.

Q. Does Brian Meyer supervise him?

A. No, I believe they're the same position.

Q. Okay.

A. But, again, these are recent changes, and I'm

not quite sure of the exact title.

Q. What was Brian Meyer's role before he changed into the role he currently is in?

A. He was assistant deputy secretary of operations.

Q. Okay. Is Brian within the Bureau of Medicaid Policy?

A. No.

Q. Okay. Is he within any specific bureau at the agency?

A. No.

Q. Describe your current role at the agency for me. What are the responsibilities?

A. I oversee the Bureau of Medicaid Policy. The Bureau of Medicaid Policy is responsible for the federal authorities; which are the contracts between us and the federal government that manage the Medicaid program in Florida. Promulgates -- we oversee the promulgation of all the rules and rule class 59G; which are the Medicaid rules. Oversee the coverage policy development; those coverage policies are promulgated in administrative rule, but outline the specific services and the criteria for reimbursement.

The administration of the CHIP program is also part of the bureau's responsibility. And the managed

care plan contracts -- the drafting of those contracts and policy actions related to the managed care program.

Q. What are coverage policies?

A. Coverage policies are documents that contain the information needed by providers and recipients that describes the service and also provides the information that they would need to be reimbursed -- providers would need to be reimbursed for a service. It describes who can provide the service, who can receive the service, and then any service criteria or details around that service.

Q. What do you mean "service criteria"? Can you explain that further.

A. A description of the service and then any exclusions, if there are any, pertaining to that service. It's different for each coverage policy.

Q. Okay. And what are coverage handbooks?

A. "Handbooks" is a term that we used to use at the agency. A lot of the coverage polices were -- they are now separate coverage policies, but they were contained in bigger handbooks that have since been kind of broken down to be more service specific. And so the term that we use now to describe the information that was previously contained in the handbooks is "coverage policy."

Q. Are the handbooks promulgated into rule?
A. Yes.
Q. And does the agency still rely on those handbooks in determining service eligibility?
A. If the information from a handbook was moved to a coverage policy, the coverage policy would be promulgated in the rule and the handbook would no longer be part of that rule.
Q. Can you give a recent example of the handbook information moving into a coverage policy rule.
A. It's not that recent, but it's the first one that comes to my mind -- is the Home Health Handbook was broken down into three coverage policies, I believe, around 2016. And those three policies are the Home Health Services Coverage Policy, Personal Care Services Coverage Policy, and the Private Duty Nursing Services Coverage Policy.
Q. Okay. And this will seem like a simple question. But where do those coverage policies -- can the public access those coverage policies?
A. Yes.
Q. And where would they access those coverage policies?
A. The agency has an external web page specific to all the coverage policies, fee schedules, reimbursement

policies.

Q. And the policies that are on that public facing website, are they all inclusive of the policies on which the agency relies for determining coverage? Strike that question.

Is it an exhaustive -- is what is contained on the agency's website, is it an exhaustive list of Medicaid coverage policies?

A. All the policies promulgated in class 59G. And the rules or links to the FAR notice are on our website, yes.

Q. Are there any coverage policies not on the website on which AHCA relies to determine coverage of Medicaid services?

A. Not that I'm aware of.

Q. What is a fee schedule?

A. A fee schedule is the document that provides information on billing codes, the description associated with a code, and the amount that Medicaid will reimburse for fee for service.

Q. What is fee for service?

A. Fee for service is a delivery system where the State pays providers directly -- reimburses them directly for the service provided.

Q. Is that in contrast to managed care?

A. It's a different delivery model.

Q. If a Medicaid service is listed on the fee schedule, does that mean Medicaid covers it?

I'll strike that. I think I can ask a question that well help here.

If a Medicaid service is on the fee schedule, does that mean Medicaid does not categorically exclude it?

MR. PERKO: Object to form.

MS. DEBRIERE: You can go ahead and answer if you understand. If you don't understand, please feel free to ask me to rephase.

THE WITNESS: I don't think I understand.

BY MS. DEBRIERE:

Q. If a Medicaid service is listed on a fee schedule, does that mean that Medicaid is willing to pay for it if the recipient meets all eligibility criteria for that service?

A. So the fee schedules have to be used in conjunction with the coverage policy. So, like I said, the fee schedule contains the coding that the provider needs to use in order to get reimbursed, and, in most cases, the amount and description. But the parameters of who can receive the service -- what kind of providers can get reimbursed for the service -- that's in the

coverage policy.

Q. Okay. What would it mean if a Medicaid service was not on the fee schedule?

A. So the fee schedule document and the term as we would use "fee schedule" does not include all of the services. Some of those are going to be found in the reimbursement methodology rules, if there's not a specific fee equated to a specific code. So there's also reimbursement methodology rules and documents as well.

Q. Are there services -- Medicaid services on the fee schedule that AHCA will not cover?

A. I don't know if there's any. But it would be -- any information about how the services covered would be included -- either on the fee schedule or in the coverage policy.

Q. Okay. Do your responsibilities currently include developing coverage policies for the Florida Medicaid program?

A. I oversee the teams that are responsible for that, yes.

Q. And who are those individuals? Or let's start with: Who are the teams?

A. The team primarily responsible for the majority of the coverage policies is the team managed by Jesse

Bottcher; he's the AHCA administrator. And he has three program administrators who report directly to him.

Q. And who are those people?

A. Christine Polacheck [phonetic], and she oversees the specialized services section. John Matson, he's the manager over at the primary and preventative services section. And then Tim Beaner is the manager over the behavioral health and behavioral analysis section.

Q. Are those the only teams over which you manage? Or are there other teams?

A. I have five AHCA administrator direct reports.

Q. Okay.

A. And then one program administrator direct report. So I have six direct management team reports.

Q. So who are the other ones?

A. Catherine Mcgrath is the AHCA administrator over the program authority section. Ashley Peterson is the AHCA administrator over at the pharmacy policy section. One of them is vacant -- the managed care contract AHCA administrator position. Devona Pickle, she is the AHCA administrator over the Canadian Prescription Drug Importation team. And Jesse Bottcher. And then Lakeva Campbell [phonetic] is a program administrator over the administrative unit who does the

administrative functions of the bureau.

Q. Who works under Jesse Bottcher?

A. That was Christine Polacheck, John Matson, and Tim Beaner.

Q. And do you know who Mr. Jeff English is?

A. Yes.

Q. And who is his supervisor?

A. His current supervisor is Cole Giering.

Q. Who is Mr. Giering's supervisor?

A. Catherine Mcgrath.

Q. And Mr. Bottcher -- does he supervise the person who undertakes GAPMS analysis?

A. The position that is designated to do the GAPMS is under Jesse Bottcher.

Q. Okay. And who does Ms. Peterson supervise?

A. The pharmacy policy team, which consists mostly of pharmacists within the bureau.

Q. How many pharmacists are there?

A. In Ashley's section, there are currently three.

Q. Do you know the names of any of those people?

A. Yes. Jessica Forbes, Kelly Rubin, Susan Williams.

Q. Are you familiar with a person named Nai Chen?

A. Yes.

Q. And who is his supervisor?

A. D.D. Pickle.
Q. And was Mr. Chen ever involved in the pharmacy policy? Did Mr. Chen ever work for the pharmacy policy unit?
A. No.
Q. How long has Mr. Chen been in that position?
A. I don't remember.
Q. More than a year?
A. Yes.
Q. More than two years?
A. I'm not sure.
Q. Okay. Does Mr. Chen in his position have any responsibilities over pharmacy coverage policies?
A. None that are currently promulgated.
Q. What about policies that are not promulgated?
A. I don't know if there's going to be the need for a coverage policy or what types of administrative rule we're going to need to implement the Canadian Prescription Drug Importation Program once that's federally approved -- which is why I answered how I did.
Q. Are there any other pharmacy related activities that Mr. Chen engaged in the past year?
A. Yes.
Q. What are those?
A. His -- he's part of the Canadian Prescription

Drug Importation Program team. And there has been pharmacy related activity regarding the SIP approval.

Q. What does SIP stand for? Or you can just describe it if that's easier.

A. It's the proposal or the importation program plan that the federal government authorized states to submit or request approval of in order to develop an importation program. And this was submitted to the FDA.

Q. What does the Canadian Prescription Drug Importation unit do?

A. Their primary responsibility is to implement the Canadian Prescription Drug Importation Program that was statutorily authorized -- and I think it was in 2019 -- which includes seeking that federal approval from the FDA and any implementation activities in managing the contract with LifeScience Logistics -- the agency's vendor who assists with that program.

Q. And did Mr. Chen over the past year have any responsibilities related to pharmacy activities that did not involve the Canadian Prescription Drug Importation Program?

A. Yes.

Q. And what were those?

A. I can't recall all the specific assignments. But he has helped with several research projects. I

think he has assisted Ashley's team with some questions or answering questions. And he's been available to assist with just different research projects.

Q. Was he involved at all with the categorical exclusion of treatment for gender dysphoria in developing the pharmacy coverage decisions related to that?

A. So when you ask that, you're specifically talking about the rule?

Q. I'm talking about the rule and the ways in which AHCA is implementing the rule.

A. I don't know to the extent -- I know that he assisted with research for the GAPMS report.

Q. Okay. And by GAPMS report, is that the report that is related to the categorical exclusion for treatment of gender dysphoria?

A. Yes.

Q. Why did Mr. Chen assist the pharmacy unit with the GAPMS report instead of the other pharmacists in the pharmacy policy unit? I'll strike that.

Why did Mr. Chen -- does the Canadian Prescription Drug Importation unit focus on pharmacy policies unrelated to the Canadian Prescription Drug Importation Program typically?

A. Since there's been such a long delay with the

federal approval of the Canadian Prescription Drug Importation Program, that team has assisted with various other projects within the bureau.

Q. Okay. Is that why Mr. Chen assisted with the GAPMS report for the exclusion of the treatment for gender dysphoria?

A. Yes.

Q. What types of services does AHCA develop coverage policies for? Actually -- I'm sorry; strike that. I apologize.

What does the Pharmacy Policy unit do?

A. Their job entails a lot of duties. Primarily they host and oversee the PNT and DUR meetings -- public meetings and the boards associated with that. They oversee the coverage policies specific to pharmacy. They assist with any contract language for the managed care contacts for pharmacy. They oversee the contract for our PBM contractor Magellan. Those are the primary duties.

Q. What does PBM stand for?

A. Pharmacy benefits manager.

Q. And what is that?

A. PBMs can have various duties. But the contract that I'm referring to is our rebate negotiation contract.

Q. Okay. And you said that PBM contract is with Magellan; is that correct?
A. Yes.
Q. Okay. What's DUR?
A. Drug Utilization Review Board.
Q. And I think you used one other acronym when you were discussing the public facing pharmacy meetings.
A. PNT.
Q. And what does that stand for?
A. I believe it's pharmaceuticals and therapeutics.
Q. Okay. And what is that?
A. All the responsibilities of that board are outlined in statute.
Q. Okay.
A. I can't think off the top of my head. But they meet quarterly. And we host those meetings and schedule them.
Q. Okay. A few more questions about Mr. Chen.
Is Mr. Chen a pharmacist?
A. I believe so.
Q. And is he the only pharmacist in the Canadian Prescription Drug Importation Program unit?
A. None of the other members of that team are pharmacists.

Q. So Mr. Chen is the only one?
A. Yes.
Q. Okay. Did any other pharmacist assist with the 2022 GAPMS relating to exclusion of treatment for gender dysphoria?
A. I don't know.
Q. What types of services does AHCA develop coverage policies for?
A. The coverage policies are -- outline the services that the State covers through the state plan -- Medicaid state plan or Medicaid waivers. So those are just any Medicaid related service.
Q. Does AHCA develop coverage policies for surgeries?
A. Yes.
Q. How about for prescription drugs?
A. Yes.
Q. Does AHCA develop coverage policies for every Medicaid service?
A. I don't know.
Q. Have you ever had a situation where a Medicaid recipient requests coverage for a service and there is no policy?
A. I personally have not, no.
Q. Okay. And what process does AHCA use to decide

whether to provide coverage of a Medicaid service?

A. That really depends on the specifics of what that service is.

Q. Does every service have a different process?

A. The process could vary based on what the service is that we are determining coverage for.

Q. Do you use the same process for developing pharmacy policy coverage?

A. I can't speak to the process or approach of the analysts. The process of promulgating the coverage policies into rule is always going to be in accordance with Chapter 120.

Q. During your time at AHCA, have you developed -- have you been involved in developing or has your team -- those you supervise -- been involved in developing new coverage policies to cover services?

A. Yes.

Q. Can you remember a specific service that you did that for?

A. Yes. We are currently in the process with promulgating the iBudget Waiver handbook. And as part of the updates to the handbook, one of those is to develop a new life skills development for Level 4 service. As part of that process, we also worked with our federal partners at CMS to get a waiver amendment

approved. That's a very recent example of a new service being developed.

Q. Do you have an example of a state plan service that you developed coverage for that's under current development?

A. Yes. We recently added some Puro Meno products to the DME fee schedule.

Q. And so in that instance, did you establish a coverage policy for those specific items of DME?

A. We did a coverage determination to determine if and how they could be included as a covered service as part of the DME service.

Q. And what is DME?

A. Durable medical equipment.

Q. And that includes medical supplies?

A. Yes.

Q. And Puro Meno would be a medical supply?

A. Yes.

Q. And you, to cover that service, incorporated it onto the fee schedule?

A. Yes.

Q. Did you do --

Okay. How did you assess whether to decide to incorporate Puro Meno into the fee schedule?

A. So I can't speak to all the steps that the

analyst -- the specific steps that they took. But just speaking overall, determined if we had the legislative and state plan authority to cover it; determined if it was -- if there would be a fiscal impact.

And we approach coverage like that example to, you know, try and make sure it's budget neutral since we are -- our coverage is driven by our general appropriations and our state general appropriations act. And then determined if and what types of updates would be needed to any of the Medicaid rules. That's the general process for determining that kind of coverage.

Q. So to make a coverage determination you look at your legislative authority -- authority under the state plan -- and you do a fiscal analysis and hope for budget neutrality. You check to see if there's any updates to Medicaid rules. Anything else?

A. Making sure that it's an allowable service under Medicaid, as well; which would entail that it meets all federal, state rules and regulations for coverage. But, like I said, all the details of the research that the team does -- I can't speak to exactly everything that they read or looked at.

Q. And if in that coverage determination you decide to cover that service, do you then incorporate it into the fee schedule?

A. In the example I gave, that's what we did, yes.
Q. Are there any situations where you would not incorporate it into the fee schedule?
A. Yes.
Q. What are those circumstances?
A. That would vary depending on what the actual request or coverage benefit is that we're looking.
Q. Can you think of an example?
A. Yes. Last legislative session, I believe it was, there was a specific language regarding the coverage of human donor milk and milk derivatives for inpatient use. Because it was under inpatient, that is a -- the reimbursement for that is different and isn't included in a fee schedule.
Q. Okay. That makes sense.
Once this coverage determination is made, do your responsibilities include reviewing that to determine whether to approve the decision?
A. Yes.
Q. And how do you go about doing that?
A. We usually meet with the team. We do a walkthrough, have discussions around the proposal and the recommendation. And then we put together -- depending on what the change is, put together a document to get approval from management -- upper management.

Q. Does that document have a specific title -- the same title every time?

A. No.

Q. How would you identify that document?

A. So if a fee schedule change was needed, there is a formal routing process for the rule promulgation process that would be routed through management and signed off on.

Q. Okay. Are there other documents that would be routed through management to be signed off on?

A. Yes.

Q. And what are the titles of those documents?

A. It depends on the situation. For example, we also have a steering committee at the agency for the division of Medicaid. And we call that a decision point that would be to the steering committee.

Q. Okay.

A. And the Medicaid director or agency leadership is part of that committee. And so that is also a way for us to get approval.

Q. For those coverage determinations that you reviewed and put together in a document for administrative review, who in the administration reviews that document?

A. Depends on what that is. So for administrative

rule -- that needs to be signed off by several agency leadership; including the general counsel, the agency secretary for a proposed rule. So it would depend on what the final document is who the final signatory would be.

Q. Distinct from implementation of the coverage determination, is there a review by the administration of just whether to cover the Medicaid service?

A. It depends on what the specific circumstances are.

Q. Okay. Can you think of an example of the administration reviewing a determination of whether to cover a service?

A. Can you be more specific? So the waiver example I used a while back would be signed to submit the waiver -- the iBudget waiver -- with the changes. That would have been signed by the Medicaid director prior to submission to federal CMS.

Q. How long have you been involved in the process of doing coverage determination?

A. Since my time at AHCA.

Q. Okay. So since -- I'm trying to take notes here. So since August of 2018?

A. January of 2018.

Q. January of 2018. Thank you.

And when you're making coverage determinations, you coordinate with AHCA rules unit if a rule change is needed; is that right?

