**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF MISSISSIPPI**
**SOUTHERN DIVISION**

STATE OF TENNESSEE, STATE OF MISSISSIPPI, STATE OF ALABAMA, STATE OF GEORGIA, STATE OF INDIANA, STATE OF KANSAS, COMMONWEALTH OF KENTUCKY, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF OHIO, STATE OF OKLAHOMA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, COMMONWEALTH OF VIRGINIA, AND STATE OF WEST VIRGINIA,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; MELANIE FONTES RAINER, in her official capacity as the Director of the Office for Civil Rights; CENTERS FOR MEDICARE AND MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services,

*Defendants*.

Civil Action No. 1:24-cv-161-LG-BWR

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**PLAINTIFFS' URGENT AND NECESSITOUS MOTION FOR § 705 RELIEF AND A PRELIMINARY INJUNCTION AND FOR EXPEDITED CONSIDERATION**

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The Plaintiff States challenge the U.S. Department of Health and Human Services' latest attempt to redefine sex discrimination under Section 1557 of the Affordable Care Act to encompass gender identity. *See* HHS, *Nondiscrimination in Health Programs and Activities*, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule"). As explained in Plaintiffs' Complaint [ECF 1] and in the accompanying

memorandum, HHS's 2024 Rule—set to take effect July 5, 2024—is contrary to law, beyond the agency's statutory authority, unconstitutional, and violates the Administrative Procedure Act.

The Plaintiff States bring this motion to seek preliminary relief from the unlawful 2024 Rule under 5 U.S.C. § 705, which allows courts to stay the effective date of a challenged rule pending judicial review, as well as under Federal Rule of Civil Procedure 65. Without preliminary relief, the 2024 Rule will impose unrecoverable compliance costs, interfere with States' longstanding authority to regulate the practice of medicine within their borders, require compliance with regulations that conflict with States' duly enacted laws protecting vulnerable citizens from risky and unproven medical interventions, and force States to subsidize those costly interventions through their state-sponsored insurance plans. If a State or healthcare provider balks at HHS's gender-identity agenda, they risk losing all federal funding. For the States, that could amount to a loss of *hundreds of billions of dollars* in aid for some of their most vulnerable citizens. Both the balance of the equities and the public interest also favor temporarily maintaining the status quo pending judicial review of the 2024 Rule.

Accordingly, the Plaintiff States request the entry of an order:

a. Declaring the 2024 Rule's redefinition of sex discrimination likely unlawful under Section 1557 of the Affordable Care Act, the Administrative Procedure Act, and the U.S. Constitution;

b. Staying the effective date of the 2024 Rule, pursuant to 5 U.S.C. § 705, as it pertains to the provisions set forth at 42 C.F.R. §§ 438.3, 438.206, 440.262, 460.98, 460.112; 45 C.F.R. §§ 92.5, 92.6, 92.7, 92.8, 92.9, 92.10, 92.101, 92.206-211, 92.301, 92.303, 92.304; and any other provision of the 2024 Rule applied with respect to "sex" discrimination that encompasses gender identity;

c. Preliminarily enjoining HHS, and any other agency or employee of the United States, from enforcing, relying on, implementing, or otherwise acting pursuant to the 2024 Rule's challenged provisions; and

d. Granting any and all other preliminary relief the Court deems proper.

In support of the instant motion, the Plaintiff States rely on their Complaint [ECF 1], the accompanying memorandum of law, and the following exhibits attached hereto:

Exhibit A – Declaration of Stephen Smith (Tennessee);

Exhibit B – Declaration of Cody Smith (Mississippi);

Exhibit C – Declaration of Kimberly Sullivan (Louisiana);

Exhibit D – Declaration of Jeremy Brunssen (Nebraska);

Exhibit E – Declaration of Cheryl Roberts (Virginia); and

Exhibit F – Declaration of Steven Voigt (Ohio);

Exhibit G – Declaration of Robert Kerr (South Carolina);

Exhibit H – Declaration of Wanda Davis (Alabama);

Exhibit I – Declaration of Michael Althoff (South Dakota); and

Exhibit J – Declaration of Stephanie Azar (Alabama).

Given the 2024 Rule's effective date of July 5, 2024, the Plaintiff States respectfully request expedited consideration of their motion pursuant to Local Rule 7(b)(8). The Plaintiff States would propose the following briefing schedule, which would align the preliminary-motions schedule in this case with that of a related case pending before this Court, *McComb Children's Clinic, Ltd. v. Becerra*, Civil Action No. 5:24-cv-48:

- June 13, 2024 — Plaintiff States' Motion for § 705 Stay and Preliminary Injunction Filed
- June 24, 2024 — Defendants' Response Due
- June 26, 2024 — Plaintiff States' Reply Brief Due

Counsel for the Plaintiff States has conferred with Counsel for the Defendants, Sarah M. Suwanda, who represented that the Defendants oppose this Motion and expedited consideration of the same. The Plaintiff States further requested that Defendants agree to a temporary stay of any enforcement of the 2024 Rule against the Plaintiff States until the end of July to provide additional time for briefing of the instant motion, but Defendants object to any such stay.

