UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Submission of Evidentiary Material

Plaintiffs, by their counsel, submit the attached evidentiary material that they rely upon as noted in their memoranda in support of their motions for preliminary injunction and class certification.

Exhibit 1	Expert Declaration of Dan H. Karasic, M.D.
Exhibit 2	Expert Declaration of Daniel Shumer, M.D.
Exhibit 3	Expert Declaration of Jack Turban, M.D., MHS
Exhibit 4	Declaration of Nathaniel Clawson and Beth Clawson
Exhibit 5	Declaration of Lisa Welch and Ryan Welch
Exhibit 6	Declaration of Emily Morris
Exhibit 7	Declaration of Maria Rivera
Exhibit 8	Declaration of Michelle (Mixhi) Marquis
Exhibit 9	Declaration of Dr. Catherine Bast
Exhibit 10	Declaration of LaRisha Hanks
Exhibit 11	Declaration of Jamie Harris
Exhibit 12	Declaration of Julia Kathary

Exhibit 13	Declaration of Patrick Rhodes
Exhibit 14	Declaration of Michael Rabinowitch and Lindsey Rabinowitch
Exhibit 15	Declaration of Gender Expansive Kids & Co.
Exhibit 16	Declaration of Indiana Youth Group
Exhibit 17	Excerpts from Indiana's State Medicaid Plan
Exhibit 18	Declaration of Gender Nexus

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
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Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-CV-595

EXPERT DECLARATION OF DAN H. KARASIC, M.D.

I, DAN H. KARASIC, M.D., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. In preparing this declaration, I reviewed Indiana Senate Bill 480 (hereafter, "the ban"). My opinions contained in this declaration are based on: my decades of clinical experience as a psychiatrist treating patients with gender dysphoria, including adolescents, and young adults; my knowledge of the peer-reviewed research, regarding the treatment of gender dysphoria, which reflects advancements in the field of transgender health; my knowledge of the clinical practice guidelines for the treatment of gender dysphoria, including my work as a contributing author of the eighth edition of the World Professional Association for Transgender Health ("WPATH")

Standards of Care for the Health of Transgender and Gender Diverse People (SOC 8); and my review of any of the materials cited herein.

5. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

SUMMARY OF OPINIONS

6. The ban prohibits medical treatments that are part of widely-accepted medical protocols for the treatment of adolescents with gender dysphoria. The following medical groups, among others, recognize that gender-affirming health care is safe and effective for adolescents: American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, and the American Medical Association, among many other mainstream medical organizations.

7. The accepted protocols for the treatment of adolescents with gender dysphoria provide for careful mental health assessments, including of co-occurring conditions; stringent criteria for eligibility for each treatment; and a thorough informed consent process with the adolescent and their parents, before any medical interventions are initiated.

8. Decades of medical research and clinical experience have demonstrated that the banned medical treatments are safe, effective, and medically necessary to relieve gender dysphoria for many adolescents.

9. I have seen first-hand, countless times over decades of practice, the many benefits of this treatment. Denying gender-affirming medical care to adolescents for whom it is medically

indicated puts them at risk of significant harm to their health and well-being, including heightened risk of depression and suicidality.

10. For adolescents for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.

11. When gender dysphoria persists until the beginning of puberty, it is rare for it to resolve on its own. The "watchful waiting" approach followed by some clinicians for pre-pubertal children does not apply to adolescents with gender dysphoria.

I. BACKGROUND AND QUALIFICATIONS

12. I am a Professor Emeritus of Psychiatry at the UCSF School of Medicine. I have been on faculty at the University of California – San Francisco since 1991. I have also had a telepsychiatry private practice since 2020.

13. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California – Los Angeles Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow at UCLA in a training program in mental health services for persons living with AIDS.

14. For over thirty years, I have worked with patients with gender dysphoria. I am a Distinguished Life Fellow of the American Psychiatric Association and the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

15. Over the past 30 years, I have provided care for thousands of transgender patients. For 17 years, I was the psychiatrist for the Dimensions Clinic for transgender youth in San

Francisco, and also have provided care for many adolescents in my UCSF faculty practice and my current private practice.

16. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, Version 8, which are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons.

17. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 2,000 health providers. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care, and co-wrote the mental health section of the original *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* and the revision in 2016.

18. I have also worked with the San Francisco Department of Public Health, having developed and implemented programs for the care of transgender patients and for mental health assessments for gender-affirming surgery. I served on the City and County of San Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

19. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at

UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of transgender, gender dysphoric, and HIV-positive patients. I also regularly provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients. I have been a consultant in transgender care to the California Department of State Hospitals and the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people.

20. In addition to this work, I have done research on the treatment of depression. I have authored many articles and book chapters, and edited the book *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation*.

21. In preparing this declaration, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. A true and accurate copy of my curriculum vitae is attached hereto as **Exhibit A**. It documents my education, training, research, and years of experience in this field and includes a list of publications.

22. I have also reviewed the materials cited in the Bibliography, attached hereto as **Exhibit B**. These sources are authoritative, scientific peer-reviewed publications.

23. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new

scientific research or publications or in response to statements and issues that may arise in my area of expertise.

Prior Testimony

24. In the last four years, I have testified as an expert by deposition in *Kadel* v. *Folwell*, 19-cv-00272 (M.D.N.C.), *Fain v. Crouch*, 20-cv-00740 (S.D.W. Va.), *C.P. v. Blue Cross Blue Shield of Illinois*, No.20-cv-06145-RJB (W.D. Wash.), by deposition in *Dekker et al., v. Weida, et al*., No. 4:22-cv-325 (N.D. Fla), and by deposition and at trial in *Dylan Brandt, et al., v. Leslie Rutledge, et al*., No. 21-CV-450 (E.D. Ark.).

Compensation

25. I am being compensated for my work on this matter at a rate of $400.00 per hour for preparation of declarations and expert reports. I will be compensated $3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

II. EXPERT OPINIONS

A. Gender Identity

26. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia.

27. The ban defines sex as "the biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." But the reality is that sex is complicated and multifactorial. Aside from external genital characteristics, chromosomes, and endogenous hormones, other factors related to sex include gonads, gender identity, and variations in brain structure and function. Because these factors may not always be in perfect

alignment as typically male or typically female, "the terms biological sex and biological male or female are imprecise and should be avoided." (Hembree, et al., 2017).

28. Gender identity is "a person's deep felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; [or another] gender." (American Psychological Association, 2015, p. 862). Everyone has a gender identity. Gender identity does not always align with a person's sex assigned at birth. Gender identity, which has biological bases, is not a product of external influence and not subject to voluntary change. As documented by multiple leading medical authorities, efforts to change a person's gender identity are ineffective, can cause harm, and are unethical. (American Psychological Association, 2021; Byne, et al., 2018; Coleman, et al., 2012).

29. For most people, their sex assigned at birth, or assigned sex, matches that person's gender identity. For transgender people, their assigned sex does not align with their gender identity. Based on data from the Williams Institute, approximately 0.6% of the United States population age 13 or older, or about 1.6 million people, identify as transgender. In Indiana, estimates are that around 4,100 people age 13-17 are transgender and approximately 25,800 adults age 18 or older are transgender. (Herman, et al., 2022).

B. Gender Dysphoria and Its Diagnostic Criteria

30. The term "gender dysphoria" is distress related to the incongruence between one's gender identity and attributes related to one's sex assigned at birth.

31. "Gender Dysphoria in Children" is a diagnosis applied only to pre-pubertal children in the Diagnostic and Statistical Manual Fifth Edition (DSM-5), released in 2013. The criteria are:

> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):

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

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social circles, school, or other important areas of functioning.

32. The DSM-5 has a separate diagnosis of "Gender Dysphoria in Adolescents and Adults". The criteria are:

A. A marked incongruence between 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 or secondary sex characteristics (or in young adolescents, the anticipated 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 (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

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.

33. Simply being transgender or gender nonconforming is not a medical condition to be treated. As the DSM-5 recognizes, diagnosis and treatment are "focus[ed] on dysphoria as the clinical problem, not identity per se." (DSM-5, at 451). The DSM-5 unequivocally repudiated the outdated view that being transgender is a pathology by revising the diagnostic criteria (and name) of gender dysphoria to recognize the clinical distress as the focus of the treatment, not the patient's transgender status.

C. Gender Dysphoria Treatment Protocols for Adolescents

34. The World Professional Association of Transgender Health (WPATH) has issued *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* ("WPATH SOC") since 1979. The current version, published in 2022, is WPATH SOC 8. The SOC 8 provides guidelines for multidisciplinary care of transgender individuals, including children and adolescents, and describes criteria for medical interventions to treat gender dysphoria, including hormone treatment and surgery when medically indicated.

35. The SOC 8 is based upon a rigorous and methodological evidence-based approach to outline treatment recommendations. These recommendations are evidence-based, informed by

a systematic review of evidence and an assessment of the benefits and harms of alternative care options, as well as expert consensus. The process for development of SOC 8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and The World Health Organization. Its recommendations were graded using a modified GRADE (Grading of Recommendations, Assessment, Development, and Evaluations) methodology considering the available evidence supporting interventions, risks and harms, and feasibility and acceptability. The evidence base supporting the recommendations in the WPATH Standards of Care is comparable to the evidence base supporting treatment for other conditions.

36. The WPATH Standards of Care are widely accepted in the medical community and relied upon by clinicians treating patients with gender dysphoria.

37. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guideline) provides similar protocols for the medically necessary treatment of gender dysphoria. (Hembree, et al, 2017).

38. In accordance with the WPATH SOC 8 and the Endocrine Society Guideline, medical interventions to treat gender dysphoria may include treatment with pubertal suppression, hormones, and surgery depending on the age and medical needs of each individual.

39. No medical or surgical treatment for gender dysphoria is provided to pre-pubertal children. For pre-pubertal children, interventions are directed at supporting the child with family, peers, and at school, as well as supportive individual psychotherapy for the child as needed.

40. Adolescents (which generally refers to minors after the onset of puberty) with gender dysphoria may be treated with medications to delay pubertal changes in the early stages of puberty if they are causing distress. Puberty blockers allow the adolescent time to better understand

their gender identity, while delaying distress from the development of secondary sex characteristics such as breasts or facial hair.

41. Under the WPATH Standards of Care, puberty-delaying medication for transgender adolescents after the beginning of puberty and gender-affirming hormone therapy for older adolescents may be medically indicated if the following criteria are met: (a) Gender diversity/incongruence is marked and sustained over time; (b) Meets the diagnostic criteria of Gender Dysphoria; (c) Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; (d) Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally; (e) Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.

42. For minor patients, all treatment decisions are made in consultation with the patient and the patient's parents or guardian. Consent for medical intervention is provided by the parent in the case of any minor receiving treatment.

43. After ongoing work with mental health professionals and when the adolescent has lived in accordance with their gender identity for a significant period of time, they may start treatment with hormones (testosterone for transgender boys, estrogen and testosterone suppressants for transgender girls) if and when medically indicated.

44. Affirming care for transgender youth does not mean steering them in any particular direction, but rather supporting them through their period of exploration of gender expression and increasing self-awareness of their identity. (Coleman, et al., 2012, at 18l; Ehrensaft, 2017).

45. The WPATH SOC 8 and the Endocrine Society Guideline further provide that before any medical or surgical interventions are provided to adolescents, a careful mental health assessment should be conducted to ascertain whether the diagnostic criteria for Gender Dysphoria in Adolescents and Adults are met, and the appropriateness of such care for the patient. The Endocrine Society Guideline states that only "[mental health professionals] who ha[ve] training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis," which usually includes "a complete psychodiagnostic assessment." (Hembree, 2017). It further provides that because gender dysphoria "may be accompanied with psychological or psychiatric problems" it is necessary that clinicians involved in diagnosis and psychosocial assessment meet specific competency requirements and that they undertake or refer for appropriate psychological or psychiatric treatment. *Id.* And "in cases in which severe psychopathology" "interfere[s] with diagnostic work or make[s] satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues." *Id.*

46. As with all medical care, the care provided to transgender young people with gender dysphoria is tailored to the unique needs of each patient based on their individual experiences, proximity to specialists, and general health, as well as the clinical experience of practitioners.

D. Evidence of Efficacy of Medical Treatments

47. There is substantial evidence that puberty blockers and hormone therapy are effective treatments for adolescents with gender dysphoria. This evidence includes scientific studies assessing mental health outcomes for adolescents who are treated with these interventions, and decades of clinical experience.

48. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health. (Cornell, "What We Know" review).

49. The studies on gender-affirming medical care for adolescents with gender dysphoria are consistent with decades of clinical experience of mental health providers across the U.S. and around the world. At professional conferences and other settings in which I interact with colleagues, clinicians report that gender-affirming medical care, for those for whom it is indicated, provides great clinical benefit. In my 30 years of clinical experience treating gender dysphoric patients, including 19 years working with adolescents, I have seen the benefits of gender affirming medical care on my patients' health and well-being. I have seen many patients show improvement in mental health, as well as in performance in school, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender-affirming medical care.

50. Claims that the risks outweigh the benefits of treatment are without foundation. The benefits of treatment, and risks of withholding care, for transgender youth with gender dysphoria are clear, as described and referenced above. In addition, a treating doctor will not offer gender-affirming medical treatments unless they have concluded after weighing the risks and benefits of care that treatment is appropriate. The risks and benefits of care are discussed with the minor's parents, who must consent to treatment, and to the youth, who must assent. This process is no different than the informed consent process for other treatments. However, for gender-affirming medical care, there may be the additional safeguard of the assessment by a mental health professional, who, in addition to diagnosing gender dysphoria, also reviews the risks and benefits of treatment with the youth and parents.

51. Regret among those who are treated with gender-affirming medical care is rare. For example, in one study in the Netherlands, none of the youth who received puberty blockers, hormones, and surgery, and followed over an 8-year period expressed regret. (DeVries 2014.) Zucker et al. (2010), summarizing key studies on regret for adolescents referred for surgery when they reached the age of majority in the Netherlands, states, "there was virtually no evidence of regret, suggesting that the intervention was effective." This is consistent with my observations in decades of clinical practice.

52. Regret rates for gender affirming surgery in adults are also very low. A pooled review across multiple studies of 7,928 patients receiving gender affirming surgery showed a regret rate of 1%. (Bustos, et al., 2021). Over 50 years of gender affirming surgery in Sweden, the regret rate, as measured by legal gender change reversal, was 2%. (Dhejne, et al 2014). These are very low regret rates for surgery. For example, 47% of women expressed at least some regret after reconstructive breast surgery following mastectomy for breast cancer. (Sheehan et al 2008).

53. Many bills like the one passed in Indiana claim that for most youth, gender dysphoria will resolve on its own, making medical interventions unnecessary. These claims are inaccurate and are often in reference to a body of literature sometimes referred to as "desistance" studies, that found that many pre-pubertal children diagnosed with Gender Identity Disorder in Children (a precursor diagnosis to Gender Dysphoria in Children in the DMS III-R and DSM-IV) identified with their sex assigned at birth at a later follow up. Reliance on this research is misplaced for two reasons. First, the diagnostic criteria for Gender Identity Disorder in Children were different from the diagnostic criteria for Gender Dysphoria in Children in meaningful ways that result in the desistance studies grossly overestimating the rate of desistance. Gender Identity Disorder in Children did not require identification with a gender other than the one assigned to the

person at birth. A diagnosis could be made solely on the basis of gender atypical behavior, such as a boy who prefers playing with dolls and dress-up. This means that a child could be diagnosed with Gender Identity Disorder without ever having a transgender identity and, therefore, any study that selected subjects based on this diagnosis could include individuals who never had a gender identity that differed from the sex they were assigned at birth. This problem with the diagnosis was remedied with the DSM-V diagnosis of "Gender Dysphoria in Children," which requires a child to have "a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." Under this updated diagnosis, a child could not be diagnosed based solely on gender atypical behavior without identifying as a different sex than the one assigned at birth. Because the desistance studies were all conducted prior to the DSM-V, a child did not need to have a transgender identity to be included in the study. Additionally, in some studies, the children did not even meet the looser criteria for Gender Identity Disorder, but were entered in the studies based on parents bringing the youth to the gender clinic. It is not surprising that many children in these studies did not identify as transgender at follow-up as these children were never transgender and never identified with a gender different from their assigned sex at birth.

54. Second, the desistance studies focused only on pre-pubertal children. Whatever conclusions can be drawn from them about the likelihood of persistence of gender dysphoria in pre-pubertal children, which again is uncertain given the diagnostic limitations identified above, data indicates that once youth reach the beginning of puberty and identify as transgender, desistance is rare. (DeVries, et al., 2011, Wiepjies, et al 2018, Brik, et al, 2020). This data is consistent with clinical experience. In fact, the Amsterdam and Toronto gender centers that published the desistance data on pre-pubertal children referenced above provided medical

interventions to youth whose gender dysphoria persisted into adolescence. (Zucker, et al 2010, DeVries, et al 2014). No medical treatments are used prior to adolescence, so the persistence and desistance rates of pre-pubertal children do not inform the decision whether or not to initiate gender affirming medical treatments in adolescents.

55. "Watchful waiting" is an approach that has been described with respect to the care of pre-pubertal children with gender dysphoria. This approach involves a stance that is neither affirming nor rejecting of a child's asserted gender, but generally does not support social transition in pre-pubertal children. "Watchful waiting" does not apply to adolescents or speak to the appropriateness of medical interventions for adolescents with gender dysphoria. Indeed, the Dutch researchers who coined the term "watchful waiting" for pre-pubertal patients provide puberty blockers, then hormones, when medically indicated during adolescence and have published the successful use of this series of treatments. (Ehrensaft, 2017; DeVries, 2014).

56. Gender-affirming medical interventions in accordance with the WPATH SOC 8 and Endocrine Society Guideline are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria. (*See* American Academy of Pediatrics, 2018; the American Medical Association, 2021; the Endocrine Society, 2020; the Pediatric Endocrine Society, 2021; the American Psychiatric Association, 2018; the American Psychological Association, 2021; the American Congress of Obstetricians and Gynecologists, 2021; the American Academy of Family Physicians (2020); and WPATH (2022)).

E. Harms of Denying Gender-Affirming Care

57. The overarching goal of treatment is to eliminate the distress of gender dysphoria by helping align an individual patient's body and presentation with their gender identity. The denial of medically indicated care to patients with gender dysphoria not only results in the

prolonging of their dysphoria, but also causes additional distress and poses other health risks, such as depression, posttraumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

58. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. To the extent one proposed alternative is psychotherapeutic treatment to encourage identification with a person's assigned sex at birth, the American Psychological Association has stated that such efforts provide no benefit and instead do harm. (APA 2021). Or if an alternative approach is to treat the worsening dysphoria only with therapy, that has not shown to be effective in any research.

59. I have had patients over the years who were unable to access gender-affirming care when it was clinically indicated, including in the years before this care was more widely available, as well as minors who could not access care due to lack of parental consent. In many of these patients, delayed or denied care resulted in increased depression, anxiety, suicidal ideation and self-harm, increased substance use, and a deterioration in school performance. For patients with severe distress due to sex characteristics, psychotherapeutic approaches did not alleviate this distress absent medical intervention. Some of my patients had years of intensive mental health interventions, including long-term psychotherapy, without relief of gender dysphoria until receiving medical intervention.

60. Accordingly, major medical organizations, such as the American Medical Association, American Psychiatric Association, the Endocrine Society, American College of Obstetricians and Gynecologists, and American Academy of Family Physicians oppose the denial of this medically necessary care and support public and private health insurance coverage for

treatment of gender dysphoria as recommended by the patient's physician. (American Medical Association, 2021; American Psychiatric Association, 2018; Endocrine Society, 2012, American Congress of Obstetricians and Gynecologists, 2021; American Academy of Family Physicians, 2020). Denial of this appropriate care for transgender adolescents is also opposed by medical professional organizations responsible for the care of youth, including the American Academy of Pediatrics, the Academy of Child and Adolescent Psychiatry, and the Pediatric Endocrine Society. (American Academy of Pediatrics, 2018; American Academy of Child and Adolescent Psychiatry, 2019; The Pediatric Endocrine Society, 2021.)

CONCLUSION

61. The ban prohibits widely-accepted, evidence-based medical treatments for gender dysphoria in adolescents. Decades of medical research and clinical experience demonstrate that these medical treatments are safe, effective, and medically necessary to relieve gender dysphoria for many adolescents. The ban prohibits the only treatments demonstrated to be effective for adolescents for with gender dysphoria for whom gender-affirming medical care is indicated. Consistent with my first-hand clinical experience over decades of practice, denying gender-affirming medical care to adolescents for whom it is medically indicated puts them at risk of significant harm to their health and well-being.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 17th day of April, 2023.

Dan H. Karasic, M.D.

University of California, San Francisco

CURRICULUM VITAE

Name: Dan H. Karasic, MD

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EDUCATION

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990	Medical Licensure, California, License Number G65105
1990	Drug Enforcement Administration Registration Number BK1765354
1993	American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clincial Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical Professor

1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry	Associate Clinical Professor
2005 - present	University of California, San Francisco	Health Sciences Psychiatry	Clinical Professor

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; UCLA Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatrist	Psychiatry
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry Francisco
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)	Clinical Director	Psychiatry and Medicine
2003 - 2020	Transgender Life Care Program and Clinic, Castro Mission Health	Psychiatrist Clinic	Dimensions Dimensions Center
2013 - 2020	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa

1990	NIMH Postdoctoral Fellowship in Mental Health Services for People with AIDS (1990-1991)	National Institute of Mental Health
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF
2023	Alumni Seal Award for Achievement	Occidental College Professional

MEMBERSHIPS

1992 - present Northern California Psychiatric Society

1992 - present American Psychiatric Association

2000 - 2019 Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)

2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

1981 - 1982	The Occidental	News Editor
1984 - 1985	Yale University School of Medicine	Class President
1989 - 1991	Kaposi's Sarcoma Group, AIDS Project Los Angeles	Volunteer Facilitator
1992 - 1996	Early Career Psychiatrist Committee, Association of Gay Lesbian Psychiatrists	Chair and
1992 - 1996	Board of Directors, Association of Gay and Lesbian Psychiatrists	Member
1993 - 1993	Local Arrangements Committee, Association of Gay and Lesbian Psychiatrists	Chair
1994 - 1995	Educational Program, Association of Gay and Lesbian Psychiatrists, 1995 Annual Meeting	Director
1994 - 1998	Board of Directors, BAY Positives	Member
1994 - present	Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society	Member
1995 - 1997	Board of Directors, Bay Area Young Positives. BAY	President

	Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth	
1995 - 1997	Executive Committee, Bay Area Young Positives.	Chair
1996 - 2004	Committee on Lesbian, Gay, Bisexual and Transgender Northern California Psychiatric Society	Chair Issues,
1998 - 2002	City of San Francisco Human Rights Commission, Gay Bisexual Transgender Advisory Committee	Member Lesbian,
2000 - 2004	Association of Gay and Lesbian Psychiatrists. the organization's educational programs	Vice President Responsible for
2004 - 2005	Association of Gay and Lesbian Psychiatrists	President-elect
2005 - 2007	Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the American Psychiatric Association	Chair
2005 - 2007	Association of Gay and Lesbian Psychiatrists	President
2007 - 2009	Association of Gay and Lesbian Psychiatrists	Immediate Past President
2009 - 2010	Consensus Committee for Revision of the Sexual and Gender Identity Disorders for DSM-V, GID of Adults subcommittee. (Wrote WPATH recommendations as advisory body to the APA DSM V Committee for the Sexual and Gender Identity Disorders chapter revision.)	Member
2010 - 2011	Scientific Committee, 2011 WPATH Biennial Symposium, Atlanta	Member
2010 -2022	World Professional Association for Transgender Care Standards of Care Workgroup and Committee (writing seventh and eighth revisions of the WPATH Standards of Care, which is used internationally for transgender care.)	Member
2010 - 2018	ICD 11 Advisory Committee, World Professional Association for Transgender Health	Member
2012 - 2014	Psychiatry and Diagnosis Track Co-chair, Scientific 2014 WPATH Biennial Symposium, Bangkok	Member Committee,
2014 - 2016	Scientific Committee, 2016 WPATH Biennial Symposium, Amsterdam	Member
2014 - 2018	Board of Directors (elected to 4 year term), World Association for Transgender Health	Member Professional
2014 - 2018	Public Policy Committee, World Professional Association for Transgender Health	Chair
2014 - 2018	WPATH Global Education Initiative: Training providers and specialty certification in transgender health	Trainer and and Steering Committee Member

2014 - 2016	American Psychiatric Association Workgroup on Gender Dysphoria	Member
2016 - present	American Psychiatric Association Workgroup on Gender Dysphoria	Chair
2016	USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017	Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

2011 - present Journal of Sexual Medicine, reviewer

2014 - present International Journal of Transgenderism, reviewer

2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009	World Professional Association for Transgender Health, Oslo, Norway	Plenary Session Speaker
2009	World Professional Association for Transgender Health, Oslo, Norway	Symposium Speaker
2009	Karolinska Institutet, Stockholm Sweden	Invited Lecturer
2012	Cuban National Center for Sex Education (CENESEX), Havana, Cuba	Invited Speaker
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China	Expert Consultant
2014	World Professional Association for Transgender Health, Thailand	Track Chair Bangkok,
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Symposium Chair
2015	Israeli Center for Human Sexuality and Gender Identity, Tel Aviv	Invited Speaker
2016	World Professional Association for Transgender Health, Amsterdam	Symposium Chair
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker
2016	World Professional Association for Transgender Health,	Invited Speaker

Amsterdam 2017
Brazil Professional
Association for Transgender
Health, Sao Paulo

2017 Vietnam- United Nations Development Programme Asia Transgender Health Conference, Hanoi

2018 United Nations Development Programme Asia Conference on Transgender Health and Human Rights, Bangkok

2018 World Professional Association for Transgender Health, Invited Speaker Buenos Aires

2021 Manitoba Psychiatric Association, Keynote Speaker

INVITED PRESENTATIONS - NATIONAL

1990 Being Alive Medical Update, Century Cable Television Televised Lecturer

1992 Institute on Hospital and Community Psychiatry, Toronto Symposium Speaker

1992 Academy of Psychosomatic Medicine Annual Meeting, San Diego Symposium Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia Workshop Chair

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia Workshop Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia Paper Session Co-chair

1995 Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach Symposium Chair

1996 American Psychiatric Association 152nd Annual Meeting, New York Workshop Speaker

1997 American Psychiatric Association Annual Meeting, San Diego Workshop Speaker

1997 Gay and Lesbian Medical Association Annual Invited Speaker Symposium

1998 American Psychiatric Association Annual Meeting, Toronto Workshop Chair

1998 American Psychiatric Association Annual Meeting, Toronto Workshop Chair

1998 American Psychiatric Association Annual Meeting, Toronto Media Session Chair

1998 American Psychiatric Association Annual Meeting, Media Session

	Toronto	Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists Chair Symposium, New Orleans	
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME Conference	Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co-Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair
2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker
2004	Association of Gay and Lesbian Psychiatrists Conference, New York	Co-Chair
2004	Mental Health Care Provider Education Program: Los	Invited Speaker

	Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial

		Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles Course Faculty	
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

2017 American Urological Association Annual Meeting, San Francisco CA Invited Speaker

2018 World Professional Association for Transgender Health GEI, Portland OR, Course Faculty

2018 World Professional Association for Transgender Health GEI, Palm Springs, Course Faculty

2019 American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker

2019 American Psychiatric Association Annual Meeting, San Francisco, Session Chair

2020 Psychiatric Congress, Invited Speaker

2022 World Professional Association for Transgender Health, Montreal, invited speaker

2023 National Transgender Health Summit, San Francisco, invited speaker

2023 American Psychiatric Association Annual Meeting, San Francisco, invited speaker

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1990 Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute Invited Lecturer

1991 Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine Symposium Speaker

1991 Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine Workshop Panelist

1992 Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute Invited Lecturer

1993 UCSF School of Nursing Invited Lecturer

1995 UCSF/SFGH Department of Medicine Clinical Care Conference Invited Speaker

1996 UCSF School of Nursing Invited Speaker

1996 Psychopharmacology for the Primary Care AIDS/Clinician, series of four lectures, UCSF Department of Medicine Invited Lecturer

		Invited Speaker
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langley Porter Psychiatric Hospital and Clinics	Invited Speaker Grand Rounds
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	Northern California Psychiatric Society LGBT Committee	Chair Fall Symposium
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Rosa	Invited Speaker Santa
1999	Northern California Psychiatric Society Annual Meeting, Rosa	Invited Speaker Santa
1999	University of California, Davis, Department of Psychiatry	Invited Speaker Grand Rounds
1999	California Pacific Medical Center Department of Grand Rounds	Invited Speaker Psychiatry
1999	San Francisco General Hospital Department of Psychiatry Departmental Case Conference	Discussant
2000	Langley Porter Psychiatric Hospital and Clinics Consultation Liaison Seminar	Invited Speaker
2000	San Francisco General Hospital, Psychopharmacology Seminar	Invited Speaker
2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker

2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker
2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender Prevention and Care, San Francisco	Invited Speaker HIV
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health San Francisco LGBT Community Center	Invited Speaker Symposium,
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2012	UCSF AIDS Health Project Veterans Affairs Medical Center.	Invited Speaker 2012 San Francisco

		Invited Speaker
2013	Association of Family and Conciliation Courts Conference, Los Angeles, CA	Invited Speaker
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2014	California Pacific Medical Center Department of Psychaitry Grand Rounds	Invited Speaker
2014	UCLA Semel Institute Department of Psychiatry Grand Rounds	Invited Speaker
2015	UCSF Transgender Health elective	Invited Speaker
2015	Fenway Health Center Boston, MA (webinar)	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Co-Chair
2015	Santa Clara Valley Medical Center Grand Rounds	Invited Speaker
2016	UCSF School of Medicine Transgender Health elective	Invited Speaker
2016	Langley Porter Psychiatric Institute APC Case Conference	Invited Speaker (2 session series)
2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker
2021	Los Angeles County Department of Mental Health,	Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005	Northern California Psychiatric Society
2005	Northern California Psychiatric Society Annual Meeting, Napa
2005	Association of Gay and Lesbian Psychiatrist Annual Conference
2006	Annual Meeting, American Psychiatric Association, Atlanta
2006	Annual Meeting, American Psychiatric Association, Toronto
2006	Institute on Psychiatric Services, New York
2007	Association of Gay and Lesbian Psychiatrists Annual Conference
2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco

2009	American Psychiatric Association, San Francisco
2009	World Professional Association for Transgender Health, Oslo, Norway
2010	Annual Meeting of the Northern California Psychiatric Society, Monterey, CA
2011	Transgender Mental Health Care Across the Life Span, Stanford University
2011	National Transgender Health Summit, San Francisco
2011	American Psychiatric Association Annual Meeting, Honolulu, HI
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA
2011	Institute on Psychiatric Services, San Francisco
2012	Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013	National Transgender Health Summit, Oakland, CA
2013	American Psychiatric Association Annual Meeting, San Francisco
2013	Gay and Lesbian Medical Association, Denver, CO
2014	American Psychiatric Association Annual Meeting, New York
2014	Institute on Psychiatric Services, San Francisco
2015	European Professional Association for Transgender Health, Ghent, Belgium
2015	National Transgender Health Summit, Oakland
2015	American Psychiatric Association Annual Meeting, Toronto
2016	American Psychiatric Association Annual Meeting, Atlanta
2016	World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002	City and County of San Francisco Human Rights Member Commission LGBT Advisory Committee

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course fort the 2015 and 2016 APA Annual Meetings, and is now embarking on a larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I have been active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8.
I chaired of the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 2000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 – 2003 HIV/AIDS Task Force Member

1992 - 1993 HIV Research Group Member

1992 - 1997	Space Committee	Member
1992 - 2003	Gay, Lesbian and Bisexual Issues Task Force	Member
1994 - 1997	SFGH Residency Training Committee	Member
1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair
1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual
1996 - 2003	HIV/AIDS Task Force	Co-Chair
1996 - 2003	Cultural Competence and Diversity Program	Member
2009 - present	Medical Advisory Board, UCSF Center of Excellence for Transgender Health	Member
2010 - 2013	Steering Committee, Child Adolescent Gender Center	Member
2011 – 2017	Mental Health Track, National Transgender Health Summit	Chair

DEPARTMENTAL SERVICE

1991 - 2003 San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force

1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group

1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee

1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force

1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee

1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program

1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force

2012 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee

2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force

2014 - 2020San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. Diabetes. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. Journal of Neural Transmission. General Section, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. Psychosomatics. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. The Northern California Psychiatric Physician. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. Focus. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association. 1997 1(1) 41-47.