A. Yes.

Q. Okay. Under what bureau does the AHCA rules unit fall?

A. Under the Bureau of Medicaid Policy.

Q. Okay. So under your unit?

A. In the bureau.

Q. I'm sorry. Under you're bureau?

A. Yes.

Q. And you coordinate with AHCA's pharmacy policy unit; which falls under your -- the pharmacy policy unit falls under your bureau as well; is that right?

A. Yes.

Q. Okay. Do you coordinate with other bureaus in developing coverage determinations?

A. Yes.

Q. Which ones?

A. All the bureaus in the division work closely together. And there have been some recent changes with that structure. But speaking prior to those changes, the Bureau of Medicaid Program Finance would be probably be the primary bureau; because they assist with determining or setting our fee schedules and our rates

and the methodologies and doing fiscal impact analyses -- data analytics -- Medicaid data analytics.

As part of the whole development package, we talk to all the bureaus because plan management operations can be affected if there is an update to the contracts. The Bureau of Medicaid Quality who monitors and oversees the provision of services through those contracts -- and they have various other duties. But depending on what the change is, we would communicate with most of the bureaus within the division.

Q. Okay. You just mentioned some recent changes in terms of that structure. What are those recent changes?

A. The Bureau of Medicaid Finance and Medicaid Data Analytics are reporting directly to Tom. And Plan Management Operations, Quality, and Policy are reporting directly to Brian Meyer.

Q. And why is that a change?

A. Previously I had been reporting directly to Tom Wallace.

Q. Is Brian Meyer's position a new one?

A. I don't know all the details of those changes.

Q. Okay. Who made the decision to make those changes?

A. I don't know.

Q. Okay. Who oversees the rules unit?
A. Cole Giering is program administrator of the rules unit.
Q. How long has he been in that position?
A. I'm not sure exactly. But it was since I've been bureau chief.
Q. Okay. So --
A. August of 2021.
Q. Thank you.
Do you coordinate -- in making coverage determinations, do you coordinate with the chief medical officer for AHCA?
A. Yes.
Q. Who is that?
A. Dr. Christopher Cogal.
Q. Can you describe how you coordinate with him, what that process looks like.
A. Again, it really depends on the specific question or policy we're reviewing. But it would consist of meetings or discussions.
Q. What types of things would you discuss?
A. So, for example -- I'm going to go back to the two examples of recent activity. So he wasn't involved in the iBudget Waiver changes at all. But for the human donor milk, he assisted when we had originally done the

legislative bill analysis when the legislation was first proposed. And so for the development of how to implement the changes, he was consulted. I don't know the specific conversation, but I do know that he was involved in that process.

Q. On what kind of expertise do you rely on him for? What kind of input does he provide in the process? Is it medical in nature?

A. I don't know.

Q. Okay.

A. To the extent -- I know he's an available resource for the team. But I don't know to the extent that -- of his involvement.

Q. When he gets involved, is it through a formal process? Or is it just a decision to reach out and ask him for advice? How would you characterize it?

A. From my experience at the bureau level, it's been more informal. I know that there have been -- he's been formally asked to review bill analysis or -- but how that process works, I don't know.

Q. Okay. Are there people under you who are more likely to communicate with Dr. Cogal?

A. I believe there's staff that communicate with him more than others, yes.

Q. What staff are those?

A. Ashley Peterson has been meeting with him on some projects lately. Again, it really depends on the project. But we are working with him on continuous glucose monitoring -- questions around coverage there. And Jesse Bottcher and his team.

Q. When you say Jesse Bottcher and his team, would that include the GAPMS process?

A. His team is responsible for it.

Q. In coordinating with Dr. Cogal -- in the coordination between Mr. Bottcher's team and Dr. Cogal, would that include the GAPMS process?

A. I don't know the extent to which he is involved in that.

Q. Okay. To your knowledge, has he ever been involved in that?

A. I don't know specifically.

Q. Have you and Dr. Cogal and anyone from Mr. Bottcher's team ever met to discuss the GAPMS process?

A. The process, yes. When I first took the role, we had met to talk through the process. But I can't remember the specific conversation.

Q. Okay. Switching gears a bit. When I use the term "Florida Medicaid managed care plan," do you know what it means?

A. Yes.
Q. What does that term mean?
A. Those are the managed care plans that the agency contracts with to provide the services through the managed care delivery model.
Q. Do Medicaid managed care plans have their own coverage policies?
A. The agency's coverage policies are incorporated into the managed care plan contracts by reference. And there are requirements outlined in the contract with how the managed care plans have to provide services.
Q. Are you aware of managed care plans having their own policies that incorporate Florida Medicaid's policies?
A. I don't know.
Q. Have you ever seen a copy of a Florida Medicare managed care plan document that discusses the coverage of a Florida Medicaid service?
A. I reviewed the plans' member handbooks or enrollee handbooks. And I've seen their resources available on their websites that weigh out what they cover. I can't remember if I've ever seen an official document titled "Coverage Policy."
Q. So my question is: Have you ever seen a document from a Medicaid managed care plan -- formal or

informal, it doesn't matter -- with information that contains the criteria used to determine if Florida Medicaid will cover a service?

A. I believe that information is in the handbooks. But I can't recall any specific documents drafted by the plans.

Q. What unit would be responsible for communicating with managed care plans about their coverage of Florida Medicaid services?

A. That would depend if they had a question for the agency on the agency's coverage of a covered service or a contractually required service. Those most likely would be sent to Medicaid policy.

Q. Okay.

A. To review.

MS. DEBRIERE: Okay. Yes. Definitely. Just a couple more questions, if that's okay.

BY MS. DEBRIERE:

Q. Are you okay Ms. Dalton?

A. Yes.

Q. Who would review those questions? Who specific -- like, what specific individuals?

A. It would depend on what the question was.

Q. Okay. If the managed care plan doesn't have a question, is there any process that exists that just

involves overseeing whether a Medicaid managed care plan is covering a Florida Medicaid service?

A. The Bureau of Plan Management Operations is the bureau that oversees the adherence to the contract. All the contract managers for the individual plans are housed there. So if it was a compliance question on if the managed care plan was following the requirements in the contract, that would be Plan Management Operations most likely who would be the first point of contact for the plans.

Q. Okay. Can MCOs create their own guidelines for implementing AHCA coverage policies?

A. I don't know.

Q. Who would know that?

A. It would be in the contracts.

Q. Okay.

A. The parameters around what their materials are allowed to contain and if the materials have to be reviewed and approved by the agency.

Q. Okay. And that would be the Bureau of Planned Management Operations who does that -- takes on that role? And if not, then who?

A. I believe it would depend on what the materials being reviewed are. Just like with reporting -- there are different report owners in different bureaus within

the division of Medicaid that review compliance with the -- the plan's compliance with the contracts. But the first point of contact for submitting those materials and making sure that they're submitted would be through Plan Management Operations.

Q. And who is that bureau chief? Remind me.

A. Pam Hall.

Q. Okay. One last question. Are you aware that MCOs have their own guidelines for specific types of Medicaid services?

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

Q. Do you know who would know?

A. Are you asking if it's a required -- or if they're allowed to --

Q. No. I'm just asking if you're aware. So are you aware that they have their own --

MR. PERKO: Asked and answered.

MS. DEBRIERE: -- criteria guidelines?

THE WITNESS: I would have to review the contract.

BY MS. DEBRIERE:

Q. Okay. So is that a no, you are not aware as we sit here today without having anything in front of you?

A. Correct. I don't know without seeing a specific example or reviewing the contract.

Q. Okay. Do you want to take a break?
A. Yes.
(Brief recess.)
BY MS. DEBRIERE:
Q. Ms. Dalton, just briefly -- when we took a break, did you discuss this deposition with anyone?
A. No.
Q. Did you discuss it with your attorneys?
A. Just briefly.
Q. Okay. When I use the term "quality improvement organizations" or QIOs, do you know what I mean?
A. Yes.
Q. What does that term mean?
A. Quality improvement organization.
Q. Yeah. Is eQHealth a QIO?
A. Yes.
Q. And what do they do?
A. I don't know the whole scope. But their main function in their contract with the agency is the -- to do prior authorization for fee for service services.
Q. Okay. What does prior authorization mean?
A. It's a utilization management tool to ensure that the services are in their scope, authorized, and appropriate.
Q. By "appropriate," what do you mean?

A. That the service that's being requested is allowable and delivered within the parameters of the Medicaid program.

Q. Who makes the request for prior authorization?

A. I don't know the details of how the process works.

Q. Okay. By parameters, do you mean the parameters set by AHCA's coverage policies?

A. Yes. And administrative rule.

Q. Okay. Is administrative rule distinct from a coverage policy?

A. Yes. Not all of the administrative rules incorporate a coverage policy by reference.

Q. Okay. So an example of that would be the definition of medical necessity -- would be an administrative rule that sets out the parameters for coverage but does not include a specific coverage policy?

A. The definition of medical necessity is actually in the definitions policy -- which is a document incorporated by reference into the text of the administrative rule.

Q. Okay. Do QIOs like eQHealth -- do they have their own coverage criteria they rely on?

A. Yes.

Q. Do you coordinate with QIOs regarding those coverage criteria?

A. I personally do not.

Q. Does anybody on your team?

A. The eQHealth contract is housed in the Bureau of Medicaid Quality.

Q. Okay.

A. So they would be a lead in managing of that contract and communicating with the vendor. But I do know that we have communicated with them in the past -- the Bureau of Medicaid Policy has.

Q. What types of things have you communicated about in the past?

A. The first example that comes to mind is recently the agency opened the definitions rule policy and did communicate that that rule was being opened with eQHealth.

Q. Okay. Are MCOs and QIOs bound by AHCA's coverage policies?

MR. PERKO: I'm going to object to form.

You can answer.

THE WITNESS: As I stated before, the contract for the managed care plans incorporates the coverage policies by reference. And the plans are not allowed to be more restrictive than the coverage

policies. I don't know the specific language off the top of my head with the requirements of how they adhere to the policies. But that is in the contract.

BY MS. DEBRIERE:

Q. Okay. So the MCO's obligation to adhere to AHCA's coverage policies is set forth in the contract?

A. Yes.

Q. Okay. What about QIOs?

A. I don't know the specific language off the top of my head. But that information is also in the contracts on how the managed care plans' contracted QIO vendors are expected to operate.

Q. Okay. Is there a formal approval process for the QIO's coverage criteria?

A. I don't know.

Q. Is Magellan a QIO?

A. I don't know.

Q. Okay. Does Magellan conduct prior authorization of Florida Medicaid services?

A. I don't know.

Q. Does Magellan review the request of a Medicaid recipient to authorize prescription drug services in the Fee for Service program?

A. I don't know.

Q. Do you know what -- do you know if Magellan plays any role in determining coverage of pharmacy services under Florida Medicaid?

A. I believe the agency has a contract with them to adjudicate the claims. But I don't know the scope of that contract.

Q. What do you mean by adjudicate the claims?

A. I don't know the whole scope of that process or the contract.

Q. When you just use that phrase, what did you mean by that?

A. That they're involved in the reimbursement process.

Q. Okay. And would the reimbursement process involve determining the eligibility for the service itself?

A. I don't know the extent of that process.

Q. Would anybody at AHCA know or be able to answer that question?

A. I don't know.

Q. Moving back to coverage determinations undertaken by your bureau, who is the final decisionmaker as to whether AHCA will adopt that coverage determination?

A. Can you repeat the question.

Q. So earlier we were talking about your bureau undertaking coverage determinations of Florida Medicaid services; correct?

A. Yes.

Q. Who is -- before AHCA or anyone at AHCA can act on that determination, who is the final decisionmaker?

A. Again, it depends on the circumstances. And I can only speak to the signatory of who needs to be -- to officially sign off. But the example I used before for a federal authority submission, that would be whoever was designated from the agency as the Medicaid director or the Medicaid state plan approver.

Q. Okay.

A. And then administrative rule to actually complete the promulgation process. That's actually signed off by the head of the agency, which here would be our secretary.

Q. Okay. When coverage policies are promulgated, are there multiple drafts of those policies? Are there ever multiple drafts of those policies?

A. Can you repeat the question.

Q. When you're developing a coverage policy, are there multiple drafts?

A. It would it depend on what the change was.

Q. So there are times when coverage policies have

multiple drafts?

A. Yes.

Q. And how do you track any changes to those policies during the drafting process?

A. So specific to the coverage policy, we typically use a document called a revisions template; which tracks the changes being proposed.

Q. Okay. Is there a limit to the people who can make changes to the revisions document?

I'm sorry; the revision just tracks who has made the changes; is that right?

A. So it tracks what the old policy said, what the new changes are, if there's a reason for the change. I'm not sure if it includes who the requester of the change is.

Q. Okay. Does it record who is making the change?

A. I can't recall if that's on the template.

Q. Is anybody at AHCA allowed to make a change?

A. So for most of the coverage policies, there's a subject matter expert assigned to that program area who any changes would filter through. And then they have to work with the rules unit who is actually making the changes to the coverage policy and promulgating that through the rulemaking process.

Q. Okay. Just switching quickly to some specific

Medicaid services. Are coverage policies regarding surgery adopted into rule?

A. Yes.

Q. And are they in handbooks or a handbook?

A. I don't believe it's one specific handbook.

Q. Do you remember the names of any of the handbooks they are contained in?

A. We have a transplant services coverage policy.

Q. Okay.

A. Which I would consider inclusive of surgical. We have an inpatient services coverage policy. Without seeing the list of policies, I can't recall off the top of my head.

Q. Give me one second.

Would coverage policies about surgeries be in the Ambulatory and Surgical Center Services Policy?

A. I don't know the content of that policy off the top of my head.

Q. Okay. You said inpatient hospital services would contain surgery policies?

A. I don't know all the content in the policy without looking at it. But it...

Q. If it mentions surgery in the handbook, is it going to have a coverage policy related to it?

How would you know if a handbook covered

surgery or contained a surgery coverage policy in it?

A. I would have to read the handbook. Depending on what the specific question was, what type of surgery.

Q. Okay. What about prescription drug coverage policies? Are those adopted into rule?

A. I believe there is a rule specific to pharmacy policies and prescription drugs, yes.

Q. Okay. And then I'm just going to flip my computer around here and go to this page. We're looking at what's titled Agency for Health Care Administration Drug Criteria. AHCA.myFlorida.com/Medicaid/prescribed_drug_criteria.shtml.

And I assume, Ms. Dalton, I'm seeing here -- are you just seeing a list of drug criteria?

A. Yes.

Q. Is this an exhaustive list of the drug criteria that AHCA relies on?

A. I don't know.

Q. Who would know that?

A. Ashley Peterson and her team may be able to confirm.

Q. Okay. And why wouldn't this be an exhaustive list?

MR. PERKO: Object to form.

THE WITNESS: I'm not personally very familiar with this page.

MR. PERKO: Counsel, for the record, can we read the URL.

MS. DEBRIERE: Absolutely. Well, I think I -- Gary, do I not know what a URL is?

MR. PERKO: The website address.

MS. DEBRIERE: So I think we read most of it. But I can start with https://AHCA.myFlorida.com/Medicaid/prescribed_drug/drug_criteria.shtml.

MR. PERKO: Thank you.

MS. DEBRIERE: Absolutely.

BY MS. DEBRIERE:

Q. Do you know what categorical exclusion means?

MR. PERKO: I'm going to object to form. I guess I'm a bit confused, Counsel. You already defined what categorical exclusion means at the beginning of this deposition.

MS. DEBRIERE: Well, that's categorical exclusion -- you're right, Counsel. It contained the statement "categorical exclusion"; just categorical exclusion of a very specific set of services. The treatment for --

MR. PERKO: That wasn't the definition at the

beginning. But go ahead.

BY MS. DEBRIERE:

Q. How about this, Ms. Dalton: Can you provide an example of a categorical exclusion under Medicaid?

A. I can't think of an example. I'm familiar with the term. I cannot think of an example.

Q. Okay. I'm trying to think of one too.

Does AHCA -- does Florida Medicaid cover private duty nursing service for individuals over the age of 21?

A. Not through the state plan.

Q. Okay. Do they cover it through home and community based services with a Medicaid waiver?

A. Yes.

Q. Okay. And if Florida Medicaid does not cover private duty nursing services for individuals over 21 under the Medicaid state plan, is that a categorical exclusion?

A. Yes.

Q. And does the agency categorically exclude any Medicaid service for beneficiaries under the age of 21?

A. Can you repeat the question.

Q. I'm sorry. Bear with me one second, Ms. Dalton. I'll come back to that.

Do your responsibilities include ensuring that

coverage policies meet the standards under EPSDT?