Dated: June 13, 2024

Respectfully submitted,

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*Admitted *Pro Hac Vice*
**Pro Hac Vice Application Forthcoming

## CERTIFICATE OF SERVICE

I hereby certify that on June 13, 2024, a true and correct copy of the foregoing document was served via the Court's electronic filing system, which sent notice of filing to all counsel of record.

*/s/ Steven J. Griffin*
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*Counsel for Plaintiff State of Tennessee*

# EXHIBIT A

Declaration of Stephen Smith, Director of the Division of TennCare

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

THE STATE OF TENNESSEE, et al.,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

*Defendants*.

Case No. 1:24-cv-161-LG-BWR

**DECLARATION OF STEPHEN SMITH**

Pursuant to 28 U.S.C. § 1746, I, Stephen Smith, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Director of the Division of TennCare ("TennCare"). TennCare is responsible for administering Tennessee's Medicaid program, as well as the State's Children's Health Insurance Program ("CHIP" or "CoverKids") and Program of All-Inclusive Care for the Elderly ("PACE").

3. As Director, I am responsible for the management of the Division of TennCare and its programs. These responsibilities include ensuring compliance with state and federal anti-discrimination laws. That comprises overseeing the teams that review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department of Health and Human

Services ("HHS"), to determine whether they necessitate policy changes. And where such changes are necessary—either because TennCare does not have a policy required by the regulation or has a conflicting policy—I am ultimately responsible for executing a plan for bringing TennCare into compliance.

4. TennCare's mission is to improve lives through high-quality, cost-effective care. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and TennCare employees. TennCare currently serves almost 1.5 million Tennesseans, including low-income individuals, pregnant women, children, caretaker relatives of young children and older adults and adults with disabilities.

5. As of May 8, 2024, approximately 824,000 minors were enrolled in Tennessee's Medicaid program and CoverKids.

6. As of May 8, 2024, approximately 670,000 adults were enrolled in Tennessee's Medicaid program and CoverKids.

7. TennCare received approximately $10.3 billion in total federal funding in State Fiscal Year 2022-2023. That includes more than $10.2 billion in federal funding for Tennessee's Medicaid program, $109.8 million in federal funding for CoverKids, and $10.8 million in federal funding for the State's PACE program. TennCare estimates that the federal share expended for each program will be even greater in State Fiscal Year 2023-2024.

8. HHS funding is used to pay a portion of TennCare's administrative costs, including many TennCare employees' salaries and benefits. Most TennCare employees' salaries and benefits are partially funded by the Medicaid Administration Grant, and certain employees' salaries and benefits are specifically approved under distinct grant programs, such as Medicaid's Money Follows the Person.

9. TennCare annually contributes approximately $11.6 million to Tennessee's state employee health insurance plan ("State Plan") on behalf of its employees, including approximately $7.3 million in HHS funds.

10. TennCare's Medicaid program does not provide coverage for sex-transition surgeries. *See* Tenn. Comp. R. & Regs. 1200-13-13-.10.

11. CoverKids maintains the same exclusions adopted by TennCare's Medicaid program, including its exclusion of coverage for sex-transition surgeries. *See* Tenn. Comp. R. & Regs. 1200-13-21-.06.

12. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

13. If the 2024 Rule requires state Medicaid programs and other health insurance plans to cover sex-transition surgeries, Tennessee risks losing significant federal funding.

14. Avoiding that loss would require TennCare to make changes to its administrative rules. Changing rules is an administratively burdensome process that requires cross-government cooperation and results in the expenditure of state resources. The administrative process for permanent rules, like those that govern the terms of Tennessee's Medicaid and CoverKids programs, is governed by the Tennessee Uniform Administrative Procedures Act and takes approximately nine months to complete. This process includes rule drafting, obtaining the review and approval of the offices of the Governor and Attorney General, posting for public comment, rule-making hearing, and a hearing before the Joint Government Operations Committee of the Tennessee legislature. In addition, the Tennessee General Assembly reaffirms the existence of all

executive branch rules through legislation on an annual basis. Thus, any compliance with HHS's new regulations would require immediate expenditure of significant resources.

15. Moreover, if Tennessee's Medicaid and CoverKids programs were required to cover sex-transition surgeries, there would be an immediate increase in state and federal expenditures.

STEPHEN SMITH

Dated: 6.10.2024

# EXHIBIT B

Declaration of Cody Smith, Representative for the Mississippi Division of Medicaid

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

THE STATE OF TENNESSEE, et al.,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

*Defendants*.