7. Karasic DH. Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 4(4) 2000 157-8.

8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. Focus: A Guide to AIDS Research and Counseling. 2002 17(9) 5-6.

9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. International Journal of Transgenderism. Volume 12, Issue 2. 2010, Pages 80-85.

10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. International Journal of Transgenderism, 13:165-232, 2011

11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. American Journal of Public Health. February 2013, Vol. 103, No. 2, pp. 308-315.

12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. AIDS and Behavior, October 2013, Volume 17, Issue 8, pp 2765-2772.

13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. LGBT Health. 2016 Aug; 3(4):245-7. PMID: 27458863

14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. Lancet. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925

15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. AIDS Care. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273

16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kuschner ES, Mandel F, Caretto A, Lewis HC, Anthony LG.
Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. J Clin Child Adolesc Psychol. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428

17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. J Sex Med 2017;14:624–634.

18. William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F.L. Meyer-Bahlburg, Richard R. Pleak, and Jack Pula.Gender Dysphoria in Adults:

An Overview and Primer for Psychiatrists.Transgender Health.Dec 2018.57-A3.http://doi.org/10.1089/trgh.2017.0053

19. Identity recognition statement of the world professional association for transgender health (WPATH). International Journal of Transgenderism. 2018 Jul 3; 19(3):1-2. Knudson KG, Green GJ, Tangpricha TV, Ettner ER, Bouman BW, Adrian AT, Allen AL, De Cuypere DG, Fraser FL, Hansen HT, **Karasic KD**, Kreukels KB, Rachlin RK, Schechter SL, Winter WS, Committee and Board of Direct

20. **Karasic, DH** & Fraser, L Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue, Vol 45, Issue 3, pp 295-299. 2018 Elsevier,Philadelphia**.** https://doi.org/10.1016/j.cps.2018.03.016

21. Milrod C, Monto M, **Karasic DH.** Recommending or Rejecting "the Dimple": WPATHAffiliated Medical Professionals' Experiences and Attitudes Toward GenderConfirming Vulvoplasty in Transgender Women. J Sex Med. 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.

22. ICD-11 and gender incongruence of childhood: a rethink is needed. Lancet Child Adolesc Health. 2019 10; 3(10):671-673. Winter S, Ehrensaft D, Telfer M, T'Sjoen G, Koh J, Pickstone-Taylor S, Kruger A, Griffin L, Foigel M, De Cuypere G, **Karasic D**. PMID: 31439494.

23. Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists. Focus (Am Psychiatr Publ). 2020 Jul; 18(3):336-350. Byne W, **Karasic DH**, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HFL, Pleak RR, Pula J. PMID: 33343244; PMCID: PMC7587914.

24. WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, **D. H. Karasic**, G. A.
Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.- B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D.
Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello,

J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

BOOKS AND CHAPTERS

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3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D.** We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html
2014 Cabading v California Baptist University

2014 CF v. Alberta
http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan
2018 https://canliiconnects.org/en/summaries/54130
https://canliiconnects.org/en/cases/2018skqb159

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

2021 Expert, Kadel v. Folwell, 1:19-cv-00272 (M.D.N.C.).

2021 Expert, Drew Glass v. City of Forest Park - Case No. 1:20-cv-914 (Southern District Ohio)

2021-2022 Expert, Brandt et al v. Rutledge et al. 4:21-cv-00450 (E.D. Ark.)

2021-2022 Expert, Fain v. Crouch, 3:20-cv-00740 (S.D.W. Va.)

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-CV-595

EXPERT DECLARATION OF DANIEL SHUMER, M.D.

I, Daniel Shumer, M.D., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a Pediatric Endocrinologist, Associate Professor of Pediatrics, and the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital at Michigan Medicine. I am also the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan.

4. I am Board Certified in Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics and licensed to practice medicine in the state of Michigan.

5. I received my medical degree from Northwestern University in 2008. After completing a Residency in Pediatrics at Vermont Children's Hospital, I began a Fellowship in Pediatric Endocrinology at Harvard University's Boston Children's Hospital. Concurrent with the Fellowship, I completed a Master of Public Health from Harvard's T.H. Chan School of Public Health. I completed both the Fellowship and the MPH degree in 2015.

6. I have extensive experience working with and treating children and adolescents with endocrine conditions including differences in sex development (DSD) (also referred to as intersex conditions), gender dysphoria, type 1 diabetes, thyroid disorders, growth problems, and delayed or precocious puberty. I have been treating patients with gender dysphoria as a pediatric endocrinologist since 2015.

7. A major focus of my clinical, teaching, and research work pertains to the assessment and medical management of transgender adolescents.

8. I have published extensively on the topic of gender identity in pediatrics and the treatment of gender dysphoria, as well as reviewed the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care the treatment of gender dysphoria, and research articles on a variety of topics with a focus on mental health in transgender adolescents.

9. I am involved in education of medical trainees. I am the Fellowship Director in the Division of Pediatric Endocrinology, Education Lead for the Division of Pediatric Endocrinology, and Course Director for a medical student elective in Transgender Medicine. My additional academic duties as an Associate Professor include teaching several lectures, including those entitled "Puberty," "Transgender Medicine," and "Pediatric Growth and Development."

10. As a Fellow at Harvard, I was mentored by Dr. Norman Spack. Dr. Spack established the Gender Management Services Clinic (GeMS) at Boston Children's Hospital. While working and training at GeMS, I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children and adolescents.

11. Based on my work at GeMS, I was recruited to establish a similar program assessing and treating gender diverse and transgender children and adolescents at the C.S. Mott Children's Hospital in Ann Arbor. In October 2015, I founded the hospital's Child and Adolescent Gender Services Clinic.

12. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment, and when appropriate, treatment with pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 21 years old. Most patients that we assess and treat at the clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 4 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

13. I also provide care in in the Differences/Disorders of Sex Development (DSD) Clinic at Michigan Medicine at Mott Children's Hospital. The DSD Clinic is a multidisciplinary clinic focused on providing care to infants and children with differences in the typical path of sex development, which may be influenced by the arrangement of sex chromosomes, the functioning

of our gonads (i.e. testes, ovaries), and our bodies' response to hormones. The clinic is comprised of members from Pediatric Endocrinology, Genetics, Psychology, Urology, Gynecology, Surgery, and Social Work. In this clinic I have assessed and treated over 100 patients with DSD.

14. In my role as Medical Director of the Comprehensive Gender Services Program (CGSP), I lead Michigan Medicine's broader efforts related to transgender services. CGSP is comprised of providers from across the health system including pediatric care, adult hormone provision, gynecologic services, adult surgical services, speech/language therapy, mental health services, and primary care. I run monthly meetings with representatives from these areas to help coordinate communication between Departments. I coordinate strategic planning aimed to improve care within the health system related to our transgender population. I also serve as the medical representative for CGSP in discussions with health system administrators and outside entities.

15. I have authored numerous peer-reviewed articles related to treatment of transgender youth. I have also co-authored chapters of medical textbooks related to medical management of transgender patients. I have been invited to speak at numerous hospitals, clinics, and conferences on topics related to clinical care and standards for treating transgender children and youth.

16. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. Prior Testimony

17. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Boe, et al. v. Marshall et al.*, No. 2:22-cv-184-LCB-CWB (US District Court for the Middle District of Alabama Northern Division); *Roe et al v. Utah*

High School Activities Association et al (Third District Court in and for Salt Lake County, UT); *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18-cv-01481 (N.D. Ala.); and *Dekker, et al., v. Weida, et al*., No. 4:22-cv-00325 (N.D. Fla). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas).

C. Compensation

18. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $400 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. Bases for Opinions

19. This declaration sets forth my opinions in this case and the bases for my opinions.

20. In preparing this declaration I reviewed the Indiana Senate Enrolled Act 480 (hereafter, "S.E.A. 480", "the Act" or "the ban").

21. I have also reviewed the materials cited here, as well as the materials listed within my curriculum vitae, which is attached as **Exhibit A**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report. I may rely on these materials as additional support for my opinions.

22. In addition, I have relied on my scientific education, training, and years of clinical and research experience, and my knowledge of the scientific literature in the pertinent fields.

23. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on these subjects.

24. To the best of my knowledge, I have not met or spoken with the Plaintiffs or their parents. My opinions are based solely on my extensive background and experience treating transgender patients.

25. I may wish to supplement or revise these opinions or the bases for them due to new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

II. EXPERT OPINIONS

A. MEDICAL AND SCIENTIFIC BACKGROUND ON SEX AND GENDER IDENTITY

26. *Sex* is comprised of several components, including, among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary sex characteristics (IOM, 2011).

27. *Gender identity* is the medical term for a person's internal sense of belonging to a particular sex. Everyone has a gender identity. The term *transgender* refers to individuals whose gender identity does not align with their sex assigned at birth (Shumer, et al., 2013).

28. A person's understanding of their gender identity may evolve over time in the natural course of their life, however, attempts to force transgender people to align their gender identity with their birth sex (sometimes descried as "conversion therapy") have been found to be both harmful and ineffective. In one study, transgender adults who recall previous attempts from healthcare professionals to alter their gender identity reported an increase in lifetime suicide

attempts and higher rates of severe psychological distress in the present (Turban, et al., 2020a). In another study, exposure to these types of attempts were found to increase the likelihood that a transgender adolescent will attempt suicide by 55% and more than double the risk for running away from home (Campbell, et al., 2002). Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, among others (Fish, et al., 2022).

29. Scientific research and medical literature across disciplines demonstrates that gender identity, like other components of sex, has a strong biological foundation. For example, there are numerous studies detailing the similarities in the brain structures of transgender and non-transgender people with the same gender identity (Luders, et al., 2009; Rametti, et al., 2011; Berglund, et al., 2008; Savic, et al., 2011). In one such study, the volume of the bed nucleus of the *stria terminalis* (a collection of cells in the central brain) in transgender women was equivalent to the volume found in cisgender women (Chung, et al., 2002).

B. ASSESSMENT OF GENDER DYSPHORIA IN CHILDREN, ADOLESCENTS, AND ADULTS

30. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of gender dysphoria, a serious medical condition defined in both the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5 TR) (APA, 2022).

31. *Gender Dysphoria* is defined as an incongruence between a patient's assigned sex and their gender identity present for at least six months, which causes clinically important distress in the person's life. This distress is further defined as impairment in social, occupational, or other

important areas of functioning (APA, 2022). Additional features may include a strong desire to be rid of one's primary or secondary sex characteristics, a strong desire to be treated as a member of the identified gender, or a strong conviction that one has the typical feelings of identified gender (APA, 2022).

32. The *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* ("SOC 8"), published by the World Professional Association for Transgender Health (WPATH), provides guidance to clinicians on how to provide comprehensive assessment and care to children and adolescents with gender dysphoria based on the best available medical evidence. These standards recommend involving relevant disciplines, including mental health and medical professionals, to reach a decision with families about whether medical interventions are appropriate and remain indicated through the course of treatment.

33. For transgender adolescents, all treatment decisions are made in consultation with the adolescent and the adolescent's parent or guardian with the parent or guardian providing ultimate consent for treatment.

C. EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES FOR THE TREATMENT OF GENDER DYSPHORIA IN CHILDREN, ADOLESCENTS AND ADULTS

34. The goal of any intervention for gender dysphoria is to reduce dysphoria, improve functioning, and prevent the harms caused by untreated gender dysphoria.

35. Gender dysphoria is highly treatable and can be effectively managed. If left untreated, however, it can result in severe anxiety and depression, eating disorders, substance abuse, self-harm, and suicidality (Reisner, et al., 2015).

36. Based on longitudinal data, and my own clinical experience, when transgender adolescents are provided with appropriate medical treatment and have parental and social support, they are more likely to thrive and grow into healthy adults (de Vries, et al., 2014).

37. In children and adolescents, a comprehensive biopsychosocial assessment is typically the first step in evaluation, performed by a provider with experience in gender identity. The goals of this assessment are to develop a deep understanding of the young person's experience with gender identity, to consider whether the child or adolescent meets criteria for a diagnosis of gender dysphoria, and to understand what options may be desired and helpful for the adolescent (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009).

38. For children younger than pubertal age, the only recommended treatments do not involve medications. For adolescents, additional treatments involving medications may be appropriate.

39. Options for treatment after the onset of puberty include the use of gonadotropin-releasing hormone agonists ("GnRHa") for purposes of preventing progression of pubertal development, and hormonal interventions such as testosterone and estrogen administration. These treatment options are based on robust research and clinical experience, which consistently demonstrate safety and efficacy.

40. WPATH and the Endocrine Society (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009) and the UCSF Center for Excellence in Transgender Health (Deutsch (ed.), 2016) have all published clinical practice guidelines for the treatment of patients with gender dysphoria. The clinical practice guidelines and standards of care provide a framework for treatment of gender dysphoria in adolescents. The evidence base supporting the

recommendations in these guidelines is comparable to the evidence base supporting other clinical care guidelines.

41. WPATH has been recognized as the standard-setting organization for the treatment of gender dysphoria since its founding in 1979. The most recent WPATH Standards of Care (SOC 8) were published in 2022 (Coleman, et al., 2022).

42. The purpose of the WPATH Standards of Care is to assist health providers in delivering necessary medical care to transgender people, to maximize patients' overall health, psychological well-being, and self-fulfillment. The WPATH Standards of Care serve as one of the foundations for the care provided in my own clinic.

43. The WPATH SOC 8 is based on rigorous review of the best available science and expert professional consensus in transgender health. International professionals were selected to serve on the SOC 8 writing committee. Recommendation statements were developed based on data derived from independent systemic literature reviews. Grading of evidence was performed by an Evidence Review Team which determined the strength of evidence presented in each individual study relied upon in the document (Coleman, et al., 2022).

44. In addition, the Endocrine Society is a 100-year-old global membership organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published clinical practice guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others (Hembree, et al, 2017).

45. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that "followed the approach recommended by the Grading of

Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines." The guidelines affirm that patients with gender dysphoria often must be treated with "a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender." (Hembree, et al., 2017).

46. The AAP is the preeminent professional body of pediatricians in the United States, with over 67,000 members. The AAP endorses a commitment to the optimal physical, mental, and social health and well-being for youth. The 2018 policy statement titled *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* further lends support to the treatment options outlined in the WPATH Standards of Care and the Endocrine Society's Clinical Practice Guidelines (Rafferty, et al., 2018).

47. Aside from the AAP, the guidelines set forth by the Endocrine Society Clinical Practice Guideline and the WPATH Standards of Care are supported by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and American Academy of Family Physicians, among others (e.g., AMA, 2019; American Psychological Association, 2015; Drescher, et al., 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); Klein, et al., 2018 (AAFP); National Academies, 2020; WPATH, 2016).

48. As a board-certified pediatric endocrinologist, I follow the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care when treating my patients.

D. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA

49. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The steps that make up a person's transition and their sequence will depend on that individual's medical and mental health needs and decisions made between the patient, family, and medical care team.

50. There are no medications considered for transition until after the onset of puberty. Puberty is a process of maturation heralded by production of sex hormones—testosterone and estrogen—leading to the development of secondary sex characteristics. Secondary sex characteristics include testosterone-induced effects such as deepening of the voice, muscular changes, facial and body hair, and estrogen-induced effects such as breast development. There is diversity in the age of pubertal onset; however, most adolescents begin puberty between ages 10 and 12 years.

51. After the onset of puberty, puberty-delaying medication and hormone-replacement therapy—both individually and in combination—can significantly improve the mental health of adolescents diagnosed with gender dysphoria. These treatments allow for a patient's physiological characteristics to more closely align with gender identity and decreases the likelihood that the young person will be incorrectly identified with their assigned sex, further alleviating their gender dysphoria.

52. At the onset of puberty, adolescents begin to experience the onset of secondary sex characteristics. Adolescents with incongruence between gender identity and assigned sex may have intensification of gender dysphoria during this time due to development of secondary sex characteristics that don't align with gender identity. Persistence or intensification of gender

dysphoria as puberty begins is used as a helpful diagnostic tool as it becomes more predictive of gender identity persistence into adolescence and adulthood (de Vries, et al., 2012).

i. Treatment with puberty-delaying medications

53. Adolescents diagnosed with gender dysphoria who have entered puberty (Tanner Stage 2) may be prescribed puberty-delaying medications (GnRHa) to prevent the distress of developing permanent physical characteristics that do not align with the adolescent's gender identity. Tanner Stage 2 refers to the stage in puberty whereby the physical effects of testosterone or estrogen production are first apparent on physical exam. Specifically, this is heralded by the onset of breast budding in an individual assigned female at birth, or the onset of testicular enlargement in an individual assigned male at birth. For individuals assigned male at birth, Tanner Stage 2 typically occurs between age 9-14, and for those assigned female at birth between age 8-12.

54. The treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the influence of a person's endogenous hormones on their body. For example, a transgender girl will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam's apple, or masculinized facial structures while undergoing treatment with the pubertal suppressant. And, in a transgender boy, those medications would prevent progression of breast development, menstruation, and widening of the hips for the duration of the treatment (Coleman, et al., 2022; de Vries, et al., 2012; Deutsch (ed.), 2016; Hembree, et al., 2017; Rosenthal, 2014).

55. GnRHa have been used extensively in pediatrics for several decades. Prior to their use for gender dysphoria, they were used (and still are used) to treat precocious puberty. GnRHa work by suppressing the signal hormones from the pituitary gland (luteinizing hormone [LH] and

follicle stimulating hormone [FSH]) that stimulate the testes or ovaries to produce sex hormones. Upon discontinuation of GnRHa, LH and FSH production resume and puberty will also resume.

56. GnRHa have no long-term implications on fertility. In transgender youth, it is most typical to use GnRHa from the onset of puberty (Tanner Stage 2) until mid-adolescence. During the course of treatment, the decision as to whether to continue treatment is continually evaluated. Should pubertal suppression no longer be desired, GnRHa would be discontinued, and puberty would re-commence.

57. Prior to initiation of GnRHa, providers counsel patients and their families extensively on potential benefits and risks. Designed benefit of treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. More specifically, use of GnRHa in transmasculine adolescents allows for decreased chest development, reducing the need for breast binding and surgical intervention in adulthood. For those transmasculine adolescents who do pursue surgical intervention to reduce breast tissue, such "top surgery" is comparable to the surgical interventions used to treat gynecomastia in non-transgender adolescent males. For transfeminine adolescents GnRHa limits facial and body hair growth, voice deepening, and masculine bone structure development, which greatly reduce distress both at the time of treatment and later in life and reduce the need for later interventions such as voice therapy, hair removal, and facial feminization surgery.

58. The goal in using GnRHa is to minimize the patient's dysphoria related to progression of puberty and allow for later initiation of puberty consistent with gender identity should that become medically indicated. When a patient presents to care, the provider assesses the patient's pubertal stage, pubertal history, and individual needs. A patient may present prior to the onset of puberty (Tanner Stage 1), at the onset of puberty (Tanner Stage 2), or further along in

puberty (Tanner Stages 3-5). The pubertal stage and individual needs of the patient then direct conversations regarding care options. A patient at Tanner Stage 2 may benefit from GnRHa, while an older patient who has completed puberty may benefit from pubertal initiation with hormones, as described below. I have observed that providing individualized care based on individual patient characteristics, using the WPATH Standards of Care as the foundation of this care, provides significant benefit to patients, minimizes gender dysphoria, and can eliminate the need for surgical treatments in adulthood.

59. As an experienced pediatric endocrinologist, I treat patients with these same medications for both precocious puberty and gender dysphoria and in both cases the side effects are comparable and easily managed. And for both patient populations the risks are greatly outweighed by the benefits of treatment.

60. In addition, I regularly prescribe GnRHa for patients who do not meet criteria for precocious puberty but who require pubertal suppression. Examples include patients with disabilities who are unable to tolerate puberty at the typical age due to hygienic concerns; minors with growth hormone deficiency who despite growth hormone treatment will have a very short adult height; and patients with endometriosis. As with gender dysphoria, the prescription of GnRHa to treat these conditions is "off-label," yet it is widely accepted within the field of endocrinology and not considered experimental. The same holds true for other common medications used in pediatric endocrinology: using metformin for weight loss; growth hormone for short stature not caused by growth hormone deficiency; countless medications used to control type 2 diabetes which have an adult indication but whose manufacturers have not applied for a pediatric indication.

ii. Treatment with hormone therapy

61. In mid-adolescence, the patient, their parents, and the patient's care team may discuss the possibility of beginning the use of testosterone or estrogen (along with a testosterone suppressant). In my practice we discuss these treatments for a patient who is currently receiving GnRHa, or patients who have already gone through their endogenous puberty and either did not have access to, desire, or elect for GnRHa treatment.

62. These hormone therapies are used to treat gender dysphoria in adolescents and adults to facilitate development of physical changes congruent with a patient's gender identity. For example, a transgender male adolescent or adult prescribed testosterone will develop a lower voice as well as facial and body hair, while a transgender female adolescent or adult prescribed estrogen will experience breast growth, female fat distribution, and softer skin.

63. Under the Endocrine Society Clinical Guidelines and SOC 8, hormone therapy is an appropriate treatment for transgender adolescents with gender dysphoria when the experience of dysphoria is marked and sustained over time, the adolescent demonstrates emotional and cognitive maturity required to provide and informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, the adolescent has discussed reproductive options with their provider. SOC 8 also highlights the importance of involving parent(s)/guardian(s) in the assessment and treatment process for minors (Coleman, et al., 2022; Hembree, et al., 2017). In the United States, parental consent is required for treatment for adolescents with gender dysphoria.

64. Similar to GnRHa, the risks and benefits of hormone treatment are discussed with patients (and families, if the patient is a minor) prior to initiation of testosterone or estrogen. When treated with testosterone or estrogen, the goal is to maintain the patient's hormone levels within

the normal range for their gender identity. Laboratory testing is recommended to ensure proper dosing and hormonal levels. If starting hormonal care after completing puberty, discussion of egg or sperm preservation prior to starting treatment is recommended.

65. Regardless of the treatment plan prescribed, at every encounter with the care team there is a re-evaluation of treatment – including the benefits, side effects, and trajectory of the treatment for the individual patient. Should a patient desire to discontinue a medical intervention, the intervention is discontinued.

E. SAFETY AND EFFICACY OF PUBERTY-DELAYING MEDICATIONS AND HORMONE THERAPY TO TREAT GENDER DYSPHORIA

66. GnRHa, prescribed for delaying puberty in transgender adolescents with gender dysphoria, is both a safe and effective treatment. Patients under consideration for treatment work with providers to ensure that each treatment decision is informed and appropriate. This process is done thoughtfully and carefully with the patient and family in the best interest of the adolescent. Physicians providing this intervention are trained and qualified in gender identity concerns and childhood growth and development and are participating in this care out of a desire to improve the health and wellness of transgender youth and prevent negative outcomes such as depression and suicide.

67. GnRHa, including injectable leuprolide and implantable histrelin, have rare side effects which are discussed with patients and families prior to initiation. Mild negative effects may include pain at the injection or implantation site, sterile abscess formation, weight gain, hot flashes, abdominal pain, and headaches. These effects can be seen in patients receiving GnRHa for gender dysphoria, or for other indications such as precocious puberty. It is appropriate to counsel patients

on maintaining a healthy diet and promote physical activity, and regularly document height and weight during treatment. Nutritional support can be provided for patients at risk for obesity.

68. Risk of lower bone mineral density in prolonged use of GnRHa can be mitigated by screening for, and treating, vitamin D deficiency when present, and by limiting the number of years of treatment based on a patient's clinical course (Rosenthal, 2014). An exceptionally rare occurrence described with the use of GnRHa is increased intracranial pressure, which has been reported in six patients (five treated for precocious puberty, one for gender dysphoria), prompting an FDA warning in July 2022 (AAP, 2022). These cases represent an extremely small fraction of the hundreds of thousands of patients who have been treated with GnRHa over decades for conditions including precocious puberty as well as gender dysphoria. Symptoms of this side effect (headache, vomiting, visual changes) are reviewed with families and if they occur the medication is discontinued.

69. GnRHa on its own does not have long-term implications on fertility. This is clearly proven from decades of use in the treatment of precocious puberty (Guaraldi, et al., 2016; Martinerie, et al, 2021). Progression through natal puberty is required for maturation of egg or sperm. If fertility after previous treatment with GnRHa followed by hormone therapy is desired, an adult patient would withdraw from hormones and allow pubertal progression. Assistive reproduction could be employed if needed (T'Sjoen, et al., 2013). Caanen et al demonstrated that transgender men have similar ovarian morphology to cisgender women, even when treated with GnRHa followed by testosterone. These treatments did not cause the ovarian changes which are seen in hyperandrogenic women with polycystic ovarian syndrome and infertility (Caanen, 2017). This lends support to the expectation that the sequence of GnRHa to testosterone does not cause permanent infertility.

70. Patients who initiate hormones after completing puberty are offered gamete preservation prior to hormonal initiation (Coleman, et al., 2022), but even when not undertaken, withdrawal of hormones in adulthood often is successful in achieving fertility when it is desired (Light, et al., 2014; Knudson, et al., 2017). For transgender men, pregnancy has occurred even when on testosterone treatment and trans male patients are regularly advised that testosterone is not an effective form of birth control.