A. The Bureau of Medicaid Policy doesn't oversee the monitoring of the adherence to the policies or the provision of services. In terms of ensuring that the policy language complies with the federal EPSDT requirements, yes.

Q. And how do you ensure that compliance when developing coverage policies?

A. It depends on the specific coverage policy. But the majority of the service specific coverage policies include language incorporating EPSDT by reference and language from the federal regulation.

Q. Generally speaking, what is that EPSDT requirement?

A. That the State must provide all medically necessary services to children ages under 21.

Q. Does the State have to provide a service under EPSDT to a Medicaid recipient under 21 if that service is experimental?

MR. PERKO: Object to form.

BY MS. DEBRIERE:

Q. Do you know what I mean when I say experimental?

A. Yes.

Q. So same question. Does the State have to

provide coverage to children under age 21 if that health service is considered experimental?

MR. PERKO: Object to form.

THE WITNESS: The State is allowed to develop its own definition of medically necessary or medical necessity; which Florida has done and promulgated in administrative rule. And part of that definition does include the parameters by which a service would not be determined medically necessary; and, therefore, not required under the EPSDT.

BY MS. DEBRIERE:

Q. Okay. And that definition of medical necessity includes the requirement that the service not be experimental; correct?

A. I cannot recall the exact definition off the top of my head. But that is in -- promulgated in the definition coverage policy.

Q. When you say that is --

A. The definition of medical necessity.

MS. DEBRIERE: Okay. We can mark -- I have a copy of the rule so you can reference it. We can mark that as Exhibit 3. And that's 59G-1.010.

We might have forgotten to put a copy in. If we did, it's my fault.

MS. DUNN: I have a copy right here.

(Plaintiff's Exhibit No. 3 was marked for identification.)

MS. DUNN: Yeah. It's right there. Last definition on that page.

THE WITNESS: It doesn't seem to be the whole --

MS. DUNN: It's not.

MS. DEBRIERE: It's not. We ended it at "N," because it's a very large coverage policy and we are trying to save some trees.

BY MS. DEBRIERE:

Q. So if you look at the definition of "medically necessary" or "medical necessity," does that contain a requirement that the service not be experimental?

A. Yes.

Q. And so under EPSDT, can the agency deny a medical service to a child under 21 if they deem it to be experimental?

A. Yes.

Q. Okay. Who is responsible for compliance with EPSDT? Is it a specific person?

A. I don't know who is responsible.

Q. Is it someone within your bureau regarding EPSDT as it relates to the development of coverage policies?

A. There isn't a specific person in my bureau, no.
Q. Are there any written guidelines about ensuring compliance with EPSDT with developing coverage policies?
A. Can you repeat.
Q. Are there any written guidelines relied on to determine whether a coverage policy complies with EPSDT, other than that contained in the Federal Medicaid Act?
A. I don't know specific -- all the specific documents that the analysts rely on when developing the coverage policy. But as part of that process, the expectation is to review the federal guidelines and statute and other rules and regulations of governing the Medicaid program to ensure that the coverage policy adheres to the Medicaid program federally and state.
Q. And that's an expectation of the staff within your bureau?
A. Yes. It's the common practice when approaching research regarding changes to the policy -- a policy.
Q. Okay. When I use the term "comparability," do you know what I mean as it's laid out in regulations implemented in the Federal Medicaid Act?
A. You may have to give me some more context.
Q. So under the Federal Medicaid Act, there is a requirement that state agencies who administer Medicaid do so in a way that all Medicaid recipients receive

comparable services. Are you familiar with that requirement?

A. Vaguely sounds familiar.

Q. Is your bureau required to be familiar with that requirement in developing coverage policies?

A. I can't speak to that without more information.

Q. Okay. Is there anyone who can speak to the requirement -- is there anyone who can speak to ensuring that the policy comply with comparability under the Federal Medicaid Act?

A. So, again, I think it really would depend on what the specific question is regarding or which specific coverage policy. As I said before, a lot of the coverage policies have a specific subject matter expert with knowledge of that service area. So it just really would depend.

Q. Okay. I'm just going to make myself a note.

What is the purpose -- turning back to Exhibit 3 and the definition of medical necessity -- what's the purpose of AHCA's medical necessity standard?

MR. PERKO: Object to form.

BY MS. DEBRIERE:

Q. Does AHCA's medical necessity standard have a purpose?

MR. PERKO: Object to form.

THE WITNESS: I don't know what you mean.
BY MS. DEBRIERE:
Q. What is the purpose of the definition of medical necessity?
MR. PERKO: Object to form.
BY MS. DEBRIERE:
Q. What do you use it for?
A. The definition is relied on a lot. Most of the service specific coverage policies refer and incorporate by reference the definitions policy and make a statement that the service must be medically necessary as part of the requirement for reimbursement.
Q. If a Medicaid recipient makes a request for a Medicaid service, in order for that service to be authorized, does it have to be medically necessary?
A. Yes.
Q. Do managed care plans rely on AHCA's medical necessity standard in their prior authorization process?
A. I can't recall the exact contract language. But, yes.
Q. And what about QIOs?
A. I don't know.
Q. Regardless of the method in which Medicaid is delivering the service -- fee for service or managed care -- in order for that surface to be authorized, does

it have to be medically necessary?

A. I don't know the details of the actual authorization process. I do know that the expectation from policy prospective is that the services have to be provided in accordance with the agency's coverage policies and administrative rules.

Q. And that includes the definition of medical necessity?

A. Yes.

Q. If AHCA finds that a Medicaid service is experimental, would AHCA or a contractor or managed care plan still review whether service meets other portions of AHCA's medical necessity definition?

A. I don't know the extent of their review.

Q. What about your review at AHCA for fee service?

A. Again, I don't know eQHealth or QIO vendors' process.

Q. Do all Florida Medicaid services require prior authorization?

A. I don't know. I don't believe so.

MS. DEBRIERE: Okay. Can I have what we'll mark as Exhibit 4, which is the GAPMS Report on Cross-Sex Hormone Therapy, dated May -- I believe we did the May version.

So what I'm showing you is Bates stamped

beginning at Defendant 00126105. I should pull out my own copy.

And that continues through, Court Reporter -- this one is not Bates stamped. It's weird. This one doesn't have a copy. This copy is not Bates stamped. But it is entitled Cross-Sex Hormone Therapy GAPMS Determination Report With Recommendation.

That's very odd. Very odd. I don't think it's a huge deal.

(Plaintiff's Exhibit No. 4 was marked for identification.)

BY MS. DEBRIERE:

Q. So on the last two pages, Ms. Dalton, starting at "Coverage policy" -- and it starts, "Federal regulations."

"Federal regulations for Medicaid..." and continues on through the definition of medical necessity --

MR. PERKO: Can you give a page number.

MS. DEBRIERE: Oh, yes. Thank you, Gary.

So page 8, 9, and a tiny bit of the top of 10.

THE WITNESS: I'm there.

BY MS. DEBRIERE:

Q. Take all the time you need to read it. And

afterwards, if you can tell me if this is an accurate portrayal of the standard used to determine Florida Medicaid coverage for prescription drugs.

MR. PERKO: Do you have another copy?

Thank you.

BY MS. DEBRIERE:

Q. I think it starts at the top of page 8 -- middle of page 8. So reviewing that standard, is that what's used to determine whether Florida Medicaid will cover a prescription drug?

A. Can you direct me more to where you're referring. I read both pages 8 and 9, and I don't think I can speak to the specifics of all this information.

Q. Okay. When reviewing whether to cover a prescription drug, does AHCA look at -- here on page 8 it says AHCA is -- "The program is required to asses data on drug use against predetermined standards consistent with the following compendia." And then it lists three types of compendia and the peer reviewed medical literature. Is that an accurate statement of AHCA policy?

A. I don't know.

Q. Who would know that?

A. I don't know if I can speak for them. But I would ask one of the pharmacists.

Q. Would you ask Ashley Peterson? Or would you ask one of the pharmacists that works under her?

A. I specifically would go to Ashley, as she's my direct report. And then she would research the question for me.

Q. Okay. Would research involve asking one of her pharmacists?

A. I don't know. I can't speak for her process.

Q. So going to page 9, top of the page says, "In order to be reimbursed by Medicaid, a drug must be medically necessary."

Is that the same as the definition contained in the 59G-1.010 that we just reviewed -- Exhibit 3?

A. I don't understand what you mean by the same.

Q. Does medically necessary mean the same as the definition in the definitions policy?

A. I would think so.

Q. Okay. And it is, "Either prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in the Medicaid Act or prior authorized by a qualified clinical specialist approved by that agency."

Is this an accurate recitation of the standard AHCA uses to authorize prescription drug coverage?

A. I don't know.

Q. Would Ashley Peterson know that information -- her or her team?

A. I would think so, yes.

Q. Okay. The next thing it says, "The criteria that are utilized under the Florida Medicaid program in the authorization of drugs for off-label purposes are as follows." And then it lists three criteria.

Reading over that statement, are these currently the criteria AHCA uses in authorizing drugs for off label purposes?

A. Again, I don't know.

Q. Would Ashley Peterson know the answer to that question?

A. I would think her team would, yes.

Q. Is this the type of information -- looking at this, is this the type of information that would be contained in a coverage policy adopted in rule?

A. I'm not sure.

Q. Why aren't you sure? What's throwing you about it?

A. I don't know the content of the rules off the top of my head.

Q. But I think my question is a little different. So does this appear to be the type of information that would be contained in a coverage policy adopted into

rule?

A. I can't speak to that. I don't know because of the reason I stated. I will say the coverage policies traditionally do not repeat regulation or requirements or information that are found elsewhere; for example, in Florida statute or in federal regulation. And each coverage policy is structured somewhat similarly, but does contain very different information. So I don't know if this is information that's found off the top of my head in one of our policies.

Q. Okay. I think you -- do all prescription drugs require prior authorization to be reimbursed by Medicaid?

A. I don't know.

Q. Who would know that?

A. I would think Ashley Peterson and her team. Or it might be available on the information on our website regarding pharmacy policy and authorization criteria.

Q. Okay. So Ms. Peterson would be familiar with authorization criteria for prescription drugs?

A. Yes. Or she would know where to look.

Q. Okay. Specifically related to pharmacy coverage policies, how are they developed?

A. The coverage of the pharmacy services is a little different than the other coverage policies. I

don't know all the details that go from the analysts into the developments. But because there is different statutory requirements -- Florida statutory requirements around pharmacy services, including the PNT and DUR board -- the process for overseeing the coverage of pharmacy services is a little different.

Q. In reviewing whether a prescription drug requires a coverage policy -- strike that.

Do you use the GAPMS process to determine pharmacy coverage -- to determine whether coverage of a prescription drug is experimental?

A. I don't know specifically for determining if a prescription drug is experimental. I don't know.

Q. When you develop coverage policies in your bureau, does that include a determination as to whether a service is experimental?

A. So the coverage policies are drafted specific to the covered services that we've been approved to provide.

Q. Okay.

A. By the federal government. So that is the driving factor on how we would initially approach the coverage and organize or draft a coverage policy asserting a service that we are authorized to provide.

Q. So separate and apart from developing coverage

policies, the responsibilities of your bureau also include determining whether a service is experimental; is that correct?

A. So that would be part of the GAPMS process that is outlined in administrative rule.

Q. Okay. Do you use the GAPMS process for prescription drugs?

A. Without researching or consulting others on the team for a specific example, I don't know the interplay between the different authorities and how that works.

Q. Which team is responsible for the GAPMS process?

A. That position is within the Medicaid -- Bureau of Medicaid Policy.

Q. Earlier speaking about teams under the bureau, which teams is responsible for the GAPMS process?

A. Jesse Bottcher is the manager over the position that is primarily responsible for the GAPMS process.

Q. Are there any other teams that are primarily responsible for the GAPMS process? Or is it only Jesse's team?

A. So in terms of listing that as a primary responsibility on a job description, that would be Jesse's team.

Q. Should the people on Jesse's team be aware of

every GAPMS process that's undertaken?

MR. PERKO: I'm going to object to form.

You can answer.

THE WITNESS: So as the bureau chief of Policy, I do try to keep staff within the bureau aware of everything that's happening within the bureau -- especially when a determination has been made. Jesse's team would definitely need to be aware, because there could be potential impacts with a specific service coverage policy. But I do think every circumstance is different. So I can't say just in a general statement to your question.

BY MS. DEBRIERE:

Q. Would it be typical for Jesse's team to not be aware of a GAPMS report being developed?

A. I can't say if it would be typical. I have not overseen very many GAPMS in my time as bureau chief.

Q. So as the bureau chief with Jesse's team being primarily responsible for GAPMS, would you as that chief endeavor to ensure that Jesse's team was aware of all GAPMS reports being written?

A. Yes. We meet the managers on -- my direct reports and I meet regularly at least twice a week for an hour and discuss projects that are going on with each team and provide updates. So the ongoing bureau

activities are regularly discussed with the management team.

Q. Okay. Do you know what a drug compendium is?

A. I recognize the term, but don't think I can define it.

Q. Do you know which compendia are listed in the Federal Medicaid Act?

A. No.

Q. I'm just going to screen share again. I'm showing right now on my screen -- the URL is https://AHCA.myFlorida.com/Medicaid/prescribed_drug/pharm_thera/pdf/PDL.pdf. The title of this document is Preferred Drug List, Effective January 21st, 2023.

Do you know what the preferred drug list is?

A. Yes.

Q. What is it?

A. It's list of drugs developed that the managed care plans must adhere to. And it has to do with rebate negotiations and is recommended by the PMT committee.

Q. Perhaps you just answered this. But who develops the PDL?

A. The agency.

Q. What is the PMT committee's role in it?

A. Per statute, they make recommendations to the agency.

Q. Okay. Does the DUR have any role in developing the PDL?

A. I don't know. I don't believe so.

Q. And this PDL applies to managed care plans; is that correct?

A. And fee for service.

Q. Okay. So on here -- I'm going to have to do Control+F. Pardon; one second.

It's very small. So tell me if you need to make it any bigger.

Okay. On here you will see the drug estradiol -- e-s-t-r-a-d-i-o-l -- listed. And there is many versions here starting at it looks like this line continuing all the way down until we hit norethindrone AC. So the fact that estradiol is lied on the PDL, does that mean Florida Medicaid will cover it if the eligibility criteria are met? Excuse me. Scratch that.

Since estradiol is listed on this PDL, does it mean that Florida Medicare will cover it?

MR. PERKO: Object to form.

THE WITNESS: I don't know.

BY MS. DEBRIERE:

Q. If any drug is listed on the PDL, does that mean Florida Medicaid will cover it?

A. I don't know the interplay between the PDL and

the other rules and regulations covering pharmacy services.

Q. Okay. Over in this column at the top of page, it reads "Clinical PA required." And it also has a column for a minimum and a maximum age. What does clinical PA required mean?

A. Operationally, I don't know.

Q. Do you know it in any other version?

A. I understand the words. But I don't know in the context of the program or the PA process what that means.

Q. What does "PA" stand for?

A. Prior authorization.

Q. Okay. Is it possible that clinical PA -- so if we scroll down to estradiol -- this version with a minimum of an age of zero, maximum age of 999 -- and it says "no" under the column of clinical PA required, do you know what that means?

A. No.

Q. Who would know that?

A. Ashley Peterson and her team are lead on this.

Q. Do you know what it means to have a minimum age column? Why that's significant or why it's on there?

A. Specific to this document, no.

Q. Same with maximum age?

A. No, I don't know the reason why it's on there.
Q. Since you've been at the agency -- January 2018?
A. Yes.
Q. How many GAPMS processes have you been involved in?
A. Two completed. And maybe one or two discussions.
Q. How many pending?
A. I don't know.
Q. Do you know currently how many GAPMS are pending?
A. Clarify "pending."
Q. Why don't you tell me what you meant by completed.
A. Two that have been signed by agency leadership.
Q. Okay. And how many reports are in the stage of being written and not yet signed?
A. I don't know.
Q. To be clear, though, as bureau chief you meet weekly with Jesse Bottcher and his team who are primarily responsible for GAPMS.
A. I meet weekly with Jesse Bottcher and my team.
Q. Okay.
A. I don't regularly meet with the individual

teams, but with the managers.

Q. When you meet with Jesse, do you discuss GAPMS?

A. Not routinely. We have before.

Q. What are the other responsibilities of Jesse's team?

A. The three managers under Jesse each have units that are responsible for the developments of the service specific coverage policies. His team also oversees the eligibility policy and the provider enrollment policy, updates all the fee schedules -- so works closely with fiscal agent operations to ensure updates are made to the MMIS system and with Medicaid program financing the development of fee schedules. And that's the bulk of their responsibilities.

