THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	No. 4:22-cv-00325-RH-MAF

PLAINTIFFS' MOTION TO ENFORCE THE COURT'S JUDGMENT OR, ALTERNATIVELY, TO CLARIFY THE COURT'S JUDGMENT

Plaintiffs hereby respectfully move this Court to enforce its Judgment [Dkt. No. 247] that resulted from the Findings of Fact and Conclusions of Law [Dkt. No. 246] or, in the alternative, to clarify its Judgment. Defendants are defying the plain language of this Court's Judgment by continuing to categorically enforce Rule 59G-1.050(7) of the Florida Administrative Code (the "Rule" or the "Challenged Exclusion"). As such, and for the reasons stated in the memorandum that follows, Plaintiffs respectfully ask this Court to grant their motion and enforce the Judgment by instructing Defendants that the Court's declaratory relief prevents them from enforcing the Challenged Exclusion, and by issuing any other remedial relief it believes appropriate. In the alternative, Plaintiffs respectfully request that this Court clarify its Judgment to make clear that the Rule, as adopted, is unlawful, or grant

broader injunctive relief preventing Defendants from enforcing the Challenged Exclusion.

MEMORANDUM OF LAW

INTRODUCTION

One year after this case was filed and months after this Court declared that "Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria," Dkt. No. 246 at 53, Defendants continue to apply and enforce the Rule as if the proceedings, trial, and the Court's ruling in this case never happened. But, as this Court emphasized in its June 21, 2023 decision, Florida state officials cannot categorically ban Medicaid coverage of puberty-delaying medications and gender-affirming hormones for the treatment of gender dysphoria, as doing so unlawfully discriminates against transgender Medicaid beneficiaries in violation of the Fourteenth Amendment's Equal Protection Clause and Section 1557 of the Affordable Care Act and also violates the Medicaid Act.

In complete defiance of the Judgment, Defendants continue to enforce and apply the Rule this Court declared invalid. They have done so by (i) categorically denying coverage to transgender Medicaid beneficiaries for gender-affirming hormones, (ii) instructing managed care organizations (MCOs) to deny coverage *and*

fining them for not abiding by the Challenged Exclusion's categorical exclusions of gender-affirming medical treatment, and (iii) seeking recoupment from providers for funds paid by MCOs for the provision of gender-affirming medical treatment to transgender Medicaid beneficiaries. This, despite that this Court declared the Challenged Exclusion "invalid to the extent [it] categorically ban[s] Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria." Dkt. No. 246 at 53.

Defendants are not free to disregard this Court's decisions and orders even if they have taken an appeal. Neither this Court nor the Eleventh Circuit has issued a stay and this Court's Judgment remains in full effect. Having fulfilled its "province and duty … to say what the law is," *Marbury v. Madison*, 5 U.S. 137, 177 (1803), this Court should be able to "presume[] that officials of the Executive Branch will adhere to the law as declared by the court." *Comm. on Judiciary of U.S. House of Reps. v. Miers*, 542 F.3d 909, 911 (D.C. Cir. 2008).

Here, however, Defendants have put these basic and foundational legal principles to the test. Plaintiffs now are in the unfortunate position of having to come back before the Court to request that the Court enforce its Judgment or, in the alternative, provide clarification as to the scope of the relief granted.

FACTUAL BACKGROUND

A. Procedural History

This case was filed on September 7, 2022, alleging that the Rule unlawfully discriminated against Florida transgender Medicaid beneficiaries, like Plaintiffs, in violation of the Equal Protection Clause of the Fourteenth Amendment Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), and the Medicaid Act's EPSDT and Comparability Requirements. Dkt. No. 1.

Following extensive discovery, the case proceeded to trial beginning on May 9, 2023. Dkt. No. 241. Over seven days, the Court heard testimony from Plaintiffs, experts, and fact witnesses. *See* Dkt. Nos. 226-28, 238-40, 241, 242. During the course of the bench trial, Florida Statutes § 286.31(2) was enacted on May 17, 2023; Plaintiffs moved to amend their Complaint on May 18, 2023, to include § 286.31(2) within their challenge. Dkt. No. 231. The Court granted such leave on May 20, 2023. Dkt. No. 237.

Following the conclusion of the trial, the Court issued its Findings of Fact and Conclusions of Law on June 21, 2023, finding for Plaintiffs on each of their claims as they pertained to puberty-delaying medications and gender-affirming hormones and declaring that: "Florida Statutes § 286.31(2) **and** Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria."

Dkt. No. 246 (emphasis added). The next day the Court entered its Judgment. Dkt. No. 247.

B. Defendants' Actions Defying the Court's Decision.

Since the decision and subsequent Judgment was issued, Defendants have continued to apply and enforce the Rule as if this Court never entered Judgment against them. Specifically, Defendants have: (1) categorically denied coverage for medically necessary gender-affirming care for transgender Floridians; (2) ordered Florida MCO's to cease and desist providing coverage for medically necessary gender-affirming medical care; (3) publicly committed to enforcing the rule, even though this Court found it invalid; and (4) demanded at least one medical institution refund money to AHCA for services related to the provision of gender-affirming care (from August 21, 2022 to present). This conduct is flatly contrary to this Court's decision and its Judgment.

1) *Denials of coverage following the Court's Decision.*

On August 18, 2023, AHCA, through one of the MCOs, Simply Healthcare, sent at least one transgender Medicaid beneficiary a Notice of Adverse Benefit Determination, denying coverage for a previously authorized and covered medication for the treatment of gender dysphoria. *See* **Ex. A**, Declaration of Cece Suarez. The Notice states that coverage for the prescription "DELESTROGEN 100MG/5 ML VIAL" has been reviewed and "this service has been TERMINATED

as of 8/18/23." The basis for the termination of benefits is stated as: "The requested **service is not a covered benefit.**" **Ex. A, Attachment 1** (Notice of Adverse Benefit Determination from Simply Healthcare) (emphasis in original).