71. Discussing the topic of fertility is important, and not specifically unique to treatment of gender dysphoria in the pediatric patient population. Medications used for other medical conditions, such as chemotherapeutics used in cancer treatment, can affect fertility. For all medications with potential impacts on fertility, the potential risks and benefits of both treatment and non-treatment should be reviewed and data regarding risk for infertility clearly articulated prior to the consent or assent of the patient. Risk for fertility changes must be balanced with the risk of withholding treatment.

72. Review of relevant medical literature clearly supports the benefits of GnRHa treatment on both short-term and long-term psychological functioning and quality of life (e.g., Achille, et al., 2020; Carmichael, et al., 2021; Costa, et al., 2015; de Vries, et al., 2014; de Vries, et al., 2011; Kuper, et al., 2020; Turban, et al., 2020b; van der Miesen, et al., 2020).

73. In my own practice, adolescent patients struggling with significant distress at the onset of puberty routinely have dramatic improvements in mood, school performance, and quality of life with appropriate use of GnRHa. Side effects encountered are similar to those seen in other patients treated with these medications for conditions other than gender dysphoria and easily managed.

74. Hormone therapy (testosterone or estrogen) is prescribed to older adolescents with gender dysphoria. As is the case with GnRHa, the need for hormone therapy is not unique to transgender adolescents. Patients with conditions such as delayed puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, agonism, premature ovarian failure, and disorders of sex development all require treatment with these hormones, often times starting in adolescence and continuing lifelong. Without testosterone or estrogen treatment, these patients would be unable to progress through puberty normally, which would have serious medical and social consequences. Whether used in adolescents to treat gender dysphoria, or to treat any of these other conditions, testosterone and estrogen are prescribed with a goal to raise the testosterone or estrogen level into the normal male or female range for the patient's age. Careful monitoring of blood levels and clinical progress are required. Side effects are rare, but most often related to overtreatment, which can be minimized with this appropriate monitoring. Additionally, side effects are considered, discussed, and appropriately managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

75. Venous thromboembolism (blood clotting) is a known side effect of estrogen therapy in all individuals placed on it including transgender women. Risk is increased with age, in patients with cancer, and in patients who smoke nicotine. This side effect is mitigated by careful and accurate prescribing and monitoring. In my career, none of my patients have suffered a thromboembolism while on estrogen therapy.

76. Treatment of gender dysphoria with testosterone or estrogen is highly beneficial for both short-term and long-term psychological functioning of adolescents with gender dysphoria and withholding treatment from those who need it is harmful (e.g., Achille, et al., 2020; Allen, et al.,

2019; Chen, et al., 2023; de Lara, et al., 2020; de Vries, et al., 2014; Grannis, et al., 2021; Green, et al., 2022; Kaltiala, et al., 2020; Kuper, et al., 2020).

77. I treat many patients with gender dysphoria with GnRHa, testosterone, and estrogen. Side effects related to these medications are very rare and can be treated with dose adjustment and/or lifestyle changes. In all cases, treatment is tailored to the individual needs of the patient, weighing the potential risks and benefits of treatment and withholding treatment, the medical history of the individual patient, as well as the best available research and clinical data for each medical intervention.

78. The research on the efficacy of hormone treatment in transgender adults is robust and can also be used to bolster our knowledge about the efficacy of treatment in adolescents. At least 11 longitudinal studies document improvement in various mental health parameters including depression, anxiety, self-confidence, body image and self-image, general psychological functioning (e.g., Colizzi, et al., 2013; Colizzi, et al., 2014; Corda, et al., 2016; Defreyne, et al., 2018; Fisher, et al., 2016; Heylens, et al., 2014; Keo-Meier, et al., 2015; Manieri, et al., 2014; Motta, et al., 2018; Oda, et al., 2017; Turban, et al., 2018).

79. In sum, the use of GnRHa and hormones in adolescents for the treatment of gender dysphoria is the current standard of care. This is of the product of the best available evidence that clearly demonstrates the safety and efficacy of this treatment for those who need it.

F. HARMS ASSOCIATED WITH PROHIBITING AND DISCONTINUING TREATMENT

80. Prohibition of gender-affirming care for adolescents is likely to have devastating consequences. I am concerned that S.E.A. 480 might lead to a staggering increase in mental health problems including suicidality for adolescents with gender dysphoria in Indiana.

81. Even more concerning is a situation where patients currently receiving care and thriving would be forced to discontinue this care. Discontinuation of GnRHa would cause the onset of a puberty discordant from gender identity, a significant source of distress for patients with gender dysphoria. Similarly, discontinuation of gender-affirming hormone therapy for adolescents with gender dysphoria will cause adolescents receiving treatment to experience physiological changes inconsistent with their gender identity. Abrupt withdrawal of hormone therapy can cause severe physical side effects including hot flashes and headaches. For patients who are titrated down in dose to avoid these effects, taking patients off of a therapeutic dose of hormone therapy would cause the types of physiological changes inconsistent with gender identity that result in severe psychological distress for adolescents with gender dysphoria. For adolescents in Indiana whose current treatment is affected by S.E.A. 480, I am concerned that the law will cause severe and rapidly deteriorating emotional problems.

III. CONCLUSION

82. In summary, banning gender-affirming care regardless of individual patient need runs counter to evidence-based best practices and standards of care for the treatment of gender dysphoria.

83. Lack of access to the treatments banned under the Act will result in worse outcomes for countless individuals in Indiana.

84. In my own clinical practice in Michigan, I have seen an influx of patients from states banning medically proven treatments for gender dysphoria who report not feeling safe living in the community that they have always called home. These patients unfortunately often have to wait long periods of time to resume care and when they are seen, the impact of this delay is devastating on their mental health.

85. Banning effective treatment for gender dysphoria will not eliminate transgender people, but will, unfortunately, lead to an increase in mental health problems and suicidality in an already vulnerable population.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 18th day of April 2023.

Daniel Shumer, M.D.

Daniel Shumer

Clinical Associate Professor
dshumer@umich.edu

Education and Training

Education

08/2000-08/2003	BA, Northwestern University, Evanston, IL
08/2004-05/2008	MD, Northwestern University, Feinberg School of Medicine, Chicago, IL
07/2013-05/2015	MPH, Harvard T.H. Chan School of Public Health, Boston, MA

Postdoctoral Training

06/2008-06/2011	Residency, Pediatrics, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2011-06/2012	Chief Resident, Chief Resident, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2012-06/2015	Clinical Fellow, Pediatric Endocrinology, Boston Children's Hospital, Boston, MA

Certification And Licensure

Certification

10/2011-Present	American Board of Pediatrics, General

Licensure

	Michigan, Medical License
	Michigan, Controlled Substance
08/2015-Present	Michigan, Medical License
09/2015-Present	Michigan, DEA Registration
09/2015-Present	Michigan, Controlled Substance

Work Experience

Academic Appointment

10/2015-Present	Clinical Assistant Professor in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor
04/2022-Present	in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor
09/2022-08/2023	Clinical Associate Professor in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor

Administrative Appointment

07/2019-Present	Fellowship Director - Pediatric Endocrinology, Michigan Medicine, Department of Pediatrics, Ann Arbor
07/2020-Present	Medical Director of the University of Michigan Comprehensive Gender Services Program, Oversee the provision of care to transgender and gender non-conforming patients at Michigan Medicine, Michigan Medicine, Ann Arbor
07/2020-Present	Education Lead - Pediatric Endocrinology, University of Michigan - Department of Pediatrics, Ann Arbor

Clinical Appointments

04/2022-05/2023	Medical Director in UMMG Faculty Benefits Appt., University of Michigan - Ann Arbor, Ann Arbor

Private Practice

08/2013-09/2015	Staff Physician, Harvard Vanguard Medical Associates, Braintree

Grants

FY23-Project AW (NEWBRSC-UM): Newborn Screening Coordinating Center:
Co-I (Principal Investigator:Ram Menon)
MDHHS
10/2022 - 09/2023
$659,065

Newborn Screening Coordinating Center:
Co-I (Principal Investigator:Ram Menon)
MDHHS
10/2023 - 09/2024
$795,278

U2CDK:*Catalyzing Health Equity and Engagement in T1D Research:*
Co-I (Principal Investigator:Joyce Lee)
NIH-DHHS-US
07/2023 - 06/2028
$11,794,578

R01:*The Intersection of Sex and Gender in Pediatric Meta-Inflammation:*
Co-I (Principal Investigator:Kanakadurga Singer)
NIH-DHHS-US
07/2020 - 06/2024
$2,087,316

Past Grants

A Phase 2b/3 study to evaluate the safety, tolerability, and effects of Livoletide (AZP-531), an unacylated ghrelin analog, on food-related behaviors in patients with Prader-Willi syndrome:
PI
Millendo Therapeutics
04/2019 - 04/2021
$162,773

Honors and Awards

National

2014	Annual Pediatric Endocrine Society Essay Competition: Ethical Dilemmas in Pediatric Endocrinology: competition winner - The Role of Assent in the Treatment of Transgender Adolescents

Institutional

2012 - 2015	Harvard Pediatric Health Services Research Fellowship; funded my final two years of pediatric endocrine fellowship and provided tuition support for my public health

	degree
2016	The University of Michigan Distinguished Diversity Leaders Award, awarded by The Office of Diversity, Equity and Inclusion to the Child and Adolescent Gender Services Team under my leadership
2019	Lecturer of the Month, Department of Pediatrics, Michigan Medicine

Teaching

Mentorship

Resident

07/2020-Present	Rebecca Warwick, Michigan Medicine (co-author on publication #22)

Clinical Fellow

07/2017-06/2020	Adrian Araya, Michigan Medicine (co-author on publication #22, book chapter #4)
12/2020-Present	Jessica Jary, Michigan Medicine - Division of Adolescent Medicine

Medical Student

09/2017-06/2020	Michael Ho, Michigan Medicine
07/2019-Present	Hadrian Kinnear, University of Michigan Medical School (co-author on book chapter #3, abstract #3)
07/2019-Present	Jourdin Batchelor, University of Michigan

Teaching Activity

Regional

08/2018-Present	Pediatric Boards Review Course sponsored by U-M: "Thyroid Disorders and Diabetes". Ann Arbor, MI

Institutional

12/2015-12/2015	Pediatric Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
02/2016-02/2016	Medical Student Education: Panelist for M1 Class Session on LGBT Health, Doctoring Curriculum. Michigan Medicine, Ann Arbor, MI
02/2016-02/2016	Psychiatry Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
03/2016-03/2017	Pharmacy School Education: "LGBT Health". University of Michigan School of Pharmacy, Ann Arbor, MI
04/2016-Present	Course Director: Medical Student (M4) Elective in Transgender Medicine. Michigan Medicine, Ann Arbor, MI
04/2016-04/2016	Rheumatology Grand Rounds: "Gender Identity". Michigan Medicine, Ann Arbor, MI
05/2016-05/2016	Lecture to Pediatric Rheumatology Division: "Gender Dysphoria". Michigan Medicine, Ann Arbor, MI
07/2016-07/2016	Internal Medicine Resident Education: "Gender Identity". Michigan Medicine, Ann Arbor, MI
09/2016-09/2016	Presentation to ACU Leadership: "Gender Identity Cultural Competencies". Michigan Medicine, Ann Arbor, MI
10/2016-10/2016	Presentation to Department of Dermatology: "The iPledge Program and Transgender Patients". Michigan Medicine, Ann Arbor, MI
02/2017-02/2017	Swartz Rounds Presenter. Michigan Medicine, Ann Arbor, MI
02/2017-02/2017	Lecture to Division of General Medicine: "Transgender Health". Michigan Medicine, Ann Arbor, MI

02/2017-02/2017	Presentation at Collaborative Office Rounds: "Transgender Health". Michigan Medicine, Ann Arbor, MI
10/2017-10/2017	Family Medicine Annual Conference: "Transgender Medicine". Michigan Medicine, Ann Arbor, MI
12/2017-12/2017	Presenter at Nursing Unit 12-West Annual Educational Retreat: "Gender Identity at the Children's Hospital". Michigan Medicine, Ann Arbor, MI
02/2018-Present	Pediatrics Residency Lecturer: "Puberty". Michigan Medicine, Ann Arbor, MI
02/2019-Present	Medical Student (M1) Lecturer: "Pediatric Growth and Development". Michigan Medicine, Ann Arbor, MI
02/2019-Present	Doctors of Tomorrow Preceptor: offering shadowing opportunities to students from Cass Technical High School in Detroit. Michigan Medicine, Ann Arbor, MI
03/2019-03/2019	Lecture to Division of Orthopedic Surgery: "Transgender Health". Michigan Medicine, Ann Arbor, MI
04/2023-Present	Guest Lecturer in Woman and Gender Studies 400 undergraduate course, University of Michigan

Memberships in Professional Societies

2012 - Present	Pediatric Endocrine Society

Committee/Service

National

2014 - 2016	Pediatric Endocrine Society - Ethics Committee, Other, Member
2017 - present	Pediatric Endocrine Society - Special Interest Group on Gender Identity, Other, Member
2018 - present	Pediatric Endocrine Society - Program Directors Education Committee, Other, Member

Regional

2013 - 2015	Investigational Review Board - The Fenway Institute, Boston, MA, Other, Voting Member

Institutional

2017 - 2019	Department of Pediatrics at Michigan Medicine; Diversity, Equity, and Inclusion Committee, Other, Fellowship Lead
2017 - 2019	University of Michigan Transgender Research Group, Other, Director

Volunteer Service

Volunteer

2014	Camp Physician, Massachusetts, Served at a camp for youth with Type 1 Diabetes

Scholarly Activities

Presentations

Extramural Invited Presentation

Speaker

1. Grand Rounds, **Shumer D**, Loyola University School of Medicine, 07/2022, Chicago, Illinois

Other

1. Gender Identity, Groton School, 04/2015, Groton, MA
2. Television Appearance: Gender Identity in Youth, Channel 7 WXYZ Detroit, 04/2016, Southfield, MI

3. It Gets Better: Promoting Safe and Supportive Healthcare Environments for Sexual Minority and Gender Non-Conforming Youth, Adolescent Health Initiative: Conference on Adolescent Health, 05/2016, Ypsilanti, MI

4. Gender Identity, Humanists of Southeast Michigan, 09/2016, Farmington Hills, MI

5. Gender Identity, Pine Rest Christian Mental Health Services, 10/2016, Grand Rapids, MI

6. Pediatric Grand Rounds - Hormonal Management of Transgender Youth, Beaumont Children's Hospital, 11/2016, Royal Oak, MI

7. Transgender Youth: A Field in Transition, Temple Beth Emeth, 11/2016, Ann Arbor, MI

8. Transgender Youth: A Field in Transition, Washtenaw County Medical Society, 11/2016, Ann Arbor, MI

9. Pediatric Grand Rounds: Transgender Youth - A Field in Transition, St. John Hospital, 02/2017, Detroit, MI

10. Transgender Medicine, Veterans Administration - Ann Arbor Healthcare System, 05/2017, Ann Arbor, MI

11. Gender Identity, Hegira Programs, 05/2017, Detroit, MI

12. Care of the Transgender Adolescent, Partners in Pediatric Care, 06/2017, Traverse City, MI

13. Conference planner, host, and presenter: Transgender and Gender Non-Conforming Youth: Best Practices for Mental Health Clinicians, Educators, & School Staff; 200+ attendees from fields of mental health and education from across Michigan, Michigan Medicine, 10/2017, Ypsilanti, MI

14. Endocrinology Grand Rounds: Transgender Medicine, Wayne State University, 11/2017, Detroit, MI

15. Care of the Transgender Adolescent, St. John Hospital Conference: Transgender Patients: Providing Compassionate, Affirmative and Evidence Based Care, 11/2017, Grosse Pointe Farms, MI

16. Hormonal Care in Transgender Adolescents, Michigan State University School of Osteopathic Medicine, 11/2017, East Lansing, MI

17. Working with Transgender and Gender Non-Conforming Youth, Michigan Association of Osteopathic Family Physicians, 01/2018, Bellaire, MI

18. Community Conversations, Lake Orion, 01/2018, Lake Orion, MI

19. "I Am Jazz" Reading and Discussion, St. James Episcopal Church, 03/2019, Dexter, MI

20. Gender Identity, Michigan Organization on Adolescent Sexual Health, 10/2019, Brighton, MI; Port Huron, MI

21. Ask The Expert, Stand With Trans, 05/2020, Farmington Hills, MI (Virtual due to COVID)

22. Lets Talk About Hormones, Stand With Trans, 10/2020, Farmington Hills, MI (Virtual due to COVID)

23. Transgender Medicine, Michigan Association of Clinical Endocrinologists Annual Symposium, 10/2020, Grand Rapids, MI (Virtual due to COVID)

24. Transgender Youth in Primary Care, Michigan Child Care Collaborative (MC3), 10/2020, Ann Arbor, MI (Virtual due to COVID)

25. Gender Identity, Universalist Unitarian Church of East Liberty, 04/2021, Virtual due to COVID

26. Unconscious Bias, Ascension St. John Hospital, 05/2021, Virtual due to COVID

Publications/Scholarship

(Co-First Author *; Corresponding author **; Co-Last author ***)

Peer-Reviewed

Journal Article

1. **Shumer DE**, Mehringer JE, Braverman LE, Dauber A: Acquired hypothyroidism in an infant related to excessive maternal iodine intake: food for thought. *Endocr Pract*.19(4): 729-731, 01/2013. PM23512394

2. **Shumer DE**, Spack NP: Current management of gender identity disorder in childhood and adolescence: guidelines, barriers and areas of controversy. *Curr Opin Endocrinol Diabetes Obes*.20(1): 69-

73, 02/2013. PM23221495

3. **Shumer DE**, Thaker V, Taylor GA, Wassner AJ: Severe hypercalcaemia due to subcutaneous fat necrosis: presentation, management and complications. *Arch Dis Child Fetal Neonatal Ed*.99(5): F419-F421, 09/2014. PM24907163

4. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples. *Prof Psychol Res Pr*.46(1): 37-45, 01/2015. PM26807001

5. **Shumer DE**, Tishelman AC: The Role of Assent in the Treatment of Transgender Adolescents. *Int J Transgend*.16(2): 97-102, 01/2015. PM27175107

6. **Shumer DE**, Roberts AL, Reisner SL, Lyall K, Austin SB: Brief Report: Autistic Traits in Mothers and Children Associated with Child's Gender Nonconformity. *J Autism Dev Disord*.45(5): 1489-1494, 05/2015. PM25358249

7. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Reply to comment on "Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples" by Tishelman et al. (2015). *Prof Psychol Res Pr*.46(4): 307, 08/2015. PM26858509

8. Guss C, **Shumer D**, Katz-Wise SL: Transgender and gender nonconforming adolescent care: psychosocial and medical considerations. *Curr Opin Pediatr*.27(4): 421-426, 08/2015. PM26087416

9. **Shumer DE**, Nokoff NJ, Spack NP: Advances in the Care of Transgender Children and Adolescents. *Adv Pediatr*.63(1): 79-102, 08/2016. PM27426896

10. **Shumer DE**, Reisner SL, Edwards-Leeper L, Tishelman A: Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic. *LGBT Health*.3(5): 387-390, 10/2016. PM26651183

11. **Shumer DE**, Abrha A, Feldman HA, Carswell J: Overrepresentation of Adopted Adolescents at a Hospital-Based Gender Dysphoria Clinic. *Transgend Health*.2(1): 76-79, 01/2017. PM28861549

12. Edwards-Leeper L, **Shumer DE**, Feldman HA, Lash BR, Tishelman AC: Psychological profile of the first sample of transgender youth presenting for medical intervention in a U.S. pediatric gender center. *Psychology of Sexual Orientation and Gender Diversity*.4(3): 374-382, 01/2017

13. Tishelman AC, **Shumer DE**, Nahata L: Disorders of Sex Development: Pediatric Psychology and the Genital Exam. *J Pediatr Psychol*.42(5): 530-543, 06/2017. PM27098964

14. Strang JF, Meagher H, Kenworthy L, de Vries AL C, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, **Shumer DE**, Edwards-Leeper L, Pleak RR, Spack N, Karasic DH, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kuschner ES, Mandel F, Caretto A, Lewis HC, Anthony LG: Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. *J Clin Child Adolesc Psychol*.47(1): 105-115, 01/2018. PM27775428

15. Mohnach L, Mazzola S, **Shumer D**, Berman DR: Prenatal diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol. *Case Reports in Perinatal Medicine*.8(1)01/2018

16. Kim C, Harrall KK, Glueck DH, **Shumer D**, Dabelea D: Childhood adiposity and adolescent sex steroids in the EPOCH (Exploring Perinatal Outcomes among Children) study. *Clin Endocrinol (Oxf)*.91(4): 525-533, 01/2019. PM31278867

17. Selkie E, Adkins V, Masters E, Bajpai A, **Shumer D**: Transgender Adolescents' Uses of Social Media for Social Support. *J Adolesc Health*.66(3): 275-280, 03/2020. PM31690534

18. Araya AC, Warwick R, **Shumer D**, Selkie E: Romantic Relationships in Transgender Adolescents: A Qualitative Study. *Pediatrics*.147(2)02/2021. PM33468600

19. Vengalil N, **Shumer D**, Wang F: Developing an LGBT curriculum and evaluating its impact on dermatology residents. *Int J Dermatol*.61: 99-102, 01/2022. PM34416015

20. Warwick RM, Araya AC, **Shumer DE**, Selkie EM: Transgender Youths' Sexual Health and Education: A Qualitative Analysis. *J Pediatr Adolesc Gynecol*.35(2): 138-146, 04/2022. PM34619356

21. Warwick RM, **Shumer DE**: Gender-affirming multidisciplinary care for transgender and non-binary children and adolescents. *Children's Health Care*.52(1): 91-115, 01/2023

Books

1. Clara A-V, Bizic M, Bockting WO, Bouman M-B, Bowers ML, Buncamper ME, Capitán L, Castillo M, Chim HW, Colebunders B, Crane C, D'Arpa S, Djordjevic ML, Estes C, Fein LA, Gasgarth R, Hoebeke P, Horne M, Joumblat NR, Kojic S, Levine JP, Lumen N, Meijerink WJ H J, Monstrey SJ, Salgado CJ, **Shumer DE**, Simon D, Sinha VR, Sinha VK, Spack NP, Sputova K, Stanojevic D, Stojanovic B, Tarsha AA, Thomas JP, van der Sluis WB, Volker MK, Weiss RE, Yamaguchi Y, Zhao LC, Zoghbi Y. *Gender Affirmation Medical & Surgical Perspectives*. Thieme, (2017)

Chapters

1. **Shumer D**: Coma. In Schwartz MW *The 5-Minute Pediatric Consult*,6, Lippincott Williams & Wilkins, Philadelphia, PA, (2012)

2. **Shumer D**, Spack N: Medical Treatment of the Adolescent Transgender Patient. In Đorđević M, Monstrey SJ, Salgado CJ Eds. *Gender Affirmation: Medical and Surgical Perspectives*,CRC Press/Taylor & Francis, (2016)

3. **Shumer DE**, Kinnear HA: Duration of Pubertal Suppression and Initiation of Gender-Affirming Hormone Treatment in Youth. In Finlayson *Pubertal Suppression in Transgender Youth*,Elsevier, (2018)

4. **Shumer DE**, Araya A: Endocrinology of Transgender Care – Children and Adolescents. In Poretsky, Hembree Ed. *Transgender Medicine: A Multidisciplinary Approach*,Springer, (2019)

Non-Peer Reviewed

Commentary

1. Martin S, Sandberg ES, **Shumer DE**: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and Adolescents. *New England Journal of Medicine*.385(7): 579-581, 05/2021. PM34010528

Comparative Study

1. Reisner SL, Vetters R, Leclerc M, Zaslow S, Wolfrum S, **Shumer D**, Mimiaga MJ: Mental health of transgender youth in care at an adolescent urban community health center: a matched retrospective cohort study. *J Adolesc Health*.56(3): 274-279, 03/2015. PM25577670

Editorial Comment

1. **Shumer DE**, Harris LH, Opipari VP: The Effect of Lesbian, Gay, Bisexual, and Transgender-Related Legislation on Children. 11/2016. PM27575000

2. **Shumer DE**: Health Disparities Facing Transgender and Gender Nonconforming Youth Are Not Inevitable, 01/2018. PM29437859

3. Martin S, Sandberg ES, **Shumer DE**: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and Adolescents, 01/2021

Erratum

1. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Correction to Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples, [Professional Psychology: Research and Practice, 46(1), (2015) 37-45]. *Professional Psychology: Research and Practice*.46(4): 249, 08/2015

Letter

1. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, **Shumer D**, Register-Brown K, Sadikova E, Anthony LG: Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals. *J Am Acad Child Adolesc Psychiatry*.57(11): 885-887, 11/2018. PM30392631

Letter to editor

1. **Shumer D**: Doctor as environmental steward, 01/2009. PM19364173

News

1. **Shumer DE**, Spack NP: Paediatrics: Transgender medicine--long-term outcomes from 'the Dutch model'. *Nat Rev Urol*.12(1): 12-13, 01/2015. PM25403246

Other

1. **Shumer D**: The Effect of Race and Gender Labels in the Induction of Traits. *Northwestern Journal of Race and Gender Criticism*.NA01/2014

2. **Shumer D**: A Tribute to Medical Stereotypes. *The Pharos, Journal of the Alpha Omega Alpha Medical Society*.Summer07/2017

3. Mohnach L, Mazzola S, **Shumer D**, Berman DR: Prenatal Diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol. *Case Reports in Perinatal Medicine*.8(1)12/2018

4. Araya A, **Shumer D**, Warwick R, Selkie E: 37. “I’ve Been Happily Dating For 5 Years” - Romantic and Sexual Health, Experience and Expectations in Transgender Youth. *Journal of Adolescent Health*.66(2): s20, 02/2020

5. Araya A, **Shumer D**, Warwick R, Selkie E: 73. "I think sex is different for everybody" - Sexual Experiences and Expectations in Transgender Youth. *Journal of Pediatric and Adolescent Gynecology*.33(2): 209-210, 04/2020

6. Araya AC, Warwick R, **Shumer D**, Selkie E, Rath T, Ibrahim M, Srinivasan A: Romantic Health in Transgender Adolescents. *Pediatrics*.Pediatrics01/2021

Podcast

1. Gaggino L, Shumer WG D: Pediatric Meltdown: Caring for Transgender Youth with Compassion: What Pediatricians Must Know, 01/2020

Abstract/Posters

1. **Shumer D**: Overrepresentation of Adopted Children in a Hospital Based Gender Program, World Professional Association of Transgender Health Biennial International Symposium, Amsterdam, The Netherlands, 2016

2. **Shumer D**: Mental Health Presentation of Transgender Youth Seeking Medical Intervention, World Professional Association of Transgender Health Biennial International Symposium, Amsterdam, The Netherlands, 2016

3. **Shumer D**, Kinnear H, McLain K, Morgan H: Development of a Transgender Medicine Elective for 4th Year Medical Students, National Transgender Health Summitt, Oakland, CA, 2017

4. Adkins V, Masters E, **Shumer D**, Selkie E: Exploring Transgender Adolescents' Use of Social Media for Support and Health Information Seeking (Poster Presentation), Pediatric Research Symposium, Ann Arbor, MI, 2017

5. Sandberg E, Baines HK, Aye T, Hart-Unger S, Lopez X, Nikita ME, Nokoff NJ, Persky R, **Shumer D**, Harris RM, Roberts SA: National Assessment for the Need of a Comprehensive Pediatric Gender Affirming Care Curriculum, Poster, Pediatric Endocrine Society Meeting, Virtual, 2021

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Allen, N. G., Krishna, K. B., & Lee, P. A. (2021). Use of gonadotropin-releasing hormone analogs in children. *Current opinion in pediatrics*, *33*(4), 442–448.

Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

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Campbell, Travis and Rodgers, Yana van der Meulen, Conversion Therapy, Suicidality, and Running Away: An Analysis of Transgender Youth in the U.S. (November 15, 2022). Available at SSRN: http://dx.doi.org/10.2139/ssrn.4180724

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Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Med.* 2023 Jan 19;388(3):240-250.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No.

DECLARATION OF JACK TURBAN, MD, MHS.

I, JACK TURBAN, MD, MHS hereby declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein.

3. In preparing this declaration, I reviewed Indiana Senate Enrolled Act 480 (hereafter "S.E.A. 480" or "the ban"). In addition to that legislation and the materials cited herein, as set out in the attached Bibliography (**Exhibit B**), I have also relied on my years of research and other experience, as set out in my curriculum vitae (**Exhibit A**) in forming my opinions. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

BACKGROUND AND QUALIFICATIONS

4. I am currently an Assistant Professor of Child & Adolescent Psychiatry at the University of California, San Francisco School (UCSF) of Medicine, where I am also Affiliate Faculty at the Philip R. Lee Institute for Health Policy Studies. As a member of the faculty at UCSF, I serve as director of the Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry. I also serve as an attending psychiatrist in the adult LGBT psychiatry clinic, and in the eating disorders program. I conduct research focusing on the determinants of mental health among transgender youth and teach medical students, psychology trainees, psychiatry residents, and child and adolescent psychiatry fellows.