Q. So when you're meeting with Jesse weekly, what are you discussing about his team?

A. It depends on what -- the highest priority assignments are usually up first; things that are due that week.

Q. Okay. So you do not routinely discuss GAPMS -- that was your testimony just a second ago?

A. Yes. I wouldn't say that it's a subject that we discuss at every meeting or routinely at our individual meetings, no.

Q. And you organize what you discuss based on what

has the highest priority?

A. Yes, typically.

Q. Okay. How familiar with you with the GAPMS process?

A. In terms of all the research and everything that goes into developing, I'm not as familiar. But I am familiar with the routing process, the rule, the authority for that process.

Q. Okay. So just generally, what does AHCA use the GAPMS process for?

A. So if the agency receives a request for coverage -- typically that's how the process would be initiated. If the coverage was determined to not be something that the agency could proceed with -- possibly adding to the fee schedule or incorporating into a service definition -- then the GAPMS process would be used.

Q. Okay. How is the GAPMS process initiated?

A. I believe it's a rule how to.

Q. Would it be helpful if you had the rule in front of you?

A. Yes.

MS. DEBRIERE: Okay. Let's mark that as Exhibit 5. That's Rule 59G-1.035.

(Plaintiff's Exhibit No. 5 was marked for

identification.)
BY MS. DEBRIERE:
Q. So how is GAPMS initiated?
A. A request is submitted to the health services research inbox in the Medicaid Policy Bureau.
Q. Who can submit a request to that inbox?
MR. PERKO: Object to form.
THE WITNESS: I believe anyone can.
BY MS. DEBRIERE:
Q. Okay. Is that the only way that a request is submitted for AHCA to undertake a GAPMS?
A. No.
Q. What are other ways?
A. So in the contracts with the plans, there's also language on how a managed care plan can submit a request to the agency for review -- not necessarily through the health services inbox. I can't recall the exact direction. But there's also the opportunity for the clients to request a review.
Q. When that review is requested, is it -- is the standard process used? Is the standard GAPMS process used?
A. I'm not sure. I believe it may be expedited. But I'm not sure to the specifics of the process.
Q. Who would be most familiar with that process?

A. Either Jesse Bottcher or Jeffrey English.
Q. Okay. So you mentioned managed care plans can submit a request -- or anyone can submit a request through the health services inbox. Are there any other ways that a request can be submitted to the agency to undertake a GAPMS?
A. Yes.
Q. And what are those ways?
A. I don't know all the ways. But I can't think of us not approaching the process if we received a request outside of getting it specifically through the health services research inbox.
Q. How often --
A. Which is -- I'm hesitating because I couldn't see us not -- like, refusing to complete the process if it was received another way.
Q. How often does that happen?
A. So, like I said before, in my time as bureau chief, there haven't very many finalized GAPMS. Or that process has not been a part of my day-to-day work. So I'm not sure.
Q. Okay. So you cannot recall another way that a GAPMS request came to the agency, other than through a managed care plan or the health services inbox?
A. So for the most recent GAPMS report, that was a

request from -- I believe it was the secretary. But I don't know if it went through the inbox specifically or not.

Q. Okay. So that's another way that the GAPMS process can be requested -- is through the secretary?

A. That's the way that it has been.

Q. Okay. How many times?

A. I don't know.

Q. And when you say the most recent GAPMS report, do you mean the GAPMS report related to gender dysphoria?

A. Yes.

Q. When that request came in through the secretary, did the secretary identify why she was making that request?

And, I'm sorry, do you mean Secretary Marstiller?

A. Yes.

Q. Okay. Did she identify why she was making that request?

A. I can't recall the contents of the specific request.

Q. Did the request come -- who did the request from Marstiller go to?

A. I don't know.

Q. How did you find out about it?
A. I just can't remember if I was sent the letter in an email. But it was then discussed by my manager.
Q. And that manager was? Is?
A. At the time was Jason Weida, who is the assistant deputy secretary.
Q. And did you receive the letter from Secretary Marstiller before that discussion occurred?
A. Yes.
Q. And how long between receiving the letter and having -- how long past between receiving that letter and having that conversation with Mr. Weida?
A. I don't remember.
Q. Was it, like, hours? A day? Several days? Within the same week?
A. I don't remember.
Q. Okay. Was that discussion just between you and Mr. Weida? Or were there other people?
A. I don't remember in the initial conversation if there was anybody with me.
Q. Okay. Was it -- where did it take place?
A. I believe it was in Jason's office.
Q. Okay. Did Jason ask you to come to his office to have the conversation? How were you notified of the meeting?

A. I don't remember. We had standing meetings in his office; he was my -- or I was his direct report. So I don't remember if it was part of that when we were talking about assignments and priorities or separate. I can't remember.

Q. What was Mr. Weida's position at the time at the agency?

A. He was the assistant deputy secretary for Medicaid policy and quality.

Q. And then who is in that position prior to him?

A. I think Shevaun Harris.

Q. Okay.

A. There was a gap in between. But I think she was the last person.

Q. Okay. And who took that position after Mr. Weida?

A. That position is currently vacant.

Q. Okay. And has Brian Meyer ever held that position?

A. No.

Q. Okay. Prior to your meeting with Mr. Weida but after your received the request from Secretary Marstiller, did you communicate with anybody else about the request?

A. Can you repeat the question.

Q. Between the time that you received the request from Secretary Marstiller -- the letter -- and meeting with Mr. Weida, did you have a conversation with anyone else about the request?

A. I don't believe so.

Q. Okay. Were you surprised to see the request?

A. No.

Q. Why not?

A. Medicaid Policy -- I think we're unique in that bureau because no one day is exactly the same. There's always something new coming out from the federal government, from legislative action, from leadership. So I think that's kind of part of the job of being the bureau chief of Medicaid policy.

Q. Okay. What was -- when you met with Mr. Weida, did you develop a plan about how to honor the Secretary's request?

A. Yes.

Q. And what was that plan?

A. The team that was going to work on it was the Canadian Prescription Drug Importation Plan team; following the regular GAPMS process in terms of research and report and development.

Q. Did you identify who was going to be on that team?

A. Yes.
Q. And who did you identify?
A. Matt Brackett, Nai Chen, and D.D. Pickle.
Q. As part of that plan -- and to be clear, the secretary's request was specifically a request to undertake a GAPMS investigation?
A. Yes; to review through that process.
Q. Okay. And the team identified was Brackett, Chen -- and I forgot the --
A. Their manager, D.D. Pickle.
Q. D.D. Pickle. Thank you.
So you previously testified that the team primarily responsible for GAPMS was led by Jesse Bottcher. Why was Jesse Bottcher not part of the team to undertake this GAPMS?
A. So there was several factors considered. Matt Brackett has worked with the bureau a long time and previously had the position responsible for -- primarily responsible for the GAPMS. D.D. Pickle has also been with the bureau and agency a very long time. So I would say that the historical knowledge, the bandwidth -- having bandwidth to focus on completing the GAPMS -- were probably the two biggest factors.
Q. When you say bandwidth, what do you mean?
A. So that team -- their primary responsibility is

the Canadian Prescription Drug Importation Program, which is not approved federally. So our ability to move forward with the day-to-day operations and implementation of that program is stalled. Due to that, that team has been available to assist in other areas within the bureau when needed.

Q. Was the team that's primarily responsible for GAPMS -- were they overwhelmed with doing GAPMS at the time?

A. I don't know.

Q. But you used the fact that Mr. Brackett and D.D.'s team generally would have a lot of time to work on GAPMS as a deciding factor to pick the team for this report; is that right?

A. Yes.

Q. But you didn't first check whether the team that's primarily responsible for GAPMS would have the time to do the report?

A. No.

Q. Okay. How long has Mr. Chen been with the agency?

A. I don't remember.

Q. Would you classify him -- as you did Ms. Pickle and Mr. Brackett -- as being with the agency for a long time?

A. No.
Q. So he did not have that historical knowledge that Mr. Brackett and Ms. Pickle have with the agency?
A. No.
Q. And that was a deciding factor in picking the team?
A. Yes.
Q. When you met with Mr. Weida to pick this team, did Mr. Weida suggest the names or did you?
A. I believe I did.
Q. Okay. Other than the length of time at the agency and bandwidth, what criteria -- did Mr. Weida give you any criteria in terms of picking the team?
A. I don't think so, no.
Q. Did you use any other factors other than the length of time at the agency and bandwidth to select this team?
A. I think it's still the same as historical knowledge. But I have worked very closely with D.D. and Matt in my various positions. I knew Matt had some knowledge of previous similar requests, as well extensive knowledge of the standard GAPMS process. And it was a team of three that was available. So I think that still kind of historical knowledge and bandwidth were really the biggest factors.

Q. You said Mr. Brackett had experience with previous similar requests. What were those previous similar requests?

A. I believe there was a GAPMS request in the past before my time with the agency that had to do with hormone treatment.

Q. Would it be -- and it was hormone treatment. When you say a similar request, was it for GAPMS?

A. Yes.

Q. Would it have been the cross-sex hormone therapy GAPMS that is Exhibit 4?

A. No.

Q. How do you know?

A. The date on this. The one I was thinking of was much earlier before my time.

Q. Before your time -- do you have any sense of when that might be?

A. Maybe 2016 or 2017.

Q. Do you know who the Governor of Florida was in 2016 or 2017? I'm sorry. It's not a test, I promise.

Was it Rick Scott?

A. Yes.

Q. Okay. And was the interim secretary at the time at AHCA, was it Justin Senior?

A. Yes.

Q. And was Beth Kidder there at that time at AHCA?
A. Yes.
Q. And all of those people are listed on this Exhibit 4 --
A. So my document has Beth Kidder crossed out and looks to be a draft document from May 20th, 2022.
Q. Is there a name that replaced Beth Kidder on that?
A. Ashley Peterson.
Q. Okay. Do you know when Ashley Peterson joined AHCA?
A. I believe it was 2021.
Q. Okay. And is it --
MR. PERKO: Counsel, it's 1:30. Are we going to stop for lunch?
MS. DEBRIERE: We can if you want to.
MR. PERKO: Do you want to? It's up to you.
THE WITNESS: At some point.
MS. DEBRIERE: That's fine. Can I just finish up here real quick.
BY MS. DEBRIERE:
Q. So is it possible that this document was created in 2017?
A. I'm looking at a document that has track changes that appear to be since then. But I don't know.

Q. Why do those track changes appear to be since then?

A. Since the date was updated to May 20th, 2022.

Q. Okay. There's some editing in the column. It's very faint. Can you see it?

A. Yes.

Q. And the initials of editor appear to be GS.

A. Yes.

Q. Do you have any idea who that would be?

A. No.

Q. Do you know anybody here with the initials GS?

A. I'm sure somebody here has those initials, but I don't know off the top of my head.

Q. So Mr. Brackett was involved with a GAPMS related to cross-sex hormone therapy, but it wasn't necessarily this one; is that right?

A. I don't know the level of his involvement, but I know that he had some knowledge or knew about it.

Q. Okay. Did he do any other GAPMS related to the treatment of gender dysphoria?

A. I don't know.

Q. Mr. Chen -- did he have any previous experience with GAPMS?

A. I don't know.

Q. Ms. Pickle -- has she had any previous

experience with GAPMS?
A. I don't know.
Q. And you've explained why Mr. Brackett, Ms. Pickle, and Mr. Chen were selected for the team. Why was Mr. Bottcher not selected?
A. I can't recall all the details of the decision. But Jesse Bottcher's team is one of the busiest in the bureau, and has a lot of time sensitive work that they are constantly working on. So I think that had something to do with it, since he is the manager of an entire section.
Q. I think you had previously testified there weren't a lot of GAPMS pending at the time this request come through; is that right?
A. I didn't know the bandwidth or the workload.
Q. Okay. You didn't know the bandwidth. So you didn't know if, for example, Mr. English had the bandwidth to handle the GAPMS report?
A. No.
Q. Do you want to take a break?
A. Yes.
(Brief recess.)
BY MS. DEBRIERE:
Q. Previously before break we were talking about the selection of Mr. Brackett to be on the GAPMS report

team for gender dysphoria. And you mentioned that he had drafted previous similar GAPMS in the past. And I believe you used the example of cross-sex hormones.

Were there any other similar requests that he drafted related to gender dysphoria in the past?

MR. PERKO: Object to form.

THE WITNESS: Just to clarify, I'm not sure if he drafted it.

MS. DEBRIERE: I'm sorry; yes.

THE WITNESS: I know he had some historical knowledge of previous GAPMS.

MS. DEBRIERE: Okay.

THE WITNESS: So can you repeat your question.

BY MS. DEBRIERE:

Q. Did he have hysterical knowledge of previous GAPMS related to gender dysphoria?

A. Outside of the one that I referred to earlier?

Q. No, including that one.

A. Yes, I believe he had some historical knowledge of previous GAPMS.

Q. Other than the one you referenced earlier, are you aware of any other GAPMS that he was involved in related to gender dysphoria?

A. I don't know the extent of all the GAPMS he was involved in.

Q. Also earlier when you were discussing your responsibilities under GAPMS, you mentioned routing.
A. Yes.
Q. Can you describe that a little bit.
A. As the bureau chief of Bureau of Medicaid Policy, any official documents that leave the bureau are usually reviewed by me. And so routing process is the hierarchy of reviewers through wherever the final reviewer or signatory or approver. That's what I was referring to by routing process.
Q. Okay. Does every GAPMS report have a routing process?
A. Yes.
MS. DEBRIERE: Okay. Can I have the 2016 GAPMS routing form. And we'll mark it as Exhibit 6.
MS. DUNN: I can tell from this exhibit that when we printed these the Bates numbering got cut off. So I will look it up and read --
MS. DEBRIERE: That's a bummer.
MS. DUNN: I know.
(Plaintiff's Exhibit No. 6 was marked for identification.)
BY MS. DEBRIERE:
Q. Okay. So do you recognize this document?
A. Not this specific document. But this appears

to be a policy routing and tracking form.

Q. And is that form the same as the form you currently use to track -- to route and track?

A. Sometimes.

Q. What other forms do you use?

A. Prior to the pandemic, we used this form primarily. Since returning to the office there have been different variations of routing and tracking forms developed for different teams or documents -- types of documents.

Q. Do you use the same routing and tracking form for GAPMS?

A. So I've only approved two GAPMS in my time. And I can't remember if this was the -- this format was what was used to route it to me.

Q. Okay. But there was a form used to route it to you when you approved -- when you approved your two GAPMS?

A. I believe so.

Q. Okay. And on this GAPMS form, it says prepared by Monique Johnson. What does it mean to be prepared by? Was the form prepared by Ms. Johnson? Or was the GAPMS report prepared by Ms. Johnson?

A. I don't know.

MS. DEBRIERE: Okay. Could I see the 2022

GAPMS. This will be Exhibit 7.

(Plaintiff's Exhibit No. 7 was marked for identification.)

BY MS. DEBRIERE:

Q. So I'm handing you -- and Gary will want to take a look at it too -- again, the first page of the document is entitled "Medicaid Policy Routing and Tracking Form." If you go through the entire document, it should also include the June 20, 2022, GAPMS report on treatment of gender dysphoria.

MR. PERKO: I believe it was June 2nd.

MS. DEBRIERE: June 2nd. Excuse me.

BY MS. DEBRIERE:

Q. So looking at the document -- the first page, is this the Medicaid Policy Routing and Tracking Form that was associated with the GAPMS report on the treatment of gender dysphoria?

A. Yes.

Q. How do you know?

A. These are my initials.

Q. Okay. So you've seen this before?

A. Yes.

Q. I do want to point out "prepared by" here. What does that mean?

A. That Matt Brackett prepared the routing

package.

Q. Okay. Did he also prepare the GAPMS report itself?

A. Yes.

Q. Do you know if the person who prepares the routing and tracking form -- if they are the person who also prepares the GAPMS report?

A. Can you repeat the question.

Q. The person who prepares the Medicaid Policy Routing and Tracking Form, do they also prepare the GAPMS report itself?

A. I don't know how all the team members are instructed to fill out the report or -- I'm sorry -- fill out the tracking form.

Q. Is there any other way to determine who has prepared a GAPMS report?

A. I don't know. But speaking in general assignments -- these forms are used for other assignments. And there are a lot of assignments that are done collaboratively. So, yeah. I don't know specifically how else you would know just looking at documentation.

Q. Would that information be contained on an AHCA shared drive?

A. It's possible.

Q. Okay. Is there a reason the GAPMS report doesn't identify an author on the report?
A. I don't know.
Q. Okay. A couple other things. On the section line here, it says Canadian Prescription Drug Importation Program. But we have established this was the routing and tracking form for the GAPMS report related to the treatment of gender dysphoria. Are those two things related?
A. So the Canadian Prescription Drug Importation Program is the section of who developed the report. And it lets us know how the hierarchy of the routing should go through the management levels within the bureau and outside.
Q. So it was the Canadian Prescription Drug Importation unit who prepared the GAPMS report on the treatment for gender dysphoria?
A. So that's what I would interpret this section -- why it's listed there next to this section. It's the section responsible for routing and lets us know the hierarchy of the management.
Q. Okay. And then just looking down at the "Reviewed by and Routing Timelines," the start date is June 1st, 2022, for everybody except Mr. Wallace; who has a date of June 2nd, 2022. And the end date is June

1st, 2022, except for Mr. Wallace. Does that indicate that you Mr. Weida and Ms. Pickle all reviewed the report and signed off on it on the same day?

