IN THE IOWA DISTRICT COURT FOR POLK COUNTY

EERIEANNA GOOD, an individual, Petitioner, v. IOWA DEPARTMENT OF HUMAN SERVICES, an independent executive-branch agency of the State of Iowa, Respondent.	Case No. **PETITION FOR JUDICIAL REVIEW OF AGENCY ACTION UNDER IOWA CODE § 17A.19**

COMES NOW Petitioner EerieAnna Good ("Ms. Good"), by her undersigned counsel, and respectfully submits the following petition for judicial review of agency action:

STATEMENT OF THE CASE

1. This action arises from Section 441.78.1(4) of the Iowa Administrative Code's ("IAC 441.78.1(4)" or the "Regulation") ban on coverage for surgical treatment of "transsexualism," "gender identity disorder," and "sex reassignment," as well as the Iowa Department of Human Services' ("DHS") decision affirming AmeriHealth Caritas Iowa's ("AmeriHealth") denial of Ms. Good's request for preapproval of expenses related to surgical treatment for gender dysphoria under the Regulation.

2. Iowa Medicaid provides coverage for medically necessary care for a broad range of medical conditions. The Regulation, however, bars Medicaid coverage for gender-affirming surgery to treat gender dysphoria, a medical condition only experienced by transgender individuals, even though Medicaid coverage is provided for the same surgical procedures for other medical conditions. This discriminatory exclusion from Medicaid coverage has no basis in

medical science and has been uniformly condemned by leading medical organizations. The ban violates the Iowa Civil Rights Act ("ICRA") and the Iowa Constitution.

3. Ms. Good, who is transgender, requested Medicaid coverage for an orchiectomy to treat her gender dysphoria. Four health-care providers agreed that the surgical procedure Ms. Good sought to undergo was medically necessary to treat her gender dysphoria. Despite the consensus of Ms. Good's providers, AmeriHealth, the managed-care organization ("MCO") to which Ms. Good is assigned under the State of Iowa's Medicaid program ("Iowa Medicaid"), denied coverage for the surgery under IAC 441.78.1(4).

4. IAC 441.78.1(4) categorically prohibits Medicaid reimbursement for surgical procedures related to gender transition and gender dysphoria. The Regulation "specifically exclude[s]" coverage for "[p]rocedures related to transsexualism . . . [or] gender identity disorders." *See* Iowa Admin. Code r. 441.78.1(4)(b)(2). It also states that "[s]urgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage." *See* Iowa Admin. Code r. 441.78.1(4).

5. An administrative-law judge ("ALJ") for the Iowa Department of Inspections and Appeals, Division of Administrative Hearings ("IDIA"), recommended affirming AmeriHealth's decision. Subsequently, DHS's director (the "Director") adopted the ALJ's recommendation and affirmed AmeriHealth's denial of coverage for Ms. Good's orchiectomy.

6. DHS's denial of coverage for the treatment requested by Ms. Good is unlawful. *See* Iowa Code § 17A.19(10)(b). IAC 441.78.1(4)'s categorical exclusion of Medicaid coverage for gender-affirming surgical procedures violates the ICRA's express prohibitions against gender-identity and sex discrimination. *See* Iowa Code §§ 216.7(1)(a), 216.2(13)(b). Under the ICRA, it is discriminatory and unlawful for any agent of a "public accommodation," including a

state government unit such as DHS, to deny services or privileges based on sex or gender identity. The Regulation discriminates based on gender identity by burdening transgender persons, the only individuals who seek surgical procedures related to "transsexualism" or "gender identity disorders" as set forth in IAC 441.78.1(4)(b)(2). The Regulation discriminates based on sex by perpetuating discrimination arising from a person's transgender status, failure to conform to stereotypical gender norms, and transition from one gender to another.

7. IAC 441.78.1(4)'s categorical exclusion of Medicaid coverage for gender-affirming surgical procedures also violates the Iowa Constitution's equal-protection guarantee. *See* Iowa Code § 17A.19(10)(a); Iowa Const. art. I, §§ 1, 6. Under the Regulation, Iowa Medicaid covers certain medically necessary treatment for nontransgender Medicaid participants that it does not cover for transgender Medicaid participants as part of their gender-affirming care. Both groups need financial assistance for medical treatment; yet, only one group receives the assistance. There is no plausible policy reason for this classification. Nor does the classification serve a compelling or important government interest.

8. Moreover, the Regulation and DHS's denial of Medicaid coverage for medically necessary gender-affirming surgery for Ms. Good have had a disproportionate negative impact on private rights and are arbitrary and capricious. *See* Iowa Code §§ 17A.19(10)(k), (n).

9. As a result of DHS's unlawful, unconstitutional, arbitrary, and capricious denial of Medicaid coverage for Ms. Good's gender dysphoria under IAC 441.78.1(4), Ms. Good is entitled to (a) a declaratory ruling that IAC 441.78.1(4) violates the ICRA, the Iowa Constitution's equal-protection guarantee, and the Iowa Administrative Procedure Act ("APA"); (b) an order invalidating the Regulation and enjoining any further application of it to deny Medicaid coverage for gender-affirming surgical care; and (c) an order reversing and vacating

DHS's decision denying Ms. Good's request for coverage and requiring DHS to approve the request.

THE PARTIES

I. The Petitioner

10. Ms. Good is a twenty-seven-year-old woman residing in Davenport, Iowa.

11. She was diagnosed with gender dysphoria in 2013.

12. At all relevant times, she has participated in Iowa Medicaid.

13. In August 2017, DHS denied Ms. Good's request for Medicaid coverage for an orchiectomy to treat her gender dysphoria.

III. The Respondent

14. DHS is the Iowa executive agency charged with administering Iowa Medicaid.

15. Medicaid is a cooperative federal–state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals.

16. Individuals eligible for Iowa Medicaid include but are not limited to adults between the ages of nineteen and sixty-four whose income is at or below 133 percent of the Federal Poverty Level, a measure of income issued every year by the United States Department of Health and Human Services.

17. AmeriHealth, an MCO, is one of DHS's designees with respect to administering Iowa Medicaid.

18. AmeriHealth is Ms. Good's designated MCO.

JURISDICTION AND VENUE

19. On January 27, 2017, Ms. Good, through her physician, requested Medicaid preapproval of expenses for an orchiectomy from AmeriHealth.

20. On February 2, 2017, AmeriHealth denied Ms. Good's request.

21. On March 3, 2017, Ms. Good timely initiated an internal appeal from AmeriHealth's February 2 decision under Section 249A.4(11) of the Iowa Code and Section VI of the AmeriHealth Caritas Iowa Provider Manual. *See* Iowa Code § 249A.4(11); AmeriHealth Caritas Iowa Provider Manual § VI, *available at*: http://amerihealthcaritasia.com/pdf/provider-manual.pdf.

22. On March 31, 2017, AmeriHealth denied Ms. Good's appeal.

23. On June 23, 2017, Ms. Good timely appealed AmeriHealth's decision to DHS.

24. On July 25, 2017, an ALJ for IDIA issued a proposed decision affirming AmeriHealth's decision.

25. On August 2, 2017, Ms. Good timely appealed the ALJ's proposed decision to the Director of DHS.

26. On August 25, 2017, the Director adopted the ALJ's proposed decision as DHS's final decision on Ms. Good's appeal.

27. Ms. Good has exhausted all administrative remedies and has been adversely affected by DHS's final agency action.

28. The Court has jurisdiction to resolve this matter under Section 17A.19(1) of the Iowa APA, which permits judicial review of final agency actions. *See* Iowa Code § 17A.19(1).

29. The Court also has jurisdiction to resolve this matter (a) under Rule 1.1101 of the Iowa Rules of Civil Procedure, *et seq.*, which permit declaratory judgments; (b) Rule 1.1501 of

the Iowa Rules of Civil Procedure, *et seq*., which permit injunctive relief; (c) the common law of the State of Iowa, which permits declaratory and injunctive relief; and (d) Section 602.6101 of the Iowa Code, which grants the Iowa district court "exclusive, general, and original jurisdiction" over all civil "actions, proceedings, and remedies . . . ." *See* Iowa R. Civ. Pro. 1.1101, *et seq*.; Iowa R. of Civ. Pro. 1.1501, *et seq*.; Iowa Code § 602.6101.

30. Venue is proper in Polk County under (a) Section 17A.19(2) of the Iowa APA, which allows proceedings for judicial review to be instituted in Polk County, and (b) Section 616.3(2) of the Iowa Code because part of the action arose in Polk County, which is where DHS's primary office is located. *See* Iowa Code §§ 17A.19(2), 616.3(2).

ALLEGATIONS COMMON TO ALL COUNTS

I. Coverage for Transition-Related Surgery in Iowa and the Regulation

31. In 1980, in *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980), the United States Court of Appeals for the Eighth Circuit ("Eighth Circuit") held that the State of Iowa's blanket policy of denying Medicaid benefits for gender-affirming surgery constituted an arbitrary denial of benefits. *See id*. at 549.

32. The *Pinneke* court found that Iowa's policy violated a federal Medicaid regulation prohibiting a state from denying benefits to an otherwise eligible individual "solely because of the diagnosis, type of illness, or condition." *See id*. (internal quotation marks and citation omitted).

33. The *Pinneke* court also found that, without any formal rulemaking proceedings or hearings, DHS's irrebuttable presumption that sex-reassignment surgery could never be medically necessary was inconsistent with the Medicaid statute's objectives. *See id*.

34. In 1993, in the wake of *Pinneke*, DHS contracted with the Iowa Foundation for Medical Care, now known as Telligen Inc. (the "Foundation"), to analyze whether to provide Medicaid coverage for treating conditions like gender dysphoria, which, at the time, was known as gender-identity disorder.

35. Following its receipt of the Foundation's report, DHS recommended a rulemaking process by publishing a notice of intended action and soliciting public commentary.

36. In 1995, after a public meeting of DHS's rulemaking body and review by the state legislature's administrative-rules committee, DHS adopted IAC 441.78.1(4).

37. The Regulation stated, in relevant part, that "[s]urgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage." Iowa Admin. Code r. 441.78.1(4).

38. It also stated that "[c]osmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are: . . . [p]rocedures related to transsexualism . . . [or] gender identity disorders." Iowa Admin. Code r. 441.78.1(4)(b)(2).

39. In *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001), the Eighth Circuit considered a challenge to the Regulation based on Section 1983 and rights conferred by the federal Medicaid Act.

40. The *Smith* court upheld the Regulation, noting that, in 1994, at the time the Regulation was adopted, the evidence before DHS reflected disagreement in the medical

community "regarding the efficacy of sex reassignment surgery" and that such surgery was also excluded from coverage under Medicare. *Id*. at 761.[1]

41. The *Smith* court's decision was based on research that was flawed at the time the Regulation was enacted and has since been superseded by new research providing additional evidence of the defects in the Foundation's report.

42. Since its promulgation, the Regulation has not been updated or modified to reflect medical developments in the research or treatment of gender dysphoria.

43. Nor have any studies been commissioned to revisit the validity of the medical research on which the Regulation was based.

II. The Standards of Care for Treating Gender Dysphoria

44. "Gender identity" is a well-established medical concept referring to a person's internal sense of gender.

45. All human beings develop this basic understanding of belonging to a gender.

46. Gender identity is an innate and immutable aspect of personality.

47. Typically, people who are designated male at birth based on their external anatomy identify as boys or men, and people designated female at birth identify as girls or women.

48. For transgender people, gender identity differs from the sex assigned at birth.

[1] On May 30, 2014, the United States Department of Health and Human Services' Departmental Appeals Board ruled that Medicare's categorical exclusion of coverage for transition-related care is inconsistent with contemporary science and medical standards of care. *See* Department of Health and Human Services, Departmental Appeals Board, Appellate Division, NCD 140.3, Transsexual Surgery, Docket No. A-13-87 (May 30, 2014), *available at*: https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

49. Transgender women are women who were assigned "male" at birth but have a female gender identity.

50. Transgender men are men who were assigned "female" at birth but have a male gender identity.

51. The medical diagnosis for the feeling of incongruence between one's gender identity and one's birth-assigned sex is "gender dysphoria" (previously known as "gender-identity disorder" or "transsexualism").

52. Gender dypshoria is a serious medical condition codified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-V"), and the International Statistical Classification of Diseases and Related Health Problems, Tenth Edition.

53. The criteria for diagnosing gender dypshoria are set forth in Section 302.85 of DSM-V.

54. If left untreated, gender dypshoria can lead to serious medical problems, including clinically significant psychological distress and dysfunction, debilitating depression, and, for some people without access to appropriate medical care and treatment, suicidality and death.

55. The World Professional Association for Transgender Health ("WPATH") is a nonprofit interdisciplinary professional and educational organization devoted to transgender health.

56. The standards of care for treating gender dysphoria ("Standards of Care") are set forth in WPATH's Standards of Care for the Health of Transsexual, Transgender, and Nonconforming People, available at: http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351.

57. The Standards of Care are widely accepted, evidence-based, best-practice medical protocols that articulate professional consensus to guide health-care professionals in medically managing gender dysphoria by providing the parameters within which they may provide care to individuals with this condition.

58. The WPATH Standards of Care are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association, among others.

59. The WPATH Standards of Care are so well established that federal courts have declared that a prison's failure to provide health care in accordance with those standards may constitute cruel and unusual punishment under the Eighth Amendment.

60. For many transgender people, necessary treatment for gender dypshoria may require medical interventions to affirm their gender identity and help them transition from living in one gender to another.

61. This transition-related care may include hormone therapy, surgery (sometimes called "gender-confirmation surgery" or "sex-reassignment surgery"), and other medical services to align transgender people's bodies with their gender identities.

62. The treatment for each transgender person is individualized to fulfill that person's particular needs.

63. The WPATH Standards of Care for treating gender dysphoria address all these forms of medical treatment, including surgery to alter primary and secondary sex characteristics.

64. By the mid-1990s, there was consensus within the medical community that surgery was the only effective treatment for many individuals with severe gender dysphoria.

65. More than three decades of research confirms that surgery to modify primary and secondary sex characteristics and align gender identity with anatomy is therapeutic, and therefore effective treatment for gender dysphoria.

66. For appropriately assessed severe gender-dysphoric patients, surgery is the only effective treatment.

67. Health experts have rejected the myth that these treatments are "cosmetic" or "experimental" and have recognized that the treatments can provide safe and effective care for a serious health condition.

68. Leading medical groups, including the American Medical Association,[2] the American Psychological Association,[3] the American Academy of Family Physicians,[4] the American Congress of Obstetricians and Gynecologists,[5] the National Association of Social Workers,[6] and WPATH,[7] all agree that gender dypshoria is a serious medical condition, that treatment for gender dypshoria is medically necessary for many transgender people, and that insurers should provide coverage for these treatments.

III. Ms. Good

69. Ms. Good is a twenty-seven-year-old transgender woman who has known herself to be female since age seven.

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[2] *See* Resolution 122 (A–108), *available at*: http://www.ama-assn.org/resources/doc/PolicyFinder/policyfiles/HnE/H-185.950.htm.