Similarly, on September 30, 2023, a transgender Medicaid beneficiary was notified that his MCO, Sunshine Health, denied coverage for his previously authorized and covered medication for the treatment of gender dysphoria. *See* **Ex. B**, Declaration of Kandle Starr. The statement provided to Mr. Starr stated that the "Rejection Code/Reason" for the denial of coverage for his prescription of Norethindrone (a form of hormone treatment) was "THIS PRODUCT IS NOT COVERED FOR MEMBERS WITH A GENDER IDENTITY DIAGNOSIS OR RELATED DIAGNOSIS." **Ex. B, Attachment 1** (Rejection Message from Sunshine Health Plan). The statement also indicated that the pharmacy had attempted to adjudicate the claim for coverage seven (7) times. *Id.* Mr. Starr is 19 years old and cannot afford to pay the $203.99 out-of-pocket expense for the hormone medication prescribed by his treating physician as necessary treatment for his gender dysphoria. *Id.*

2) *Defendants sent cease-and-desist letters to MCOs ordering them to not cover any gender-affirming medical care.*

On August 17, 2023, Defendant AHCA sent "cease and desist" letters to five Florida MCOs assessing fines, liquidated damages, and monetary sanctions against the plans for violations of Rule 59G-1.050 and directing the MCOs to cease and

desist *further violations* of the Rule. *See* **Composite Addendum 1 (**Letters from AHCA to Simply Healthcare Plans, Sunshine State Health Plan, Humana Medical Plan, Molina Healthcare of Florida, and Children's Medical Services (CMS) Health Plan), **to Ex. C**, Declaration of Omar Gonzalez-Pagan. Among other things, these letters include the following language:

> The Plan "**must immediately cease and desist from violating Rule 59G-1.050, F.A.C.** Further violations will be subjection to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes. **Please confirm in writing no later than five days following receipt of this letter that CMS Plan has ceased coverage of the services listed in Rule 59G-1.010, F.A.C., for the treatment of gender dysphoria.**"

See **Composite Addendum 1 (AHCA Letters to MCOs) to Ex. C**, each at p. 3 (emphasis in original). These letters are in direct violation of the Court's rulings in this case, which declared that the Rule is unconstitutional and unlawful, and therefore invalid. Plaintiffs ask this Court to make clear to Defendants that sending communications instructing MCOs to comply with the Rule is a violation of the Judgment, and is unlawful.

3) ***Defendants publicly declare they will continue to enforce the Invalid Rule, despite the Court's Decision.***

On August 18, 2023, Defendant Secretary Jason Weida appeared as a guest on the Daily Wire Podcast to discuss AHCA's decision to fine healthcare providers for funding gender-affirming medical care, including warning that his office

"would consider more drastic penalties for any further violations."[1] Defendant Weida stated "[t]hese plans recklessly continued to cover these services with permanent, harmful effects, after the rule was adopted. [They] will not stand in the way of our fight to protect the innocence of Florida's kids." *Id.*

The article about the podcast interview with Defendant Weida goes on to state:

> Simply Healthcare, the provider that covered the mastectomy, is facing a $30,000 penalty and will be sanctioned. The other providers face smaller, unspecified fines, but the non-willful sanction is the more serious penalty as it places a black mark on a provider's record that must be disclosed when it competes for contracts. Providers who have been sanctioned are much less likely to be awarded other state contracts for 10 years until the sanction expires. According to the Agency for Healthcare Administration, Simply Health has already replaced the team that approved the mastectomy coverage.

Id. Defendant Weida told the Daily Wire that he is "grateful Governor Ron DeSantis empowered his office to issue the rule blocking public money from going to" gender-affirming medical care. *Id.*

Defendant Weida likewise provided an interview to the Daily Signal, the contents of which are captured in an article published on August 18, 2023 titled:

---

[1] *See* Podcast Episode: FL Trans Treatment Fines & Homelessness Rises 8.18.23, MorningWire (August 18, 2023), https://www.dailywire.com/podcasts/morning-wire/fl-trans-treatment-fines-homelessness-rises-8-18-23; *see also* Megan Basham, "Exclusive: Florida Fines Medicaid Providers for Using Tax Dollars to Cover Trans Treatments for Minors," DailyWire.com (August 18, 2023), https://www.dailywire.com/news/exclusive-florida-fines-medicaid-providers-for-using-tax-dollars-to-cover-trans-treatments-for-minors.

"Florida Becomes First State to Sanction Medicaid Providers for Covering Minor Transitions."[2] Defendant Weida stated: "Given the notice that they are on now, with the rule being passed last year, and now that we have this audit and the letters and this discipline, any type of violation going forward would be deemed an Intentional violation and would be subject to very severe consequences." *Id.*

The article quotes Defendant Weida saying: "We are also issuing fines against four other Medicaid plans that used public dollars to support prescription drugs used for gender dysphoria." *Id.* In his interview, Defendant Weida praised Governor Ron DeSantis for taking "concrete steps" within Florida to protect "the innocence of our children." *Id.*

An email from Defendant AHCA to a local reporter who inquired about these statements in light of the Court's Judgment stated that the Rule "continues being in effect within the parameters outlined by the District Court." *Id.* The email further states that "the rule can't serve as a categorical ban because it isn't one." *Id.* To be sure, that is false. The Rule in fact does categorically bans coverage for puberty blockers and hormones as treatment for gender dysphoria, and Defendants' communications and warnings to MCOs clearly treat it as a

[2] Mary Margaret Olohan, "Florida Becomes First State to Sanction Medicaid Providers for Covering Minor Transitions," The Daily Signal (August 18, 2023), https://www.dailysignal.com/2023/08/18/florida-becomes-first-state-to-sanction-medicaid-providers-for-covering-minor-transitions/.

categorical ban.