A. That the official routing and the signature occurred on the same day, yes.

Q. What do you mean by official routing?

A. So the date that this form and the final routing package was ready for signature.

Q. And what was continued in the final routing package?

A. I believe it was just the report.

Q. Okay. So the final report -- what was being tracked through this routing and tracking form?

A. Yes.

Q. Were there any attachments to the final report that were also reviewed?

A. The expert witness reports were also reviewed. But I can't remember if they were included in this routing package at the same time.

Q. Who reviewed those final expert reports?

A. I don't remember.

Q. Did you review them?

A. I don't remember if I reviewed them all. But I had seen them -- at least some of them. I can't remember if I reviewed them all formally.

Q. Okay. Turning just back to the general GAPMS process. Is the GAPMS process ever initiated to assess existing coverage of Medicaid services?

A. Can you repeat the question.

Q. Is the GAPMS process ever used to assess existing coverage of Medicaid services?

A. I don't know specifically.

Q. Okay. Who would know that?

A. Are you asking if it ever has or ever would?

Q. Ever would.

Would Ms. Pickle know that?

A. So my personal experience with the GAPMS process is somewhat limited. But it is such a unique process. I feel it's hard to answer that without each situation or each request that we would get would be unique, because that process is dealing with questions that fall outside of something that's easily answered policy question.

MS. DEBRIERE: Have we entered the GAPMS rule into evidence yet? Can we do that now. And that's to be 59G-1.0 -- I thought we had. Oh, it's 5. Okay. Sorry. That's my fault.

MR. PERKO: That's fine.

BY MS. DEBRIERE:

Q. So a couple questions about the language of the

rule. First under (1)(b), "health services" is defined as diagnostic tests, therapeutic procedures, or medical devices or technologies.

Under what category would prescription drugs fall in this definition?

A. I don't know.

Q. You are familiar with the GAPMS rule, though; correct?

A. Yes. I've read the GAPMS rule.

Q. Would prescription drugs fall under any of these categories?

MR. PERKO: Object to form.

THE WITNESS: I don't know. I wasn't part of the original drafting of this rule text. So in order to interpret the policy, I would need to do research.

BY MS. DEBRIERE:

Q. Who would you ask?

A. I would probably start with Ashley Peterson.

Q. Okay. And going down to 3, the second sentence -- "The public may request that a health service be considered for coverage under the Florida Medicaid program by submitting a request."

What does this sentence mean to you?

A. There's much room for interpretation. It says

the public may request a public health service be considered for coverage.

Q. Does this sentence mean that the public may request that Florida Medicaid consider whether to exclude a service previously covered?

MR. PERKO: I'm going to object to form.

THE WITNESS: So I think it could. Not only do we update the coverage policies to include new services, but we do change the scope of a service as part of that process. So if there was a question that was not clear within the scope of the service, I can see how that might apply.

Or the example that you used earlier with a service that's only provided to under 21. If that service was -- if we received a request to make that service available for over 21. So I can think of examples where it wouldn't have to be a new service.

BY MS. DEBRIERE:

Q. Does this rule cover a public's request to take a service away?

MR. PERKO: Object to form.

THE WITNESS: I don't know.

BY MS. DEBRIERE:

Q. Okay. Who would know?

A. Public -- that would be a legal interpretation

or policy interpretation that would need consultation with the agency for me to answer.

Q. As the bureau chief of Medicaid Policy, you're responsible for developing coverage policies; correct?

A. I oversee the teams that develop coverage policies, yes.

Q. And you are responsible for overseeing the teams that develop administrative rules to implement those coverage policies; correct?

A. Yes.

Q. So you would be responsible for understanding how rules that implement coverage policies should be interpreted.

MR. PERKO: Object to form.

BY MS. DEBRIERE:

Q. Is it your responsibility to understand the content of this rule?

A. Yes.

Q. Okay. But you can't tell me how to interpret that second sentence in Subpart 3?

A. So if we received a request and I wasn't clear on the authority, there's several steps I would take to confirm that the agency's position is we have authority -- which would be to review any other applicable laws or regulations; would be to consult with

my team and with agency management and perhaps with legal if I was not sure whether a specific question or scenario that was received. We may not have the authority to take an action.

Q. So when reading the second sentence in Subpart 3 -- "The public may request a health service be considered for coverage" -- in order to understand what that sentence means, would you undertake any of the steps you just described?

A. It would depend on the exact question. If I wasn't clear with what the request was and how that authority applied, then I would take further steps to make sure that I understood how the rule applied to the request.

Q. Did you do that for -- okay. Okay. Let me make a note.

In the legal consultation part, it trigged me to remember just a housekeeping question. At lunch did you speak with your attorneys --

A. No.

Q. -- about the deposition?

A. No.

Q. Okay. Does the GAPMS process typically look at an individual service when you're undertaking analysis?

A. I don't know.

MS. DEBRIERE: Okay. Can I have either the Van Mol or Van Meter ATF. It doesn't matter. And we'll mark that as Exhibit 8.

(Plaintiff's Exhibit No. 8 was marked for identification.)

BY MS. DEBRIERE:

Q. So at the top of the page you have a -- did you approve this document?

A. Yes.

Q. Okay. So under "Reason for Occurrence," it says, "On April 20th, 2022, the Bureau of Medicaid Policy received a request for a time-sensitive analysis of service coverage. While such requests are typically for a single service or good --" Is that a correct statement?

A. I don't know.

Q. But you wrote this?

A. No. I signed this.

Q. Okay. Were you the one making the request?

A. No.

Q. Who was making the request?

A. Devona Pickle.

Q. Okay. Before you sign something, do you have to agree with the language contained therein?

A. Yes.

Q. So at the time you signed this, you agreed with the statement that such requests are typically for a single service or good?

A. Yes.

Q. Okay. But now you don't know if GAPMS are typically used for a single service or good?

A. My experience with GAPMS is limited. And I trust the expertise of my staff. And one of the reasons I asked or had recommended that this team be responsible was because of their historic knowledge of the GAPMS process.

Q. And when you say that, that includes D.D. Pickle; correct? You trust her expertise on the GAPMS process?

A. Yes.

Q. Okay. Are you aware of a standard operating procedure used for the GAPMS process?

A. I've heard mention of it. But I don't believe I've ever seen it.

Q. Who did you hear mention of it from?

A. I can't remember. Either Matt or Jesse.

MS. DEBRIERE: Okay. Can I have what we'll mark as Exhibit 9, which is the GAPMS Decision Tree Checklist.

(Plaintiff's Exhibit No. 9 was marked for

identification.)
BY MS. DEBRIERE:
Q. Do you recognize this document, Ms. Dalton?
A. I believe I've seen this before.
Q. Do you know what it's used for?
A. I believe this was developed to determine if a request just goes through the coverage determination process or should be handled as a GAPMS.
Q. Okay. And tell me the difference between a coverage determination and something that needs to go through the GAPMS.
A. I don't know everything that goes into how that decision is concluded. But in general, a coverage determination is when it's very clear that the agency has the authority to add a service and that it meets all of the agency's rules and -- for example, an optional state plan service that the agency currently doesn't cover but is clearly allowed through federal CMS would be a coverage determination. Where the GAPMS process is driven by the rule you referenced earlier that describes when it's not clearly meeting all the requirements and laid out in the current coverage policies.
Q. So much earlier in the deposition you gave an example of a coverage determination of a medical supply for -- was it Amino Foods?

A. Puro Meno.
Q. Puro Meno Foods. Why didn't you use the GAPMS process for that? Did you use the GAPMS process for that?
A. No.
Q. Why not?
A. Because the agency already covered similar products.
Q. Okay. Was that the only factor in determining whether to assess it using GAPMS?
A. I don't remember the conversations with the team when I was briefed on the recommendation.
Q. Was a GAPMS Decision Tree Checklist done for Puro Meno Foods?
A. I don't believe so. I never saw one, no.
Q. Okay. Who undertakes the process to fill out the decision tree?
A. I don't know.
MS. DEBRIERE: I apologize. Can we take just a two-minute break.
MR. PERKO: Sure.
(Brief recess.)
BY MS. DEBRIERE:
Q. Do you know how to interpret the answers on a decision tree checklist?

A. No, I don't believe I've ever seen one filled out.

Q. Okay. There's a space here that says "GAPMS Topic." What would go in that space? Do you know?

A. I don't know.

Q. Would a decision tree checklist be generated for every GAPMS request that comes in?

A. I don't know.

Q. Who would know that?

A. I don't know. I don't know if this is still the internal process. I don't know.

Q. Who would know whether it was still the internal process?

A. Jesse Bottcher.

Q. Okay. Would the members of Jesse Bottcher's team also know?

A. No, I don't think anyone currently on his team would know.

Q. How about anybody previously on his team -- I'm sorry; back up.

So no one on Jesse Bottcher's team is in charge of the GAPMS process?

A. The GAPMS position is currently vacant.

Q. Would anybody who was in charge of the GAPMS process at some point know whether the decision tree

checklist is used in the GAPMS process?
A. I don't know.
Q. And there's only one position that would know that, and that is currently vacant; correct?
A. I believe so, yes.
Q. And what is that position called?
A. I believe it's a Government Analyst II.
Q. And so there's just that one position in charge of knowing the GAPMS process?
A. As far as I know, yes.
Q. Okay. We touched on this a bit earlier. Does AHCA use the GAPMS process for prescription drugs?
A. I don't know.
Q. When you were giving an example of similar requests that Mr. Brackett handled for GAPMS, the example you gave was cross hormone therapy; correct?
MR. PERKO: Object to form.
THE WITNESS: I believe that was the example I gave.
BY MS. DEBRIERE:
Q. And what is cross-sex hormone? What is a hormone?
A. I don't think I can recite the clinical definition.
Q. Is the hormone a prescribed drug?

A. I believe so.
Q. So then you're aware of one instance in which GAPMS was used for determining -- for assessing a prescription drug?
A. Yes.
Q. But you don't know generally if GAPMS is used to assess prescription drugs?
A. My knowledge of GAPMS is limited. So to speak in generalities -- but I do see where in 2016 there was the GAPMS on hormone suppression.
Q. Okay. Is GAPMS the only method AHCA relies on to determine whether a Medicaid service is experimental?
A. I don't know. I know we have a clinical trials coverage policy. So there may be circumstances where it's clear that coverage would be -- that coverage policy or the clinical trials rule would apply. And I don't know all the details of how the QIO vendors -- what that process, all that entails.
Q. Whether the QIO venders would determine whether something is experimental?
A. Or if it was clear the clinical trial policy would apply instead. So I don't know to the extent of if there could possibly be.
Q. What is the clinical trials policy?
A. It's a rule that outlines the agency's coverage

for recipients participating in a clinical trial.

Q. And what does that type of authorization entail?

A. I don't know the specifics.

Q. Is GAPMS the only method that AHCA relies on to determine whether a Medicaid service is experimental and therefore should be excluded?

A. Can you repeat the question.

Q. Is GAPMS the only method that AHCA relies on to determine whether a Medicaid service is experimental and therefore should not be covered?

A. I don't know the specifics. But if, for example, a pharmaceutical is not FDA approved, there would be perhaps, like, a different process where it wouldn't have to go through the process.

Q. What is the significance of a drug being FDA approved for the purposes of coverage?

A. I don't know the details.

Q. What do you know about it?

A. I believe there's federal requirements on if a drug is not FDA approved -- there is certain coverage requirements.

Q. Do you know if that relates to the compendia we were earlier talking about?

A. I don't know.

Q. Okay. If AHCA is determining whether a production drug is experimental, does AHCA consider whether the drug is FDA approved?

A. I believe so.

Q. If a particular use for a drug has been FDA approved, can AHCA deem the drug experimental for that use?

A. Can you repeat the question.

Q. If a particular use for a drug has been FDA approved, can AHCA deem that drug experimental for that use?

MR. PERKO: I'm going to object to form.

THE WITNESS: I don't know.

BY MS. DEBRIERE:

Q. But FDA approval bears on a determination as to whether AHCA will cover a drug; is that correct?

A. Yes, I think it's considered.

Q. If it's not -- if a drug is not FDA approved, are there circumstances under which AHCA will still cover the drug?

A. I don't know. But I think there is federal regulations around what's allowable.

Q. In the Federal Medicaid Act?

A. I believe.

Q. You mentioned just a second ago, a clinical

trials coverage policy. Where does that policy live?
A. In Rule Class 59G on our website.
Q. If it's not there where would we find it?
A. In the Florida Administrative Code.
Q. It should be in Chapter 59G?
A. But it should be on our website.
Q. Okay. And it is adopted as a rule?
A. Yes.
Q. Okay. Once AHCA reaches a decision through the GAPMS process, describe the implementation of that decision.
A. So, again, in my experience -- I've only been bureau chief for two finalized decisions that were different. And I can't remember all the steps to implementation. But once a determination of any coverage is made, then there's a process of how to notify the public. There's a process for notifying the plans of changes if it affects the plans. There's a process of making sure that the -- any other associated rules that may be impacted are updated.
Q. Anything else?
A. If a training is needed, it depends on what it is. But there could be other.
Q. Who would you train?
A. So, again, just speaking generally -- the

managed care plans; the public; if it's fee for service, the providers; especially if it has to do with submitted claims.

Q. What are the two final reports that you have overseen as bureau chief?

A. So it was the GAPMS that we're discussing today.

Q. And, again, that's the one that relates to treatment of gender dysphoria?

A. Yes. And then the -- I can't remember the exact name of the other GAPMS. But it was through a managed care plan request.

Q. Was it an expedited GAPMS?

A. I don't believe so.

Q. Do you remember what the service was at issue?

A. I do not.

Q. Okay. And the process for an expedited GAPMS, that's different from the traditional GAPMS process?

A. I'm not sure of the differences outside of the timeframe.

Q. Is it different as to how you would inform the public about it?

A. I don't know. I can't recall what steps we took after notifying the plans of the final decision.

Q. Okay. Through the traditional GAPMS process --

do you have any GAPMS right now that are in the final stages?

A. No.

Q. Okay. And you don't know how many requests are currently pending?

A. I don't know.

Q. So the last GAPMS that was finalized was in June of 2022?

A. Yes.

Q. Okay. And now we're in February of 2023. And there's no GAPMS that are ready for finalization at this point?

A. I don't know what stages of development they are.

Q. Okay. Is there anything on your desk to review?

A. I don't know. I don't remember if I have anything pending.

Q. Okay. When you were meeting with Mr. Weida about the June 2022 GAPMS report related to the treatment for gender dysphoria, that report had not been drafted; correct?

A. Sorry. Can you repeat that.

Q. Yeah. Absolutely. So earlier you spoke to meeting with Mr. Weida once you received the request

from the secretary to undertake the GAPMS for treatment of gender dysphoria; do you remember?

A. Yes.

Q. During that meeting had the GAPMS report been drafted yet? I know it seems like a silly question. But I'm asking at face value.

At the time you met with Mr. Weida, had the GAPMS report been drafted yet?

A. The GAPMS report I was discussing with him? No.

Q. Okay. But you have a good memory of that report before it was even drafted; is that right? You were able to recount details to me about discussing that report about before it had been drafted; is that right?

A. Throughout the process there had been discussions. But I don't know if I remember all the details.

Q. What I'm wondering is just why that report sticks out in your mind, but now you can't recount any other GAPMS reports that are pending. Is there a reason for that?

A. I have a lot of documentS in my queue at any one time. And it's really on the onus of the analyst -- part of their job responsibilities -- to make sure assignments are completed and finalized and routed and

closed. So because there was discussion and updates on the status and progress of the report -- and it was not that long ago -- I remember having conversations about the report.

Q. There are GAPMS reports pending right now, though; right?

A. I don't know. I don't know what the GAPMS queue is right now.

Q. Okay. So you don't know if there's anything in the queue right now?

A. Correct.

Q. But you do remember details about the GAPMS report related to treatment of gender dysphoria?

A. Details on the process?

Q. Yeah.

A. Yes.

Q. Okay. When I say "rulemaking process," do you understand what I'm referring to?

A. Yes.

Q. And do your current responsibilities at AHCA include the rulemaking process?

A. Yes.

Q. Can you describe those responsibilities.

A. I review drafts of the coverage policy and the documents that go along with the rule promulgation

process. I sometimes participate in the public meetings and review provider alerts or other notices associated with the process.