5. I received my undergraduate degree in neuroscience from Harvard College. I received both my MD and Master of Health Science (MHS) degrees from Yale University School of Medicine. I completed residency training in general psychiatry in the combined Massachusetts General Hospital / McLean Hospital residency training program (Harvard Medical School) and fellowship training in child and adolescent psychiatry at Stanford University. I am board certified in psychiatry by The American Board of Psychiatry and Neurology.

6. My research focuses on the mental health of transgender youth and youth experiencing gender dysphoria. While at Yale, I was awarded the Ferris Prize for my thesis entitled "Evolving Treatment Paradigms for Transgender Youth." In 2017, I received the United States Preventative Health Services Award for Excellence in Public Health based on my work related to the mental health of transgender youth. I have lectured on the mental health of transgender youth at Yale School of Medicine, UCSF, Stanford University, and The Massachusetts General Hospital (a teaching hospital of Harvard Medical School). I have given invited grand rounds presentations at academic institutions around the country and have presented nationally and internationally on

topics related to the mental health of transgender people and people experiencing gender dysphoria.

7. I have served as a manuscript reviewer for numerous professional publications, including *The Journal of The American Medical Association (JAMA)*, *JAMA Pediatrics*, *JAMA Psychiatry*, *The Journal of The American Academy of Child & Adolescent Psychiatry*, *Pediatrics*, *The Journal of Adolescent Health*, and *The American Journal of Public Health*. I received commendation as a top peer reviewer from *Annals of Internal Medicine*, the academic journal of the American College of Physicians. I have served as lead author for textbook chapters on the mental health of transgender youth, including for *Lewis's Child & Adolescent Psychiatry: A Comprehensive Textbook* and the textbook of The International Academy for Child & Adolescent Psychiatry and Allied Professionals. I am co-editor of the textbook *Pediatric Gender Identity: Gender-Affirming Care for Transgender and Gender Diverse Youth.*

8. I have published extensively on the topic of transgender youth, including ten articles in peer-reviewed journals within the past two years.

9. In the last four years, I have been retained as an expert and provided testimony at trial or by deposition in the following case: *Brandt et al. v. Rutledge, et al.*, No. 21-CV-450 (D. Ark. 2021) (deposition and trial testimony).

10. I am being compensated at an hourly rate of $400 per hour for preparation of expert declarations and reports and time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

SUMMARY OF OPINIONS

11. In this declaration, I cite relevant literature to support my opinions that: (1) gender-affirming medical interventions improve mental health for adolescents with gender dysphoria when medically indicated, (2) adolescents who experience gender dysphoria at the onset of puberty rarely come to identify with their assigned sex at birth, and (3) regret among individuals receiving medical treatment for gender dysphoria is uncommon.

GENDER-AFFIRMING MEDICAL INTERVENTIONS IMPROVE MENTAL HEALTH OUTCOMES FOR ADOLESCENTS WITH GENDER DYSPHORIA WHEN MEDICALLY INDICATED

12. Existing research shows gender-affirming medical treatments for adolescents with gender dysphoria are consistently linked to improved mental health, and denial of such care is expected to lead to adverse mental health outcomes, including, in some instances, worsening suicidality.

13. All relevant major medical organizations have highlighted the importance of this care and have issued explicit statements opposing bans on gender-affirming medical care for adolescents with gender dysphoria. These organizations include The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American College of Physicians, The American Academy of Family Physicians, The American Academy of Child & Adolescent Psychiatry, The Endocrine Society, The Pediatric Endocrine Society, The World Professional Association for Transgender Health, and the United States Professional Association for Transgender Health.[1]

[1] Turban, J. L., Kraschel, K. L., & Cohen, I. G. (2021). Legislation to criminalize gender-affirming medical care for transgender youth. *JAMA*, *325*(22), 2251-2252 (listing statements).

14. Peer-reviewed cross-sectional and longitudinal studies[2] have found that pubertal suppression is associated with a range of improved mental health outcomes for adolescents with gender dysphoria, including statistically significant improvements in internalizing psychopathology (*i.e.*, anxiety and depression), externalizing psychopathology (*e.g.*, disruptive behaviors), global functioning, and suicidality.[3] For example, in the realm of cross-sectional studies, Turban et al. *Pediatrics* 2020 found that, after controlling for a range of other variables, those who accessed pubertal suppression had lower odds of lifetime suicidal ideation than those who desired but were unable to access this intervention during adolescence.[4] A similar study by van der Miesen et al. in the *Journal of Adolescent Health* compared 272 adolescents who had not yet received pubertal suppression with 178 adolescents who had been treated with pubertal

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[2] A note on methodology: cross-sectional studies examine mental health at a single point in time. For example, van der Miesen et al. 2020 *Journal of Adolesent Health* compared, at a single time point, those who accessed pubertal suppression with those who desired but had not accessed it and found that those who accessed care had better mental health. Longitudinl studies examine multiple time points (*e.g.*, looking at levels of suicidality before and after gender-affirming medical care).

[3] See for example, de Vries, A.L., Steensma, T.D., Doreleijers, T.A., & Cohen-Kettenis, P.T. (2011). Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study. *The Journal of Sexual Medicine*, 8(8), 2276-2283., Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*, 145(2):e20191725., van der Miesen, A.I., Steensma, T.D., de Vries, A.L., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704., and Achille, C., Taggart, T., Eaton, N.R., *et al*. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*, 2020(8), 1-5.

[4] Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*, 145(2):e20191725.

suppression.[5] Those who had received pubertal suppression had statistically significant lower "internalizing psychopathology" scores (a measure of anxiety and depression). Longitudinal studies have yielded similar results.[6]

15. Peer-reviewed research studies have likewise found improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen or testosterone) for individuals with gender dysphoria, including adolescents. These include statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and depression), general well-being, and suicidality.[7] For example, Chen et al. followed a cohort of 315 transgender youth receiving gender-affirming hormone treatment and found improvements in anxiety, depression, and life

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5 van der Miesen, A.I., Steensma, T.D., de Vries, A.L., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704.

6 See for example, de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al*. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, 134(4), 696-704 and Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, *12*(11), 2206-2214.

7 See for example, Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., ... & Olson-Kennedy, J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine*, *388*(3), 240-250., Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311., Achille, C., Taggart, T., Eaton, N.R., *et al*. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*, 2020(8), 1-5., and de Lara, D.L., Rodríguez, O.P., Flores, I.C., *et al*. (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48.

satisfaction.[8] Similarly, Allen et al. followed a cohort of 47 adolescents with gender dysphoria, and found statistically significant improvements in general well-being and suicidality, as measured by the National Institutes of Health "Ask Suicide Screening Questions" instrument.[9] Cross-sectional studies comparing those who accessed gender-affirming hormones during adolescence to those who did not access these interventions have similarly linked access to gender-affirming hormone treatment during adolescence to lower odds of suicidality.[10]

16. Peer-reviewed research has also shown improvements in mental health following gender-affirming chest surgery[11] for transmasculine adolescents with gender dysphoria, where medically indicated.[12] A study by Tang et al. examined 209 adolescents who had undergone

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8 Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., ... & Olson-Kennedy, J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine*, *388*(3), 240-250.

9 Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

10 See for example, Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, *17*(1), e0261039 and Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health*, *70*(4), 643-649.

11 Of note, all surgical interventions in pediatrics (for gender dysphoria or otherwise) are approached with substantial caution, given the risks inherit with any kind of surgery. Gender-affirming chest surgery is only considered for adolescents with gender dysphoria when an interdisciplinary team, including medical providers, surgical providers, mental health providers, the adolescent, and their legal guardians are in agreement that the benefits of such an intervention would outweigh the risks.

12 Olson-Kennedy, J., Warus, J., Okonta, V., *et al*. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*, 172(5), 431-436; Mehringer, J.E., Harrison, J.B., Quain, K.M., *et al*. (2021). Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth. *Pediatrics*, 147(3):e2020013300. Large studies of

gender-affirming chest surgery between 2013 and 2020 and found an extremely low rate of post-operative regret (0.95%).[13]

17. Overall, as summarized above, existing peer-reviewed published research studies consistently link gender-affirming medical interventions to improved mental health for individuals with gender dysphoria, including adolescents.

18. Though lawmakers advocating for laws like S.E.A. 480 have claimed that gender-affirming medical care is "experimental in nature," that is not correct. In ascribing this term to gender-affirming medical interventions, some people allude to the fact that pubertal suppression and gender-affirming hormones do not have FDA indications for gender dysphoria specifically, but rather for other conditions. Prescribing FDA-approved medications without specific FDA indications for the condition being treated is common in medicine generally and particularly in pediatrics. It is referred to as "off-label" prescribing.[14] The American Academy of Pediatrics has explained, "it is important to note that the term 'off-label' does not imply an improper, illegal, contraindicated, or investigational use."[15] The Academy goes on to explain that "off-label use of

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primarily adults have also shown high rates of satisfaction with gender-affirming chest surgery; for example, a recent systematic review that included data from 1,052 transmasculine patients found that pooled overall postoperative satisfaction was 92%. Bustos, V.P., Bustos, S.S., Mascaro, A., *et al*. (2021). Transgender and Gender-Nonbinary Patient Satisfaction After Transmasculine Chest Surgery. *Plastic and Reconstructive Surgery Global Open*, 9(3):e3479.

13 Tang, A., Hojilla, J. C., Jackson, J. E., Rothenberg, K. A., Gologorsky, R. C., Stram, D. A., ... & Yokoo, K. M. (2022). Gender-affirming mastectomy trends and surgical outcomes in adolescents. *Annals of Plastic Surgery*, *88*(4), S325-S331

14 American Academy of Pediatrics Committee on Drugs. (2014). Policy Statement: Off-label use of drugs in children. *Pediatrics*, *133*(3), 563-567.

15 *Id.*

medications is neither experimentation nor research." A substantial body of evidence links gender-affirming medical interventions to improved mental health outcomes for adolescents with gender dysphoria, who, without treatment, experience higher levels of depression, anxiety, and suicidality. While each of these studies—as with all studies in medicine—has strengths and limitations, and no one study design can answer all questions regarding an intervention, taken together, these studies indicate that gender-affirming medical care improves mental health for adolescents who require such care.

19. Other than the gender-affirming medical care banned under S.E.A. 480, there are no evidence-based treaments for adolescents with gender dysphoria. There are no evidence-based psychotherapy protocols that effectively treat gender dysphoria. If the ban were to go into effect, medical and mental health providers would be left with no evidence-based treatment approaches to support their adolescent patients with gender dysphoria. This would be a devastaing situation for adolescents and their parents, physicians, and other mental health providers who care for them.

20. In the past, some clinicians have described psychotherapeutic strategies that aimed to result in youth with gender dysphoria identifying with their sex assigned at birth.[16] Such practices, termed "gender identity conversion efforts" have subsequently been linked to adverse mental health outcomes, including suicide attempts.[17] In addition to being linked with these particular harms, there is no peer-reviewed research to suggest that these gender identity conversion efforts are successful in changing a person's gender identity from transgender to

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16 Meyer-Bahlburg, H.F. (2002). Gender Identity Disorder in Young Boys: A Parent-and Peer-Based Treatment Protocol. *Clinical Child Psychology and Psychiatry*, 7(3), 360-376.

17 Turban, J.L., Beckwith, N., Reisner, S.L., & Keuroghlian, A.S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, 77(1), 68-76.

cisgender. Gender identity conversion efforts have been labelled unethical by major medical organizations including The American Medical Association[18] and The American Academy of Child & Adolescent Psychiatry.[19]

21. The body of research demonstrating the efficacy of the banned treatments for gender dysphoria in adolescents, include longitunal studies that follow patients for a substantial period of time. One study by deVries et al. in the journal *Pediatrics* examined mental health outcomes a mean 5.9 years after starting pubertal suppression.[20] Turban et al. 2022 *PLoS One*, which found associations between access to gender-affirming hormone treatment during adolescence and better mental health outcomes, similarly examined mental health outcomes a mean six to seven years after starting gender-affirming hormones. [21] To put this into context, a major study used by the FDA to approve the medication lurasidone for bipolar depression in children and adolescents followed study participants for six weeks.[22] If the state were to ban all

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18 American Medical Association. (2017). Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations. H-160.991. *Available at* https://policysearch.ama-assn.org/policyfinder/detail/gender%20identity?uri=%2FAMADoc%2FHOD.xml-0-805.xml.

19 The American Academy of Child & Adolescent Psychiatry. (2018). Conversion Therapy. *Available at* https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

20 de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al*. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, 134(4), 696-704.

21 Turban J.L., King D., Kobe J., Reisner S.L., Keuroghlian A.S. (2022) Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*. 17(1): e0261039.

22 DelBello, M. P., Goldman, R., Phillips, D., Deng, L., Cucchiaro, J., & Loebel, A. (2017). Efficacy and safety of lurasidone in children and adolescents with bipolar I depression: a double-blind, placebo-controlled study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(12), 1015-1025.

medications that lack at least a decade of long-term follow up studies, that would require banning a significant portion of FDA-approved and relied-upon medications.

22. Given the well-documented benefits of gender-affirming medical care outlined above, and the known harms of untreated adolescent gender dysphoria, banning this care is expected to lead to substantial deterioration of mental health for adolescents with gender dysphoria. For many of these patients, this is likely to include worsening suicidality.[23] A recent qualitative study of 273 parents of transgender youth identified that bans on gender-affirming care led to substantial concerns that their children would have worsening mental health and be at an increased risk of death from suicide.[24] These parents implored lawmakers to leave critical decisions about gender-affirming medical interventions to families and their medical providers.[25] Another qualitative study of 103 healthcare providers who care for transgender youth similarly identified substantial concerns that such bans would lead to worsening mental health and increased risk of suicide for adolescents with gender dysphoria.[26]

ADOLESCENTS WHO EXPERIENCE GENDER DYSPHORIA AT THE ONSET OF PUBERTY RARELY COME TO IDENTIFY WITH THEIR ASSIGNED SEX AT BIRTH

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[23] See, for example, Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health*, *70*(4), 643-649 and other studies cited above.

[24] Kidd, K. M., Sequeira, G. M., Paglisotti, T., Katz-Wise, S. L., Kazmerski, T. M., Hillier, A., ... & Dowshen, N. (2021). "This could mean death for my child": Parent perspectives on laws banning gender-affirming care for transgender adolescents. *Journal of Adolescent Health*, *68*(6), 1082-1088.

[25] *Id.*

[26] Hughes, L. D., Kidd, K. M., Gamarel, K. E., Operario, D., & Dowshen, N. (2021). "These laws will be devastating": Provider perspectives on legislation banning gender-affirming care for transgender adolescents. *Journal of Adolescent Health*, *69*(6), 976-982.

23. Though the terms "children" and "adolescents" are sometimes used synonymously in common parlance, these terms have specific and distinct meanings in the context of child and adolescent psychiatric research. In this field, "child" and "children" refer to minors who have not yet reached the earliest stages of puberty. The terms "adolescent" and "adolescents" refer to minors who have begun puberty. Studies of prepubertal children (who are not candidates for gender-affirming medical interventions under any existing clinical guidelines) cannot be conflated with studies of adolescents (who, depending on several factors, may be candidates for various forms of gender-affirming medical interventions).

24. This distinction is vital in the realm of "desistence" studies (*i.e.*, studies that aim to assess how many young people who identify as transgender will later identify as cisgender). The suggestion that a majority of transgender minors affected by the ban will come to identify with their assigned sex at birth inappropriately relies on studies of gender diverse *prepubertal* children, which have, in the past, shown that many of these children will not grow up to be transgender. These studies do not apply to transgender minors who have reached puberty (*i.e.*, "adolescents"). Once a transgender youth begins puberty, it is rare for them to later identify as cisgender.[27] Furthermore, physicians and families must weigh the low risk of a future cisgender identification against the often substantial risk of deteriorating mental health due to active gender dysphoria. Under existing medical guidelines, any minor who is considering gender-affirming medical or

[27] See for example de Vries, A.L., McGuire, J.K., Steensma, T.D., *et al*. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, 134(4), 696-704., Turban, J.L., de Vries, A.L.C., & Zucker, K. (2018). Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., & Volkmar F.R. (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition*. Philadelphia: Wolters Kluwer.

surgical interventions must first work with a mental health professional to conduct a complete biopsychosocial evaluation,[28] which includes ensuring that an adolescent and their parents understand the complexity of this decision. Such evaluations are designed to minimize regret rates.

25. Any study regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess the interventions targeted by the ban, namely, pubertal suppression, hormone therapy, and gender-affirming surgery, since none of these interventions are provided to prepubertal patients under current medical guidelines.[29]

26. Further, the utility of "desistence" studies even for assessing the likelihood that prepubertal children will persist in a transgender identity has been questioned due to their reliance on an outdated diagnosis of "gender identity disorder in children," which did not require a child to identify as a sex different than their sex assigned at birth. This diagnosis likely captured many cisgender "tomboys" or cisgender boys with feminine interests like dresses or dolls who never identified as transgender and, thus, unsurprisingly did not identify as transgender when followed up with later in life. In contrast, the diagnosis of "gender dysphoria in children" requires one to not merely have gender atypical interests and behaviors; one must identify as a gender different than one's sex assigned at birth. This is a vital distinction. While the diagnostic category of "gender identity disorder" would capture many cisgender children, the diagnostic category of "gender dysphoria," by definition, does not.[30] Of note, a recent study by Olson et al. found that

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28 Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., ... & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, *102*(11), 3869-3903.

29 *Id.*

30 The desistance have also been criticized for a range of methodological limitations. Olson, K.R. (2016). Prepubescent Transgender Children: What We Do and Do Not

the vast majority of prepubertal transgender children continued to identify as transgender over a five-year follow-up period.[31] Another study from this research group showed that prepubertal social transition does not alter gender identification or preferences, arguing against the notion that social transition increases "persistence" likelihood.[32]

REGRET AMONG INDIVIDUALS RECEIVING MEDICAL TREATMENT FOR GENDER DYSPHORIA IS UNCOMMON

27. De-transition and transition regret are distinct concepts, and transition regret is uncommon.

28. The term "de-transition" is used inconsistently in the literature and may sometimes refer to simply the stopping of medical interventions. Discontinuation of gender-affirming medical interventions does not always coincide with a change in understanding of one's gender identity or with transition-related regret. Rather, transgender adolescent patients who discontinue gender-affirming medical interventions may do so becuase of external factors (*e.g.*, pressure from family, societal rejection, harassment by peers). They may also discontinue gender-affirming medical interventions because they have achieved the needed effects from these medications, are satisfied with the intended effects, and no longer require the medications. A substantial number of currently identified transgender people (13.1%) have "de-transitioned" at some point in their life, with the

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Know. *Journal of the American Academy of Child & Adolescent Psychiatry*, 3(55), 155-156.

31 Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender identity 5 years after social transition. *Pediatrics*, *150*(2).

32 Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, *30*(5), 669-681.

majority (82.5%) citing external factors like family rejection, societal stigma, or harassment.[33] Given that these people *currently* identify as transgender, it highlights that many people who "de-transition" choose to transition again in the future.

29. Studies focused specifically on regret, as opposed to the broad heterogeneous category of "de-transition," indicate that regret is extremely rare. In 2018, Amsterdam's VUMC Center of Expertise on Gender Dysphoria published the rates of regret among their cohort of 6,793 transgender patients who had undergone gender-affirming medical and/or surgical interventions.[34] Among transgender women with gender dysphoria who underwent gender-affirming surgery, 0.6% experienced regret. Among transgender men with gender dysphoria who underwent gender-affirming surgery, 0.3% experienced regret. Several of those who experienced regret were classified as having "social regret" rather than "true regret," defined in the study as still identifying as transgender but deciding to reverse their gender-affirming surgery due to factors like "the loss of relatives [being] a large sacrifice." The study also reported that only 1.9% of adolescents who started pubertal suppression did not choose to go onto gender-affirming hormones. In a second study of 143 transgender adolescents who started pubertal suppression, five adolescents (3.5%) decided not to proceed with further gender-affirming medical treatments.[35] One of these

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33 Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*, 8(4), 273-280.

34 Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, *15*(4), 582-590.

35 Brik, T., Vrouenraets, L. J., de Vries, M. C., & Hannema, S. E. (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. *Archives of Sexual Behavior*, 49(7), 2611-2618.

adolescents noted that pubertal suppression helped them to better understand their gender identity, and they ultimately identified with their sex assigned at birth. One birth-assigned female had ongoing chest dysphoria but chose to live with a female gender expression regardless, though was dreading further breast development and menstruation. One stopped due to unspecified "psychosocial reasons" but continued to identify as transgender. One identified as gender non-binary and felt they no longer needed treatment. One came to identify with his sex assigned at birth. There was no indication that any of these adolescents *regretted* pubertal suppression; rather, this study shows that the treatment served its goal of allowing adolescents more time to better understand their gender identity before being assessed for additional treatment. Cases of initiating then discontinuing gender-affirming hormones like estrogen or testosterone appear to be uncommon, largely at the case report level.[36] In one of these case reports, a patient similarly noted that a trial of estrogen helped them to better understand their gender identity, which had evolved to non-binary, and they did not regret initiating estrogen therapy.[37] Though there have been scattered and difficult-to-confirm social media reports of people regretting gender-affirming medical care, this must be considered in the context of the 1.4 million transgender people in the United States alone.[38]

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[36] A case report is a publication in which clinicians report on what occurred with a single patient.

[37] Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, *172*(10), 903-904.

[38] Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). How Many Adults Identifyas Transgender in the United States? Los Angeles: The Williams Institute.

30. All treatments in medicine carry risks, benefits, and side effects. It is essential that parents, adolescents, and their doctors be able to work together to weigh these factors and choose a path forward that is *most likely* to improve a young person's health, including their mental health. If the government were to ban all medical treatments with potential adverse side effects or the possibility of regret, it would ban essentially of all medicine. As one example, the vast majority of people who take the antibiotic penicillin find that their infections resolve; however, a small number of people will experience Stevens-Johnson syndrome (SJS) or toxic epidermal necroylysis (TEN) from the medication – rare potentially fatal conditions in which the person's skin detaches.[39] Mortality rates from SJS/TEN are as high as 50%. The cholesterol-lowering medication atorvastatin (known to many under the brand name Lipitor) is one of the most commonly prescribed medications in the U.S., given its potential to lower cholesterol and subsequently reduce the risk of a heart attack. However, a small number of people will experience rhabdomyolysis as a side effect – a potentially fatal form of muscle breakdown that can cause kidney damage. Though both these medications carry a serious risk of adverse side effects, they help the vast majority of people, and thus should not be—and are not—banned. The responsibility of the provider of care is to inform patients about these risks, benefits, and potential side effects, and work with patients and families to identify the best course of action. Gender-affirming care is not unique in carrying risks, side effects, or the possibility of regret.

31. While there is undoubtedly a small number of people who start gender-affirming medical interventions and later stop them, only a minority of this small number appear to regret the treatment, and existing research suggests that regret following gender-affirming medical

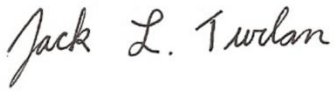
[39] Lee, E. Y., Knox, C., & Phillips, E. J. (2023). Worldwide Prevalence of Antibiotic-Associated Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: A Systematic Review and Meta-analysis. *JAMA Dermatology.*

interventions is rare. As with all medical interventions, gender-affirming medical interventions cannot claim a 100% success rate. However, for the vast majority of adolescents, these interventions improve mental health. Accordingly, it is dangerous to take the only evidence-based treatment option away from families and physicians as they work together to examine existing evidence and their individual case to determine what pathway is most likely to result in favorable mental health outcomes for an adolescent.

CONCLUSION

32. In summary, gender-affirming medical care for adolescent gender dysphoria, when medically indicated, is supported by a substantial body of peer-reviewed scientific evidence that has been collected over more than a decade. Though these treatments, like all medical treatments, carry potential risks and side effects, these must be weighed against the benefits of treatment. There is nothing anamolous about the risks and side effects of treatment for gender dysphoria that would warrant singling out this care for prohibition. It is essential that physicians be able to work with adolescents and their families to weigh benefits against potential risks and side effects and provide the care that is appropriate for a given adolescent and their family. Banning these medical interventions would leave physicians without any evidence-based treatments for adolescent gender dysphoria, which, when left untreated, has been linked to dramatic adverse mental health outcomes, including suicidality. For these reasons, all relevant major medical organizations (The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American Academy of Child & Adolescent Psychiatry, The Endocrine Society, and The Pediatric Endocrone Society, to name a few) oppose bans on gender-affirming medical care for adolescents with gender dysphoria.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.



Executed on: April 18, 2023 JACK L. TURBAN, MD, MHS

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ACADEMIC APPOINTMENTS

University of California, San Francsisco School of Medicine San Francisco, CA. September 2022-Present
Assistant Professor of Child & Adolescent Psychiatry and Affiliate Faculty in the Philip R. Lee Institute for Health Policy Studies. Responsibilities include directing the Gender Psychiatry Program and serving as an attending psychiatrist in the adult gender and sexual minority clinic, and in the eating disorders clinic, as well as research focusing on the determinants of mental health among transgender and gender diverse youth and the teaching of medical students, residents, and fellows.

EDUCATION & TRAINING

Stanford University School of Medicine Palo Alto, CA July 2020-Present
Fellow in Child & Adolescent Psychiatry. Fellow in child and adolescent psychiatry. Research focuses on pediatric gender identity and LGBTQ mental health. Serves as administrative chief fellow 2021-2022.

Massachusetts General Hospital & McLean Hospital Boston, MA July 2017 – May 2020
Integrated Adult, Child, & Adolescent Psychiatry Resident. Resident physician in the integrated adult, child, and adolescent psychiatry program. Research focused on pediatric gender identity and LGBT mental health.

Yale School of Medicine New Haven, CT. August 2012- May 2017
Doctor of Medicine & Master of Health Science with honors. Clinical rotations included inpatient pediatrics, inpatient child psychiatry, inpatient adolescent psychiatry, residential adolescent psychiatry, psychiatric consult liaison service, clinical neuromodulation, neurology clinics, and neurosurgery. Completed award-winning masters' thesis as a Howard Hughes Medical Institute (HHMI) medical research fellow on evolving treatment paradigms for transgender youth.
Clerkship Grades: All Honors
USMLE: Step 1 (252), Step 2 (256)

Harvard University Cambridge, MA September 2007- May 2011
B.A. Neurobiology magna cum laude with a secondary in the Dramatic Arts. Coursework included clinical neuroscience, systems neurobiology, visual neuroscience, positive psychology, neurobiology of behavior, CNS regenerative techniques, neuroanatomy, vertebrate surgery, and extensive coursework in dramatic theory and practice. International study included Spanish language (Alicante, Spain), stem cell biology (Shanghai, China), and studying how visual art may be used as a window into the mechanisms of neural processing (Trento, Italy). Honors thesis completed at The Massachusetts Eye & Ear Infirmary studying inner-ear development and regeneration. GPA: 3.8/4.0

SELECTED PEER REVIEWED PUBLICATIONS: ORIGINAL RESEARCH

Turban J.L., Dolotina B., Freitag T.M., King D., Keuroghlian A.S. Age of realization of transgender identity and mental health outcomes among transgender and gender diverse adults: examining the "rapid onset gender dysphoria" hypothesis. *Journal of Adolescent Health*. [Online First]

Turban J.L., Dolotina B., King D., Keuroghlian A.S. (2022) Sex assigned at birth ratio among transgender and gender diverse adolescents in the United States. *Pediatrics*. [Online First]

Turban J.L., King D., Kobe J., Reisner S.L., Keuroghlian A.S. (2022) Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE*, 17(1): e0261039.

Passell E., Rutter L.A., **Turban J.L.**, Scheuer L., Wright N., Germine L. (2021) Generalized Anxiety Disorder Symptoms are Higher Among Same- and Both-Sex Attracted Individuals in a Large, International Sample. *Sexuality Research and Social Policy*. [ePub ahead of print]

Lewis, J. M., Monico, P. F., Mirza, F. N., Xu, S., Yumeen, S., **Turban, J. L.**, Galan A., & Girardi, M. (2021). Chronic UV radiation–induced RORγt+ IL-22–producing lymphoid cells are associated with mutant KC clonal expansion. *Proceedings of the National Academy of Sciences*, 118(37).

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Turban J.L., King, D., Li, J.L., Keuroghian, A.S. (2021) Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes. *Journal of Adolescent Health*. 69(6), 991-998.

Turban J.L., Loo, S. S., Almazan, A. N., Keuroghlian, A.S. (2021) Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*. 8(4), 273-280.