[3] *See* Position Statement on Access to Care for Transgender and Gender Variant Individuals (2012), *available at*: www.psychiatry.org/File%20Library/Advocacy%20and20%Newsroom/Position%20Statements/ps2012_TransgenderCare.pdf.

[4] *See* Resolution No. 1004 (2012), *available at*: http://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf.

[5] *See* Committee Opinion No. 512: Health Care for Transgender Individuals, *available at*: http://www.ncfr.org/news/acog-releases-new-committee-opinion-transgender-persons.

[6] *See* Transgender and Gender Identity Issues Policy Statement, *available at*: http://www.socialworkers.org/da/da2008/finalvoting/documents/Transgender%202nd%20round%20-%20Clean.pdf.

[7] *See* Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the USA (2008), *available at*: http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf

70. She has presented as female full-time and used female pronouns since 2010 and has lived full-time as a woman in every aspect of her life for several years as treatment for her gender dypshoria.

71. In 2014, Ms. Good began hormone therapy.

72. In 2016, Ms. Good legally changed her name, birth certificate, driver's license, and social-security card to reflect her female identity.

73. Ms. Good's gender dysphoria exacerbates her existing depression and anxiety.

74. She is distressed and very uncomfortable with her genitalia, which does not align with her gender identity.

75. To better present as female, she tucks and wears a girdle for up to twelve hours or more each day.

76. These measures help Ms. Good present outwardly as female in conformity with her gender identity but are very painful and uncomfortable.

77. In or around January 2017, Ms. Good began the process of seeking Medicaid coverage for gender-affirming surgery from her MCO, AmeriHealth.

78. Ms. Good, a participant in Iowa Medicaid, is eligible for Medicaid reimbursement.

IV. Ms. Good's Health-Care Providers

79. Ms. Good's health-care providers have uniformly concluded that surgery is necessary to treat her gender dysphoria.

80. Katherine Imborek, MD ("Dr. Imborek"), is Ms. Good's primary-care physician.

81. In February 2017, Dr. Imborek assessed Ms. Good's condition.

82. She confirmed that Ms. Good has been diagnosed with gender dysphoria, has been on hormone treatment since February 2014 without complications, and has been living fully in her affirmed gender since that time as well. (Ex. 1, Imborek Aff., ¶ 4.)

83. She also concluded that gender-affirming surgery is medically necessary to treat Ms. Good's gender dysphoria. (*Id*.)

84. A true and correct copy of Dr. Imborek's affidavit is attached as Exhibit 1.

85. Jacob Priest, PhD ("Dr. Priest"), is the Director of the University of Iowa's LGBTQ Clinic.

86. In February 2017, Dr. Priest performed a psychosocial assessment on Ms. Good in which he stated:

> [Ms. Good] . . . meets the eligibility and readiness criteria for surgery as set forth [in] the [WPATH standards of care]. Specifically, she is aware of the potential risks of surgery and she is capable of making an[] informed decision. Additionally, even though she has been taking estrogen, she still experiences distress because her body is not congruent with her gender. Given this, she meets diagnostic criteria for gender dysphoria. This dysphoria is not better accounted for by another diagnosis.
>
> It is my opinion that gender affirming surgery is a necessary treatment for [Ms. Good's] gender dysphoria. It is likely that much of the distress that she is currently experiencing stems from the lack of congruence between her body and her gender. It is likely that surgery would help alleviate much of her distress and improve her quality of life. Therefore, I support [Ms. Good's] desire for gender affirming surgery. She understands the potential risks and benefits of surgery and appears to be making an informed decision.

(Ex. 2, Priest Aff., ¶ 4.)

87. A true and correct copy of Dr. Priest's affidavit is attached as Exhibit 2.

88. Armeda Wojciak, PhD ("Dr. Wojciak"), is the Program Coordinator for the Couple and Family Therapy Program of the University of Iowa's LGBTQ Clinic.

89. In March 2017, Dr. Wojciak performed a psychosocial assessment on Ms. Good.

90. Dr. Wojciak concurred with Dr. Priest's assessment that Ms. Good meets the diagnostic criteria for gender dysphoria, that she meets WPATH's eligibility and readiness criteria for gender-affirming surgery, and that gender-affirming surgery is medically necessary treatment for Ms. Good's gender dysphoria. (Ex. 3, Wojciak Aff., ¶ 3.)

91. A true and correct copy of Dr. Wojciak's affidavit is attached as Exhibit 3.

92. Bradley Erickson, MD ("Dr. Erickson"), is Ms. Good's surgeon.

93. In March 2017, Dr. Erickson opined:

> [Drs. Imborek, Priest, and Wojciak] believe (and I concur) that Ms. Good's gender dysphoria would be significantly improved by undergoing an orchiectomy. Further, AmeriHealth . . . covers orchiectomy procedures for other medical conditions, such as testicular cancer, pain and torsion [and an orchiectomy procedure] is an equally necessary and proper treatment for transgender women with gender dysphoria, including Ms. Good.
>
> The treatment of Ms. Good is consistent with the [WPATH] guidelines . . . .

(Ex. 4, Erickson Aff., ¶ 3.)

94. A true and correct copy of Dr. Erickson's affidavit is attached as Exhibit 4.

V. AmeriHealth's Denial of Ms. Good's Application for Preapproval

95. On January 27, 2017, Dr. Erickson requested Medicaid preapproval from AmeriHealth to perform an orchiectomy on Ms. Good.

96. On February 2, 2017, AmeriHealth denied the request, advising Dr. Erickson that "the request for orchiectomy for gender dysphoria" could not be approved because of IAC 441.78.1(4), which excludes from coverage "[s]urgeries for the purpose of sex reassignment coverage."

97. A true and correct copy of AmeriHealth's February 2 decision is attached as Exhibit 5.

98. On March 3, 2017, Ms. Good timely initiated an internal appeal from AmeriHealth's February 2 decision under Section 249A.4(10) of the Iowa Code and Section VI of the AmeriHealth Caritas Iowa Provider Manual.

99. In support of her appeal, Ms. Good provided assessments from Drs. Imborek, Priest, Wojciak, and Erickson; her own affidavit; the affidavit of Randi Ettner, PhD ("Dr. Ettner"), the Secretary of WPATH and a member of the organization's Executive Board of Directors; and a memorandum of law explaining that the Regulation violates the ICRA and the Iowa Constitution's equal-protection guarantee.

100. A true and correct copy of Ms. Good's affidavit is attached as Exhibit 6.

101. A true and correct copy of Dr. Ettner's affidavit is attached as Exhibit 7.

102. A true and correct copy of Ms. Good's memorandum of law is attached as Exhibit 8.

103. On March 31, 2017, AmeriHealth denied Ms. Good's appeal.

104. AmeriHealth's March 31 decision reiterated that, based on the information provided to AmeriHealth, the orchiectomy requested by Ms. Good was excluded from coverage by IAC 441.78.1(4).

105. A true and correct copy of AmeriHealth's March 31 decision is attached as Exhibit 9.

VI. DHS's Affirmance of AmeriHealth's Denial

106. On June 23, 2017, Ms. Good timely appealed AmeriHealth's decision to DHS.

107. On July 11, 2017, an ALJ for IDIA conducted an administrative hearing at which counsel for Ms. Good and AmeriHealth argued their respective positions on AmeriHealth's denial of Ms. Good's request for Medicaid coverage.

108. On July 25, 2017, after considering the parties' posthearing briefs and the administrative record, the ALJ issued a proposed decision affirming AmeriHealth's decision.

109. The ALJ's July 25 decision did not resolve Ms. Good's challenges to AmeriHealth's decision on the merits, but rather concluded that resolving those challenges was the judiciary's role and did not fall within the scope of the pending administrative proceeding, noting that the issues raised by Ms. Good were "preserved for judicial review."

110. A true and correct copy of the ALJ's July 25 decision is attached as Exhibit 10.

111. On August 2, 2017, Ms. Good timely appealed the ALJ's proposed decision to the Director of DHS.

112. On August 25, 2017, the Director adopted the ALJ's proposed decision as DHS's final decision on Ms. Good's appeal.

113. The Director concluded that the agency "lack[ed] jurisdiction" to decide Ms. Good's arguments that the Regulation "violates the equal protection clause [of the Iowa Constitution] and the [Iowa] Civil Rights Act," noting that these issues were "preserved for judicial review."

114. A true and correct copy of the Director's August 25 decision is attached as Exhibit 11.

CLAIMS FOR RELIEF

COUNT I
Iowa APA, Section 17A.19(10)(b), Gender-Identity Discrimination Under Section 216.7(1)(a) of the ICRA

115. Ms. Good incorporates paragraphs 1 through 114 as though fully set forth in this paragraph.

116. Under Section 17A.19(10)(b) of the Iowa APA, a court may reverse an agency action if substantial rights of the person seeking judicial relief have been prejudiced because the agency action is beyond the authority delegated to the agency by any provision of law or in violation of any provision of law. *See* Iowa Code § 17A.19(10)(b).

117. IAC 441.78.1(4)'s categorical exclusion of Medicaid coverage for gender-affirming surgical procedures violates the ICRA's express prohibition on gender-identity discrimination.

118. Under the ICRA, it is discriminatory and unlawful for any agent of a "public accommodation," including a state government unit such as DHS, to deny services or privileges based gender identity. *See* Iowa Code §§ 216.7(1)(a), 216.2(13)(b).

119. The Regulation's ban on coverage for surgical procedures to treat "transsexualism" or "gender identity disorders" as set forth in IAC 441.78.1(4)(b)(2) discriminates based on gender identity by burdening transgender persons, the only individuals who seek surgical procedures for those conditions.

120. As a result, the Regulation is unlawful, and DHS's reliance on the Regulation to deny Ms. Good Medicaid reimbursement was improper.

COUNT II
Iowa APA, Section 17A.19(10)(b),
Sex Discrimination Under Section 216.7(1)(a) of the ICRA

121. Ms. Good incorporates paragraphs 1 through 114 as though fully set forth in this paragraph.

122. Under Section 17A.19(10)(b) of the Iowa APA, a court may reverse an agency action if substantial rights of the person seeking judicial relief have been prejudiced because the

agency action is beyond the authority delegated to the agency by any provision of law or in violation of any provision of law. *See* Iowa Code § 17A.19(10)(b).

123. IAC 441.78.1(4)'s categorical exclusion of Medicaid coverage for gender-affirming surgical procedures violates the ICRA's express prohibition on sex discrimination.

124. Under the ICRA, it is discriminatory and unlawful for any agent of a "public accommodation," including a state government unit such as DHS, to deny services or privileges based on sex. *See* Iowa Code §§ 216.7(1)(a), 216.2(13)(b).

125. Discrimination on the basis of transgender status, gender nonconformity, and gender transition is discrimination on the basis of sex.

126. The Regulation discriminates based on sex because it is directed at transgender people, it enforces gender stereotypes, and it is directed toward preventing surgical treatments for gender transition.

127. As a result, the Regulation is unlawful, and DHS's reliance on the Regulation to deny Ms. Good Medicaid reimbursement was improper.

COUNT III
Iowa APA, Section 17A.19(10)(a),
Violation of the Iowa Constitution's Equal-Protection Guarantee

128. Ms. Good incorporates paragraphs 1 through 114 as though fully set forth in this paragraph.

129. Under Section 17A.19(10)(a) of the Iowa APA, a court may reverse an agency action if substantial rights of the person seeking judicial relief have been prejudiced because the agency action is unconstitutional on its face or as applied or is based on a provision of law that is unconstitutional on its face or as applied. *See* Iowa Code § 17A.19(10)(a).

130. The Iowa Constitution includes two equal-protection clauses.

131. Article I, Section 6, states that "[a]ll laws of a general nature shall have a uniform operation; the general assembly shall not grant any citizen or class of citizens, privileges or immunities, which, upon the same terms shall not equally belong to all citizens." *See* Iowa Const. art. I, § 6.

132. Article I, Section 1, states that "[a]ll men and women are, by nature, free and equal, and have certain inalienable rights—among which are those of enjoying and defending life and liberty, acquiring, possessing and protecting property, and pursuing and obtaining safety and happiness." *See* Iowa Const. art. I, § 1

133. Under the Iowa Constitution's equal-protection guarantee, people who are similarly situated with respect to the purpose of a law must be treated alike.

134. With respect to the need to obtain financial assistance for medical care, transgender people in need of surgical treatment for gender dysphoria, such as Ms. Good, are situated similarly to nontransgender people who need medically necessary treatment for other conditions.

135. The Regulation categorically prohibits Medicaid coverage for medically necessary gender-affirming surgical treatment for Ms. Good.

136. As a result, under the Regulation, Iowa Medicaid covers certain medically necessary treatment for nontransgender Medicaid participants that it does not cover for transgender Medicaid participants as part of their medically necessary gender-affirming care.

137. Discrimination on the basis of transgender status, gender transition, or gender nonconformity is discrimination on the basis of sex.

138. The Regulation, and DHS's reliance on it to deny Ms. Good gender-affirming surgery, discriminates on the basis of sex.

139. Sex discrimination involves a quasi-suspect classification and demands a heightened level of scrutiny under the Iowa Constitution.

140. Discrimination based on transgender status is suspect and demands a heightened level of scrutiny under the Iowa Constitution.

141. DHS's actions purposefully single out a minority group—transgender people—that historically has suffered discriminatory treatment and been relegated to a position of political powerlessness solely on the basis of stereotypes and myths about their transgender status, a characteristic that bears no relation to their ability to contribute to society and is immutable in that it is central to their core identity.

142. No plausible policy reason is advanced by, or rationally related to, this classification.

143. Nor is the classification substantially related to achieving an important government objective or narrowly tailored to serve a compelling government interest.

144. For these reasons, the Regulation is unconstitutional, both facially and as applied, and DHS's reliance on the Regulation to deny Ms. Good Medicaid reimbursement violated the Iowa Constitution's equal-protection guarantee.

COUNT IV
Iowa APA, Section 17A.19(10)(k),
Disproportionate Negative Impact on Private Rights

145. Ms. Good incorporates paragraphs 1 through 114 as though fully set forth in this paragraph.

146. Under Section 17A.19(10)(k) of the Iowa APA, a court may reverse an agency action if substantial rights of the person seeking judicial relief have been prejudiced because the agency action is not required by law and its negative impact on the private rights affected is so

grossly disproportionate to the benefits accruing to the public interest that it must necessarily be deemed to lack any foundation in rational agency policy. *See* Iowa Code § 17A.19(10)(k).

147. An unlawful, unconstitutional administrative regulation such as IAC 441.78.1(4) is not only "not required," it is forbidden.

148. Ms. Good has a right to be treated in accordance with the provisions of the ICRA and the Iowa Constitution.

149. The Regulation causes a disproportionate negative impact on the private rights of transgender individuals such as Ms. Good by categorically prohibiting them from receiving Medicaid coverage for medically necessary surgical treatment of gender dysphoria.