Q. Anything else?

A. Not that I can think of.

Q. Okay. Do you ever review public comment associated with the rule?

A. It depends.

Q. So you have before?

A. More in my old role as the AHCA administrator.

Q. Okay. Can you remind me the dates you were in that role.

A. August 2018 to August 2021.

Q. And in your previous roles at AHCA as well as DOEA, you had rulemaking responsibilities; is that right?

A. DOEA was more of the drafting of the policy and not the promulgation process.

Q. Okay.

A. And then AHCA has been more on the promulgation process -- administrative process.

Q. So you'd say you had experience with Florida agency rulemaking?

A. Yes.

Q. When I say "rule workshop," do you understand

what I'm referring to?

A. Yes.

Q. When I say "rule hearing," do you understand what I'm referring to?

A. Yes.

Q. What is the difference?

A. Chapter 120 has different public meetings outlined in different stages of the process. The workshop as we use it here is primarily for the rule development stage of the administrative process. And the hearing occurs at the proposed rule stage.

Q. Okay. When you say the development of the rule, does that mean generally the rule language itself has not yet been drafted or proposed?

A. It depends.

Q. Okay. So is there a difference between workshop and hearing?

A. They're both public meetings meant to garner input from the public and make the public aware of the changes. But per Chapter 120, there are differences because of the different stages of the process.

Q. Okay. Why was there no public workshop held for the rule development of the change to Rule 1.050 excluding the treatment for gender dysphoria?

A. I don't know.

Q. Were you here were when that happened?
You were?
A. Yes.
Q. Okay. While here, have you had public comment on rule workshops for other rules?
A. Can you repeat the question.
Q. Since you've been here at AHCA, have you -- let me ask this question: When the rule was developed to exclude treatment of gender dysphoria per 1.050, were the you bureau chief for Medicaid Policy?
A. When the rule was promulgated?
Q. Well, when you were having the -- when you noticed the proposed rule and had the rule hearing.
A. For this specific rule?
Q. Yes.
A. Yes.
Q. Okay. In your role as bureau chief, have you ever -- in your role as bureau chief, have you been involved in rule workshops for other rules?
A. Yes.
Q. So why weren't you involved in the rule workshop for the exclusion of treatment for gender dysphoria; do you know?
A. I can't remember. I believe I was out of town.
Q. Okay. If you weren't out of town, would you

have been involved in it?

A. I don't remember the discussion around that. But I'm not always involved in the workshops or rules.

Q. How is that determined?

A. It depends on the circumstances and the content of the rule. But I can't remember the specific conversation when that was determined.

Q. Was there a public workshop for the exclusion of the treatment for gender dysphoria? There was only a public hearing; correct?

A. I know there was only one public meeting. I can't remember.

Q. Generally what's the process for planning a rule hearing?

A. We determine a date, a location, and who will be in attendance. And the date and location is included in the notice.

Q. And when you say who will be in attendance, who does that mean?

A. Who the subject matter experts or other agency staff will conduct the public meeting.

Q. Okay. And what do you mean by subject matter expert?

A. So I think I described it a little before how for most of the coverage areas there is a specific

analyst responsible for the development of that policy. So, for example, if there was a change to respiratory services, whoever that suggest matter expert or analyst is would typically be present at the workshop since they have the in-depth knowledge on the changes being proposed.

Q. Is that person always a person employed by the agency?

A. The subject matter expert for all our coverage policies are individuals employed with the agency.

Q. Okay. Are there any written protocols regarding the planning of a rule hearing?

A. I know we've developed process maps and procedures. But I don't know the details of planning a hearing specifically and how detailed those documents are on that process.

Q. What's a process map? What does that entail or detail?

A. There's a graphic that was created before my time that -- it's a real nice layout of the administrative rulemaking process.

Q. Okay.

A. And so it has -- it's a graphic, and it's one page. So it's easy to put on your wall.

Q. And your responsibilities include sometimes

attending rule hearings?

A. Yes.

Q. Since you've been the bureau chief, how many rule hearings have you attended?

A. I don't think I've attended any hearings.

Q. As a State agency employee -- either at DOEA or AHCA -- how many rule hearings have you attended?

A. So at DOEA I attended several AHCA rule hearings in the audience. In my previous position with the agency, I think it was only a handful.

Q. Does that mean five?

A. Yes; I'd say five or less.

Q. Okay. Who else from AHCA attends rule hearings? Let me ask this: Are there AHCA staff who attend rule hearings as part of their job description -- they have to be at every rule hearing?

A. I don't know if that's actually in the job descriptions. But Cole and his team -- since they set up the workshop or hearing or the public meeting -- their responsibilities include making sure they have the speaker list, making sure that everybody is escorted into the building, that the speakers can be heard. So they're in attendance for all of the public meetings.

Q. Okay. And do you know if they have any protocol off which they operate -- written protocol for

conducting the hearing?

A. I believe there's an internal process and process map. But I don't know the details off the top of my head what's included in that document.

Q. Is it the rules unit that is in possession of that document?

A. I would think so, yes.

Q. Okay. In your experience, aside from the agency who attends the hearing?

A. From the public?

Q. I mean, I think that would be the only other option; right?

What types of people from the public?

MR. PERKO: Object to form.

THE WITNESS: That would really depend on what the change is and who is impacted.

BY MS. DEBRIERE:

Q. In your experience attending public hearings -- rule hearings -- are there typically more than 25 people from the public that show up at the rule hearing?

A. I would say yes. Especially since the hearings are now -- have a virtual option. The majority of them are virtual and in person.

Q. Are there typically more than 25 people who show up in person?

A. So I haven't participated in all of them. In the last few that I participated in, there was not 25.

Q. In the last one you participated in how many were there?

A. Less than ten.

Q. Does AHCA ever invite specific persons from the public to attend the rule hearings?

A. Yes.

Q. And how do they do that invite?

A. A provider alert is sent out to the providers. Usually that goes along with the FAR notice that was posted and the public was noticed. If it's a sister agency, it might be by email. So if we believe a rule might impact a sister agency, we might reach out specifically.

Q. So other than posting the public notice and the FAR provider alerts and emails to potentially impacted sister agencies, is there any other way the agency invites specific people to attend the hearing?

A. I believe we sent calendar invites before.

Q. To what people? How did you decide on sending calendar invites?

A. The specific example I'm thinking of is a sister agency for the iBudget handbook. We invited ADP to participate and sent them a meeting invite so they

can block that time.

Q. Okay. Have you ever invited Medicaid recipients other than through the public notice to attend a rule hearing?

A. I don't know, outside of the public notice process.

Q. In your experience?

A. I personally have not.

Q. Okay. Do any State agencies in hosting a rule hearing, do they arrange for transportation for individuals from the public to attend that hearing?

MR. PERKO: Object to form.

THE WITNESS: I can't speak for any other agency. I don't know.

BY MS. DEBRIERE:

Q. What about at DOEA? Did that ever happen?

A. I don't believe I ever participated in an actual public meeting hosted by DOEA.

Q. That's right. You said that.

What about AHCA? Are you aware of AHCA ever arranging transportation for individuals from the public to attend a hearing?

A. Not that I'm aware of.

Q. Are you aware of anyone from the public being paid to attend a hearing?

A. No.
Q. Are you aware of anyone who is a subject matter expert being paid to attend a hearing?
A. I know we've reimbursed the subject matter experts. But I'm not sure if that was specifically -- attending the hearing was specifically included.
Q. And these are subject matter experts that are employed with the agency?
A. I don't know how that process works. But they're not full-time employees with the agency. I believe it's like consultants.
Q. Okay. What's the average length of a hearing?
A. I don't know the average. I know our public meetings typically range between 30 minutes and two hours.
Q. Okay. On average how many comments do agencies receive for a rule hearing? Is there an average?
MR. PERKO: Object to form.
THE WITNESS: I don't know.
BY MS. DEBRIERE:
Q. Do you think 100 comments is a lot of public comments to receive at a hearing?
MR. PERKO: Same objection.
THE WITNESS: I really don't know.
BY MS. DEBRIERE:

Q. In your experience, does a State agency ask outside legal counsel to attend and perhaps in rule hearings?

A. Can you repeat the question.

Q. In your experience, does a State agency normally ask that outside legal counsel attend a rule hearing?

A. I don't know.

Q. When you planned this last rule hearing, did you ask outside legal counsel to attend?

A. Can you specify which hearing.

Q. Yeah. There was a hearing a couple of weeks ago on the change to the medical necessity definition.

A. Yes. The workshop.

Q. Workshop. Did you ask outside legal counsel to attend that workshop?

A. I personally did not.

Q. Did outside legal counsel attend that workshop?

A. I don't believe so.

Q. And have you ever attended a rule hearing where outside legal counsel was asked to participate in?

A. I can't recall if that circumstance has ever happened.

Q. So it's not usually -- it's not the standard course of things for outside legal counsel to attend?

A. Correct.
Q. All right. Turning to the exclusion for treatment of gender dysphoria under Rule 59G-1.050. Prior to the adoption of this exclusion, did any coverage policies regarding any of the services listed there -- sorry. Strike that.
Prior to the adoption of the exclusions set forth -- I'm not sure you're looking at the right rule. 59G-1.050. Exhibit 2. It would help me to tell you the exhibit number. And then it's Subpart 7.
So prior to the adoption of that rule -- that Subpart 7 -- did any coverage policies exist regarding the services that are now subject to that exclusion?
A. Can you repeat that question.
MS. DEBRIERE: Court Reporter, can you read back that last question.
(The preceding question was read back by the reporter.)
THE WITNESS: There was not a specific coverage policy for services for the treatment of gender dysphoria.
BY MS. DEBRIERE:
Q. Does that mean those services were never covered to treat gender dysphoria by Florida Medicaid?
A. I don't believe there was any policy language

that specifically outlined coverage of the services listed in this section.

Q. If there was no specific policy language, does that then mean those services were not covered to treat gender dysphoria by Florida Medicaid?

A. I don't know the extent to what providers were reimbursed for providing the services.

Q. So even if there wasn't a coverage policy specifically related to these services, it's possible that Florida Medicaid was covering the services for the treatment of gender dysphoria?

A. It's possible Florida Medicaid reimbursed for these.

Q. Are there circumstances in which AHCA might not have an explicit or affirmative coverage policy, but would consider a request for a service on a case-by-case basis?

A. Can you repeat the question.

Q. Are there circumstance in which AHCA might not have an explicit coverage policy regarding those services -- or any service -- but would consider a request for a service on a case-by-case basis?

A. I don't know specifically if it's case-by-case basis. But I believe that the plans -- that some of the request from the managed care plans may be specific to a

request for a specific coverage. So when plans request for a GAPMS to be provided, it could be being driven by a specific case.

Q. Okay. So even though a coverage policy does not exist regarding the coverage of a specific service, there are circumstances in which AHCA might still cover that service?

A. Yes.

And I apologize. On your last question I think I heard you specific about GAPMS, which is what I answered. So I apologize.

Q. That's okay. No, that's fine. You're referring to not the last question, but the question before that; is that right?

A. Yes.

Q. Okay. But your response on that last question, you understood the question?

A. Yes.

Q. Okay. Will Florida Medicaid cover an EPSDT service if that service is experimental?

A. So in order for an EPSDT service to be covered, it has to meet the definition of medical necessity.

Q. And that medical necessity definition includes the requirement that the service not be experimental?

A. Yes.

Q. Okay. So you received a request from Secretary Marstiller via email to engage in a GAPMS regarding treatment for gender dysphoria; correct?
A. I can't remember if it was email.
Q. Right. But you received the request somehow?
A. Yes.
Q. And roughly when was that; do you remember?
A. I don't remember.
Q. And then the next step was speaking with Mr. Weida about the letter?
A. Yes.
Q. And developing the plan as to who was going to --
A. Yes. Developing how the process would work.
Q. Were all the decisions reached in that one meeting with Mr. Weida?
MR. PERKO: Object to form.
THE WITNESS: No.
BY MS. DEBRIERE:
Q. Okay. So after that meeting with Mr. Weida, what happened next?
A. I can't remember the exact timeline of events. I know we met at some point with the Canadian Prescription Drug Importation team.
Q. And they were the ones who were put in charge

of doing this GAPMS?
A. Yes.
Q. Okay.
A. And there was several conversations following that.
Q. Were those conversations limited to yourself, Mr. Brackett, Mr. Chen, and Ms. Pickle? Or were there other people involved?
A. I can't remember the chronology. I know after the report and then into the rulemaking Cole Giering was brought into the conversation. Legal counsel -- there was conversations with the experts.
Q. Who were the experts?
A. I can't remember all their names. I don't know if we have that list here.
Q. Did you ever personally speak with any of the experts?
A. No.
Q. Are all the experts listed here on what would be will be your Exhibit 7 on page 45?
A. I believe so, yes.
Q. Was a Dr. Von Mol ever involved as an expert?
A. I believe so.
MS. DEBRIERE: And let me just mark this as Exhibit 10.

(Plaintiff's Exhibit No. 10 was marked for identification.)

BY MS. DEBRIERE:

Q. And this is a document -- an After the Fact Request Form Under 35K. This form is indicating what?

A. Consultant services for vendor name Andre Van Mol.

Q. And what kind of consulting services did Dr. Van Mol provide?

A. I don't know all the details of that -- what the contractor provided. But it was as part of the GAPMS process.

Q. Okay. Why was it time sensitive? It indicates on that form it was time sensitive. Why?

A. I don't know why the request was time sensitive.

Q. Who would know that?

A. I don't know.

Q. Okay. At any time throughout the process did you feel like there was an urgency to the development of the report and rule?

A. Yes. The time sensitive nature was communicated.

Q. By?

A. I don't know remember if it was in the original

request or if it was later in conversations with leadership. I can't remember exactly who. But I think the expectation to follow the process but work as quickly as possible was apparent.

Q. Okay. But you cannot provide me an explanation as to why it was identified as time sensitive?

A. Correct.

Q. I believe we already marked ATF to Dr. Van Meter as Exhibit 8.

Dr. Van Mol -- do you know if he attended the rule hearing for the exclusion of treatment for gender dysphoria?

A. I don't know.

Q. Okay. What does this document, Exhibit 8, indicate to you?

A. An approval for consultant services for vendor named Quintan Van Meter.

Q. Okay. And what kind of services did he provide in exchange for that reimbursement?

A. Consultant services.

Q. Consulting on what?

A. As part of the GAPMS process.

Q. Do you know what specific stages he provided consultation on?

A. I don't.

Q. Do you know whose idea it was to use him?
A. I don't.
Q. Do you know whose idea it was to retain any of the outside experts?
A. No.
Q. Was it internal to AHCA, that decision? Did someone at AHCA decide to retain outside experts?
A. I don't know.
Q. Who would have made that decision?
MR. PERKO: Asked and answered.
THE WITNESS: I don't know.
BY MS. DEBRIERE:
Q. Are you aware of AHCA retaining outside experts for any other GAPMS report?
A. I don't know.
Q. Other than Dr. Van Meter and Dr. Van Moll -- I'm sorry.
Was there a Dr. Grossman involved in the process?
A. Yes.
Q. And what was Dr. Grossman's role?
A. I believe it was the same -- consultant services.
Q. For the development of the report?
A. Yes.

Q. Okay. Do you know if they were reimbursed to participate in the hearing?

A. I don't know.

Q. Okay. Were any of the -- other than Dr. Van Mol and Dr. Van Meter -- was Dr. Brignardello-Petersen reimbursed by AHCA for consultant services related to the development of the exclusion of treatment for gender dysphoria?

A. I don't know off the top of my head.

Q. What about Dr. James Cantor?

A. I don't know off the top of my head without consulting if there was an invoice.

Q. Is that true for all the experts?

A. I can't remember how exactly the contracts -- the contracted services were reimbursed.

Q. Were they reimbursed?

A. They were.

Q. Looking at Van Meter's form -- why did you sign that form for a $34,000 reimbursement if you didn't know what Van Meter was doing?

MR. PERKO: I'm going to object to form.

THE WITNESS: So I know that Van Meter was consulting as part of the project. I just don't know throughout the process all the specific details of that consultation.

BY MS. DEBRIERE:

Q. Would you assume each expert listed was similarly compensated for the amount that Dr. Van Meter and Van Mol were compensated?

A. I'm not going to assume. Just looking at the two invoices, they are very different.

Q. In what ways?

A. This one has a not to exceed amount. And then this one has as dollar amount.

Q. Okay. Is that the only way they're different?

A. No.

Q. How else are they different?

A. The one for Quinton Van Meter has specific information regarding his MFMP registration.

Q. What is MFMP?

A. My Florida Market Place.

Q. Okay. Any other ways that they're different?

A. Some of the other language is different. The dates are different. But aside from that, no.

Q. How often do you approve an After the Fact Request Form for reimbursement of outside expertise?

A. Not often.

Q. How many times have you done it for expertise not related to the treatment of gender dysphoria?

A. I can't recall if I actually approved the

invoice; but I believe there was a consultant for the Canadian Prescription Drug Importation Program at one point. And I just can't remember the time.