Turban, J. L., Passell E, Scheer L, Germine L. (2020) Use of Geosocial Networking Applications Is Associated With Compulsive Sexual Behavior Disorder in an Online Sample. *The Journal of Sexual Medicine*. 17(8), 1574-1578.

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725.

Turban, J. L., Shirk, S. D., Potenza, M. N., Hoff, R. A., & Kraus, S. W. (2020). Posting Sexually Explicit Images or Videos of Oneself Online Is Associated With Impulsivity and Hypersexuality but Not Measures of Psychopathology in a Sample of US Veterans. *The Journal of Sexual Medicine*, *17*(1), 163-167.

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, *77*(1), 68-76.

Acosta, W., Qayyum, Z., **Turban, J. L.**, & van Schalkwyk, G. I. (2019). Identify, engage, understand: Supporting transgender youth in an inpatient psychiatric hospital. *Psychiatric Quarterly*, 90(3), 601-612.

Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019). Psychological Attempts to Change a Person's Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015. *American Journal of Public Health*, 109(10), 1452-1454.

Turban, J. L., Winer, J., Boulware, S., VanDeusen, T., & Encandela, J. (2018). Knowledge and attitudes toward transgender health. *Clinical Teacher*, *15*(3), 203-207.

Turban, J. L., Potenza, M. N., Hoff, R. A., Martino, S., & Kraus, S. W. (2017). Psychiatric disorders, suicidal ideation, and sexually transmitted infections among post-deployment veterans who utilize digital social media for sexual partner seeking. *Addictive Behaviors*, 66, 96-100.

Turban J. L.*, Lu, A. Y*., Damisah, E. C., Li, J., Alomari, A. K., Eid, T., ... & Chiang, V. L. (2017). Novel biomarker identification using metabolomic profiling to differentiate radiation necrosis and recurrent tumor following Gamma Knife radiosurgery. *Journal of Neurosurgery*, 127(2), 388-396.

Kempfle, J. S., **Turban, J. L.,** & Edge, A. S. (2016). Sox2 in the differentiation of cochlear progenitor cells. *Scientific Reports*, 6, 23293.

SELECTED PEER REVIEWED PUBLICATIONS: COMMENTARY, REVIEWS, & PERSPECTIVES

Kraschel KL, Chen A, **Turban JL**, Cohen IG. Legislation restricting gender-affirming care for transgender youth: politics eclipse healthcare. Cell Reports Medicine. 2022 Aug 16;3(8):100719.

Turban J.L., Brady C., & Olson-Kennedy J. Understanding & Supporting Patients with Dynamic Desires for Gender-affirming Medical Interventions. *JAMA Network Open*.

Dolotina B. **& Turban J.L.** "Phantom Networks" Prevent Children & Adolescents from Obtaining the Mental Health Care They Need. *Health Affairs*. 41(7).

Turban J.L., Kamceva M, Keuroghlian A.S. Pharmacologic Considerations for Transgender and Gender Diverse People. *JAMA Psychiatry*. 79(6): 629-630.

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Dolotina B. & **Turban J.L.**. (2022) A multipronged, evidence-based approach to improving mental health among transgender and gender diverse youth. *JAMA Network Open*. 5(2): e220926.

Turban J.L., Almazan A.N., Reisner S.L., Keuroghlian A.S. (2022) The importance of non-probability samples in minority health research: lessons learned from studies of transgender and gender diverse mental health. *Transgender Health*. [ePub ahead of print]

Turban J.L., Kraschel K.L., Cohen, G.C. (2021) Legislation to Criminalize Gender-affirming Medical Care for Transgender Youth. *JAMA*. 325(22), 2251-2252.

Liu M., **Turban J.L.**, Mayer K.H. (2021) The US Supreme Court and Sexual and Gender Minority Health. *American Journal of Public Health*. 111(7), 1220-1222.

Suto, D.J., Macapagal, K., **Turban, J.L.** (2021) Geosocial Networking Application Use Among Sexual Minority Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 60(4), 429-431.

Turban, J. L., Keuroghlian, A. S., & Mayer, K. H. (2020) Sexual Health in the SARS-CoV-2 Era. *Annals of Internal Medicine*. 173(5), 387-389.

Suozzi, K., **Turban, J.L.,** & Girardi, M. (2020). Focus: Skin: Cutaneous Photoprotection: A Review of the Current Status and Evolving Strategies. *The Yale Journal of Biology and Medicine*, *93*(1), 55.

Malta, M., LeGrand, S., **Turban, J.L.**, Poteat, T., & Whetten, K. (2020). Gender-congruent government identification is crucial for gender affirmation. *The Lancet Public Health*. 5(4), e178-e179.

Turban J.L. (2019). Medical Training in the Closet. *The New England Journal of Medicine*, *381*(14), 1305.

Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: understanding transition and" de-transition" among transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 57(7), 451-453.

Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, *172*(10), 903-904.

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Turban, J. L., & van Schalkwyk, G. I. (2018). "Gender dysphoria" and autism spectrum disorder: Is the link real?. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(1), 8-9.

Turban, J. L., & Ehrensaft, D. (2018). Research review: gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228-1243.

Turban J. L., Genel, M. (2017) Evolving Treatment Paradigms for Transgender Patients. *Connecticut Medicine*, 81(8), 483-486.

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Turban, J. L. (2017). Transgender Youth: The Building Evidence Base for Early Social Transition. *Journal of the American Academy of Child and Adolescent Psychiatry*, 56(2), 101.

Turban J. L., Martin A. (2017) Book Forum: Becoming Nicole. *Journal of the American Academy of Child & Adolescent*

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Psychiatry, 56(1): 91-92.

TEXTBOOKS AND TEXTBOOK CHAPTERS

Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth. Springer Nature, 2020.

Challa M., Scott C., **Turban J.L.** Epidemiology of Pediatric Gender Identity. In Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth. Springer Nature, 2020.

Turban J.L., Shadianloo S. Transgender & Gender Non-conforming Youth. In Rey, J.M. (Editor): IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva. International Association of Child and Adolescent Psychiatry and Allied Professionals, 2018.

Turban, J. L., DeVries, A.L.C., Zucker, K. Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., Volkmar F.R. (Editors): Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

INVITED GRAND ROUNDS PRESENTATIONS

Turban JL. Resaerch Updates: Supporting the Mental Health of Transgneder and Gender Diverse Youth. Department of Behavioral Health, Wake Forest School of Medicine / Atrium Health, 2023.

Turban JL. Supporting the Mental Health of Transgender and Gender Diverse Youth. Child & Adolescent Psychiatry Grand Rounds, Long Island Jewish Medical Center / Zucker Hillside, 2023.

Turban JL. Suicidality in Sexual and Gender Minority Youth. Psychiatry Grand Rounds, Boston Children's Hospital, 2023.

Turban JL. Opinion Writing to Promote Public Health & Evidence-Based Public Policy. Medical Education Grand Rounds, The University of Vermont Larner College of Medicine, 2022.

Turban JL. Research Updates: Supporting the Mental Health of Transgender & Gener Diverse Youth. Division of Child & Adolescent Psychiatry Grand Rounds, Stanford University School of Medicine, 2022.

Turban JL. Supporting Transgender & Gender Diverse Youth: Research Updates & Treatment Paradigms. Department of Psychiatry Grand Rounds, University of Nebraska Medical Center, 2022.

Turban JL. Supporting the Mental Health of Transgender & Gender Diverse Youth. Department of Pediatrics, Division of Behavioral Health Grand Rounds, University of Utah, 2022.

Turban JL. Gender Diverse Youth: Treatment Paradigms & Research Updates. Psychiatry Grand Rounds, Thomas Jefferson University, 2021.

Turban JL. Supporting Gender Diverse Youth Throughout Development. Child Psychiatry Grand Rounds, Georgetown, 2021.

Turban JL. Understanding Pediatric Gender Identity through Childhood and Adolescence. Grand Rounds, Institute of Living, 2021.

Turban JL. Evolving treatment paradigms for transgender youth. Pediatric Grand Rounds, Albany Medical Center, 2021.

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Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, McLean Hospital (Harvard Medical School), 2021.

Turban JL. Einstein Psychiatry Grand Rounds: Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Einstein Medical Center, 2021.

Turban JL. COVID19 and Pediatric Mental Health. Pediatrics Grand Rounds, Stanford University School of Medicine, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Beth Israel Deaconess Medical Center (Harvard Medical School), 2020.

ADDITIONAL INVITED PRESENTATIONS

Turban JL. The Research on Gender-affirming Care for Transgender Youth. *AusPATH Research Seminar*. Sydney, 2023.

Turban JL. Building a Career in Sexual & Gender Minority Health Research. *National Institutes of Health*, Bethesda, 2022.

Turban JL. Research Updates: Gender-affirming Care for Transgender Youth. MUSC LGBTQ+ Health Equity Summit, Medical University of South Carolina, 2022.

Turban JL. Keynote: Supporting The Mental Health of Transgender & Gender Diverse Youth. Edythe Kurz Educational Institute Conference, Westchester, 2022.

Turban JL, Peters B, Olson-Kennedy J. Gender-Affirming Care: Through a Medical, Surgical, and Mental Health Lens. Critical Issues in Child & Adolescent Mental Health Conference, San Diego, 2022.

Turban JL. Improving Mental Health Outcomes for Transgender and Gender Diverse (TGD) Youth Through Gender-affirming Care. National LGBTQIA+ Health Education Center, The Fenway Institute, 2022.

Turban JL. Combatting anti-trans legislation through science, data, and writing. State of Queer Mental Health Conference by The Mental Health Association of San Francisco, Online, 2021.

Turban JL. Updates on LGBTQ Mental Health. Annual Psychiatric Times World CME Conference, Online, 2021.

Turban JL. Imbasciani LGBTQ Health Equity Lecture: Evolving Treatment Paradigms for Transgender and Gender Diverse Youth. University of Vermont Larner College of Medicine, Burlington, 2021.

Turban JL. The Emergence of Gender-affirming Care for Transgender & Gender Diverse Youth, United Nations NGO Committee on Mental Health, Oral Presentation, Online, 2021.

Turban JL. Keynote – Transgender & Gender Diverse Youth: Research Updates. Stony Brook Transgender Health Conference, Online, 2021.

Turban JL. Opinion Writing on Sensitive Topics. Harvard Media & Medicine Course, Live Lecture, Online, 2021.

Turban JL. Gender affirming care for transgender and gender diverse youth: what we know and what we don't. University of Texas Pride Health Institute, Oral Presentation, Online, 2020.

Turban JL. Q&A on Transgender Youth Mental Health. PEOPLE in Healthcare at University of Toledo, Oral Presentation, Online, 2020.

Turban JL, Pagato S, Gold J, Broglie J, Naidoo U, Alvarado A. Innovation of Student Mental Health during COVID19.

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Panel to the People, Oral Presentation, Online, 2020.

Turban JL, Belkin B, Vito J, Campos K, Scasta D, Ahuja A, Harris S. Discussion on Abomination: Homosexuality and the Ex-Gay Movement. Panelist, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

Turban JL. Is Grindr affecting gay men's mental health? Oral Presentation, UCLA & AETC Coping with Hope, Online, Oral Presentation, 2020.

Turban JL, Hall TM, Goldenberg D, Hellman R. Gay Sexuality and Dating. Moderator, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

CONFERENCE PRESENTATIONS & ABSTRACTS

Turban JL. A Systematic Approach for Understanding Gender Identity Evolution. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. Transgender Youth: Evolving Gender Identities and "Detransition." Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL. From The New York Times to Hollywood: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV, Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL. Writing for the Lay Press to Combat Misinformation Regarding Pediatric Mental Health, Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. COVID-19 and Psychosexual Dynamics, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Oral Presentation, Toronto, 2022.

Dolotina B, **Turban JL**, King D, Keuroghlian AS. Age of Realization of Gender Identity and Mental Health Outcomes among Transgender Adults: Evaluating the "Rapid Onset Gender Dysphoria" Hypothesis, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Toronto, 2022.

Turban JL. Sex ratio among transgender adolescents in the United States. World Professional Association for Transgender Health Scientific Symposium, Oral Presentation, Montreal, 2022.

Turban JL. Access To Gender-Affirming Hormones During Adolescence And Mental Health Outcomes Among Transgender Adults. World Professional Association for Transgender Health Scientific Symposium, Oral Presentation, Montreal, 2022.

Turban JL, Gold J, Hartselle S, Yen J. From The New York Times to the Big Screen: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

Turban JL. Creating Change through Opinion Writing in Child & Adolescent Psychiatry. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Giedinghagen A, Janssen A, Myint M, Daniolos P. Transgender Youth: Understanding "De-transition," Non-linear Gender Trajectories, and Dynamic Gender Identities. Annual Meeting of The American Academy of Child & Adolesent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

Turban JL. A framework for understanding dynamic gender identities through internal and external factors. Annual

Jack Lewis Turban III MD MHS
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Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Geosocial networking application use among birth-assigned male adolescents. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL. LGBTQ Families and the US Supreme Court. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentations, Online, 2021.

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS. Access to Gender-affirming Hormones during Adolescence and Mental Health Outcomes among Transgender Adults. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Online, 2021.

Turban JL. Gender Identity Conversion Efforts: Quantitative Perspectives. Annual Meeting of The American Psychiatric Association, Oral Presentation, Online, 2021.

Turban JL. For Worse: Negative Aspects of Social Media for LGBT Youth. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2020.

Turban JL. Hookup App Use among Gay and Bisexual Males: Sexual Risk and Associated Psychopathology. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

Turban JL. Communicating with the Public: From The New York Times to The Big Screen. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

Turban JL, McFarland C, Walters O, Rosenblatt S. An Overview of Best Outpatient Practice in the Care of Transgender Individual. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL, Lakshmin P, Gold J, Khandai C. #PsychiatryMatters: Combating Mental Health Misinformation Through Social Media and Popular Press. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL. The Pen and the Psychiatrist: Outreach and Education Through the Written Word. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. For Better and For Worse: Gender and Sexuality Online, Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. Gender Diverse Young Adults: Narratives and Clinical Considerations, Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. Transgender Youth: Controversies and Research Updates, Oral Presentation, Annual Meeting of the American Psychiatric Association, San Francisco, 2019.

Turban JL, Beckwith N, Reisner S, Keuroghlian A. Exposure to Conversion Therapy for Gender Identity Is Associated with Poor Adult Mental Health Outcomes among Transgender People in the U.S. Poster Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Seattle, 2018.

Shirk SD, **Turban JL**, Potenza M, Hoff R, Kraus S. Sexting among military veterans: Prevalence and correlates with psychopathology, suicidal ideation, impulsivity, hypersexuality, and sexually transmitted infections. Oral Presentation, International Conference on Behavioral Addictions, Cologne, Germany, 2018.

Turban JL. Gender Identity and Autism Spectrum Disorder. Oral Presentation, Annual Meeting of the American

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Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban JL. Tackling Gender Dysphoria in Youth with Autism Spectrum Disorder from the Bible Belt to New York City. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent psychiatry, Washington D.C., 2017.

Turban JL. Affirmative Protocols for Transgender Youth. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban, JL. Evolving Management of Transgender Youth. Oral Presentation, Klingenstein Third Generation Foundation Conference, St Louis, 2017.

Turban, JL, Potenza M, Hoff R, Martino S, Kraus S. Clinical characteristics associated with digital hookups, psychopathology, and clinical hypersexuality among US military veterans. Oral Presentation, International Conference on Behavioral Addictions, Haifa, Israel, 2017.

Lewis J, Monaco P, **Turban JL**, Girardi M. UV-induced mutant p53 ketatinocyte clonal expansion dependence on IL-22 and RORγT. Poster, Society of Investigative Dermatology, Portland, 2017.

Turban JL, Winer J, Encandela J, Boulware S, VanDeusen T. Medical Student Knowledge of and Attitudes toward Transgender Pediatric Patient Care. Abstract, Gay & Lesbian Medical Association, St Louis, 2016.

Turban JL, Lu A, Damisah E, Eid T, Chiang V. Metabolomics to Differentiate Radiation Necrosis from Recurrent Tumor following Gamma Knife Stereotactic Radiosurgery for Brain Metastases. Oral Presentation, 14th Annual Leksell Gamma Knife Conference, New York City, 2014

Turban JL, Lewis J, Girardi M. UVB-induced HMGB1 and extracellular ATP increase Langerhans cell production of IL-23 implicated in ILC3 activation. Poster, Society of Investigative Dermatology, Scottsdale, 2016

Turban JL, Lewis J, Girardi M. Characterization of cytokine pathways associated with Langerhans cell facilitation of UVB-induced epidermal carcinogenesis. Poster, American Society of Clinical Investigation, Chicago, 2016.

Lewis J, **Turban JL**, Girardi M, Michael Girardi. Langerhans cells and UV-radiation drive local IL22+ ILC3 in association with enhanced cutaneous carcinogenesis. Poster, Society of Investigative Dermatology, Scottsdale, 2016.

Sewanan L, Zheng D, Wang P, Guo X, Di Bartolo I, Marukian N, **Turban JL**, Rojas-Velazques D, Reisman A. Reflective Writing Workshops Led By Near Peers During Third-Year Clerkships: A Safe Space for Solidarity, Conversation, and Finding Meaning in Medicine. Poster & Workshop, Society of General Internal Medicine, New Haven and Hollywood, 2016.

AWARDS & HONORS

Top Peer Review Service, *Annals of Internal Medicine* (2022)
Stanford Child & Adolescent Psychiatry Chief Fellow (2021-2022)
Top Manuscript of The Year - *Pediatrics* (2020)
American Psychiatric Association Child & Adolescent Psychiatry Fellowship (2019-2021)
Ted Stern Scholarship and Travel Award (2019)
Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychatry* (2018)
Ted Stern Scholarship and Travel Award (2018)
Medaris Grant (2018)
Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychatry* (2017)
United States Preventative Health Services Award for Excellence in Public Health (2017)
NBC Pride 30 Innovator (2017)

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Ferris Thesis Prize, Yale School of Medicine (2017)
Parker Prize, Yale School of Medicine (2017)
Howard Hughes Medical Institute Medical Research Fellowship (2015-2016)
American Academy of Child and Adolescent Psychiatry Life Members Mentorship Grant (2016)
Student Scholarship, Gender Conference East (2016)
Farr Award for Excellence in Research (2016)
Yale Office of International Medical Education Grant, Buenos Aires, Argentina (2016)
Yale Office of International Medical Education Grant, VU Medical Center, The Netherlands (2016)
Yale Summer Research Grant (2012)
AIG International Scholar, Harvard College (2007-2011)
Harvard International Study Grant, Alicante, Spain (2008)
David Rockefeller International Study Grant, Shanghai, China (2009)

PROFESSIONAL MEMBERSHIPS & COMMITTEES

American Medical Association, Member
American Psychiatric Association, Member
American Academy of Child & Adolescent Psychiatry, Member
American Psychiatry Association, Council on Communications
American Academy of Child & Adolescent Psychiatry, Media Committee
American Academy of Child & Adolescent Psychiatry, Chair of Subcomittee on Interfacing with the Media
World Professional Association for Transgrender Health, Member
US Professional Association for Transgender Health, Member
US Professional Association for Transgender Health, Research Committee
Psychiatric Times, Editorial Board
Alpha Omega Alpha (AOA) Honor Medical Society, Member

ACADEMIC JOURNAL SERVICE & AD HOC PEER REVIEW

PLoS One, Academic Editor
JAMA, Peer Reviewer
JAMA Pediatrics, Peer Reviewer
JAMA Psychiatry, Peer Reviewer
JAMA Network Open, Peer Reviewer
Annals of Internal Medicine, Peer Reviewer
Pediatrics, Peer Reviewer
Journal of the American Academy of Child & Adolescent Psychiatry, Peer Reviewer
Journal of Child Psychology and Psychiatry, Peer Reviewer
Journal of Adolescent Health, Peer Reviewer
Academic Psychiatry, Peer Reviewer
Journal of Autism and Developmental Disorders, Peer Reviewer
American Journal of Public Health, Peer Reviewer
Perspectives on Psychological Science, Peer Reviewer
Transgender Health, Peer Reviewer
Journal of Clinical Medicine, Peer Reviewer
Brain Sciences, Peer Reviewer
Social Science & Medicine, Peer Reviewer
Sexual Health, Peer Reviewer
Women, Peer Reviewer

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Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

American Academy of Child & Adolescent Psychiatry. (2018). Conversion Therapy. *Available at* https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

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Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health*, *70*(4), 643-649.

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Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health,* 8(4), 273-280.

van der Miesen, A.I., Steensma, T.D., de Vries, A.L., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704

Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, *15*(4), 582-590.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al*.,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al*.,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Nathaniel Clawson and Beth Clawson

Come now Nathaniel Clawson and Beth Clawson, being duly sworn and say that:

1. We are adult residents of Monroe County, Indiana, and are married to each other.

2. We are the parents of plaintiff K.C.

3. K.C. is currently ten years old.

4. Although K.C.'s birth-assigned sex was male, she has lived as a girl since before she was four.

5. When she was three, she grabbed a pair of scissors after leaving her bath and asked if she could cut off her penis.

6. Shortly thereafter she was diagnosed by a doctor as having gender dysphoria.

7. Since before she was four, she has lived as a girl and consistently has presented herself as a girl, wearing girls' hairstyles and clothing. In fact, at an early age she would

refuse to leave the house unless she was wearing a dress or tutu. The gender marker on her birth certificate has been changed to female.

8. By the time she was 4 or 5 she wanted to wear make-up to make herself look as feminine as possible.

9. Her gender dysphoria has triggered severe anxiety and depression and she has been in therapy periodically since she was very young to try to help her cope with the mental health difficulties that the gender dysphoria has caused.

10. She has been a patient of the Riley Gender Health Program since she was 4. The Riley Gender Health Program is operated by Riley Children's Hospital and Indiana University Health and offers comprehensive medical care and other support to children, teens, and young adults under the age of 21 who, among other things, suffer from gender dysphoria.

11. K.C. recently began the first stages of puberty, and she has an appointment for later this month for a subcutaneous insertion of a device that will deliver Supprelin LA to her. This is a puberty blocking drug.

12. The advantage of delivering the puberty blocker in this manner is that it is long-lasting and will not require frequent injections. The reason we elected this method was because of our fear that after July 1, 2023, our daughter would not be able to obtain a puberty blocker because of S.E.A. 480.

13. We agreed to our daughter receiving puberty blocking drugs only after medical personnel at Riley thoroughly explained to us and our daughter the benefits and potential negative side effects of the puberty blocking drugs.

14. We have noted that with the advent of puberty that our daughter's anxiety, depression, and other symptoms of gender dysphoria are increasing.

15. For example, approximately 6 months ago she noticed that her armpits began to smell different, a circumstance that she attributed to male puberty. This made her extremely upset. She insisted on immediately taking a shower and when this has continued to occur, she will do what she can to remove the odor. This sign of maturation continues to be a point of stress and discomfort for her. She avoids looking in a mirror and she has extreme concerns about changes in her body making her look more masculine. She is reluctant to even let her doctors see her body.

16. We have seen our daughter struggle with the profound negative effects of gender dysphoria, and she is eagerly awaiting the administration of the puberty blocking drugs from Riley Gender Health Program. She desperately wishes to remain a girl.

17. If she is denied the ability to receive puberty blocking drugs it will be devastating to her as there will be no way to control the negative consequences of her gender dysphoria.

18. If she is condemned to having to suffer through male puberty and is denied the ability to be the girl that she truly is, it will be catastrophic.

19. Assuming they are deemed to be appropriate by her medical providers, we will want our daughter to receive female hormones when she is able to do so. She has already spoken of wanting the hormones to assist her being a girl and recognized as a girl.

20. We have watched our daughter struggle through the serious problems caused by her gender dysphoria, and we recognize that the puberty blocking drug is a medical necessity for her.

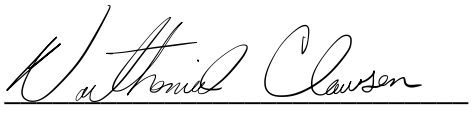
21. As noted, we have been well informed by her medical practitioners as to the benefits and potential negative consequences of the puberty blocking drug and we have made the informed choice to begin this necessary treatment and she needs to continue receiving this necessary treatment even after July 1, 2023.

22. We strongly believe that it is our right as parents to make this choice, in consultation with our daughter and her doctors, and we also believe that the State has no business in interfering with our ability to get our daughter this care.

Verification

We verify under penalty of perjury that the foregoing is true and correct.

Executed on: April 17, 2023



Nathaniel Clawson

Beth Clawson

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v. No. 1:23-cv-00595-JPH-KMB

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

Declaration of Lisa Welch and Ryan Welch

Come now Lisa Welch and Ryan Welch, being duly sworn upon their oath, and say that:

1. We are adult residents of Marion County, Indiana.

2. We are the parents of plaintiff M.W. who is currently 16.

3. Although M.W.'s birth-assigned sex was female, for some time he has suffered depression and anxiety concerning the fact that his gender identity was that of a boy.

4. He socially transitioned at 14 and has consistently used a boy's first name since then and dresses and presents as male.

5. He has been seen and treated by medical professionals at the Riley Gender Health Program since 2022 and was diagnosed as suffering from gender dysphoria. The Riley Gender Health Program is operated by Riley Children's Hospital and Indiana University

Health and offers comprehensive medical care and other support to children, teens, and young adults under the age of 21 who, among other things, suffer from gender dysphoria.

6. The gender dysphoria has caused M.W.'s depression and anxiety inasmuch as there is a profound disconnect between the gender he was assigned at birth and his gender identity, which is clearly male.

7. Before he began to seek care at Riley, we purchased a chest binder for M.W. to wear to allow his body to better conform to his male identity. The medical professionals at Riley have given him further instruction on wearing the chest binder.

8. The medical professionals at Riley also prescribed testosterone for him that he has been receiving for approximately a year.

9. M.W. began to receive the testosterone as part of his gender-affirming therapy only after the medical professionals at Riley fully discussed the hormone with us and with M.W. and we were informed of its benefits and potential negative side effects.

10. M.W. also receives mental health therapy to assist him in dealing with the negative mental health effects of his gender dysphoria.

11. With the testosterone he has developed male characteristics, including facial hair and changes to his musculature. His voice has also deepened. It is our understanding that he will continue in his development of male characteristics as he continues to receive testosterone.

12. The positive changes in M.W. since he has begun to receive testosterone are profound.

13. As he has developed more of a male physical appearance, there has been an enormous decrease in the symptoms of his gender dysphoria. His depression and anxiety have decreased, and he has made friends who treat him as the boy that he is.

14. His whole attitude has changed for the better.

15. If his hormone therapy is no longer allowed to occur, the development of his male body will cease and he will, instead, develop female characteristics.

16. This will be extremely devastating to him. Before receiving testosterone, we watched our son struggle with gender dysphoria and its negative effects. It is clear that the receipt of the testosterone has caused him to be much happier and is allowing him to live as he is, an adolescent boy. Without the testosterone he will revert to experiencing the profoundly negative effects of gender dysphoria.

17. The hormones are a medical necessity for him.

18. We have exercised our rights as M.W.'s parents to agree that he receive this necessary treatment after we were informed of both its likely benefits and its potential negative consequences, and we most certainly wish for him to continue this treatment.

19. We strongly believe that we made the right choice for our son, and we strongly believe that we, in consultation with our son and medical professionals, have the right to do this and that the State should not be interfering with parental rights in the way that S.E.A 480 clearly does.

Verification

We verify under penalty of perjury that the foregoing is true and correct.

Executed on: 4/17/23

Lisa Welch

Ryan Welch

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v. No. 1:23-cv-00595-JPH-KMB

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

Declaration of Emily Morris

Emily Morris, being duly sworn upon her oath, says that:

1. I am an adult resident of Marion County, Indiana.

2. I am the mother of plaintiff A.M., who will be 11 at the time that this declaration is filed with the Court, although she is 10 on the date that the declaration is signed.

3. Although A.M's birth-assigned sex was male, she informed me and other members of our family before she was 4 years old that she was really a girl and she stated that she was thinking about trying to cut off her penis to get rid of it.

4. Since that time, she has been living as a girl. She consistently uses a female first name and dresses and appears to the world as a girl.

5. An Indiana court has changed the marker on A.M's birth certificate to female and changed her legal first name to her preferred female first name.

6. The world accepts her as a girl and very few persons outside of our immediate family know that her birth-assigned sex was male.

7. Because of the disconnect between her gender identity and birth-assigned sex, A.M. suffers from anxiety and depression and has been in counseling since she was 6 years of age.

8. She has been diagnosed with gender dysphoria and receives anti-depressant medication.

9. She is followed by an endocrinologist at the Riley Gender Health Program, and she has a counselor through Eskenazi Hospital.

10. In August of 2021, after there was clinical documentation of the initial signs of puberty, she was prescribed a puberty blocking drug, leuprorelin, and has been taking it ever since. To receive this drug, I take A.M. to the Riley Gender Health Program, and she receives an injection of the puberty blocking drug administered by medical professionals every three months. These injections are provided as a part of, and in the same setting as, a visit to A.M.'s physician. I am not a medical professional and am not capable of providing A.M. these injections myself, and no one has ever asked me to do so or even offered me the opportunity to do so.