150. There is no public interest served by denying Medicaid coverage for medically necessary and effective treatment.

151. For these reasons, DHS's reliance on the Regulation to deny Ms. Good Medicaid reimbursement was improper.

COUNT V
Iowa APA, Section 17A.19(10)(n),
Unreasonable, Arbitrary, and Capricious Decision

152. Ms. Good incorporates paragraphs 1 through 114 as though fully set forth in this paragraph.

153. Under Section 17A.19(10)(l) of the Iowa APA, a court may reverse an agency action if substantial rights of the person seeking judicial relief have been prejudiced because the agency action is unreasonable, arbitrary, capricious, or an abuse of discretion. *See* Iowa Code § 17A.19(10)(n).

154. DHS's denial of Ms. Good's request for Medicaid coverage for her orchiectomy was unreasonable, arbitrary, and capricious because DHS relied on a Regulation that violates

Section 216.7(1)(1) of the ICRA and the Iowa Constitution's equal-protection guarantee and denied Medicaid coverage for medically necessary treatment for one medical condition that it provides for others. *See* Iowa Code §§ 216.7(1)(a), 216.2(13)(b); Iowa Const. art. I, §§ 1, 6.

155. For these reasons, DHS's reliance on the Regulation to deny Ms. Good Medicaid reimbursement was improper.

PRAYER FOR RELIEF
Declaratory and Injunctive Relief

156. Ms. Good incorporates paragraphs 1 through 114 as though fully set forth in this paragraph.

157. This matter is appropriate for declaratory relief under Section 17A.19(10) of the Iowa APA and Rule 1.1101, *et seq.*, of the Iowa Rules of Civil Procedure. *See* Iowa Code § 17A.19(10); Iowa R. of Civ. Pro. 1.1101, *et seq.*

158. Granting the declaratory relief sought by Ms. Good will terminate the dispute over the legality of IAC 441.78.1(4)'s surgical ban that gave rise to this petition.

159. This matter is also appropriate for temporary and permanent injunctive relief under Section 17A.19(10) of the Iowa APA, Rule 1.1106 of the Iowa Rules of Civil Procedure, and Rule 1.1501, *et seq.*, of the Iowa Rules of Civil Procedure. *See* Iowa Code § 17A.19(10); Iowa R. Civ. Pro. 1.1106; Iowa R. of Civ. Pro. 1.1501, *et seq.*

160. Ms. Good has suffered irreparable harm as a result of IAC 441.78.1(4), which categorically prohibits Medicaid coverage for surgical treatment of gender dysphoria.

161. Absent injunctive relief, Ms. Good will continue to suffer irreparable harm.

162. There is no adequate remedy at law for IAC 441.78.1(4)'s categorical surgical ban.

RELIEF SOUGHT

FOR THESE REASONS, Petitioner EerieAnna Good requests the following relief:

a. A declaratory ruling that IAC 441.78.1(4):

   i. violates the ICRA's prohibitions on sex and gender-identity discrimination; and

   ii. violates the Iowa Constitution's equal-protection guarantee facially and as applied;

b. An order invalidating IAC 441.78.1(4) and enjoining any further application of the Regulation to deny Medicaid coverage for gender-affirming surgical procedures;

c. An order reversing and vacating DHS's affirmance of AmeriHealth's denial of Ms. Good's request for Medicaid coverage for her orchiectomy and requiring DHS to approve coverage for that procedure;

d. An award of attorneys' fees and costs; and

e. Any other relief the Court deems just and proper.

Dated: September 21, 2017

Respectfully submitted,

/s/ Rita Bettis
Rita Bettis, AT0011558
ACLU of Iowa Foundation Inc.
505 Fifth Avenue, Ste. 901
Des Moines, IA 50309-2316
Telephone: 515-207-0567
Facsimile: 515-243-8506
rita.bettis@aclu-ia.org

/s/ Joseph Fraioli
Joseph Fraioli, AT0011851
ACLU of Iowa Foundation Inc.

505 Fifth Avenue, Ste. 901
Des Moines, IA 50309-2316
Telephone: 515-259-7047
Facsimile: 515-243-8506
joseph.fraioli@aclu-ia.org

/s/ F. Thomas Hecht
F. Thomas Hecht, pro hac vice pending
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4322
Facsimile: 312-977-4405
fthecht@nixonpeabody.com

/s/ Tina B. Solis
Tina B. Solis, pro hac vice pending
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4482
Facsimile: 312-977-4405
tbsolis@nixonpeabody.com

/s/ Seth A. Horvath
Seth A. Horvath, pro hac vice pending
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4443
Facsimile: 312-977-4405
sahorvath@nixonpeabody.com

/s/ John Knight
John Knight, pro hac vice pending
ACLU Foundation
LGBT & HIV Project
180 North Michigan Avenue, Ste. 2300
Chicago, IL 60601
Telephone: 312-201-9740
Facsimile: 312-288-5225
jknight@aclu-il.org

In the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA	)	
	)	**Case No. 8656390206**
(Re: Type of Service Appealed: Denial of Orchiectomy for gender dysphoria)	)	**AFFIDAVIT OF KATHERINE IMBOREK IN SUPPORT OF APPEAL**
Appeal # MED: 17008723	)	

AFFIDAVIT OF KATHERINE IMBOREK

STATE OF IOWA)
)
COUNTY OF JOHNSON)

I, Dr. Katherine Imborek, being duly sworn, depose, and state the following to the best of my recollection and under oath and penalty of perjury:

1. I am a legal adult of sound mind and, if called upon to do so, could testify competently to the facts set forth in this affidavit.
2. I am EerieAnna Good's primary care physician. I have been treating Ms. Good since July 2013.
3. On February 22, 2017, I wrote a letter in support of Ms. Good's candidacy for an orchiectomy due to her gender dysphoria, wherein I

Exhibit 1

stated that this gender confirmation surgery is medically necessary and clinically appropriate treatment for Ms. Good's gender dysphoria.

4. I attest that the attached letter, labeled Exhibit A, is a true an accurate copy of the letter I wrote on February 22, 2017, which was later submitted in support of Ms. Good's request for Medicaid coverage for her orchiectomy.
5. I further attest that the assertions in the letter are true and accurate to the best of my knowledge, information, and belief.

Katherine Imborek, Affiant

Subscribed and sworn to me on this 7 day of July, 2017.

NOTARY PUBLIC
SIGNATURE AND STAMP

NOTARIAL SEAL IOWA
Amy Shalla
Commission Number 781983
My Commission Expires
December 30, 2019

UNIVERSITY OF IOWA HOSPITALS & CLINICS
University of Iowa Health Care

UIHC Iowa River Landing

LGBTQ Clinic
Internal Medicine
105 East 9th Street
Coralville, IA 52241
319-467-2000 Tel
319-467-2505 Fax

2/22/2017

RE: Sex Designation Change of EerieAnna Good
DOB: [redacted]
Notarized Affidavit of Katherine Imborek, MD

To Whom It May Concern:

I, Katherine Imborek, MD, am a licensed physician in the State of Iowa, and the primary care physician of EerieAnna Good who is interested in gender confirmation sugery to further her transition from male to female. By way of background, I am a Doctor of Medicine and a primary care physician at the University of Iowa Hospitals and Clinics' Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Clinic.

I have treated EerieAnna Good since 7/2013 and confirm that she has a diagnosis of gender dysphoria. She has been on estradiol and spironolactone since 2/2014 without complications. She has been living fully in her affirmed gender since that time as well. She has no medical co-morbidities that are uncontrolled. Gender confirmation surgery is medically necessary to treat her gender dysphoria and I support this decision. Additionally, this surgery, which would include removal of her testicles and result in a lower and safer dose of estradiol.

All of the treatments EerieAnna Good received under my care were medically necessary, clinically appropriate, and in accord with the standards and guidelines for treatment of Gender Dysphoria, ICD-9 Code 302.85, by the World Professional Association for Transgender Health, American Medical Association, American Psychiatric Association, American Psychological Association, and the American College of Obstetricians and Gynecologists.

Respectfully submitted,

Katherine Imborek, MD
Iowa License # 39223
University of Iowa Hospitals and Clinics -- Iowa River Landing
105 East 9th Street Level 4
Coralville, Iowa 52241
319-384-7444

In the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA (Re: Type of Service Appealed: Denial of Orchiectomy for gender dysphoria) Appeal # MED: 17008723	**Case No. 8656390206** **AFFIDAVIT OF JACOB PRIEST IN SUPPORT OF APPEAL**

AFFIDAVIT OF JACOB PRIEST

STATE OF IOWA)
)
COUNTY OF JOHNSON)

I, Jacob Priest, being duly sworn, depose and state the following to the best of my recollection and under oath and penalty of perjury:

1. I am a legal adult of sound mind and, if called upon to do so, could testify competently to the facts set forth in this affidavit.
2. I am a family therapist and the director of the LGBTQ Clinic in the Department of Rehabilitation and Counselor Education at the University of Iowa. I evaluated EerieAnna Good on February 16, 2017 for her candidacy for gender confirmation surgery.
3. On February 16, 2017, I wrote a letter in support of Ms. Good's candidacy for an orchiectomy due to her gender dysphoria, wherein I

Exhibit 2

stated that this gender affirming surgery is medically necessary and clinically appropriate treatment for Ms. Good's gender dysphoria.

4. I attest that the attached letter, labeled Exhibit A, is a true an accurate copy of the letter I wrote on February 16, 2017, which was later submitted in support of Ms. Good's request for Medicaid coverage for her orchiectomy.

5. I further attest that the assertions in the letter are true and accurate to the best of my knowledge, information, and belief.

Jacob Priest, Affiant

Subscribed and sworn to me on this 13th day of July, 2017.

Judith E. Brewer
NOTARY PUBLIC
SIGNATURE AND STAMP

10.8.19

THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
Leaders. Scholars. Innovators.
Department of Rehabilitation and Counselor Education

LGBTQ Clinic in RCE
Psychosocial Assessment Report

Legal Name: EerieAnna Good
Preferred Name: EerieAnna
Address: [redacted]

Date: 2-16-2017
Birthdate: [redacted]

Referral and Background:
EerieAnna Good was referred to the LGBTQ Clinic for a psychosocial assessment for gender affirming surgery. This report is based on a 90 minute session on February 16, 2017 by Jacob B. Priest as well as her responses to standardized mental health, well-being, and trauma measures.

[redacted]

[redacted]

[redacted]

338 Lindquist Center North
Iowa City, IA 52242-1529
319-335-5275 Fax 319-335-5291
www.education.uiowa.edu/rce

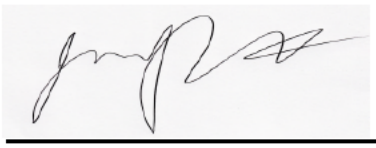
[redacted]

Recommendation:

[redacted]

EerieAnna also meets the eligibility and readiness criteria for surgery as set forth the Standards of Care of the World Professional Association for Transgender Health (WPATH). Specifically, she is aware of the potential risks of surgery and she is capable of making and informed decision. Additionally, even though she has been taking estrogen, she still expereinces distress because her body is not congruent with her gender. Given this, she meets diagnotic criteria for gender dysphoria. This dyshporia is not better accounted for by another diagnosis.

It is my opinion that gender affirming surgery is a necessary treatment for EerieAnna's gender dysphoria. It is likely that much of the distress that she is currently experiencing stems from the lack of congruence between her body and her gender. It is likely that surgery would help allievate much of her distress and improve her quality of life. Therefore, I support EerieAnna's desire for gender affirming surgery. She understand the potentail risks and benefits of surgery and appears to be making an informed decision.



Jacob B. Priest, PhD, LMFT
Director, LGBTQ Clinic in RCE

In the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA (Re: Type of Service Appealed: Denial of Orchiectomy for gender dysphoria) Appeal # MED: 17008723	)	**Case No. 8656390206** **AFFIDAVIT OF ARMEDA WOJCIAK IN SUPPORT OF APPEAL**

AFFIDAVIT OF ARMEDA WOJCIAK

STATE OF IOWA)
)
COUNTY OF JOHNSON)

I, Armeda Wojciak, being duly sworn, depose and state the following to the best of my recollection and under oath and penalty of perjury:

1. I am a legal adult of sound mind and, if called upon to do so, could testify competently to the facts set forth in this affidavit.
2. I am a marriage and family therapist with the LGBTQ Clinic in the Department of Rehabilitation and Counselor Education at the University of Iowa. I evaluated EerieAnna Good for her candidacy for gender confirmation surgery based on a recording of my colleague Dr. Priest's interview with Ms. Good, held on February 16, 2017.

3. On March 9, 2017, I wrote a letter in support of Ms. Good's candidacy for an orchiectomy due to her gender dysphoria, wherein I stated that this gender affirming surgery is medically necessary and clinically appropriate treatment for Ms. Good's gender dysphoria.
4. I attest that the attached letter, labeled Exhibit A, is a true an accurate copy of the letter I wrote on March 9, 2017, which was later submitted in support of Ms. Good's request for Medicaid coverage for her orchiectomy.
5. I further attest that the assertions in the letter are true and accurate to the best of my knowledge, information, and belief.

Armeda Wojciak, Affiant

Subscribed and sworn to me on this 13th day of July, 2017.

Judith E. Brewer
NOTARY PUBLIC
SIGNATURE AND STAMP

10.8.19

THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
Leaders. Scholars. Innovators.
Department of Rehabilitation and Counselor Education

LGBTQ Clinic in RCE
Psychosocial Assessment Report

Legal Name: EerieAnna Good
Preferred Name: EerieAnna
Address: [redacted]

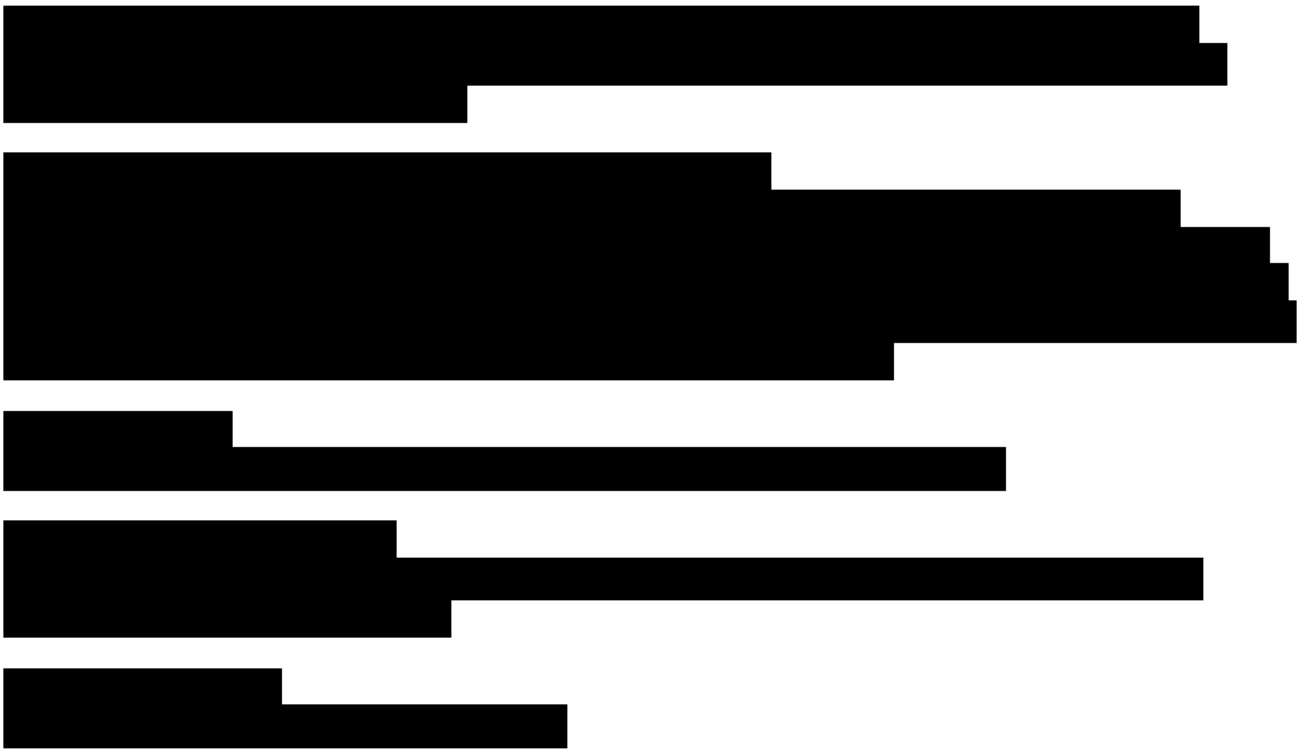
Date: 3-9-2017
Birthdate: [redacted]

Referral and Background:
EerieAnna Good was referred to the LGBTQ Clinic for a psychosocial assessment for gender affirming surgery. This report is based on an independent observation of the 90 minute session Jacob B. Priest conducted with EerieAnna on February 16, 2017.