In short, the denials of coverage and instructions to MCOs are categorical, and Defendants have announced their intent to continue to enforce this categorical ban on Medicaid coverage of puberty blockers and hormones as treatment for gender dysphoria despite this Court having deemed it unconstitutional and unlawful.

4) *Defendants demand refunds from providers who have provided gender-affirming medical services*.

On August 23, 2023, University of Miami physicians received an email that outlined actions taken by Defendant AHCA against the University of Miami related to alleged violations of the Challenged Exclusion. *See* **Ex. D**, Declaration of Dr. Lydia Fein. In the email, physicians are informed that AHCA amended the Gender Medicaid Policy rule to exclude treatments of gender dysphoria, and "as a result, our office has been compelled to refund any Medicaid and Medicaid Managed Care reimbursement for services related to the provision of gender affirming care as of the effective date of the regulation (August 21, 2022) to present." **Ex. D, Attachment 1** (Email from University of Miami, subject line: "FW: Notice on Florida's Ban on Medicaid Coverage on Gender Affirming Care") (emphasis added). The email continues to state: "Consequently, for the foreseeable future, and until any further notice on the status/overturn of the current policy, we ask that you please abstain from billing Medicaid or any Medicaid Managed care plan for any implicated

services." *Id.* This has resulted in University of Miami providers canceling appointments for any transgender patient seeking gender-affirming medical care as treatment for gender dysphoria and who is covered by Florida Medicaid. *See* **Ex. D**, at ¶ 6.

LEGAL STANDARD

"A district court has the power to issue an order requiring the parties to carry out the terms of an earlier order." *S.E.C. v. Hermil, Inc.*, 838 F.2d 1151, 1153 (11th Cir. 1988); *see also Flaherty v. Pritzker*, 17 F. Supp. 3d 52, 55 (D.D.C. 2014) ("District courts have the authority to enforce the terms of their mandates."). That authority is grounded in "the interest of the judicial branch in seeing that an unambiguous mandate is not blatantly disregarded by parties to a court proceeding." *Int'l Ladies' Garment Workers' Union v. Donovan*, 733 F.2d 920, 922 (D.C. Cir. 1984). "The usual method for having the court interpret its judgment is to file a motion to enforce the judgment." *Hermil*, 838 F.2d at 1153. "[A]n appeal does not automatically stay the enforcement of a judgment." *U.S. Commodity Futures Trading Comm'n v. Escobio*, 946 F.3d 1242, 1251 (11th Cir. 2020) (citing Wright & Miller, 16A Fed. Prac. & Proc. Juris. § 3954 (5th ed. 2019)). Rather, "[a]bsent entry of a stay, a district court retains jurisdiction to enforce its judgment—via contempt or other means—during the pendency of an appeal." *Escobio*, 946 F.3d at 1251.

The court should grant a motion to enforce if a "prevailing plaintiff demonstrates that a defendant has not complied with a judgment entered against it." *Heartland Hosp. v. Thompson*, 328 F. Supp. 2d 8, 11 (D.D.C. 2004). Included within "a court's power to administer its decrees is the power to construe and interpret the language of the judgment." *Id.* at 11–12 (citing *Hermil*, 838 F.2d at 1153).

ARGUMENT

I. Plaintiffs Have a Judicially Cognizable Interest in Ensuring Compliance with the Court's Decision and Judgment.

It is well settled that "[a] party that obtains a judgment in its favor acquires a 'judicially cognizable' interest in ensuring compliance with that judgment." *Salazar v. Buono*, 559 U.S. 700, 712 (2010). Here, through the Court's Judgment, Plaintiffs acquired a right to have Defendants refrain from any enforcement of "Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) … to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria," Dkt. No. 246 at 53. *See Allen v. Wright*, 468 U.S. 737, 763 (1984), *abrogated on other grounds by Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014). This acquired interest is "judicially cognizable because it was a personal interest, created by law, in having the State refrain from taking specific actions." *Allen*, 468 U.S. at 763.

"Having obtained a final judgment granting relief on their claims," Plaintiffs have "standing to seek its vindication." *Salazar*, 559 U.S. at 712.

II. Defendants are violating this Court's Judgment by enforcing the Rule's categorical ban on Medicaid coverage of gender-affirming medical care.

In its decision, the Court found that "Florida has adopted a rule and statute that prohibit Medicaid payment for these treatments even when medically appropriate," and held that "[t]he rule and statute violate the federal Medicaid statute, the Equal Protection Clause, and the Affordable Care Act's prohibition of sex discrimination." Dkt. No. 246, at 52-53. As such, among other things, the Court "declared that Florida Statutes § 286.31(2) and Florida Administrative Code rule 59G-1.050(7) are invalid to the extent they categorically ban Medicaid payment for puberty blockers and cross-sex hormones for the treatment of gender dysphoria." *Id.*, at 53.

And, of course, "[a]n unconstitutional act [like the Rule] is not a law; it binds no one, and protects no one." *Little Rock & Ft. S. Ry. v. Worthen*, 120 U.S. 97, 101–02 (1887); *see also Coral Springs St. Sys., Inc. v. City of Sunrise*, 371 F.3d 1320, 1334 (11th Cir. 2004) ("There is no question that an unconstitutional statute is void under state law.").

Nonetheless, notwithstanding this Court's decision, Defendants have continued to enforce the Rule's categorical ban on Medicaid coverage of puberty delaying medications and gender-affirming hormones as treatment for gender dysphoria.

For example, citing to the Rule, Defendants told MCOs two months ***after this Court's decision*** was issued, in ***categorical*** terms, that "Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists … and any other procedures that alter primary or secondary sexual characteristics" and that "for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C." **Addendum 1 to Ex. C**, at 1 (emphasis added).