Case No. 1:24-cv-161-LG-BWR

**DECLARATION OF CODY SMITH**

Pursuant to 28 U.S.C. § 1746, I, Cody Smith, declare as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as an attorney within the Mississippi Division of Medicaid. The Mississippi Division of Medicaid is responsible for administering Mississippi's Medicaid Program, as well as Mississippi's Children's Health Insurance Program ("CHIP").

3. As an attorney with the Mississippi Division of Medicaid, I am responsible for legislative affairs and advise on policy matters for the Mississippi Division of Medicaid and its programs.

4. The Mississippi Division of Medicaid's mission is to provide health insurance coverage to eligible beneficiaries. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and the Mississippi State Government. As

of May 1, 2024, Mississippi Medicaid and CHIP served approximately 752,000 Mississippians, including low income children; low income aged, blind, and disabled individuals; low income parents and caretakers; and pregnant women.

5. As of May 1, 2024, approximately 412,306 minors between the ages of 0-19 were enrolled in the Mississippi Medicaid Program and CHIP.

6. As of May 1, 2024, approximately 340,526 adults were enrolled in the Mississippi Medicaid Program and CHIP.

7. The Mississippi Division of Medicaid is expected to receive approximately $6.34 billion in total federal funding in State Fiscal Year 2024. The Mississippi Division of Medicaid expects that the federal share expended for the programs will be even greater in State Fiscal Year 2025.

8. The Mississippi Medicaid Program and CHIP do not cover any "operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form," and the Mississippi Medicaid Program and CHIP exclude coverage if the service is "experimental, investigational, or cosmetic in nature." *See* Miss. Admin. Code Pt. 200, R. 2.2(A)(7), R. 5.1(B)(7).

9. The Mississippi Division of Medicaid is barred by state law from providing coverage for gender transition procedures for a person under the age of 18. See Miss. Code Ann.§43-13-117.7.

10. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

11. If the 2024 Rule requires the Mississippi Medicaid Program and CHIP to cover operative procedures to treat a mental condition, to cover services that are cosmetic in nature, or to cover gender transition procedures for a person under the age of 18, Mississippi will incur additional costs and risks losing existing federal funds because the Mississippi Division of Medicaid would be required to provide federally mandated services that do not comply with state law.

12. If the 2024 Rule requires the Mississippi Medicaid Program and CHIP to cover operative procedures to treat a mental condition, to cover services that are cosmetic in nature, or to cover gender transition procedures for a person under the age of 18, the only option that the Mississippi Division of Medicaid has to avoid these extra costs and the potential loss of existing federal funds would be making changes to its administrative rules, which is an administratively burdensome and costly process that requires cross-government cooperation and results in the expenditure of state resources. The administrative process for changes to the administrative rules, like those that govern the terms of the Mississippi Medicaid Program and CHIP, is governed by Mississippi's administrative procedures laws. This process includes rule drafting, potentially preparing financial impact statements, executive review of the proposed rule, submission of the proposed rule to the Secretary of State's office including a public comment period, and a final filing before the rule can be effective. Thus, any compliance with HHS's new regulations would require immediate expenditure of resources.

13. Moreover, if the Mississippi Medicaid Program and CHIP were required to cover operative procedures to treat a mental condition, to cover services that are cosmetic in nature, or to cover gender transition procedures for a person under the age of 18, that would likely lead to an immediate increase in state expenditures.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Cody Smith

Dated: 06/11/2024

# EXHIBIT C

Declaration of Kimberly Sullivan, Medicaid Executive Director
for the Louisiana Medicaid Program

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

| | |
|---|---|
| THE STATE OF TENNESSEE, et al.,<br>*Plaintiffs*,<br><br>v.<br><br>XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,<br>*Defendants*. | Case No. 1:24-cv-161-LG-BWR |

**DECLARATION OF KIMBERLY SULLIVAN**

Pursuant to 28 U.S.C. § 1746, I, Kimberly Sullivan, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Medicaid Executive Director for the Louisiana Medicaid Program, which includes Louisiana's medical assistance program, the Louisiana Children's Health Insurance Program ("LaCHIP") and Program of All-Inclusive Care for the Elderly ("PACE"). The Louisiana Medicaid Program operates within the Louisiana Department of Health ("LDH").

3. As Medicaid Executive Director, I am responsible for the management of the Louisiana Medicaid Program and its programs. These responsibilities include ensuring compliance with state and federal anti-discrimination laws. That comprises overseeing the teams that review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department

of Health and Human Services ("HHS"), to determine whether they necessitate policy changes. And where such changes are necessary—either because the Louisiana Medicaid Program does not have a policy required by the regulation or has a conflicting policy—I am ultimately responsible for executing a plan for bringing the Louisiana Medicaid Program into compliance.

4. The Louisiana Medicaid Program's mission is to improve lives through high-quality, cost-effective care. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and Louisiana Medicaid Program employees. As of May 2024, the Louisiana Medicaid Program currently serves 1,712,169 Louisianans, including low-income individuals, pregnant women, children, parents and caretaker relatives of children, older adults, and adults with disabilities.