[redacted]

338 Lindquist Center North
Iowa City, IA 52242-1529
319-335-5275 Fax 319-335-5291
www.education.uiowa.edu/rce

Exhiibt A to Exhibit 3



Recommendation:

EerieAnna also meets the eligibility and readiness criteria for surgery as set forth in the Standards of Care of the World Professional Association for Transgender Health (WPATH). Specifically, she is aware of the potential risks of surgery and she is capable of making and informed decision. Additionally, even though she has been taking estrogen, she still expereinces distress due to her body not being congruent with her gender. Given this, she meets diagnotic criteria for gender dysphoria. This dyshporia is not better accounted for by another diagnosis.

It is my opinion that gender affirming surgery is a necessary treatment for EerieAnna's gender dysphoria. It is likely that much of the distress that she is currently experieincing stems from the lack of congruence between her body and her gender. It is likely that surgery would help allievate much of her distress and improve her quality of life. Therefore, I support EerieAnna's desire for gender affirming surgery. She understand the potentail risks and benefits of surgery and appears to be making an informed decision.

Armeda Wojciak, PhD, LMFT
Program Coordination, Couple and Family Therapy Program
University of Iowa

In the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA	)	
	)	**Case No. 8656390206**
(Re: Type of Service Appealed: Denial of Orchiectomy for gender dysphoria)	)	**AFFIDAVIT OF BRAD ERICKSON IN SUPPORT OF APPEAL**
Appeal # MED: 17008723	)	

AFFIDAVIT OF BRAD ERICKSON

STATE OF IOWA)
)
COUNTY OF JOHNSON)

I, Dr. Brad A. Erickson, being duly sworn, depose, and state the following to the best of my recollection and under oath and penalty of perjury:

1. I am a legal adult of sound mind and, if called upon to do so, could testify competently to the facts set forth in this affidavit.
2. I am the treating physician and surgeon for EerieAnna Good with respect to her desired orchiectomy procedure. I have been treating Ms. Good since January 18, 2017.
3. On March 15, 2017, I wrote a letter in support of Ms. Good's candidacy for an orchiectomy due to her gender dysphoria, wherein I

Exhibit 4

stated that Ms. Good's gender dysphoria would be significantly improved by undergoing an orchiectomy. I further agree that this procedure is medically necessary treatment for Ms. Good's gender dysphoria.

4. I attest that the attached letter, labeled Exhibit A, is a true an accurate copy of the letter I wrote on March 15, 2017, which was later submitted in support of Ms. Good's request for Medicaid coverage for her orchiectomy.
5. I further attest that the assertions in the letter are true and accurate to the best of my knowledge, information, and belief.

Brad Erickson, Affiant

Subscribed and sworn to me on this 12 day of July, 2017.

NOTARY PUBLIC
SIGNATURE AND STAMP

NOTARIAL SEAL IOWA
SANDY MOENK
Commission Number 781809
My Commission Expires
December 19, 2019

UNIVERSITY OF IOWA HEALTH CARE

Department of Urology

200 Hawkins Drive, Room 3120 RCP
Iowa City, IA 52242-1089
319-353-8939 ***Tel***
319-356-3900 ***Fax***
319-356-2421 ***Scheduling***
www.uihealthcare.org

Chair & Department Executive Officer
Karl J. Kreder Jr., M.D.

Urodynamics, Female and Reconstructive Urology
Karl J. Kreder, Jr., M.D., Director
Elizabeth B. Takacs, M.D.
Bradley A. Erickson, M.D.
James B. Mason, M.D., Fellow

Robotics and Minimally Invasive Surgery
Chad R. Tracy, M.D., Director
Sam J. Brancato, M.D.
James A. Brown, M.D.
Kenneth G. Nepple, M.D.

Urologic Oncology
Michael A. O'Donnell, M.D., Director
Sam J. Brancato, M.D.
James A. Brown, M.D.
Kenneth G. Nepple, M.D.
Chad R. Tracy, M.D.

Pediatric Urology
Christopher S. Cooper, M.D., Director
Douglas W. Storm, M.D.
Charles E. Hawtrey, M.D., Emeritus

Brachytherapy
Chad R. Tracy, M.D.

Stones
Chad R. Tracy, M.D.

Andrology, Male Infertility & Sexual Dysfunction
Moshe Wald, M.D.
Bradley A. Erickson, M.D.
Bernard Fallon, M.D., Emeritus

Urologic Research Faculty
Yi Luo, M.D., Ph.D.
David M. Lubaroff, Ph.D., Emeritus

March 15, 2017

Re: Letter in Support of Appeal of Denial of Coverage for EerieAnna Good

Dear Sir or Madam:

I am writing with regard to EerieAnna Good, a Medicaid-eligible patient seeking surgical treatment from me. Ms. Good is a twenty-seven year-old transgender female who has been diagnosed with gender dysphoria as set forth in the letters of Dr. Imborek, Dr. Priest, and Dr. Wojciak that accompany this submission. Ms. Good has a scrotum and testicles, which are not consistent with her female gender and exacerbate her gender dysphoria. Dr. Imborek, Dr. Priest, and Dr. Wojciak have concluded that an orchiectomy is medically necessary to treat Ms. Good's gender dysphoria.

They believe (and I concur) that Ms. Good's gender dysphoria would be significantly improved by undergoing an orchiectomy. Further, AmeriHealth Caritas Iowa covers orchiectomy procedures for other medical conditions, such as testicular cancer, pain and torsion, is an equally necessary and proper treatment for transgender women with gender dysphoria, including for Ms. Good.

The appropriate ICD-10 code for her condition is:

F64.1 Gender Identity Disorder

The appropriate CPT coding for the procedure is:

54520 Scrotal Orchiectomy

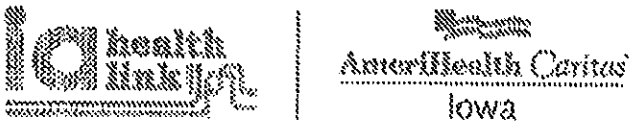
This treatment of Ms. Good is consistent with the World Professional Association for Transgender Health guidelines which articulate the standards for an orchiectomy to include: (1) persistent, well-documented gender dysphoria, (2) capacity to make an informed consent for treatment, (3) age of majority, (4) if significant medical or mental health concerns are present, control of such concerns, and (5) twelve continuous months of hormone therapy appropriate for the patient's gender.

This letter is in support of Ms. Good's appeal of AmeriHealth Caritas Iowa's denial of coverage for the surgical treatment of Mr. Good described above.

Please contact me if you have any further questions.

Sincerely,

Brad A. Erickson, MD
Associate Professor of Urology
University of Iowa Hospitals and Clinics



February 2, 2017

2900IAOPMEDNECPROV

–

Subject: EERIEANN GOOD
Member's Date of Birth: [redacted]
Member's ID number: [redacted]
Requesting provider: BRADLEY ERICKSON
Admission/Service Date: 03/28/17 to 07/28/17
Reference number: 1701071770

Dear BRADLEY ERICKSON:

Beginning 02/02/2017, the request for **orchiectomy for gender dysphoria** is unable to be approved/cannot be certified. This is based on the medical information provided to our physician reviewer.

The reason(s) for this determination is (are) as follows: Based on review of the submitted clinical information by the AmeriHealth Caritas Iowa Medical Director, your request for orchiectomy is denied. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage. This denial of orchiectomy for gender dysphoria is in accordance with Iowa Administrative Code Section 441.78.1(4) .

This determination was based on: Medical Director review.

All references in this letter to the term "you" or "your" refer solely to the named member.

You may obtain free copies of the medical and other documents on which this decision was based on by contacting Member Services at **1-855-332-2440 or TTY 1-844-214-2471** or by sending a request to:

AmeriHealth Caritas Iowa
Attention: Request for Criteria
Member Appeals Department
601 Locust Street, Suite 900

AmeriHealth Caritas Iowa
Two Ruan Center
601 Locust Street, Suite 900
Des Moines, Iowa 50309
www.amerihealthcaritasia.com

Exhibit 5

Des Moines, Iowa 50309

If your provider would like to discuss this case with a reviewer, called a peer-to-peer review, please have him or her call the Medical Management department at **1-844-412-7887.**

If you disagree with this decision, you have the right to appeal it. If you want your provider or an authorized representative to act on your behalf, you must give your provider or authorized representative written permission to do so.

Expedited appeal

If you or your provider believes your appeal is an emergency and that it would be harmful or painful to you if you had to wait for a standard appeal to be decided, you or your provider may request an expedited appeal by AmeriHealth Caritas Iowa. If you want your provider to represent you, you must give your provider written permission to do so.

An expedited appeal can be requested by calling AmeriHealth Caritas Iowa's Member Services department at **1-855-332-2440 or TTY 1-844-214-2471.** You or your provider can fax documents to support your appeal to AmeriHealth Caritas Iowa Appeals department at **1-844-412-7890.** You will be notified of AmeriHealth Caritas Iowa's decision as soon as possible, but no later than three business days after AmeriHealth Caritas Iowa receives your request for an expedited appeal.

Standard appeal

You or your provider has the right to appeal this decision to AmeriHealth Caritas Iowa within 30 calendar days from the date at the top of this letter by calling Member Services at **1-855-332-2440 or TTY 1-844-214-2471**, by faxing your request to **1-844-412-7890** or by sending a written notice to:

AmeriHealth Caritas Iowa
Attention: Member Appeals Coordinator
Member Appeals Department
601 Locust Street, Suite 900
Des Moines, Iowa 50309

You may receive assistance from Member Services at **1-855-332-2440 or TTY 1-844-214-2471** in filing your appeal or you may contact the Iowa Department of Human Services directly.

If you file your appeal by telephone, you must follow up your call with a written, signed appeal letter. AmeriHealth Caritas Iowa will help you by writing this appeal letter and sending it to you for your signature.

You can keep getting covered services while you wait for AmeriHealth Caritas Iowa to decide on an appeal, if all of the following apply:

- The appeal is filed:
  - Within 10 calendar days from the date AmeriHealth Caritas Iowa mailed the notice of action or
  - Before the effective date of this notice.
- The appeal is related to reduced or suspended services or to services that were previously authorized for you.
- The services were ordered by an authorized provider.
- The authorization period for the services has not ended.
- You asked that the services continue.

If AmeriHealth Caritas Iowa continues your benefits while deciding an appeal, the services must be continued until one of the following happens:

- You decide not to continue the appeal.
- The authorization for services expires or authorization service limits are met.

You may submit medical information and documents that support your appeal and written comments for review to AmeriHealth Caritas Iowa. You will be notified of the decision in writing within 30 calendar days after AmeriHealth Caritas Iowa receives your appeal.

To ask for free legal help with your appeal, you can call:

- Iowa Legal Aid at **1-800-532-1275** Monday – Friday from 9 a.m. to 11 a.m. or from 1:30 p.m. to 3:30 p.m., **except Thursday afternoon.** <OR>
- You may apply online at any time by visiting www.iowalegalaid.org and choosing Apply Online. Offices are open 8:30 a.m. to 4:30 p.m. (emergencies taken when open).

Iowans age 60 and over may call the **Legal Hotline for Older Iowans** at **1-800-992-8161**, Monday – Friday from 9 a.m. to 4:30 p.m.

If you did not request the service listed above, please call the Fraud Hotline at 1-866-833-9718.

Sincerely,

Utilization Management
CC: EERIEANN GOOD
AMANDA DALASKA
UNIVERSITY OF IOWA

AmeriHealth Caritas Iowa
Two Ruan Center
666 Locust Street, Suite 300
Des Moines, Iowa 50309
www.amerihealthcaritasia.com

Exhibit 5

AmeriHealth Caritas Iowa
As Agent for the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA GOOD (Re: Type of Service Appealed: Denial of Orchiectomy for gender dysphoria) Case ID Number: [redacted] Case Provider: Katherine Imborek, MD	Member's Name: EerieAnna Good Member's DOB: [redacted] Member's ID Number: [redacted] **AFFIDAVIT OF EERIEANNA GOOD IN SUPPORT OF APPEAL**

AFFIDAVIT OF EERIEANNA GOOD

STATE OF IOWA)
)
COUNTY OF SCOTT)

I, EerieAnna Good, being duly sworn, depose, and state:

1. I am a United States citizen and I am twenty-seven years old.
2. I currently reside in Davenport, Iowa.
3. I am a woman. I am also transgender, having been assigned the male sex at birth. However, since I was about seven years old, I knew that I was female. I felt like a girl trapped in a boy's body. I would often dress in girl's clothes, wear makeup, and play with girl's toys.
4. I was diagnosed with gender dysphoria in 2013. My gender dysphoria exacerbates my already existing depression and anxiety. As part of my medical treatment for gender dysphoria, my healthcare provider

advised me to continue to live full-time as female in every aspect of my life.

5. Prior to coming out as transgender, I identified as a gay man, and was bullied in high school. I decided to come out as transgender in 2010, after I graduated high school. Since then, I have presented as female full-time in the way that I dress and style my hair.
6. I began using the pronouns "she," "her," and "hers" in 2010. In 2014, after receiving my first dose of hormones, I began using women's restrooms in public places and have used them consistently ever since.
7. In 2014, my healthcare provider prescribed hormone therapy as additional treatment for my gender dysphoria. I have taken this medication continuously since then.
8. In 2016, I legally changed my name to reflect my gender identity as a woman. I have also amended my birth certificate and driver's license to reflect my female gender and legal name, and Social Security card to reflect my legal name.
9. While I have been very pleased with the physical changes to my body resulting from the hormone therapy, I remain distressed and very uncomfortable with my genitalia. I have a penis and scrotum which do not align with my gender identity. To better present as female, I tuck

my scrotum and penis into my body and wear a girdle, which holds it in place for up to twelve hours or more each day. While binding my genitals in this way is very painful and uncomfortable, it helps me present outwardly as female in conformity with my gender identity.