Similarly, Defendants also ***categorically*** denied transgender Medicaid beneficiaries like Ms. Suarez and Mr. Starr. They denied Ms. Suarez Medicaid coverage for hormone treatment for her gender dysphoria on the basis that it is "not a covered benefit." **Ex. A, Attachment 1**. Defendants similarly denied Mr. Starr Medicaid coverage for hormone treatment for her gender dysphoria on the basis that the medication "is not covered for members with a gender identity diagnosis or related diagnosis." **Ex. B, Attachment 1**. These are not situations where Defendants' contractors, reviewed Ms. Suarez's and Mr. Starr's individual circumstances to determine whether hormone treatment was medically necessary for them and then found that Ms. Suarez and Mr. Starr, based on their individual medical needs, did not need the treatment requested. *See Rush v. Parham*, 625 F.

2d 1150, 1155 (5th Cir. 1980). Rather, Defendants have made clear that they will not cover the benefit of hormone treatment to treat gender dysphoria even when it is medically necessary.

Defendants have thus acted as if this Court's decision is a legal nullity that they can simply ignore on their whim. That is not how our legal system works, however. "It is simply an illegal act upon the part of a state official in attempting, by the use of the name of the state, to enforce a legislative enactment which is void because unconstitutional." *Ex parte Young*, 209 U.S. 123, 159 (1908).

Defendants may argue that because there is a variance and waiver process for administrative rules (*see* Fla. Stat. § 120.542; Fla. Admin. Rules 28-104.001 – 28-104.006), the Rule is not categorical and therefore they are not prohibited from enforcing it. That is a red herring. In over nine months of litigation, Defendants failed to develop that argument or present any supporting evidence; rather, they alluded to the supposed variance process as a throwaway point only twice over the course of the entire case: at the end of the hearing on Plaintiffs' Motion for a Preliminary Injunction, and at the very end of trial. Conspicuously absent from trial was any evidence that a single variance was approved for treatment that AHCA has (wrongly) determined is experimental and never medically necessary.

Moreover, Defendants own communications to MCOs and Notices of Adverse Benefit Determinations to transgender Medicaid beneficiaries also make

no reference to case-by-case determinations for coverage of gender-affirming medical care. *See* **Exs. A, B, and C**. To the contrary, these communications, based on and citing to the Rule, are ***categorical*** in nature and do not communicate the existence or availability of any exceptions or waivers.

What is more, Defendant Weida's own statements are similarly unequivocal, making clear that Defendants will not cover this medical care, period. *See* Section B(3), *supra*.

Finally, the term categorical is defined as "absolute, unqualified." *See* categorical, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/categorical (accessed Sept. 25, 2023). The Rule, on its face, categorically excludes from Medicaid coverage all gender-affirming medical treatment, including puberty-delaying medications and hormones. And, on its face, the Rule has no exceptions.[3]

[3] The existence of the waiver-and-variance process for administrative rules to which Defendants have alluded to in the past does not make the Rule at issue here non-categorical. For one, there is no evidence, and after nine months of discovery, Defendants presented no argument that the waiver-and-variance process for administrative rules operates to make medical necessity determinations when the agency has determined that a particular medical treatment is never medically necessary. Indeed, the process is meant to grant waivers that will *serve the purpose* of the underlying statute and rule. For another, the Rule, at a minimum, categorically singles out gender-affirming medical care for denials in the first instance, notwithstanding medical necessity.

Taken to its logical conclusion, Defendants could evade any legal requirements set forth by federal law by adopting an unlawful rule and simply

Here, Plaintiffs facially challenged the Rule and the Court ruled in no uncertain terms that the Rule "violate[s] the federal Medicaid statute, the Equal Protection Clause, and the Affordable Care Act's prohibition of sex discrimination." Dkt. No. 246, at 53. That is enough to communicate to Defendants that they may not enforce the Rule in any way. Indeed, the Court's decision "relates to conduct that the court concluded was unlawful" rather than merely to "particular statutory provisions." *One Wisc. Inst. v. Thomsen*, 351 F. Supp. 3d 1160, 1162 (W.D. Wisc. 2019).

Accordingly, Plaintiffs respectfully ask this Court to grant the instant motion and enforce its Judgment by instructing Defendants that the Court's declaratory relief prevents them from enforcing the Challenged Exclusion, and by issuing any other remedial relief it believes appropriate.

III. In the Alternative, the Court Should Clarify that Its Decision Prevents Defendants from Enforcing the Rule Against Anyone.

While Plaintiffs believe the Findings of Fact and Conclusions of Law and resulting Judgment are clear, in the alternative, Plaintiffs request that this Court clarify its Judgment to make clear that Defendants cannot enforce the Challenged Exclusion against anyone. The Court can do so by clarifying the scope of its declaratory relief, or by expanding the scope of its injunctive relief.

---

arguing that there is also a waiver-and-variance process. Of course, that cannot be the law.

With regards to expanding the scope of injunctive relief, in civil rights cases "injunctive relief may benefit non-parties as well as parties." *Carmichael v. Birmingham Saw Works*, 738 F.2d 1126, 1136 (11th Cir. 1984); *see also Bresgal v. Brock*, 843 F.2d 1163, 1171 (9th Cir. 1987) ("Class-wide relief may be appropriate even in an individual action."); *Garcia v. Stillman*, No. 22-CV-24156, 2023 WL 5095540, at *20 (S.D. Fla. Aug. 9, 2023) (permanently enjoining Defendants from enforcing Article II, Section 8(f)(2) of the Florida Constitution, without limitation).

Indeed, in *Garrido*, a case brought by a single individual, the district court permanently enjoined AHCA "from enforcing Florida Behavioral Health Rule 2–1–4 as it relates to autism, Autism Spectrum Disorder, and Applied Behavioral Analysis treatment." *K.G. ex rel. Garrido v. Dudek*, 864 F. Supp. 2d 1314, 1327 (S.D. Fla. 2012), *aff'd in part, rev'd in part sub nom. Garrido v. Dudek*, 731 F.3d 1152 (11th Cir. 2013). The Eleventh Circuit spoke with approval of this aspect of the district court's permanent injunction when it held that "the district court did not abuse its discretion in issuing a permanent injunction that overrules AHCA's determination that ABA is experimental (and AHCA's larger determination that ABA is never medically necessary) and requires Medicaid coverage of this treatment." *Garrido*, 731 F.3d at 1160.