11. The Riley Gender Health Program is operated by Riley Children's Hospital and Indiana University Health and offers comprehensive medical care and other support to

children, teens, and young adults under the age of 21 who, among other things, suffer from gender dysphoria.

12. Prior to receiving the puberty blocker, A.M.'s depression was increasing, undoubtedly because puberty was beginning.

13. She even threatened again to harm her genitals before she began receiving the puberty blocker.

14. Before I agreed that A.M. could receive the puberty blocker, a medical practitioner fully explained to me and A.M. both the positive and potential negative effects of the medication.

15. After hearing all the information about the puberty blocker, I consented to A.M. receiving it as it was clear that it was necessary to preserve my child's mental health and perhaps her physical health.

16. Since she has begun taking the puberty blocker her depression has decreased as she is not developing any male characteristics, which would be extremely upsetting to her.

17. I am afraid to think about what might happen if the puberty blocker were stopped and my daughter began to go through male puberty and developed male physical characteristics that could never be reversed. I believe that this would also cause her to have irreversible depression and might cause her to again think about mutilating herself to remover her penis.

18. Moreover, stopping the puberty blockers, and the therefore allowing her to develop male physical characteristics, would expose her birth-assigned sex to the world, which knows her only as a girl, and would tell the world that she is not a "real" girl. This would be devastating to her and would cause her depression to greatly increase.

19. Because of our limited income, A.M. is enrolled in the Medicaid program through the Indiana Family and Social Services Administration. Medicaid pays both for her visits to her medical professionals and for the puberty blocking drugs themselves. Due to her enrollment in the Medicaid program, we are not required to pay any of her medical expenses out of pocket. Medicaid has consistently paid for A.M.'s gender-affirming care, including her visits to her physician or other medical staff and her puberty-blocking drugs. Her visits started in 2019 and, as noted above, she started receiving the puberty blocker in 2021.

20. Before she began to receive the puberty blocker, I was forced to watch my daughter struggle with gender dysphoria. After receiving all the information about her condition and her treatment, I exercised my right as a parent, in consultation with A.M.'s doctors, to provide her with the puberty blocker, which I believe is an essential treatment for her.

21. It is my right as a parent to make these decisions for my daughter, in consultation with my daughter and her doctors.

22. The puberty blocker that she is receiving is clearly medically necessary for her and clearly has caused the symptoms of her gender dysphoria to decrease.

23. In the future, once it is medically appropriate, A.M. will be prescribed estrogen and progesterone (the latter of which I understand will serve to suppress the production or effects of testosterone) so that she can develop many of the physiological changes associated with puberty in females. Due to her age, A.M. will not begin taking these drugs prior to July 1, 2023.

24. Again, I believe that it is my right as A.M.s mother to make this future decision concerning her receipt of female hormones when they are deemed appropriate by her medical professionals so that A.M. can continue to live as a girl.

25. I do not believe that the State has any right to interfere with the treatment decisions that I am making so my daughter can get the care that she needs.

Verification

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

Executed on: 4/19/23

Emily Morris

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Maria Rivera

Comes now Maria Rivera, being duly sworn upon her oath, and says that:

1. I am an adult resident of Elkhart County, Indiana.

2. I am the mother of M.R. I am his legal custodian, along with his father. While his father is not serving as next friend, he fully supports M.R.'s participation in this litigation.

3. M.R. is 15.

4. M.R.'s birth-assigned sex was female.

5. However, he has experienced profound discomfort with his birth-assigned sex for quite some time.

6. He has suffered from serious depression and anxiety and became suicidal. He began cutting himself and was hospitalized because of his mental health issues.

7. These issue all arose from the fact that his gender identity of male did not match his birth-assigned gender.

8. Approximately eighteen months ago he began to transition as a boy and began receiving mental health treatment to deal with the symptoms of what I know now was his gender dysphoria.

9. Approximately three months ago he began to receive testosterone. His treatment providers are at Mosaic Health and Healing Arts in Goshen, Indiana.

10. I agreed to him receiving testosterone only after a medical professional explained to me and my son the benefits of hormone therapy and its potential risks.

11. As soon as he began to receive testosterone his emotional condition greatly improved. His depression and anxiety lessened substantially.

12. Before receiving the testosterone, my son did not want to leave the house. He had an enormous amount of anxiety over the fact that people would misgender him. This anxiety led directly to him harming himself.

13. He is able to go out now and people recognize that he is a boy. This is incredibly important to him.

14. He has become much more outgoing and comfortable with other persons his age.

15. I believe that the terrible symptoms of his gender dysphoria will continue to decrease as he continues receiving testosterone as part of his gender-affirming therapy.

16. If he is not allowed to continue receiving the hormone therapy, I am sure that his gender dysphoria will come roaring back as he stops developing male characteristics and develops female ones. This would literally threaten his life.

17. I do not understand why the State is attempting to prevent my son from getting this treatment that is clearly a medical necessity for him.

18. In deciding that M.R. should receive testosterone, after being fully informed about the hormone by M.R.'s medical provider, I exercised my right as a parent to determine that my son should receive this medically necessary treatment and the State should not interfere with my decision to provide care to my child. M.R.'s father also supports M.R.'s receipt and continued receipt of testosterone.

Verification

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

Executed on: 4-18-2023 @ 1203

Maria Rivera

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Michelle (Mixhi) Marquis

Comes now Michelle (Mixhi) Marquis, being duly sworn, and says that:

1. I am the co-founder, along with Dr. Catherine Bast, of Mosaic Health and Healing Arts, Inc. ("Mosaic") and I serve as its Executive Director.

2. I am filing this declaration on behalf of Mosaic.

3. I am an adult person.

4. Mosaic is located in Goshen, Indiana and opened in 2016.

5. Mosaic was founded to provide health and other services to the transgender and gender-nonconforming community in Michiana as well as all others in the community.

6. Mosaic provides the complete range of family-practice medical services, which include well visits, chronic disease management, acute care as needed, medical support

for mental wellness, sexually transmitted infection testing and treatment, HIV care and prevention, and other medical and mental health services.

7. In addition to providing this full spectrum of family medicine, Mosaic has developed into a center for gender-affirming care for adults and persons under the age of 18.

8. Mosaic staff also provide trainings in various areas designed to assist the LGBTQ community and those otherwise gender diverse. This includes supplying provider training as well as engaging in peer consultation with other providers.

9. At the current time Mosaic employs a physician, Dr. Catherine Bast, two licensed nurse practitioners, and a licensed mental health professional.

10. At the current time Mosaic has more than 1200 adult patients who are transgender and are receiving health services.

11. I have reviewed S.E.A. 480.

12. Mosaic provides its transgender patients diagnosed with gender dysphoria, including patients under the age of 18, with what S.E.A. 480 defines as "gender transition procedures." This includes the provision of care that S.E.A. 480 defines as either "puberty blocking drugs" or "gender transition hormone therapy," which I believe is more appropriately labeled "gender-affirming hormone therapy."

13. Mosaic is an Indiana Medicaid provider and receives Medicaid reimbursement for Dr. Bast's care for its minor patients, including reimbursement for patient visits,

including visits where puberty blockers and gender-affirming hormones are prescribed or administered. The puberty blockers and hormones are administered in our offices either through injection or implantation. The injections are done by Dr. Bast or the licensed nurse practitioners under Dr. Bast's supervision. Medicaid will pay for the visits of the transgender youth with the nurse practitioners including, but not limited to, visits where they administer injections. Medicaid will also pay for the puberty blockers and hormones themselves by directly paying the pharmacies that issue the medication. Medicaid will pay for the laboratory tests and costs that are required under the standard of care to monitor the efficacy and results of the medications that have been administered. The puberty blockers and hormones administered in our office through injection or implantation are all administered as part of and in the same setting as services furnished by or under the supervision of our physician.

14. I am aware that Indiana Medicaid only reimburses for services it deems medically necessary and Medicaid has consistently approved and provided reimbursement for the gender-affirming services that I describe above since Mosaic opened in 2016.

15. At the current time Mosaic provides puberty blockers and gender-affirming hormones to approximately 72 transgender persons under the age of 18, with 31 of those persons on Medicaid, and Mosaic receives Medicaid reimbursement for services provided to these youth. In total, Mosaic has approximately 92 patients under the age of 18 who have a diagnosis of gender dysphoria.

16. Mosaic has a constant stream of new patients under the age of 18 who are transgender, are suffering from gender dysphoria, and for whom puberty blockers or gender-affirming hormones will be prescribed. For instance, we have 3 appointments scheduled this week for persons under the age of 18 that are Medicaid recipients. These are new patients that are not included within the total number of patients in the paragraph immediately above.

17. The frequency with which we are accepting new minor transgender patients who ultimately receive puberty blockers and/or gender-affirming hormones is increasing.

18. Mosaic currently provides referrals for its patients to other physicians and clinics where they can receive care, including gender-affirming hormones and puberty blockers. Mosaic will do this, for instance, if there are other practitioners who are more conveniently located for the patients.

19. If S.E.A. 480 takes effect Mosaic will want to continue to be able to provide these referrals for its patients, including those patients receiving puberty blockers and gender-affirming hormones, to out-of-state practitioners so that they may continue to receive this medically necessary treatment.

20. If S.E.A. 480 takes effect Mosaic will want to cooperate when those out-of-state practitioners contact Mosaic staff to discuss former minor patients at their request and to provide their medical records to the out-of-state practitioners, as authorized by the patients, so that the patient can receive continuity of care.

21. I understand, however, that if S.E.A. 480 goes into effect, Mosaic's physicians and other licensed practitioners will not be able to make referrals for patients to receive puberty blockers or gender-affirming hormones and will not be able to respond to inquiries from other practitioners that concern their providing the former patients puberty blockers or gender affirming hormones, as all of that would be prohibited by S.E.A. 480's ban on "aiding" or "abetting" another physician or practitioner in providing gender transition procedures.

22. I am aware of many of the physicians and clinics in Indiana that provide gender-affirming care to minors that will be prohibited under SEA 480. I have gained this awareness because Mosaic will make patient referrals to these providers and receive referrals from them. I have also gained this awareness because of training that Mosaic has offered and provided to practitioners and clinics around the state. As Executive Director I am also frequently involved in informal networking and conferences with other providers. I am responsible for creating collaborations and partnerships with other medical and non-medical organizations. With the consideration of so many potential laws, including this one, in the General Assembly this year, I have frequently been touching base with other LGBTQ community leaders and allies who frequently focus on the availability of transgender care for youth under the age of 18.

23. Through informal contacts and networking, I am therefore aware of a number of other practitioners providing gender-affirming care to minors that will be prohibited by S.E.A. 480.

24. I am aware that there are approximately 12 physicians or practitioners at the Riley Gender Health Program who provide gender-affirming therapy that will be banned by S.E.A. 480 as it involves the provision of puberty blockers and hormones. I believe that there are 3 other physicians or practitioners providing this to-be-banned care at Eskenazi Hospital in Indianapolis. Mosaic has trained 3 other health-care providers who furnish gender-affirming care in Indiana that will be prohibited by S.E.A. 480. And I am aware that there are 12 other providers in Indiana that were trained by another doctor to serve transgender youth by, among other things, providing care that will not be permitted under S.E.A 480. I am also aware of at least 8 other providers furnishing this care throughout Indiana. I am sure that there are others as well. I presume that all of these persons have contacts with transgender youth who are receiving gender-affirming care, or who are considering the receipt of this care. The above numbers include nurse practitioners, but do not include other nursing staff or licensed professionals (other than physicians) assisting in the providing of the care that will be prohibited by S.E.A. 480.

25. From discussions with doctors at the Riley Gender Health Program, I am aware that this program provides gender-affirming hormone care and puberty blockers to hundreds of minor patients at any one time.

26. Mosaic wishes to continue to provide the necessary medical care it is currently providing to transgender youth and to receive Medicaid reimbursement for services provided to its patients receiving Medicaid. It certainly does not wish to discriminate against its patients by denying this care.

Verification

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

Executed on: 4/20/2023

Michelle (Mixhi) Marquis

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Dr. Catherine Bast

Comes now Catherine Bast, being duly sworn, and says that:

1. I am an adult resident of Elkhart County, Indiana.

2. I am a medical doctor, licensed in the State of Indiana.

3. I graduated from the Indiana University School of Medicine in 2013.

4. My residency was in family practice medicine, and I am board certified in family practice medicine.

5. I am an Adjunct Clinical Assistant Professor of Family Medicine at Indiana University School of Medicine.

6. I am a member of the World Professional Association for Transgender Health (WPATH) and the Gay and Lesbian Medical Association (GLMA).

7. I am a co-founder, with Mixhi Marquis, of Mosaic Health and Healing Arts, Inc. ("Mosaic").

8. I supervise the medical care provided at Mosaic and I supervise the treatment staff, which currently consists of two licensed nurse practitioners and a licensed mental health professional.

9. I have reviewed S.E.A. 480.

10. At the current time I provide services directly to, or supervise the provision of services to, approximately 72 transgender patients under the age of 18 for whom I have prescribed what S.E.A. 480 defines as either "puberty blocking drugs" or "gender transition hormone therapy," which I believe is more appropriately labeled "gender-affirming hormone therapy."

11. These youth have been diagnosed with gender dysphoria as that condition is defined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) and the medications are prescribed to treat their gender dysphoria.

12. The puberty-blocking drugs and gender-affirming hormones are provided only where it is medically necessary to do so.

13. I also have approximately 20 patients who are under the age of 18, are transgender, and have been diagnosed with gender dysphoria, but are not receiving puberty blockers or gender-affirming hormones. Many of these youth are pre-pubertal and therefore medication treatment is not appropriate. However, they and their parents may wish to

begin puberty blockers when it is medically appropriate and necessary to do so. A number of the other youth are already in puberty and they and their parents are considering medical intervention through gender-affirming hormones.

14. In providing services to my patients, including puberty blocking drugs and gender-affirming hormone therapy, I utilize and rely upon the WPATH *Standards of Care of the Health of Transgender and Gender Diverse People* (SOC 8).

15. The puberty-blocking drugs and gender-affirming hormones are provided to minor patients only after the benefits and potential side effects of the treatments are explained to both the patients and their parent(s) or guardian(s). I make sure that all consent is fully informed.

16. I, and the other licensed practitioners at Mosaic, will assist in providing transgender persons, including minors, with devices to aid them in their social transition, such as chest binders for transgender boys.

17. I am an Indiana Medicaid provider, separate from Mosaic, but I allow Mosaic to bill Medicaid for my services, which include reimbursement for services that are provided to my minor transgender patients who are Medicaid recipients and for whom I prescribe puberty blockers and gender-affirming hormones. These Medicaid-reimbursed services include: the patients' visits with me including visits where the puberty blockers and hormones are administered either through injections or implants. I have

approximately 31 of these minor Medicaid patients who are currently receiving puberty blockers or hormones.

18. I am aware that Medicaid will only reimburse for services that are deemed to be medically necessary and Medicaid consistently provides reimbursement for the gender-affirming services, noted above, that I provide or that are provided at my direction to the minor patients.

19. I wish to continue providing medically necessary puberty blockers and hormones, as well as related care, to my minor transgender patients who need this care, receiving Medicaid reimbursement where appropriate and available. I believe that I have an ethical obligation to alleviate my patients' suffering by providing this care.

20. Moreover, I am obligated under the Affordable Care Act to provide this medically necessary care to my patients.

21. I will not be able to provide this care if S.E.A. 480 goes into effect.

22. I currently provide referrals for my patients to other physicians and clinics where they can receive care, including gender-affirming hormones and puberty blockers. I will do this currently, for instance, if there are other practitioners who are more conveniently located for the patients.

23. If S.E.A. 480 takes effect I will want and need, consistent with my ethical obligations as a doctor, to provide referrals for my patients, including those patients

receiving puberty blockers and gender-affirming hormones, to out-of-state practitioners so that they may continue to receive this medically necessary treatment.

24. If S.E.A. 480 takes effect I will want, as I believe I am ethically obligated, to cooperate when those out-of-state practitioners contact me to talk about my former minor patients at their request and to provide my patients medical records to the out-of-state practitioners, as authorized by my patients, so that the patient can receive continuity of care.

25. I understand, however, that if S.E.A. 480 goes into effect, I will not be able to make referrals for my patients to receive puberty blockers or gender-affirming hormones and I will not be able to respond to inquiries from other practitioners that concern their providing my former patients puberty blockers or gender affirming hormones, as all of that would be prohibited by S.E.A. 480's ban on "aiding" or "abetting."

26. I am well aware that if my transgender patients under the age of 18 are denied puberty blockers or gender-affirming hormones that they will suffer grave harm. This treatment is necessary to eliminate the profound distress and symptoms of gender dysphoria and to allow the person to realize their identity. The inability to obtain this treatment will cause anxiety, depression, stress, and suicidality. This is medically necessary treatment and denying it will have serious and dire consequences.

27. I am extremely concerned about the many minor patients that I have who will have their care terminated as a result of S.E.A. 480. It is my understanding that I will not

be able to prescribe puberty blockers as of July 1, 2023. And, although it is my understanding that I will be able to continue to prescribe gender-affirming hormones to patients who are receiving them as of July 1, 2023, this "grandfather" period will end on December 31, 2023. There are no protocols that define how to stop gender affirming hormones and I am concerned that this process will cause serious physical discomfort for my patients.

28. With the ending of puberty blockers and the eventual ending of the gender-affirming hormones my patients will experience the effect of hormones that do not match their gender identity. This will undoubtedly greatly increase their gender dysphoria with attendant depression, anxiety, and suicidality. The "reversion" process will be terrible. Transgender men with beards who are known only as men to the world will begin to menstruate and develop breasts. Transgender women will grow facial hair and will have their voices become deeper. This will be simply horrible.

29. I do not wish to discriminate against my minor patients by denying them medically necessary puberty blocking drugs and gender-affirming hormones and I very much wish to be able to continue to care for them.

Verification

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

Executed on: April 20, 2023

Catherine Bast, M.D.

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of LaRisha Hanks

LaRisha Hanks, being duly sworn upon her oath says that:

1. I am an adult resident of Madison County.

2. I have a child who is now 14.

3. Although my child's birth-assigned sex was female, he has identified as male for some time.

4. He is currently a patient at the Riley Gender Health Clinic and receives testosterone and progesterone.

5. He was diagnosed with gender dysphoria in counseling that he began 3 years ago.

6. The symptoms caused by his gender dysphoria caused depression, anxiety, and night terrors and at times he engaged in self-harm.

7. He has been prescribed anti-depressants.

8. He socially transitioned more than two years ago and presents to the world as a boy.

9. With his receipt of gender-affirming hormones he has improved an enormous amount. It has been like night and day. His anxiety and depression have decreased, and he is much more comfortable in public and with his peers.

10. He is clearly comfortable in presenting as a boy.

11. I agreed to my child receiving hormones only after we were given information about their benefits and potential negative side effects, and I was able to give informed consent.

12. I am certain that if the hormones were to stop and my child would have to resume female puberty that this would be absolutely devastating to him. The symptoms of his gender dysphoria would increase with disastrous consequences. This would cause him permanent and irreversible harm.

13. I should have the right to make decisions concerning my child's necessary medical treatment in consultation with his doctors without interference from the State.

Verification

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

Executed on: 4/14/23

LaRisha Hanks

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v. No. 1:23-cv-00595-JPH-KMB

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

Declaration of Jamie Harris

Jamie Harris, being duly sworn upon her oath, says that:

1. I am an adult resident of Clark County, Indiana.

2. I have a 14-year-old transgender daughter.

3. My daughter began to social transition as a girl in 2021. She has received a gender marker change and a name change to her female first name in and Indiana court.

4. She has been diagnosed with gender dysphoria and suffers from depression and anxiety because of the disconnect between her birth-assigned sex of male and her gender identity. She had suicidal ideations.

5. She has been receiving a puberty blocking drug for 18 months.

6. The puberty blocking drug has been prescribed and administered by the Pediatric and Adolescent Gender Education Program ("PAGE") through Norton's Children's Hospital in Louisville, Kentucky.

7. The medication was prescribed only after medical practitioners at PAGE fully explained the benefits and potential negative effects of the medication.

8. The puberty blocker has made a remarkable difference for my daughter. Her mental health symptoms have lessened, and she is much happier.

9. Kentucky has passed a law similar to Indiana's concerning the denial of transgender-affirming care that will prevent PAGE from providing puberty blocker or hormones once the law goes into effect.

10. My daughter will be able to obtain one more puberty blocking drug injection from PAGE before the Kentucky law takes effect.

11. Prior to the Kentucky law being passed, my daughter's medical practitioners at PAGE were discussing prescribing female hormones for her. No hormones had yet been prescribed.

12. My daughter's pediatrician has made a referral to the Riley Gender Health Clinic so that my daughter can receive continued care. I have not heard back yet from the Riley Gender Health Clinic.

13. But I am aware that as of July 1, 2023, due to S.E.A. 480, my daughter will not be able to receive her puberty blocking drug in Indiana and will not be able to receive the gender-affirming hormones that I believe she needs.

14. If my daughter ceases receiving her puberty blocking drug, she will resume having testosterone-induced puberty and she will develop male physical characteristics.

15. This will be extremely harmful to her as it will plunge her back into a very precarious mental health situation that will only get worse with her knowledge that many of the changes to her body will be difficult, if not impossible, to reverse.

16. As a mother, I decided that my daughter should have gender-affirming care after receiving information from her doctors. She needs to continue this care and receive gender-affirming hormones as recommended by medical professionals in the future.

17. The State of Indiana has no right to interfere with my parental decisions here.

18. Because of our limited income my daughter is on Medicaid and Medicaid pays for her necessary medical expenses. It was paying for her transgender care, including the puberty blocking drug, that she was receiving through PAGE.

Verification

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

Executed on: 4/13/2023

Jamie Harris

Jamie Harris

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v. No. 1:23-cv-00595-JPH-KMB

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

Declaration of Julia Kathary

Julia Kathary, being duly sworn upon her oath, says that:

1. I am an adult resident of the State of Indiana.

2. I am the mother of a transgender girl who is now 16½ years old.

3. For the last four months she has been prescribed and has been taking estradiol and a testosterone blocker. She receives this gender-affirming care at Riley Gender Health Clinic.

4. Before she was seen at Riley Gender Health Clinic, she was suffering a great deal of depression and anxiety and she was taking an antidepressant prescribed by her primary care provider.

5. She described herself as feeling that everything about her was wrong.

6. The estradiol and testosterone blocker was given to my daughter only after its effects were fully explained to my daughter and me.

7. With the gender-affirming hormones that she is receiving she is now getting comfortable in her own skin. She finally feels that her body is lining up with who she is. Her improvement is significant and obvious.

8. However, the fact that Indiana has passed a law that will prohibit the vitally necessary care that my daughter is receiving is causing my daughter an enormous amount of stress and anxiety.

9. We cannot risk our daughter being denied the medication that is necessary for her continued growth and mental health.

10. We are therefore planning to move out of state so my daughter can continue to obtain the care that she needs.

Verification

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

Executed on: 4/17/23

Julia Kathary

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Patrick Rhodes

Patrick Rhodes, being duly sworn, says that:

1. I am an adult resident of the State of Indiana.

2. I have a son who is 14 years old whose birth-assigned sex was female.

3. My son has identified as male since he was very young.

4. He has been diagnosed as having gender dysphoria and has suffered anxiety and other emotional issues because of the disconnect between his birth-assigned sex and his gender identity.

5. Since 2016 he has received care through the Riley Gender Health Clinic. Prior to that time, he received care at the Lurie Children's Hospital in Chicago.

6. He has been placed on a puberty blocker by his medical practitioners.

7. He is scheduled to begin receiving gender-affirming hormone therapy within the next 30 days.

8. My son's medical practitioners provided us with information concerning the benefits and potential effects of puberty blockers and the gender-affirming hormone therapy, and I provided informed consent for the treatment.

9. With the puberty blocker and the promise of hormonal therapy my son has become much more at ease in his own skin. He has been able to develop friendships with peers and is much more comfortable and relaxed.

10. If he were not able to continue with the therapy—the puberty blocker and hormones—he would not be able to be the person who he is. This would be devastating to him and would cause him serious harm.

Verification

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

Executed on: 4/18/23
Date

Patrick Rhodes

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Michael Rabinowitch and Lindsey Rabinowitch

Come now Michael and Lindsey Rabinowitch, being duly sworn upon their oaths, and say that:

1. We are adult residents of Marion County, Indiana and are married to each other.

2. We have a 15-year-old daughter.

3. Although our daughter's birth-assigned sex was male, she has identified as female for some time.

4. She receives care through the Gender Health Program at Riley Hospital and has since January of 2022.

5. She has been diagnosed as suffering from gender dysphoria. This has led her in the past to be extremely depressed and anxious.

6. She receives mental health counseling because of her gender dysphoria.

7. Beginning in May of 2022 she was prescribed and began to receive a puberty blocker.

8. Beginning in May/June of 2022 she began to receive estradiol, a feminizing hormone, and she continues to receive the hormone.

9. The gender-affirming treatment that she has received through the puberty blocker and then the hormone has greatly improved her mental health. She is much happier now, is more confident and outgoing, and has developed friendships.

10. We agreed to the puberty blocker and feminizing hormone for our daughter only after being fully informed by medical personnel of their benefits and potential negative effects.

11. We strongly believe that we, in consultation with our daughter and her doctors, have the right to make medical decisions for our daughter. This is not an area into which the State of Indiana has any right to intrude.

12. However, we recognize that if S.E.A. 480 goes into effect our daughter will eventually be denied the ability to receive the gender-affirming hormone. This will cause her to develop male physical characteristics that will be permanent. This will be profoundly damaging to her and will cause injuries that will not be able to be repaired. It will be terrible for her.

13. Our daughter will turn 16 during summer of 2023, which means that now arbitrarily the state of Indiana has chosen to take away potentially life-saving treatment, administered

under the diagnosis, care, and treatment by licensed medical professionals, for a two year period until she turns 18.

Verification

We verify under penalty of perjury that the foregoing is true and correct.

Executed on: Apr. 17, 2023

Michael Rabinowitch

Lindsey Rabinowitch

Prepared by:

Kenneth J. Falk
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Krisztina Inskeep (GEKCO)

Comes now Krisztina Inskeep, and states that:

1. I am an adult resident of Indiana.

2. I am the co-founder and host of Gender Expansive Kids & Co., otherwise known as GEKCO.

3. GEKCO is an Indianapolis-based unincorporated association, created in 2015, and is a peer-led monthly support group for families of transgender and gender expansive children.

4. Among other things, GEKCO organizes and hosts monthly meetings for the families of transgender and gender expansive youth. These meetings are designed to connect families with one another, provide peer support, discuss the issues these families

face, and provide resources that may help families navigate the complex issues that are common to transgender youth, such as education and healthcare.

5. GEKCO is a vital resource in the community of transgender youth and their families, and we focus on serving Indiana families with children ages 13 and under who do not have many, if any, similar peer-support resources in their communities.

6. Due to threats to and persecution generally faced by transgender and gender expansive youth and their families, we carefully screen those who are invited to attend our meetings. Only transgender and gender expansive youth and their affirming families are invited to attend. At the current time, we have vetted, share resources with, and invite to meetings approximately two hundred individuals. Our group continues to grow, and attendance at our meetings has recently spiked in response to the numerous bills introduced in 2023 in the Indiana General Assembly that would adversely impact these families.

7. Our meetings are closed, due to confidentiality and safety concerns. At any given meeting, we usually have more than thirty people in attendance, including transgender and gender expansive youth and their family members.

8. Parents are particularly focused on finding appropriate, gender-affirming medical care for their children and seek recommendations from one another for medical providers who can educate them about the medical options available for their children. Families in our group with children approaching puberty uniformly seek information

and medical advice regarding use of puberty blockers and gender-affirming hormones. Based on the discussion at our meetings, these families appear to have opted for these treatments for their children when physicians advise they are medically appropriate.

9. Finding recommended and trusted medical providers is a major, ongoing challenge for families with transgender and gender expansive children. It has become much more difficult as families try to obtain medical treatment for their children outside Indiana's borders.

10. Since the introduction of S.E.A. 480, families have increasingly expressed concern and distress over whether they will need to relocate out of state in order to provide gender-affirming medical care to their children. Other families have expressed concern about the burden, cost, and medical insurance coverage issues of having to seek medical care for their children outside of Indiana's borders. As some of our families have sought care out of state at the few available medical facilities with this specialty, they have reported long wait times for appointments because of the number of states that have made such care illegal. At least one major out-of-state clinic has reportedly stated to an Indiana family that it is refusing to accept any out-of-state patients until their legal counsel can analyze the provisions of these many state laws to determine what treatment, if any, they can legally provide to patients from those states.