10. My healthcare provider for my gender dysphoria, Dr. Katherine Imborek, mental health providers, psychologists Jacob Priest and Armeda Wojciak, and surgeon, Dr. Brad Erickson, agree that having this procedure is medically necessary to treat my pervasive gender dysphoria.

I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

Executed on March 16, 2017.

EerieAnna Good, Affiant

Subscribed and sworn to me on this 16 day of March, 2017.

NOTARY PUBLIC
SIGNATURE AND STAMP

NOTARIAL SEAL IOWA
JAMES A. SILVERSMET JR.
Commission Number 736968
My Commission Expires
10-5-17

AmeriHealth Caritas Iowa
As Agent for the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA GOOD	)	Member's Name: EerieAnna Good
	)	Member's DOB: [redacted]
	)	Member's ID Number: [redacted]
(Re: Type of Service Appealed: Denial of Orchiectomy for gender dysphoria	)	**AFFIDAVIT OF RANDI ETTNER IN SUPPORT OF APPEAL**
Case ID Number: [redacted]	)	
Case Provider: Katherine Imborek, MD	)	

AFFIDAVIT OF RANDI ETTNER

STATE OF ILLINOIS)
)
COUNTY OF COOK)

I, Randi Ettner, being duly sworn, depose, and state:

1. I have been asked to provide an expert opinion regarding Gender Dysphoria and its treatment and, whether the *Iowa Foundation for Medical Care,* "Definition, Diagnosis, and Treatment of Gender Dysphoria: A Literature Review for the Iowa Department of Human Services" (Dec. 1993) ("*Iowa Foundation Report*"), the *Human Services Department*, Notice of Intended Action, ARC 5220A (Iowa Admin. Bull. Nov. 9, 1994) ("*DHS Rulemaking Notice*") and the *Human Services Department*, Adopted and Filed, ARC 5345A (Iowa Admin. Bull. Jan. 4, 1995) ("*DHS Rule Adoption Notice*") accurately reflect the current scientific and medical standard of care and evidence-based clinical best-practices for the treatment of Gender Dysphoria.

2. In preparation for this report I was provided with the following materials: the *Iowa Foundation Report*, the *DHS Rulemaking Notice,* the *DHS Rule Adoption Notice*, the rulemaking comments of Thomas A. Krause to Iowa Department of Human Services dated November, 29, 1994, and the response from the Department of Human Services to Mr. Krause's rulemaking comments, dated December 5, 1994.

Qualifications

3. I received my doctorate in psychology from Northwestern University in 1979. I am the chief psychologist at the Chicago Gender Center, a position I have held since 2005.

4. I have expertise working with children, adolescents and adults with Gender Dysphoria. I have been involved in the treatment of gender dysphoric individuals since 1977, when I was an intern at Cook County Hospital, and, in the course of my career, I have evaluated

Exhibit 7

and/or treated 2,500 to 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance.

5. I have published four books related to transgender healthcare including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey and Eyler; Routledge, 2007) and the 2nd edition (co-editors Monstrey and Coleman; Routledge, 2016). I have authored numerous articles in peer-reviewed journals regarding the provision of health care to this population. I served as a member of the University of Chicago Gender Board, and am a member of the editorial boards of the *International Journal of Transgenderism* and *Transgender Health.*

6. I am the Secretary of the World Professional Association for Transgender Health (WPATH) (formerly the Harry Benjamin International Gender Dysphoria Association) a member of the Executive Board of Directors, and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th version). The WPATH- promulgated *Standards of Care* are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

7. I have lectured throughout North America, Europe and Asia on topics related to Gender Dysphoria. On numerous occasions, I have given grand rounds presentations on Gender Dysphoria at medical hospitals. I am the honoree of the Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota, and have been an invited guest at the National Institute of Health to participate in developing a strategic plan to advance the health of sexual and gender minorities.

8. I have been retained as an expert regarding Gender Dysphoria and its treatment in numerous court cases in state and federal courts, as well as administrative proceedings. I have also been a consultant to policy makers regarding appropriate care for transgender inmates.

Opinions

What does it mean to be transgender?

9. Transgender refers to a diverse group of individuals who cross or transcend culturally defined categories of gender and sex. For these individuals, their gender identity–the innate sense of being male or female–differs from the category they were assigned at birth. Gender identity is different than sexual orientation.

10. Although the term “transgender” is a recent addition to the medical lexicon, the condition of gender incongruity is not. Accounts of individuals who displayed cross-gender behavior first appeared in German medical literature in 1877, and biological attempts to manipulate gender date as far back as the Iron Age.

What is gender dysphoria?

11. Gender Dysphoria, formerly known as Gender Identity Disorder, is a serious medical condition codified in the *International Classification of Diseases* (10th revision; World Health Organization) and the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-5th edition.* The condition is characterized by a strong and persistent incongruence between one's experienced and/or expressed gender identity and sex assigned at birth, resulting in clinically significant distress or impairment in functioning. The suffering that arises from this condition has often been described as 'being trapped in the wrong body." "Gender dysphoria" is also the psychiatric term used to describe the severe and unremitting emotional pain associated with the condition.

12. Gender Identity Disorder is not to be confused with Body Dysmorphic Disorder. Body Dysmorphic Disorder is characterized by a distorted perception that a particular aspect of one's physical appearance, e.g. one's nose, is flawed, causing the individual to feel "deformed." Surgery is not therapeutic for individuals with Body Dysmorphic Disorder. Gender Dysphoria, is based on a realistic perception that one's body habitus does not align with one's gender identity.

13. The diagnostic criteria for Gender Dysphoria in adults are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning (DSM-5 p. 452).

14. Adults who manifest a severe degree of the condition are often referred to as being "transsexual." Without treatment, gender dysphoric individuals experience anxiety, depression, suicidality and other attendant mental health issues. They are also frequently isolated, because they carry a burden of shame and low self-esteem attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many individuals are unable to function effectively in daily life. Studies show a 41-43% rate of suicide attempts among this population without treatment, far above the baseline of 4.6% for North America (Haas et al., 2014).

How is gender dysphoria treated?

15. The standards of care for treating Gender Dysphoria are set forth in the *World Professional Association for Transgender Health's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (WPATH Standards of Care). The WPATH *Standards of Care* are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association (see AMA:2008; Resolution 122 [A-08]; American Psychiatric Association DSM-5; American Psychological Association Policy Statement on Transgender, Gender Identity, and Gender Expression Non-discrimination; 2009).

16. The *Standards of Care* are universally accepted, evidence-based, best-practice medical protocols, and have been translated into many languages. They articulate professional consensus to guide health care professionals in the medical management of Gender Dysphoria, and the parameters within which they may provide care to individuals with the condition.

17. The *Standards of Care* identify the following therapeutic options for treatment of individuals with Gender Dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition).
- Counseling for purposes such as addressing the negative impact of stigma, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to masculinize or feminize the body.
- Surgery to alter primary and/or secondary sex characteristics.

18. Of those individuals who seek treatment for Gender Dysphoria, only a subset requires surgical intervention. *The Iowa Foundation Report* includes a chart that purports to distinguish "good candidates" from "poor candidates" for surgery. These criteria have been superseded by thorough assessment protocols by qualified mental health professionals and clinical outcome research. The *Standards of Care* explicitly specifies the necessary elements of

assessment, the essential qualifications of referring mental health and medical providers, and the criteria for initiation of medically indicated surgical treatments.

Can psychotherapy replace surgery as treatment for Gender Dysphoria?

19. The *Iowa Foundation Report*, the *DHS Rulemaking Notice* and the *DHS Rule Adoption Notice* cite several studies that claim psychotherapy is as effective as surgery for the treatment of Gender Dysphoria. Specifically, reports by Lothstein, Beatrice, and Somerset are cited as the basis for asserting psychotherapy as the sole, appropriate treatment.

20. Lothstein and other proponents of the psychoanalytic model viewed gender dysphoric individuals as seriously disturbed and delusional, with pathological mother-child relations (Lothstein, 1979). These theorists maintained that the adult transsexual patient was a child who could not separate without intense anxiety and could not adequately regulate the intrapsychic distance between self and others. Some viewed the pathology to be psychotic in nature (Socarides, 1978) while others conceptualized transsexualism as a borderline personality disorder. According to Lothstein, the patient seeks to "discard bad and aggressive features and replace them with a new, idealized perfection" (1984). Lothstein claimed that only psychoanalysis could resolve what he considered profound emotional disturbance.

21. In 1985, Beatrice compared *Minnesota Multiphasic Personality Inventory* (MMPI) test scores of 10 individuals post surgery to 10 non-transgender males, 10 pre-operative patients and 10 "transvestic" individuals, (a diagnostic category that has since been abandoned). He reported that 2-code point scale scores of the post-operative and pre-operative patients were elevated. He opined that these individuals had rampant psychopathology, thereby rendering surgery an inappropriate intervention. This study serves as an example of how, prior to the establishment of blinded peer review, editors had sole discretion as to what to publish. A simple statistical power analysis would indicate that a sample size of 10 is far too small to distinguish an effect from random chance. Further attenuating the already scant sample, only 7 of 10 subject's met Beatrice's criteria for elevation, diluting the already questionable results and belying any basis for Beatrice's conclusion that the elevation of 2-point code scores reflect *inherent* psychopathology, let alone conclusions regarding the efficacy of surgery. Beatrice admits that, "The findings of this study conflict with other MMPI research which indicated that the psychological status of the postoperative transsexuals had been improved over preoperative levels." To further confound Beatrice's conclusions, when a psychometric instrument he utilized yielded normal scores for all groups, Beatrice suggested that the instrument was "not an adequate measure" and dismissed the findings.

22. The MMPI, first developed in the 1930's and 40's, required revision when it became apparent that validity flaws inherent in the instrument could not be overlooked. The original control group (normative sample) consisted of a small group of white, married, Midwestern people, primarily living in rural areas. Over time, researchers called for revision, as this "normative" sample did not reflect a heterogeneous populace. Additionally, certain items became outdated due to religious or sexual content. The femininity/masculinity scale, which Beatrice relied on, was found to lack validity and was omitted in subsequent iterations. By 1989,

the revised MMPI-2 was released. Research and further advancements led to the current, highly sophisticated MMPI-2-RF.

23. In addition, several early studies reached opposing conclusions to the Beatrice report, utilizing the original MMPI but with superior methodological design and larger numbers of subjects yielding greater statistical power. To cite but one example, in 1979, researchers administered the MMPI to 27 candidates for reassignment surgery and compared their scores with matched control groups of men awaiting kidney transplant and men who had a known psychological disorder. The authors concluded that the transsexual group had "a notable absence of psychopathology." (Tsushima & Wedding, 1979).

24. Somerset, in a 1989 study cited, referred to post-surgical patients as having chosen to "mutilate" themselves. Snaith, a consulting psychiatrist at Leeds, and member of a United Kingdom committee examining the efficacy of surgery, wrote in the *Journal of the Royal Society of Medicine*: "The views of Mrs. Somerset…challenge those of us who recommend gender reassignment for some patients. The views require reply. The belief that transsexualism is a coping device to absolve guilt over homosexual inclination is not supported by the considerable literature on the subject (1990)." In 1993, Snaith et al studied outcomes of 141 patients undergoing reassignment and concluded, … "there is no reason to doubt the therapeutic effect of sex reassignment surgery."

25. The *Iowa Foundation Report* likewise relies on a study by Lundstrom, et al citing a 10-15% failure rates for sex-reassignment surgery. Closer examination of the findings however show that this failure rate is not a reasonable basis for concluding that surgery is ineffective at treating Gender Dypshoria. The authors state that "…the vast majority of patients who have undergone sex reassignment surgery thus far have had a satisfactory outcome…The outcome is dependent on a good cosmetic and functional result from the surgery itself." Lundstrom cites the inability of individuals assigned female at birth to attain phalloplasty, or poor results of phalloplasty, as a major contributor to surgical failure, as well as improper assessment of patients. The authors conclude that surgical intervention is the appropriate treatment. Given the extraordinary advances in the surgical field over the past three decades, genital surgery presently yields normal urogenital function and cosmesis, and complications are rare.

26. The theory that the desire for reassignment surgery was a result of a delusion or deep psychological disturbance was disputed at the time by many mental health professionals and scientists who sought a biological basis for the condition. The idea that gender dysphoric patients were "demonstrating psychotic mechanisms" was, in the ensuing years, discredited by the weight of the research.

27. Using psychological testing, clinical psychologists debunked these early psychoanalytic theories, the controversy they gave rise to, and the patient could be cured through psychoanalysis or a "full blown transference neurosis." As early as 1978, large scale studies designed to provide quantitative data found no evidence that child rearing practices accounted for the development of the phenomenon of Gender Dysphoria (Buhrich & McConaghy). Psychometric data failed to substantiate the claim that gender dysphoric individuals had rampant psychopathology. One such study concluded that gender dysphoric individuals who were living

in their affirmed female gender role did not evidence psychopathology (Greenberg & Laurence, 1981). Similarly, Cole et al (1997) studied 435 gender dysphoric patients and concluded "transsexualism is usually an isolated diagnosis and not part of any general psychopathological disorder."

28. By 1995, a ground breaking article widely reported that the brains of transsexual persons differed from non-transsexual persons viewed post-mortem in the bed nucleus of the stria terminalis (BSTc). The theory that gender identity evolves as a result of the interaction of the developing brain and sex hormones gained momentum as subsequent studies bore out this relationship and similar findings of sexually dimorphic areas of the brain. A review article summarizing the controversy of psychotherapy versus surgery demonstrated that there was no convincing evidence for reversal of cross-gender identity by means of psychotherapy: "The only rational solution to the problem seemed to be the adaptation of sex characteristics to the cross-gender identity" (Cohen-Kettenis & Gooren). Thus, by the mid-1990's, the psychoanalytic theory lost its foothold and was replaced by the consensus that surgery was the only effective treatment for individuals with severe gender dysphoria.

29. In 2001, the WPATH *Standards of Care Version 6* no longer required psychotherapy as a necessary prerequisite to medical and/or surgical treatment for Gender Dysphoria, and, in 2010, WPATH issued the following "de-pathologizing statement:"

> "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth, is a common and culturally diverse human phenomenon, which should not be judged as inherently pathological or negative. The psychopathologisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalization and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people."

30. By 2011, consensus regarding the notion that a person with Gender Dysphoria is not suffering from a disordered identity or pathological condition had crystallized and that the nomenclature itself was pathologizing. The *DSM-5* changed the Gender Identity Disorder nomenclature to Gender Dysphoria, in recognition that an individual's *identity* is not disordered, but that one experiences distress as a result of the incongruence of identity and anatomy and the attendant social problems. This change in taxonomy acknowledged that the condition requires medical treatment but doesn't impugn the patient's mental health.