5. As of May 2024, approximately 707,833 minors were enrolled in the Louisiana Medicaid Program.

6. As of May 2024, approximately 1,004,336 adults were enrolled in the Louisiana Medicaid Program.

7. The Louisiana Medicaid Program received approximately $13,376,842,689 in total federal funding in State Fiscal Year 2022-2023. That includes $547,772,410 in federal funding for LaCHIP and $10,520,811 in federal funding for the State's PACE program. LDH estimates that the federal share expended for each program will be even greater in State Fiscal Year 2023-2024, with a projection of $13,805,754,054 in total federal funding.

8. Federal funding is used to pay a portion of the Louisiana Medicaid Program's administrative costs, including many Louisiana Medicaid Program employees' salaries and benefits. Most Louisiana Medicaid Program employees' salaries and benefits are partially funded by the Medicaid Administration Grant, and certain employees' salaries and benefits are

specifically approved under distinct grant programs, such as Medicaid's Money Follows the Person.

9. In State Fiscal Year 2022-2023, LDH contributed $6,740,336 to Louisiana's state employee health insurance plan, Office of Group Benefits, on behalf of Louisiana Medicaid Program employees, including $3,370,168 in federal funds. LDH estimates its contribution to be $7,497,445 in State Fiscal Year 2023-2024, including $3,748,723 in federal funding.

10. The Louisiana Medicaid Program's fee-for-service program does not cover sex transition surgery; but managed care organizations may pay for this service if deemed medically necessary.

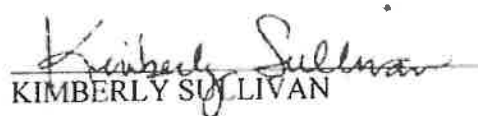
11. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

12. If the 2024 Rule requires state Medicaid programs and other health insurance plans to cover sex transition surgeries, Louisiana risks losing significant federal funding.

13. Avoiding that loss would require the Louisiana Medicaid Program to make changes to its administrative rules. Changing rules is an administratively burdensome process that requires cross-government cooperation and results in the expenditure of state resources. The administrative process for implementing final rules, like those that govern the operation of the Louisiana Medicaid Program, is dictated by the Louisiana Administrative Procedure Act and takes approximately six to nine months to complete. This process includes rule drafting, obtaining the, posting for public comment, rulemaking hearing, and possibly a hearing before the Louisiana

legislature and review and approval by the Governor. Thus, any compliance with HHS's new regulations would require immediate expenditure of significant resources.

14. Moreover, if the Louisiana Medicaid Program was required to cover sex transition surgeries, there would be an immediate increase in state and federal expenditures.



KIMBERLY SULLIVAN

Dated: 6/12/24

# EXHIBIT D

Declaration of Jeremey Brunssen, Deputy Director of Finance and Program Integrity for the Nebraska Department of Health and Human Services

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

| | |
|---|---|
| THE STATE OF TENNESSEE, et al.,<br>*Plaintiffs*,<br>v.<br>XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,<br>*Defendants*. | Case No. 1:24-cv-161-LG-BWR |

**DECLARATION OF JEREMY BRUNSSEN**

Pursuant to 28 U.S.C. § 1746, I, Jeremy Brunssen, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Deputy Director of Finance and Program Integrity for the Nebraska Department of Health and Human Services ("DHHS") Department of Medicaid and Long-Term Care ("MLTC"). DHHS is responsible for administering Nebraska's Medicaid and CHIP programs.

3. As Deputy Director, I am responsible for several operational functions for the Nebraska Medicaid program including budget, finance, provider reimbursement, claims payment, provider screening and enrollment, and program integrity. These responsibilities include ensuring compliance with state and federal anti-discrimination laws. That comprises overseeing teams that

review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department of Health and Human Services ("HHS"), to determine whether they necessitate policy and operational changes. And where such changes are necessary—either because Nebraska Medicaid does not have a policy required by the regulation or has a conflicting policy—I am responsible, along with the Medicaid Director, and other Medicaid program deputy directors, for executing a plan for bringing Nebraska Medicaid into compliance.

4. DHHS's mission is to improve lives through high-quality, cost-effective care. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and DHHS employees. DHHS currently serves almost three hundred and forty-six thousand Nebraskans, including low-income individuals, pregnant women, children, caretaker relatives of young children and older adults and adults with disabilities.

5. As of May 1, 2024, approximately 178,875 minors were enrolled in Nebraska's Medicaid and CHIP programs.

6. As of May 1, 2024, approximately 166,973 adults were enrolled in Nebraska's Medicaid program.

7. DHHS received approximately $2.9 billion in total federal funding in State Fiscal Year 2022-2023 for Nebraska's Medicaid and CHIP programs. DHHS estimates that the federal share expended for each program will be even greater in State Fiscal Year 2023-2024.