11. It is difficult to describe fully the depth of harm that S.E.A. 480 will cause our families and their children. They have reported increased bullying of their children as a

consequence of this and similar bills, and deep distress over their ability to obtain the life-saving medical treatment that their children require. Many of these children have already been living as their affirmed gender for years as they approach puberty, and will urgently require access to puberty blockers and gender-affirming hormones. That this care is not available in Indiana will not just burden their families; it will cause these children extreme pain, anxiety, depression, and potentially suicidality. It is a threat to their very personhood. For parents, it has caused a sense of powerlessness and acute distress over the significant damage to the health and welfare of their families.

Verification

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

Executed on: April 20, 2023
DATE

Krisztina Inskeep, GEKCO

Prepared by:

Stevie J. Pactor
ACLU of Indiana

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Indiana Youth Group

Comes now Christine Paulsen, being duly sworn, and says that:

1. I am an adult resident of Indiana.

2. I am the Chief Executive Officer of Indiana Youth Group.

3. Indiana Youth Group is an Indianapolis-based nonprofit corporation, created in 1987, which creates safer spaces to foster community and provides programming that empowers LGBTQ+ youth and magnifies their voices.

4. IYG provides housing, mental health therapy, food, case management, and general supports to LGBTQ+ and straight/cis youth, their families, and other supportive adults in their lives.

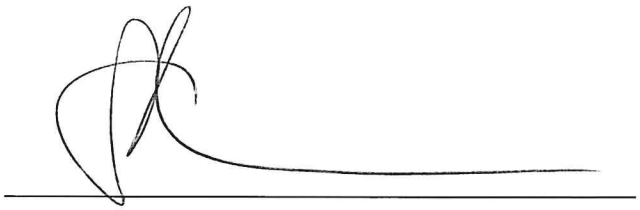
5. We also assist in connecting transgender youth to gender-affirming medical care.

6. At the current time Indiana Youth Group is providing counseling, care coordination, group meetings, parental support, or otherwise working with at least 10 transgender persons under the age of 18 who are currently receiving puberty blockers or gender-affirming hormone therapy. We are also working with over 35 youth who are in the process of accessing gender-affirming puberty blockers or hormones.

Verification

We verify under penalty of perjury that the foregoing is true and correct.

Executed on: 4/20/23
DATE



Christine Paulsen, CEO
Indiana Youth Group

Prepared by:

Stevie J. Pactor
ACLU of Indiana

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

State/Territory: Indiana

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation	3.1 Amount, Duration, and Scope of Services
42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act	(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.
	(1) Categorically needy.
	Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:
1902(a)(10)(A) and 1905(a) of the Act	(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
	(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.
	___ Not applicable. Nurse-midwives are not authorized to practice in this State.

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Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

XX (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

State/Territory: Indiana

Citation			3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	X	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	____	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of: Indiana

Citation (Continued) 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B (a)(2) Medically needy.

/ / This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act (i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

/ / Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act (ii) Prenatal care and delivery services for pregnant women.

13

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

/ (vii) Services in an institution for mental diseases for individuals over age 65..

/ (viii) Services in an intermediate care facility for the mentally retarded.

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: INDIANA

Citation	3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1902(e)(9) of Act	___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1905(a)(23) and 1929 of the Act	___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of: Indiana

Program of All-Inclusive Care for the Elderly State Plan Amendment

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1905(a)(26) and 1934

____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 3.1-A
Page 1
OMB No.: 0938-

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/X/ Provided: /_/ No limitations /X/With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

/_/ Provided: /_/ No limitations /_/With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/With limitations*

*Description provided on attachment.

State of Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES

FURNISHED TO THE CATEGORICALLY NEEDY

4.a Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations _X_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations _X_ With limitations*

4.c (i) Family planning services and supplies for individuals who are not pregnant and for individuals eligible pursuant to Attachment 2.2-A Page 23f.

Provided: ___ No limitations _X_ With limitations*

*Description provided on attachment.

4.d. 1) Face-to-Face Tobacco Dependence Counseling Services provided (by):

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco dependence services; * or

(iii) Any other health care professional legally authorized to provide tobacco dependence services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

* Limitations to provider type and coverage listed in the Addendum to Attachment 3.1A.

2) Face-to-Face Tobacco Dependence Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations ☒ With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations: Listed in the Addendum to Attachment 3.1A.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: _____ No limitations __X___ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: _____ No limitations __X___ With limitations*

* Description provided on attachment.

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment 6.

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Respiratory therapy.

/X/ Provided with limitations.

*Description provided on attachment

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

ATTACHMENT 3.1-A
Page 5
OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Dentures.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Prosthetic devices.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Eyeglasses.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachments

TN No. ~~95-016~~ 03-017
Supersedes
TN No. ~~91-13~~ 95-016

Approval Date 9/10/03 ~~9/1/95~~

Effective Date 6/1/03 ~~8/1/95~~

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

c. Preventive services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

d. Rehabilitative services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

/XX/ Not provided.

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*

/XX/ Not provided.

*Description provided on attachment.

State/Territory_____

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [ ] No limitations

[X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services & Tuberculosis related services.

a. Case management services as defined in, and according to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

____ Provided: _____ With limitations

__X__ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: _____ With limitations *

__X__ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

_____ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/X/ Provided: /X/ No limitations / /With limitations*

/ / Not provided.

23. Pediatric or family nurse practitioners' services.

Provided: / / No limitations /X/With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Indiana

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245(A)(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. Categorically Needy

24. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

☒ Non-emergency transportation is provided in accordance with 42 CFR §431.53 as an administrative Service.

☐ Without limitations ☒ With limitations (Describe limitations in a Supplement to 3.1A either a Supplement or in Attachment 3.1D)

☐ Non-emergency transportation is provided without a broker in accordance with 42 CFR §440.170 as an optional medical service, excluding "school-based" transportation.

☐ Without limitations ☐ With limitations (Describe limitations in either a Supplement to 3.1A or in Attachment 3.1D)

(If non-emergency transportation is provided without a broker as an optional medical service or as an administrative service, **the state should describe in Attachment 3.1D how the transportation program operates** including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.)

☒ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

☒ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without regard to the requirements of the following paragraphs of section 1902(a);

☐ (1) state-wideness (Please indicate the areas of State that are covered by the broker. If the State chooses to contract with more than one broker the State must provide a separate preprint for each broker)

☒ (10)(B) comparability

☒ (23) freedom of choice

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi

☒ stretcher car

☒ bus passes

☒ tickets

☒ secured transportation

☒ other transportation (if checked describe below other types of transportation provided.) - **Volunteers, gas reimbursement for family members and close associates**

☒ (3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.) The broker shall not itself be a provider of transportation; however the state may require that the broker own/operate and have available vehicles referred to as "quick response vehicles" in the event the scheduled transportation provider is unavailable for transport or if there are no other qualified providers available to provide the transportation. The state acknowledges that the broker will use quick response vehicles only as a back-up measure to assure that beneficiaries are able to access medical service and not as a standard means of transportation. Usage of quick response vehicles are limited to selected counties. The State of Indiana discusses provider network weekly with SET to monitor the situation and to work on solutioning the gaps in the network. These meetings will continue until all QRVs would be retired.

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒ Low-income families with children (section 1931)
☒ Deemed AFDC-related eligibles
☒ Poverty-level related pregnant women
☒ Poverty-level infants
☒ Poverty-level children 1 through 5
☒ Poverty-level children 6 – 18
☒ Qualified pregnant women AFDC – related
☒ Qualified children AFDC – related

☐ IV-E foster care and adoption assistance children
☐ TMA recipients (due to employment) (section 1925)
☒ TMA recipients (due to child support)
☒ SSI recipients
☒ Individuals eligible under 1902(a)(10)(A)(i)- new eligibility group VIII (very-low income adults who are not otherwise eligible under any other mandatory eligibility group) – Becomes effective January 1, 2014, but states can elect to cover now as an early option.

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☒ Optional poverty-level - related pregnant women
☒ Optional poverty-level - related infants
☒ Optional targeted low income children
☒ Non IV-E children who are under State adoption assistance agreements
☒ Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
☒ Individuals who meet income and resource requirements of AFDC or SSI
☒ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
☒ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
☒ Children aged 15-20 who meet AFDC income and resource requirements
☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
☒ Individuals infected with TB
☒ Individuals screened for breast or cervical cancer by CDC program
☐ Individuals receiving COBRA continuation benefits
☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution (please note that the broker may only provide transportation to and from 1905(a) services)
☒ Individuals terminally ill if in a medical institution and will receive hospice care
☒ Individuals aged or disabled with income not above 100% FPL
☒ Individuals receiving only an optional State supplement in a 209(b) State
☒ Individuals working disabled who buy into Medicaid (BBA working disabled group)
☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

Any beneficiary enrolled in fee-for-service who is also eligible for transportation coverage will have his or her non-emergency transportation arranged through a broker.

(6) Payment Methodology

(A) Please describe the methodology used by the State to pay the broker:

The broker receives a fixed monthly risk-based capitated payment for all FFS members. This all-inclusive rate will cover all costs associated with the contract. The capitated rate may be adjusted on an annual basis.

(B) Please describe how the transportation provider will be paid:

The broker maintains a network of providers and is responsible for direct payments to providers.

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

State General Assembly funding

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

☒ (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

☐ (F) The State has included Federal Medicaid matching funds as State match when drawing down FTA SAFETEA–LU grants.

☒ (7) The broker is a non-governmental entity:

☐ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 42 CFR 440.170(4)(ii).

☒ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

☐ Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-government broker

☒The availability of other non-governmental Medicaid participating providers or other Providers determined by the State to be qualified is insufficient to meet the need for transportation. QRVs will operate in the following counties: Allen, Bartholomew, Blackford, Boone, Clark, Clay, Dearborn, Decatur, Delaware, Elkhart, Fayette, Floyd, Franklin, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, LaGrange, Lake, Lawrence, Madison, Marion, Marshall, Monroe, Morgan, Noble, Ohio, Orange, Owen, Porter, Posey, Putnam, Ripley, Rush, Scott, Shelby, St. Joseph, Starke, Vanderburgh, Vermillion, Vigo, Wabash, Warrick, Washington, Wayne, Wells

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the amount charged to other human services agencies for the same service.

(9) Please provide a complete description of how the NEMT brokerage program operates. Include all services provided by the broker (call center, over-sight of providers, etc.). If applicable, describe any transportation services that will not be provided by the broker and how these services will be

The FSSA contracts with a single broker for the administration of the Non-Emergency Medical Transportation program for the FFS population. The broker is responsible for the following activities:

- **Ensuring that members seeking NEMT services are eligible for Indiana Medicaid services**
- **Ensuring that non-emergency transportation providers are first enrolled as Indiana Health Coverage Programs (IHCP) providers.**
- **Recruiting, maintaining, and continuously improving a network of local qualified transportation providers, which is available statewide. This network includes, but is not limited to, specialized motor vehicles, common vehicles, taxies, and public transit.**
- **Scheduling recurring trips, one-time trips, advance reservations, hospital and emergency room discharges, trip which require prior authorization, and requests for urgent trips.**
- **Determining the appropriate mode of transportation to meet a member's medical needs, including any special transport requirements for medically fragile or physically/mentally challenges members or long-distance travel requirements.**
- **Seeking and confirming any prior authorization requirements in accordance with state and federal requirements.**
- **Responding to telephone and written inquiries from members, their representatives, health care providers, non-emergency transportation providers, and other stakeholders.**
- **Assisting the state with ongoing program operations, policy and procedures development and review, monthly status meetings with FSSA and related contractors, and a monthly quality improvement committee.**
- **Tracking and resolving quality issues and any other issues as identified within the state's quality strategy, as appropriate.**
- **Reimbursing claims for services rendered.**

- **Determining payment based on the least expensive mode and the shortest, most efficient route.**
- **Monitoring and controlling fraud, waste, and abuse from transportation providers.**

Nursing facility services for patients under 21 years of age

☒ Provided ☐ No Limitations ☒ With Limitations* ☐ Not Provided

Services provided in Religious Nonmedical Health Care Institutions.

☒ Provided ☐ No Limitations ☒ With Limitations* ☐ Not Provided

Emergency Hospital Services

☒ Provided ☒ No Limitations ☐ With Limitations* ☐ Not Provided

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____provided __X__ not provided

26. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse

☐ Provided ☐ No Limitations ☐ With Limitations*☒ Not Provided

Electronic Visit Verification System. The state became compliant with the Electronic Visit Verification System (EVV) requirements for personal care services on January 1, 2021, in accordance with section 12006 of the 21st Century CURES Act.

State of: Indiana

Program of All-Inclusive Care for the Elderly State Plan Amendment

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE

AND SERVICES TO THE CATEGORICALLY NEEDY

Freestanding Birth Center Services (in accordance with section 1905(a)(28) and 1905(1)(3)(A)-(c) of the Act).

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations X With limitations ☐ None licensed or approved

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations X With limitations

State: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE

AND SERVICES TO THE CATEGORICALLY NEEDY

29. Psychosocial rehabilitation services

Provided: ☐ No limitations X With limitations

State/Territory: Indiana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: _X_

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1.	Inpatient Hospital services	Provided with limitations. Inpatient hospital services are covered when provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Reimbursement shall not be made for any hospital services not covered under the Medicaid program. The following require prior authorization: (1) any procedure ordinarily rendered on an outpatient basis when rendered on an inpatient basis (2) psychiatric inpatient admissions (3) rehabilitation, including substance abuse, inpatient admissions (4) burn inpatient admissions (5) out of state hospitalization (6) nonemergent inpatient admissions The following are exempt form the prior authorization requirements: (1) Inpatient hospital admissions when covered by Medicare. (2) Routine vaginal and cesarean section deliveries. If an inpatient procedure requires prior authorization and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.
2.a.	Outpatient Hospital services	Provided with limitations. Outpatient hospital services are covered when provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Reimbursement shall not be made for any hospital services not covered under the Medicaid program. For general anesthesia services, documentation in the patient's record must include specific reasons why such services are needed, if such services are to be provided on an outpatient basis.
2.b.	Rural Health Clinic services	Provided with limitations. Reimbursement is available to rural health clinics for medically necessary services provided by a physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, chiropractor, licensed clinical addiction counselor, licensed marriage and family therapist, or licensed mental health counselor employed by the rural health clinic. Reimbursement shall not be made for any services not covered under the Medicaid program.

2.c.	Federally Qualified Health Center services	Provided with limitations. Reimbursement is available to FQHCs for medically necessary services provided by a physician, as defined in 42 C.F.R. 405.2412, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, chiropractor, licensed clinical addiction counselor, licensed marriage and family therapist, or licensed mental health counselor. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by Medicaid. Any other ambulatory service included in the Medicaid state plan is considered a covered FQHC service if the FQHC offers such a service. Reimbursement shall not be made for any service not covered under the Medicaid program.
3.	Other Laboratory and X-ray services	Provided with limitations. All laboratory and x-ray services must be ordered by a physician or other practitioner licensed to do so under state law. Covered when necessitated by a condition-related diagnosis. Only one (1) charge per day for each patient is allowed for venipuncture.

4.a.	Nursing Facility services for individuals 21 years of age or older	Provided with limitations. Reimbursement is available for nursing facility services provided by a licensed and certified nursing facility in accordance with Attachment 4.19-D, when rendered to a recipient whose level of care has been approved by the Office of Medicaid Policy and Planning. Those services and products furnished by the nursing facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with State law. The per diem rate for nursing facilities includes the following services: room and board, room accommodations, all dietary services, and laundry services; nursing care provided by a registered nurse, licensed practical nurse, or nurse's aid; all medical and nonmedical supplies and equipment; durable medical equipment (DME), and associated repair costs routinely required for the care of patients; medically necessary therapy services which include physical, occupational, respiratory, and speech pathology services; transportation to vocational/habilitation service programs; the cost of both legend and non-legend water products in all forms and for all uses.
4.b	Early and Periodic Screening, Diagnosis Treatment	Provided in excess of federal requirements. Treatment services are covered subject to prior authorization requirements and reimbursement limitations. Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the services. However, if a service is not covered under the state plan, it is still available to EPSDT eligible recipients subject to prior authorization requirements in accordance with State law if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Medicaid reimbursement is available for Individualized Education Program (IEP) nursing services rendered by a Registered Nurse (RN) who is employed by or under contract with a Medicaid-participating school corporation provider when the services are: medically necessary; provided pursuant to a Medicaid-enrolled student's IEP; and provided in a school setting.
4.c.	Family Planning services	Provided with limitations. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services includes: diagnosis and treatment of sexually transmitted diseases, if medically indicated; follow-up care for complications associated with contraceptive methods issued by the family planning provider; health education and counseling necessary to make informed choices and understand contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraceptive methods; limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; screening, testing, and counseling of members at risk for HIV and referral and treatment; tubal ligation or Essure device; and vasectomy.
4c(i)	Family Planning services	Provided with limitations Family planning services are those services provided to individuals who are not pregnant to temporarily or permanently prevent or delay pregnancy. Family planning services include: diagnosis and treatment of sexually transmitted diseases, if medically indicated; follow-up care for complications associated with contraceptive methods issued by the family planning provider; health education and counseling necessary to make informed choices and understand contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraceptive methods; limited history and physicial examination, pregnancy testing, and counseling; provision of contraceptive pills, devices, and supplies; screening, testing, and counseling of members at risk for HIV and referral and treatment; tubal ligation or Essure device; and vasectomy.

4.d.1	Face-to-Face Tobacco Dependence Services	Provided with Limitations: Reimbursement is available for tobacco dependence treatment. Tobacco dependence treatment includes covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products as well as tobacco dependence counseling. A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy. Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program. The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations set out in this state plan: (1) A physician. (2) A physician's assistant. (3) A nurse practitioner. (4) A registered nurse. (5) A psychologist. (6) A pharmacist. (7) A dentist. (8) An optometrist. (9) A clinical social worker. (10) A martial and family counselor. (11) A mental health counselor. (12) A licensed clinical addictions counselor.

5.a. Physicians' services

Provided with limitations.
Reimbursement is available for medically necessary services provided by a doctor of medicine or osteopathy for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within the scope of the practice of medicine, as defined by Indiana law, and subject to limitations.

Reimbursement is available for office visits limited to a maximum of office visits per rolling 12 months, per recipient, per provider without prior authorization. Additional office visits may be approved with prior authorization based on medical necessity. Office visits should be appropriate to the diagnosis and treatment given and properly coded. New patient office visits are limited to one per recipient, per provider within the last three (3) years. For purposes of this subsection, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the last three (3) years.

A physician will not be reimbursed for the following: preparation of reports, missed appointments, writing or telephoning prescriptions to pharmacies, telephone calls to laboratories, any extra charge for after-hours services, mileage.

Reimbursement is available for a physician as an assistant surgeon and is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in coding guidelines. When extenuating circumstances require an assistant surgeon when customarily one is not required, these circumstances must be well documented in the hospital record and documentation must be attached to the claim form. Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.

Reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient's condition. Possible noncompliance by a recipient to oral medication is insufficient justification to administer injections.

5.b. Medical and Surgical services furnished by a dentist	Provided with limitations. Reimbursement is available only for those services listed below subject to limitations. The following are covered medical and surgical services furnished by a dentist under the Indiana Medicaid program: oral biopsies, alveoplasty, excision of lesions, excision of benign tumor, nonodontogenic cyst removal, incise and drain abscess, fracture simple stabilize, compound fracture of the mandible, compound fracture of the maxilla, repair of wounds, suturing, , periodontal surgery limited to drug-induced periodontal hyperplasia, other medical and surgical services furnished by a dentist as medically necessary to treat recipients eligible for the EPSDT program, general anesthesia, intravenous (IV) sedation covered only for oral surgical services, and maxillofacial surgery
6.a. Podiatrists' Services	Provided with limitations. (1) Are provided by a podiatrist who is licensed by the State and meets standards issued by the Secretary of Health and Human Services; and (2) Consists of treatment that the podiatrist is legally authorized by the State to perform and services of a doctor of podiatric medicine, acting within the scope of his or her license, if the services would be covered as physicians' services when performed by a doctor of medicine or osteopathy. (3) Reimbursement is limited to 1 office visit and up to 6 routine foot care services per recipient with systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous per 12 months. New patient office visits are limited to one (1) per recipient, per provider, within the last three (3) years. "New patient" is one who has not received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years. Reimbursement is available within the scope of the practice of podiatry as defined by Indiana law. Covered services include diagnosis of foot disorders and mechanical, medical or surgical treatment of these disorders. Reimbursement is not available for any podiatric service provided outside the scope of state licensure or for any podiatric service for which federal financial participation is not available. Subject to prior authorization requirements, these limits do not apply to treatments found necessary for children under the age 21, after a diagnosis as a result an EPSDT service.

6.b. Optometrists' services

Optometrists' services are provided in accordance with 42 CFR 440.060.

Reimbursement is available for medically necessary services provided by an optometrist within the scope of practice as define by Indiana law and subject to procedure code limitations.

6.c. Chiropractors' services

Chiropractors' services include only services that—

(1) Are provided by chiropractor who is licensed by the State and meets standards issued by the Secretary of Health and Human Services under 42 CFR 420.21(a); and
(2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform
(3) Provided with limitations
Coverage is limited to 5 office visits and up to 50 therapeutic physical medicine treatments per recipient per year; however, the 5 office visits are included in the 50 visit/treatment maximum. Additional treatments may be authorized with prior authorization and are based on medical necessity.

(4) Are eligible for federal financial participation.

6.d. Other Practitioners' services

Nurse Practitioners' services

Provided with limitations.
Reimbursement is available for medically necessary, reasonable and preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

Diabetes Self-Management
And Training Services

Reimbursement is limited to a total of sixteen units (15 minutes each) per recipient, per rolling calendar year. Additional units may be prior authorized. Services must be medically necessary; provided by health care professionals who are licensed, registered or certified under applicable Indiana law and who have specialized training in the management of diabetes; and ordered in writing by a physician, podiatrist, nurse practitioner, clinical nurse specialist, certified nurse midwife and physician assistant.

6.d.	Other Practitioners' services (continued)	Provided with limitations.
	Physician Assistants' Services	Licensed Physician Assistants may provide medically necessary healthcare services within their scope of practice according to state law.
	Community Health Workers' Services	Reimbursement is available for medically necessary health care services provided by a certified community health worker within the scope of the applicable certification program. The services within the applicable certification program of a certified community health worker should be within the scope of practice for each of the following supervising licensed practitioners: health services provider in psychology, advanced practice nurse, physician assistant, podiatrist, and chiropractor. Supervision of the certified community health worker is included in the scope of practice for each supervising licensed practitioner. Each supervising licensed practitioner shall assume professional responsibility for the services provided by the certified community health worker. Each supervising licensed practitioner shall bill for the services of the certified community health worker
	Licensed Behavioral Health Practitioners Services	Licensed Clinical Social Workers may provide medically necessary healthcare services within their scope of practice according to state law. Licensed Marriage and Family Therapists may provide medically necessary healthcare services within their scope of practice according to state law. Licensed Mental Health Counselors may provide medically necessary healthcare services within their scope of practice according to state law. Licensed Clinical Addiction Counselors may provide medically necessary healthcare services within their scope of practice according to state law.

Psychologists' services

Psychologists' services include only services that are provided by licensed psychologists within the scope of practice as defined under 868 IAC 1.1-13 and IC 25-33-1.

Reimbursement is available for outpatient mental health and substance abuse treatment services provided by a licensed psychologist endorsed as a health services provider in psychology (HSPP), subject to the following limitations:

(1) Subject to prior authorization by the office or its designee, Medicaid will reimburse HSPP supervised outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:
- (A) A licensed psychologist.
- (B) A licensed independent practice school psychologist.
- (C) A licensed clinical social worker (LCSW).
- (D) A licensed marital and family therapist (LMFT).
- (E) A licensed mental health counselor (LMHC).
- (F) A licensed clinical addiction counselor (LCAC).
- (F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
- (G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

(2) A HSPP is responsible for certifying the diagnosis for the purpose of developing the plan of treatment and providing continuous supervision as follows:
- (A) The supervising practitioner is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the plan of treatment within seven (7) days.
- (B) The supervising practitioner must provide face to face visits with the patient or review the plan of treatment submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the supervising practitioner assuming responsibility for the plan of treatment.

(3) Medicaid will reimburse for evaluation, psychological testing and group, family, and individual psychotherapy when provided by a licensed psychologist, licensed independent practice school psychologist, and a licensed psychologist endorsed as an HSPP.

(4) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by an HSPP.

(5) Prior authorization is required for mental health service provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization.

(6) The following are services that are not reimbursable by the Medicaid program:
- (A) Daycare.
- (B) Hypnosis.
- (C) Biofeedback.
- (D) Missed appointments.

Telehealth

Coverage is available for health care services delivered via telehealth. Telehealth must be provided in accordance with Indiana state law.

The following services may not be delivered via telehealth:

(A) Ambulatory surgical services.
(B) Outpatient surgical services.
(C) Radiological services.
(D) Laboratory services.
(E) Anesthesia services or nurse anesthetist services.
(F) DME and HME services.
(G) Transportation services.

For more information on telehealth monitoring reimbursement for home health care services, please refer to Attachment 4.19-B, Page 3c.1.1

7. Home Health services

Home Health Services are provided in accordance with 42 CFR 440.70 and include:

(1) Intermittent or part-time nursing services in accordance with 42 CFR 440.70 (b)(1).
(2) Home health aide services in accordance with 42 CFR 440.70(b)(2).
(3) Medical supplies, equipment, and appliances suitable for use in the home in accordance with 42 CFR 440.70(b)(3).
(4) Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided by a home health agency or medical rehabilitation facility in accordance with 42 CFR 440.70(b)(4) and 42 CFR 440.110.

Reimbursement for Home Health Services provided by licensed individuals within the scope of practice as defined under state law is available with prior authorization, for medically necessary and reasonable care.

All medically necessary Home Health Services will be provided to children under the age of 21.

Medically necessary and reasonable service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

All home health services require prior authorization by the Office of Medicaid Policy & Planning (OMPP), except the following:
(1) Services ordered in writing prior to inpatient hospital discharge provided by an RN, LPN, or home health aide, if the services do not exceed 120 units within 30 calendar days following hospital discharge.
(2) Nursing services that do not meet the definition of emergency services, are covered without prior authorization when provided to a recipient for whom home health services have been currently authorized.

Coverage is not available for:
(1) Homemaker, chore services, and sitter/companion service.
(2) Educational activities.
(3) Out of state home health agency services.
(4) Therapy rendered for diversional, vocational, recreational, or avocational purposes.
(5) Activities that can be conducted by non-medical personnel.

All incontinence supplies must be provided by the one provider under contract with the Indiana Medicaid program to provide incontinence supplies.

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7.d.	Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided by a home health agency or medical rehabilitation facility	Reimbursement is available only for medically necessary and reasonable therapy and is provided with limitations. Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology services provided by a home health agency in accordance with 42 CFR 440.70 (b) (4) and 42 CFR 440.110. Prior authorization is required by the OMPP for all therapy services except the following; (1) Initial evaluations. (2) Any combination of therapy services ordered in writing prior to inpatient hospital discharge, if the services do not exceed 30 units in thirty 30 calendar days following hospital discharge. (3) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators. (4) Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate. (5) Physical therapy and occupational therapy ordered in writing by a physician to treat an acute medical condition. Prior authorization is required by the OMPP for all audiology services except the following; (1) The initial assessment of hearing. (2) Determination of suitability of amplification and the recommendation regarding a hearing aid. (3) The determination of functional benefit to be gained by the use of a hearing aid. (4) Audiology services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate.
8.	Private Duty Nursing	Private Duty Nursing services provided by a home health agency in accordance with 42 CFR 440.80. Reimbursement is available for medically necessary and reasonable services rendered by registered nurses, licensed practical nurses and home health agencies who are Medicaid providers, subject to prior authorization requirements applicable to home health agencies.

9.	Clinic services	Covered for medically necessary clinic services..
10.	Dental services	Covered subject to a $1,000 cap per recipient per 12 month period for all Dental services. Coverage limits based on diagnostic and treatment services..
11.	Physical Therapy and Related services	Covered for medically necessary therapy services. Therapy provided for diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities which can be conducted by nonmedical personnel, is not covered.
11.a.	Physical Therapy	Provided in accordance with the requirements of 42 CFR 440.110. Therapy services will not be approved for more than one (1) hour per day per type of therapy. Evaluations and reevaluations are limited to three (3) hours of service per evaluation A certified physical therapist's assistant may provide services within scope of practice as defined by Indiana State law.
11.b.	Occupational Therapy	Provided in accordance with the requirements of 42 CFR 440.110. Therapy services will not be approved for more than one (1) hour per type of therapy. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. A certified occupational therapy assistant may provide services within scope of practice as defined by Indiana State law.
11.c.	Services for individuals with speech, hearing and language disorders (provided by a speech pathologist or audiologist)	Provided in accordance with the requirements of 42 CFR 440.110. Therapy services will not be approved for more than one (1) hour per day per type of therapy. Speech therapy evaluations and reevaluations are limited to three (3) hours of service per evaluation. A registered speech-language pathology aide may provide services within scope of practice as defined by Indiana State law.
11.d.	Respiratory Therapy services	Provided in accordance with the requirements of 42 CFR 440.185. Coverage is limited by diagnosis and medical necessity. A certified respiratory therapy technician may provide services within scope of practice as defined by Indiana State law.