31. As the World Health Organization prepares for the 2018 release of the updated edition of the *International Classification of Diseases* (ICD), the category of Gender Identity Disorder (F64) was similarly reviewed. The conclusion, based on this review, "…it is now appropriate to abandon the psychopathological model of transgender people based on 1940's models of sexual deviance and to move towards a model that is more reflective of current scientific evidence and best practices…" (2016).

Can gender identity be altered?

32. Gender identity cannot be altered, either for transgender or for non-transgender individuals. Past attempts to "cure" transgender individuals and change their gender identity to match their birth-assigned gender were ineffective and caused extreme psychological damage. Such efforts are now considered unethical. Medical science recognizes that transgender individuals represent a normal variation of the diverse human population.

33. Current scientific research strongly suggests that gender identity is innate or fixed at an early age and has a strong biological basis. Both post-mortem and functional brain imaging studies in living persons show that transgender persons have areas of the brain that differ from the brains of non-transgender individuals. Additionally, research has shown that the probability of a sibling of a transgender person also being transgender was almost five times higher than the general public, and twins have a 33.3% concordance rate for being transgender, even when reared apart. This suggests a genetic component to the condition, and some researchers are looking at specific genes that are implicated in the genesis of gender incongruity.

34. Given that gender identity is biologically based, it cannot be altered. Historical attempts to manipulate gender identity included, in addition to psychoanalysis, faith healing, exorcism, electroshock and other forms of reparative therapy, all of which were unsuccessful, harmful, and are now considered unethical.

Does being transgender affect an individual's ability to contribute to society?

35. With appropriate treatment and social acceptance, transgender people are fully capable of leading healthy, happy and productive lives. Being transgender does not affect a person's ability to be a good employee, parent, or citizen.

Is surgery an effective treatment for Gender Dysphoria?

36. Surgeries are considered "effective" from a medical perspective if they "have a therapeutic effect" (Monstrey et al. 2007). More than three decades of research confirms that surgery to modify primary and/or secondary sex characteristics and align gender identity with anatomy is therapeutic and therefore effective treatment for Gender Dysphoria. Indeed for appropriately assessed severely gender dysphoric patients, surgery is the *only* effective treatment.

37. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded, "…reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences, and all aspects of the reassignment process contributed to overwhelmingly positive outcomes" (Pfafflin & Junge 1998).

38. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in The Netherlands concluded that after surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous

conclusions that sex reassignment is effective" (Smith et al. 2005). Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, gender dysphoria had decreased to such a degree that it had disappeared."

39. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: "Summarizing the results from the last two decades, the conclusion that [sex reassignment surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare."

40. Studies conducted in countries throughout the world conclude that surgery is an extremely effective treatment for gender dysphoria. For example, a 2001 study published in Sweden states: "The vast majority of studies addressing outcome have provided convincing evidence for the benefit of sex reassignment surgery in carefully selected cases" (Landen). Similarly, urologists at the University Hospital in Prague, Czech Republic, in a *Journal of Sexual Medicine* article concluded, "Surgical conversion of the genitalia is a safe and important phase of treatment..." (Jarolim 2009).

41. Studies have shown that by alleviating the suffering and dysfunction caused by gender dysphoria, surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehaman et al. 1999; Johansson et al. 2010; Hepp et al. 2002; Ainsworth & Spiegel 2010; Smith et al. 2005); improving self-image and satisfaction with body and physical appearance (Lawrence 2003; Smith et al. 2005; Weyers et al. 2009; and greater acceptance and integration into the family (Lobato et al. 2006). Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al. 2006; Lawrence 2005; Lawrence 2006; Imbimbo et al 2009; Klein & Gorzalka 2009; Jarolim 2009; Smith et al 2005; Rehman et al. 1999; DeCuypere et al 2005).

42. Several of the studies cited in the *Iowa Foundation Report* (eg. Clemmenson, 1990; Dickey and Steiner, 1990) speak more to the harsh social obstacles these individuals historically faced than to the efficacy of surgical therapy. Difficulty changing documents and securing employment, lack of social support, stigmatization and victimization, and the conflation of transsexualism and homosexuality made gender transition exceedingly difficult in that era (1965-1990). Greater visibility and laws that prohibit discrimination have eased some hurdles, but in any event social marginalization should not be confused with, or seen as a challenge to the efficacy of, surgical treatment.

43. The *DHS Rulemaking Notice* and *DHS Rule Adoption Notice* cite a 1979 study as a basis to discredit surgical therapy. Jon Meyer and his secretary, Donna Reter, published a report on 15 patients who underwent surgery, which ultimately led to the closure of the Johns Hopkins Hospital surgical program. Although outdated by current standards, the study was criticized even at the time of publication for serious methodological flaws. In 1980, Fleming, Steinman and Bocknek mounted a challenge to the Meyer's study citing numerous problems not only with methodology, but conceptual flaws in research design, score reporting, interpretation

of data, and conclusions. To cite but one example, transsexual patients were assigned a quantitative score of (minus 1) if they cohabited with a person of "the non-gender appropriate sex." It is not clear from Meyer's report whether this cohabitation implied sexual intimacy, or on what basis this cohabitation would be negative. It is but one example of the value judgments and researcher bias that woefully contaminated the findings. These researchers wrote:

> The finality with which he [Meyer] makes his assertion merits criticism…many people will use his results to treat transsexualism as a psychological problem which warrants no more attention than simply letting time heal (Fleming, et al).

44. Indeed, some early studies cited in the *Iowa Foundation Report* recognized the efficacy of surgical therapy. Kuiper and Cohen-Kettenis (1988), for example, evaluated 141 patients undergoing both masculinizing and feminizing surgeries. Although the *Iowa Foundation Report* states that the findings were inconclusive the authors state, "…there is no reason to doubt the therapeutic effect of sex reassignment surgery." Indeed both Kuiper and Cohen-Kettenis published numerous subsequent studies attesting to the benefits of surgery, even in carefully assessed adolescent patients (see for example, Smith, Van Goozeen, Kuiper & Cohen-Kettenis, 2005).

45. The *Iowa Foundation Report* cites Meyer's (1983) assertion that there is a lack of long-term follow-up studies to document the efficacy of surgery. However, over the past two decades, a large body of research has documented the efficacy of surgery in long-term follow up of patients. These studies confirm that surgery is an effective treatment with low complication rates. For example, see "Transsexualism in Serbia: a twenty-year follow-up study" (Vujovic et al 2009); "Long-term assessment of the physical, mental, and sexual health among transsexual women (Weyers 2009); "Treatment follow-up of transsexual patients" (Hepp et al. 2002); "A five-year follow-up study of Swedish adults with gender identity disorder" (Johansson et al 2010); "A report from a single institute's 14 year experience in treatment of male-to-female transsexuals" (Imbimbo et al. 2009); "Follow-up of sex reassignment surgery in transsexuals: a Brazilian cohort" (Lobato et al. 2006).

46. While the gold standard of scientific research is "controlled" studies, which yield reliable baseline data by eliminating and isolating variables in two comparable groups, this is not easily implemented in surgical research. It is unethical to randomize patients in a trial where only one group receives surgical intervention, and extremely difficult to recruit patients willing to "not receive" a known, desirable treatment. However, Mate-Kole et al. successfully designed such an investigation. Patients who qualified for surgery were randomly assigned either to immediately undergo surgery, or be placed on a waiting list for two years. The two groups were matched for family and psychiatric histories and severity of Gender Dysphoria. The patients who underwent surgery demonstrated dramatically improved psychosocial outcomes compared to the still-waiting controls. The post-surgery patients were more active socially and had significantly fewer psychiatric symptoms (1990).

47. Kockott & Fahrner (1987) employed a different strategy, which also utilized controls. They conducted a retrospective study comparing gender dysphoric patients who had undergone surgery with those who had not, but were otherwise matched. At follow-up, 4.6 years

after surgery, the patients who underwent surgery were better adjusted psychosocially, had improved financial circumstances, and reported increased satisfaction with sexual experiences, as compared to the un-operated group.

Is surgical treatment considered experimental?

48. Surgery for Gender Dysphoria is not experimental. These same surgeries are routinely performed in other contexts such as in the treatment of individuals with 46XY gonadal dysgenesis, defects in testicular development, vaginal atresia, Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome, ambiguous genitalia and other Disorders of Sexual Development (DSD).

49. Indeed, such surgeries are performed routinely for disease and trauma. Breast reduction surgery for non-transgender women with back problems or male gynecomastia, hysterectomy and other uro-genital surgeries, such as phalloplasty for non-transgender men, are often medically indicated and routinely performed.

50. Surgeries for Gender Dysphoria have been performed for many decades and such surgeries are part of the WPATH established standards of care for patients with severe Gender Dysphoria. The American Medical Association (Resolution 122 A-08) states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are "cosmetic" or "experimental" and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

51. WPATH is explicit in this regard. In 2008, WPATH issued a "Medical Necessity Statement" for insurance coverage for medical treatment stating:

> These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient.

52. Surgery to treat Gender Dysphoria is not "experimental" or "investigational."

When medically indicated for severe Gender Dysphoria, is surgery the only effective treatment?

53. Surgery is the only effective treatment for severely gender dysphoric patients. Only reconstruction of the primary and/or secondary sex characteristics can create body congruence and eliminate anatomical dysphoria. Achieving an authentic physical appearance is crucial to a patient's ability to live safely and comfortably. Studies have repeatedly demonstrated that surgery creates functional and normal physical appearance enabling the patient to function in everyday life. This alleviates the suffering and dysfunction caused by Gender Dysphoria and improves virtually every facet of a patient's life.

Is there controversy in the medical community regarding the efficacy or appropriateness of surgery when medically necessary for the treatment of Gender Dysphoria?

54. There is no controversy amongst mainstream medical professionals regarding the appropriateness and necessity of surgical care for Gender Dysphoria. Professional medical associations such as *The American Medical Association, The Endocrine Society, The American Psychiatric Association, The American Psychological Association, The World Health Organization, The American Academy of Family Physicians, The National Commission of Correctional Health Care, The American Public Health Association, The National Association of Social Workers, The American College of Obstetrics and Gynecology* and *The American Society of Plastic Surgeons* all endorse the established standards of care described in Section 3 and in the WPATH standards.

Conclusion

55. In summary, the findings, recommendations and conclusions set forth in the *Iowa Foundation Report, DHS Rulemaking Notice*, and *DHS Rule Adoption Notice* are not reasonably supported by scientific or clinical evidence, or standards of professional practice, and fail to take into account the robust body of research that surgery relieves or eliminates Gender Dysphoria.

56. The report primarily relies on materials and studies published in the 1980's, before the American Association for the Advancement of Science endorsed the process of blinded peer review, and articles were published largely at the discretion of the editor. In stark contrast to the early problems of diagnosis, when the criteria were inconsistent and lacked uniformity, current diagnostic criteria for Gender Dysphoria are clear, well-established, and universal, and have been since 1994. The ensuing decades ushered in an era of technology and the ability to perform meta-analyses incorporating vast amounts of data and advances in surgical technique. This galvanized a tectonic shift in the understanding of Gender Dysphoria, rendering the 1993 findings and recommendations anachronistic by current scientific standards.

57. In 2004, guided by the U.S. Preventive Services Task Force, a unified system and taxonomy for grading the strength of clinical recommendations was developed, based on a body of evidence. Evidence-based recommendations are determined by an algorithm, the Strength of Recommendation Taxonomy (SORT), which incorporates consensus guidelines, bench research, usual practice, case series, benefit vs. risk, and other parameters of evidence. Consistent with national health objectives, the WPATH *Standards of Care Version 7* are evidence-based.

58. There is now abundant evidence that refutes the *Iowa Foundation Report*, the *DHS Rulemaking Notice*, and *DHS Rule Adoption Notice* and establishes the safety, efficacy, and necessity of gender affirming surgery to treat intractable Gender Dysphoria.

I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

Executed on March 13, 2017.

Randi Ettner PhD

Randi Ettner, PhD

Subscribed and sworn to me on this 13 day of Mar., 2017.

OFFICIAL SEAL
KAREN P CONORQUIE
Notary Public - State of Illinois
My Commission Expires Jun 21, 2017

NOTARY PUBLIC
SIGNATURE AND STAMP

State of Illinois
County of Cook

AmeriHealth Caritas Iowa
As Agent for the Iowa Department of Human Services

IN RE: APPEAL OF EERIEANNA GOOD	)	Member's Name: EerieAnna Good
	)	Member's DOB: [redacted]
	)	Member's ID Number: [redacted]
(Re: Type of Service Appealed: Denial of orchiectomy for gender dysphoria	)	
	)	
Case ID Number: [redacted]	)	
Case Provider: Katherine Imborek, MD	)	

MEMORANDUM OF LAW IN SUPPORT OF APPEAL

EerieAnna Good ("Ms. Good"), by her counsel, submits this memorandum of law in support of her appeal from the denial of her request for pre-approval of expenses related to surgical treatment for gender dysphoria.

JURISDICTION

Ms. Good's pre-approval request was denied on February 2, 2017. This appeal to AmeriHealth Caritas Iowa ("AmeriHealth") was timely filed on March 3, 2017. The appeal is authorized by the Iowa Medicaid statute, *see* Iowa Code Ann. § 249A.4(10), and by the AmeriHealth Caritas Iowa Provider Manual. AmeriHealth is a designee of the Iowa Department of Human Services ("DHS") with respect to administering the Iowa Medicaid program.

INTRODUCTION

On January 27, 2017, Dr. Bradley A. Erickson ("Dr. Erickson") requested Medicaid pre-approval from AmeriHealth, Ms. Good's managed-care organization, which subcontracts with DHS to administer her Medicaid coverage. On February 2, 2017, AmeriHealth denied the request for pre-approval (the "Decision"). The Decision advised Dr. Erickson that "the request for orchiectomy for gender dysphoria" could not be approved because of Iowa Administrative Code Section 441.78.1(4) (the "Regulation"), which excludes from coverage "[s]urgeries for the

purpose of sex reassignment coverage." Despite this, Medicaid coverage is available for orchiectomies for other medical conditions affecting non-transgender persons. (*See* 3/15/17 Letter from Dr. Erickson.)[1] The impact of the Decision is that Iowa Medicaid will cover treatment for non-transgender Medicaid participants, but not for the same treatment when performed as part of transition-related care for transgender individuals.

AmeriHealth's denial of pre-approval for the expenses related to Ms. Good's surgery to treat her gender dysphoria is unlawful and unconstitutional.[2] First, the denial violates the Iowa Civil Rights Act's express prohibitions on gender-identity and sex discrimination. Second, it violates the equal-protection clause of the Iowa Constitution. For these reasons, and as set forth in further detail below, AmeriHealth's decision should be reversed and vacated, and Ms. Good should receive pre-approval for her surgery.

ARGUMENT

A. The Regulation cited as the sole basis for the denial violates the Iowa Civil Rights Act.

The Iowa Civil Rights Act specifically prohibits discrimination based on gender identity and sex in public accommodations. Iowa Code Ann. § 216.7(1)(a). Units of state government, such as DHS, are public accommodations, as are their agents, such as AmeriHealth. *See* Iowa Code Ann. § 216.2(13)(b). They are prohibited from discriminating on these bases.