CONCLUSION

Defendants have continued to enforce a Rule that the Court has determined "violate[s] the federal Medicaid statute, the Equal Protection Clause, and the Affordable Care Act's prohibition of sex discrimination" and is therefore "invalid." Dkt. No. 246, at 53. Accordingly, Plaintiffs respectfully request that the Court enforce its Judgment, as well as its Findings of Fact and Conclusions of Law, by instructing Defendants that the Court's declaratory relief prevents them from enforcing Rule 59G-1.050(7) of the Florida Administrative Code and issuing any other remedial relief it believes appropriate.

In the alternative, Plaintiffs respectfully request that the Court clarify its decision and order to make clear that the Rule, as adopted, is unlawful, or grant broader injunctive relief preventing Defendants from enforcing the Challenged Exclusion.

Dated this 4th day of October 2023.

Respectfully submitted,

/s/ Omar Gonzalez-Pagan
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

Omar Gonzalez-Pagan*
120 Wall Street, 19th Floor
New York, NY 10005
(212) 809-8585
ogonzalez-pagan@lambdalegal.org

PILLSBURY WINTHROP SHAW PITTMAN, LLP

Jennifer Altman (Fl. Bar No. 881384)
Shani Rivaux (Fl. Bar No. 42095)
600 Brickell Avenue, Suite 3100
Miami, FL 33131
(786) 913-4900
jennifer.altman@pillsbury.com
shani.rivaux@pillsbury.com

William C. Miller*
Gary J. Shaw*
1200 17th Street N.W.
Washington, D.C. 20036
(202) 663-8000
william.c.miller@pillsburylaw.com

* *Admitted pro hac vice*

/s/ Simone Chriss
SOUTHERN LEGAL COUNSEL, INC.

Simone Chriss (Fl. Bar No. 124062)
Chelsea Dunn (Fl. Bar No. 1013541)
1229 NW 12th Avenue
Gainesville, FL 32601
(352) 271-8890
Simone.Chriss@southernlegal.org
Chelsea.Dunn@southernlegal.org

FLORIDA HEALTH JUSTICE PROJECT

Katy DeBriere (Fl. Bar No. 58506)
3900 Richmond Street
Jacksonville, FL 32205
(352) 278-6059
debriere@floridahealthjustice.org

NATIONAL HEALTH LAW PROGRAM

Abigail Coursolle*
3701 Wilshire Boulevard, Suite 315
Los Angeles, CA 90010
(310) 736-1652
coursolle@healthlaw.org

Catherine McKee*
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27514
(919) 968-6308
mckee@healthlaw.org

Counsel for Plaintiffs

CERTIFICATE OF CONFERRAL

Pursuant to Local Rule 7.1(D), Counsel for Plaintiffs certifies they conferred with Defendants' counsel via email, including communications on September 25, 26, 27, and October 2, 2023. Defendants have not indicated their position on Plaintiffs' motion.

CERTIFICATE OF WORD COUNT

As required by Local Rules 7.1(F), I certify that this Motion and Memorandum of Law contains 4,168 words.

CERTIFICATE OF SERVICE

I hereby certify that on this 4th day of October 2023, a true copy of the foregoing has been filed with the Court utilizing its CM/ECF system, which will transmit a notice of electronic filing to counsel of record for all parties in this matter registered with the Court for this purpose.

/s/ Omar Gonzalez-Pagan
Counsel for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

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

JASON WEIDA, et al.,

Defendants.
_____/

DECLARATION OF CECE SUAREZ

I, Cece Suarez, hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I receive my health coverage through Florida Medicaid, as administered through Simply Healthcare Plans ("Simply Health").

3. I am a woman and I am also transgender. I have been prescribed hormone therapy as medically necessary treatment for my diagnosis of gender dysphoria. The hormone I am currently prescribed is Delestrogen.

4. My prescription of Delestrogen has been covered by my Medicaid plan previously, but on August 18, 2023, I received a Notice of Adverse Benefit Determination informing me that my coverage has been terminated.

5. The Notice of Adverse Benefit Determination states the following as the sole basis for the termination: "The requested service is not a covered benefit."

6. On August 28, 2023, within the ten-day period for requesting continuation of services, I submitted a request to appeal the termination, via email and fax, to Simply Health Plan in accordance with the Member Handbook.

7. The August 28, 2023 correspondence stated: "I received the notice of adverse benefit determination dated August 18, 2023. I disagree with the decision because the benefit is a covered benefit. I ask that my services continue during the plan appeal. I am requesting that services continue no later than 10 days after the date of the letter and am therefore entitled to continued benefits during my appeal. Please send written confirmation of receiving this appeal as set forth in the Simply Health Plan member handbook. Additionally, I'm currently arranging for legal representation. Please send me the forms I need to fill out for my attorney to represent me."

8. On August 29, 2023, I received an email from Simply Health requesting additional information related to the denial, which I provided promptly. I have called to check on the status of the request for continued services and the request for appointing an attorney representative but have not received any information from Simply Health at this time.

9. On or about September 7, 2023, I contacted my pharmacy to ask whether I would be able to pick up my prescription Delestrogen for the treatment of my gender dysphoria, and I was informed by the pharmacist that the request for coverage of the prescription was denied.

10. I cannot afford to pay out of pocket for the prescription. If Medicaid will not pay for my Delestrogen, I will not have another way to access this needed medical treatment prescribed by my treating physician.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 27th day of September 2023.

Respectfully Submitted,

DocuSigned by:
Cece Suarez
9B215D7357341C49B...