12.a. Prescribed Drugs

Provided with limitations.

Reimbursement is available for prescribed drugs subject to the limitations set out in 405 lAC 5. The following are not covered: anorectics or any agent used to promote weight loss; topical minoxidil preparations; fertility enhancement drugs; drugs used to treat sexual or erectile dysfunction, as set forth in section 1927(d)(2)(K) of the Act, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and such uses have been approved by the Food and Drug Administration; drugs prescribed solely or primarily for cosmetic purposes. All over-the-counter and non-legend items are subject to the limitations set out in 405 lAC 5-24.

In accordance with Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990), Indiana Medicaid will fully participate in the manufacturer rebate program. In doing so, all applicable provisions and restrictions of the legislation, as well as that of any subsequent rules and/or regulations, will be strictly adhered to. Specifically, Indiana Medicaid will reimburse for all rebating manufacturers' (as identified to the agency by CMS) products fully in accordance with the specifications of the legislation. The program will also adhere to all reporting requirements of the legislation.

Supplemental Rebates--The State is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates. A rebate agreement between the State and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on November 20, 2020and entitled, State of Indiana Supplemental Rebate agreement, has been authorized by CMS.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of prior authorization requirement, will comply with the provisions of the national rebate agreement.

12.b.	Dentures	Provided with limitations. Prior review and authorization by the agency is required for all dentures, partials and repairs. Reimbursement is subject to the limitations set out in 405 IAC 5.
12.c.	Prosthetic devices	Prior authorization by the Office of Medicaid Policy and Planning is required for all prosthetic devices, except for all customizing features, once the basic prosthesis is approved. Coverage is not available for prosthetic devices dispensed for purely cosmetic reasons.
12.d.	Eyeglasses	Covered for medically reasonable and necessary eyeglasses, with the following limitations: (1) Eyeglasses provided to a recipient under 21 years of age will be limited to a maximum of 1 pair per year. (2) Eyeglasses provided to a recipient 21 years of age or over will be limited to a maximum of 1 pair every 5 years. Medically necessary and reasonable is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. Coverage is not available for: (1) Lenses with decorative designs. (2) Fashion tints, gradient tints, sunglasses and photochromatic lenses. (3) Oversized lenses larger than 61 mm, except when medically necessary.
13.	Other diagnostic, screening preventive and rehabilitative services	Covered for medically necessary diagnostic preventative, therapeutic, and rehabilitative services. Medically necessary is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.
13.a.	Diagnostic services	Covered for medically necessary diagnostic preventative, therapeutic, and rehabilitative services. Coverage for environmental lead investigations is available for a one-time, on-site environmental lead investigation of a child's home (or primary residence) for a child with an elevated blood lead level. This environmental lead investigation will be provided by a licensed risk assessor or licensed lead inspector. Medically necessary is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

13.a.1 Face-to-Face Tobacco Dependence Services

Provided with Limitations:
Reimbursement is available for tobacco dependence treatment.

Tobacco dependence treatment includes covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products as well as tobacco dependence counseling. A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy.

Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program.

The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations set out in this state plan:

(1) A physician.
(2) A physician's assistant.
(3) A nurse practitioner.
(4) A registered nurse.
(5) A psychologist.
(6) A pharmacist.
(7) A dentist.
(8) An optometrist.
(9) A clinical social worker.
(10) A martial and family counselor.
(11) A mental health counselor.
(12) A licensed clinical addictions counselor.

13.b. Screening services

Reimbursement is available for medically reasonable and necessary screening services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:
(1) be medically reasonable and necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
(2) not be considered a noncovered service, or otherwise excluded from coverage.

Services excluded from coverage are the following:

(a) Radiology examinations of any body part taken as a routine study not necessary to the diagnosis or treatment of a medical condition.
(b) Doppler Evaluations - The ultrasonic measurement cannot be used for routine screening purposes.
(c) Vision Care Services - Screening services (excluding EPSDT) for recipients are not covered by Medicaid, and payment will not be made for such care.
(d) Podiatric Services - Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on patients on a routine basis for screening purposes.

13.c. Preventive services

Reimbursement is available for medically reasonable and necessary preventative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:
(1) be medically reasonable and necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
(2) not be considered a noncovered service, or otherwise excluded from coverage.

13.d. Rehabilitative services

Reimbursement is available for medically reasonable and necessary rehabilitative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:

(1) be medically reasonable and necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
(2) not be considered a noncovered service, or otherwise excluded from coverage.

All therapies provided in a rehabilitation center must be provided in accordance with the following:

Demonstration of the inability of the recipient to function independently with demonstrated impairment:
(1) Cognitive function (attention span, memory, or intelligence).
(2) Communication (aphasia with major receptive or expressive dysfunction).
(3) Continence (bladder or bowel).
(4) Mobility (transfer, walk, climb stairs, or wheelchair).
(5) Pain management (pain behavior limits functional performance).
(6) Perceptual motor function (spatial orientation or depth or distance perception).
(7) Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).

The intensity of service criteria shall be as follows:
(1) Multidisciplinary team evaluations should occur at minimum every two (2) weeks.
(2) Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
(A) Occupational therapy.
(B) Speech therapy.
(3) Participation in a rehabilitation program under the direction of a qualified physician.
(4) Skilled rehabilitative nursing care or supervision required at least daily.

Discharge criteria may include, at minimum, the following:
(1) Evidence in the medical record indicating the patient has achieved stated goals.
(2) Medical complications precluding intensive rehabilitative effort.
(3) Multidisciplinary therapy is no longer needed.
(4) Additional functional improvement is not anticipated.
(5) Patient's functional status has remained unchanged for fourteen (14) days.

Educational services are not covered.

13.d.1. Medicaid Rehabilitation Option

Reimbursement is available for Medicaid Rehabilitation Option (MRO) services, which are defined as:

(1) Behavioral Health Counseling and Therapy services. Refers to a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan.

These services include the following:

- Individual counseling and therapy
- Family/Couple (Individual) with the consumer present counseling and therapy
- Family/Couple (Individual) without the consumer present counseling and therapy
- Group counseling and therapy
- Family/Couple (Group) with the consumer present counseling and therapy
- Family/Couple (Group) without the consumer present counseling and therapy

Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed professional, except for a licensed clinical addiction counselor, defined as: Individuals wishing to be addiction counselors or clinical addiction counselors must meet the education, counseling experience, examination and exemptions, renewal of licensure, and temporary permit requirements of the State of Indiana.
- Qualified Behavioral Health Professional (QBHP)

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5	Individual Counseling and Therapy	48
5A	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5	Group Counseling and Therapy	60
5A	Group Counseling and Therapy	60

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5 /6	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5 /6	Group Counseling and Therapy	60

(2) Medication Training and Support services. Refers to monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing/medical assessments. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed physician
- Authorized health care professional
- Licensed physician assistant (PA)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a two (2) year clinical program

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5	Medication Training and Support	104
5A	Medication Training and Support	104

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5 /6	Medication Training and Support	104

(3) Skills Training and Development services. Refers to the development and/or restoration of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living. Development and/or restoration of skills is provided

through structured interventions for attaining recovery goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Services may be provided for persons who are living in the community, or who are residing in an ASAM 3.1 Substance Use Disorder Residential Treatment Facility, and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5	Skills Training and Development	900
5A	Skills Training and Development	1000

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5 /6	Skills Training and Development	900

(4) Behavioral Health Level of Need Redetermination. Refers to services required to assess an individual's functional needs and strengths, determine level of need, and make changes to the individualized integrated care plan. The assessment is used as a clinical guide and a treatment planning tool which assists providers in creating a person-centered plan of care. The redetermination includes face-to-face contact with the consumer and face-to-face or telephone collateral contacts with family members or non-professional caretakers, which results in a completed redetermination. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction.

The following providers are qualified to deliver this service:

- Individuals meeting the Division of Mental Health and Addiction's (DMHA) training competency standards for the performance of the DMHA approved assessment tool.

Limitations:

- Reimbursement is allowed for one redetermination per 180 days for Adults LON 3-5A and Children/Adolescents LON 3-6.

- Care Coordination services. Refers to the coordination of services to manage a mental health or substance use disorder. Care coordination services include the assessment of the eligible consumer to determine mental health and substance abuse treatment service needs, development of an individualized integrated care plan, referral and related activities to help the consumer obtain needed services, monitoring and follow-up, and evaluation. Care coordination is a service on behalf of the consumer, not to the consumer, and is management of the case, not the consumer.
  The following providers are qualified to deliver this service:
  - A licensed professional
  - A QBHP
  - An OBHP

  Limitations:
- Activities billed under behavioral health level of need redetermination.
- The actual or direct provision of medical services or medical treatment.

(5) [Crisis Intervention services has been moved to Attachment 3.1-A, Addendum Page 9c.2].

(6) Child and Adolescent Intensive Resiliency Services (CAIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. CAIRS is designed to alleviate emotional or behavioral problems with the goal of reintegrating the child into the community setting and restore a beneficiary to his best possible functional level. CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is time-limited, curriculum-based, with goals that include reintegration into age appropriate community settings (e.g., school and activities with pro-social peers). Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, or addiction. Children who do not meet the medical necessity criteria for CAIRS will receive comparable treatment services under Early and Periodic Screening, Diagnostic and Treatment.
The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations:

- The program is required to operate 2-4 hours per day and 3-5 days per week.
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	252-Limited to 90 consecutive days
5 /6	CAIRS	252-Limited to 90 consecutive days

(7) Adults Intensive Rehabilitative Services (AIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness, or addiction.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations:

- The program is required to operate 2-6 hours per day and 3-5 days per week
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	270-Limited to 90 consecutive days
5 /6	CAIRS	270-Limited to 90 consecutive days

(8) [Intensive Outpatient Treatment (IOT) has been moved to Attachment 3.1-A, Addendum Page 9c.2].

(9) Addiction Counseling services. Refers to a planned and organized service where addiction professionals and clinicians provide counseling intervention. Addiction counseling services to the beneficiary's family and caretakers is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery. In addition to individual, group, and family addiction counseling, other activities included are: education on addiction disorders and skills training in communication, anger management, stress management and relapse prevention. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5	Addiction Counseling	32
5A	Addiction Counseling	50

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5 /6	Addiction Counseling	32

(10) [Peer Recovery Services has been moved to Attachment 3.1-A, Addendum Page 9c.3].

(11) Psychiatric Assessment and Intervention services. Refers to face-to-face and non-face-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to consumers who are receiving services from an interdisciplinary team. Services may be provided for persons with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community.
The following providers are qualified to deliver this service:

- Physician
- Authorized healthcare professional

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

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Opioid Treatment Services

Opioid treatment services refers to rehabilitative services for an individual to administer opioid treatment medication and to alleviate the adverse medical, psychological, or physical effects incident to opioid addiction. Opioid treatment services consist of the following Medicaid service components:

- Oral medication administration, including the administration of methadone
- Periodic alcohol and drug screening
- Individual psychotherapy
- Group psychotherapy
- Coordination of services
- Daily methadone dosage
- Pharmacologic management
- Self-management education
- Periodic laboratory tests for Hepatitis, pregnancy, TB, Syphilis, HIV, and complete blood count
- Periodic evaluation and management visits

Any individual providing opioid treatment services that is not licensed by the State must instead be credentialed in addictions counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction. All opioid treatment services furnished by these credentialed individuals must be recommended by a physician or other licensed practitioner of the healing arts.

Limitations:

- Services must be rendered in an Opioid Treatment Program that has been certified under 42 C.F.R. 8 (regarding the process and standards by which SAMHSA determines that an opioid treatment program is qualified to provide opioid treatment under the Federal opioid treatment standards), and approved by the Family and Social Services Administration's Division of Mental Health and Addiction.

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Crisis Intervention Services	Refers to short-term emergency behavioral health services, available twenty-four (24) hours a day, seven (7) days a week. Crisis Intervention includes, but is not limited to crisis assessment planning and counseling specific to the crisis, intervention at the site of the crisis (when clinically appropriate), and pre-hospital assessment. The goal of Crisis Intervention is to resolve the crisis, and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis Intervention may be provided in an emergency room, clinic setting, or within the community. Services may be provided to any Medicaid eligible individual in need of crisis services. The following providers are qualified to deliver this service: • Licensed professional • QBHP • OBHP There are no limitations on this service.
Intensive Outpatient Treatment (IOT)	Reimbursement is available for intensive outpatient treatment when provided to treat substance abuse or psychiatric disorders, subject to prior authorization. IOT must operate at least three (3) hours per day, at least three (3) days per week and must be based on an individualized integrated care plan. The Medicaid covered service components are covered by the State through licensed professionals under 42 C.F.R. 440.60 and are as follows: • Individual/Family Therapy (Attachment 3.1-A Addendum Page 3.1); and • Group Therapy (Attachment 3.1-A Addendum Page 3.1). The Medicaid covered service components and the practitioners who are qualified to provide them are as follows: • Skills Training (Attachment 3.1A Addendum Page 8b and 8c); • Medication Training and Support (Attachment 3.1A Addendum Page 8b); • Peer Recovery Services (Attachment 3.1A Addendum Page 9c.3); and • Care Coordination (Attachment 3.1A Addendum Page 9). Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Therapy services to the beneficiary's family and caretakers are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery. The following providers are qualified to deliver Individual/Family Therapy; Group Therapy; Skills Training; Medication Training and Support; Peer Recovery Services; and Care Coordination. • Licensed professional • QBHP • OBHP

MRO SERVICES WILL CONTINUE ON PAGE 9d

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Peer Recovery Services	Refers to individual face-to-face services that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services which may be provided include: • Assisting the consumer with developing self-care plans, and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services. • Assisting the consumer in the development of psychiatric advanced directives. • Supporting day-to-day problem solving related to normalization and reintegration into the community. • Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction. Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan (IICP). An IICP is developed with the consumer and must reflect the consumer's desires and choices. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness or addiction. Services must be provided at home or at other locations outside the clinic setting. The following providers are qualified to deliver this service: • Individuals certified in Peer Recovery Services. Individuals providing Peer Recovery Services must be under the supervision of a Licensed professional or QBHP and must be self-identified consumers who are in recovery from mental illness and/or substance use disorders, are trained in a basic set of competencies necessary to perform the peer support function, have demonstrated the ability to support the recovery of others from mental illness and/or substance use disorders, and receive continuing and ongoing education as administered by agencies certified by the Department of Mental Health and Addiction (DMHA).

MRO SERVICES WILL CONTINUE ON PAGE 9d

(12) Psychosocial rehabilitation services. Refers to Medicaid Rehabilitation Option (MRO) services provided in a community based Clubhouse setting in which the member, with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member services such as employment training, housing assistance, and educational support. These activities are designed to alleviate emotional or behavior problems with the goal of transitioning to a less intense level of care, reintegrating the member into the community, and increasing social connectedness beyond a clinical or employment setting. The Clubhouse setting is tailored to address the social isolation and social stigma experienced by many persons suffering from mental illness. Psychosocial rehabilitation services are covered when provided under the authority of an approved Division of Mental Health and Addiction (DMHA) Medicaid Rehabilitation Option (MRO) provider as authorized by a physician or health service provider in psychology (HSPP). Psychosocial rehabilitation services consist of the following Medicaid covered service component:

- Skills Training and Development: Refers to the development and/or restorations of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living.

The following providers are qualified to provide these services:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)
- Authorized health care professional (AHCP)

Limitations:

- Services may only be rendered in an internationally accredited Clubhouse setting certified by DMHA.
- Services are available for individuals with an Adult Needs and Strengths Assessment (ANSA) level of need (LON) of 3, 4, 5 or 5A.
- Service packages authorize the following units of service for 180 days for any member with a level of need LON of 3 or above. Any additional medically necessary units of service may be prior authorized.

Level of Need	Service Type	Units per 180 days (15 min.)
3, 4, 5, 5A	Clubhouse psychosocial rehabilitation services	1,820

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

Service Packages and Prior Authorization

MRO service packages are assigned to persons with a behavioral health need as demonstrated by a qualifying diagnosis and level of need. Services packages are designed to authorize a set of services and units of service necessary for the majority of persons with similar functional needs to achieve recovery. Service packages are assigned for 180 days based on the level of need assessment. Within the last 30 days of an assigned service package, a provider may reassess the person and a new service package will be assigned to start the day after the existing service package ends.

- Prior authorization is available under the following circumstances: A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- A member does not have one or more qualifying MRO diagnoses and/ or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.

Providers must demonstrate that the service requested is medically necessary.

Individualized Integrated Care Plan Requirements

The following providers are able to certify a diagnosis for the purpose of developing an individualized integrated care plan (IICP) and approve the IICP for MRO services:

- A physician
- A licensed psychologist endorsed as a health service provider in psychology (HSPP)
- An advanced practice registered nurse (APRN)
- A licensed clinical social worker (LCSW)
- A licensed marriage and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A licensed clinical addiction counselor (LCAC)

The supervising practitioner is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the individualized integrated care plan within seven (7) days. Services included in an individualized plan of treatment must commence within two (2) weeks upon completion of a patient's intake assessment. The supervising practitioner must provide face to face visits with the patient or review the individualized integrated care plan submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the supervising practitioner assuming responsibility for the care plan

Provider Qualification Definitions
A licensed professional is defined as:
(1) A licensed psychiatrist.
(2) A licensed physician.
(3) A licensed independent practice school psychologist.
(4) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(5) A licensed clinical social worker (LCSW).
(6) A licensed mental health counselor (LMHC).
(7) A licensed marriage and family therapist (LMFT).
(8) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

A "qualified behavioral health professional" (QBHP) means any of the following persons:
(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
(a) In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana.
(b) In pastoral counseling from an accredited university.
(c) In rehabilitation counseling from an accredited university.
(2) An individual who is under the supervision of a licensed professional, as defined above, is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
(a) In social work from a university accredited by the Council on Social Work Education.
(b) In psychology from an accredited university.
(c) In mental health counseling from an accredited university.
(d) In marital and family therapy from an accredited university.
(3) An authorized healthcare provider (AHCP), defined as follows:
(a) a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of their scope of practice as defined by the Indiana Professional Licensing Agency (IPLA) (IC 25-27.5-5)/.
(b) a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician as stated in the section of state law (IC 25-23-1) related to advanced practice nurse collaboration with a licensed practitioner.

Other behavioral health professional (OBHP) means any of the following persons:
(1) An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency
standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined above, or a QBHP, as defined above.

may include: twenty-four (24) hour a day crisis intervention; care coordination to fulfill individual patient needs, including assertive care coordination when indicated; outpatient services, including intensive outpatient services, substance abuse services, counseling, and treatment; acute stabilization services, including detoxification services; residential services; day treatment; family support services; medication evaluation and monitoring; and services to prevent unnecessary and inappropriate treatment and hospitalization.

(c) Community Mental Health Centers wishing to provide MRO services must be certified to provide a continuum of care to Medicaid consumers. These providers may subcontract for services as appropriate.

(d) This MRO State Plan service is to run concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN.03).

14. Services for individuals age 65 or older in institutions for mental diseases

Provided with limitations.

14.a.

Inpatient hospital services Reimbursement is available for medically reasonable and necessary inpatient psychiatric hospital services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse

Reimbursement is available for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

(1) Danger to the individual.
(2) Danger to others.
(3) Death of the individual.

Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization or stay in a psychiatric residential treatment facility is found not to have been medically necessary.

15.a.	Intermediate Care Facility Services	Provided with limitations. Reimbursement is available for medically reasonable and necessary services provided by a certified intermediate care facility for the mentally retarded (ICF/MR), subject to prior authorization.
15.b.	Including such services in a public institution for the mentally retarded	Provided with limitations. Reimbursement is available for medically reasonable and necessary services provided by a certified intermediate care facility for the mentally retarded (ICF/MR), subject to prior authorization
16.	Inpatient Psychiatric Facility Services for Individuals under Age 21	Provided with limitations. Reimbursement is available for medically reasonable and necessary services for inpatient psychiatric hospital and psychiatric residential treatment facility services for individuals under age 21 years of age subject to prior authorization.
17.	Nurse-Midwife Services	Provided with limitations. Medicaid reimbursement is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services the nurse-midwife is legally authorized to perform, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post-delivery.
18.	Hospice Care	Provided with limitations. Medicaid reimbursement is available for hospice services subject to prior authorization. Hospice services consist of the following: (1) Palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness. (2) Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death. In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months. For recipients twenty-one (21) years of age and older, In order to receive hospice services, a recipient must elect hospice services. Election of the hospice benefit requires the recipient to waive Medicaid coverage for other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness. For recipients less than twenty-one (21) years of age who elect hospice care, the recipient may receive concurrent curative treatment in conjunction with hospice services for the terminal illness. This allows the recipient or the recipient's representative to elect the hospice benefit, without forgoing any curative service the recipient is entitled to under Medicaid for treatment of the terminal condition.

19. Targeted Case Management for: Recipients with Elevated Blood Lead Levels	Reimbursement is available for targeted case management when provided in accordance with 42 CFR 440.169 and for individuals, who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level, as defined by the Centers for Disease Control and Prevention. Reimbursement is limited to no more than 26, 15 minute units, per recipient, per twelve month period of time. Prior authorization is required for additional units of medically necessary targeted case management.
20. Extended Services for Pregnant Women	Reimbursement is available for extended services for pregnant women with limitations and include the following: - Pregnancy-related and postpartum services for 60 days after the pregnancy ends -Services for any other medical conditions that may complicate pregnancy Services must be medically necessary and reasonable and defined as a covered service required for the care or well being of the patient and provided in accordance with generally accepted standards of medical or professional practice.
20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends	Coverage is limited to legend and non-legend drugs, prescribed for indications directly related to the pregnancy and routine prenatal, delivery and postpartum care, including family planning services. Additionally, transportation services, to and from the aforementioned services, will be provided. Payment for pregnancy-related services is subject to prior authorization.
20.b. Services for any other medical conditions that may complicate pregnancy	Reimbursement is available for services provided to a pregnant woman for the treatment of a chronic condition or other abnormal condition related to the pregnancy or complicates the medical management of the mother during pregnancy, childbirth and Puerperium including those conditions associated with fetal abnormalities and conditions. A condition that may complicate the pregnancy, is any condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient's condition or a need for a higher level of care. Reimbursement is available subject to prior authorization.

23.	Pediatric or Family Nurse Practitioners' services	Provided with limitations. Reimbursement is available for medically necessary and preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
24.	Any other medical or remedial care recognized by state law	Provided as described in 24a – 24d.
24.a.	Transportation services	Reimbursement is available for emergency and nonemergency transportation to or from a Medicaid covered service. Providers located within Indiana or in a designated out-of-state area may be reimbursed for up to twenty (20) one-way trips of less than fifty (50) miles each, per recipient, per twelve (12) month period, without prior authorization. Designated out-of-state areas are the following: (A) Louisville, Kentucky (B) Cincinnati, Ohio (C) Harrison, Ohio (D) Hamilton, Ohio (E) Oxford, Ohio (F) Sturgis, Michigan (G) Watseka, Illinois (H) Danville, Illinois (I) Owensboro, Kentucky Prior authorization is required for the following: (1) More than 20 one-way trips, per recipient, per rolling 12 month period. (2) Trips of 50 miles or more one way (3) Train or bus transportation services (4) Transportation services rendered by a provider located in a non-designated out-of-state area. (5) Airline, air ambulance, and interstate transportation (6) Family member transportation Except for trips over 50 miles, the following services are exempt from the numeric trip cap and prior authorization requirements: (1) Emergency ambulance services (2) Transportation to or from a hospital for an inpatient admission or discharge, including transfers between hospitals (3) Transportation for patients on renal dialysis or residing in a nursing home (4) Accompanying parent or recipient attendant or both (5) Return trip from emergency room in an ambulance, when medically necessary
24.b.	Services provided in Religious Nonmedical Health Care Institutions	Provided within the limitations of 42 CFR 440.170(b).
24.c		Reserved
24.d.	Skilled Nursing Facility Services for Patients under 21 Years of Age	Reimbursement is available for skilled nursing services provided by a licensed and certified nursing facility when rendered to a Medicaid recipient whose level of care has been approved by the Medicaid agency.

State: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE

AND SERVICES TO THE CATEGORICALLY NEEDY

28. (i) Freestanding Birth Center services: Reimbursement is available for licensed or otherwise State-approved freestanding birthing centers

Provided: ___ No limitations _X_ With limitations ___ None licensed or approved

Provided with limitations:

1) Recipients must be considered low-risk, normal or having an uncomplicated pregnancy;
2) Delivery shall be performed by a:
   a. Certified nurse midwife; or
   b. Physician
3) Surgical services are limited to episiotomy and episiotomy repair; and shall not include operative obstetrics or cesarean sections;
4) Labor shall not be inhibited, stimulated or augmented with chemical agents during the first or second stage of labor;
5) Systemic analgesia may be administered and local anesthesia for prudential block and episiotomy repair may be performed;
6) General and conductive anesthesia shall not be administered at birthing centers;
7) Recipients shall not routinely remain in the facility in excess of twenty-four (24) hours.

28 (ii) Licensed or Otherwise recognized State-Recognized covered professionals providing services in the Freestanding Birth Center

Please check all that apply:

X (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Indiana

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D covered drug for verified full-benefit dual eligible individuals who are enrolled in or entitled to receive Medicare benefits under Part A or Part B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Indiana

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

(1) Nonlegend (over-the-counter) drugs included on the Medicaid nonlegend drug formulary set out at:

http://www.indianapbm.com/Downloads/OTC%20Drug%20Formulary.xls

and

(2) Legend drugs that are:
(a) approved by the U.S. Food and Drug Administration;
(b) not designated by the Centers for Medicare and Medicaid Services as less than effective; or identical, related, or similar to a less than effective drug;
(c) subject to the terms of a rebate agreement between the drug's manufacturer and the CMS;
(d) prior authorized by Indiana Medicaid if subject to applicable prior authorization requirements for brand name drugs; and
(e) not specifically excluded from coverage by Indiana Medicaid. The following are specifically excluded from coverage by Indiana Medicaid:

- Anorectics or any agent used to promote weight loss;
- Topical minoxidil preparations;
- Fertility enhancement drugs;
- Drugs used to treat sexual or erectile dysfunction, as set forth in section 1927(d)(2)(K) of the Social Security Act, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and such uses have been approved by the U.S. Food and Drug Administration;
- Drugs when prescribed solely or primarily for cosmetic purposes.

SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Declaration of Emma Vosicky

Comes now Emma Vosicky, being duly sworn, and says that:

1. I am an adult resident of Indiana.

2. I am the Executive Director of GenderNexus Inc.

3. GenderNexus is an Indianapolis-based nonprofit corporation, created in 2014, which provides assistance and services to and for gender-diverse persons, including transgender and gender-diverse youth under the age of 18.

4. Among other things, GenderNexus provides care coordination and short-term supportive counseling with licensed social workers, both for gender-diverse persons and for parents and caregivers. Additionally, GenderNexus conducts specific support groups for parents and caregivers of transgender and gender-diverse youth.

5. GenderNexus also offers trainings for schools, business, counselors, business groups and government agencies, all of which trainings are designed to provide

information and understanding concerning gender-diversity and to assist in constructing a supportive environment for gender-diverse persons.

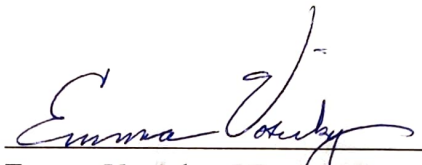
6. In order to support its clients, GenderNexus regularly obtains information as to those medical providers who offer gender-affirming care for adults and adolescents, including those providers who are available to prescribe puberty blockers and gender-affirming hormone therapy for adolescents. If and when appropriate and based upon meeting and consultation with the client and their parents/caregivers, GenderNexus can provide a medical referral letter which is required for certain gender-affirming care for individuals under 18.

7. Since September of 2022, GenderNexus has provided care coordination, for at least 137 transgender persons (together with their parents/caregivers) between the ages of eleven to seventeen, inclusive. A significant portion of these individuals (in conjunction with their parents' involvement) are considering or receiving puberty blockers or gender-affirming hormone therapy. The removal of these medical options, whether already being received or considered, substantively harms the mental and physical health and well-being of these individuals as they are forced to experience their bodies developing in ways that are absolutely contrary to their deeply held understanding of their own gender identity.

Verification

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

Executed on: April 21,2023



Emma Vosicky, J.D., MAT

Prepared by:

Kenneth J. Falk
ACLU of Indiana