The denial of reimbursement for medically necessary services related to surgical treatment of gender dysphoria expressly discriminates against transgender persons, who are the only persons who seek care for "transsexualism" or "gender identity disorders," thereby violating the Act's express prohibition on "gender identity" discrimination. Iowa Code Ann. § 217.7(1)(a).

[1] A copy of Dr. Erickson's 3/15/17 letter has been submitted with this memorandum.

[2] Ms. Good recognizes that neither AmeriHealth nor DHS has the authority to resolve these claims but asserts them here to ensure that she has preserved them for review.

Such a denial also discriminates on the basis of sex. Many federal courts have recognized that discrimination against transgender persons is sex discrimination. *See Glenn v. Brumby*, 663 F.3d 1312, 1316–20 (11th Cir. 2011); *Barnes v. City of Cincinnati*, 401 F.3d 729, 736–37 (6th Cir. 2005); *Smith v. City of Salem*, 378 F.3d 566, 573–75 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust*, 214 F.3d 213, 215–16 (1st Cir. 2000); *Schwenk v. Harford*, 204 F.3d 1187, 1998–1203 (9th Cir. 2000). And Iowa courts look to federal antidiscrimination case law when interpreting Iowa's state antidiscrimination statutes. *See Nelson v. James H. Knight DDS, P.C.*, 834 N.W.2d 64, 67 (Iowa 2013). Such discrimination often takes the form of discrimination on the basis of transgender status or failure to comply with gender stereotypes, *see Glenn*, 663 F.3d at 1316 ("A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes."), which is a form of sex discrimination, *see id.* at 1317 ("[D]iscrimination against a transgender individual because of her gender-nonconformity is sex discrimination."). Discrimination based on a person's transgender status, *see, e.g., Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016), or gender transition, *see, e.g., Schroer v. Billington*, 577 F. Supp. 2d 293, 308 (D.D.C. 2008), also constitutes sex discrimination.

The Regulation discriminates on the basis of sex because it enforces gender stereotypes by preventing transgender persons, and only transgender persons, from obtaining coverage for medically necessary surgical treatment and because it explicitly prohibits "[s]urgeries for the purpose of sex reassignment." The Regulation also discriminates on the basis of sex because it is directed at transgender persons who are seeking coverage for gender transition, even in the absence of evidence of gender stereotyping.

Close to 35 years ago, the Iowa Supreme Court rejected the sex-discrimination argument in *Sommers v. Iowa Civil Rights Commission*, 337 N.W.2d 470, 473–74 (Iowa 1983). However, *Sommers* preceded the U.S. Supreme Court's decision in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), and relied on older federal decisions predicated on a narrow definition of what constitutes "sex." *Sommers*, 337 N.W.2d at 474 (citing *Sommers v. Budget Marketing, Inc.*, 667 F.2d 748 (8th Cir.1982); *Holloway v. Arthur Andersen & Co.*, 566 F.2d 659 (9th Cir.1977)). Subsequent federal decisions have clarified that "the approach in *Holloway* [and] *Sommers* . . . has been eviscerated by *Price Waterhouse*." *Smith*, 378 F.3d at 573.

Whether one characterizes the Decision as an act of discrimination on the basis of gender identity or sex, the Decision clearly contravenes the Iowa Civil Rights Act.

B. The Regulation cited as the sole basis for the denial violates the equal-protection clause of the Iowa Constitution.

The Iowa Constitution guarantees that "[a]ll men are, by nature, free and equal," Iowa Const. art. I, §1, and that "[a]ll laws of a general nature shall have a uniform operation; the general assembly shall not grant any citizen or class of citizens, privileges or immunities, which, upon the same terms shall not equally belong to all citizens," Iowa Const. art. I, § 6. The Iowa Supreme Court in general deems the federal and state equal-protection clauses to be identical in scope, import, and purpose. *Exira Comm. Sch. Dist. v. State*, 512 N.W.2d 787, 792–93 (Iowa 1994); *see also Varnum v. Brien*, 763 N.W.2d 862, 878 (Iowa 2009). That said, Iowa courts jealously reserve the right to develop an independent framework for examining equal-protection challenges under the Iowa Constitution "as well as to independently apply the federally

formulated principles." *Varnum*, 763 N.W.2d at 879 (citing *Racing Ass'n of Cent. Iowa v. Fitzgerald*, 675 N.W.2d 1, 4–7 (Iowa 2004) (hereinafter, "*RACI*")).[3]

Iowa's constitutional promise of equal protection is essentially a direction that all persons similarly situated should be treated alike under the law. *State v. Dudley*, 766 N.W.2d 606, 615 (Iowa 2009); *see also City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). More precisely, the equal-protection guarantee requires that a law treat alike all those who are similarly situated with respect to the purpose of the law. *Varnum*, 763 N.W.2d at 882.

Medicaid is a "cooperative federal–state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals." *TLC Home Health Care, LLC v. Iowa Dep't of Human Servs.*, 638 N.W.2d 708, 711 (Iowa 2002) (quoting *Madrid Home for the Aging v. Iowa Dep't of Human Servs.*, 557 N.W.2d 507, 511 (Iowa 1996)). With respect to the need to obtain financial assistance for medical care, transgender persons in need of surgical treatment for gender dysphoria, such as Ms. Good, are situated similarly to non-transgender persons who need medical treatment for other conditions.

The Iowa Supreme Court has not decided the level of scrutiny applicable to classifications that disfavor transgender persons. However, a heightened level of review should apply because transgender people have faced a history of discrimination, their status as transgender is unrelated to their ability to contribute to society, their gender identity and transgender status are central to their personal identity and may be changed only by causing them significant harm, and they are politically powerless. *See Varnum*, 763 N.W.2d at 889–896 (applying same four factors to conclude that sexual-orientation classifications are entitled to

[3] Even in cases where a party has not suggested that the approach under the Iowa Constitution should be different from that under the federal Constitution, Iowa courts reserve the right to apply the standard in a fashion at variance with federal cases under the Iowa Constitution. *See, e.g., State v. Pals*, 805 N.W.2d 767, 771–72 (Iowa 2011); *Varnum* , 763 N.W.2d at 896 n.23.

heightened scrutiny).[4] The Regulation on which AmeriHealth based its denial of Medicaid coverage to Good should be reviewed under heightened scrutiny because it discriminates against her on the basis of her status as transgender. It also discriminates on the basis of sex and should be reviewed under heightened scrutiny for that additional reason. *Id.* at 880.

Of the two forms of heightened scrutiny, "classifications subject to strict scrutiny . . . are presumptively invalid and must be narrowly tailored to serve a compelling governmental interest." *Id.* 880. Intermediate scrutiny requires that a party seeking to uphold a classification demonstrate that the challenged classification is substantially related to the achievement of an important government objective. *Id.*

Neither AmeriHealth nor DHS can meet either of these standards. Nor can they meet rational-basis review, which requires (i) a "plausible policy reason for the classification" and (ii) that "the legislative facts on which the classification is apparently based rationally may have been considered to be true by the governmental decisionmaker" and (iii) that "the relationship of the classification to its goal is not so attenuated as to render the distinction arbitrary or irrational." *Id.* at 879 (quoting *RACI*, 675 N.W.2d at 7).

There simply is no legitimate government objective or plausible policy reason that is advanced by, or rationally related to, the exclusion of transgender individuals from Medicaid reimbursement for medically necessary procedures. Surgical treatment for gender dysphoria is medically necessary and effective treatment, so the denial of coverage cannot be justified on that basis. Moreover, the exclusion cannot be justified as a measure to save money under either heightened review, *id.* (cost savings could not justify exclusion of same-sex couples from

[4] In *Varnum* the court did not decide whether sexual-orientation classifications were entitled to strict scrutiny since Iowa's marriage law failed even intermediate scrutiny. 763 N.W.2d 896.

marriage), or rational-basis review, *RACI*, 675 N.W.2d at 12–15 (even under rational-basis review, there must be some reasonable distinction between the group burdened with higher taxes as compared to the favored group to justify the higher costs).

CONCLUSION

For the reasons stated above, the AmeriHealth decision denying expense reimbursement for EerieAnna Good's gender-reassignment surgery violates the Iowa Civil Rights Act and the Iowa Constitution. It should be vacated.

Dated: March 17, 2017

Respectfully submitted,

EERIEANNA GOOD

By: _____
One of Her Attorneys

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March 31, 2017

EerieAnna Good
[redacted]

Member ID number: [redacted]
Service being appealed: Denial of Orchiectomy for gender dysphoria
Effective date: 03/31/2017
Subject: Decision on your appeal

Dear EerieAnna Good:

AmeriHealth Caritas Iowa has reviewed your appeal about the denied request for Orchiectomy for gender dysphoria. This appeal was submitted by your attorney, Seth Horvath on your behalf and was received on March 03, 2017. All findings were presented to AmeriHealth Caritas Iowa's Appeal Committee for review.

Your health records and all supporting documentation were reviewed by the Appeal Committee. The Appeal Committee has **upheld** the denial of Orchiectomy for gender dysphoria.

The reason for the decision is that the information reviewed **fails to establish** medical necessity for the requested service.

Per Iowa Code Administrative Code Section 441.78.1(4) Cosmetic, reconstruction, or plastic surgery performed in connection with certain conditions are specifically excluded. These conditions are:

- Procedures related to transsexualism, hermaphrodism, gender identity disorders, or body dysmorphic disorders

The clinical information received indicated, you are a 27 year old transgender female who has been diagnosed with gender dysphoria. You report you are very distressed and very uncomfortable with your genitalia. You wish to undergo gender affirming surgery to further your transition from male to female.

AmeriHealth Caritas Iowa
PO Box 1516
Des Moines, Iowa 50306
www.amerihealthcaritasia.com

Exhibit 9

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Based on review of all the information provided, per the Iowa Administrative Code (IAC 441.78) procedures related to transsexualism, hermaphrodism, gender identity disorders, or body dysphormic disorders are excluded for payment under the Iowa Medicaid Plan. Therefore, the request for Orchiectomy for gender dysphoria remains denied.

This case was reviewed by a specialist with the same/similar background in the service that was requested. The specialist is board certified in Internal Medicine and was the decision maker in this case.

This determination was made on March 30, 2017.

All references in this letter to the term "you" and "your" refer solely to the named member.

You may obtain copies (at no charge) of the medical and behavioral health records and other documents. These other documents include the contract provision, guideline, protocol and other similar criteria on which the decision was based. For copies of these materials, write to:

AmeriHealth Caritas Iowa
Attn: Request for Criteria
Member Appeals Department
601 Locust St., Suite 900
Des Moines, IA 50309

State fair hearings

If you disagree with this decision, you or your representative have the right to request a fair hearing with the Iowa Department of Human Services. You or your representative must request a state fair hearing within 90 calendar days of the date at the top of this letter.

Continuing benefits during the state fair hearing

You can keep getting covered services while a state fair hearing is pending, if all of the following apply:

- The state fair hearing request is filed:
  - Within 10 calendar days from the date AmeriHealth Caritas Iowa mailed the notice of action, or
  - Before the effective date of this notice.
- The state fair hearing is related to reduced or suspended services or to services that were previously authorized for you:
  - The services were ordered by an authorized provider.
  - The authorization period for the services has not ended.
  - You asked that the service continue.
- If AmeriHealth Caritas Iowa continues your benefits while a state fair hearing is pending, the services must be continued until one of the following happens:
  - You decide not to continue the state fair hearing.
  - You do not request a state fair hearing within 10 days from the date that AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
P.O. Box 1516
Des Moines, Iowa 50305
www.amerihealthcaritasia.com

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mailed the notice of action.
- The authorization for services expires or service authorization limits are met.
- A hearing decision is issued in the state fair hearing that is adverse to the member.

Please note that you may be held liable for the cost of the services or benefits if the state fair hearing upholds AmeriHealth Caritas Iowa's decision.

You may request a state fair hearing with the Iowa Department of Human Services in person, by telephone or in writing. To file a request in writing, do one of the following:

- Complete a state fair hearing request electronically at http://dhs.iowa.gov/node/966, or
- Write a letter telling the Iowa Department of Human Services why you think AmeriHealth Caritas Iowa's decision is wrong.

Call the Department of Human Services Appeals Section at (515) 281-3094 if you want to appeal by telephone. Or, mail, fax or take your appeal to:

Department of Human Services
Appeals Section
1305 E. Walnut Street, 5th Floor
Des Moines, IA 50319
Fax: 1-515-564-4044
Email: appeals@dhs.state.ia.us

At the state fair hearing, you may represent yourself. You may also have a lawyer, a relative, a friend or other spokesperson represent you. Your representative cannot be an Iowa government employee or AmeriHealth Caritas Iowa employee.

Most hearings are held by phone. You may present witnesses on your behalf. If the hearing is held in-person, AmeriHealth Caritas Iowa may pay for your reasonable expenses for the hearing, including transportation costs, if you file a request.

To ask for free legal help with your appeal, you can call:

- Iowa Legal Aid at **1-800-532-1275** Monday – Friday from 9 a.m. to 11 a.m. or from 1:30 p.m. to 3:30 p.m., **except Thursday afternoon.** <OR>
- You may apply online at any time by visiting www.iowalegalaid.org and choosing Apply Online. Offices are open 8:30 a.m. to 4:30 p.m. (emergencies taken when open).

Iowans age 60 and over may call the **Legal Hotline for Older Iowans** at **1-800-992-8161** Monday – Friday from 9 a.m. to 4:30 p.m.

AmeriHealth Caritas Iowa
PO Box 1616
Des Moines, Iowa 50306
www.amerihealthcaritasia.com

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Sincerely,

Anne Cohen
Member Appeals Coordinator

Cc: Katherine Imborek, M.D.
Seth Horvath, Esq.

AmeriHealth Caritas Iowa
PO Box 1516
Des Moines, Iowa 50305

www.amerihealthcaritasia.com

Exhibit 9

Iowa Department of Inspections and Appeals
Division of Administrative Hearings
Wallace State Office Building
Des Moines, Iowa 50319

EERIEANNA GOOD
[redacted]

Appellant,

v.

IOWA DEPARTMENT OF HUMAN SERVICES,

Respondent.

Appeal No. 17008723

PROPOSED DECISION

STATEMENT OF THE CASE

Hearing for this appeal was held by telephone conference call on July 11, 2017. The Appellant, EerieAnna Good, was represented by attorney, Seth Horvath. F. Thomas Hecht with Nixon Peabody LLP, and John Knight, Rita Bettis, and Joseph Fraioli with the American Civil Liberties Union (ACLU) were present on behalf of the Appellant. The Department of Human Services (Department) was represented by the Managed Care Organization (MCO), AmeriHealth Caritas Iowa, and attorney James White. Dr. Brian Morley was present on behalf of the MCO.

The Department's income maintenance worker filed an appeal summary to confirm that the Appellant was eligible for Medicaid and services. The MCO submitted an appeal summary with attached exhibits A-I, which were entered into the record. The Appellant submitted exhibits 1-5 into the record.[1] Both parties submitted post hearing briefs, and the Appellant submitted a response to the MCO's post hearing brief.