Cece Suarez

Attachment 1

Simply healthcare

simplyhealthcareplans.com

PLAN ID: [redacted]

August 18, 2023

[redacted]SUAREZ
[redacted]

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear [redacted]SUAREZ:

Simply Healthcare Plans, Inc. has reviewed your request for DELESTROGEN 100 MG/5 ML VIAL, which we received on 2/21/2023. After our review, this service has been TERMINATED as of 8/18/2023.

We made our decision because:
(Check all boxes that apply.)

☐ We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010.)*

- ☐ Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain
- ☐ Must be individualized, specific, and consistent with symptoms or diagnosis of illness or injury, and not be in excess of the patient's needs
- ☐ Must meet accepted medical standards and not be experimental or investigational
- ☐ Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- ☐ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider
  (The convenience factor is not applied to the determination of the medically necessary level of private duty nursing [PDN] for children under the age of 21.)

☒ The requested **service is not a covered benefit**

☐ **Other authority:** <<explain and cite authority>>

[redacted]

- Your name
- Your member ID number
- Your Medicaid ID number
- A phone number where we can reach you or your legal representative

You may also include the following information if you have it:

- Why you think we should change the decision
- Any written comments, documents, medical records, or provider letters that might help your appeal
- Who you would like to help with your plan appeal

Within five days of getting your plan appeal request, we will tell you in writing that we got your plan appeal request, unless you ask for an expedited (fast) plan appeal. We will give you an answer to your plan appeal within 30 calendar days of your asking for a plan appeal.

How to ask for an expedited (fast) plan appeal if your health is at risk

You can ask for an "expedited plan appeal" if you think that waiting 30 days for a plan appeal decision resolution could put your life, health, or your ability to attain, maintain, or regain maximum function in danger. You can call or write us (see address on the prior page/above), but you need to make sure that you ask us to **expedite** the plan appeal. We may not agree that your plan appeal needs to be expedited, but you will be told of this decision. We will still process your plan appeal under normal time frames. If we do need to expedite your plan appeal, you will get our plan appeal resolution within 48 hours after we receive your plan appeal request. This is true whether you asked for the plan appeal by phone or in writing.

How to ask for your services to continue

If you are now getting a service that is scheduled to be reduced, suspended, or terminated, you have the right to keep getting those services until a final decision is made in a plan appeal and, if requested, fair hearing. If your services are continued, there will be no change in your services until a final decision is made in your plan appeal and, if requested, fair hearing.

If your services are continued and our decision is upheld in a plan appeal or fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during the plan appeal, you **must** file your plan appeal **and** ask to continue your services within this time frame: File a request for your services to continue with Simply no later than 10 days after this letter was mailed **or** on or before the first day that your services are scheduled to be reduced, suspended, or terminated, **whichever is later**. You can ask for a plan appeal by phone. If you do this, you must then **also** make a request in writing. **Be sure to tell us if you want your services to continue.**

To have your services continue during the fair hearing, you **must** file your fair hearing request **and** ask for continued services within this time frame: If you were receiving services during your

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

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

JASON WEIDA, et al.,

Defendants.
_____/

DECLARATION OF KANDLE STARR

I, Kandle Starr, hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I receive my health coverage through Florida Medicaid, as administered through Sunshine State Health Plan ("Sunshine Health").

3. I am a man and I am also transgender. I have been prescribed Norethindrone as medically necessary treatment for my diagnosis of gender dysphoria.

4. My prescription of Norethindrone has always been covered by my Medicaid plan, but on September 30, 2023, I was informed by my pharmacy that coverage for my medication was denied. The "Rejection Message" provided by my

pharmacist states: "Rejection Code/Reason: THIS PRODUCT IS NOT COVERED FOR MEMBERS WITH A GENDER IDENTITY DISORDER OR RELATED DIAGNOSIS." The "rejection message" also indicated the number of times the pharmacy had attempted to adjudicate the claim. ("Adjudication attempts: 7").

5. I cannot afford to pay out of pocket for the prescription. As noted on the "rejection message," the out of pocket cost for my medication is $203.99. If Medicaid will not pay for my Norethindrone, I will not have another way to access the needed medical treatment prescribed by my treating physician.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 2nd day of October, 2023.

Respectfully Submitted,

DocuSigned by:
Kandle Starr
057FCBB081DF4D6...

Kandle Starr

Attachment 1

Rejection Message

User: [redacted] wks07:Alt-F2 - WS-CHAIN : Sat, 30 Sep 2023 3:03:32 PM

STARR, KANDLE A.
DOB [redacted] **Age** 19 Years **Gender** Male **Address** [redacted] **Phone Number** [redacted] **Rx Number** 0991020

Prescriber TUDEEN, BRADLEY MICHAEL **NPI** 1700271038 **Phone No.** (352) 265-7001 **FAX No.** (352) 265-9584

Drug Name NORETHINDRONE 5 MG TABLET **NDC #** 65162047505 **Qty** 90
SIG TAKE 3 TABLETS BY MOUTH EVERY DAY. NOT COVERED **Days Supply** 30 **DAW Code** 0

TP Plan Name SUNSHINE STATE HP MCO: FL **BIN** 004336 **PCN** MCAIDADV **Cardholder ID** 00204019201 **Person Code** 01
Help Desk No. (800) 311-0539 **TP Plan Code** 26450 **Group** RX5441 **Relationship Code** H

Store NPI 1184728057 **Authorization#** 232735045610303999 **Cash Price** $ 203.99

Ln No.	Priority	TP Plan Code	TP Plan Name	Processor Name	Status	Copay
1.	Primary	26450	SUNSHINE STATE HP MCO: FL	CAREMARK RXBE	REJECTED	

Rejection Code/Reason	Message
39 - M/I Diagnosis Code	THIS PRODUCT IS NOT COVERED FOR MEMBERS WITH A GENDER IDENTITY DISORDER OR RELATED DIAGNOSIS

Select a function and press <Enter>
Select Line (#), Patient Notes (N), Edit Rx (E), Additional Info (A), Transaction History (TH), Reprocess (R), View Action Note(AN), Make Call (MC), TP Plan Details (TP), Skip Item (SI), Exit (X)

Adjudication Attempts	7
Last Updated Date/Time	09/30/2023 03:00 PM
Last Updated By	K,Camp

Patient F1 | Prescriber F2 | Drug F3 | Third Party F4 | Profile F5 | Store Portal F6 | Clinical F7 | Refill F8 | Dashboard F9 | Log In/Out Credentials F10 | Store Info F11 | Rx Status F12

THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

DECLARATION OF ATTORNEY OMAR GONZALEZ-PAGAN

I, Omar Gonzalez-Pagan, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am over the age of eighteen and make this declaration from my own personal knowledge. If called as a witness, I could and would testify competently to the matters stated herein.