Q. Is that the only time you can remember?

A. Yes.

Q. Okay. So when you were approving these forms that don't come across your desk often, do they strike you as something that needed careful review?

A. The invoice itself?

Q. The reason for reimbursement.

A. Yes. But the invoice itself seems pretty straightforward that a reimbursement based on services provided -- that had already been provided would be signed.

Q. Did you do a carful review of the reason for reimbursement?

MR. PERKO: Object to form.

THE WITNESS: I guess I'm not sure what you mean by careful review. I personally was not involved in all of the consultation services provided. But I did meet with the team and knew that services were provided.

BY MS. DEBRIERE:

Q. Prior to you receiving this request for reimbursement, did you know these experts were being

relied on for consultation?
A. Yes.
Q. Did you have to approve that request?
A. I don't know if there was a request initiating the services. I don't remember.
Q. Was there a need to approve the decision to rely on outside experts?
MR. PERKO: Object to form.
BY MS. DEBRIERE:
Q. Was there a requirement that consulting with outside experts be approved prior to the consultation?
MR. PERKO: Object to form.
THE WITNESS: Can you repeat that question.
BY MS. DEBRIERE:
Q. Was there -- who consulted with the outside experts?
A. Again, I don't know the extent of what the consultation services were or who all was part of that.
Q. In order for them to -- in order for the team to develop the GAPMS report -- who wrote it -- in order for them to consult with outside experts, did it require your approval?
A. I don't recall ever approving them.
Q. And the team relying on outside experts to write the GAPMS report on gender dysphoria, did it

require the approval of D.D. Pickle?

MR. PERKO: Object to form.

THE WITNESS: I can't recall how the formal process was initiated.

And I do want to say relying on experts -- there was a lot of additional research done as well as part of the GAPMS process. So I wanted to clarify that.

BY MS. DEBRIERE:

Q. But part of writing the report was consulting with these outside experts; correct?

A. Yes.

Q. And you don't know who made the decision to consult with those experts; is that right?

A. Correct.

Q. Whoever made the decision -- we don't know who that is. But whoever made the decision, did they require approval before they could implement that decision?

MR. PERKO: Object to form.

THE WITNESS: I don't know.

BY MS. DEBRIERE:

Q. Okay. As the bureau chief who oversees the team who wrote this GAPMS report, did you have an expectation that they would come to you for approval to

consult with outside experts that would then be paid?
A. Can you repeat that.
Q. As the bureau chief, the person who oversees the team that wrote the GAPMS report on treatment for gender dysphoria, did you have an expectation that they first ask you permission before they consulted with outside experts who charged for their services?
A. No.
Q. Why didn't you have that expectation?
A. I can't really answer that, as I was not part of the decision to consult with the experts.
Q. Who was part of the decision?
A. I don't know.
Q. But you know you were not part of it. Okay.
At the bottom of the After the Request Form, it states -- for Dr. Van Mol, which is Exhibit 10 -- it states supervisor approval is required. What does that mean?
A. In the routing hierarchy for approval.
Q. Approval of what?
A. For invoices for My Florida Marketplace. I'm the direct supervisor of D.D. Pickle.
Q. So your approval is required for D.D. Pickle to pay this bill?
A. Yes.

Q. Okay. But your approval was not required for D.D. Pickle to incur this bill?

MR. PERKO: Object to form.

THE WITNESS: I don't remember if there was a formal approval to initiate the services.

BY MS. DEBRIERE:

Q. Did you have to have approval to authorize this payment to Dr. Van Mol?

A. I can't remember. I don't know where this goes next in the routing.

Q. Okay. Did you ask permission to approve this from anyone?

A. I can't remember a specific conversation. But I knew it was approved by the agency to consult with -- to have the consultant services.

Q. Okay. Related to that, the last sentence is -- how did you know that?

A. How did I know what? Can you repeat that.

Q. I think you had responded that you knew the agency had approved it. And so my question was: How did you know that?

A. I don't remember the specific conversation. But I do know that it was approved by leadership.

Q. And how do you know that?

A. There must have been a conversation. I just

can't remember an exact -- if there was an exact conversation or a document I signed. I can't remember.

Q. Okay. Do you remember who you had the conversation with or had the document signed by?

A. I don't remember.

Q. The last sentence under that first paragraph, it says, "Verification of the availability of funding and approval from executive leadership was obtained prior to any work being conducted for this project."

Who was that executive leadership?

A. The majority of my discussions were with my direct supervisor. But Tom Wallace ultimately signed the report. And I don't know outside of that who all was involved.

Q. Do you need a break?

A. Yeah.

(Brief recess.)

BY MS. DEBRIERE:

Q. Who decided the amount in those forms?

A. I don't know how the amount was negotiated.

Q. Did you follow up on the amount being requested -- ask any questions about it?

A. I can't remember if I asked any questions. But, again, as it states on the form -- the availability of funding approval for leadership.

Q. So you think whoever that leadership was had approved that amount?

A. I don't know how the reimbursement for the services was negotiated.

Q. Okay. So you didn't ask any questions about the amount or what it was being used for?

MR. PERKO: Object to form.

THE WITNESS: I knew what it was being used for. But I can't remember if I asked any questions about the amount.

MS. DEBRIERE: Okay.

THE WITNESS: I can't recall any.

BY MS. DEBRIERE:

Q. Are there any subject matter experts for the services listed in that exclusion that are full-time employees with the agency?

MR. PERKO: Object to form.

THE WITNESS: I don't believe so, since the services outlined in the policy were not clearly outlined in any existing coverage policy that would have had any subject matter expert assigned to the coverage policy.

BY MS. DEBRIERE:

Q. Do you have a subject matter expert in surgery?

A. I don't know if it's one person or more than

one. We have an area that's responsible for the coverage policies we talked about earlier that contain coverage for surgical procedures.

Q. So you have a subject matter expert for outpatient hospital services?

A. Yes.

Q. And do you have a subject matter expert for inpatient hospital services?

A. I don't know if it's the same person.

Q. Okay. But do you have a subject matter expert in inpatient, it just might be the same person?

A. There's a team responsible for oversight of those policies, yes.

Q. Was that team involved in the development of this GAPMS report?

A. Not to my knowledge. But I can't speak to all of the research and activities that were part of the completion of the project.

Q. Who is that team -- that team that are the suggest matter experts in inpatient and outpatient hospital services?

A. That would be John Matson under Jesse Bottcher who is responsible for primary and preventive surgeries, including dental.

Q. Okay. You had mentioned before the break that

you had communications about the development of the GAPMS report with legal counsel; is that correct?

A. I believe so. I can't remember if it was part of the report or part of the rule. I know for sure with the rulemaking process that legal is involved in that process normally. And they were in this instance as well.

Q. Did that legal include outside counsel?

A. I don't know. I don't remember meeting with outside counsel.

Q. Okay. You don't remember with meeting with Holtzman & Vogel, the law firm?

A. No.

Q. Did you communicate with any other State agencies like the Florida Department of Health about the GAPMS report?

A. I personally did not.

Q. Did anybody at the Agency for Health Care Administration?

A. I don't know.

Q. Did you communicate -- were there any communications between AHCA and the Governor about the development of this report?

A. I don't know.

Q. Did you personally communicate with the

Governor's office about the development of this report?
A. No.
Q. Did you personally communicate with the Governor's office about the exclusion of treatment for gender dysphoria?
A. No.
Q. Were there any communications between AHCA and people that provided public comment at the hearing?
A. I'm sorry; can you repeat the question.
Q. Were there any communications between AHCA -- prior to the hearing, were there any communications between AHCA and the people who provided public comment at the hearing?
A. I don't know.
Q. Did you personally communicate with anyone who provided public content at the hearing prior to the hearing?
A. No.
Q. Was anyone at AHCA aware that specific people would provide public content at the hearing prior to the hearing?
A. I don't know.
Q. Were you aware that there were any specific members of the public who would provide public comment at the hearing prior to the hearing?

A. No.
Q. The person who is identified as authoring the GAPMS report on gender dysphoria is Matt Brackett; correct?
A. Yes, he was the primary author.
Q. Do you recall a meeting between you, Mr. Weida, and Mr. Bottcher discussing who the author of the report would be?
A. I don't remember if Jesse was in any of the conversations.
Q. Okay. Did Jesse ever express a concern to you about someone -- anyone on his team drafting the GAPMS report on gender dysphoria treatment?
A. Prior to?
Q. At any time.
A. Can you say that again.
Q. Did Mr. Bottcher ever express to you concerns over someone on his team drafting the GAPMS report on the treatment for gender dysphoria?
A. Not that I can recall.
Q. Was the GAPMS decision tree used before you decided to undertake the GAPMS analysis that is contained in the June 2022 report?
A. I don't know.
Q. Who would have that information?

Did Secretary Marstiller in her letter to Tom Wallace -- did she direct Tom Wallace to undertake the GAPMS process?

MR. PERKO: Object to form.

THE WITNESS: I can't recall the details of the letter.

MS. DEBRIERE: Me neither. Do we have a copy?

MS. CHRISS: It's the last page right there. It's Attachment A.

MS. DEBRIERE: Oh. It's the very back of Exhibit --

MR. PERKO: It's not attached to ours.

MS. DEBRIERE: Okay.

MS. DUNN: Why don't you pull it off and mark it as a separate exhibit.

MS. DEBRIERE: So we'll mark the letter from Simone Marstiller dated April 10th, 2022, as Exhibit 11. And that's Attachment A to the June 2022, GAPMS report related to the treatment for gender dysphoria.

(Plaintiff's Exhibit No. 11 was marked for identification.)

BY MS. DEBRIERE:

Q. So in this letter is Secretary Marstiller directing Mr. Wallace to undertake the GAPMS process?

MR. PERKO: Object to form.
THE WITNESS: Yes.
BY MS. DEBRIERE:
Q. Do you think that Secretary Marstiller undertook a decision tree prior to writing this letter and sending it to Mr. Wallace?
MR. PERKO: Object to form.
THE WITNESS: I don't know.
BY MS. DEBRIERE:
Q. Has the secretary of AHCA ever personally completed a decision tree on the GAPMS process?
A. I don't know.
Q. Would it be unusual if the secretary of AHCA completed a decision tree on the GAPMS process?
A. I don't know.
Q. Looking at the GAPMS report itself, does it contain a fiscal analysis?
A. I don't know off the top of my head.
Q. Yeah. No, take your time.
A. No, I do not see a fiscal analysis.
Q. Do you see anything related to cost effectiveness?
A. No.
Q. Do you know why that was not included?
A. No.

Q. Is budget neutrality in reaching a GAPMS decision important?

MR. PERKO: Object to form.

THE WITNESS: I don't know. I know that that's something when determining a coverage determination that is taken into consideration. But specific to the GAPMS process, I don't know.

BY MS. DEBRIERE:

Q. Okay. Who would know that? Would the person responsible for writing GAPMS reports know that?

A. Yes. Or Jesse Bottcher or Matt Brackett.

Q. Or Jeff English?

A. Yes.

Q. Who decided which services would be assessed in the GAPMS report?

A. I don't know.

Q. So typically a request comes in from the public for a specific service. In this instance, the request came from the secretary; correct?

A. Yes.

Q. So would it have been the secretary who decided which services should be assessed?

A. I can't recall how the decision was made. I do know that that was part of conversations we had during this process. But I can't recall exactly how the

decision was finalized.

Q. Was there ever a discussion about narrowing the types of services to be included?

A. I don't recall specifically. I know that the coverage of behavioral health services was something that was always covered. But outside of that specifically, I can't remember.

Q. Was there ever any discussion about undertaking the GAPMS process for a set of services simultaneously as opposed to a single service?

A. Can you clarify.

Q. In the discussions about writing the report or assessing the services, were there ever any concerns raised about undertaking the process for a set of services as opposed to a single one?

A. I don't recall specifically.

Q. Was there any discussion about EPSDT?

A. I can't remember if it was specific to the development of the report or the rulemaking more specifically. But I believe there was.

Q. And what was discussed?

MR. PERKO: I'm going to object for a second. Did that include counsel? Did those discussions include counsel?

THE WITNESS: Yes.

MR. PERKO: And who was that?
THE WITNESS: I don't remember.
MR. PERKO: But it did include counsel?
THE WITNESS: I believe it was a discussion on the rulemaking with counsel.
MR. PERKO: I'm going to instruct the witness not to answer.
BY MS. DEBRIERE:
Q. Were all discussions had in front of counsel about EPSDT?
A. I don't remember.
Q. How about comparability?
MR. PERKO: I'll ask you the same thing.
THE WITNESS: Can you remind me what you're referencing when you say comparability. I think you mentioned that at the very beginning of the day.
MS. DEBRIERE: Comparability is a requirement under the Federal Medicaid Act in the administration of the coverage of the Medicaid services.
THE WITNESS: I don't recall.
BY MS. DEBRIERE:
Q. Were there communications with the Centers for Medicare and Medicaid Services about AHCA's decision to assess whether the services listed in the exclusion were experimental?

A. I don't know. I personally did not have any conversations.

Q. Who communicates with CMS about those kinds of things?

A. Those kinds of things, you mean changes in coverage?

Q. Does CMS ever reach out to AHCA about concerns they have about an action that they're taking related to Medicaid coverage?

A. Yes.

Q. Who would be the point person at AHCA to have those conversations?

A. So if an update to a federal authority were needed, that would be either Catherine Mcgrath or myself.

Q. Okay. You would not have had -- have you had any conversations with CMS about the GAPMS report related to the treatment of gender dysphoria?

A. No.

Q. Has Catherine?

A. Not to my knowledge.

Q. Have you had any conversations with CMS about the exclusion of the treatment for gender dysphoria as contained in Rule 59G-1.050?

A. I have not.

Q. Has Catherine?
A. Not to my knowledge.
Q. Has anybody else at AHCA?
A. I don't know.
Q. Okay. You mentioned a second ago that you weren't sure if you were talking about EPSDTs as it related to the report or the rulemaking. When you make that distinction, are you referring the writing of the report versus the adoption of the rule?
A. Yes.
Q. Okay. How was it decided that the conclusions from the GAPMS report should be adopted into rule?
A. I'm trying to remember the specific conversations. But I do believe those were conversations with counsel as well.
Q. Okay. The expedited GAPMS that you were involved in from start to finish, was that decision adopted into rule?
A. It was just one other GAPMS. And I don't believe any rule update was needed for that one.
Q. Why was a rule update needed for this GAPMS report?
MR. PERKO: If that's discussion with counsel, I will instruct you not to answer.
THE WITNESS: Because there was not any policy

language that clearly explained the coverage, it was determined that developing policy language was the best approach. Anything past that was -- how that process went was conversation with counsel.

BY MS. DEBRIERE:

Q. How often in your day-to-day in making decisions in your job do you have to consult with legal counsel?

A. Often.

Q. Okay. So does that mean -- okay. Like, every day?

A. I would say the majority of days.

Q. Okay.

A. And I'll just specify. I have some sort of contact or interaction with legal counsel.

Q. On most days?

A. Yes. And, again, because the rule promulgation does require review and some other documents we route are managed care contracts also route through legal. Just to give you examples of why it's quite often.

Q. They're all contacts with legal counsel about things related to the doing of your job?

A. The development of policy and -- yes.

Q. Okay. So there was -- you said there was -- the reason that it needed to be adopted into rule is

because there was no clear coverage policy on the services at issue; is that correct?

A. I can't remember all the factors that went into the decision. But I believe that was one of the factors when it was assessed that there was no coverage policy specific to the treatment of gender dysphoria.

Q. Were there existing coverage guidelines?

A. Not to my knowledge.

Q. At the time were you aware of existing pharmacy policies related to the treatment of gender dysphoria?

A. At what time? Can you specify.

Q. It was 2017/2016.

A. I was not with the agency in 2016. So I would not have been part of any development of policy at that time.

Q. But when you were deciding whether to adopt this exclusion into the rule, did you do any review of existing coverage guidelines or past coverage decisions?

A. I believe we did. But I can't recall the specifics.

Q. Did you review past GAPMS reports regarding the treatment of gender dysphoria?

A. I believe we did.

Q. And why weren't they enough to establish the coverage policy?

MR. PERKO: Object to form.

THE WITNESS: I don't know.

BY MS. DEBRIERE:

Q. 59G-1.050, Subpart 7 -- it bans Medicaid coverage for puberty blockers, hormones and surgery if done so to treat gender dysphoria; correct?