ISSUE

Whether the managed care contractor correctly denied payment for cosmetic, reconstructive or plastic surgery.

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[1] The documents submitted by both parties were duplicative. For purposes of clarity, as agreed upon by the parties, the MCO's exhibits will be referenced throughout the decision.

DECISION

The Department's decision is AFFIRMED.

FINDINGS OF FACT

Appellant EerieAnna Good is receiving medical assistance through the Iowa Medicaid program. The Appellant was diagnosed with gender dysphoria. Her physician, Katherine Imborek, M.D., submitted a request for prior approval for an orchiectomy to the managed care organization (MCO), AmeriHealth Caritas Iowa. The request was initially examined by the MCO and given to the medical director for a medical necessity determination. On February 2, 2017, the reviewer denied the request, based on the following rationale,

> Based on review of the submitted clinical information by AmeriHealth Caritas Iowa Medical Director, your request for orchiectomy is denied. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage. This denial is in accordance with Iowa Administrative Code Section 441.78.1(4). (Ex. A).

On March 3, 2017, the Appellant appealed this decision. (Ex. C). In support of her appeal, the Appellant submitted (1) a letter from her primary care physician, Dr. Imborek, and (2) a letter from Dr. Jacob Priest, the director of the University of Iowa's LGBTQ clinic. On March 7, 2017, the MCO acknowledged receipt of the appeal and requested any additional medical information. (Ex. D, E). The Appellant supplemented the appeal by providing (1) a personal affidavit, (2) a memorandum of law in support of the appeal, (3) a letter from Armeda Wojciak, Ph.D, who conducted a psychosocial assessment of the Appellant, (4) a letter from Brad A. Erickson, M.D., the Appellant's surgeon, and (5) an affidavit of Randy Etter, Ph.D. (Ex. C).

On March 31, 2017, the Appellant received a decision on her appeal request for an orchiectomy. Her request was denied. The decision explained,

> **The clinical information received indicated** you are a 27-year old transgender female who has been diagnosed with gender dysphoria. You report you are very distressed and very uncomfortable with your genitalia. You wish you undergo gender affirming surgery to further your transition from male to female.
>
> **Based on review of all the information provided**, per the Iowa Administrative Code (IAC 441.78) procedures related to transsexualism, hermaphrodism, gender identity disorders, or body dysphormic disorders are excluded for payment under the Iowa Medicaid Plan. Therefore, the request for Orchiectomy for gender dysphoria remains denied. (Ex. F)

The Appellant filed a timely appeal with regard to the denial of the orchiectomy. The Appellant first argues that 441 Iowa Administrative Code 78.1(4), as the sole basis for the denial, violates the Iowa Civil Rights Act. Specifically, the denial of reimbursement for medically necessary services related to surgical treatment of gender dysphoria expressly discriminates against transgender persons, who are the only persons who seek care for "transsexualism" or "gender identity disorders," thereby violating the Iowa Civil Rights Act and its express prohibition on gender identity discrimination. She asserts that such a denial discriminates on the basis of sex; specifically pointing out that discrimination against transgender persons is sex discrimination. The Appellant notes that the Iowa courts look to federal antidiscrimination case law when interpreting Iowa's state antidiscrimination statutes. (Appellant post hearing brief)

The Appellant next argues that 441 Iowa Administrative Code 78.1(4), as the sole basis for the denial violates the equal-protection clause of the Iowa Constitution. Specifically, the equal-protection guarantee requires that a law treat alike all those who are similarly situated with respect to the purpose of the law. A transgender person in need of surgical treatment for gender dysphoria is situated similarly to non-transgender persons who need medical treatment for other conditions. She argues there is no legitimate government objective or plausible policy reason that is advanced by, or rationally related to, the exclusion of transgender individuals from Medicaid reimbursement for medically necessary procedures. Surgical treatment for gender dysphoria is a medically necessary and effective treatment, so the denial of coverage cannot be justified on that basis. Further, the rule should be reviewed under heightened scrutiny because it discriminates against the Appellant on the basis of her status as transgender and on the basis of sex. (Appellant post hearing brief)

To support her argument, the Appellant included a personal affidavit, letters, and verifications from two physicians and two clinical psychologists, and the affidavit of a clinical psychologist, to demonstrate that the requested orchiectomy is medically necessary. The Appellant explained her personal background and need for an orchiectomy; she began presenting as female full-time in 2010, began hormone therapy in 2014, and legally changed her name, birth certificate, driver's license, and social-security card in 2016. [redacted] (Ex. C)

Primary-care physician, Dr. Katherine Imborek, MD, felt that gender confirmation surgery was medically necessary to treat the Appellant's gender dysphoria. Dr. Jacob Priest, PhD, the Director of the University of Iowa's LGBTQ Clinic, performed a psychosocial assessment on the Appellant and found that she met the eligibility and readiness criteria for surgery as set forth [in] the Standards of Care of the World Professional Association for Transgender Health (WPATH).' (Ex. C)

Dr. Armeda Wojciak, Ph.D, the Program Coordinator for the Couple and Family Therapy Program of the University of Iowa's LGBTQ Clinic, performed a psychosocial assessment on the Appellant and found that she met the diagnostic criteria for gender dysphoria, met

WPATH's eligibility and readiness criteria for gender-affirming surgery, and determined gender-affirming surgery was a medically necessary treatment for gender dysphoria. (Ex. C)

The Appellant's surgeon, Dr. Brad Erickson, MD, stated that the Appellant's gender dysphoria would be significantly improved by undergoing an orchiectomy. He noted that AmeriHealth Caritas Iowa covered orchiectomy procedures for other medical conditions, such as testicular cancer, and an orchiectomy was an equally necessary and proper treatment for transgender women with gender dysphoria. Finally, Dr. Randi Etter, PhD, a clinical psychologist and Secretary of WPATH opined on the necessity, effectiveness, and appropriateness of surgery for treatment of gender dysphoria. (Ex. C)

In support of its original decision, the MCO firmly asserts that both the denial letter and decision on appeal appropriately cite rule 441 Iowa Administrative Code 78.1(4) as the basis for AmeriHealth's decision. The Appellant failed to meet her burden to show that the rule is invalid. Rule 441 Iowa Administrative Code 78.1(4) has been challenged and upheld by the Eighth Circuit Court of Appeals. In accordance with applicable law, the application of the rational basis test is the appropriate standard of review. (MCO post hearing brief)

The MCO argues that the Appellant's equal protection challenge fails, as she cannot demonstrate that 441 Iowa Administrative Code 78.1(4) results in discrimination against individuals who are similarly situated. It is not persuasive to compare a transgender individual with gender dysphoria and a non-transgender individual who needs treatment for conditions such as testicular cancer. Rule 441 Iowa Administrative Code 78.1(4) does not discriminate against transgender individuals, as a general prohibition of "cosmetic, reconstructive, or plastic surgery" applies equally to those seeking the surgery. The rule is orchestrated primarily to improve physical appearance such as "correct[ing] or materially improv[ing] bodily functions;" however, the Appellant is seeking the surgery primarily for psychological purposes. Given that the rule applies equally to individuals seeking cosmetic, reconstructive, or plastic surgery, the MCO argues 441 Iowa Administrative Code 78.1(4) does not violate the equal protection clause of the Iowa Constitution. (MCO post hearing brief)

The MCO further disagrees that 441 Iowa Administrative Code 78.1(4) violates the Iowa Civil Rights Act, reaffirming that that the rule does not discriminate on the basis of gender identity and applies equally to individuals seeking cosmetic, reconstructive, or plastic surgery. (MCO post hearing brief)

CONCLUSIONS OF LAW

Medical assistance is available to Iowans who meet eligibility requirements under one of several established programs. The programs are generally focused on children, parents of children, elderly persons, and persons with disabilities. The medical assistance program is authorized by Title IX of the Social Security Act, 42 C.F.R. Parts 430 through 456, and Iowa Code chapter 249A. The Department administers the Medicaid program in Iowa pursuant

to 42 U.S.C. sections 1396a-1396c, and it has adopted rules under a state plan to implement the program.[2]

Most Iowa Medicaid services are provided by managed care organizations (MCO). A MCO must provide all medically-necessary benefits and services that are covered under the organization's contract with the Department of Human Services.[3]

> [T]he managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.
>
> * * *
>
> The managed care organization may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract.[4]

With regard to medical necessity, MCO AmeriHealth's contract provides:

> **Medically Necessary Services**
> Those covered services that are under the terms and conditions of the Contract, determined through contractor utilization management to be;
> 1. Appropriate and necessary for symptoms, diagnosis or treatment of the condition of the member;
> 2. Provided for the diagnosis or direct care and treatment of the condition of the member enabling the member to make reasonable progress in treatment;
> 3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
> 4. Not primarily for the convenience of the member, the member's physician or other provider; and
> 5. The most appropriate level of covered services, which can safely be provided.

(Ex. H – AmeriHealth contract excerpt)[5]

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[2] *See* 441 Iowa Administrative Code (IAC) chapters 75-92.
[3] 441 IAC 73.6(1).
[4] 441 IAC 73.6(1)-(2).
[5] The full contract may be found at https://dhs.iowa.gov/sites/default/files/AmeriHealth_Iowa_Contract.pdf.

Payment will be approved for all medically necessary services and supplies provided by the physician, subject to specific limitations and exclusions.[6]

> For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.
>
> *a.* Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:
>
> (1) Correction of a congenital anomaly; or
>
> (2) Restoration of body form following an accidental injury; or
>
> (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.
>
> (4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.
>
> *b.* Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:
>
> (1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions. IAC Ch 78, p.3
>
> (2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.
>
> (3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
>
> (4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.[7]

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[6] 441 IAC 78.1.
[7] 441 IAC 78.1(4).

The MCO initially denied the prior authorization request at issue here because "[S]urgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage." In an appeal review, the MCO determined that the further documentation did not establish medical necessity, stating, "procedures related to transsexualism, hermaphrodism, gender identity disorders, or body dysphormic disorders are excluded for payment under the Iowa Medicaid Plan. Therefore, the request for Orchiectomy for gender dysphoria remains denied."

As noted above, the Appellant argues that the MCO's decision denying expense reimbursement for the Appellant's gender-reassignment surgery violates the Iowa Civil Rights Act and the Iowa Constitution. Whatever the merits of the Appellant's claims, an administrative proceeding such as this can only preserve and not decide claims whose resolution is entrusted only to those wielding judicial authority.[8] This includes deciding whether the MCO acted appropriately in denying the Appellant's prior authorization request. Therefore, these issues are preserved for judicial review. With no basis to address the constitutional challenges, the MCO decision must be affirmed.

ORDER

The Department's decision is AFFIRMED.

Dated this 25th day of July, 2017.

Kathleen M. O'Neill

Kathleen M. O'Neill
Administrative Law Judge

cc: Clinton Co. – Katie M. Graham
IME Policy; IME – Liz Matney
Attorney for MCO – James White
Attorney for MCO - Rebecca A. Brommel
Mailbox – Appeals AmeriHealth Caritas Iowa
Atty – Seth Horvath

[8] *See Doe v. State*, 688 N.W.2d 265, 271 (Iowa 2004) ("Although the distinction between the executive and judicial powers is often unclear, they do differ. The executive department has the general power to execute and carry out the laws; the judicial department has the power to interpret the constitution and laws, apply them, and decide controversies."); *See, e.g., McCracken v. Iowa Dept. of Human Services*, 595 N.W.2d 779, 785 (Iowa 1999) ("To preserve constitutional issues for . . . review, a party must raise such issues at the agency level. The party must raise such issues, even though the agency lacks authority to decide constitutional issues."); *See, e.g., Soo Line R. Co. v. Iowa Dep't of Transp.*, 521 N.W.2d 685, 688 (Iowa 1994).

Iowa Department of Human Services

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Jerry R. Foxhoven
Director

August 25, 2017

EerieAnna Good
[redacted]

RE: Appeal #: MED 17008723 EerieAnna Good
Case #: 8656390206

FINAL DECISION

After review of the record the **PROPOSED DECISION** you received dated July 25, 2017, is **ADOPTED** as the **FINAL DECISION**.

DISCUSSION

A Proposed Decision was issued stating the managed care contractor correctly denied payment for cosmetic, reconstructive or plastic surgery. The appellant and her attorney disagreed with the judge's decision and requested a review. The attorney argues the orchiectomy is medically necessary to treat the appellant's gender dysphoria and challenges the validity of the Department's rules at 441 IAC 78.1(4).

"For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage. 441 IAC 78.1(4)."

Agency rules are presumed valid and the party challenging the rule has the burden to demonstrate that no rational agency could conclude the rule was within its delegated authority. *Iowa Med Soc. v. Iowa Bd. of Nursing*, 831 N.W.2d 826, 839 (Iowa 2013).

This particular rule has been challenged and was upheld by the Eighth Circuit Court of Appeals. *See Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001) ("*Smith II*"). In *Smith II*, the plaintiff challenged the Rule's exclusion of surgeries related to gender identity disorder. Initially, the trial court entered judgment in favor of the plaintiff, finding the Rule was neither reasonably promulgated nor substantively reasonable. *See Smith v. Rasmussen*, 57 F. Supp. 2d 736 (N.D. Iowa 1999) ("*Smith I*"). However on appeal, the Eighth Circuit reversed and found the Rule is reasonable, non-arbitrary, and consistent with the Medicaid Act. *Smith II*, 249 F.3d at 761. The

Exhibit 11

Eighth Circuit relied in large part on the rulemaking process summarized in the Iowa Administrative Bulletin dated November 9, 1994.

The appellant's attorney also argues the rule violates the equal protection clause and the Iowa Civil Rights Act. While constitutional issues must be raised at the agency level to be preserved for judicial review, administrative agencies lack authority to decide such issues. *Soo Line R.R. Co. v. Iowa Dept. of Transp.*, 521 N.W.2d 685, 688 (Iowa 1994). As this review is conducted in conjunction with an administrative proceeding, the reviewer lacks jurisdiction over this matter. This issue is preserved for judicial review.

Based on a review of the appeal record, AmeriHealth Caritas' actions are correct and must be AFFIRMED.

The department is directed to implement the directions contained in the Proposed Decision.

Please call (515)-281-8438 collect if you have any questions with regard to this decision.

Under the provisions of Section 17A.19, Code of Iowa, you may file an appeal to the District Court in Polk County or in your county within thirty days of the date of this **FINAL DECISION** if you are dissatisfied with the decision. Within ten days after the filing of a petition for judicial review a copy of the petition shall be mailed to:

Jerry R. Foxhoven, Director
Department of Human Services, Fifth Floor
1305 East Walnut
Des Moines, Iowa 50319-0114

Sincerely,

Jerry R. Foxhoven
Director

JRF/NF/dd

cc: Clinton Co. – Katie M Graham CMB5
IME Policy
AAC IME
Mailbox – Appeals IME
Iowa Med Enterprise – Liz Matney
Mailbox – Appeals AmeriHealth Caritas Iowa
Mailbox – County Clinton
Attorney for MCO – Rebecca A Brommel
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