2. I am an attorney with Lambda Legal Defense and Education Fund, Inc., and I have been retained by Plaintiffs as co-counsel in the above-captioned matter.

3. I make this declaration in support of Plaintiffs' Motion to Enforce the Court's Judgment or, Alternatively, to Clarify the Court's Judgment.

4. Attached as **Composite Addendum 1** to this declaration are true and correct copies of letters sent by the Florida Agency for Health Care Administration to five managed care organizations (MCOs)—namely, Simply Healthcare Plans, Inc.;

Sunshine State Health Plan, Inc.; Humana Medical Plan, Inc.; Molina Healthcare of Florida, Inc.; and Children's Medical Services Health Plan—directing the MCOs to comply with Rule 59G-1.050(7) of the Florida Administrative Code, as publicly published by The Daily Signal on August 18, 2023.[1]

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of October 2023.

By: */s/ Omar Gonzalez-Pagan*
Lambda Legal Defense
and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, NY 10005
(212) 809-8585
ogonzalez-pagan@lambdalegal.org

[1] *See* https://first-heritage-foundation.s3.amazonaws.com/live_files/2023/08/AHCA-Letters.pdf (last accessed Oct. 4, 2023).

Composite Addendum 1

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO BRODRIGUEZ2@SIMPLYHEALTHCAREPLANS.COM

August 17, 2023

Case No.: 2023012203
File No.: 601000022

Ms. Blanche Fuentes
Contract Manager
Simply Healthcare Plans, Inc.
9250 West Flagler Street, Suite 600
Miami, FL 33174

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Ms. Fuentes:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP068 (Contract), Simply Healthcare Plans, Inc. (Simply) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In January 2023, Simply inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $2,500 for Simply's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012203 and AHCA File No. 601000022 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

Pursuant to Attachment II, Section XIV.A, Simply "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Simply must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Simply has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Leeanne Peoples, at 850-412-4041 or via email at Leeanne.Peoples@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

K Bailey

Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Simply may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO BRODRIGUEZ2@SIMPLYHEALTHCAREPLANS.COM

August 17, 2023

Case No.: 2023012208
File No.: 601000022

Ms. Blanche Fuentes
Contract Manager
Simply Healthcare Plans, Inc.
9250 West Flagler Street, Suite 600
Miami, FL 33174

Re: Monetary Sanction for Failure to Comply with Florida Administrative Code (F.A.C.)

Dear Ms. Fuentes:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP068 (Contract), Simply Healthcare Plans, Inc. (Simply) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

Simply paid for services related to the treatment of gender dysphoria for a minor performed by Dr. Sara Danker (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section II.A, item 3., “[t]he Managed Care Plan shall comply with all provisions of this Contract, including all Attachments, applicable Exhibit(s), and any amendments and shall act in good faith in the performance of these Contract provisions.” Pursuant to Attachment II, Section XIII.A, item 2., “[t]he Managed Care Plan agrees that failure to comply with all provisions of this Contract may result in the assessment of sanctions and/or termination of this Contract, in whole or in part, in accordance with Section XIII., Sanctions.”

Pursuant to Attachment II, Section XIII.A, “[t]he Managed Care Plan shall comply with all requirements and performance standards set forth in this Contract” and “[i]n the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan…”

Pursuant to Attachment II, Section XIII.F, Simply waives any dispute not raised within twenty-one (21) days of receiving the sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

Please contact your Contract Manager, Leeanne Peoples, at 850-412-4041 or via email at Leeanne.Peoples@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

K Bailey

Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO WARREN.MOORE@SUNSHINEHEALTH.COM

August 17, 2023

Case No.: 2023012201
File No.: 6

Mr. Warren Moore
Senior Compliance Administrator
Sunshine State Health Plan, Inc.
215 South Monroe Street, Ste. 535
Tallahassee, FL 32301

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Mr. Moore:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP060 (Contract), Sunshine State Health Plan, Inc. (Sunshine) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In December 2022 and January 2023, Sunshine inappropriately paid for prescriptions related to the treatment of gender dysphoria for five (5) minors and one (1) adult (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., “[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan’s failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed

Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $15,000 for Sunshine's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $15,000 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012201 and AHCA File No. 6 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals

or disputes that are not delivered in the format and timeframes specified by the Agency.

Pursuant to Attachment II, Section XIV.A, Sunshine "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Sunshine must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Sunshine has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Joy Williams, at 850-412-4169 or via email at Joy.Williams@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

K Bailey

Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Sunshine may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO RQUINTANA3@HUMANA.COM

August 17, 2023

Case No.: 2023012206
File No.: 4

Ms. Rebecca Quintana
Contract Manager
Humana Medical Plan, Inc.
3401 SW 160 Avenue
Miramar, FL 33027

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Ms. Quintana:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP059 (Contract), Humana Medical Plan, Inc. (Humana) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In January 2023, Humana inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., “[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan’s failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan’s subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach.”