8. HHS funding is used to pay a portion of DHHS's administrative costs, including many DHHS's employees' salaries and benefits. Most DHHS employees' salaries and benefits are partially funded by the Medicaid Administration Grant.

9. DHHS annually contributes approximately $45 million to Nebraska's state employee health insurance plan ("State Plan") on behalf of its employees including approximately

$20.25 million in federal funds. Included in these contributions is approximately $5.5 million specifically for Medicaid program employees, including approximately $3.6 million in federal Medicaid HHS funds.

10. Nebraska's Medicaid program does not provide coverage for sex-transition surgeries. *See* 471 Nebraska Administrative Code 18-006.01(DD).

11. In 2023, the Nebraska "Let Them Grow Act" was enacted (Nebraska Revised Statutes §§ 71-7301, *et seq.*), disallowing use of state funds for gender-altering procedures for minors.

12. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

13. If the 2024 Rule requires state Medicaid programs and other health insurance plans to cover sex-transition surgeries, Nebraska risks losing significant federal funding.

14. Avoiding that loss would require Nebraska DHHS to make changes to its administrative rules. Changing rules is an administratively burdensome process that requires cross-government cooperation and results in the expenditure of state resources. The administrative process for permanent rules, like those that govern the terms of Nebraska's Medicaid programs, is governed by the Nebraska Uniform Administrative Procedures Act and takes approximately eight to twelve months to complete. This process includes rule drafting, obtaining the review and approval of the offices of the Governor and Attorney General, posting for public comment, rule-making hearing, and a hearing before the Health and Human Services Committee of the Nebraska legislature. This process would cost the State of Nebraska approximately $16,000 in immediate

costs for the regulation promulgation process. Thus, any compliance with HHS's new regulations would require immediate expenditure of significant resources.

15. Moreover, if Nebraska's Medicaid programs were required to cover sex-transition surgeries, there could be an immediate increase in state and federal expenditures.

16. Under current Nebraska law, State funds cannot be used to pay for gender altering surgeries, and DHHS cannot be ordered to pay for such surgeries or treatments for children placed in the custody of the State. If the 2024 Rule preempts State laws and regulations, Nebraska could be ordered to pay for such surgeries on children in the custody of the State, resulting in the expenditure of State funds.

Jeremy Brunssen, Deputy Director of
Finance and Program Integrity

Dated: June 12, 2024

# EXHIBIT E

Declaration of Cheryl Roberts, Director of the Department of Medical Assistance Services

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

THE STATE OF TENNESSEE, et al.,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

*Defendants*.

Case No. 1:24-cv-161-LG-BWR

**DECLARATION OF CHERYL ROBERTS**

Pursuant to 28 U.S.C. § 1746, I, Cheryl Roberts, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Director of the Department of Medical Assistance Services (DMAS). DMAS is responsible for administering Virginia's Medicaid program, and the State's Children's Health Insurance Program ("CHIP" or "FAMIS"). These programs are collectively referred to as "Cardinal Care".

3. As Director, I am responsible for the management of DMAS and its programs, which includes ensuring compliance with state and federal anti-discrimination laws. That comprises overseeing the teams that review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department of Health and Human Services ("HHS"), to

determine whether they necessitate policy changes. And where such changes are necessary—either because Cardinal Care does not have a policy required by the regulation or has a conflicting policy—I am ultimately responsible for executing a plan for bringing Cardinal Care into compliance.

4. DMAS's mission is to improve the lives of Virginians through access to high-quality health care coverage and services. DMAS staff work to accomplish this mission through contracts with managed care organizations, an extensive network of providers, and collaboration with stakeholders and community partners.

5. Cardinal Care currently serves about 2 million Virginians, including low-income individuals, pregnant women, children, caretaker relatives of young children and older adults and adults with disabilities. As of May 15, 2024, approximately 787,000 children and 784,000 non-elderly adults were enrolled in Cardinal Care.

6. Cardinal Care is budgeted to receive approximately $15.6 billion in total federal funding in State Fiscal Year 2024-2025.

7. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

8. Cardinal Care does not provide coverage for gender reassignment surgery for individuals under the age of 18. Further, Cardinal Care only covers hormone replacement therapy for Gender Dysphoria for individuals under the age of 18 if parental consent is obtained (Gender Dysphoria is defined using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – DSM-5).

9. If the 2024 Rule requires state Medicaid programs and other health insurance plans to cover gender reassignment surgeries and hormone replacement therapies for individuals under the age of 18, Virginia risks losing significant federal funding for the Cardinal Care program that supports 2 million Virginians.

10. Mitigating this risk of losing federal funding would require Cardinal Care to come into compliance with the 2024 Rule by covering these services, but DMAS lacks the authority to unilaterally do so.

11. The Virginia Appropriation Act prohibits DMAS from making changes to the Cardinal Care program that have a material fiscal impact on the state general fund (Chapter 2, Acts of Assembly of 2024, Special Session I, Part I, Item 288.E). The interpretation of this statute in Virginia is that any fiscal impact is deemed material, and therefore requires additional appropriation authority by the General Assembly.

12. The Virginia Appropriation Act further restricts any state agency, including DMAS, from making program changes that would alter the cost of benefits without the General Assembly appropriating funds for the cost of those changes (Chapter 2, Acts of Assembly of 2024, Special Session I, Part IV, Item 4-5.03(a)).

CHERYL ROBERTS

Dated: June 12, 2024

# EXHIBIT F

Declaration of Steven T. Voigt, Deputy Director of the Ohio Department of Medicaid

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

THE STATE OF TENNESSEE, et al.,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

*Defendants*.

Case No. 1:24-cv-161-LG-BWR

**DECLARATION OF STEVEN T. VOIGT**

Pursuant to 28 U.S.C. § 1746, I, Steven T. Voigt, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as a Deputy Director of the Ohio Department of Medicaid ("ODM"). ODM is responsible for administering Ohio's Medicaid program, as well as the State's Children's Health Insurance Program ("CHIP")

3. As a Deputy Director, I am responsible for the management of certain ODM bureaus.

4. ODM's mission is to improve lives through high-quality, cost-effective care. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and ODM employees. ODM serves over three million Ohioans, including

individuals with low incomes, children, older adults, and adults with disabilities.

5. In SFY 2023, approximately 1.4 million minors were enrolled in Ohio's Medicaid program or CHIP programs.

6. In SFY 2023, approximately 2.3 million adults were enrolled in Ohio's Medicaid program.

7. ODM received approximately $48.5 billion in total federal funding in State Fiscal Years 2022-2023. That includes more than $1.1 billion in federal funding for CHIP. ODM estimates that the federal share expended for each program will be even greater in State Fiscal Year 2024-2025.

8. HHS funding is used to pay a portion of ODM's administrative costs, including many ODM employees' salaries and benefits.

9. ODM annually contributes several million dollars to Ohio's state employee health insurance plan on behalf of its employees, including approximately $5 million in HHS funds in SFY23.

Steven T. Voigt

Dated: 6/13/24

# EXHIBIT G

Declaration of Robert M. Kerr, Director of the South Carolina
Department of Health and Human Services

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

| | |
|---|---|
| THE STATE OF SOUTH CAROLINA, et al.,<br>*Plaintiffs*,<br><br>v.<br><br>XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,<br>*Defendants*. | Case No. 1:24-cv-161-LG-BWR |

**DECLARATION OF ROBERT M. KERR**

Pursuant to 28 U.S.C. § 1746, I, Robert M. Kerr, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Director of the South Carolina Department of Health and Human Services ("SCDHHS"). SCDHHS is responsible for administering South Carolina's Medicaid program.

3. As Director, I am responsible for the management of SCDHHS and its programs. These responsibilities include ensuring compliance with state and federal anti-discrimination laws. That comprises overseeing the teams that review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department of Health and Human Services ("HHS"), to determine whether they necessitate policy changes. And where such changes are necessary—

either because SCDHHS does not have a policy required by the regulation or has a conflicting policy—I am ultimately responsible for executing a plan for bringing SCDHHS into compliance.

4. SCDHHS's mission is to improve the health and quality of life for South Carolinians through coverage of high-quality, cost-effective care. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and SCDHHS employees. SCDHHS currently serves approximately 1.2 million South Carolinians, including low-income individuals, pregnant women, children, caretaker relatives of young children and older adults and adults with disabilities.

5. SCDHHS received approximately $6.5 billion in total federal funding in State Fiscal Year 2022-2023. SCDHHS has received approximately $7 billion in federal funding year to date in State Fiscal Year 2023-2024.

6. HHS funding is used to pay a portion of SCDHHS's administrative costs, including many SCDHHS employees' salaries and benefits.

7. SCDHHS's Medicaid program is prohibited from using public funds directly or indirectly for gender transition procedures. *See* SC Code Section 44-42-310, et seq.

8. It is not the policy of SCDHHS's Medicaid program to provide coverage for gender transition procedures. *See* SCDHHS Hospital Services Provider Manual and SCDHHS Physicians Services Provider Manual.

9. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

10. If the 2024 Rule requires state Medicaid programs to cover gender transition procedures, SCDHHS risks losing significant federal funding.

11. If South Carolina's Medicaid program were required to cover gender transition procedures, there would be an immediate increase in state and federal expenditures.

ROBERT M. KERR

Dated: June 13, 2024

# EXHIBIT H

Declaration of Wanda Davis, Director of the Children's Health Insurance Program for the Alabama Department of Public Health

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

THE STATE OF TENNESSEE, STATE OF ALABAMA, STATE OF GEORGIA, STATE OF INDIANA, STATE OF KANSAS, COMMONWEALTH OF KENTUCKY, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF OHIO, STATE OF OKLAHOMA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, COMMONWEALTH OF VIRGINIA, AND STATE OF WEST VIRGINIA,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; MELANIE FONTES RAINER, in her official capacity as the Director of the Office for Civil Rights; CENTERS FOR MEDICARE AND MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services,

*Defendants*.

Case No. 1:24-cv-161-LG-BWR

**DECLARATION OF WANDA DAVIS**

Pursuant to 28 U.S.C. § 1746, I, Wanda Davis, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I am employed by the Alabama Department of Public Health ("Department") and serve as the Director of The Children's Health Insurance Program ("CHIP"). The Department is responsible for administering Alabama's CHIP and our mission is to promote, protect and improve the health of Alabama's children by providing access to the care children need to be healthy and reach their full potential. Alabama's CHIP is a combination program, including children enrolled in its separate program known as "ALL Kids" and children enrolled in a Medicaid expansion program known as "MCHIP".

3. As Director, I am responsible for the management of Alabama's CHIP, including ALL Kids and MCHIP. As Director, I oversee the day-to-day operations of the program and ensure compliance with state and federal rules and regulations.

4. Alabama's CHIP believes that access to healthcare is vital. To stay healthy and reach their full potential children need regular checkups and immunization, sick child doctor visits, prescriptions, vision and dental care, hospitalization, mental health and substance abuse services and much more. ALL Kids uses Blue Cross Blue Shield of Alabama ("BCBSAL") to provide medical, mental health and substance abuse services through their preferred provider network ("PPO"). The MCHIP population receives these services through Alabama Medicaid.

5. As of April 30, 2024, approximately 182,300 minors were enrolled in Alabama's CHIP program.

6. As of fiscal year 2023, Approximately $368 million in total federal funding was received through Alabama's CHIP program. It is expected that Alabama's CHIP program will exceed this amount in fiscal year 2024.

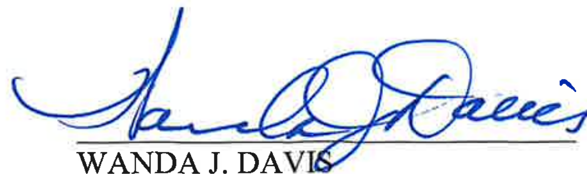
7. Alabama's CHIP program does not provide coverage for gender-dysphoria-related medical procedures on minors. *See* Alabama Vulnerable Child Compassion and Protection Act, Act 2022-289, codified at Ala. Code § 26-26-4.

8. The U.S. Department of Health and Human Services ("HHS") has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

9. If the HHS 2024 Rule referenced above requires state Medicaid programs and other health insurance plans to cover sex-transition surgeries, Alabama risks losing significant federal funding.

10. Avoiding that loss would require Alabama's CHIP program to make changes to its administrative rules. Changing rules is an administratively burdensome process that requires cross-government cooperation and results in the expenditure of state resources. The administrative process for permanent rules, like those that govern the terms of Alabama's CHIP program, is governed by the Alabama Administrative Procedure Act ("AAPA"). Compliance with HHS's new regulations would almost certainly result in an immediate increase of expenditures.

11. If Alabama's CHIP program were required to comply with HHS's new regulations, there would be an immediate increase in state and federal expenditures.



WANDA J. DAVIS

Dated: 6/12/24

# EXHIBIT I

Declaration of Matthew K. Althoff, Cabinet Secretary of the
South Dakota Department of Social Services

**UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF MISSISSIPPI**
**SOUTHERN DIVISION**

| | | |
|---|---|---|
| STATE OF TENNESSEE, et al., *Plaintiffs,* | ) | |
| v. | ) | Civil Action No. 1:24cv161 LG-BWR |
| XAVIER BECERRA, in his official Capacity as Secretary of the United States Department of Health and Human Services, et al., *Defendants.* | ) | |

**DECLARATION OF MATTHEW K. ALTHOFF**

Pursuant to 28 U.S.C. § 1746, I, Matthew K. Althoff, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Cabinet Secretary of the South Dakota Department of Social Services (Hereinafter "the Department"). The Department, through its Division of Medical Services, administers the State's Medicaid program, as well as the State's Children's Health Insurance Program ("CHIP").

3. As Secretary, my responsibilities include ensuring compliance with state and federal anti-discrimination laws. That comprises overseeing the teams that review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department of Health and Human Services ("HHS"), to determine whether they necessitate policy changes. Where such

changes are necessary – either because the Department does not have a policy required by the regulation or has a conflicting policy – I am ultimately responsible for executing a plan for bringing the Department into compliance.

4. The Department's mission is to improve lives through high-quality, cost-effective care. Accomplishing this mission requires partnership between the provider community, stakeholders, advocates, families, and the Department's employees. The Division of Medical Services, within the Department of Social Services, currently serves approximately 136,000 South Dakotans, including low-income individuals, pregnant women, children, caretaker relatives of young children and older adults and adults with disabilities.

5. As of June 12, 2024 approximately 76,000 minors were enrolled in the South Dakota's Medicaid program.

6. As of June 12, 2024, approximately 60,000 adults were enrolled in South Dakota's Medicaid program.

7. South Dakota Medicaid and CHIP received approximately $873 Million in total federal funding in State Fiscal Year 2023.

8. HHS funding is used to pay a portion of the administrative costs of the Division of Medical Services, including employees' salaries and benefits. Most of these salaries and benefits are partially funding the Medicaid Administration Grant, and certain employees' salaries and benefits are specifically approved under distinct grant programs, such as Medicaid's Money Follows the Person.

9. The South Dakota Medicaid program does not provide coverage for puberty blockers, cross-sex hormones, or sex-transition surgeries. *See* South Dakota Codified Law §§ 28-6-1, and 34-24-34; Administrative Rules of South Dakota 67:16:01:06.01, 67:16:01:06.02, and 67:16:01:08; and South Dakota Medicaid Billing and Policy Manual, Physician Services.

10. South Dakota CHIP has the same exclusions for puberty blockers, cross-sex hormones, and sex-transition surgeries. *See* South Dakota Codified Law §§ 28-6-1, and 34-24-34; Administrative Rules of South Dakota 67:16:01:06.01, 67:16:01:06.02, and 67:16:01:08; and South Dakota Medicaid Billing and Policy Manual, Physician Services.

11. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

12. If the 2024 Rule requires state Medicaid programs and health insurance plans to cover puberty blockers, cross-sex hormones, and sex-transition surgeries, South Dakota would not be able to enforce duly enacted laws, particularly SDCL34-24-34 without coming into conflict with the Rule.

13. If the 2024 Rule requires state Medicaid programs and health insurance plans to cover puberty blockers, cross-sex hormones, and sex transition surgeries, South Dakota risks losing significant federal funding.

14. Moreover, if South Dakota's Medicaid and CHIP programs were required to cover puberty blockers, cross-sex hormones, and sex-transition surgeries, there would be an immediate increase in state and federal expenditures.

Matthew K. Althoff

Dated: June 13, 2024

# EXHIBIT J

Declaration of Stephanie McGee Azar, Commissioner of the Alabama Medicaid Agency

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

THE STATE OF TENNESSEE, et al.,

*Plaintiffs*,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

*Defendants*.

Case No. 1:24-cv-161-LG-BWR

**DECLARATION OF STEPHANIE MCGEE AZAR**

Pursuant to 28 U.S.C. § 1746, I, Stephanie McGee Azar, duly affirm under penalty of perjury as follows:

1. I am over 18 years of age, have personal knowledge of the matters set forth herein, and am competent to make this Declaration.

2. I serve as the Commissioner of the Alabama Medicaid Agency ("Alabama Medicaid").

3. As Commissioner, I am responsible for the management of Alabama Medicaid. These responsibilities include ensuring Alabama Medicaid is compliant with state and federal anti-discrimination laws. In this role, I oversee the teams that review and evaluate rules and regulations promulgated by federal agencies, including the U.S. Department of Health and Human Services ("HHS"), to determine whether they affect Alabama Medicaid. And where there is an effect on Alabama Medicaid, either because Alabama Medicaid does not have a policy required by the regulation or has a conflicting policy—I am ultimately responsible for executing a plan for

bringing Alabama Medicaid into compliance.

4. Alabama Medicaid's mission is to provide a system of financing health care for eligible Alabamians in accordance with established statutes and Executive Orders. Alabama Medicaid currently serves approximately 1.2 million Alabamians annually, including low-income individuals, pregnant women, children, caretaker relatives of young children, as well as the elderly and disabled individuals.

5. As of March 2024, of the approximately 1.18 million recipients, approximately 630,000 were children under age 19 and 549,000 were age 19 and over.

6. Alabama Medicaid received approximately $7.02 billion in total federal funding in State Fiscal Year 2023. Alabama Medicaid estimates that the federal share expended for the program will be even greater in State Fiscal Year 2024.

7. HHS funding is used to pay a portion of Alabama Medicaid's administrative costs, including employees' salaries and benefits.

8. Alabama Medicaid does not provide coverage for sex-transition surgeries.

9. HHS has promulgated new regulations interpreting Section 1557 of the Affordable Care Act's prohibition on discrimination "on the basis of sex" to include "gender identity" and other "sex characteristics." Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Rule").

10. If the 2024 Rule requires state Medicaid programs to cover sex-transition surgeries, Alabama would experience an immediate increase in state and federal expenditures.

Date: 6/13/24

STEPHANIE MCGEE AZAR
Commissioner