A. It covers that Medicaid does not cover those services for the treatment of gender dysphoria; correct.

Q. Does it distinguish between adults and children?

A. No.

Q. So the exclusion applies equally to both children and adults; is that correct?

A. Yes.

Q. Okay. And it excludes Medicaid coverage for puberty blockers and hormones and surgery to treat gender dysphoria, but it does not exclude Medicaid coverage for those services to treat other diagnoses; is that correct?

A. Correct.

Q. And I just forgot you answer; I apologize. Were you involved in the rule hearing held on July 8th regarding the exclusion set forth in 1.050?

A. No.

Q. Were you aware that outside legal counsel

participated in that hearing?

A. I don't know if I was made aware prior to today. I can't remember.

Q. At rule hearings you've been in in the past, do the State agencies have a panel of subject matter experts who respond to public comment during the hearing?

A. I can't cite the specific language, but it's actually required per Chapter 120 that the agency has subject matter experts who can speak to the contents of whatever is being discussed at a public meeting available.

Q. Other than the July 8th hearing, are you aware of any time that any agency has retained outside subject matter experts to participate on that panel?

A. I'm not aware of any.

Q. To your knowledge is this the only time AHCA has created a slogan to advertise the conclusion in its GAPMS memo?

MR. PERKO: Object to form.

BY MS. DEBRIERE:

Q. Are you aware of the slogan "Let kids be kids"?

A. I've seen the website, yes.

Q. In your experience has AHCA ever designed a website page for any other rule adoption?

A. I can't remember if it was specific to rule adoption. But I can think of a couple of examples where we created web pages for policy updates; for example, for home and community based settings rule that was an administrative rule as well as a federal rule. There's a specific external web page for updates regarding that and information on that rule.

When we received the American Rescue Act funding approval, we created a web page with information on that funding and what those funding could be used for. So I feel like it's pretty common for us to update our external website when there's important information to communicate.

Q. In those other examples, did AHCA ever develop a slogan to go along with those web pages?

A. Not in the examples that I used, I don't think.

Q. Did they issue press releases?

A. The American Rescue Act funding may have had one. But I can't remember.

Q. Okay. Just going back quickly. My co-counsel has pointed out to me that in Chapter 120 it says that at the rule hearing agency staff must be available but not an expert. Do you think maybe you were confusing that requirement that an expert needs to be available under 120?

A. I think it says an agency staff with knowledge.
Q. Okay. "Ensure that staff are available to explain the agency's proposal and to respond to questions or comments regarding the rule." Is that the provision you were --
A. Yes.
Q. -- thinking of? Okay.
Typically when AHCA decides not to cover a particular service, where is that information included?
MR. PERKO: Object to form.
THE WITNESS: I think it depends on the policy. Each policy has different exclusions, if there are any, with the service. Or most of the coverage policies include a section specific to exclusions.
MS. DEBRIERE: Most of the policies? Is that what you said? I apologize.
THE WITNESS: Most of the coverage policies.
BY MS. DEBRIERE:
Q. Okay. And those coverage policies are service specific policies?
A. The examples I was thinking of, yes, were service specific coverage policies and include -- I can't remember exactly what section in the example of where to find that in the coverage policy. But, yes, it would include exclusion specific to the coverage that's

being described in the policy.

Q. Okay. The exclusion on the treatment of gender dysphoria, is it in a service specific coverage policy?

A. No. This is a general Medicaid policy. But it does include coverage information including what Florida Medicaid reimburses for and what it does not.

Q. Does it speak to the exclusion of any other services under Florida Medicaid but those services excluded for the treatment of gender dysphoria?

A. Yes.

Q. Which ones?

A. No. 4 is an example. (4)(b), that speaks to that Florida Medicaid does not cover continuous services after the emergency has been alleviated.

Q. Is that a specific service? Or is that the length of time for any service?

A. I apologize. It's emergency service. It's under the section for emergency Medicaid.

Q. But, again, is that speaking to the coverage of any service deemed emergency?

A. It's specific to emergency services provided to aliens who meet all Florida Medicaid eligibility requirements except for citizenship.

Q. It says an exclusion under Subpart 7 speaks specifically to the exclusion of sex reassignment

surgeries; correct?
A. Services for the treatment of gender dysphoria.
Q. But only three services.
A. Four.
Q. What are examples of procedures that alter primary or secondary sexual characteristics that are not related to surgery?
A. I don't know.
Q. Just going back to the surgery, why not include that in service specific policies that discuss surgery?
A. Can you repeat the question.
Q. Looking at the exclusion of sex reassignment surgeries, why was that not included in the coverage policies related to surgeries that we discussed earlier?
A. I don't recall the specific conversation on how it was decided that this was the most appropriate policy. And I do believe that most of that conversation was with counsel.
Q. So same question for puberty blockers. Why wouldn't you include that in a pharmacy coverage policy?
A. I don't know.
Q. And Subpart 7's subject line is "Gender Dysphoria"; correct?
A. Yes.
Q. And that's a diagnosis?

A. I don't know clinically the definition.
Q. We've been talking about the treatment of gender dysphoria; right?
A. Yes.
Q. So in order to exclude treatment of gender dysphoria, it would be the exclusion of a treatment for a diagnosis; correct?
A. Yes. But I can't speak to the specifics of the diagnosis or what that means in clinical terms.
Q. Okay. For the July 8th hearing, do you know how many public comments were submitted?
A. I don't know.
Q. Do you know if it was more than 100?
MR. PERKO: Asked and answered.
THE WITNESS: I know it was a lot.
BY MS. DEBRIERE:
Q. Okay. And do you know how long it took AHCA to review and consider the comments before adopting the final rule?
A. I don't know the length of time. But I know that all the public comments were reviewed.
Q. Who reviewed them?
A. I know Cole Giering did. I don't know if anybody else -- if anybody else did.
Q. Okay. So after the July 8th hearing up until

the final adoption of the rule, other than reviewing and considering public comment, what else did AHCA do before adopting the rule?

A. Can you repeat the question.

Q. So after the July 8th hearing up until the final adoption of the rule, other than reviewing public comment, what other activities did AHCA undertake in deciding to adopt the rule?

A. I don't know. I can't remember specific to this rule. But after it's been determined there's no changes needed to the rule, the filing for adoption would be the next step.

Q. How do you reach that decision that no changes should be made?

MR. PERKO: Object to form.

THE WITNESS: There's various factors involved in that decision. And it really depends on the specific circumstances.

MS. DEBRIERE: Okay. I don't know what it would be labeled, but do you have an exhibit -- it's an email from Ms. McGriff to Magellan.

MS. CHRISS: Yes. The email exchange between Magellan and AHCA.

MS. DEBRIERE: Thank you.

Court Reporter, just for your reference what we

just marked as Exhibit 12 is Bates stamped DEF_00288753 to 000288756.

(Plaintiff's Exhibit No. 12 was marked for identification.)

BY MS. DEBRIERE:

Q. So Magellan is emailing several people at AHCA. And she says, "Attached are the internal criteria not publicly posted."

What are the internal criteria?

A. I don't know.

Q. Does Magellan rely on internal criteria for the coverage of Medicaid services?

A. I don't know.

Q. What does "CCM" mean? It's right after that sentence. "Attached are the internal criteria 'not publicly posted' CCM."

A. I don't know.

Q. What does gender code mean?

A. I don't know.

Q. Do you know hot had significance of "B for both" is?

A. I do not.

Q. Who is Linda Simone Moore?

A. Who?

Q. So there's a sender up top here -- I'm sorry.

Leslie.

A. Moore-Simons.

Q. I need reading glasses. Leslie Moore-Simons. That's exactly right.

A. I don't know.

Q. Okay. Who is Susan Williams?

A. She works for Ashley Peterson in the pharmacy unit in the Bureau of Medicaid Policy.

Q. Okay. And who is Arlene Elliott? I'll just note the date that Arlene's email was sent was 8/21/2017.

A. Currently Arlene Elliott is in a different division at the Agency for Health Care Administration. But at this time, she was the AHCA administrator over the pharmacy policy section of the Bureau of Medicaid Policy.

Q. And what unit is she in now?

A. I don't know. She's no longer in the division of Medicaid.

Q. What division is she in?

A. I believe it's Health Quality Assurance.

Q. Do you know when she left her position in the Bureau of Medicaid Policy?

A. I believe it was spring or summer 2021. I'm not sure the exact date.

Q. Okay. Earlier in the exchange -- and yet dated later -- is the email dated April 20th, 2022, from Elica King-Wilson at Magellan. And she's included some language which she underlined and bolded. And it says, "All requests require vetting by AHCA before a final determination is made."

And it appears this is related to a final determination as to whether -- well, it says -- Leslie noted, "MMA does have an internal gender dysphoria criteria, which is attached."

MMA stands for?

A. I don't know in what context she's using it.

Q. Okay.

A. But to me, MMA would normally stand for managed medical assistance.

Q. I assume you're confused because this is coming from Magellan which is not a managed medical assistance program; is that right?

A. Yes. So I don't know if that's what she's referring to.

Q. And it says, "This internal document serves for GnRH analog use to delay puberty in adolescents with gender dysphoria." This document was provided by AHCA due to a fair hearing request received for Lupron for a recipient with this diagnosis" -- meaning gender

dysphoria. And it goes on with the underlying language that all of those requests -- coverage of Lupron for gender dysphoria -- need to be vetted by AHCA before a final determination is made.

Were you familiar with that process at all?

A. No. I don't know what process they were referring to.

Q. Would Ashley Peterson know?

A. I don't know. But she does work closely with Magellan.

Q. Okay. Did AHCA work with managed care plans to implement the exclusion in 1.050?

A. They were notified. But the specifics of how that communication happened, I can't recall.

MS. DEBRIERE: Okay. Can I have the SMMC Policy Transmittal relating to the Non-Coverage of Gender Dysphoria Treatment.

MS. DUNN: Do you want the policy or the emails?

MS. DEBRIERE: Could you do both.

MS. DUNN: Do you want them together?

MS. DEBRIERE: That would be great. But separate exhibits.

(Plaintiff's Exhibit No. 13 was marked for identification.)

(Plaintiff's Exhibit No. 14 was marked for identification.)

BY MS. DEBRIERE:

Q. So right now we're looking at an email that's Bates stamped DEF_000258835 to 000258838. It's an email from D.D. Pickle CC-ing you. And it's to Jason Weida.

In this -- I'm sorry. Looking specifically at an email dated August 22, 2022, from D.D. to Ashley Peterson and Matt Brackett. It states, "Ashley, Ann wants to include the 60-day language in the alert?"

What alert is D.D. Pickle referring to?

A. I believe it was the provider alert.

Q. And what's a provider alert?

A. It's the main way -- one of the main ways we communicate information to our providers and external stakeholders.

(Plaintiff's Exhibit No. 15 was marked for identification.)

BY MS. DEBRIERE:

Q. I'm handing you a document that's marked as Exhibit 15, called Florida Medicaid Health Care Alert Sign-Off Form, starting at Bates stamp DEF_000258839.

Is this the provider alert you were referring to?

A. Yes. It looks to be a provider alert regarding

the coverage of treatment for gender dysphoria.

MS. DEBRIERE: Okay. And then what was the transmittal?

MS. DUNN: It was 14.

BY MS. DEBRIERE:

Q. No. 14 -- can you look at that document. And that's Bates stamped DEF_000258833.

What is this document?

A. It looks to be a draft -- a policy transmittal.

Q. And who does that go to?

A. This specific one is marked to be sent to the medical assistance and specialty plans.

Q. Is that the final that was sent?

A. It does not appear so, no.

Q. Okay. How do you know that?

A. The policy transmittal number is not completed and it's not signed.

Q. Okay. Going back to the provider alert, was that the final that was sent?

A. I can't tell from this document if this was the final that was sent.

Q. Okay. Would you be able to tell from any of the versions whether it was the final?

A. Seeing the actual email alert would be how I would make sure. My team actually does not send out the

final provider alerts. So that's typically how I would look at the final version.

Q. Okay. And the policy transmittals and the provider alerts -- are those available on the agency's website? The finals?

A. Yes.

Q. Okay. So turning back to that email exchange where D.D. mentions you by name.

What is 60-day language?

A. I believe she's referring to the continuity of care.

Q. What is continuity of care?

A. It's a contract requirement for the plans to provide services for a period of time. I don't know if it's specific to when they change plans. I can't recall the exact contract language, but it's a contract provision.

Q. And are services previously being covered supposed to be continue being covered for 60 days according to the 60-day language?

A. I can't recall the exact parameters of the requirement.

Q. Do you recall why --

MR. PERKO: Counsel, we're getting on seven hours here.

BY MS. DEBRIERE:

Q. Do you recall why the 60-day language -- you wanted the 60-day language included in this alert?

A. I can't remember the conversation around this. And I can't speak for D.D.

Q. Well, D.D. is speaking for you; right?

The subject is "GD Policy Transmittal"; correct?

A. Yes.

Q. And what does "GD" stand for?

A. Based on the attachments, I would conclude that it is for gender dysphoria.

Q. Okay. And this would be discussion had after the rule was adopted excluding coverage of services for the treatment of gender dysphoria; correct?

A. Can you repeat that question.

Q. The date of this email is after the rule was adopted to exclude coverage of services for treatment of gender dysphoria.

A. I believe so.

Q. You don't recall why you thought it was important to have the 60-day language included in the alert?

A. I don't recall the specifics of the conversation. But I believe it was to ensure if there

was any current reimbursement or authorization that would apply.

Q. Current authorization of treatment of gender dysphoria?

A. Of the services listed in Rule 1.050, No. 7.

Q. Did any plans state to AHCA that they would continue coverage of the services excluded in the rule even though that rule had been adopted?

A. I don't know.

Q. Who would know that?

A. I don't know who it would have gone to. If there was a question, the communications typically go through the contract managers.

Q. Okay. Do you know if all plans have implemented the exclusion contained in the rule?

A. I don't know.

Q. Are you familiar with the variance and waiver process under Chapter 120?

A. Yes.

Q. Okay. What is the purpose of that statute?

MR. PERKO: Object to form; calls for a legal conclusion.

BY MS. DEBRIERE:

Q. What it the purpose of the variance and waiver process?

MR. PERKO: Object to form.
THE WITNESS: I don't know.
MR. PERKO: Counsel, we're getting on seven hours here.
MS. DEBRIERE: All right. Let me just consult with my team for just a second.
(Brief recess.)
MS. DEBRIERE: We'll all set with direct.
Thank you for your time, Ms. Dalton.
MR. PERKO: I don't have any questions.
THE COURT REPORTER: Would you like to read or waive?
THE WITNESS: Read.
THE COURT REPORTER: Would you like to order at this time?
MS. DEBRIERE: Yes.
THE COURT REPORTER: Would anybody like to order a copy?
MR. PERKO: Yes.
(This deposition was concluded at 6:05 p.m.)

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CERTIFICATE OF OATH

STATE OF FLORIDA:
COUNTY OF LEON:

I, GREG T. SMITH, Notary Public, State of Florida, do hereby certify that ANN DALTON personally appeared before me on January 24, 2023 and was duly sworn and produced her ID badge as identification.

Signed this 30TH day of JANUARY, 2023.

GREG T. SMITH

Notary Public, State of Florida
My Commission No.: GG933698
Expires: March 21, 2024

CERTIFICATE OF REPORTER

STATE OF FLORIDA:

COUNTY OF LEON:

I, GREG T. SMITH, Notary Public, State of Florida, certify that I was authorized to and did stenographically report the deposition of ANN DALTON; that a review of the transcript was requested; and that the foregoing transcript, pages 6 through 175, is a true and accurate record of my stenographic notes.

I further certify that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 30TH day of JANUARY, 2023.

GREG T. SMITH

KATHERINE J. DEBRIERE, ESQUIRE
DEBRIERE@FLORIDAHEALTHJUSTICE.ORG

January 30, 2023

RE: Dekker, August v Marstiller, Simone
1-24-23 Ann Dalton, Job# 5662663

The above-referenced transcript is available for review.

(The witness/You) should read the testimony to verify its accuracy. If there are any changes, (the witness/you) should note those with the reason on the attached Errata Sheet.

(The witness/You) should, please, date and sign the Errata Sheet and email to the deposing attorney as well as to Veritext at Transcripts-fl@veritext.com and copies will be emailed to all ordering parties.

It is suggested that the completed errata be returned 30 days from receipt of testimony, as considered reasonable under Federal rules*, however, there is no Florida statute to this regard.

If the witness fails to do so, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

*Federal Civil Procedure Rule 30(e)/Florida Civil Procedure Rule 1.310(e).

Dekker, August v Marstiller, Simone
1-24-23 Ann Dalton, Job# 5662663

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REASON_____

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

_____ _____

(WITNESS NAME) DATE

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

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

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