The Agency is assessing liquidated damages in the amount of $2,500 for Humana's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012206 and AHCA File No. 4 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

Pursuant to Attachment II, Section XIV.A, Humana "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Humana must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Humana has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Marco Waters, at 850-412-4327 or via email at Marco.Waters@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

K Bailey

Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Humana may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO HECTOR.FELICIANO@MOLINAHEALTHCARE.COM

August 17, 2023

Case No.: 2023012205
File No.: 5

Mr. Hector Feliciano
VP of Government Contract
Molina Healthcare of Florida, Inc.
8300 NW 33 Street, Suite 300
Doral, FL 33027

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Mr. Feliciano:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP072 (Contract), Molina Healthcare of Florida, Inc. (Molina) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In December 2022, Molina inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., “[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan’s failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan’s subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach.”

The Agency is assessing liquidated damages in the amount of $2,500 for Molina's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012205 and AHCA File No. 5 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

Pursuant to Attachment II, Section XIV.A, Molina "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Molina must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Molina has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Marco Waters, at 850-412-4327 or via email at Marco.Waters@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

K Bailey

Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Molina may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO AMIE.BOUNDS@FLHEALTH.GOV

August 18, 2023

Case No.: 2023012200
File No.: 13

Ms. Amie Bounds
Contract Manager
Department of Health
Children's Medical Services Health Plan
4052 Bald Cypress Way, Bin A-06
Tallahassee, Florida 32399

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Ms. Bounds:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP078 (Contract), the Florida Department of Health Children's Medical Services Health Plan (CMS Plan) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In February 2023, CMS Plan inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed

Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $2,500 for CMS Plan's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012200 and AHCA File No. 13 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals

or disputes that are not delivered in the format and timeframes specified by the Agency.

Pursuant to Attachment II, Section XIV.A, CMS Plan "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, CMS Plan must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that CMS Plan has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Chanel Smith, at 850-412-4030 or via email at Chanel.Smith@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

K Bailey

Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, the CMS Plan may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

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

JASON WEIDA, et al.,

Defendants.
_____/

DECLARATION OF DR. LYDIA FEIN

I, Dr. Lydia Fein, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I am a physician and an assistant professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of Miami Miller School of Medicine ("UM"). I am board certified in Obstetrics and Gynecology.

3. My primary clinical focus is on gender-affirming care, and I lead the transgender health program where I specialize in the medical care of gender diverse patients.

4. In my practice, I see many transgender patients who receive their health coverage through Florida's Medicaid program.

5. On August 23, 2023, I received an email from UM stating:

> "[T]he Agency for Health Care Administration amended the General Medicaid Policy to exclude coverage for treatments of gender dysphoria. The excluded services include: 1. Puberty blockers; 2. Hormones and hormone antagonists; 3. Sex reassignment surgeries; and 4. Any other procedures that alter primary or secondary sexual characteristics. As a result, our office has been compelled to refund any Medicaid and Medicaid Managed Care reimbursement for services related to the provision of gender affirming care as of the effective date of the regulation (August 21, 2022) to present. Consequently, for the foreseeable future, and until any further notice on the status/overturn of the current policy, we ask that you please abstain from billing Medicaid or any Medicaid Managed care plan for any implicated services."

6. As a result of the Agency for Health Care Administration compelling my institution to refund reimbursement for services provided to transgender Medicaid beneficiaries, my institution is requiring that providers such as myself cease providing treatment for gender dysphoria to any patient who is enrolled in Medicaid or any Medicaid Managed care plan, because my institution will not be able to bill Medicaid for these services. As a result, I have had to cancel all patient appointments for transgender patients who receive their health coverage through Florida Medicaid and need such medical care as treatment for their gender dysphoria.

7. This is causing harm to my transgender patients, many of whom do not have access to alternative gender-affirming medical care providers who accept Medicaid.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 27th day of September, 2023.

Respectfully Submitted,

DocuSigned by:

C9DBA2E5CB344E9...

Lydia Fein, M.D.

Attachment 1

FW: Notice on Florida's Ban on Medicaid Coverage on Gender Affirming Care

From: [redacted]@med.miami.edu>
Sent: Wednesday, August 23, 2023 4:26 PM
To: Fein, Lydia <LAFein@med.miami.edu>; [redacted]
Subject: Fwd: Notice on Florida's Ban on Medicaid Coverage on Gender Affirming Care

Please see email below related to billing Medicaid.

Thanks,

[redacted]

Sr. Administrative Officer (SAO)

Department of Obstetrics, Gynecology & Reproductive Sciences

Don Soffer Clinical Research Center

1120 NW 14th Street, 1156

Miami, FL 33136

T: (305) 689-8001

Email: Jdp147@med.miami.edu

University of Miami Health System / University of Miami Miller School of Medicine

From: [redacted]
Sent: Wednesday, August 23, 2023 4:21:38 PM
To: [redacted]
Cc: [redacted]
Subject: FW: Notice on Florida's Ban on Medicaid Coverage on Gender Affirming Care

Dear Team,

The Office of Billing Compliance would like to inform you that effective August 21st, 2022, the Agency for Health Care Administration amended the General Medicaid Policy rule to exclude coverage for treatments of gender dysphoria. The excluded services include:

1. Puberty blockers;
2. Hormones and hormone antagonist;
3. Sex reassignment surgeries; and
4. Any other procedures that alter primary or secondary sexual characteristics.

As a result, our office has been compelled to refund any Medicaid and Medicaid Managed Care reimbursement for services related to the provision of gender affirming care as of the effective date of the regulation (August 21, 2022) to present.

Consequently, for the foreseeable future, and until any further notice on the status/overturn of the current policy, we ask that you please abstain from billing Medicaid or any Medicaid Managed care plan for any implicated services.

Thank you for your understanding and cooperation.

[redacted], please distribute to other billing providers in your team, as you deem appropriate.

Kind Regards,

[redacted]

Billing Compliance Manager

UHealth Compliance

Office of Billing Compliance

1501 NW 9th Avenue, 4th Floor

Miami, FL 33136

(305)243-3393

Website: www.officeofregulatorycompliance.med.miami.edu

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM