IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA[1], et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

DEFENDANTS' RESPONSE TO PLAINTIFFS' FIRST SET OF REQUESTS FOR ADMISSION

Pursuant to Federal Rule of Civil Procedure 36, Defendants Secretary Weida and the Agency for Health Care Administration ("Defendants") submit their response to Plaintiffs' First Set of Requests for Admission.

GENERAL OBJECTIONS

Defendants make the following general objections to Plaintiffs' Requests for Admission, which apply to each request regardless of whether the general objections are expressly incorporated into the specific objections below:

[1] Jason Weida has succeeded Simone Marstiller as Secretary of the Agency for Health Care Administration, as reflected in ECF 78.

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1. Defendants object to the Requests for Admission to the extent they are overly broad, unduly burdensome, not reasonably calculated to lead to the discovery of admissible evidence, and not proportional to the needs of the case.

2. Defendants object to the Requests for Admission to the extent they seek to elicit information or evidence otherwise protected by the attorney-client privilege, the work-product privilege, the First Amendment associational privilege, the legislative privilege, or any other applicable privilege recognized under federal or Florida law.

3. Defendants object to the Requests for Admission to the extent they seek to elicit information that is in the public domain or already in Plaintiffs' possession, and therefore of no greater burden for Plaintiffs than for the Secretary to obtain.

4. Defendants object to the Requests for Admission to the extent they seek publicly available information, statements, or documents that speak for themselves and require neither an admission nor a denial from any party.

5. Only to the extent that Federal Rule of Civil Procedure 36(a)(4) would be construed as requiring an admission or denial and that an objection alone is not sufficient, the Secretary deny each Request for Admission. Otherwise, Defendants stand on the foregoing General Objections

and the below-stated specific objections without expressly admitting or denying any Request for Admission.

RESPONSES TO REQUESTS FOR ADMISSION

1. Admit that gender-affirming care can be medically necessary.

RESPONSE: Defendants object to the definition of gender-affirming care because it is contrary to the term's ordinary use. Subject to and without waiving such objection, Defendants admit that certain types of behavioral health services to treat gender dysphoria can be medically necessary, but other types of treatment are not.

2. Admit that the Challenged Exclusion prohibits Florida Medicaid coverage of gender affirming care that can be medically necessary for the treatment of Gender Dysphoria.

RESPONSE: Denied insofar as the Challenged Exclusion does not preclude the coverage of behavioral health services for gender dysphoria, and the services for which coverage is precluded are not medically necessary.

3. Admit that each of the Various Services can be medically necessary for the treatment of Gender Dysphoria.

RESPONSE: Denied.

4. Admit that each Plaintiff identifies as transgender.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

5. Admit that each Plaintiff has been diagnosed with Gender Dysphoria.

RESPONSE: Admitted that each Plaintiff has been diagnosed with

Gender Dysphoria, but Defendants reserve the right to challenge such diagnoses.

6. Admit that each Plaintiff receives health care coverage through Florida's Medicaid program.

RESPONSE: Admitted.

7. Admit that, prior to the enactment of the Challenged Exclusion, Florida Medicaid covered "services for the treatment of gender dysphoria," as that term is defined in the Challenged Exclusion, for each Plaintiff.

RESPONSE: Admitted that the Agency did not have a policy excluding coverage for such treatments prior to the adoption of the Challenged Exclusion.

8. Admit that Florida Medicaid covers each of the Various Services when necessary to treat at least one condition other than Gender Dysphoria.

RESPONSE: Admitted. However, these services not medically necessary for the treatment of gender dysphoria.

9. Admit that Florida Medicaid covers mastectomy, reduction mammoplasty, and breast reconstruction surgery when necessary to treat at least one condition other than Gender Dysphoria.

RESPONSE: Admitted. However, these services not medically necessary for the treatment of gender dysphoria.

10. Admit that Florida Medicaid covers hysterectomy and oophorectomy procedures when necessary to treat at least one condition other than Gender

Dysphoria.

RESPONSE: Admitted. However, these services not medically necessary for the treatment of gender dysphoria.

11. Admit that Florida Medicaid covers vaginoplasty procedures when necessary to treat at least one condition other than Gender Dysphoria.

RESPONSE: Admitted. However, these services not medically necessary for the treatment of gender dysphoria.

12. Admit that Florida Medicaid covers orchiectomy, penectomy, and/or phalloplasty procedures when medically necessary to treat at least one condition other than Gender Dysphoria.

RESPONSE: Admitted. However, these services not medically necessary for the treatment of gender dysphoria.

13. Admit that, prior to the enactment of the Challenged Exclusion, Florida Medicaid did not exclude coverage of prescribed hormones for the treatment of Gender Dysphoria.

RESPONSE: Admitted that the Agency did not have a policy categorically excluding coverage for such treatments prior to the adoption of the Challenged Exclusion.

14. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff August Dekker received coverage under Florida Medicaid for hormone therapy as treatment for his Gender Dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

15. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff August Dekker received coverage under Florida Medicaid for a double mastectomy as treatment for his Gender Dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

16. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff Brit Rothstein received coverage under Florida Medicaid for hormone therapy as treatment for his Gender Dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

17. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff Susan Doe received coverage under Florida Medicaid for a GnRH antagonist as treatment for her Gender Dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

18. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff K.F. received coverage under Florida Medicaid for a GnRH antagonist as treatment for his Gender Dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

19. Admit that, prior to the enactment of the Challenged Exclusion,

Florida Medicaid gave Plaintiff Brit Rothstein prior authorization for double mastectomy as treatment for his Gender Dysphoria.

RESPONSE: Admitted that such authorization was given by the relevant Health Plan, but was not given by the Agency.

20. Admit that, following the enactment of Challenged Exclusion, Plaintiffs have not received coverage under Florida Medicaid for the services described in Requests 14 to 19 above.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

21. Admit that if Plaintiff August Dekker does not continue to receive hormone therapy, he may undergo physical changes.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

22. Admit that if Plaintiff Brit Rothstein does not continue to receive hormone therapy, he may undergo physical changes.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

23. Admit that if Plaintiff Brit Rothstein does not receive the double mastectomy previously authorized by Defendants, he may experience exacerbated distress and chest dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

24. Admit that if Plaintiff Susan Doe does not continue to receive a GnRH antagonist, she will undergo endogenous puberty.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

25. Admit that if Plaintiff K.F. does not continue to receive a GnRH antagonist, he will undergo endogenous puberty.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

26. Admit that undergoing endogenous puberty causes development of secondary sex characteristics.

RESPONSE: Admitted.

27. Admit that undergoing endogenous puberty causes irreversible physical changes.

RESPONSE: Admitted.

28. Admit that you did not prepare any criteria for determining whether to grant a variance under Florida Statutes § 120.542 to permit Florida Medicaid coverage of any of the Various Services when used to treat Gender Dysphoria.

RESPONSE: Admitted that the Agency did not prepare any such criteria, but the Florida Legislature did as set forth in the cited statute.

29. Admit that you have no existing criteria for determining whether to grant a variance under Florida Statute § 120.542 to permit Florida Medicaid

coverage of any of the services excluded by the Challenged Exclusion.

RESPONSE: Denied.

30. Admit that you are not currently preparing any criteria for determining whether to grant a variance under Florida Statute § 120.542 to permit Florida Medicaid coverage of any of the services excluded by the Challenged Exclusion.

RESPONSE: Admitted. The criteria are set forth in the cited statute.

31. Admit that none of the Various Services are experimental when used to treat Gender Dysphoria.

RESPONSE: Denied.

32. Admit that none of the Various Services are investigational when used to treat Gender Dysphoria.

RESPONSE: Denied.

33. Admit that licensed medical professionals with experience treating Gender Dysphoria are in the best position to make medical determinations regarding the diagnosis and treatment of patients with Gender Dysphoria.

RESPONSE: Objection. The request is vague insofar as the term "best position" is not defined and could be interpreted in a number of ways.

34. Admit that, as recently as 2016, you did not consider puberty

suppression therapy for the treatment of Gender Dysphoria to be experimental.

RESPONSE: Denied.

35. Admit that, as recently as 2016, you did not consider puberty suppression therapy for the treatment of Gender Dysphoria to be investigational.

RESPONSE: Denied.

36. Admit that the individuals involved in the process of creating and implementing the Challenged Exclusion were not the same individuals who are typically involved in this process on your behalf.

RESPONSE: Denied.

37. Admit that, as recently as 2016, you did not consider any of the Various Services to be experimental.

RESPONSE: Denied.

38. Admit that, as recently as 2016, you did not consider any of the Various Services to be investigational.

RESPONSE: Denied.

39. Admit that you have criteria for determining whether to grant a variance under Florida Statutes § 120.542 for any service used to treat a healthcare condition besides Gender Dysphoria.

RESPONSE: Denied.

40. Admit that the Challenged Exclusion restricts coverage for gender-affirming care that has been the subject of decades of scholarly research.

RESPONSE: Objection. This request is vague insofar as the term "scholarly research" is not defined and could be interpreted in a number of ways.

41. Admit that no major medical organization recommends or supports prohibiting coverage of the Various Services when used to treat Gender Dysphoria.

RESPONSE: Defendants are without sufficient knowledge to admit or deny; therefore denied.

42. Admit that transgender people have historically been subject to discrimination.

RESPONSE: Objection. This request is not relevant to any party's claim or defense and is not proportional to the needs of the case.

43. Admit that, prior to the enactment of the Challenged Exclusion, you were aware that transgender people have historically been subject to discrimination.

RESPONSE: Objection. This request is not relevant to any party's claim or defense and is not proportional to the needs of the case.

44. Admit that being transgender is immutable.

RESPONSE: Denied.

45. Admit that being transgender bears no relation to one's ability to contribute to society.

RESPONSE: Objection. This request calls for an opinion, not a matter of fact. Furthermore, the request is not relevant to any party's claim or defense and is not proportional to the needs of this case.

46. Admit that you provide Florida Medicaid coverage for some health care services that have not been studied through randomized clinical trials.

RESPONSE: Objection. This request is vague and overly burdensome. Each health service is unique, and such a broad statement does not apply. To fully answer, the Agency would incur an undue burden of having to assess thousands of individual health services and determine whether they lack randomized clinical trials.

47. Admit that you provide Florida Medicaid coverage for some health care services that have not been studied through long-term longitudinal studies.

RESPONSE: Objection. This request is vague and overly burdensome. Each health service is unique, and such a broad statement should not apply. To fully answer, the Agency would incur an undue burden of having to assess thousands of individual health services and determine whether they lack long-term longitudinal studies.

48. Admit that you provide Florida Medicaid coverage for some health care services that have a risk of producing unintended, irreversible consequences.

RESPONSE: Objection. This request is vague insofar as the terms "unintended" and "consequences" are undefined and could be interpreted in a number of ways.

49. Admit that the well-established medical consensus is that gender-affirming care should be provided to transgender people with Gender Dysphoria.

RESPONSE: Denied.

50. Admit that the WPATH Standards of Care are the most widely used standards in the United States for treating Gender Dysphoria.

RESPONSE: Denied.

51. Admit that the WPATH Standards of Care are the leading standards of care for the treatment of Gender Dysphoria.

RESPONSE: Denied.

52. Admit that the WPATH Standards of Care are authoritative standards of care for the treatment of Gender Dysphoria.

RESPONSE: Denied.

53. Admit that the WPATH Standards of Care are widely accepted as the leading standards of care for the treatment of Gender Dysphoria.

RESPONSE: Denied.

54. Admit that the WPATH Standards of Care are widely accepted as authoritative standards of care for the treatment of Gender Dysphoria.

RESPONSE: Denied.

55. Admit that the Endocrine Society's Clinical Practice Guidelines are widely accepted as authoritative standards of care for the treatment of Gender Dysphoria.

RESPOSNE: Denied.

56. Admit that the Endocrine Society's Clinical Practice Guidelines are authoritative standards of care for the treatment of Gender Dysphoria.

RESPOSNE: Denied.

57. Admit that Defendants are not aware of any other widely used standards of care to treat Gender Dysphoria other than the WPATH Standards of Care or the Endocrine Society's Clinical Practice Guidelines.

RESPONSE: Denied.

58. Admit that your coverage of medical care should be made pursuant to the standards of care for a particular condition.

RESPONSE: Objection. This request calls for an opinion not a matter of fact. Furthermore, it is overly broad and lacks specificity.

59. Admit that the treatment of a medical condition should be made pursuant to the standards of care for a particular condition.

RESPONSE: Objection. This request calls for an opinion not a matter of fact. Furthermore, it is overly broad and lacks specificity.

60. Admit that persons from the Office of the Governor Ronald DeSantis were involved in your decision to promulgate the Challenged Exclusion.

RESPONSE: Denied.

61. Admit that persons from the Florida Department of Health were involved in your decision to promulgate the Challenged Exclusion.

RESPONSE: Denied.

62. Admit that you caused Chloe Cole to be invited to the July 8 Hearing.

RESPONSE: Denied.

63. Admit that you caused Sophia Galvin to be invited to the July 8 Hearing.

RESPONSE: Denied.

64. Admit that you caused Anthony Verdugo to be invited to the July 8 Hearing.

RESPONSE: Denied.

65. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Christian Family Coalition.

RESPONSE: Denied.

66. Admit that you caused to be invited to the July 8 Hearing any persons

affiliated with the Florida Citizens Alliance.

RESPONSE: Denied.

67. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Warriors of Faith.

RESPONSE: Denied.

68. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Protect our Children Project.

RESPONSE: Denied.

69. Admit that, in promulgating the Challenged Exclusion, you did not consult "evidence-based clinical practice guidelines", as that term is used in 59G-1.035.

RESPONSE: Denied.

70. Admit that, in promulgating the Challenged Exclusion, you did not consult articles "published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty association", as that term is used in 59G-1.035.

RESPONSE: Denied.

71. Admit that, in promulgating the Challenged Exclusion, you did not consult "coverage policies by other creditable insurance payor sources", as that term is used in 59G-1.035.

RESPONSE: Denied.

72. Admit that only Dr. Andre Van Mol, Dr. Quentin Van Meter, and Dr. Miriam Grossman were included on the July 8 Hearing panel.

RESPONSE: Denied.

73. Admit that Dr. Andre Van Mol, Dr. Quentin Van Meter, and Dr. Miriam Grossman have all taken positions that support Defendants' promulgation of exclusions for coverage of treatment of Gender Dysphoria.

RESPONSE: Objection. This request is vague insofar as the term "positions" is not defined and could be interpreted in a number of ways.

74. Admit that you did not include anyone on the July 8 Hearing panel who has taken a position that opposes Defendants' promulgation of exclusions for coverage of Gender Dysphoria.

RESPONSE: Objection. This request is vague insofar as the term "positions" is not defined and could be interpreted in a number of ways.

75. Admit that you selected the authors of the GAPMS Memo reports because of their opposition to gender-affirming care.

RESPONSE: Denied.

76. Admit that each of the authors of the GAPMS Memo have publicly taken positions in opposition to gender-affirming care.

RESPONSE: Denied.

77. Admit that you selected the panel members for the July 8 Hearing because of their opposition to gender-affirming care.

RESPONSE: Denied.

78. Admit that, prior to the GAPMS Memo's drafting and promulgation, you determined that gender-affirming care was experimental or investigational.

RESPONSE: Defendants object to the definition of gender-affirming care because it is contrary to the term's ordinary use. Subject to and without waiving such objection, Defendants deny.

79. Admit that, regardless of what information was available to you, you intended to reach the conclusion in the GAPMS Memo that gender-affirming care was experimental or investigational.

RESPONSE: Defendants object to the definition of gender-affirming care because it is contrary to the term's ordinary use. Subject to and without waiving such objection, Defendants deny.

* * *

Dated: January 12, 2023

/s/ Gary V. Perko
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Counsel for Secretary Weida and the Agency for Health Care Administration

CERTIFICATE OF SERVICE

I hereby certify that on January 12, 2023, a true and correct copy of the foregoing document was served upon all counsel of record via email, as follows:

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

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

SIMONE MARSTILLER, et al.,

Defendants.
_____/

DEFENDANTS' RESPONSES TO PLAINTIFFS' FIRST SET OF INTERROGATORIES

Defendants Simone Marstiller and the Agency for Health Care Administration respond to Plaintiffs' first set of interrogatories. Defendants respond as follows:

PRELIMINARY STATEMENT

1. Defendants reserve the right to supplement, clarify, or otherwise amend their responses to these interrogatories.

2. Defendants are still reviewing documents related to Plaintiffs' first request for production. As stated in Defendants' response to Plaintiffs' first request for production, responsive documents will be produced to Plaintiffs on a rolling basis. To the extent the material contains protected health information or trade secrets provided by third-party health plans, Defendants will produce the information subject to a protective order as contemplated in the parties' Rule 26(f)

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report. ECF No. 66 at 14. And to the extent that the documents require Defendants to amend these responses, they will do so.

RESPONSES TO INTERROGATORIES

Interrogatory No. 1: Identify all persons with information or knowledge concerning the facts and allegations set forth in Plaintiffs' Complaint and/or your defenses thereto.

Response: Defendants object to this interrogatory as they cannot identify "all persons" everywhere "with information or knowledge concerning the facts and allegations set forth in Plaintiffs' Complaint" and Defendants' pleadings. The information sought is thus overly broad and unduly burdensome.

Subject to and without waiving the objection, the following individuals employed at or contracted with Defendants have information or knowledge on the facts and allegations in Plaintiffs' complaint and Defendants' answer:

- Matthew Brackett, Program Consultant, Agency for Health Care Administration
- Dr. Romina Brignardello-Petersen
- Dr. James Cantor
- Nai Chen, Senior Pharmacist, Agency for Health Care Administration
- Ann Dalton, Bureau Chief, Agency for Health Care Administration
- Dr. G. Kevin Donovan
- Cody Farrill, Former Chief of Staff, Agency for Health Care Administration
- Cole Giering, Program Administrator, Bureau of Medicaid Policy, Agency for Health Care Administration
- Shena Grantham, Rule Coordinator, Agency for Health Care Administration
- Dr. Miriam Grossman
- Kim Kellum, Chief Medicaid Counsel, Agency for Health Care Administration
- Dr. Patrick Lappert
- Simone Marstiller, Secretary, Agency for Health Care Administration
- Devona Pickle, Administrator, Agency for Health Care Administration
- Andrew Sheeran, Acting General Counsel, Agency for Health Care Administration
- Josefina Tamayo, Former General Counsel, Agency for Health Care Administration
- Dr. Quintin Van Meter
- Dr. Andre Van Mol

- Tom Wallace, Deputy Secretary for Medicaid, Agency for Health Care Administration
- Jason Weida, Chief of Staff/Assistant Deputy Secretary for Medicaid Policy and Quality, Agency for Health Care Administration
- Dr. Wojtek Wiercioch

Interrogatory No. 2: Identify all persons who assisted in preparing the answers to these Interrogatories or provided information contained in the answers. For each person identified, state their title, duties, role in preparing the answers, and the Interrogatory answer(s) to which they provided information or assistance. This identification should also indicate whether the information provided is within their knowledge or was obtained from some other person or source; if the information was obtained from another person or source, that person or source should also be identified.

Response: The following individuals, upon information and belief, assisted in preparing answers in the following manner:

- Outside Counsel, assisted with responses to Nos. 1 – 15; information was obtained from personal knowledge and individuals mentioned in this response
- Matthew Brackett, Program Consultant, assisted in drafting answers to Nos. 1 – 15; information was obtained from personal knowledge and individuals mentioned in this response
- Nai Chen, Senior Pharmacist, Agency for Health Care Administration, assisted in drafting answers to and collecting documents for Nos. 6, 9, and 10.
- Cole Giering, Program Administrator, Bureau of Medicaid Policy, Agency for Health Care Administration, assisted in drafting answers to and collecting documents for No. 8.
- Andrew Sheeran, Acting General Counsel, Agency for Health Care Administration, assisted with responses to Nos. 1 – 15; information was obtained from personal knowledge and individuals mentioned in this response

Interrogatory No. 3: Describe in detail the process AHCA uses to determine whether a particular procedure, treatment, or service is experimental. Please include in your response the identities and roles of each individual involved in the process, the duration of the process (meaning how long it takes from beginning to end), and any Documents that describe the process. A complete response to this Interrogatory should identify all Documents related to that process.

Response: Please refer to the response to Interrogatory No. 5 and Rule 59G-1.035, Florida Administrative Code.

Interrogatory No. 4: Identify all persons involved in researching, preparing, drafting, or editing the GAPMS Memo, including each person's role(s) in researching, preparing, drafting, or editing the GAPMS Memo, their employer and job title, and the date on which their involvement began and if applicable, ended.

Response: Defendants object to this interrogatory. Identifying "all persons," as defined in Plaintiffs' first set of interrogatories, is too broad and burdensome, and includes anyone who provided administrative support or undertook ministerial tasks.

Defendants interpret the interrogatory as requiring the disclosure of anyone whom the GAPMS Memo was routed to within the agency:

- Matthew Brackett, Program Consultant, Agency for Health Care Administration, researching and drafting the GAPMS Memo
- Nai Chen, Senior Pharmacist, Agency for Health Care Administration, researching and preparing maps for the GAPMS Memo
- Ann Dalton, Bureau Chief, Agency for Health Care Administration
- Cody Farrill, Former Chief of Staff, Agency for Health Care Administration
- Devona Pickle, Administrator, Florida Agency for Health Care Administration, researching and preparing maps for the GAPMS Memo
- Tom Wallace, Deputy Secretary for Medicaid, Agency for Health Care Administration
- Jason Weida, Chief of Staff/Assistant Deputy Secretary for Medicaid Policy and Quality, Agency for Health Care Administration, reviewing the GAPMS Memo

Upon information and belief, each individual became involved in this process on or around April 2022.

Interrogatory No. 5: Describe in detail the process by which the GAPMS Memo was researched, prepared, drafted, and edited. A complete answer to this Interrogatory should list all public and non-public meetings at which Defendants discussed the GAPMS Memo and identify all research, studies, data, reports, publications, testimony, or other Documents considered, reviewed, or relied on in researching, preparing, drafting, and editing the GAPMS Memo.

Response: Defendants object to this interrogatory. Identifying "all" public and non-public meetings and "all" research, studies, data, reports, publications, testimony, or other "Documents," as defined in Plaintiffs' first set of interrogatories, is too broad and burdensome.

Subject to and without waiving such objection, below is the process in which a GAPMS report is created and how the GAPMS Memo was created:

When preparing a Generally Accepted Professional Medical Standards (GAPMS) report, the Agency for Health Care Administration takes the following steps to comply with the requirements specified in Rule 59G-1.035, Florida Administrative Code (F.A.C.):

- Completing a comprehensive review of the available literature and evidence-based clinical practice guidelines regarding the health service and corresponding clinical indication.
- Assessing the effectiveness of the health service under consideration based on the conclusions of research articles published in peer-reviewed, academic journals.
- Researching available coverage policies from other insurers for the health service and its corresponding clinical indication.
- Reviewing recommendations and assessments by experts on the health service and its corresponding clinical indication.

Following completion of the research phase, the Agency then composes a report organized into three parts (Health Service Summary, Literature Review, and Other Coverage Policies) and submits it for review by the Deputy Secretary for Florida Medicaid. The Deputy Secretary then decides whether to concur or not concur and signs the GAPMS report.

As to dates of meetings concerning the creation of the GAPMS Memo, Defendants collected electronic calendar invitations of meetings concerning Rule 59G-1.050(7). Those electronic calendar invitations identify the dates, subjects, and required and optional attendees of those meetings. Those documents will be

produced to Plaintiffs on a rolling basis, and Defendants will supplement this response with bates ranges of corresponding documents.

As to documents and testimony concerning the GAPMS Memo, the Agency considered the documents contained in the works-cited section of the GAPMS Memo (https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf) and considered the testimony of experts and the public during the July 8 Hearing.

Interrogatory No. 6: Identify all public or non-public meetings involving you in which Florida Medicaid coverage for procedures, treatments, and services requested or intended for the treatment of gender dysphoria were discussed, listing the date of each meeting, the nature of each meeting, and the attendees of the meeting, and identifying any Documents or other materials relating to those meetings in your custody or control.

Response: Defendants object to this interrogatory. Identifying "all" public and non-public meetings and "any Documents," as defined in Plaintiffs' first set of interrogatories, is too broad and burdensome.

Subject to and without waiving such objection, Defendants have collected electronic calendar invitations of meetings concerning Rule 59G-1.050(7). Those electronic calendar invitations identify the dates, subjects, and required and optional attendees of those meetings. Those documents will be produced to Plaintiffs on a rolling basis, and Defendants will supplement this response with bates ranges of corresponding documents.

Interrogatory No. 7: Identify all persons involved in the drafting, promulgation, and implementation of the Challenged Exclusion, including each person's role(s) in drafting, promulgating, and implementing the Challenged Exclusion, their employer and job title, and the date on which their involvement began and if applicable, ended.

Response: Defendants object to this interrogatory. Identifying "all persons," as defined in Plaintiffs' first set of interrogatories, is too broad and burdensome.

Subject to and without waiving such objection, please refer to the responses to Interrogatory Nos. 1 and 4.

Interrogatory No. 8: Describe in detail the process by which the Challenged Exclusion was originally drafted, promulgated, and implemented. A complete answer to this Interrogatory should list all public and non-public meetings at which you discussed the proposed regulation that became the Challenged Exclusion and identify all research, studies, data, reports, publications, testimony, or other Documents considered, reviewed, or relied on in the drafting, promulgation, and implementation of the Challenged Exclusion.

Response: Defendants object to this interrogatory. Identifying "all" public and non-public meetings and "all" research, studies, data, reports, publications, testimony, or other "Documents," as defined in Plaintiffs' first set of interrogatories, is too broad and burdensome.

Subject to and without waiving such objection, the following, upon information and belief, are relevant dates concerning Rule 59G-1.050(7):

- April 20, 2022, Secretary Marstiller asks Deputy Secretary Wallace to determine whether certain treatments for gender dysphoria are consistent with generally accepted professional medical standards
- June 3, 2022, Notice of Development of Rulemaking
- June 17, 2022, Notice of Proposed Rule publication
- July 8, 2022, Hearing held on Rule 59G-1.050(7)
- July 25, 2022, General Counsel Tamayo signed a memorandum that stated that (1) there was no administrative determination pending on the amendment to Rule 59G-1.050(7) and (2) the rule file documents were in order
- July 25, 2022, Secretary Marstiller concurred with recommendation to adopt Rule 59G-1.050(7)
- August 1, 2022, Rule 59G-1.050(7) was sent to the Department of State
- August 21, 2022, Rule 59G-1.050(7) became effective

As to dates of meetings concerning Rule 59G-1.050(7), Defendants collected electronic calendar invitations of meetings concerning Rule 59G-1.050(7). Those electronic calendar invitations identify the dates, subjects, and required and optional attendees of those meetings. Those documents will be produced to Plaintiffs on a rolling basis, and Defendants will supplement this response with bates ranges of corresponding documents.

As to documents and testimony concerning Rule 59G-1.050(7), the Agency considered the documents contained in the works-cited section of the GAPMS Memo

(https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf) and considered the testimony of experts and the public during the July 8 Hearing.

Interrogatory No. 9: State whether the following medical procedures, treatments, and services are excluded from coverage under Florida Medicaid for the treatment of gender dysphoria: penectomy, orchiectomy, vaginoplasty, feminizing genitoplasty, breast reconstruction, chondrolaryngoplasty, phalloplasty, metoidioplasty, masculinizing genitoplasty, mastectomy, reduction mammoplasty, hysterectomy, oophorectomy, salpingo-oophorectomy, estradiol (in all forms, including oral/sublingual estradiol, transdermal estradiol, estradiol valerate IM, and estradiol cypionate IM), medroxyprogesterone acetate (Provera), micronized progesterone, spironolactone, finasteride, dutasteride, and testosterone (in all forms, including testosterone cypionate, testosterone enthanate, testosterone topical gel 1%, testosterone topical gel 1.62%, testosterone patches, testosterone cream, testosterone axillary gel 2%, testosterone undecanoate), and Gonadotropin-releasing hormone (GnRH) antagonists. A complete answer to this Interrogatory should state whether the procedures, treatments, and services are excluded from coverage for beneficiaries under twenty-one years of age as well as for individuals twenty-one years of age and older.

Response: Upon information and belief, those procedures, treatments and services are excluded from coverage for the treatment of *only* one medical diagnosis (gender dysphoria) and not transgender status. The exclusion applies regardless of age. That said, behavioral and mental health services are not excluded. *See* ECF No. 49-2 at 84, ¶ 28 (App. 267).

Interrogatory No. 10: For each medical procedure, treatment, and service identified in response to interrogatory No. 9 as being excluded from Florida Medicaid coverage to treat gender dysphoria, state whether the exclusion is because of the Challenged Exclusion or for some other reason.

Response: For each procedure, treatment, and service identified in response to Interrogatory No. 9, they are excluded from coverage for the treatment of gender dysphoria due to Rule 59G-1.050(7). That said, behavioral and mental health services are not excluded. *See* ECF No. 49-2 at 84, ¶ 28 (App. 267).

Interrogatory No. 11: For each medical procedure, treatment, and service identified in response to Interrogatory No. 9 as being excluded from Florida Medicaid coverage to treat gender dysphoria, state whether Florida Medicaid covers the procedure, treatment, or service to treat a condition or conditions other than gender dysphoria, and if so, identify the condition or conditions and all Documents, including provider guides and manuals, provider bulletins, plan bulletins, clinical coverage policies, and claims processing manuals, related to the medical procedures, treatments, and services covered to treat the condition or conditions.

Response: Defendants direct Plaintiffs to the following regulations where they can obtain an answer:

- Inpatient Hospital Services Coverage Policy (Rule 59G-4.150, F.A.C.)
- Ambulatory Surgical Center Services Coverage Policy (Rule 59G-4.020, F.A.C.)
- Prescribed Drug Services Coverage Policy (Rule 59G-4.250, F.A.C.)
- Practitioner Fee Schedule (Rule 59G-4.002, F.A.C.)

Moreover, Florida Medicaid will cover any outpatient drug that is FDA approved and meets medical necessity guidelines. Defendants are not aware of any other manuals or bulletins that outline coverage requirements for the services considered in the GAPMS Memo when it comes to other diseases or conditions. Defendants also do not specify which conditions a treatment can apply to as long as it meets all medical necessity criteria as defined in the Definitions Policy (Rule 59G-1.010, F.A.C.).

Interrogatory No. 12: Describe in detail the entire process by which a Medicaid Recipient can request coverage of an excluded service pursuant to Florida Statutes § 120.542. Please include in your response the identities and roles of each individual involved in the process, the duration of the process (meaning how long it takes from beginning to end), and any Documents that describe the process or set forth any rules or conditions that apply.

Response: Section 120.542, Florida Statutes, as well as Chapter 28-104, Florida Administrative Code, details the process that a Medicaid recipient can request a variance and waiver. Richard Shoop is the Agency Clerk and receives the variance and waiver petition. The Secretary of the Agency for Health Administration signs the final order on the variance and waiver petition.

Interrogatory No. 13: Describe in detail the written notice afforded a Medicaid Recipient who requests coverage of an excluded service through the process described in response to interrogatory No. 12. Please include in your response the identities of each person involved in writing and sending such notice, and any deadlines for when written notice shall be provided.

Response: Defendants object to this interrogatory as being vague and ambiguous. Subject to and without waiving this objection, Defendants interpret this question to refer to notices that are provided to a Medicaid recipient who requests a variance and waiver. The final order from the Secretary of the Agency for Health Care Administration would provide the Medicaid recipient written notice of the variance and waiver decision as required by Chapter 120 of the Florida Statutes.

Interrogatory No. 14: Identify each time that a Medicaid Recipient has requested a variance or waiver pursuant to Fla. Stat. § 120.542 to receive Medicaid coverage of a health care procedure, treatment or service, the outcome the request, and all Documents related to the request and its resolution. An answer to this Interrogatory should not contain any "protected health information" as defined in 45 CFR § 160.103.

Response: Defendants object to this interrogatory. Identifying "all Documents," as defined in Plaintiffs' first set of interrogatories, is too broad and burdensome.

Subject to and without waiving such objection, Defendants have identified final orders, which will be produced to Plaintiffs on a rolling basis. Defendants will supplement this response with bates ranges of corresponding documents.

Interrogatory No. 15: Describe in detail the factual basis for each governmental interest that you contend supports the Challenged Exclusion.

Response: The State of Florida has a compelling governmental interest in protecting its citizens from experimental medical procedures. As explained in the GAPMS Memo; the response in opposition to the motion for preliminary injunction and its supporting materials, ECF No. 49; and as will be further explained in Defendants' expert reports, the at-issue treatments for gender dysphoria are experimental and could lead to negative, irreversible consequences.

VERIFICATION

Pursuant to 28 U.S.C. § 1746, I, Matthew Brackett, Program Consultant, Bureau of Medicaid Policy, Agency for Health Care Administration, declare under penalty of perjury that the foregoing answers to the First Set of Interrogatories are true and correct.

Executed on December 19, 2022.

Matthew Brackett

Dated: December 19, 2022

As to Objections,

/s/ Mohammad O. Jazil
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Gary V. Perko (FBN 855898)
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(850) 270-5938

Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on December 19, 2022, the document was emailed to counsel of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

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

JASON WEIDA[1], et al.,

Defendants.
_____/

DEFENDANTS' RESPONSES TO PLAINTIFFS' SECOND SET OF INTERROGATORIES

Defendants Secretary Weida and the Agency for Health Care Administration respond to Plaintiffs' second set of interrogatories. Defendants respond as follows. Defendants reserve the right to supplement, clarify, or otherwise amend their responses to these interrogatories.

RESPONSES TO INTERROGATORIES

Interrogatory No. 16: For each response to the Requests for Admissions (served concurrently with these Interrogatories) that is anything other than an unqualified admission, state all facts upon which you base your response.

Response: Defendants object to this interrogatory as they cannot identify "all facts" upon which the responses are based. The interrogatory is thus overly broad and unduly burdensome. Subject to and without waiving such objection, the Agency responds as follows:

[1] Jason Weida has succeeded Simone Marstiller as Interim Secretary of the Agency for Health Care Administration, as reflected in ECF 78.

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- Request for Admission No. 2: Denied. The Challenged Exclusion does not preclude the coverage of behavioral health services for gender dysphoria, and the services for which coverage is precluded are not medically necessary.
- Request for Admission No. 3: Denied. The Agency determined that the drugs and surgical procedures defined under the Plaintiffs' definition of "Various Services" are experimental and investigational. The basis for that determination is explained in detail in the GAPMS report.
- Request for Admission No. 4: Denied. The Agency is unable to determine how the Plaintiffs identify at any given time. Additionally, the Agency is only aware that the Plaintiffs' attorneys are claiming they are transgender.
- Request for Admission No. 14: Defendants are without sufficient knowledge to admit or deny, and therefore denied.
- Request for Admission No. 15: Defendants are without sufficient knowledge to admit or deny, and therefore denied.
- Request for Admission No. 16: Defendants are without sufficient knowledge to admit or deny, and therefore denied.
- Request for Admission No. 17: Defendants are without sufficient knowledge to admit or deny, and therefore denied.
- Request for Admission No. 18: Defendants are without sufficient knowledge to admit or deny, and therefore denied.
- Request for Admission No. 20: Defendants are without sufficient knowledge to admit or deny, and therefore denied. To form a basis for admitting or denying, the Agency would have to review encounter date which may still be pending submission by the Medicaid Plan.
- Request for Admission No. 21: Defendants are without sufficient knowledge to admit or deny, and therefore denied, because the Agency cannot predict an individual's health.
- Request for Admission No. 22: Defendants are without sufficient knowledge to admit or deny, and therefore denied, because the Agency cannot predict an individual's health.
- Request for Admission No. 23: Defendants are without sufficient knowledge to admit or deny, and therefore denied, because the Agency cannot predict an individual's health.
- Request for Admission No. 24: Defendants are without sufficient knowledge to admit or deny, and therefore denied, because the Agency cannot predict an individual's health.

- Request for Admission No. 25: Defendants are without sufficient knowledge to admit or deny, and therefore denied, because the Agency cannot predict an individual's health.
- Request for Admission No. 29: Denied. The criteria are set forth in the cited statute.
- Request for Admission No. 31: Denied. The Agency determined that the "Various Services" are experimental and investigational when used to treat gender dysphoria. The basis for that determination is set forth in detail in the GAPMS report.
- Request for Admission No. 32: Denied. The Agency determined that the "Various Services" are experimental and investigational when used to treat gender dysphoria. The basis for that determination is set forth in detail in the GAPMS report.
- Request for Admission No. 34: Denied. Florida Medicaid did not have a policy on coverage for puberty suppression.
- Request for Admission No. 35: Denied. Florida Medicaid did not have a policy on coverage for puberty suppression.
- Request for Admission No. 36: Denied. The individuals who promulgated the amendment to Rule 59G-1.050, F.A.C are those that promulgate all rules and rule amendments for Florida Medicaid.
- Request for Admission No. 37: Denied. Florida Medicaid did not have a policy on coverage of services for the treatment of gender dysphoria.
- Request for Admission No. 38: Denied. Florida Medicaid did not have a policy on coverage of services for the treatment of gender dysphoria.
- Request for Admission No. 39: Denied. The criteria for all variance requests are set forth in the cited statute
- Request for Admission No. 41: Defendants are without sufficient knowledge to admit or deny, and therefore denied.
- Request for Admission No. 44: Denied. The Agency has heard the testimony from multiple detransitioners.
- Request for Admission No. 49: Denied. Debate persists around these treatments listed under the definition of Various Services, which is becoming more evident as revealed by recent reports in Reuters and the New York Times.
- Request for Admission No. 50: Denied. The WPATH Standards of Care are not a standard of care but rather guidelines composed by an advocacy group. Currently, no standard of care exists for the condition that endorses such treatments, just clinical guidelines. The term "standard of care" has specific legal ramifications. For example,

physicians who practice outside of a given standard can be found liable for medical malpractice.

- Request for Admission No. 51: Denied. The WPATH Standards of Care are not a standard of care but rather guidelines composed by an advocacy group. Currently, no standard of care exists for the condition that endorses such treatments, just clinical guidelines. The term "standard of care" has specific legal ramifications. For example, physicians who practice outside of a given standard can be found liable for medical malpractice.
- Request for Admission No. 52: Denied. The WPATH Standards of Care are not a standard of care but rather guidelines composed by an advocacy group. Currently, no standard of care exists for the condition that endorses such treatments, just clinical guidelines. The term "standard of care" has specific legal ramifications. For example, physicians who practice outside of a given standard can be found liable for medical malpractice.
- Request for Admission No. 53: Denied. The WPATH Standards of Care are not a standard of care but rather guidelines composed by an advocacy group. Currently, no standard of care exists for the condition that endorses such treatments, just clinical guidelines. The term "standard of care" has specific legal ramifications. For example, physicians who practice outside of a given standard can be found liable for medical malpractice.
- Request for Admission No. 54: Denied. The WPATH Standards of Care are not a standard of care but rather guidelines composed by an advocacy group. Currently, no standard of care exists for the condition that endorses such treatments, just clinical guidelines. The term "standard of care" has specific legal ramifications. For example, physicians who practice outside of a given standard can be found liable for medical malpractice.
- Request for Admission No. 55: Denied. The Endocrine Society's clinical guidelines do not constitute a standard of care, which is noted in the Endocrine Society's guidelines stating they are not a standard of care.
- Request for Admission No. 56: Denied. The Endocrine Society's clinical guidelines do not constitute a standard of care, which is noted in the Endocrine Society's guidelines stating they are not a standard of care.
- Request for Admission No. 57: Denied. No standard of care exists for the treatment of gender dysphoria.

- Request for Admission NO. 60: Denied. The decision to promulgate the rule was made by the Agency.
- Request for Admission NO. 61: Denied. The decision to promulgate the rule was made by the Agency.
- Request for Admission No 62: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No 63: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No 64: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No 65: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No 66: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No 67: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No 68: Denied. The Agency did not invite anyone to the hearing.
- Request for Admission No. 69: Denied. The Agency's considered available guidelines, as discussed in the GAPMS report.
- Request for Admission No. 70: Denied. The Agency consulted peer-reviewed literature, as discussed in the GAPMS Report.
- Request for Admission No. 71: Denied. The Agency consulted the policies of other insurers, as discussed in the GAPMS Report.
- Request for Admission No. 72: Denied. The Agency also included Jason Weida, Matt Brackett, and Shena Grantham.
- Request for Admission No. 75: Denied. The Agency selected the authors based on their knowledge of peer-reviewed literature pertaining to the treatment of gender dysphoria.
- Request for Admission No. 76: Denied. Those employed by the Agency have not taken a public position on this issue.
- Request for Admission No. 77: Denied. The Agency selected the panelists based on their knowledge of peer-reviewed literature pertaining to the treatment of gender dysphoria or based on their role in the rule promulgation process.
- Request for Admission No. 78: Denied. The Agency had no policy with respect to treatments for gender dysphoria prior to preparation of the GAPMS memo.

- Request for Admission No. 79: Denied. The Agency did not have a predetermined conclusion and intended only to reach whatever conclusion was best supported by available evidence.

Interrogatory No. 17: State the names, addresses, and telephone numbers of all persons who have knowledge of the facts you identify in your response to Interrogatory No. 16.

Response: Objection, this interrogatory is overbroad and unduly burdensome. The Agency cannot identify "all persons" with knowledge as to responses identified in response to Interrogatory No. 16. Subject to and without waiving said objection, the following persons at the Florida Agency for Health Care Administration prepared and have knowledge of the responses to Plaintiffs' First Set of Requests for Admissions:

- Matthew Brackett, Program Consultant, Florida Agency for Health Care Administration, 2727 Mahan Drive Bldg. 3 MS #20, Tallahassee, FL 32308. 850-412-4151.
- Devona Pickle, Agency for Health Care Administrator, Florida Agency for Health Care Administration, 2727 Mahan Drive Bldg. 3 MS #20, Tallahassee, FL 32308. 850-412-4646.
- Nai Chen, Senior Pharmacist, Florida Agency for Health Care Administration, 2727 Mahan Drive Bldg. 3 MS #20, Tallahassee, FL 32308. 850-412-4216.
- Ann Dalton, Bureau Chief, Florida Agency for Health Care Administration, 2727 Mahan Drive Bldg. 3 MS #20, Tallahassee, FL 32308. 850-412-4257.
- Cole Giering, Program Administrator, Florida Agency for Health Care Administration, 2727 Mahan Drive Bldg. 3 MS #20, Tallahassee, FL 32308. 850-412-4691.

Interrogatory No. 18: For each response to the Requests for Admissions (served concurrently with the Interrogatories) that is anything other than an unqualified admission, identify all Documents that support your response.

Response: The documents supporting the Agency's responses are publicly available on the Agency's website at the following URL: https://ahca.myflorida.com/. No documentation exists for responses that do not identify supporting documentation.

Interrogatory No. 19: For each Document you identify in response to Interrogatory No. 18, state the name, address, and telephone number of each person or entity who has the Document or a copy of the Document.

Response: The documents supporting the Agency's responses are publicly available on the Agency's website at the following URL: https://ahca.myflorida.com/. No documentation exists for responses that do not identify supporting documentation.

VERIFICATION

Pursuant to 28 U.S.C. § 1746, I, Matthew Brackett, Program Consultant, Bureau of Medicaid Policy, Agency for Health Care Administration, declare under penalty of perjury that the foregoing answers to the Second Set of Interrogatories are true and correct.

Executed on January _12_, 2023.

John M. Brackett
Matthew Brackett

Dated: January 12, 2023

As to Objections,

/s/ Gary V. Perko
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CERTIFICATE OF SERVICE

I hereby certify that on January 12, 2023, the document was emailed to counsel of record.

/s/ Gary V. Perko
Gary V. Perko

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

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

PLAINTIFFS' FIRST SET OF REQUESTS FOR ADMISSION TO DEFENDANTS FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION AND SECRETARY SIMONE MARSTILLER

Pursuant to Federal Rules of Civil Procedure 26 and 36, Plaintiffs propound this First Set of Requests for Admission to Defendants Florida Agency for Health Care Administration and Secretary Marstiller to be answered fully and within the timeframe required under the Federal Rules and the Local Rules of this Court.

DEFINITIONS

As used herein, the following terms shall have the meanings indicated below:

1. "Defendants," "you," and "your" mean both Defendant Simone Marstiller and the Florida Agency for Health Care Administration ("AHCA"), their agents, employees, administrators, attorneys, representatives, contractors,

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consultants, investigators, and all other Persons and entities working or purporting to act on behalf of, or in concert with, or in participation with AHCA.

2. The "Challenged Exclusion" means Florida Administrative Code 59G-1.050(7), which was enacted on August 21, 2022, prohibiting coverage for "services for the treatment of gender dysphoria," including "puberty blockers," "hormones and hormone antagonists," "sex reassignment surgeries," and "any other procedures that alter primary or secondary sexual characteristics."

3. "Florida Medicaid" means the same as "Medicaid" defined at Fla. Stat. 409.901(14) & 409.962(11) and includes all contractors, including health insurance plans, engaged by Defendants for the administration of Florida's Medicaid program.

4. "Florida Medicaid program" means the same as "Medicaid program" defined at Fla. Stat. 409.901(16).

5. "GAPMS Memo" refers to Defendants' June 2022 publication titled "Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria," including by reference all attachments and exhibits.

6. Unless otherwise specified, "gender-affirming care" means any health care, physical, mental, or otherwise, administered or prescribed for the treatment of Gender Dysphoria.

7. "Gender Dysphoria" refers to the clinically significant distress or impairment related to the incongruence between one's experienced/expressed gender and their assigned sex at birth, including their primary and/or secondary sex characteristics. For purposes of these Requests, "Gender Dysphoria" shall include: (a) the diagnoses for "Gender dysphoria in adolescents and adults" and "Gender dysphoria in children," as defined within *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR); (b) the diagnosis for "gender identity disorder," including any subcategories such as "Gender Identity Disorder in Adolescents and Adults," "Gender Identity Disorder in Children," and "Gender Identity Disorder Not Otherwise Specified," as defined within the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) and the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR); (c) the diagnosis for "gender identity disorder," including any subcategories such as "Gender Identity Disorder in Children," "Transsexualism," and "Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type," and Gender Identity Disorder not Otherwise Specified," as defined within the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revision* (DSM-III-TR); (d) the diagnosis for "gender identity disorder," including any subcategories such as "Gender Identity Disorder

in Children," "Transsexualism," and "Atypical Gender Identity Disorder," as defined within the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III); and (e) the diagnoses for "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood," as defined within the *International Classification of Diseases, Eleventh Revision* (ICD-11); and the diagnoses for "transsexualism" and "gender identity disorder," including any subcategories, as defined within the *International Classification of Diseases, Tenth Revision* (ICD-10) and *International Classification of Diseases, Ninth Revision* (ICD-9).

8. "July 8 Hearing" refers to the hearing that Defendants held on July 8, 2022 in Tallahassee, Florida regarding the Challenged Exclusion.

9. The term "major medical organization" shall mean the American Medical Association, the American Psychological Association, the American Psychiatric Association, Endocrine Society, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Academy of Family Physicians.

10. "Medically necessary" shall have the same meaning as in 59G-1.010(166).

11. "Person" and "persons" mean any natural person, partnership, association, corporation, joint venture, trust, community group, government or

subdivision of any government (including any instrumentality, bureau, department, office, or agency of any government), not-for-profit enterprise, or other business entity, and all present and former officers, directors, agents, administrators, managers, representatives, contractors, consultants, employees, or other persons acting or purporting to act on behalf of such person.

12. "Plaintiffs" means the named plaintiffs in this action and any other plaintiff that is added in the future.

13. "Various Services" refers to the following procedures: penectomy, orchiectomy, vaginoplasty, feminizing genitoplasty, breast reconstruction, chondrolaryngoplasty, phalloplasty, metoidioplasty, masculinizing genitoplasty, single or double mastectomy, reduction mammoplasty, hysterectomy, oophorectomy, salpingo-oophorectomy, estradiol (in all forms, including oral/sublingual estradiol, transdermal estradiol, estradiol valerate IM, and estradiol cypionate IM), medroxyprogesterone acetate (Provera), micronized progesterone, spironolactone, finasteride, dutasteride, and testosterone (in all forms, including testosterone cypionate, testosterone enthanate, testosterone topical gel 1%, testosterone topical gel 1.62%, testosterone patches, testosterone cream, testosterone axillary gel 2%, testosterone undecanoate), and Gonadotropin-releasing hormone (GnRH) antagonists.

INSTRUCTIONS

1. These Requests are issued to each of the Defendants. Defendants' responses to these Requests shall be made within thirty (30) days of service of these Requests.

2. All responses to these Requests should be directed to: Jennifer Altman, Pillsbury Winthrop Shaw Pittman LLP, 600 Brickell Avenue, Suite 3100, Miami, FL 33131, Email: jennifer.altman@pillsbury.com, cc: soraya.garcia@pillsburylaw.com.

3. Unless otherwise specified, the time period covered by these Requests is January 1, 2015 to the present. If it is necessary to refer to periods of time prior to January 1, 2015 to respond to a Request, please do so.

4. These Requests are continuing in nature, up to and during the course of trial. Defendants' responses to these Requests are to be promptly supplemented or amended if, after the time of their initial responses, Defendants learn that any response is or has become in some material respect incomplete or incorrect, to the full extent provided for by Federal Rule of Civil Procedure 26(e). Plaintiffs will object to any attempt to introduce evidence to the Court that should have been but was not disclosed in the responses or supplementation of the responses.

5. If a Request cannot be complied with in full, it shall be complied with to the extent possible, and accompanied by an explanation of your objection to the request or other reasons you are unable to fully comply.

6. As to each Request, Defendants shall specifically admit or deny the statement contained therein. If denied, the denial must fairly meet the substance of the requested admission. If Defendants qualify their answer or deny any part of the matter for which admission is requested, Defendants shall admit so much of the statement as is true and qualify or deny the remainder.

7. If Defendants object that a term or phrase is vague or ambiguous, Defendants shall respond with their understanding of the term or phrase and specifically admit or deny the statement.

8. If Defendants object to any part of a Request, Defendants shall specify each part of the Request to which Defendants object; set forth with specificity the grounds for objecting to each such part of the Request, including the reasons, and otherwise respond to all parts of the Request to which Defendants do not object.

11. Responses to these Requests shall include all information within the custody, possession, or control of you, your employees, partners, contractors, accountants, attorneys, or other agents, or which are otherwise available to you.

12. When, after a reasonable and thorough investigation using due diligence, you are unable to admit or deny a Request or any part thereof, specify in

full the reason that you are unable to admit or deny the Request and the steps you have taken to locate information that would allow you to admit or deny the Request. If you deny any part of a matter for which admission is requested, you shall admit so much of the statement as is true.

13. For purposes of interpreting or construing the scope of these Requests, all terms shall be given their most expansive and inclusive interpretation. This includes, without limitation, the following:

a. Construing "and" as well as "or" in the disjunctive or conjunctive, as necessary to make the Request more inclusive;

b. Construing the singular form of the word to include the plural, and the plural form to include the singular;

c. Construing the masculine to include the feminine, and vice versa;

d. Construing the term "including" to mean "including but not limited to" and construing the term "all" to mean "any and all," and vice versa;

e. Construing the term "each" to include "every," and construing "every" to include "each";

f. Construing the use of a verb in any tense as applying to the use of the verb in all other tenses as is necessary to make any paragraph more, rather than less, inclusive;

g. Construing and interpreting all spelling, syntax, grammar, abbreviations, idioms, and proper nouns to give proper meaning and consistency to their context.

REQUESTS FOR ADMISSION

1. Admit that gender-affirming care can be medically necessary.

2. Admit that the Challenged Exclusion prohibits Florida Medicaid coverage of gender affirming care that can be medically necessary for the treatment of Gender Dysphoria.

3. Admit that each of the Various Services can be medically necessary for the treatment of Gender Dysphoria.

4. Admit that each Plaintiff identifies as transgender.

5. Admit that each Plaintiff has been diagnosed with Gender Dysphoria.

6. Admit that each Plaintiff receives health care coverage through Florida's Medicaid program.

7. Admit that, prior to the enactment of the Challenged Exclusion, Florida Medicaid covered "services for the treatment of gender dysphoria," as that term is defined in the Challenged Exclusion, for each Plaintiff.

8. Admit that Florida Medicaid covers each of the Various Services when necessary to treat at least one condition other than Gender Dysphoria.

9. Admit that Florida Medicaid covers mastectomy, reduction mammoplasty, and breast reconstruction surgery when necessary to treat at least one condition other than Gender Dysphoria.

10. Admit that Florida Medicaid covers hysterectomy and oophorectomy procedures when necessary to treat at least one condition other than Gender Dysphoria.

11. Admit that Florida Medicaid covers vaginoplasty procedures when necessary to treat at least one condition other than Gender Dysphoria.

12. Admit that Florida Medicaid covers orchiectomy, penectomy, and/or phalloplasty procedures when medically necessary to treat at least one condition other than Gender Dysphoria.

13. Admit that, prior to the enactment of the Challenged Exclusion, Florida Medicaid did not exclude coverage of prescribed hormones for the treatment of Gender Dysphoria.

14. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff August Dekker received coverage under Florida Medicaid for hormone therapy as treatment for his Gender Dysphoria.

15. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff August Dekker received coverage under Florida Medicaid for a double mastectomy as treatment for his Gender Dysphoria.

16. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff Brit Rothstein received coverage under Florida Medicaid for hormone therapy as treatment for his Gender Dysphoria.

17. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff Susan Doe received coverage under Florida Medicaid for a GnRH antagonist as treatment for her Gender Dysphoria.

18. Admit that, prior to the enactment of the Challenged Exclusion, Plaintiff K.F. received coverage under Florida Medicaid for a GnRH antagonist as treatment for his Gender Dysphoria.

19. Admit that, prior to the enactment of the Challenged Exclusion, Florida Medicaid gave Plaintiff Brit Rothstein prior authorization for double mastectomy as treatment for his Gender Dysphoria.

20. Admit that, following the enactment of Challenged Exclusion, Plaintiffs have not received coverage under Florida Medicaid for the services described in Requests 14 to 19 above.

21. Admit that if Plaintiff August Dekker does not continue to receive hormone therapy, he may undergo physical changes.

22. Admit that if Plaintiff Brit Rothstein does not continue to receive hormone therapy, he may undergo physical changes.

23. Admit that if Plaintiff Brit Rothstein does not receive the double mastectomy previously authorized by Defendants, he may experience exacerbated distress and chest dysphoria.

24. Admit that if Plaintiff Susan Doe does not continue to receive a GnRH antagonist, she will undergo endogenous puberty.

25. Admit that if Plaintiff K.F. does not continue to receive a GnRH antagonist, he will undergo endogenous puberty.

26. Admit that undergoing endogenous puberty causes development of secondary sex characteristics.

27. Admit that undergoing endogenous puberty causes irreversible physical changes.

28. Admit that you did not prepare any criteria for determining whether to grant a variance under Florida Statutes § 120.542 to permit Florida Medicaid coverage of any of the Various Services when used to treat Gender Dysphoria.

29. Admit that you have no existing criteria for determining whether to grant a variance under Florida Statute § 120.542 to permit Florida Medicaid coverage of any of the services excluded by the Challenged Exclusion.

30. Admit that you are not currently preparing any criteria for determining whether to grant a variance under Florida Statute § 120.542 to permit Florida Medicaid coverage of any of the services excluded by the Challenged Exclusion.

31. Admit that none of the Various Services are experimental when used to treat Gender Dysphoria.

32. Admit that none of the Various Services are investigational when used to treat Gender Dysphoria.

33. Admit that licensed medical professionals with experience treating Gender Dysphoria are in the best position to make medical determinations regarding the diagnosis and treatment of patients with Gender Dysphoria.

34. Admit that, as recently as 2016, you did not consider puberty suppression therapy for the treatment of Gender Dysphoria to be experimental.

35. Admit that, as recently as 2016, you did not consider puberty suppression therapy for the treatment of Gender Dysphoria to be investigational.

36. Admit that the individuals involved in the process of creating and implementing the Challenged Exclusion were not the same individuals who are typically involved in this process on your behalf.

37. Admit that, as recently as 2016, you did not consider any of the Various Services to be experimental.

38. Admit that, as recently as 2016, you did not consider any of the Various Services to be investigational.

39. Admit that you have criteria for determining whether to grant a variance under Florida Statutes § 120.542 for any service used to treat a healthcare condition besides Gender Dysphoria.

40. Admit that the Challenged Exclusion restricts coverage for gender-affirming care that has been the subject of decades of scholarly research.

41. Admit that no major medical organization recommends or supports prohibiting coverage of the Various Services when used to treat Gender Dysphoria.

42. Admit that transgender people have historically been subject to discrimination.

43. Admit that, prior to the enactment of the Challenged Exclusion, you were aware that transgender people have historically been subject to discrimination.

44. Admit that being transgender is immutable.

45. Admit that being transgender bears no relation to one's ability to contribute to society.

46. Admit that you provide Florida Medicaid coverage for some health care services that have not been studied through randomized clinical trials.

47. Admit that you provide Florida Medicaid coverage for some health care services that have not been studied through long-term longitudinal studies.

48. Admit that you provide Florida Medicaid coverage for some health care services that have a risk of producing unintended, irreversible consequences.

49. Admit that the well-established medical consensus is that gender-affirming care should be provided to transgender people with Gender Dysphoria.

50. Admit that the WPATH Standards of Care are the most widely used standards in the United States for treating Gender Dysphoria.

51. Admit that the WPATH Standards of Care are the leading standards of care for the treatment of Gender Dysphoria.

52. Admit that the WPATH Standards of Care are authoritative standards of care for the treatment of Gender Dysphoria.

53. Admit that the WPATH Standards of Care are widely accepted as the leading standards of care for the treatment of Gender Dysphoria.

54. Admit that the WPATH Standards of Care are widely accepted as authoritative standards of care for the treatment of Gender Dysphoria.

55. Admit that the Endocrine Society's Clinical Practice Guidelines are widely accepted as authoritative standards of care for the treatment of Gender Dysphoria.

56. Admit that the Endocrine Society's Clinical Practice Guidelines are authoritative standards of care for the treatment of Gender Dysphoria.

57. Admit that Defendants are not aware of any other widely used standards of care to treat Gender Dysphoria other than the WPATH Standards of Care or the Endocrine Society's Clinical Practice Guidelines.

58. Admit that your coverage of medical care should be made pursuant to the standards of care for a particular condition.

59. Admit that the treatment of a medical condition should be made pursuant to the standards of care for a particular condition.

60. Admit that persons from the Office of the Governor Ronald DeSantis were involved in your decision to promulgate the Challenged Exclusion.

61. Admit that persons from the Florida Department of Health were involved in your decision to promulgate the Challenged Exclusion.

62. Admit that you caused Chloe Cole to be invited to the July 8 Hearing.

63. Admit that you caused Sophia Galvin to be invited to the July 8 Hearing.

64. Admit that you caused Anthony Verdugo to be invited to the July 8 Hearing.

65. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Christian Family Coalition.

66. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Florida Citizens Alliance.

67. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Warriors of Faith.

68. Admit that you caused to be invited to the July 8 Hearing any persons affiliated with the Protect our Children Project.

69. Admit that, in promulgating the Challenged Exclusion, you did not consult "evidence-based clinical practice guidelines", as that term is used in 59G-1.035.

70. Admit that, in promulgating the Challenged Exclusion, you did not consult articles "published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty association", as that term is used in 59G-1.035.

71. Admit that, in promulgating the Challenged Exclusion, you did not consult "coverage policies by other creditable insurance payor sources", as that term is used in 59G-1.035.

72. Admit that only Dr. Andre Van Mol, Dr. Quentin Van Meter, and Dr. Miriam Grossman were included on the July 8 Hearing panel.

73. Admit that Dr. Andre Van Mol, Dr. Quentin Van Meter, and Dr. Miriam Grossman have all taken positions that support Defendants' promulgation of exclusions for coverage of treatment of Gender Dysphoria.

74. Admit that you did not include anyone on the July 8 Hearing panel who has taken a position that opposes Defendants' promulgation of exclusions for coverage of Gender Dysphoria.

75. Admit that you selected the authors of the GAPMS Memo reports because of their opposition to gender-affirming care.

76. Admit that each of the authors of the GAPMS Memo have publicly taken positions in opposition to gender-affirming care.

77. Admit that you selected the panel members for the July 8 Hearing because of their opposition to gender-affirming care.

78. Admit that, prior to the GAPMS Memo's drafting and promulgation, you determined that gender-affirming care was experimental or investigational.

79. Admit that, regardless of what information was available to you, you intended to reach the conclusion in the GAPMS Memo that gender-affirming care was experimental or investigational.

* * *

Respectfully submitted this 12th day of December, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was served by email on December 12, 2022, on all counsel of record:

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

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

EXPERT DECLARATION OF ARMAND H. MATHENY ANTOMMARIA, MD, PhD, FAAP, HEC-C

I, ARMAND H. MATHENY ANTOMMARIA, MD, PhD, FAAP, HEC-C, have been retained by counsel for Plaintiffs in connection with the above-captioned litigation.

1. This declaration provides the following expert opinions, which are explained in further detail below:

2. General Medicaid Policy Rule 59G-1.050 ("the Exclusion") excludes from coverage certain medical services, which I will refer to as gender-affirming medical care, when these interventions are used to treat gender dysphoria.[1]

[1] Gender dysphoria is "a marked incongruence between one's experienced/expressed gender and their assigned gender" which is "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, Text Revision. American

Pl. Trial Ex. 005

3. Gender-affirming medical care is consistent with generally accepted professional medical standards and is not experimental or investigational. It is endorsed by evidence-based clinical practice guidelines that are themselves based on studies published in the peer-reviewed literature demonstrating that it improves individuals' health outcomes. Gender-affirming medical care is also supported by increasing utilization trends and coverage by other creditable insurance payors.

4. In the Exclusion and other supporting documents, the Florida Agency for Health Care Administration (AHCA) persistently mischaracterizes these treatments and singles them out for anomalous treatment by withholding Medicaid coverage for them only when they are used to treat gender dysphoria. Specifically, AHCA mischaracterizes

a. individuals as diagnosing themselves with gender dysphoria,

b. treatments for gender dysphoria and "off-label" treatments as experimental,

c. treatments of gender dysphoria as "eminence-based medicine" and the evidence base supporting many medical treatments, and

d. the informed consent process for the treatment of gender dysphoria in minors.

Psychiatric Publishing; 2022.

5. I have actual knowledge of the matters stated in this declaration. In preparing this declaration, I reviewed the Exclusion, "Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" ("GAPMS Memo"),[2] including Attachment G, a commissioned, unpublished paper written by G. Kevin Donovan, MD, MA, entitled "Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children."[3] I also reviewed the materials listed in the attached Bibliography (Exhibit A), and I may rely on those documents as additional support for my opinions. I have also relied on my years of research and clinical practice, as set out in my curriculum vitae (Exhibit B), and on the materials listed therein. The materials I have relied upon in preparing this declaration are the same types of materials that experts in medicine and bioethics regularly rely upon when forming opinions on this type of subject. I may wish to supplement 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.

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[2] June 2022. Accessed September 6, 2022. Available at https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf.

[3] May 12, 2022. Accessed September 6, 2022. Available at https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Attachment_G.pdf.

BACKGROUND AND QUALIFICATIONS

6. I am the Director of the Ethics Center, the Lee Ault Carter Chair of Pediatric Ethics, and an Attending Physician in the Division of Hospital Medicine at Cincinnati Children's Hospital Medical Center ("Cincinnati Children's"). I am also a Professor in the Departments of Pediatrics and Surgery at the University of Cincinnati College of Medicine.

7. In 2000, I received both my medical degree from Washington University School of Medicine in St. Louis, Missouri and my PhD in Religious Ethics from The University of Chicago Divinity School. I completed my pediatrics residency at the University of Utah in 2003.

8. I have been licensed to practice medicine since 2001 and am currently licensed to practice medicine in Ohio. I have been Board Certified in General Pediatrics since 2004 and in Pediatric Hospital Medicine since the inception of this certification in 2019. I have been certified as a Healthcare Ethics Consultant since the inception of this certification in 2019.

9. I have extensive experience as a practicing physician. I have been in clinical practice since 2003 and approximately 30 percent of my current work is dedicated to caring for hospitalized patients. Cincinnati Children's is a nonprofit pediatric academic medical center with 622 total registered beds. It admits patients up to age 25 and older patients under certain conditions, including patients in the

Adults with Congenital Heart Disease and Young Adults with Cancer programs. I routinely admit and care for adult patients.

10. I also have extensive experience as a bioethicist. Bioethicists examine the ethical issues that arise in medicine and the life sciences. I was Chair of the Ethics Committee at Primary Children's Medical Center in Salt Lake City, Utah from 2005 to 2012 and have been Director of the Ethics Center at Cincinnati Children's since 2012.

11. I regularly consult on patients in the Transgender Health Clinic at Cincinnati Children's whose care presents unique ethical issues and participate in the Clinic's monthly multidisciplinary team meetings. I remain current with the medical and bioethics literature regarding the treatment of individuals with gender dysphoria, particularly minors. I am also the Chair of Cincinnati Children's Fetal Care Center's Oversight Committee which provides the Center with recommendations on the use of innovative treatments and experimental interventions.

12. I am a member of the American Academy of Pediatrics (AAP), the American Society for Bioethics and Humanities (ASBH), the Association of Bioethics Program Directors, and the Society for Pediatric Research. I was a member of the AAP's Committee on Bioethics from 2005 to 2011. I have also served as a member of the ASBH's Clinical Ethics Consultation Affairs Committee from 2009

to 2014 and currently serve on its Healthcare Ethics Consultant Certification Commission.

13. I am the author of 41 peer-reviewed journal articles, 11 non-peer-reviewed journal articles, six book chapters, and 28 commentaries. My peer-reviewed journal articles have been published in high-impact journals including the *Journal of the American Medical Association* and *Annals of Internal Medicine.* I am also an author of 17 policy statements and technical reports, including four as lead author, by the AAP.

14. I am a member of the Executive Editorial Board and the Associate Editor for Ethics Rounds of *Pediatrics*. *Pediatrics* is the AAP's flagship journal and Ethics Rounds is a type of article in which commentators analyze cases that raise ethical issues. I am an active peer reviewer for many medical journals, including the *American Journal of Bioethics* and the *Journal of Pediatrics*. I also review abstracts for the annual meetings of professional organizations, including the Pediatric Academic Societies and ABSH. I was previously a member of the editorial boards of the *Journal of Clinical Ethics* and the *Journal of Medical Humanities*.

15. I previously testified as an expert witness at trial or deposition in the following cases: *Brant v. Rutledge*, Case No. 4:21CV450-JM (E.D. Ark.), *Doe v. Abbott*, No. D-1-GN-22-000977, 2022 WL 628912 (Tex. Dist. 353rd Judicial

District, March 2, 2022), and *Eknes-Tucker* v *Marshall*, Case No. 2:22-cv-184-LCB (M.D. Ala. May 13, 2022).

16. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for 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.

GENDER-AFFIRMING MEDICAL CARE IS SUPPORTED BY EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES

17. Medical care for individuals with gender dysphoria is evidence-based and is supported by clinical practice guidelines developed by medical professional organizations including the Endocrine Society ("the Society").

18. The Society was established in 1916[4] and is an international medical organization whose membership is comprised of over 18,000 endocrinology researchers and clinicians.[5] It uses rigorous methods to develop guidelines on a variety of clinical conditions. Members of guideline development panels are nominated by the Society's Board of Directors, its Clinical Guidelines Committee, and any co-sponsoring organizations; they are selected based on their clinical

[4] Endocrine Society. Our History. Accessed December 31, 2022. Available at https://www.endocrine.org/our-community/advancing-endocrinology-and-public-health/history/.
[5] Endocrine Society. Who We Are. Accessed December 31, 2022. Available at https://www.endocrine.org/about-us.

expertise and other skills; and they are screened for conflicts of interest. Panels are multidisciplinary and include a patient representative and a methodologist—someone trained in the methods for developing clinical practice guidelines. The Society uses the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology. Guidelines undergo both internal and external review including a public comment period. After any revisions, the proposed guidelines undergo a second review by the Society's Clinical Guidelines Committee, its Board of Directors Reviewer, and an expert reviewer. If approved, they undergo peer review prior to publication. Guidelines are periodically reviewed and may be updated or retired.[6]

19. The GRADE approach is a widely utilized method for developing clinical practice guidelines.[7] It involves both rating the quality of the evidence and the strength of the recommendations.[8] In this context, evidence is the studies' relevant to a recommendation. It is best practice to ascertain the studies via systematic reviews of the literature.[9] The evidence provides an estimate of the effect

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[6] Endocrine Society Guideline Methodology. Accessed November 25, 2022. Available at https://www.endocrine.org/-/media/endocrine/files/cpg/methodology-page-refresh/endocrine_society_guideline_methodology_links.pdf.

[7] GRADE: Welcome to the GRADE working group. Accessed November 23, 2022. Available at https://www.gradeworkinggroup.org/#pub.

[8] Guyatt G, Oxman AD, Akl EA, et al. GRADE guidelines: 1. Introduction-GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol*. 2011;64(4):383-394.

[9] Systematic reviews use exhaustive, transparent, and repeatable methods to identify, select, and appraise the relevant research. For example, medical librarians may help develop strategies to search multiple databases and several investigators may screen each articles' title and abstract

of an intervention both in terms of the size of the effect and the certainty of the knowledge about it. The quality of the evidence rating reflects "the extent of our confidence that the estimates of an effect are adequate to support a particular decision or recommendation."[10] The higher the quality of the evidence, the more confidence there is in our knowledge about the estimated magnitude of the effect and the more likely the true magnitude of the effect is the same as the estimate. The lower the quality of the evidence, the less confidence there is in the estimate of the effect and the more likely the true effect differs from the estimate. The GRADE approach uses four categories to rate the quality of the evidence: "high," "moderate," "low," and "very low."[11]

20. In the rating process, randomized trials are initially rated as high quality and observational studies as low quality.[12] In randomized trials, participants are randomly assigned to an intervention or a control group. Randomization is like flipping a coin. In double blind or masked randomized trials, neither the investigators nor the participants know to which group the participants are assigned.

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against inclusion and exclusion criteria. Cook DJ, Greengold NL, Ellrodt AG, Weingarten SR. The relation between systematic reviews and practice guidelines. *Ann Intern Med.* 1997;127(3):210-6.

[10] Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):403.

[11] Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

[12] Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

Observational studies include cross-sectional and cohort studies. In cross-sectional studies, investigators collect data at a single point in time or within a short period of time. In cohort studies, researchers identify a group of participants and then make measurements over time. The measurements may be retrospective and/or prospective.[13]

21. The initial rating of the evidence may subsequently be modified based on additional factors. The rating of randomized trials may, for example, be decreased if they have serious risks of bias[14] like a lack of masking.[15] The rating of observational trials may be increased if they have large effects, e.g., those receiving the intervention are more than two times or less than one-half as likely to experience the outcome.[16]

22. The strength of a recommendation is related to the confidence that a treatment's desirable outcomes outweigh its undesirable ones. The GRADE approach conceptualizes recommendations on a continuum: "strong against," "weak against," "only in research," "weak for," and "strong for." Strong recommendations are ones where all or almost all informed people would make the recommended

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[13] Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2023.
[14] Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.
[15] Guyatt GH, Oxman AD, Vist G, et al. GRADE guidelines: 4. Rating the quality of evidence—study limitations (risk of bias). *J Clin Epidemiol*. 2011;64(4):407-415.
[16] Guyatt GH, Oxman AD, Sultan S, et al. GRADE guidelines: 9. Rating up the quality of evidence. *J Clin Epidemiol*. 2011;64(12):1311-1316.

choice and weak recommendations are ones where most informed people would, but a substantial number would not, make the recommended choice.[17] The strength of a recommendation is based on the balance between desirable and undesirable outcomes, confidence in the magnitude of estimates of the intervention's effect, confidence in values and preferences, and resource use.[18] Low quality evidence may be sufficient to justify a strong recommendation.[19] Because of the potential to confuse low quality evidence and weak recommendations, the GRADE approach offers the following alternative ways to describe a weak recommendation: "conditional," "discretionary," and "qualified."[20]

23. The Society's clinical practice guideline for the endocrine treatment of gender-dysphoric/gender-incongruent persons makes 28 recommendations.[21] Ten are strong, 12 are weak, and six are ungraded good practice statements; three are

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[17] Andrews J, Guyatt G, Oxman AD, et al. GRADE guidelines: 14. Going from evidence to recommendations: The significance and presentation of recommendations. *J Clin Epidemiol*. 2013;66(7):719-725.

[18] Andrews JC, Schunemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol*. 2013;66(7):726-735.

[19] Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-6; Andrews JC, Schunemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol*. 2013;66(7):726-735.

[20] Andrews J, Guyatt G, Oxman AD, et al. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. *J Clin Epidemiol*. 2013;66(7):719-725.

[21] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

based on moderate, 14 on low, and five on very low-quality evidence. Table 1 (Exhibit C). The recommendation, "We suggest that adolescents who meet diagnostic criteria for [gender dysphoria]/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development," for example, is a weak recommendation based on low-quality evidence. Recall that a weak recommendation is one where most informed people would make the recommended choice. The evidence includes cohort studies conducted at VU University Medical Center in the Netherlands demonstrating that gender-affirming medical care improves individuals' mental health outcomes.[22] The recommendation "We recommend that clinicians confirm the diagnostic criteria of [gender dysphoria]/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment" is a strong recommendation based on moderate quality evidence. The evidence includes a randomized trial of three different testosterone formulations in transgender men (individuals who were assigned female at birth and identify as male).[23]

24. Professional associations' treatment recommendations for pediatric

[22] Cohen-Kettenis PT, van Goozen SHM. Sex reassignment of adolescent transsexuals: A follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1997;36(2):263–271; Smith YLS, Van Goozen SHM, Kuiper AJ, Cohen-Kettenis PT. Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. Psychol Med. 2005;35(1):89–99; and de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8(8):2276-2283.

[23] Pelusi C, Costantino A, Martelli V, et al. Effects of three different testosterone formulations in female-to-male transsexual persons. *J Sex Med*. 2014;11(12):3002-3011.

patients are infrequently based on well-designed and conducted randomized controlled trials due to their rarity and are frequently based on observational studies. For example, the Society has developed two other guidelines that focus on the pediatric population: guidelines on pediatric obesity and congenital adrenal hyperplasia. They contain 84 recommendations. None are based on high, 24 (29%) on moderate, and 49 (58%) on low or very low-quality evidence. Forty-three (51%) recommendations are strong and 30 (36%) weak. The remaining recommendations (11, 13%) are Ungraded Good Practice Statements.[24] Table 1 (Exhibit C).

25. Medical research on children is less likely to use randomized trials than is medical research for adults. Reasons for this disparity include the low prevalence of childhood disease or conditions, small market share for therapeutic agents in children, low level of National Institutes of Health funding, and difficulty enrolling children in research.[25]

26. It may also, at times, be unethical to conduct randomized trials. For randomized trials to be ethical, clinical equipoise must exist; there must be uncertainty about whether the efficacy of the intervention or the control is greater.

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[24] Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2018;103(11):4043-4088; Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(3):709-757.

[25] Martinez-Castaldi C, Silverstein M, Baucher H. Child versus adult research: The gap in high-quality study design. *Pediatrics*. 2008;122(1):52-57.

It would be unethical to knowingly expose some participants to an inferior intervention. Trials must also be feasible. It would be unethical to expose individuals to the risks of trial participation without the benefit of the trial generating generalizable knowledge. A randomized trial that is unlikely to enroll enough participants because they believe they might be randomized to an inferior intervention would be unethical because it could not generate generalizable knowledge due to an inadequate sample size.[26]

27. Under the applicable ethical standards, randomized, placebo-controlled trials (trials that compare pharmacological treatment to no pharmacological treatment) of individuals with gender dysphoria are currently unethical. Potential investigators no longer have equipoise between pharmacological treatment and no pharmacological treatment; they believe that pharmacological treatment is superior. It is also highly unlikely that enough participants would enroll in such randomized controlled trials for them to be informative.[27]

28. Even if randomized, placebo-controlled trials of gender-affirming health care were ethical, they would provide a lower quality of evidence because of intrinsic limitations in their design. For example, it would be impossible to mask

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[26] Emanuel EJ, Wendler D, Grady C. What makes clinical research ethical? *JAMA*. 2000;283(20):2701-2711.

[27] Chew D, Anderson J, Williams K, May T, Pang K. Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*. 2018;141(4):e20173742; Reisner SL, Deutsch MB, Bhasin S, et al. Advancing methods for US transgender health research. *Curr Opin Endocrinol Diabetes Obes*. 2016;23(2):198-207.

which participants were receiving an active medication or a placebo; the investigators and the participant would know if the participant was in the intervention or control group due to the physical changes in the participant's body, or the lack thereof, over time. This might bias their perception of the outcomes and lower the rating of the study's quality.[28]

29. Gender-affirming medical care is also recommended by the World Professional Association for Transgender Health's (WPATH's) Standards of Care for the Health of Transgender and Gender Diverse People which is currently in its 8th version ("SOC-8").[29] WPATH is an international interdisciplinary professional and educational organization[30] whose over 2,500 members include physicians, psychologists, lawyers, and social workers.[31] The SOC-8 revision committee included subject matter experts, stakeholders, and an expert in developing clinical practice guidelines each of whom completed conflict of interest declarations. An independent, evidence review team conducted selected systematic reviews of the literature. Consensus on recommendations was attained using a Delphi process; a voting process requiring approval by 75% of participating committee members. If

[28] Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.
[29] Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. *Int J Transgend Health*. 2022;23(Suppl 1):S1-S259.
[30] WPATH. Mission and Vision. Accessed December 31, 2022. Available at https://www.wpath.org/about/mission-and-vision.
[31] WPATH. Member Search. Accessed February 13, 2023. Available at https://www.wpath.org/member/search/results?showAll=1.

a recommendation was not approved, it was revised and was removed if not approved in 3 rounds of voting. Approved recommendations were subsequently graded. A draft of the revision was reviewed by an International Advisory Committee and open to public comment.[32]

30. In addition to these clinical practice guidelines, gender-affirming medical care is endorsed by other types of statements by numerous medical professional associations including the American Academy of Family Physicians,[33] the AAP,[34] the American College of Obstetricians and Gynecologists,[35] the American Medical Association,[36] the American Psychiatric Association,[37] the

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[32] Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. *Int J Transgend Health*. 2022;23(Suppl 1): S1-S259.

[33] American Academy of Family Physicians. Care for the transgender and gender nonbinary patient. Accessed January 8, 2023. Available at https://www.aafp.org/about/policies/all/transgender-nonbinary.html#:~:text=The%20American%20Academy%20of%20Family,patients%2C%20including%20children%20and%20adolescents.

[34] Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, et al. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4): e20182162.

[35] American College of Obstetricians and Gynecologists. ACOG Committee Opinion Number 823: Health care for transgender and gender diverse individuals. March 2021. Accessed January 8, 2023. Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals/; American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and Committee on Health Care for Underserved Women. Health Care for Transgender and Gender Diverse Individuals: ACOG Committee Opinion, Number 823. *Obstet Gynecol*. 2021;137(3):e75-e88.

[36] American Medical Association. Removing financial barriers to care for transgender patients H-185.950. 2022. Accessed January 8, 2023. Available at https://policysearch.ama-assn.org/policyfinder/detail/H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml; Madara JL to McBride B. April 26, 2021. Accessed January 8, 2023. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf.

[37] American Psychiatric Association. Position statement on treatment of transgender (trans) and

American Psychological Association, [38] the Endocrine Society and Pediatric Endocrine Society,[39] and WPATH.[40]

GENDER-AFFIRMING MEDICAL CARE IS NOT EXPERIMENTAL

31. Clinical practice and research are distinguished by their goals and methods. The goal of clinical practice is to benefit individual patients, and its method is individualized decision-making. The goal of research is to contribute to generalizable knowledge, and its method uses formal protocols that describe the research study's objectives and procedures.[41]

32. To the extent that the GAPMS Memo uses the term "experimental" or "investigational" to convey that gender-affirming medical care is new, untested, or different, that suggestion is baseless. GAPMS Memo at 29, 30; Attachment G at 1, 4. Hormone treatment for gender dysphoria began after estrogen and testosterone

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gender diverse youth. July 2020. Accessed January 8, 2023. Available at https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf.

[38] American Psychological Association. Transgender, gender identity, and gender expression non-discrimination. August 2008. Accessed January 8, 2023, Available at https://www.apa.org/about/policy/transgender.pdf.

[39] Endocrine Society and Pediatric Endocrine Society. Transgender health: Position Statement. December 2020. Accessed January 8, 2023. Available at https://www.endocrine.org/advocacy/position-statements/transgender-health; Anton BS. Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives. *Am Psychol.* 2009;64:372-453.

[40] WPATH. Position statement on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A. December 21, 2016. Accessed January 8, 2023. Available at https://www.wpath.org/newsroom/medical-necessity-statement.

[41] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* The Commission; 1978.

became commercially available in the 1930's. The first documented male to female gender-affirming genital surgery was performed in 1931 and Christine Jorgensen famously underwent gender-affirming surgery in 1952.[42] The use of gonadotropin releasing hormone analogues, also known as puberty blockers or puberty-delaying medications, to treat gender dysphoria in adolescents, while a somewhat more recent treatment, is also not new. The first reference to this treatment in the medical literature was in 1998, approximately 25 years ago.[43] Observational studies of puberty blockers began recruiting participants in 2000.[44] As described above, gender-affirming medical care is supported by clinical studies, the same type of studies that support many other widely accepted medical treatments.

33. The clinical use of puberty blockers, gender-affirming hormone treatment and surgeries are not research or experimentation. When administering these treatments, clinicians seek to benefit individual patients and adjust the treatment based on individual patients' responses.

34. The GAPMS Memo's suggestion that, because puberty blockers and gender-affirming hormone treatment are being used "off-label," they are experimental, untested, or unsafe is also misleading. GAPMS Memo at 8, 14, 16, 19,

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[42] Stryker S. *Transgender History*. 2nd ed. Seal Press; 2017.
[43] Cohen-Kettenis PT, van Goozen SH. Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. *Eur Child Adolesc Psychiatry*. 1998;7(4):246-248.
[44] de Vries AL, Steensma TD, Doreleijers TA, Cohen- Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8(8):2276-2283.

21; Attachment G at 4. Off-label use of medications is legal, common, and often evidence-based.

35. Approval by the United States (US) Food and Drug Administration (FDA) is not required for all uses of a medication. Once the FDA has approved a medication for one indication,[45] thereby agreeing that it is safe (i.e., its benefits outweigh its potential risks) and effective for this intended use, as is the case with the medications at issue here, prescribers are generally free to prescribe it for other indications.[46] Prescribing an approved medication for an unapproved indication is colloquially referred to as "off-label" use. The AAP Committee on Drugs states, "[i]t is important to note that the term 'off-label' does not imply an improper, illegal, contraindicated, or investigational use" and "[t]he administration of an approved drug for a use that is not approved by the FDA is not considered research and does

[45] According to the FDA, an indication includes several factors: the particular disease or condition or the manifestation or symptoms of the disease or condition for which the drug is approved; whether the drug is approved for treatment, prevention, mitigation, cure, or diagnosis; and the population, including age group, for which the drug is safe and effective. Center for Drug Evaluation and Research and Center for Biologics Evaluation and Research, Food and Drug Administration, U.S. Department of Health and Human Services. Indications and Usage Section of Labeling for Human Prescription Drug and Biological Products—Content and Format: Guidance for Industry. July 2018. Accessed August 25, 2022. Available at https://www.fda.gov/files/drugs/published/Indications-and-Usage-Section-of-Labeling-for-Human-Prescription-Drug-and-Biological-Products-%E2%80%94-Content-and-Format-Guidance-for-Industry.pdf. A medication approved for the treatment of asthma in adults would, for example, be prescribed off label if used to treat a different disease, like pneumonia, or a different age group, like children.

[46] U.S. Food & Drug Administration. Understanding unapproved use of approved drugs "off label." February 5, 2018. Accessed August 25, 2022. Available at https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label.

not warrant special consent or review if it is deemed to be in the individual patient's best interest."[47]

36. The AAP Committee on Drugs further states "in no way does a lack of labeling signify that therapy is unsupported by clinical experience or data in children."[48] Among the reasons for this is that, even if there is substantial evidence of safety and efficacy for a new indication, a sponsor may not seek FDA approval for it because the sponsor does not expect that the future revenue will offset the costs of obtaining approval.[49]

37. "Off-label" use of drugs is common in many areas of medicine, including pediatrics. For example, magnesium sulfate is only approved by the FDA for replacement therapy in magnesium deficiency, in nutrition given by vein to correct or prevent low magnesium levels, or to prevent or control seizures due to high blood pressure during pregnancy.[50] It is, nonetheless, recommended for the short-term prolongation of pregnancy and to prevent neurologic injuries to the fetus and newborn [51] and as an adjunct treatment in severe, unresponsive asthma

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[47] Frattarelli DA, Galinkin JL, Green TP, et al. Off-label use of drugs in children. *Pediatrics*. 2014; 133(3): 563, 565.
[48] Frattarelli DA, Galinkin JL, Green TP, et al. Off-label use of drugs in children. *Pediatrics*. 2014; 133(3): 564.
[49] Wittich CM, Burkle CM, Lanier WL. Ten common questions (and their answers) about off-label drug use. *Mayo Clin Proc*. 2012;87(10):982-990.
[50] Magnesium Sulfate. February 2016. Accessed August 31, 2022. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/019316s024lbl.pdf.
[51] Committee Opinion No 652: Magnesium sulfate use in obstetrics. *Obstet Gynecol*. 2016;127(1): e52-e53.

exacerbations.[52] A recent study of children's hospitals found that in 28.1% of encounters, at least one off-label drug was prescribed.[53] Examples of medications used off-label in this study included: albuterol, which is used to treat asthma; morphine, which is used to treat pain; and lansoprazole (Prevacid®), which is used to treat gastrointestinal reflux. The rate of off-label use may be significantly higher in certain age groups, categories of drugs, and clinical settings.

38. The GAPMS Memo misleadingly notes that testosterone is a Schedule III controlled substance because of its "high probability of abuse." GAPMS Memo at 19. But there is no evidence of abuse or dependence of anabolic-androgenic steroids from therapeutic use. And Schedule III drugs have a moderate to low potential for physical and psychological dependence.[54] Dependence has only been reported among weightlifters and bodybuilders receiving non-therapeutic, supraphysiologic doses.[55]

SUBSTANTIAL INCREASES IN THE UTILIZATION OF GENDER-AFFIRMING MEDICAL CARE

[52] National Heart, Lung, and Blood Institute. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. 2007. Accessed August 31, 2022. Available at https://www.nhlbi.nih.gov/sites/default/files/media/docs/EPR-3_Asthma_Full_Report_2007.pdf.
[53] Yackey K, Stukus K, Cohen D, Kline D, Zhao S, Stanley R. Off-label medication prescribing patterns in pediatrics: An update. *Hosp Pediatr*. 2019;9(3):186-193.
[54] United States Drug Enforcement Administration. Drug scheduling. July 10, 2018. Accessed August 25, 2022. Available at https://www.dea.gov/drug-information/drug-scheduling.
[55] Brower KJ. Anabolic steroid abuse and dependence. *Curr Psychiatry Rep*. 2002;4(5):377-387.

39. In addition to evidence-based clinical practice guidelines, utilization trends and insurance coverage policies provide further evidence that gender-affirming medical care is a consistent with generally accepted medical standards. The peer-reviewed evidence of the efficacy of gender-affirming medical care and the recommendations of it by clinical practice guidelines are likely to increase the utilization of gender-affirming medical care and coverage by insurance companies. There have been substantial increases in the utilization of gender-affirming medical care in the last 30 years. This has included increases in referrals for care as well as the use of different forms of care. Evidence for these changes comes from a variety of sources and investigators use different ways to describe the increases in utilization. Studies demonstrate increasing referrals to children's hospitals and specialized gender clinics.[56] Handler and colleagues, for example, report that between February 2015 and June 2018 there was a significant increase in the volume of pediatric referrals to the specialized gender clinic at Kaiser Permanente North California; the average number of monthly referrals increased from 5.1 to 25.7 individuals per month which is an increase of 504%.[57]

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[56] Spack NP, Edwards-Leeper L, Feldman HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;129(3):418-425; Chen M, Fuqua J, Eugster EA. Characteristics of referrals for gender dysphoria over a 13-year period. *J Adolesc Health*. 2016;58(3):369-371.

[57] Handler T, Hojilla JC, Varghese R, Wellenstein W, Satre DD, Zaritsky E. Trends in referrals to a pediatric transgender clinic. *Pediatrics*. 2019;144(5): e20191368.

40. Studies have also demonstrated significant increases in the utilization of various forms of gender-affirming medical care including puberty blockers,[58] hormone therapy,[59] and surgery.[60] Baker and colleagues, for example, conducted a study using the OptumLabs Data Warehouse. The Warehouse includes de-identified administrative claims data for commercially insured enrollees in a large, private US health plan. They found that the percentage of transgender people who were receiving hormone therapy or underwent surgery increased from 17% and 0.5% respectively in 2011 to 65% and 8% by 2019. This percentile increase represents a substantial number of individuals as the number of transgender people with coverage increased from 71 per million enrollees in 1993 to 411 per million in 2019.[61] The Society for Plastic Surgery reports also that the number of gender-affirming

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[58] Lopez CM, Solomon D, Boulware SD, Christison-Lagay ER. Trends in the use of puberty blockers among transgender children in the United States. *J Pediatr Endocrinol Metab*. 2018;31(6):665-670.

[59] Leinung MC, Joseph J. Changing demographics in transgender individuals seeking hormonal therapy: Are trans women more common than trans men? *Transgend Health*. 2020;5(4):241-245.

[60] Das RK, Perdikis G, Al Kassis S, Drolet BC. Gender-affirming chest reconstruction among transgender and gender-diverse adolescents in the US from 2016 to 2019. *JAMA Pediatr*. 2023;177(1):89-90.

[60] Canner JK, Harfouch O, Kodadek LM, et al. Temporal trends in gender-affirming surgery among transgender patients in the United States. *JAMA Surg*. 2018;153(7):609-616; Lane M, Ives GC, Sluiter EC, et al. Trends in gender-affirming surgery in insured patients in the United States. *Plast Reconstr Surg Glob Open*. 2018;6(4):e1738; Das RK, Evans AG, Kalmar CL, Al Kassis S, Drolet BC, Perdikis G. Nationwide estimates of gender-affirming chest reconstruction in the United States, 2016-2019. *Aesthet Surg J*. 2022;42(12):NP758-NP762; Das RK, Perdikis G, Al Kassis S, Drolet BC. Gender-affirming chest reconstruction among transgender and gender-diverse adolescents in the US from 2016 to 2019. *JAMA Pediatr*. 2023;177(1):89-90; Tang A, Hojilla JC, Jackson JE, et al. Gender-affirming mastectomy trends and surgical outcomes in adolescents. *Ann Plast Surg*. May 2022;88(4 Suppl): S325-S331.

[61] Baker K, Restar A. Utilization and costs of gender-affirming care in a commercially insured transgender population. *J Law Med Ethics*. 2022;50(3):456-470.

surgeries performed by its members increased from 2,470 in 2015[62] to 16,353 in 2020,[63] which is an increase of 562%.

COVERAGE BY OTHER CREDITABLE INSURANCE PAYORS

41. Coverage of gender-affirming medical care is provided by other creditable insurance payors. In 2014, the Department of Health and Human Services' Departmental Appeals Board determined that the National Coverage Determination denying Medicare coverage of gender-affirming surgery was invalid.[64] A 2018 analysis of Medicare prescription drug plans found that the proportion of plans providing coverage of hormone therapy varied by hormone with 100/75% providing coverage/unrestricted coverage of testosterone-cypionate, 89/89% estradiol-valerate, and 100/100% spironolactone.[65] A study of state Medicaid programs published in 2021 found that 67% covered gender affirming

[62] American Society of Plastic Surgeons. Plastic surgery statistics report 2016. Accessed January 8, 2023. Available at https://www.plasticsurgery.org/documents/News/Statistics/2016/plastic-surgery-statistics-full-report-2016.pdf.

[63] American Society of Plastic Surgeons. Plastic surgery statistics report 2020. Accessed January 8, 2023. Available at https://www.plasticsurgery.org/documents/News/Statistics/2020/plastic-surgery-statistics-full-report-2020.pdf.

[64] Department of Health and Human Services Departmental Appeals Board Appellate Division. NCD 140.3 Transexual Surgery. May 30, 2014. Accessed January 8, 2023. Available at https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf; Centers for Medicare & Medicaid Services. National coverage determination: Gender dysphoria and gender reassignment surgery 140.9. August 30, 2016. Accessed January 8, 2023. Available at https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=368.

[65] Solotke MT, Liu P, Dhruva SS, Gulanski B, Shah ND, Ross JS. Medicare prescription drug plan coverage of hormone therapies used by transgender individuals. *LGBT Health*. 2020;7(3):137-145. Spironolactone is an anti-androgen used in the treatment of transgender women in conjunction with estrogen to reduce testosterone production.

hormone treatment, 18% did not cover it, and 16% were indeterminate. With respect to gender affirming surgery, the results were 51%, 43%, and 8% respectively.[66]

42. Gender-affirming medical care is also covered by private health insurance plans. A study of self-insured, corporate health insurance benefit plans conducted in 2019 found that 56.4% covered transition care, 8.8% did not cover it, 5.8% were ambiguous, and 29.1% were silent. The investigators did not differentiate between gender-affirming hormone treatment and surgery.[67] Coverage for surgery is highest for bilateral mastectomy for transgender men and genital surgery for transgender men and women (transgender women are individuals assigned male at birth who identify as female). National surveys of private insurance plans found 96% covered mastectomy[68] and 91% genital surgery.[69] Private insurance plans cover other types of gender-affirming surgery,[70] such as breast augmentation,[71]

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[66] Zaliznyak M, Jung EE, Bresee C, Garcia MM. Which U.S. states' Medicaid programs provide coverage for gender-affirming hormone therapy and gender-affirming genital surgery for transgender patients?: A state-by-state review, and a study detailing the patient experience to confirm coverage of services. *J Sex Med*. 2021;18(2):410-422.

[67] Kirkland A, Talesh S, Perone AK. Transition coverage and clarity in self-insured corporate health insurance benefit plans. *Transgend Health*. 2021;6(4):207-216.

[68] Ngaage LM, Knighton BJ, McGlone KL, et al. Health insurance coverage of gender-affirming top surgery in the United States. *Plast Reconstr Surg*. 2019;144(4):824-833.

[69] Ngaage LM, Knighton BJ, Benzel CA, et al. A review of insurance coverage of gender-affirming genital surgery. *Plast Reconstr Surg*. 2020;145(3):803-812.

[70] Ngaage LM, McGlone KL, Xue S, et al. Gender surgery beyond chest and genitals: Current insurance landscape. *Aesthet Surg J*. 2020;40(4):NP202-NP210.

[71] Ngaage LM, Knighton BJ, McGlone KL, et al. Health insurance coverage of gender-affirming top surgery in the United States. *Plast Reconstr Surg*. 2019;144(4):824-833.

facial feminization surgery,[72] voice surgery,[73] and hair removal procedures[74] for transgender women albeit at lower rates.

GENDER DYSPHORIA IS A MEDICAL DIAGNOSIS

43. Several other mischaracterizations of gender-affirming medical care in the GAPMS Memo should be addressed. While the GAPMS Memo correctly acknowledges that gender dysphoria is a medical diagnosis contained in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* 5th ed,[75] it falsely characterizes individuals with gender dysphoria as "self-diagnosing." GAPMS Memo at 30; Attachment G at 5. The diagnosis of gender dysphoria in adolescents and adults, like many other common medical diagnoses, relies on individuals' self-report of their symptoms. The diagnosis of migraine headaches, for example, depends on individuals' report of the number, duration, and characteristics of their headaches. The characteristics include the

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[72] Gorbea E, Gidumal S, Kozato A, Pang JH, Safer JD, Rosenberg J. Insurance coverage of facial gender affirmation surgery: A review of Medicaid and commercial insurance. *Otolaryngol Head Neck Surg*. 2021;165(6):791-797; Gadkaree SK, DeVore EK, Richburg K, et al. National variation of insurance coverage for gender-affirming facial feminization surgery. *Facial Plast Surg Aesthet Med*. 2021;23(4):270-277.

[73] DeVore EK, Gadkaree SK, Richburg K, et al. Coverage for gender-affirming voice surgery and therapy for transgender individuals. *Laryngoscope*. 2021;131(3):E896-E902.

[74] Peloza K, Kahn B, Stoff BK, Yeung H. Insurance coverage for hair removal procedures in the treatment of gender dysphoria. *Dermatol Surg*. 2021;47(2):306-308.

[75] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. American Psychiatric Publishing; 2013. A text revision, which contains the same diagnosis and diagnostic criteria, has subsequently been published. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, Text Revision. American Psychiatric Publishing; 2022.

headaches' location, quality, intensity, and aggravating factors as well as the presence of nausea and/or vomiting, and light and sound sensitivity. It is common for diagnostic criteria to utilize qualitative terms, e.g., the intensity of migraine headaches is moderate to severe.[76] Like gender dysphoria, there is no confirmatory laboratory or radiographic study for the diagnosis of migraine headaches. Radiographic studies and electroencephalograms (EEG) are only used if the history and physical examination suggest that the headache is secondary to another condition, e.g., meningitis or subarachnoid hemorrhage.[77]

44. Individuals with symptoms of gender dysphoria may anticipate their diagnosis in the same way that individuals with fever, cough, and difficulty breathing may reasonably suspect that they have pneumonia. It is, however, incorrect to suggest that these patients "self-diagnose," or that such suspicions serve as the basis for the diagnosis or subsequent treatment. Only licensed healthcare providers or teams of providers, based on patient reports and, in the case of minors, parent reports, make the diagnosis of gender dysphoria and any subsequent treatment recommendations.

[76] Headache Classification Committee of the International Headache Society (IHS). The international classification of headache disorders, 3rd edition. *Cephalalgia*. 2018;38(1):1-211.
[77] Steiner TJ, Jensen R, Katsarava Z, et al. Aids to management of headache disorders in primary care, 2nd edition. *J Headache Pain*. 2019;20(1):57.

PARENTS AND LEGAL GUARDIANS ARE CAPABLE OF PROVIDING INFORMED CONSENT FOR GENDER-AFFIRMING MEDICAL CARE

45. The GAPMS Memo and attachments incorrectly claim that parents or legal guardians are unable to understand and appreciate the potential risks of gender-affirming health care and, therefore, are incapable of providing informed consent. GAPMS Memo at 18, 29; Attachment G at 3-4.

46. First and foremost, the current standard of care for treating gender dysphoria in minors is consistent with general ethical principles instantiated in the practices of informed consent and shared decision-making.

47. Parents or legal guardians generally must provide informed consent for medical treatment for their minor children, including for gender-affirming medical care. AHCA and Dr. Donovan cite no evidence in support of the assertion that parents or guardians of adolescents with gender dysphoria, nor the adolescents themselves, are unable to understand or appreciate the potential risks of gender-affirming medical care. ACHA and Dr. Donovan also cite to no evidence that clinicians are not sufficiently disclosing the risks of gender-affirming medical care to parents or legal guardians, or to minor patients. GAPMS Memo p. 29-30; Attachment G at 2-4.

48. Parents and legal guardians frequently consent to medical treatments for minors unrelated to gender dysphoria which have comparable risks, uncertainty,

or levels of evidence. For example, parents and legal guardians consent to the treatment of nonmalignant medical conditions for their minor children, including some rheumatologic disorders and hematologic conditions, which may impair fertility.[78]

49. Adolescents generally possess comparable medical decision-making capacity to adults.[79] There is evidence that most adolescents with gender dysphoria have sufficient medical decision-making capacity to make decisions regarding puberty blockers.[80] And there are steps that healthcare providers take to promote adolescents' decision-making capacity.[81]

50. The Society's clinical practice guideline extensively discusses the potential benefits, risks, and alternatives to gender-affirming medical care, and its recommendations regarding the timing of interventions are based in part on the treatment's potential risks and the adolescent's decision-making capacity. The guideline recommends that informed consent for pubertal blockers and gender-

[78] Hirshfeld-Cytron J, Gracia C, Woodruff TK. Nonmalignant diseases and treatments associated with primary ovarian failure: An expanded role for fertility preservation. *J Womens Health (Larchmt)*. 2011;20(10):1467-77.
[79] Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. *Child Dev*. 1982;53(6):1589-98.
[80] Vrouenraets L, de Vries ALC, de Vries MC, van der Miesen AIR, Hein IM. Assessing medical decision-making competence in transgender youth. *Pediatrics*. 2021;148(6): e2020049643.
[81] Katz AL, Webb SA, Committee on Bioethics. Informed consent in decision-making in pediatric practice. *Pediatrics*. 2016;138(2): e20161485.

affirming hormones include a discussion of the implications for fertility and options for fertility preservation.[82]

51. The Society's clinical guideline also advises delaying gender-affirming hormone treatment, which results in partly irreversible physical changes, until an adolescent has developed sufficient medical decision-making capacity. The guideline states clinicians should individualize decision-making for chest surgery in transgender males and that chest surgery may be considered in some instances for individuals under 18 years old. The guideline recommends gender-affirming genital surgery involving gonadectomy and/or hysterectomy only in individuals 18 years old or older. [83]

THE EXCLUSION SINGLES OUT GENDER-AFFIRMING CARE FOR ANOMALOUS TREATMENT

52. The Exclusion does not provide a basis for excluding coverage of the provision of gender-affirming medical care to individuals with gender dysphoria and treating it differently from other comparable medical interventions. For example, while the Exclusion would eliminate coverage of chest surgery for the treatment of gender dysphoria for transgender Medicaid beneficiaries, cisgender Medicaid

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[82] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

[83] Or the legal age of majority in his or her country. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

beneficiaries are provided coverage for comparable surgeries, such as those for gynecomastia.[84] Gynecomastia is the proliferation of ductal or glandular breast tissue, as opposed to adipose tissue or fat, in individuals whose sex assigned at birth is male. While surgery to treat gynecomastia may at times lessen pain, it also commonly reduces psychosocial distress. The surgery has the effect of affirming cisgender male patients' gender identity, that is, to help individuals assigned male at birth feel their bodies are more typically masculine. Risks associated with the procedure include bruising, bleeding, infection, scarring, poor cosmetic outcome, and loss of sensation.[85]

53. There is nothing unique about chest surgery for gender dysphoria that justifies singling this treatment, or other medical treatments for gender dysphoria, out for non-coverage based on a concern regarding evidence of safety or efficacy; adult patients', or parents' or guardians' ability to consent; or adolescents' ability to assent. As with other conditions, medical decisions regarding treatment for gender dysphoria should continue to be left to the discretion of adult patients, or parents or legal guardians and their minor children, and their healthcare providers.

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[84] State of Florida Agency for Health Care Administration. Florida Medicaid's Covered Services and HCBS Waivers: Integumentary Services. Accessed February 16, 2023. Available at https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/primary_care_policy/Integumentary.shtml.

[85] Nordt CA, DiVasta AD. Gynecomastia in adolescents. *Curr Opin Pediatr*. 2008;20(4):375-382.

CONCLUSION

54. Based on my research and experience as a physician and bioethicist, treatment for gender dysphoria is not experimental and is consistent with generally accepted professional medical standards including standards for informed consent. There is not a sound medical or ethical basis for excluding such care from coverage by Florida Medicaid and so doing is inconsistent with the program's other medical coverage decisions.

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

Executed on February 16, 2023

ARMAND H. MATHENY ANTOMMARIA, MD, PhD

EXHIBIT A

BIBLIOGRAPHY

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EXHIBIT B

Curriculum Vitae

Last Updated: January 24, 2023

PERSONAL DATA

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Citizenship: United States of America

CONTACT INFORMATION

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EDUCATION

1983-1987	BSEE	Valparaiso University, with High Distinction Valparaiso, IN
1983-1987	BS	Valparaiso University (Chemistry), with High Distinction Valparaiso, IN
1987-1989	MD	Washington University School of Medicine
1998-2000		Saint Louis, MO
1989-2000	PhD	The University of Chicago Divinity School (Religious Ethics) Chicago, IL
2000-2003	Resident	University of Utah (Pediatrics) Salt Lake City, UT
2005-2006	Certificate	Conflict Resolution Certificate Program, University of Utah Salt Lake City, UT

BOARD CERTIFICATION

2019 Pediatric Hospital Medicine, American Board of Pediatrics
2019 Healthcare Ethics Consultant-Certified, Healthcare Ethics Consultation Certification Commission
2004 General Pediatrics, American Board of Pediatrics

PROFESSIONAL LICENSES

2012-Present	Doctor of Medicine, Ohio
2006-2010	Alternative Dispute Resolution Provider—Mediator, Utah
2001-2014	Physician and Surgeon, Utah
2001-2014	Physician and Surgeon Controlled Substance, Utah

PROFESSIONAL EXPERIENCE

Full Time Positions

2019-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Department of Surgery

2019-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Surgery

2017-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine

2017-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2016-2017 *Associate Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2012-2017 *Associate Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine

2012-Present *Lee Ault Carter Chair in Pediatric Ethics*
Cincinnati Children's Hospital Medical Center

2012-2016 *Associate Professor-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics

2010-2012 *Associate Professor of Pediatrics* (with Tenure)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2010-2012 *Adjunct Associate Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities

2004-2010 *Assistant Professor of Pediatrics* (Tenure Track)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2004-2010 *Adjunct Assistant Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities

2003-2004 *Instructor of Pediatrics* (Clinical Track)
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics

2003-2004 *Adjunct Instructor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics

Part Time Positions

2022- Present *Expert Witness,* Testimony
Eknes-Tucker, et al., v. Marshall, et al., United States District Court Middle District of Alabama Northern Division, Case No. 2:22-cv0-184-LCB.

2022-Present	*Expert Witness,* Testimony Jane Doe, et al., v. Greg Abbott, et al., District Court of Travis County, Texas 353rd Judicial District, Case No. D-1-GN-22-000977
2021-2022	*Expert Witness*, Deposition and Testimony Dylan Brandt, et al., v. Leslie Rutledge, et al., United States District Court, Eastern District of Arkansas, Case No.: 5:21-CV-00450-JM-1
2021	*Consultant* Proctor & Gamble, Cincinnati, OH
2019	*Consultant* Sanofi Genzyme, Cambridge, MA
2018-Present	*Consultant* Center for Conflict Resolution in Healthcare, Memphis, TN
2017-2020	*Consultant* Amicus Therapeutics, Cranbury, NJ
2017	*Consultant* Sarepta Therapeutics, Cambridge, MA
2014	*Consultant* Genzyme, A Sanofi Company, Cambridge, MA

Editorial Experience

Editorial Board

2020-Present	*Pediatrics,* Associate Editor for Ethics Rounds and Member of the Executive Editorial Board
2015-2020	*Journal of Clinical Ethics*
2009-2020	*Journal of Medical Humanities*

Guest Academic Editor

2017	*PLOS|ONE*

Ad Hoc Reviewer: *Academic Medicine, Academic Pediatrics, AJOB Primary Research, American Journal of Bioethics, American Journal of Law & Medicine, American Journal of Medical Genetics, American Journal of Transplantation, BMC Medical Ethics, BMJ Open, Canadian Journal of Bioethics, CHEST, Clinical Transplantation, European Journal of Human Genetics, European Journal of Pediatrics, Frontiers in Genetics, Hospital Medicine, International Journal of Health Policy and Management, International Journal of Nursing Studies, Journal of Adolescent and Young Adult Oncology, Journal of Clinical Ethics, Journal of Empirical Research on Human Research Ethics, Journal of General Internal Medicine, Journal of Healthcare Leadership, Journal of Hospital Medicine, Journal of the Kennedy Institute of Ethics, Journal of Law, Medicine & Ethics, Journal of Medical Ethics, Journal of Medical Humanities, Journal of Medicine and Life, Journal of Palliative Care, Journal of Pediatrics, Journal of Pediatric Surgery, Mayo Clinic Proceedings, Medicine, Healthcare and Philosophy, Molecular Diagnosis & Therapy, New England Journal of Medicine, Patient Preference and Adherence, Pediatrics, Pediatrics in Review, Personalized Medicine, PLOS\|ONE, Risk Management and Healthcare Policy, Saudi Medical Journal, SSM - Qualitative Research in Health,* and *Theoretical Medicine and Bioethics*

SCHOLASTIC AND PROFESSIONAL HONORS

2021	*Hidden Gem Award,* Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2019-2022	*Presidential Citation,* American Society for Bioethics and Humanities, Chicago, IL
2016	*Laura Mirkinson, MD, FAAP Lecturer,* Section on Hospital Medicine, American Academy of Pediatrics, Elk Grove Village, IL
2016, 2018	*Certificate of Excellence*, American Society for Bioethics and Humanities, Glenview, IL
2013, 2016	*Senior Resident Division Teaching Award,* Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012	*Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT
2011	*Member*, Society for Pediatric Research, The Woodlands, TX
2011	*Presidential Citation*, American Society for Bioethics and Humanities, Glenview, IL
2009	*Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT
2008	*Nominee,* Physician of the Year, Primary Children's Medical Center, Salt Lake City, UT
2005-2006	*Fellow,* Medical Scholars Program, University of Utah School of Medicine, Salt Lake City, UT
1995-1997	*Doctoral Scholar*, Crossroads, A Program of Evangelicals for Social Action, Philadelphia PA
1989-1992	*Fellow*, The Pew Program in Medicine, Arts, and the Social Sciences, University of Chicago, Chicago, IL

ADMINISTRATIVE EXPERIENCE

Administrative Duties

2019-Present	*Chair,* Oversight Committee, Cincinnati Fetal Center, Cincinnati, OH
2014-Present	*Chair*, Ethics Committee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012-Present	*Director*, Ethics Center, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2012-Present	*Chair,* Ethics Consultation Subcommittee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2010	*Co-Chair,* Ethics Subcommittee, Work Group for Emergency Mass Critical Care in Pediatrics, Centers for Disease Control and Prevention, Atlanta, GA
2009	*Chair*, Ethics Working Group, H1N1 and Winter Surge, Primary Children's Medical Center, Salt Lake City, UT
2005-2012	*Chair*, Ethics Committee, Primary Children's Medical Center, Salt Lake City, UT
2005-2012	*Chair*, Ethics Consultation Subcommittee, Primary Children's Medical Center, Salt Lake City, UT
2003-4	*Chair*, Clinical Pertinence Committee, Primary Children's Medical Center, Salt Lake City, UT

Professional & Scientific Committees

Committees

2021	*Member*, EMCO Capacity Collaboration, Ohio Hospital Association, Columbus, OH
2020-2021	*Member*, Allocation of Scarce Resources Work Group, Ohio Hospital Association, Columbus, OH
2020-Present	*Member,* Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD
2020	*Member*, Crisis Standards of Care Workgroup, The Health Collaborative, Cincinnati, OH
2019-Present	*Member,* Healthcare Ethics Consultant Certification Commission, Oak Park, IL

2019	*Member,* Expert Panel, Pediatric Oncology End-of-Life Care Quality Markers, Institute for Cancer Outcomes & Survivorship, University of Alabama at Birmingham, Birmingham, AL
2018	*Member,* Resource Planning and Allocation Team Implementation Task Force, Ohio Department of Health, Columbus, OH
2012-Present	*Member*, Gaucher Initiative Medical Expert Committee, Project HOPE, Millwood, VA
2009-2014	*Member,* Clinical Ethics Consultation Affairs Committee, American Society for Bioethics and Humanities, Glenview, IL
2005-2011	*Member,* Committee on Bioethics, American Academy of Pediatrics, Oak Park, IL

Data Safety and Monitoring Boards

2019-Present	*Member,* Data and Safety Monitoring Board, Sickle Cell Domestic Trials, National Heart, Lung, and Blood Institute, Bethesda, MD
2018-2019	*Member,* Standing Safety Committee for P-188-NF (Carmeseal-MD™) in Duchenne Muscular Dystrophy, Phrixus Pharmaceuticals, Inc., Ann Arbor, MI
2017-Present	*Member*, Observational Study Monitoring Board, Sickle Cell Disease Observational Monitoring Board, National Heart, Lung, and Blood Institute, Bethesda, MD
2016-2018	*Member,* Observational Study Monitoring Board, Long Term Effects of Hydroxyurea in Children with Sickle Cell Anemia, National Heart, Lung, and Blood Institute, Bethesda, MD

Reviewer

2020-Present	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2020	*Grant Reviewer,* The Croatian Science Foundation, Hvatska zaklada za znanost (HRZZ)
2018	*Book Proposal Reviewer*, Elsevier
2018-2019	*Category Leader,* Religion, Culture, and Social Sciences, American Society for Bioethics and Humanities Annual Meeting
2017	*Timekeeper,* American Society for Bioethics and Humanities Annual Meeting
2017-Present	*Abstract Reviewer,* Pediatric Academic Societies Annual Meeting
2016-2021	*Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2016	*Grant Reviewer*, Innovation Research Incentives Scheme, The Netherlands Organisation for Health Research and Development
2016-2017	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2014, 2016	*External Peer Reviewer*, PSI Foundation, Toronto, Ontario, Canada
2014	*Member,* Scientific Committee, International Conference on Clinical Ethics and Consultation
2013	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2013	*Reviewer*, Open Research Area Plus, Agence Nationale de la Research, Deutsche Forschungsgemeinschaft, Economic and Social Research Council, National Science Foundation, and Organization for Scientific Research
2011-2012	*Abstract Reviewer,* Pediatric Academic Societies Annual Meeting
2011-2013	*Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2011-2014	*Abstract Reviewer*, Pediatric Hospital Medicine Annual Meeting
2011-2012	*Religious Studies Subcommittee Leader,* Program Committee, American Society for Bioethics and Humanities Annual Meeting
2010	*Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

Other

2021	*Timekeeper,* American Society for Bioethics and Humanities Annual Meeting
2021	*Mentor,* Early Career Advisor Professional Development Track, American Society for Bioethics and Humanities.

2021	*Mentor,* Early Career Advisor Paper or Project Track, American Society for Bioethics and Humanities.
2109	*Mentor*, Early Career Advising Program, American Society for Bioethics and Humanities
2018	*Passing Point Determination*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission
2018	*Member*, Examination Committee, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission
2018	*Item Writer*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

UNIVERSITY COMMUNITY ACTIVITIES

Cincinnati Children's Hospital Medical Center

2020-Present	*Member*, Faculty Diversity and Inclusion Steering Committee
2020-Present	*Member*, Medical Management of COVID-19 Committee
2020-2021	*Member,* Caregiver Refusal Team
2020-2021	*Member,* COVID-19 Vaccine Allocation Committee
2020	*Member*, Personal Protective Equipment Subcommittee of the COVID-19 Steering. Committee
2018-2019	*Member,* Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference
2017-Present	*Member*, Donor Selection Committee
2017-2020	*Member,* Employee Emergency Fund Review Committee
2017	*Member,* Root Cause Analysis Team
2016-2017	*Member,* Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference
2015-2019	*Member,* Destination Excellence Medical Advisory Committee
2015-Present	*Member,* Disorders of Sexual Development Case Review Committee
2015-2019	*Member,* Destination Excellence Case Review Committee
2014-2018	*Member,* Genomics Review Group, Institutional Review Board
2014-2017	*Member,* Center for Pediatric Genomics Leadership Committee
2013-2017	*Member,* Genetic Testing Subcommittee, Health Network
2013-2016	*Member,* Schwartz Center Rounds Planning Committee
2013-2014	*Member*, Genomics Ad Hoc Subcommittee, Board of Directors
2012-Present	*Member,* Cincinnati Fetal Center Oversight Committee
2012-Present	*Member,* Ethics Committee
2012-Present	*Member,* G-23
2012-2016	*Member,* Integrated Solid Organ Transplant Steering Committee

University of Utah

2009-2012	*Member,* Consolidated Hearing Committee

University of Utah School of Medicine

2010-2012	*Member,* Medical Ethics, Humanities, and Cultural Competence Thread Committee
2008-2010	*Member,* Fourth Year Curriculum Committee

University of Utah Department of Pediatrics

2010-2011	*Member,* Planning Committee, 25th Annual Biological Basis of Children's Health Conference, "Sex, Gender, and Sexuality"
2009-2012	*Member,* Medical Executive Committee
2005-2012	*Member,* Retention, Promotion, and Tenure Committee
2004-2012	*Interviewer,* Residency Program

2003-2012 *Member,* Education Committee

Intermountain Healthcare
2009-2012 *Member,* System-Wide Bioethics Resource Service
2009-2012 *Member,* Pediatric Guidance Council

Primary Children's Medical Center
2012-2012 *Member,* Shared Accountability Organization Steering Committee
2009 *Member*, H1N1 and Winter Surge Executive Planning Team
2005-2010 *Member,* Continuing Medical Education Committee
2005-2010 *Member*, Grand Rounds Planning Committee
2003-2012 *Member*, Ethics Committee

ACTIVE MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012-Present Association of Bioethics Program Directors
2011-Present Society for Pediatric Research
2000-Present American Academy of Pediatrics
1999-Present American Society of Bioethics and Humanities

FUNDING

Past Grants

2015-2019 "Better Outcomes for Children: Promoting Excellence in Healthcare Genomics to Inform Policy."
Percent Effort: 9%
National Human Genome Research Institute
Grant Number: 1U01 HG008666-01
Role: Investigator

2015-2016 "Ethics of Informed Consent for Youth in Foster Care"
Direct Costs: $10,000
Ethics Grant, Center for Clinical and Translational Science and Training
University of Cincinnati Academic Health Center
Role: Co-Investigator

2014-2015 "Extreme Personal Exposure Biomarker Levels: Engaging Community Physicians and Ethicists for Guidance"
Direct Costs: $11,640
Center for Environmental Genetics
University of Cincinnati College of Medicine
Role: Investigator

2014-2015 "Child, Adolescent, and Parent Opinions on Disclosure Policies for Incidental Findings in Clinical Whole Exome Sequencing"
Direct Costs: $4,434
Ethics Grant, Center for Clinical and Translational Science and Training, University of Cincinnati Academic Health Center
Role: Principal Investigator

2013-2014 "Better Outcomes for Children: GWAS & PheWAS in eMERGEII
Percent Effort: 5%
National Human Genome Research Institute
Grant Number: 3U01HG006828-0251
Role: Investigator

2004-2005 "Potential Patients' Knowledge, Attitudes, and Beliefs Regarding Participating in Medical Education: Can They be Interpreted in Terms of Presumed Consent?"
Direct Costs: $8,000
Interdisciplinary Research in Applied Ethics and Human Values, University Research Committee, University of Utah
Role: Principal Investigator

TEACHING RESPONSIBILITIES/ASSIGNMENTS

Course and Curriculum Development

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

Course Lectures

2018, 2021 Introduction to Biotechnology, "Ethics and Biotechnology" and "Clinical Ethics," BIOL 3027, University of Cincinnati, Taught 1 time per year, Taken by undergraduate students, Enrollment 25.

2018-Present Biomedical Ethics, "Conscientious Objection in Healthcare" and "Ethical Issues in the Care of Transgender Adolescents," MEDS 4035 & MEDS 4036, University of Cincinnati College of Medicine, Taught 1 time per year, Taken by senior undergraduate students, Enrollment 52.

2016 Foundations of Healthcare Ethics and Law, "Clinical Ethics," HESA 390, Xavier University.

2014-Present Physicians and Society, "Transfusion and the Jehovah's Witness Faith," "Obesity Management: Ethics, Policy, and Physician Implicit Bias," "Embryos and Ethics: The Ethics of Designer Babies," "Ethics and Genetic Testing," and "Ethics and Direct to Consumer Genetic Testing," 26950112 and 26950116, University of Cincinnati School of Medicine, Taken by first and second year medical students, Enrollment 100.

2014-Present Ethical Issues in Health Care, "Ethical Issues in Managing Drug Shortages: The Macro, Meso, and Micro Levels," HESA 583, College of Social Sciences, Health, and Education Health Services Administration, Xavier University, Taken by health services administration students, Enrollment 25.

2009 Physical Diagnosis II, Internal Medicine 7160, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth year medical students, Enrollment 100

Small Group Teaching

2018-Present Ethics in Research, GNTD 7003-001, University of Cincinnati School of Medicine, Taught 1 time per year, Taken by fellows, MS, and PhD students, Enrollment 110.

2007 Physical Diagnosis I, Internal Medicine 7150, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth medical students, Enrollment 100

2003 Pediatric Organ System, Pediatrics 7020, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

Graduate Student Committees

2018-2022 *Chair,* Scholarship Oversight Committee, William Sveen, Pediatric Critical Care Fellowship, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2018-2020 *Member*, Scholarship Oversight Committee, Anne Heueman, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2017-2019 *Chair*, Scholarship Oversight Committee, Bryana Rivers, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2013-2015 *Mentor*, Sophia Hufnagel, Combined Pediatrics/Genetics Residency, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2013-2015 *Co-Chair,* Scholarship Oversight Committee, Andrea Murad, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2013-2014 *Member*, Scholarship Oversight Committee, Grace Tran, Genetic Counseling, University of Cincinnati, Cincinnati, OH

2011-2012 *Chair,* Scholarship Oversight Committee, Kevin E. Nelson, MD, PhD, Pediatric Inpatient Medicine Fellowship, University of Utah, Salt Lake City, UT

Continuing Education Lectures

2008 Choosing Healthplans All Together (CHAT) Exercise Facilitator, 18th Annual Intermountain Medical Ethics Conference, "Setting Priorities for Healthcare in Utah: What Choices are We Ready to Make?," Salt Lake City, Utah, October 3.

2007 *Speaker*, Infant Medical Surgical Unit, Primary Children's Medical Center, "Withholding and Withdrawing Artificial Nutrition and Hydration: Can It Be Consistent With Care?," Salt Lake City, Utah, September 6.

2007 *Faculty Scholar-in Residence,* Summer Seminar, "The Role of Religion in Bioethics," Utah Valley State College, Orem, Utah, May 1.

2006 *Workshop Leader,* Faculty Education Retreat, "Publications and Publishing in Medical Education," University of Utah School of Medicine, Salt Lake City, Utah, September 15.

2006 *Breakout Session,* 16th Annual Intermountain Medical Ethics Conference, "Donation after Cardiac Death: Evolution of a Policy," Salt Lake City, Utah, March 28.

Other Educational Activities

2008 *Instructor*, Contemporary Ethical Issues in Medicine and Medical Research, Osher Lifelong Learning Institute, University of Utah, "Religion and Bioethics: Religiously Based Demands for and Refusals of Treatment," Salt Lake City, Utah, February 7.

2007 *Speaker*, Biology Seminar, Utah Valley State College, "Is He Dead?: Criteria of the Determination of Death and Their Implications for Withdrawing Treatment and Recovering Organs for Transplant," Orem, Utah, September 21.

PEER-REVIEWED JOURNAL ARTICLES

1. William N. Sveen, Armand H. Matheny Antommaria, Stephen Gilene, and Erika L. Stalets. (Forthcoming) "Adverse Events During Apnea Testing for the Determination of Death by Neurologic Criteria: A Single Center, Retrospective Pediatric Cohort." *Pediatric Critical Care Medicine.*
2. Erica K. Salter, Jay R. Malone, Amanda Berg, Annie Friedrich, Alexandra Hucker, Hillary King, and Armand H. Matheny Antommaria. (Online ahead of print) "Triage Policies at U.S. Hospitals with Pediatric Intensive Care Units." *AJOB Empirical Bioethics.* PMID: 36576201.
3. Armand H. Matheny Antommaria, Elizabeth Lanphier, Anne Housholder, and Michelle McGowan. (2023). "A mixed methods analysis of requests for religious exemptions to a COVID-19 vaccine requirement." *AJOB Empirical Bioethics.* 14: 15-22. PMID: 36161802.

4. Anne C Heuerman, Danielle Bessett, Armand H. Matheny Antommaria, Leandra. K. Tolusso, Nicki Smith, Alison H. Norris and Michelle L. McGowan (2022). "Experiences of reproductive genetic counselors with abortion regulations in Ohio." *Journal of Genetic Counseling*. 31: 641-652. PMID: 34755409.
5. Armand H. Matheny Antommaria and Ndidi I. Unaka. (2021) "Counterpoint: Prioritizing Health Care Workers for Scarce Critical Care Resources is Impractical and Unjust. *Journal of Hospital Medicine.* 16: 182-3. PMID 33617445.
6. Gregory A. Grabowski, Armand H. Matheny Antommaria, Edwin H. Kolodny, and Pramod K. Mistry. (2021) "Gaucher Disease: Basic and Translational Science Needs for More Complete Therapy and Management." *Molecular Genetics and Metabolism*. 132: 59-75. PMID: 33419694.
7. Armand H. Matheny Antommaria, Laura Monhollen, and Joshua K. Schaffzin. (2021) "An Ethical Analysis of Hospital Visitor Restrictions and Masking Requirements During the COVID-19." *Journal of Clinical Ethics.* 32(1): 35-44. PMID 33416516.
8. Armand H. Matheny Antommaria (2020) "The Pediatric Hospital Medicine Core Competencies: 4.05 Ethics." *Journal of Hospital Medicine.* 15(S1): 120-121.
9. Armand H. Matheny Antommaria, Tyler S. Gibb, Amy L. McGuire, Paul Root Wolpe, Matthew K. Wynia, Megan K. Applewhite, Arthur Caplan, Douglas S. Diekema, D. Micah Hester, Lisa Soleymani Lehmann, Renee McLeod-Sordjan, Tamar Schiff, Holly K. Tabor, Sarah E. Wieten, and Jason T. Eberl for a Task Force of the Association of Bioethics Program Directors (2020) "Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors." *Annals of Internal Medicine.* 173(3): 188-194. PMID: 32330224.
10. Armand H. Matheny Antommaria (2020) "Conflicting Duties and Reciprocal Obligations During a Pandemic." *Journal of Hospital Medicine.* 5:284-286. PMID: 32379030.
11. Mary V. Greiner, Sarah J. Beal, and Armand H. Matheny Antommaria (2020) "Perspectives on Informed Consent Practices for Minimal-Risk Research Involving Foster Youth." *Pediatrics*. 45:e20192845. PMID: 32156772.
12. Jennifer deSante-Bertkau, Michelle McGowan, and Armand H. Matheny Antommaria (2018) "Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations." *Journal of Clinical Ethics.* 29:291-304. PMID: 30605439.
13. Andrew J. Redmann, Melissa Schopper, Armand H. Matheny Antommaria, Judith Ragsdale, Alessandro de Alarcon, Michael J. Jutter, Catherine K. Hart, and Charles M. Myer. (2018) "To Transfuse or Not to Transfuse? Jehovah's Witnesses and PostOperative Hemorrhage in Pediatric Otolaryngology." *International Journal of Pediatric Otorhinolaryngology*. 115:188-192. PMID: 30368384.
14. Armand H. Matheny Antommaria, Kyle B. Brothers, John A. Myers, Yana B Feygin, Sharon A. Aufox, Murray H. Brilliant, Pat Conway, Stephanie M. Fullerton, Nanibaa' A. Garrison, Carol R. Horowitz, Gail P. Jarvik, Rongling Li, Evette J. Ludman, Catherine A. McCarty, Jennifer B. McCormick, Nathaniel D. Mercaldo, Melanie F. Myers, Saskia C. Sanderson, Martha J. Shrubsole, Jonathan S. Schildcrout, Janet L. Williams, Maureen E. Smith, Ellen Wright Clayton, Ingrid A. Holm. (2018) "Parents' Attitudes toward Consent and Data Sharing in Biobanks: A Multi-Site Experimental Survey." *AJOB Empirical Research.* 21:1-15. PMID: 30240342.
15. Armand H. Matheny Antommaria and Cynthia A. Prows. (2018) "Content Analysis of Requests for Religious Exemptions from a Mandatory Influenza Vaccination Program for Healthcare Personnel" *Journal of Medical Ethics.* 44: 389-391. PMID: 29463693.
16. Armand H. Matheny Antommaria (2017) "May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?" *Journal of Clinical Ethics.* 28: 217-221. PMID: 28930708.

17. Andrea M. Murad, Melanie F. Myers, Susan D. Thompson, Rachel Fisher, and Armand H. Matheny Antommaria (2017) "A Qualitative Study of Adolescents' Understanding of Biobanks and Their Attitudes Toward Participation, Re-contact, and Data Sharing." *American Journal of Medical Genetics: Part A.* 173: 930-937. PMID: 28328120.
18. Saskia Sanderson, Kyle Borthers, Nathaniel Mercaldo, Ellen Wright Clayton, Armand Antommaria, Sharon Aufox, Murray Brillant, Diego Campos, David Carrell, John Connolly, Pat Conway, Stephanie Fullerton, Nanibaa Garrison, Carol Horowitz, Gail Jarvik, David Kaufman, Terrie Kitchner, Rongling Li, Evette Ludman, Cahterine McCarty, Jennifer McCormick, Valerie McManus, Melanie Myers, Aaron Scrol, Janet Williams, Martha Shrubsole, Jonathan Schildcrout, Maureen Smith, and Ingrid Holm (2017) "Public Attitudes Towards Consent and Data Sharing in Biobank Research: A Large Multisite Experimental Survey in the US." *The American Journal of Human Genetics*. 100: 414-427. PMID: 28190457.
19. Maureen E. Smith, Saskia C Sanderson, Kyle B Brothers, Melanie F Myers, Jennifer McCormick, Sharon A Aufox, Martha J Shrubsole, Nanibaa' A Garrison, Nathaniel D Mercaldo, Jonathan S Schildcrout, Ellen Wright Clayton, Armand H. Matheny Antommaria, Melissa Basford, Murray Brilliant, John J Connolly, Stephanie M Fullerton, Carol R Horowitz, Gail P Jarvik, Dave Kaufman, Terrie Kitchner, Rongling Li, Evette J Ludman, Catherine McCarty, Valerie McManus, Sarah C Stallings, Janet L Williams, and Ingrid A Holm (2016) "Conducting a Large, Multi-Site Survey about Patients' Views on Broad Consent: Challenges and Solutions." *BMC Medical Research Methodology.* 16: 162. PMID: 27881091.
20. Angela Lorts, Thomas D. Ryan, Armand H. Matheny Antommaria, Michael Lake, and John Bucuvalas (2016) "Obtaining Consensus Regarding International Transplantation Continues to be Difficult for Pediatric Centers in the United States." *Pediatric Transplant.* 20: 774-777. PMID: 27477950.
21. Sophia B. Hufnagel, Lisa J. Martin, Amy Cassedy, Robert J. Hopkin, and Armand H. Matheny Antommaria (2016) "Adolescents' Preferences Regarding Disclosure of Incidental Findings in Genomic Sequencing That Are Not Medically Actionable in Childhood." *American Journal of Medical Genetics Part A*. 170: 2083-2088. PMID: 27149544.
22. Nanibaa' A. Garrison, Nila A. Sathe, Armand H. Matheny Antommaria, Ingrid A. Holm, Saskia Sanderson, Maureen E. Smith, Melissa McPheeters, and Ellen Wright Clayton (2016) "A Systematic Literature Review of Individuals' Perspectives on Broad Consent and Data Sharing in the United States." *Genetics in Medicine.* 18: 663-71. PMID: 26583683.
23. Kyle B. Brothers, Ingrid A. Holm Janet E. Childerhose, Armand H. Matheny Antommaria, Barbara A. Bernhardt, Ellen Wright Clayton, Bruce D. Gelb, Steven Joffe, John A. Lynch, Jennifer B. McCormick, Laurence B. McCullough, D. William Parsons, Agnes S. Sundaresan, Wendy A. Wolf, Joon-Ho Yu, and Benjamin S. Wilfond (2016) "When Genomic Research Participants Grow Up: Contact and Consent at the Age of Majority." *The Journal of Pediatrics* 168: 226-31. PMID: 26477867.
24. Erin E. Bennett, Jill Sweney, Cecile Aguayo, Criag Myrick, Armand H. Matheny Antommaria, and Susan L. Bratton (2015) "Pediatric Organ Donation Potential at a Children's Hospital." *Pediatric Critical Care Medicine.* 16: 814-820. PMID: 26237656.
25. Anita J. Tarzian, Lucia D. Wocial, and the ASBH Clinical Ethics Consultation Affairs Committee (2015) "A Code of Ethics for Health Care Ethics Consultants: Journey to the Present and Implications for the Field." *American Journal of Bioethics*. 15: 38-51. PMID: 25970392.
26. Armand H. Matheny Antommaria, Christopher A. Collura, Ryan M. Antiel, and John D. Lantos (2015) "Two Infants, Same Prognosis, Different Parental Preferences." *Pediatrics*, 135: 918-923. PMID: 25847802.
27. Stefanie Benoit, Armand H. Matheny Antommaria, Norbert Weidner, and Angela Lorts (2015) "Difficult Decision: What should we do when a VAD supported child experiences a severe stroke?" *Pediatric Transplantation* 19: 139-43. PMID: 25557132.

28. Kyle B. Brothers, John A. Lynch, Sharon A. Aufox, John J. Connolly, Bruce D. Gelb, Ingrid A. Holm, Saskia C. Sanderson, Jennifer B. McCormick, Janet L. Williams, Wendy A. Wolf, Armand H. Matheny Antommaria, and Ellen W. Clayton (2014) "Practical Guidance on Informed Consent for Pediatric Participants in a Biorepository." *Mayo Clinic Proceedings,* 89: 1471-80. PMID: 25264176.
29. Sophia M. Bous Hufnagel and Armand H. Matheny Antommaria (2014) "Laboratory Policies on Reporting Secondary Findings in Clinical Whole Exome Sequencing: Initial Uptake of the ACMG's Recommendations." *American Journal of Medical Genetics Part A*, 164: 1328-31. PMID: 24458369.
30. Wylie Burke, Armand H. Matheny Antommaria, Robin Bennett, Jeffrey Botkin, Ellen Wright Clayton, Gail E. Henderson, Ingrid A. Holm, Gail P. Jarvik, Muin J. Khoury, Bartha Maria Knoppers, Nancy A. Press, Lainie Friedman Ross, Mark A. Rothstein, Howard Saal, Wendy R. Uhlmann, Benjamin Wilfond, Susan M. Wold, and Ron Zimmern (2013) "Recommendations for Returning Genomic Incidental Findings? We Need to Talk!" *Genetics in Medicine*, 15: 854-859. PMID: 23907645.
31. Armand H. Matheny Antommaria (2013) "An Ethical Analysis of Mandatory Influenza Vaccination of Health Care Personnel: Implementing Fairly and Balancing Benefits and Burdens," *American Journal of Bioethics*, 13: 30-37. PMID: 23952830.
32. Joseph A. Carrese and the Members of the American Society for Bioethics and Humanities Clinical Ethics Consultation Affairs Standing Committee (2012) "HCEC Pearls and Pitfalls: Suggested Do's and Don't's for Healthcare Ethics Consultants," *Journal of Clinical Ethics*, 23: 234-240. PMID: 23256404.
33. Christopher G Maloney, Armand H Matheny Antommaria, James F Bale Jr., Jian Ying, Tom Greene and Rajendu Srivastiva (2012) "Factors Associated with Intern Noncompliance with the 2003 Accreditation Council for Graduate Medical Education's 30-hour Duty Period Requirement," *BMC Medical Education* 12: 33. PMID: 22621439.
34. Armand H. Matheny Antommaria, Jill Sweney, and W. Bradley Poss (2010) "Critical Appraisal of: Triaging Pediatric Critical Care Resources During a Pandemic: Ethical and Medical Considerations," *Pediatric Critical Care Medicine,* 11:396-400. PMID: 20453611.
35. Armand H. Matheny Antommaria, Karen Trotochaud, Kathy Kinlaw, Paul N. Hopkins, and Joel Frader (2009) "Policies on Donation After Cardiac Death at Children's Hospitals: A Mixed-Methods Analysis of Variation," *Journal of the American Medical Association,* 301: 1902-8. PMID: 19436017.
36. Kristine M. Pleacher, Elizabeth S. Roach, Willem Van der Werf, Armand H. Matheny Antommaria, and Susan L. Bratton (2009) "Impact of a Pediatric Donation after Cardiac Death Program," *Pediatric Critical Care Medicine,* 10: 166-70. PMID: 19188881.
37. Flory L. Nkoy, Sarah Petersen, Armand H Matheny Antommaria, and Christopher G. Maloney (2008) "Validation of an Electronic System for Recording Medical Student Patient Encounters," *AMIA [American Medical Informatics Association] Annual Symposium Proceedings*, 6: 510-14. PMID: 18999155. Nominated for the Distinguished Paper Award
38. Armand H. Matheny Antommaria, Sean D. Firth, and Christopher G. Maloney (2007) "The Evaluation of an Innovative Pediatric Clerkship Structure Using Multiple Outcome Variables including Career Choice" *Journal of Hospital Medicine*, 2: 401-408. PMID: 18081170.
39. Armand H. Matheny Antommaria (2006) "'Who Should Survive?: One of the Choices on Our Conscience:' Mental Retardation and the History of Contemporary Bioethics." *Kennedy Institute of Ethics Journal*, 16: 205-224. PMID: 17091558.
40. Armand H. Matheny Antommaria (2004) "Do as I Say Not as I Do: Why Bioethicists Should Seek Informed Consent for Some Case Studies." *Hastings Center Report,* 34 (3): 28-34. PMID: 15281724.
41. Armand H. Matheny Antommaria (2004) "A Gower Maneuver: The American Society for Bioethics and Humanities' Resolution of the 'Taking Stands' Debate." *American Journal of Bioethics,* 4 (Winter): W24-27. PMID: 15035934.

NON PEER-REVIEWED JOURNAL ARTICLES

1. Katherine Wade and Armand H. Matheny Antommaria (2016) "Inducing HIV Remission in Neonates: Children's Rights and Research Ethics." *Journal of Medicine and Biology*, 58(3): 348-54. PMID 27157354.
2. Armand H. Matheny Antommaria (2014) "Response to Open Peer Commentaries on 'An Ethical Analysis of Mandatory Influenza." *American Journal of Bioethics,* 14(7): W1-4. PMID: 24978422.
3. Armand H. Matheny Antommaria and Brent D. Kaziny (2012) "Ethical Issues in Pediatric Emergency Medicine's Preparation for and Response to Disasters." *Virtual* Mentor, 14: 801-4. PMID: 23351860.
4. Armand H. Matheny Antommaria, Tia Powell, Jennifer E. Miller, and Michael D. Christian (2011) "Ethical Issues in Pediatric Emergency Mass Critical Care," *Pediatric Critical Care Medicine*, 12(6 Suppl): S163-8. PMID: 22067926.
5. Armand H. Matheny Antommaria and Emily A. Thorell (2011) "Non-Pharmaceutical Interventions to Limit Transmission of a Pandemic Virus: The Need for Complementary Programs to Address Children's Diverse Needs." *Journal of Clinical Ethics,* 22: 25-32. PMID: 21595352.
6. Armand H. Matheny Antommaria (2010) "Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment." *Ave Maria Law Review*, 9: 81-99.
7. Armand H. Matheny Antommaria (2008) "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," *Theoretical Medicine and Bioethics,* 29: 201-12. PMID: 18821078.
8. Armand H. Matheny Antommaria (2008) "How can I give her IV antibiotics at home when I have three other children to care for?: Using Dispute System Design to Address Patient-Provider Conflicts in Health Care." *Hamline Journal of Public Law & Policy*, 29: 273-86.
9. Armand H. Matheny Antommaria (2007) "Alternative Dispute Resolution and Pediatric Clinical Ethics Consultation: Why the Limits of Ethical Expertise and the Indeterminacy of the Best Interests Standard Favor Mediation." *Ohio State Journal on Dispute Resolution,* 23: 17-59.
10. Armand H. Matheny Antommaria (2006) "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," *Journal of Law and Family Studies,* 8: 293-316.
11. Armand H. Matheny Antommaria and James F. Bale, Jr. (2002) "Ethical Issues in Clinical Practice: Cases and Analyses," *Seminars in Pediatric Neurology* 9: 67-76. PMID: 11931129.

REVIEW ARTICLES

Armand H. Matheny Antommaria (2010) "Conceptual and Ethical Issues in the Declaration of Death: Current Consensus and Controversies." *Pediatrics in Review* 31: 427-430. PMID: 20889737.

BOOKS

Armand H. Matheny Antommaria (1998) *A Retrospective, Political and Ethical Analysis of State Intervention into Parental Healthcare Decisions for Infants with Disabilities*. Wynnewood, Pennsylvania: Evangelicals for Social Action.

BOOK CHAPTERS

1. Armand H. Matheny Antommaria (2018) "Against Medical Advice Discharges: Pediatric Considerations." In *Against-Medical-Advice Discharges from the Hospital: Optimizing Prevention and Management to Promote High-Quality, Patient-Centered Care.* David Alfandre. New York, Springer: 143-157.
2. Armand H. Matheny Antommaria (2016) "Conscientious Objection in Reproductive Medicine." In *The Oxford Handbook of Reproductive Ethics.* Leslie Francis. Oxford, Oxford University Press: 209-225.
3. Armand H. Matheny Antommaria (2011) "Patient Participation in Medical Education." In *Clinical Ethics in Pediatrics: A Case-based Approach.* Douglas Diekema, Mark Mercurio, and Mary Beth Adam. Cambridge, Cambridge University Press: 221-225.

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OTHER

Policy Statements and Technical Reports

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2. American Academy of Pediatrics Committee on Bioethics. Armand H. Matheny Antommaria Lead Author. (2013) "Ethical Controversies in Organ Donation After Circulatory Death." *Pediatrics.* 131: 1021-1026. PMID: 23629612.
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4. Lainie Friedman Ross, Howard M. Saal, Karen L. David, Rebecca R. Anderson and the American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Technical Report: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Genetics in Medicine.* 15: 234-245. PMID: 23429433.
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7. American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Committee on Bioethics (2011) "Consent for Emergency Medical Services for Children and Adolescents." *Pediatrics* 128: 427-433. PMID: 21788221.
8. Council on School Health and Committee on Bioethics. Robert Murray and Armand H. Matheny Antommaria Lead Authors. (2010) "Honoring –Do-Not-Attempt Resuscitation Requests in Schools." *Pediatrics* 125; 1073-1077. PMID: 20421255.
9. Committee on Bioethics (2010) "Ritual Genital Cutting of Female Minors." *Pediatrics* 125; 1088-1093. PMID: 20421257.
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12. Committee on Bioethics (2009) "Pediatrician-Family-Patient Relationships: Managing the Boundaries." *Pediatrics* 124; 1685-8. PMID: 19948635.
13. Douglas S. Diekema, Jeffrey R. Botkin, and Committee on Bioethics (2009) "Forgoing Medically Provided Nutrition and Hydration in Children." *Pediatrics* 124; 813-22. PMID: 19651596.

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16. Marcia Levetown and Bioethics and the Committee on Bioethics (2008) "Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information." *Pediatrics* 121: 1441-60. PMID: 18450887.
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Ethics Rounds

1. Erwin Jiayuan Khoo, Devan M. Duenas, Benjamin S. Wilfond, Luke Gelinas, Armand H. Matheny Antommaria. (Online ahead of print) "Incentives in Pediatric Research in Developing Countries: When Are They Too Much?" *Pediatrics*. 2023 Jan 20: e2021055702. PMID: 36660851.
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10. Liza-Marie Johnson, Erica C. Kaye, Kimberly Sawyer, Alex M. Brenner, Stefan J. Friedrichsdorf, Abby R. Rosenberg, Armand H. Mathey Antommaria. (2021) "Opioid Management in the Dying Child With Addiction." *Pediatrics* 147: e2020046219. PMID 33446508.

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1. Armand H. Matheny Antommaria, Chris Feudtner, Mary Beth Benner, and Felicia Cohn on Behalf of the Healthcare Ethics Consultant-Certified Certification Commission (2020) "The Healthcare Ethics Consultant-Certified Program: Fair, Feasible, and Defensible, But Neither Definite Nor Finished," *American Journal of Bioethics* 20:1-5. PMID: 32105202.
2. Armand H. Matheny Antommaria and Pamela W. Popp (2020) "The Potential Roles of Surrogacy Ladders, Standby Guardians, and Medicolegal Partnerships, in Surrogate Decision Making for Parents of Minor Children," *Journal of Pediatrics* 220:11-13. PMID 31952849.

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1. Jerry Schwartz, Dawn Nebrig, Laura Monhollen, and Armand H. Matheny Antommaria. (2023) "Transforming Behavior Contracts into Collaborative Commitments with Families." *American Journal of Bioethics.* 23(1): 73-75. PMID: 36594997.
2. Armand H. Matheny Antommaria and Elizabeth Lanphier. (2022) "Supporting Marginalized Decision-Marker's Autonom(ies)." *American Journal of Bioethics*. 22(6):22-24. PMID: 35616965.
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8. Armand H. Matheny Antommaria (2018) "Accepting Things at Face Value: Insurance Coverage for Transgender Healthcare." *American Journal of Bioethics.* 18: 21-23. PMID: 31159689.
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12. Armand H. Matheny Antommaria and Ron King. (2016) "Moral Hazard and Transparency in Pediatrics: A Different Problem Requiring a Different Solution." *American Journal of Bioethics* 16: 39-40. PMID: 27292846.
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15. Armand H. Matheny Antommaria (2015) "Characterizing Clinical Ethics Consultations: The Need for a Standardized Typology of Cases." *American Journal of Bioethics* 15: 18-20. PMID: 25970383.

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17. Lainie Friedman Ross and Armand H. Matheny Antommaria (2014) "The need to promote all pediatric stem cell donors' understanding and interests." *Pediatrics* 133: e1356-e1357. PMID: 24777208.
18. Armand H. Matheny Antommaria (2014) "Pubertal Suppression and Professional Obligations: May a Pediatric Endocrinologist Refuse to Treat an Adolescent with Gender Dysphoria." *American Journal of Bioethics* 13: 43-46. PMID: 24422933.
19. Armand H. Matheny Antommaria (2012) "Empowering, Teaching, and Occasionally Advocating: Clinical Ethics Consultants' Duties to All of the Participants in the Process." *American Journal of Bioethics* 12 11-3. PMID: 22852533.
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22. William Meadow, Chris Feudtner, Armand H. Matheny Antommaria, Dane Sommer, John Lantos (2010) "A Premature Baby with Necrotizing Enterocolitis Whose Parents Are Jehovah's Witnesses." *Pediatrics.* 216: 151-155. PMID: 20566607.
23. C. C. Weitzman, S. Schlegel, Nancy Murphy, Armand H. Matheny Antommaria, J. P. Brosco, Martin T. Stein (2009) "When Clinicians and a Parent Disagree on the Extent of Medical Care." *Journal of Developmental and Behavioral Pediatrics.* 30: 242-3. PMID: 19525718. Reprinted as (2010) *Journal of Developmental and Behavioral Pediatrics.* 31: S92-5. PMID: 20414087
24. Armand H. Matheny Antommaria and Susan Bratton (2008) "Nurses' Attitudes toward Donation after Cardiac Death: Implications for Nurses' Roles and Moral Distress." *Pediatric Critical Care Medicine,* 9: 339-40. PMID: 18446100.
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26. Armand H. Matheny Antommaria (2006) "The Proper Scope of Analysis of Conscientious Objection in Healthcare: Individual Rights or Professional Obligations" *Teaching Ethics*, 7: 127-31.
27. Armand H. Matheny Antommaria and Rajendu Srivastava (2006) "If Cardiologists Take Care of Patients with Heart Disease, What do Hospitalists Treat?: Hospitalists and the Doctor-Patient Relationship." *American Journal of Bioethics*, 6: 47-9. PMID: 16423793.
28. Armand H. Matheny Antommaria (2003) "I Paid Out-of-Pocket for My Son's Circumcision at Happy Valley Tattoo and Piercing: Alternative Framings of the Debate over Routine Neonatal Male Circumcision," *American Journal of Bioethics* 3: 51-3. PMID: 12859817.

Letters

1. Benjamin S. Wilfond, David Magnus, Armand H Matheny Antommaria, Paul Appelbaum, Judy Aschner, Keith J. Barrington, Tom Beauchamp, Renee D. Boss, Wylie Burke, Arthur L. Caplan, Alexander M. Capron, Mildred Cho, Ellen Wright Clayton, F. Sessions Cole, Brian A. Darlow, Douglas Diekema, Ruth R. Faden, Chris Feudtner, Joseph J. Fins, Norman C. Fost, Joel Frader, D. Micah Hester, Annie Janvier, Steven Joffe, Jeffrey Kahn, Nancy E. Kass, Eric Kodish, John D. Lantos, Laurence McCullough, Ross McKinney, Jr., William Deadow, P. Pearl O'Rourke, Kathleen E. Powderly, DeWayne M. Pursley, Lainie Friedman Ross, Sadath Sayeed, Richard R. Sharp, Jeremy Sugarman, William O. Tarnow-Mordi, Holly Taylor, Tom Tomlison, Robert D. Truog, Yoram T. Unguru, Kathryn L. Weise, David Woodrum, Stuart Youngner (2013) "The OHRP and SUPPORT," *New England Journal of Medicine,* 368: e36. PMID: 23738513.

2. Lainie Friedman Ross and Armand H. Matheny Antommaria (2011) "In Further Defense of the American Academy of Pediatrics Committee on Bioethics 'Children as Hematopoietic Stem Cell Donors' Statement." *Pediatric Blood & Cancer*. 57: 1088-9.
3. Armand H. Matheny Antommaria (2011) "Growth Attenuation: Health Outcomes and Social Services." *Hastings Center Report*, 41(5): 4. PMID: 21980886.
4. Susan Bratton and Armand H. Matheny Antommaria (2010) "Dead Donor Rule and Organ Procurement: The Authors Reply." *Pediatric Critical Care Medicine*, 11: 314-5.
5. Armand H. Matheny Antommaria and Joel Frader (2009) "Policies of Children's Hospitals on Donation After Cardiac Death—Reply." *Journal of the American Medical Association*, 302: 845.

Case Reports

Armand H. Matheny Antommaria (2002) "Case 4.9: Inappropriate Access to a Celebrity's Medical Records." In *Ethics and Information Technology: A Case-Based Approach to a Health Care System in Transition*, James G. Anderson and Kenneth W. Goodman, 79-80. New York: Springer-Verlag.

Book Reviews

1. Armand H. Matheny Antommaria (Forthcoming) Review of *Disability's Challenge to Theology: Genes, Eugenics, and the Metaphysics of Modern Medicine* by Devan Stahl. *Hastings Center Report.*
2. Armand H. Matheny Antommaria (2021) Review of *When Harry Became Sally: Responding to the Transgender Moment,* by Ryan T. Anderson. *Journal of Medical Humanities* 42: 195-9. PMID 31808021.
3. Armand H. Matheny Antommaria (2012) Review of *The Ethics of Organ Transplantation*, by Steven J. Jensen, ed., *Journal of the American Medical Association* 308: 1482-3.
4. Armand H Matheny Antommaria (2012) Review of *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*, by John R. Peteet and Michael N. D'Ambra, ed., *Journal of the American Medical Association* 308: 87.
5. Armand H. Matheny Antommaria (2009) Review of *Conflicts of Conscience in Health Care: An Institutional Compromise,* by Holly Fernandez Lynch. *American Journal of Bioethics* 9: 63-4.
6. Armand H. Matheny Antommaria (2008) Review of *A Practical Guide to Clinical Ethics Consulting: Expertise, Ethos, and Power*, by Christopher Meyers. *American Journal of Bioethics* 8: 72-3.
7. Armand H. Matheny Antommaria (2004) Review of *Children, Ethics, and Modern Medicine*, by Richard B. Miller. *American Journal of Bioethics* 4: 127-8.
8. Armand H. Matheny Antommaria (2002) Review of *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, by Thomasine Kushner and David Thomasma, ed. *American Journal of Bioethics* 2: 70-1. PMID: 22494193.
9. Armand H. Matheny Antommaria (1999) Review of *Human Cloning: Religious Responses*, by Ronald Cole-Turner, ed. *Prism* 6 (March/April): 21.
10. Armand H. Matheny Antommaria (1999) Review of *Christian Theology and Medical Ethics: Four Contemporary Approaches*, by James B. Tubbs, Jr. *Journal of Religion* 79 (April): 333-5.
11. Armand H. Matheny Antommaria (1997) Review of *Body, Soul, and Bioethics*, by Gilbert C. Meilaender. *Prism* 4 (May/June): 28.

Newspaper Articles

1. W. Bradley Poss and Armand H. Matheny Antommaria (2010) "Mass casualty planning must incorporate needs of children." *AAP News* 31 (July): 38.
2. Robert Murray and Armand H. Matheny Antommaria (2010) "Pediatricians should work with school nurses to develop action plans for children with DNAR orders." *AAP News* 31 (May): 30..
3. Armand H. Matheny Antommaria (2009) "Addressing physicians' conscientious objections in health care." *AAP News* 30 (December): 32.

UNPUBLISHED POSTER PRESENTATIONS

1. Armand H. Matheny Antommaria. (2018) "Ethical Issues in the Care of International Patients: A Case Study." International Conference on Clinical Ethics and Consultation, Oxford, United Kingdom.
1. Jill S Sweney, Brad Poss, Colin Grissom, Brent Wallace, and Armand H Matheny Antommaria, (2010) "Development of a Statewide Pediatric Pandemic Triage Plan in Utah." Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20103713.147.
2. Christopher G. Maloney, Armand H. Matheny Antommaria, James F. Bale, Thomas Greene, Jian Ying, Gena Fletcher, and Rajendu Srivastava (2010) "Why Do Pediatric Interns Violate the 30 Hour Work Rule?" Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20101500.596
3. Armand H. Matheny Antommaria and Edward B. Clark (2007) "Resolving Conflict through Bioethics Mediation." 3rd International Conference on Ethics Consultation and Clinical Ethics, Toronto, Canada.
4. Elizabeth Tyson, Tracy Hill, Armand Antommaria, Gena Fletcher, and Flory Nkoy (2007) "Physician Practice Patterns Regarding Nasogastric Feeding Supplementation and Intravenous Fluids in Bronchiolitis Patients." Pediatrics Academic Societies Annual Meeting, Toronto, Canada. E-PAS2007:61300.

ORAL PRESENTATIONS

Keynote/Plenary Lectures

International

1. 2021, *Panelist*, Partnership for Quality Medical Donations, Charitable Access Programming for Rare Diseases, "Ethical Issues," Webinar, April 6.
2. 2017, *Invited Speaker*, Spina Bifida Fetoscopic Repair Study Group and Consortium, "Ethics of Innovation and Research in Fetal Surgery," Cincinnati, Ohio, October 26.
3. 2014, *Invited Speaker,* CIC 2013 CCI: Canadian Immunization Conference, "Condition-of-Service Influenza Prevention in Health Care Settings," Ottawa, Canada, December 2.
4. 2014, *Invited Speaker*, National Conference of the Chinese Pediatric Society, "A Brief Introduction to Pediatric Research and Clinical Ethics," Chongqing, China, September 12.

National

1. 2020, *Panelist*, Children's Mercy Bioethics Center, "Ethical Issues in the COVID Pandemic at Children's Hospitals," Webinar, March 2.
2. 2019, *Invited Speaker*, North American Fetal Therapy Network (NAFTnet), "Ethics of Innovation," Chicago, Illinois, October 12.
3. 2019, *Panelist,* National Society of Genetic Counselors Prenatal Special Interest Group, "Fetal Intervention Ethics," Webinar, September 12.
4. 2017, *Invited Participant,* American College of Epidemiology Annual Meeting, Preconference Workshop, "Extreme Personal Exposure Biomarker Levels: Guidance for Study Investigators," New Orleans, Louisiana, September 24.
5. 2016, *Invited Speaker,* American Academy of Pediatrics National Conference & Exhibition, Joint Program: Section on Hospital Medicine and Section on Bioethics, "Resource Allocation: Do We Spend Money to Save One Patient with Ebola or Over a 1,000?" San Francisco, California, October 23.
6. 2016, *Invited Speaker*, 26th Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECHMO) Conference, "Ethical Issues in ECMO: The Bridge to Nowhere," Cincinnati, Ohio, June 5.
7. 2015, *Invited Speaker,* Extracorporeal Life Support Organization (ELSO) 26th Annual Conference, "ECMO-Supported Donation after Circulatory Death: An Ethical Analysis," Atlanta, Georgia, September 20.

8. 2014, *Invited Speaker*, Pediatric Evidence-Based Practice 2014 Conference: Evidence Implementation for Changing Models of Pediatric Health Care, "Ethical Issues in Evidence-Based Practice," Cincinnati, Ohio, September 19.
9. 2014, *Invited Speaker,* 6th Annual David Kline Symposium on Public Philosophy: Exploring the Synergy Between Pediatric Bioethics and Child Rights, "Does Predictive Genetic Testing for Adult Onset Conditions that Are Not Medically Actionable in Childhood Violate Children's Rights?" Jacksonville, Florida, March 6.
10. 2010, *Invited Speaker,* Quest for Research Excellence: The Intersection of Standards, Culture and Ethics in Childhood Obesity, "Research Integrity and Religious Issues in Childhood Obesity Research," Denver, Colorado, April 21.
11. 2010, *Invited Speaker*, Symposium on the Future of Rights of Conscience in Health Care: Legal and Ethical Perspectives, J. Reuben Clark Law School at Brigham Young University and the Ave Maria School of Law, "Conscientious Objection in Clinical Practice: Disclosure, Consent, Referral, and Emergency Treatment," Provo, Utah, February 26.
12. 2009, *Invited Speaker*, Pediatric Organ Donation Summit, "Research Findings Regarding Variations in Pediatric Hospital Donation after Cardiac Death Policies," Chicago, Illinois, August 18.
13. 2008, *Meet-the-Experts*, American Academy of Pediatrics National Conference & Exhibition, "Physician Refusal to Provide Treatment: What are the ethical issues?" Boston, Massachusetts, October 11.
14. 2008, *Invited Conference Faulty*, Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy, The MacLean Center for Clinical Medical Ethics at the University of Chicago, "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," Chicago, IL, March 18.
15. 2007, *Symposium Speaker*, Alternative Dispute Resolution Strategies in End-of-Life Decisions, The Ohio State University Mortiz College of Law, "The Representation of Children in Disputes at the End-of-Life," Columbus, Ohio, January 18.
16. 2005, *Keynote Speaker*, Decisions and Families, *Journal of Law and Family Studies* and The University of Utah S.J. Quinney College of Law, "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," Salt Lake City, Utah, September 23.

Regional/Local

1. 2021, *Panelist*, Pediatric Residency Noon Conference, University of Tennessee Health Science Center, "Bioethics Rounds—Ethical Issues in the Care of Transgender Adolescents," Memphis, Tennessee, September 21.
2. 2020, *Keynote Speaker*, 53rd Annual Clinical Advances in Pediatrics, "Referral to a Fetal Care Center: How You Can Help Patients' Mothers Address the Ethical Issues," Kansas City, Kansas, September 16.
3. 2019, *Speaker,* Patient and Family Support Services, Primary Children's Hospital, "Ethical Issues in the Care of Trans Adolescents," Salt Lake City, Utah, December 5.
4. 2019, *Speaker,* Evening Ethics, Program in Medical Ethics and Humanities, University of Utah School of Medicine, "Patients, Parents, and Professionals: Ethical Issues in the Treatment of Trans Adolescents," Salt Lake City, Utah, December 4.
5. 2019, *Speaker,* Pediatric Hospital Medicine Board Review Course, "Ethics, Legal Issues, and Human Rights including Ethics in Research," Cincinnati, Ohio, September 8.
6. 2019, *Speaker,* Advances in Fetology, "Evolving Attitudes Toward the Treatment of Children with Trisomies," Cincinnati, Ohio, September 6.
7. 2019, *Speaker,* Half-Day Ethics Training: Ethics Consultation & Ethics Committees, "Navigating the Rapids of Clinical Ethics Consultation: Intake, Recommendations, and Documentation," Salt Lake City, Utah, June 1.

8. 2019, *Speaker*, Scientific and Ethical Underpinnings of Gene Transfer/Therapy in Vulnerable Populations: Considerations Supporting Novel Treatments, BioNJ, "What Next? An Ethical analysis of Prioritizing Conditions and Populations for Developing Novel Therapies," Cranbury, New Jersey, March 7.
9. 2018, *Panelist*, Periviability, 17th Annual Regional Perinatal Summit, Cincinnati, Ohio, October 12.
10. 2018, *Speaker,* Regional Advance Practice Registered Nurse (APRN) Conference, "Adults are Not Large Children: Ethical Issues in Caring for Adults in Children's Hospitals," Cincinnati, Ohio, April 26.
11. 2018, *Speaker*, Southern Ohio/Northern Kentucky Sigma Theta Tau International Annual Conference, "Between Hope and Hype: Ethical Issues in Precision Medicine," Sharonville, Ohio, March 2.
12. 2017, *Speaker*, Advances in Fetology 2017, "Ethics of Innovation and Research: Special Considerations in Fetal Therapy Centers," Cincinnati, Ohio, October 27.
13. 2016, *Speaker*, End-of-Life Pediatric Palliative Care Regional Conference, "Ethical/Legal Issues in Pediatric Palliative Care," Cincinnati, Ohio, September 15.
14. 2016, *Speaker*, 26th Annual Bioethics Network of Ohio (BENO) Conference, "When Does Parental Refusal of Medical Treatment for Religious Reasons Constitute Neglect?" Dublin, Ohio, May 29.
15. 2014, *Speaker,* Cincinnati Comprehensive Sickle Cell Center Symposium: Research Ethics of Hydroxyurea Therapy for Sickle Cell Disease During Pregnancy and Lactation, "Ethical Issues in Research with Pregnant and Lactating Women," Cincinnati, Ohio, October 30.
16. 2014, *Speaker,* Advances in Fetology 2014, "The 'Miracle Baby' and Other Cases for Discussion," Cincinnati, Ohio, September 26.
17. 2014, *Speaker,* Advances in Fetology 2014, "'Can you tell me …?': Achieving Informed Consent Given the Prevalence of Low Health Literacy," Cincinnati, Ohio, September 26.
18. 2014, *Panelist*, Center for Clinical & Translational Science & Training, Secrets of the Dead: The Ethics of Sharing their Data, Cincinnati, Ohio, August 28.
19. 2014, *Speaker,* Office for Human Research Protections Research Community Forum: Clinical Research … and All That Regulatory Jazz, "Research Results and Incidental Findings: Do Investigators Have a Duty to Return Results to Participants," Cincinnati, Ohio, May 21.
20. 2013, *Opening Presentation*, Empirical Bioethics: Emerging Trends for the 21st Century, University of Cincinnati Center for Clinical & Translational Science & Training, "Empirical vs. Normative Ethics: A Comparison of Methods," Cincinnati, Ohio, February 21.
21. 2012, *Videoconference,* New York State Task Force on Life and the Law, "Pediatric Critical Care Triage," New York, New York, March 1.
22. 2011, *Presenter,* Fall Faculty Development Workshop, College of Social Work, University of Utah, "Teaching Ethics to Students in the Professions, " Salt Lake City, Utah, November 14.
23. 2011, *Speaker,* 15th Annual Conference, Utah Chapter of the National Association of Pediatric Nurse Practitioners, "Ethical Issues in Pediatric Practice," Salt Lake City, Utah, September 22.
24. 2011, *Speaker*, Code Silver! Active Shooter in the Hospital, Utah Hospitals & Health Systems Association, Salt Lake City, Utah, March 21.
25. 2009, *Speaker,* Medical Staff Leadership Conference, Intermountain Healthcare, "The Ethics of Leadership," Park City, Utah, October 30.
26. 2008, *Speaker*, The Art and Medicine of Caring: Supporting Hope for Children and Families, Primary Children's Medical Center, "Medically Provided Hydration and Nutrition: Ethical Considerations," Salt Lake City, Utah, February 25.
27. 2005, *Speaker*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners) Chapter Pharmacology and Pediatric Conference, "Immunization Update," Salt Lake City, Utah, August 18.
28. 2005, *Keynote Speaker,* 17th Annual Conference, Utah Society for Social Work Leadership in Health Care, "Brain Death: Accommodation and Consultation," Salt Lake City, March 18.
29. 2004, *Continuing Education Presentation*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners), "Febrile Seizures," Salt Lake City, Utah, April 22.

30. 2004, *Speaker,* Advocacy Workshop for Primary Care Providers, "Ethics of Advocacy," Park City, Utah, April 3.
31. 2002, *Speaker,* 16th Annual Biologic Basis of Pediatric Practice Symposium, "Stem Cells: Religious Perspectives," Deer Valley, Utah, September 14.

Meeting Presentations

International

1. 2018, *Speaker*, International Conference on Clinical Ethics and Consultation, "A Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations," Oxford, United Kingdom, June 21.

National

1. 2022, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "A Mixed Methods Analysis of Requests for Religious Exemptions to a COVID-19 Vaccine Requirement." Portland, Oregon, October 27.
2. 2022, *Panelist,* American Society for Bioethics and Humanities Annual Meeting, Pediatric Ethics Affinity Group, "When Ethical Healthcare Is Prohibited By Law, How Do We Respond?" Portland, Oregon, October 27.
3. 2022, *Speaker,* APPD/PAS Fellow Core Curriculum Workshop, Pediatric Academic Societies Annual Meeting, "From Idea to Implementation: Navigating the Ethical Landscape of Pediatric Clinical Research," Denver, Colorado, April 22.
4. 2021, *Panelist,* Pediatric Endocrine Society Annual Meeting, Difference of Sex Development Special Interest Group, Virtual Conference, April 29.
5. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Is This Child Dead? Controversies Regarding the Neurological Criteria for Death," Virtual Conference, October 17.
6. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Contemporary Ethical Controversy in Fetal Therapy: Innovation, Research, Access, and Justice," Virtual Conference, October 15.
7. 2020, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "K-12 Schools and Mandatory Public Health Programs During the COVID-19 Pandemic," Virtual Conference, October 15.
8. 2019, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Ethical Issues in Translating Gene Transfer Studies Involving Children with Neurodegenerative Disorders," Pittsburgh, Pennsylvania, October 26.
9. 2019, *Moderator,* Pediatric Academic Societies Annual Meeting, Clinical Bioethics, Baltimore, Maryland, April 28.
10. 2018, *Presenter,* American Society for Bioethics and Humanities Annual Meeting, "Looking to the Past, Understanding the Present, and Imaging the Future of Bioethics and Medical Humanities' Engagement with Transgender Health," Anaheim, California, October 19.
11. 2018, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Should Vaccination Be a Prerequisite for Sold Organ Transplantation?" Anaheim, California, October 18.
12. 2018, Lindsey Douglas, Armand H. Matheny Antommaria, Derek Williams. *Workshop Presenter*, Pediatric Hospital Medicine Annual Meeting, "IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB)." Atlanta, Georgia, July 20.
13. 2018, Alan Schroeder, Armand H. Matheny Antommaria, Hannah Bassett, Kevin Chi, Shawn Ralston, Rebecca Blankenburg. *Workshop Speaker,* Pediatric Hospital Medicine Annual Meeting, "When You Don't Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress," Atlanta, Georgia, July 20.

14. 2018, Alan Schroeder, Hannah Bassett, Rebecca Blankenburg, Kevin Chi, Shawn Ralston, Armand H. Matheny Antommaria. *Workshop Speaker,* Pediatric Academic Societies Annual Meeting, "When You Don't Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress," Toronto, Ontario, Canada, May 7.
15. 2017, *Speaker,* American Society for Bioethics and Humanities Annual Meeting, "Tensions in Informed Consent for Gender Affirming Hormone Therapy and Fertility Preservation in Transgender Adolescents," Kansas City, Missouri, October 19.
16. Lindsey Douglas, Armand H. Matheny Antommaria, and Derek Williams. 2017, *Workshop Leader,* PHM[Pediatric Hospital Medicine]2017, "IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB) Process," Nashville, Tennessee, July 21.
17. 2016, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Ethical Challenges in the Care of International Patients: Organization, Justice, and Cultural Considerations," Washington, DC, October 9.
18. 2015, *Coauthor,* The American Society of Human Genetics Annual Meeting, "Adolescents' Opinions on Disclosure of Non-Actionable Secondary Findings in Whole Exome Sequencing," Baltimore, Maryland, October 9.
19. 2012, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "A Public Health Ethics Analysis of the Mandatory Immunization of Healthcare Personnel: Minimizing Burdens and Increasing Fairness," Washington, DC, October 21.
20. Armand H. Matheny Antommaria, Valerie Gutmann Koch, Susie A. Han, Carrie S. Zoubul. 2012, *Moderator*, American Society for Bioethics and Humanities Annual Meeting, "Representing the Underrepresented in Allocating Scarce Resources in a Public Health Emergency: Ethical and Legal Considerations," Washington, DC, October 21.
21. 2012, *Platform Presentation,* Pediatric Academic Societies Annual Meeting, "Qualitative Analysis of International Variation in Donation after Circulatory Death Policies and Rates," Boston, Massachusetts, April 30. Publication 3150.4.
22. 2011, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "The Intersection of Policy, Medicine, and Ethics during a Public Health Disaster: Special Considerations for Children and Families," Minneapolis, Minnesota, October 13.
23. Armand H. Matheny Antommaria and Joel Frader. 2010, *Workshop Leader,* Pediatric Academic Societies Annual Meeting, "Conscientious Objection in Health Care: Respecting Conscience and Providing Access," Vancouver, British Columbia, Canada. May 1. Session 1710.
24. 2009, *Workshop Leader,* American Society for Bioethics and Humanities Annual Meeting, "Advanced Clinical Ethics Consultation Skills Workshop: Process and Interpersonal Skills," Washington, DC, October 15.
25. 2009, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, "Qualitative Analysis of Donation after Cardiac Death Policies at Children's Hospitals," Baltimore, Maryland, May 2. Publication 2120.6.
26. 2008, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, "Qualitative Analysis of Donation After Cardiac Death (DCD) Policies at Children's Hospitals," Cleveland, Ohio, October 26.
27. 2007, *Participant,* Hamline University School of Law Biennial Symposium on Advanced Issues in Dispute Resolution, "An Intentional Conversation About Conflict Resolution in Health Care," Saint Paul, Minnesota, November 8-10.
28. *2007*, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "Bioethics Consultation and Alternative Dispute Resolution: Opportunities for Collaboration," Washington, DC, October 21.
29. 2007, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "DNAR Orders in Schools: Collaborations Beyond the Hospital," Washington, DC, October 18.

30. Armand H. Matheny Antommaria and Jeannie DePaulis. 2007, *Speaker,* National Association of Children's Hospitals and Related Institutions Annual Meeting, "Using Mediation to Address Conflict and Form Stronger Therapeutic Alliances," San Antonio, Texas, October 9.
31. 2006, *Speaker,* American Society of Bioethics and Humanities Annual Meeting, "Bioethics Mediation: A Critique," Denver, Colorado, October 28.
32. 2005, *Panelist,* American Society of Bioethics and Humanities Annual Meeting, "How I See This Case: 'He Is Not His Brain,'" Washington, DC, October 20.
33. 2005, *Paper Presentation,* Pediatric Ethics: Setting an Agenda for the Future, The Cleveland Clinic, "'He Is Not His Brain:' Accommodating Objections to 'Brain Death,'" Cleveland, Ohio, September 9.
34. 2004, *Speaker,* American Society for Bioethics and Humanities Spring Meeting, "Verification and Balance: Reporting Within the Constraints of Patient Confidentiality," San Antonio, Texas, March 13.
35. 2002, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, "'Who Should Survive?:' Mental Retardation and the History of Bioethics," Baltimore, Maryland, October 24.

Invited/Visiting Professor Presentations

1. 2013, Visiting Professor, "How to Listen, Speak and Think Ethically: A Multidisciplinary Approach," Norton Suburban Hospital and Kosair Children's Hospital, Louisville, Kentucky, May 22.
2. 2010, Visiting Professor, Program in Bioethics and Humanities and Department of Pediatrics, "What to Do When Parents Want Everything Done: 'Futility' and Ethics Facilitation," University of Iowa Carver College of Medicine, Iowa City, Iowa, September 10.

Grand Round Presentations

1. 2019, David Green Lectureship, "Establishing Goals of Care and Ethically Limiting Treatment," Primary Children's Hospital, Salt Lake City, Utah, December 5.
2. 2018, "The Ethics of Medical Intervention for Transgender Youth," El Rio Health, Tucson, Arizona, September 29.
3. 2018, Pediatrics, "Patient Selection, Justice, and Cultural Difference: Ethical Issues in the Care of International Patients," Cleveland Clinic, Cleveland, Ohio, April 10.
4. 2018, Bioethics, "Reversibility, Fertility, and Conflict: Ethical Issues in the Care of Transgender and Gender Nonconforming Children and Adolescents," Cleveland Clinic, Cleveland, Ohio, April 9.
5. 2017, Heart Institute, "'Have you ever thought about what you would want—if god forbid—you became sicker?': Talking with adult patients about advance directives," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 16.
6. 2017, Pediatrics, "Respectful, Effective Treatment of Jehovah's Witnesses," with Judith R. Ragsdale, PhD, MDiv and David Morales, MD, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, March 14.
7. 2017, Pediatrics, "Ethical Dilemmas about Discharging Patients When There Are Disagreements Concerning Safety," Seattle Children's Hospital, Seattle, Washington, January 19.
8. 2015, Pediatrics, "'Nonbeneficial' Treatment: What must providers offer and what can they withhold?," Greenville Health System, Greenville, South Carolina, May 10.
9. 2014, Advance Practice Providers, "Common Ethical Issues," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, August 13.
10. 2014, Respiratory Therapy, "Do-Not-Resuscitate (DNR) Orders," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, July 15.
11. 2013, Heart Institute, "No Not Months. Twenty-Two *Years*-Old: Transiting Patients to an Adult Model of Care." Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 21.
12. 2013, Division of Neonatology, "This Premature Infant Has a *BRCA1* Mutation!?: Ethical Issues in Clinical Whole Exome Sequencing for Neonatologists." Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, October 11.

13. 2013, Department of Pediatrics, "Adults are Not Large Children: Ethical Issues in Caring for Adults in Children's Hospitals," Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, February 26.
14. 2012, "Mandate or Moratorium?: Persisting Ethical Controversies in Donation after Circulatory Death," Cedars-Sinai Medical Center, Los Angeles, California, May 16.
15. 2011, Division of Pediatric Neurology Friday Lecture Series, "Inducing or Treating 'Seizures' with Placebos: Is It Ever Ethical?," University of Utah, Salt Lake City, Utah, October 7.
16. 2011, Department of Surgery, "DNR Orders in the OR and other Ethical Issues in Pediatric Surgery: Case Discussions," Primary Children's Medical Center, Salt Lake City, Utah, October 3.
17. 2009, Department of Pediatrics, "What to Do When Parents Want Everything Done: 'Futility' and Bioethical Mediation," Primary Children's Medical Center, Salt Lake City, Utah, September 17.
18. 2008, Division of Pulmonology and Critical Care, "Futility: May Clinicians Ever Unilaterally Withhold or Withdraw Medical Treatment?" Utah Valley Regional Medical Center, Provo, Utah, April 17.
19. 2007, Division of Otolaryngology-Head and Neck Surgery, "Advance Directives, Durable Powers of Attorney for Healthcare, and Do Not Attempt Resuscitation Orders: Oh My!," University of Utah School of Medicine, Salt Lake City, Utah, June 20.

Outreach Presentations

1. 2019, *Panelist*, Cincinnati Edition, WVXU, "The Ethics of Human Gene Editing," Cincinnati, Ohio, June 13.
2. 2019, *Speaker,* Adult Forum, Indian Hill Church, "Medical Ethics," Indian Hill, Ohio, March 24.
3. 2016, *Speaker,* Conversations in Bioethics: The Intersection of Biology, Technology, and Faith, Mt. Washington Presbyterian Church, "Genetic Testing," Cincinnati, Ohio, October 12.
4. 2008, *Speaker,* Science in Society, Co-sponsored by KCPW and the City Library, "Death—Choices," Salt Lake City, Utah, November 20.
5. 2003, *Panelist,* Utah Symposium in Science and Literature, "The Goodness Switch: What Happens to Ethics if Behavior is All in Our Brains?" Salt Lake City, Utah, October 10.
6. 2002, *Respondent*, H. Tristram Englehardt, Jr. "The Culture Wars in Bioethics," Salt Lake Community College, Salt Lake City, Utah, March 29.

Podcasts

1. 2021, "Ethics of COVID Vaccines in Kids," PHM from Pittsburgh, August 12.
2. 2020, COVID Quandaries: Episode 1, "Is Getting Sick Just Part of the Job?" Hard Call, October 6.

EXHIBIT C

TABLE 1: Strength of Recommendation and Quality of Evidence in Recommendations Made by the Endocrine Society

Strength of the Recommendation/ Quality of the Evidence[1]	Endocrine Treatment of Gender-Dysphoric/Gender-	Pediatric Obesity-Assessment, Treatment, and Prevention	Congenital Adrenal Hyperplasia Due to Steroid 21-Hydroxylase Deficiency
Strong|High	0 (0)[2]	0 (0)	0 (0)
Strong|Moderate	3 (11)	4 (13)	18 (33)
Strong|Low	5 (18)	6 (20)	13 (25)
Strong|Very Low	2 (7)	1 (3)	1 (2)
Weak|High	0 (0)	0 (0)	0 (0)
Weak|Moderate	0 (0)	0 (0)	2 (4)
Weak|Low	9 (32)	5 (17)	4 (7)
Weak|Very Low	3 (11)	12 (40)	7 (13)
Ungraded Good Practice Statement[3]	6 (21)	2 (7)	9 (17)
Weak	12 (43)	17 (57)	13 (24)
Either Low or Very Low	19 (68)	24 (80)	25 (46)
Total	28	30	54

[1] Quality of the Evidence
High: "Consistent evidence from well-performed RCTs [Randomized Controlled Trials] or exceptionally strong evidence from unbiased observational studies"
Moderate: "Evidence from RCTs with important limitations (inconsistent results, methodological flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies"
Low: "Evidence for at least one critical outcomes from observational studies, from RCTs with serious flaws, or indirect evidence"
Very Low: "Evidence for at least one of the critical outcomes from unsystematic

clinical observations or very indirect evidence"
See Swiglo BA, Murad MH, Schunemann HJ, et al. A case for clarity, consistency, and helpfulness: State-of-the-art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. *J Clin Endocrinol Metab*. 2008;93(3):666-73.

[2] n (%)

[3]Ungraded Good Practice Statement: "Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles." See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

Guidelines:
Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.
Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(3):709-757.
Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2018;103(11):4043-4088.

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

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

EXPERT REPORT OF KELLAN E. BAKER, MA, MPH, PhD

I, Kellan E. Baker, MA, MPH, PhD, declare and state as follows:

1. I have been retained by counsel for Plaintiffs 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.

BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am the Executive Director and Chief Learning Officer of the Whitman-Walker Institute. In this role I oversee the Whitman-Walker Institute, which is the research, policy, and educational arm of Whitman-Walker, a community health system that includes Whitman-Walker Health, a federally qualified

Pl. Trial Ex. 006

community health center with 50 years of expertise in serving diverse communities across the Washington, D.C. metro area, particularly LGBTQ+ people and people living with HIV.

4. In 2021, I received my Doctor of Philosophy in Health Policy and Management from the Johns Hopkins Bloomberg School of Public Health, where I focused on Health Services Research and Policy as a Centennial Scholar and a Robert Wood Johnson Health Policy Research Scholar. I also completed a three-year Certificate Program in Public Health Economics at the Johns Hopkins Bloomberg School of Public Health and received an Executive Certificate in Health Care Leadership and Management from the Johns Hopkins Carey Business School.

5. In 2011, I received my Master of Public Health in Global Health Policy from The George Washington University Milken Institute School of Public Health and in the same year received my Master of Arts in International Development Studies from The George Washington University Elliott School of International Affairs.

6. Through my academic training and professional experience, I have extensive experience as a researcher and health policy expert regarding topics such as insurance reform and the Patient Protection and Affordable Care Act ("Affordable Care Act"), federal and state regulatory policy, public health, and government statistics. I have expertise in developing and analyzing health policy; conducting,

synthesizing, and communicating scientific research; and working with government, philanthropy, and other partners toward health policy objectives.

7. A significant part of my scholarship, research, and experience has focused on ensuring health equity for medically underserved populations, including sexual and gender minority communities, communities of color, and people with disabilities. My work has a particular emphasis on health care access and insurance issues in relation to the transgender population.

8. I have also worked with the National Academies of Sciences, Engineering, and Medicine ("National Academies") in several capacities. In 2017-2018, I served as a Steering Committee Member for the National Academies Project on Demography of Sexual and Gender Minority Populations. In 2019-2021, I served as a consultant to the National Academies Committee on Population on the convening of a National Academies Consensus Study Committee to assess the health and well-being of sexual and gender diverse populations. In this capacity, I advised on the preparation, creation, and dissemination of the Consensus Study Report "Understanding the Well-Being of LGBTQI+ Populations," which was published in 2020. As part of my role I participated in Consensus Study Committee discussions and authored and edited report components related to physical and mental health,

health services access and use, health policy, data collection, and demography.[1] As a consensus study report by the National Academies, the report documents the evidence-based consensus on the study's statement of task, was subjected to a rigorous and independent peer-review process, and represents the position of the National Academies on the statement of task.

9. Of relevance to this case, the National Academies 2020 consensus study report states that:

a. "Clinicians who provide gender-affirming psychosocial and medical services in the United States are informed by expert evidence-based guidelines";

b. Each of the guidelines published by the World Professional Association for Transgender Health ("WPATH") (Coleman et al., 2012); the Endocrine Society (Hembree et al., 2017); and the Center of Excellence for Transgender Health (UCSF Transgender Care, 2016) "is informed by the best available data and is intended to be flexible and holistic in application to individual people"; and

c. "Mental and physical health problems need not be resolved before a person can begin a process of medical gender affirmation, but they

[1] National Academies of Sciences, Engineering, and Medicine. (2020). Understanding the Well-Being of LGBTQI+ Populations. Washington, DC: The National Academies Press. https://doi.org/10.17226/25877.

should be managed sufficiently such that they do not interfere with treatment."

10. In 2021, I was appointed as a member of the National Academies Consensus Study Committee on Measuring Sex, Gender Identity, and Sexual Orientation, which was charged with developing recommendations for the National Institutes of Health on the measurement of sex, gender identity, and sexual orientation. In March 2022, the Committee published the report "Measuring Sex, Gender Identity and Sexual Orientation."[2]

11. In 2013, I co-founded Out2Enroll, which is a nationwide nonprofit initiative focused on connecting low- and middle-income LGBT people with health insurance coverage under the Affordable Care Act. Over the last decade, Out2Enroll has provided technical assistance to enrollment organizations, federal and state governments, and other stakeholders on insurance coverage issues related to LGBT populations; trained more than 15,000 enrollment assisters in all 50 states; and conducted annual research on the content of coverage sold through the Health Insurance Marketplaces.

[2] National Academies of Sciences, Engineering, and Medicine. 2022. Measuring Sex, Gender Identity, and Sexual Orientation. Washington, DC: The National Academies Press. https://doi.org/10.17226/26424.

12. For the last two years, I have been an appointed consumer representative to the National Association of Insurance Commissioners (NAIC), where I bring expert and consumer perspectives to inform the activities and policy positions of the NAIC.

13. I am the author of 22 peer-reviewed journal articles, 42 non-peer-reviewed articles and reports, and three book chapters. My peer-reviewed journal articles have been published in high-impact journals such as the *Journal of the American Medical Association*, *New England Journal of Medicine*, and *American Journal of Public Health*, among others.

14. Among my peer-reviewed publications are the following: "Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population," published in 2022 in the *Journal of Law, Medicine, and Ethics*; "Health and Health Care Among Transgender Adults in the United States," published in 2021 in the *Annual Review of Public Health*; "Hormone Therapy, Mental Health, and Quality of Life among Transgender People: A Systematic Review," published in 2021 in the *Journal of the Endocrine Society*; "The Future of Transgender Coverage," published in 2017 in the *New England Journal of Medicine*; and "Coverage for Gender Affirmation: Making Health Insurance Work for Transgender Americans," published in 2017 in *LGBT Health*.

15. I am also a senior researcher with the What We Know Project, a Cornell University–based initiative that conducts scoping reviews of the evidence in relation to complex legal and social issues involving LGBTQ populations in order to present the public and other stakeholders with primary source materials and summary findings. In 2018, I was the lead author of the What We Know Project's review of the effects of gender affirmation on the well-being of transgender people.[3]

16. This project included a systematic literature review of all peer-reviewed articles published in English between 1991 and June 2017 that assessed the effects of gender-affirming medical care on health-related outcomes among transgender people. We identified 55 studies that consisted of primary research on this topic, of which 51 (93%) found that gender-affirming medical care improves outcomes for transgender people, while 4 (7%) reported mixed or null findings. We found no studies concluding that gender-affirming care causes overall harm.

17. In addition, I am an author of multiple policy statements and technical reports, and I have served as a reviewer for 30 peer-reviewed journals, including the *New England Journal of Medicine*, *Journal of the American Medical Association*, and *Transgender Health*.

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[3] What We Know Project. (2018). What Does the Scholarly Research Say About the Effect of Gender Transition on Transgender Wellbeing? Cornell University Center for the Study of Inequality. https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/

18. I have taught courses in LGBTQ health policy and health equity, as well as given dozens of invited lectures, presentations, keynotes, and plenaries related to health policy, health coverage, health disparities, and transgender health.

19. More detailed information regarding my professional background, experiences, publications, and presentations is outlined in my curriculum vitae, a true and correct copy of which is attached as **Exhibit B**.

B. Prior Testimony

20. I have not testified as an expert at deposition or trial within the last four years.

C. Compensation

21. I am being compensated at an hourly rate of $200 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.

BASES FOR OPINIONS

22. This report sets forth my opinions in this case and the bases for my opinions.

23. In preparing this report, I reviewed Florida's Administrative Rule governing the determination of generally accepted professional medical standards under Florida Medicaid coverage (Fla. Admin. Code R. 59G-1.035); the text of

"Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" ("GAPMS Memo"),[4] including all attachments; Fla. Admin. Code. R. 59G-1.050(7), which prohibits Medicaid coverage of puberty-delaying medications (commonly referred to as "puberty blockers"), hormone and hormone antagonists, "sex reassignment" surgeries, and any other procedures that alter primary or secondary sexual characteristics, on the basis that the services do not meet Florida's definition of "medical necessity" for purposes of its Medicaid program; and the Complaint in this Case.

24. I also reviewed the materials listed in the attached Bibliography (**Exhibit A**), as well as the materials listed within my curriculum vitae (attached as **Exhibit B**). I may rely on those documents as additional support for my opinions.

25. In addition, I have relied on my education, training, and years of professional and research experience, as well as my knowledge of the scientific literature in the pertinent fields.

26. The materials I have relied upon in preparing this declaration are the same types of materials that experts in health and public policy regularly rely upon when forming opinions on this type of subject. I may wish to supplement these

[4] June 2022. Accessed February 6, 2022. Available at https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf.

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.

TRANSGENDER PEOPLE AND GENDER DYSPHORIA

27. Transgender people are individuals whose gender identity, meaning their innate, deeply seated knowledge of their own gender, is different from that typically associated with the sex they were assigned at birth.[5]

28. There are approximately 1.6 million transgender people in the United States today, comprising approximately 0.6 percent of the U.S. population.[6] This estimate has remained steady since the authors' initial assessments of this population size in 2016[7] and 2017.[8] Compared to the general U.S. population, transgender people are more likely to not have health insurance coverage, to be unemployed and living in poverty, and to have a disability.[9] Scientific studies consistently identify experiences of discrimination and a lack of access to appropriate medical care as

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[5] National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring Sex, Gender Identity, and Sexual Orientation for the National Institutes of Health*. Washington, DC: National Academies Press.

[6] Herman JL, Flores AR, O'Neill KK. (2022). *How Many Adults and Youth Identify as Transgender in the United States?* Los Angeles: The Williams Institute. https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

[7] Flores AR, Herman JL, Gates GJ, Brown TNT. (2016). *How Many Adults Identify as Transgender in the United States?* Los Angeles: The Williams Institute. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf

[8] Herman JL, Flores AR, Brown TNT, Wilson BDM, Conron KJ. (2017). *Age of Individuals Who Identify as Transgender in the United States.* Los Angeles: The Williams Institute. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf

[9] James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. https://www.ustranssurvey.org/reports

major drivers of these disparities.[10] Because of these systematic and well-documented gaps in health and overall well-being, the transgender population is designated as a health disparity population by the National Institutes of Health.[11]

29. Many transgender people seek medical treatment to physically transition from the sex that they were assigned at birth to the sex that aligns with their gender. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), the diagnostic term that describes the medical necessity of transition is gender dysphoria, which refers to the distress and impairment transgender individuals may experience due to a profound misalignment between their gender and their assigned birth sex.[12]

30. Gender dysphoria is recognized as a serious medical condition by major medical associations such as the American Medical Association (AMA), the American Psychiatric Association, and the American Psychological Association, among many others.[13] A 2008 AMA resolution notes that the consequences of gender dysphoria can include "clinically significant psychological distress,

[10] National Academies of Sciences, Engineering, and Medicine. (2020). *Understanding the Well-Being of LGBTQI+ Populations*. Washington, D.C.: National Academies Press.
[11] National Institute for Minority Health and Health Disparities. (2016). Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes. https://www.nimhd.nih.gov/about/directors-corner/messages/message_10-06-16.html
[12] American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, revised). Arlington, VA: American Psychiatric Publishing.
[13] See https://transhealthproject.org/resources/medical-organization-statements/

dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death."[14]

31. Treatment for gender dysphoria, which may include mental health counseling, hormone therapy, and surgeries, is provided in the United States by licensed clinicians according to expert standards developed by professional medical associations such as the Endocrine Society[15] and the World Professional Association for Transgender Health (WPATH).[16] Interventions to treat gender dysphoria have been linked to multiple positive health outcomes, including better quality of life; lower rates of mental health conditions such as depression, anxiety, and psychological distress; decrease in or elimination of distress associated with gender dysphoria; and mitigation of stigma and discrimination.[17]

INSURANCE COVERAGE OF TREATMENT FOR GENDER DYSPHORIA

32. The first U.S. clinics opened to provide treatment for gender dysphoria to transgender individuals in the 1960s and 1970s, and the first edition of the

[14] American Medical Association House of Delegates. (2008). Removing Barriers to Care for Transgender Patients. H-185.950 (Res. 122; A-08). https://www.tgender.net/taw/ama_resolutions.pdf

[15] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*, *102*(11), 3869–903.

[16] Coleman E, Radix AE, Bouman WP, et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*, *23*(Suppl 1), S1-S259.

[17] National Academies of Sciences, Engineering, and Medicine. (2020). Understanding the Well-Being of LGBTQI+ Populations. Washington, DC: The National Academies Press.

WPATH Standards of Care was published in 1979.[18] By the late 1970s, nationwide trends favored insurance coverage for treatment of gender dysphoria, particularly through state Medicaid programs.

Private Health Coverage

State-Regulated Individual and Group Coverage

33. In the U.S., the states are the traditional regulators of private insurance coverage sold in the individual, small group, and large group markets. Over the last two decades, many states have required plans under their jurisdiction to remove exclusions of coverage for gender dysphoria.

34. In 2005, California became the first state to prohibit discrimination against transgender individuals by state-regulated individual and group plans by enacting the Insurance Gender Nondiscrimination Act (IGNA), which bans discrimination in health insurance coverage because of gender identity.

35. In 2012, the California Department of Insurance issued a regulation under IGNA defining gender identity discrimination in health insurance coverage to mean "denying or limiting coverage, or denying a claim, for…health care services related to gender transition if coverage is available for those services under the policy when the services are not related to gender transition, including but not limited to

[18] Allee KM. (2009). Harry Benjamin International Gender Dysphoria Association. In *Encyclopedia of gender and society, volume 1* (Ed. J O'Brien). Thousand Oaks, CA: SAGE.

hormone therapy, hysterectomy, mastectomy, and vocal training."[19] Since 2012, 24 other states and the District of Columbia have prohibited exclusions of coverage for gender dysphoria in state-regulated individual and group plans.[20]

36. Most recently, Colorado added new explicit coverage requirements for plans in its state-regulated individual and small group markets.[21] Those plans in Colorado are now required to cover the following procedures for transgender people: gender-affirming hormone therapy, chest reconstruction, augmentation mammoplasty, genital surgeries, facial feminization surgeries, and laser or electrolysis hair removal. An actuarial analysis commissioned by the state to assess the cost of these procedures estimated that their long-term steady state cost is 0.04% of total allowed claims.[22]

37. Similarly, in 2022, 21 state regulators wrote a joint letter to the U.S. Department of Health and Human Services (HHS) stating, "Transgender people should have equal access to the same health insurance and care as every other insured American. This includes health care related to gender affirmation, which for years

[19] CAL. CODE REGS., tit. 10, § 2561.2(a)(4)(A).
[20] LGBT Movement Advancement Project. (2023). Equality Maps. https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/private_insurance
[21] Keith K. (2021). Unpacking Colorado's New Guidance on Transgender Health. Commonwealth Fund Blog. https://www.commonwealthfund.org/blog/2021/unpacking-colorados-new-guidance-transgender-health
[22] Colorado Benchmark Plan for 2023. https://www.cms.gov/files/zip/co-ehb-benchmark.zip

has been recognized by every major U.S. medical society as effective and medically necessary for many individuals."[23]

38. In addition to state regulators, insurance carriers themselves have also spoken strongly about their interest in ensuring that transgender enrollees can access treatment for gender dysphoria. In 2022, America's Health Insurance Plans (AHIP), the professional trade association that represents 1,300 member companies that sell health insurance coverage for more than 200 million people nationwide, wrote in a letter to HHS that they "strongly support ensuring that appropriate gender-affirming care is available and accessible to enrollees. We [are committed] to ensuring benefit designs and coverage decisions reflect evidence-based guidelines and recommendations and do not restrict coverage related to gender identity."[24]

Employer-Sponsored Coverage

39. Employee coverage through large employers in the U.S. is primarily regulated by the federal government under the Employee Retirement Income Security Act (ERISA), though states retain authority over the plans they offer to their employees. The federal government also oversees coverage requirements for federal

[23] Letter from state insurance commissioners to U.S. Department of Health and Human Services Secretary Xavier Becerra. (2022). http://www.insurance.ca.gov/0400-news/0100-press-releases/2022/upload/joint-Letter-Final_ACA_SECTION_1557_NPRM_sign-on_letter_2022-2.pdf

[24] America's Health Insurance Plans. (2022). Letter to Dr. Ellen Montz, Administrator, Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Letter-to-CMS-on-Nondiscrimination-2.16.22.pdf

employees nationwide through the Federal Employees Health Benefits Program (FEHBP). Trends in employer coverage of treatment for gender dysphoria parallel the expansion of coverage evident in state-regulated individual and group coverage.

40. Among state employee benefit plans, 42 states and territories do not have categorical transgender-specific exclusions in their plans; of these, 24 states and D.C. affirmatively spell out the gender-affirming services that their state employee plans cover.[25]

41. According to the Corporate Equality Index (CEI), which has tracked the status of private employer-sponsored coverage for treatment of gender dysphoria since 2002, 67 percent of the entire Fortune 500—and 86 percent of all CEI-rated businesses (1,088 of 1,271)—offered employee benefits with no transgender-specific exclusions in 2022.[26] In 2015, 54 percent (421 of 781) companies offered at least one fully inclusive plan to their employees, and by 2022 that number had reached 91 percent (1,160 out of 1,271).

42. In 2016, the White House Office of Personnel Management (OPM) required all FEBHP carriers to remove blanket exclusions of services, drugs, or

[25] LGBT Movement Advancement Project. (2023). Equality Maps. https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/state_employees. West Virginia's exclusion was recently removed as a result of a settlement agreement.
[26] Human Rights Campaign Foundation. (2022). Corporate Equality Index. https://reports.hrc.org/corporate-equality-index-2022

supplies related to the treatment of gender dysphoria. For plan year 2023, OPM instituted the following requirements for FEHB carriers:[27]

a. Have adopted one or more recognized entities in order to guide evidence-based benefits coverage and medical policies pertaining to gender affirming care and services, such as the World Professional Association of Transgender Health (WPATH) Standards of Care, the Endocrine Society, and the Fenway Institute. These entities provide evidence-based clinical guidelines for health professionals to assist transgender and gender diverse people with safe and effective pathways that maximize their overall health, including physical and psychological well-being.

b. Will provide individuals diagnosed with and/or undergoing evaluation for gender dysphoria the option to use a Care Coordinator to assist and support them as they seek gender-affirming care and services. If network providers are not available to provide medically necessary treatment of gender dysphoria, FEHB Carriers will provide members direction on how to find qualified providers with experience delivering this specialized care.

c. Have reviewed their formularies to ensure that transgender and gender diverse individuals have equitable access to medications and provide coverage of medically necessary hormonal therapies for gender transition care.

Health Insurance Marketplace Coverage

43. Another major source of individual and small group insurance beyond traditional state-regulated private markets are the Health Insurance Marketplaces established by the Patient Protection and Affordable Care Act (ACA), where

[27] United States Office of Personnel Management. (2022). Federal Benefits Open Season November 14, 2022 – December 12, 2022. https://cdn.govexec.com/media/gbc/docs/pdfs_edit/093022ew1.pdf

income-eligible consumers can purchase plans with government financial subsidies. Approximately one-third of states operate their own Marketplace, while the federal government operates the Marketplace for the remaining states, including Florida, through the HealthCare.gov platform.

44. Since 2017, the Out2Enroll initiative has conducted research on the prevalence of exclusions for gender dysphoria in plans sold through HealthCare.gov. Over the past seven years, this research has documented that the vast majority of plans sold through HealthCare.gov do not have transgender-specific exclusions.[28]

45. In 2023, for instance, 92% of 1,429 HealthCare.gov plans reviewed from 33 states, including Florida, did not have categorical exclusions of gender dysphoria treatment. Almost half (47%) of all plans reviewed explicitly stated that medically necessary treatment for gender dysphoria is covered.

46. Of the eight carriers selling coverage through HealthCare.gov in Florida, seven (88%) expressly cover medical care related to gender affirmation. The remaining carrier excludes coverage only for some gender-affirming services, and no carriers offer plans with categorical exclusions of the type established in Fla. Admin. Code R. 59G-1.035.[29]

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[28] Out2Enroll. (2022). Summary of Findings: 2023 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act. https://out2enroll.org/2023-cocs/

[29] Out2Enroll. (2022). Transgender Health Insurance Guide to the Marketplace: Florida. https://drive.google.com/file/d/1XliTnjuwi_6pCQuOj3Nm9vlGalAdTOaE/view

Public Health Coverage

Medicare

47. An exclusion of Medicare coverage for "transsexual surgery" was introduced in 1981 and codified in a 1989 National Coverage Determination. In 2014, the HHS Departmental Appeals Board (DAB) ruled that this exclusion of treatment for gender dysphoria was invalid on the grounds that it was based on outdated evidence that was not complete or adequate to support the determination that this treatment was never medically necessary.[30]

48. In its ruling, the DAB rejected the assertion that gender-affirming surgeries are "experimental" and "controversial," finding instead that current evidence "indicates a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for transsexualism." Following the rescinding of the exclusion, Medicare covers surgeries and other gender-affirming care for transgender individuals according to case-by-case assessments of medical necessity.

49. An example of this coverage policy in practice is a 2016 ruling by the Medicare Appeals Council ("the Council"), which is part of the DAB, finding that a Medicare Advantage plan's decision to deny coverage for gender-affirming surgery

[30] Dep't of Health & Human Servs., Departmental Appeals Bd., Appellate Div., Decision No. 2676 (May 30, 2014), hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

to a transgender Medicare beneficiary did not comport with Medicare's statutory "reasonable and necessary" coverage criterion.[31]

50. The Council asserted that the WPATH Standards of Care are "reasonable guidelines to determine medical necessity" and found that, inasmuch as the enrollee "satisfies all of the WPATH clinical requirements for gender reassignment surgery…the requested vaginoplasty is medically reasonable and necessary for treatment of this enrollee's gender dysphoria under Section 1862(a)(1)(A) of the [Social Security] Act and is covered under existing [Centers for Medicare & Medicaid Services] guidance."

Medicaid

51. Medicaid coverage for gender-affirming care predates the first iteration of WPATH's Standards of Care. For example, Medicaid coverage for such care in California can be documented as far back as the 1970s. In a pair of cases decided in 1978 (*J.D. v. Lackner* and *G.B. v. Lackner*) pertaining to Medicaid coverage of vaginoplasty for transgender women, a California court found that the plaintiff "has an illness and … as far as her illness affects her, the proposed surgery is medically reasonable and necessary and…there is no other effective treatment method." The judges further asserted that "the proposed surgery is medically reasonable and

[31] In the Case of United Health Care / AARP Medicare Complete, No. M-15-1069 at 8 (Jan. 21, 2016), https://www.hhs.gov/sites/default/files/static/dab/decisions/council-decisions/m-15-1069.pdf.

necessary" and should thus be covered by Medicaid, and they added that "we do not believe, by the wildest stretch of the imagination, that such surgery can reasonably and logically be characterized as cosmetic."

52. Other states likewise provided Medicaid coverage for gender-affirming care as far back as the 1970s and 1980s.[32] When the federal Medicare program instituted its exclusion in 1981, however, many Medicaid programs followed suit.

53. Beginning in the early 2000s and over the course of the next 20 years, categorical exclusions of coverage in many state Medicaid programs began to be removed—whether administratively, by statute, or after court orders—in response to successive iterations of the standards of care and increasingly sophisticated clinical practice guidelines for the treatment of gender dysphoria.

54. As of present, the overwhelming majority of states do not exclude coverage of gender-affirming care from Medicaid. As of early 2023, 47 states and territories, as well as D.C., no longer have categorical exclusions of gender dysphoria treatment in their Medicaid programs. Of these, 27 states and D.C. explicitly and affirmatively delineate coverage of a range of gender-affirming services.

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[32] *See*, *e.g.*, *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980) (pertaining to Iowa's Medicaid program); *Doe v. State, Dep't of Pub. Welfare*, 257 N.W.2d 816 (Minn. 1977) (pertaining to Minnesota's Medicaid program).

55. The GAPMS Memo outlines that there are eight states that explicitly ban coverage for treatment of gender dysphoria. However, these limitations are typically not as broad or all-encompassing as Fla. Admin. Code. R. 59G-1.050(7). For example, the exclusions in Missouri, Nebraska, and Texas are limited to surgery and do not extend to coverage for puberty delay medications and hormone therapy, while the exclusion in Arkansas is limited to minors.[33] Meanwhile, the exclusion in Ohio appears to be inoperative, as officials in Ohio do not appear to be enforcing the exclusion and managed care organizations operating under Ohio's Medicaid program have clinical policy guidelines for covering gender-affirming care; thus, the scope of coverage is unclear. Finally, the GAPMS Memo erroneously states that Georgia excludes coverage of gender-affirming care in Medicaid.

56. Taking stock of Medicaid coverage policies requires assessment not just of a state's regulations and statutes, but also operative guidance, managed care organizations' policies, and relevant administrative and court decisions in the state.

57. When one does so, Florida stands apart as one of less than a handful of states with exclusions of similar breadth and scope among the 56 jurisdictions in the United States that operate Medicaid programs (i.e., the 50 states, five U.S. territories, and D.C.). Florida's recently adopted exclusion therefore runs counter to the clear and overwhelming trend among Medicaid programs to remove such exclusions and, as

[33] ARK. CODE § 20-9-1503(d).

outlined further below, to affirmatively provide guidance on coverage for treatment of gender dysphoria.

58. Some states have recently explicitly broadened and clarified the scope of Medicaid coverage for gender dysphoria. In Washington State, for instance, 2021 legislation codified that the state's Medicaid program covers a range of "surgical and ancillary services," as well as puberty-delaying medications, for transgender people.[34] The legislation indicates that the list of covered services is not exhaustive and requires that a "health care provider with experience prescribing and/or delivering gender affirming treatment must review and confirm the appropriateness of any adverse benefit determination.[35]

COSTS AND UTILIZATION OF TREATMENT FOR GENDER DYSPHORIA

59. While the number of people with transgender-specific diagnostic codes in commercial insurance claims databases has increased over the last decade, the increase is attributable to national policy trends that have made coverage for gender-affirming care more accessible. As such, more transgender people are now able to access coverage for treatment of gender dysphoria, and more providers are able to appropriately code for these encounters without triggering coverage exclusions.

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[34] Washington State Legislature. SB 5313 (2021-2022). https://app.leg.wa.gov/billsummary?BillNumber=5313&Initiative=false&Year=2021

[35] Washington State Healthcare Authority. (2022). Transhealth Program. https://www.hca.wa.gov/billers-providers-partners/programs-and-services/transhealth-program

60. Even as coverage has become more accessible, utilization rates remain low. Moreover, evidence indicates that insurance coverage of treatment for gender dysphoria is low-cost and highly cost-effective. The impact of gender-affirming care on payer budgets has thus remained nominal even as coverage has become more available, standardized, and routine.

61. A California Department of Insurance assessment of IGNA, the state law that broadly prohibited insurance discrimination against transgender beneficiaries, for instance, showed that a major state university-sponsored plan had a utilization rate of only 0.062 per 1,000 covered persons for this care over the 6.5 years following the law's enactment; across the state, impacts on premium costs were "immaterial," leading the Department to conclude that "the benefits of eliminating discrimination far exceed the insignificant costs."[36]

62. A 2016 economic model evaluating the cost-effectiveness of care for transgender men that included hormone replacement therapy, mastectomy, abdominoplasty, hysterectomy, genital reconstruction, and other services underscores this conclusion, finding that the incremental cost-effectiveness ratio

[36] State of California Department of Insurance. (2012). Economic Impact Assessment: Gender Nondiscrimination in Health Insurance. http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf

(ICER) of these services was less than $8,000 per quality-adjusted life year (QALY) gained over a ten-year time horizon.[37]

63. This is far below a typical U.S. "willingness to pay" threshold of $100,000 per QALY.[38] This study also found that, on a per member per month (PMPM) basis, coverage of surgical and other services for transgender men and women together cost $0.016.

64. My own recent research indicates that each covered transgender person in a major national commercial insurance database incurred an average of less than $1,800 in costs per year for hormone therapy (including puberty delay medications) and surgeries (including facial surgeries) combined to treat gender dysphoria.[39] Considered on a PMPM basis, the budget impact of covering this care was $0.73 per year, or $0.06 PMPM.

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[37] Padula, W. V., Heru, S., & Campbell, J. D. (2016). Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. Journal of General Internal Medicine, 31(4), 394–401. https://doi.org/10.1007/s11606-015-3529-6

[38] Cameron, D., Ubels, J., & Norström, F. (2018). On what basis are medical cost-effectiveness thresholds set? Clashing opinions and an absence of data: a systematic review. Global health action, 11(1), 1447828. https://doi.org/10.1080/16549716.2018.1447828

[39] Baker, K., & Restar, A. (2022). Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population. Journal of Law, Medicine & Ethics, 50(3), 456-470. doi:10.1017/jme.2022.87

65. Similarly, an actuarial assessment conducted for the North Carolina State Health Plan estimated a PMPM cost range of $0.06-$0.15 (0.011% to 0.027% of premiums).[40]

66. Estimates from other states show equally low utilization and related low costs, with Alaska estimating that coverage for gender dysphoria would result in increases of 0.03% to 0.04% of total costs for its state employee plan[41] and Wisconsin noting costs to its state employee plan are "immaterial, since it represents less than 0.1% of the overall costs of medical care."[42]

67. Cost estimates of coverage for gender-affirming care under Wisconsin Medicaid were "actuarially immaterial, as they are equal to approximately 0.008% to 0.03%" of Wisconsin's share of its Medicaid budget.[43]

68. An analysis in the military context concluded that the cost of covering gender-affirming care was "too low to matter"[44] or, as military leadership noted, "'budget dust,' hardly even a rounding error.[45]

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[40] Schatten, K. R., & Viera, K. C. (2016). Memorandum to Mona Moon, Administrator, North Carolina State Health Plan, re: Transgender Cost Estimate. https://www.shpnc.org/media/22/download

[41] Plaintiffs' Motion for Partial Summary Judgment, Fletcher v. Alaska, No. 1:18-cv-00007-HRH (D. Alaska July 1, 2019), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/fletcher_ak_20190701_plaintiffs-motion-for-partial-summary-judgment.pdf.

[42] Boyden v. Conlin, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018).

[43] Flack v. Wis. Dept of Health Servs., 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).

[44] Belkin A. (2015). Caring for our transgender troops – The negligible cost of transition-related care. *New Eng J Med, 373*, 1089–1092. https://www.nejm.org/doi/full/10.1056/NEJMp1509230

[45] Declaration of Raymond Edwin Mabus, Jr., Former U.S. Secretary of the Navy, in Support of Plaintiff's Motion for Preliminary Injunction, Doe v. Trump, No. 17-cv-1597-CKK (D.D.C.) filed Aug. 31, 2017, at 41). http://files.eqcf.org/wp-content/uploads/2017/09/13-Ps-App-PI.pdf

69. Overall, the actuarial evidence indicates that gender-affirming care is not expensive when considered from a payer or societal perspective, but it can easily be beyond the individual reach of transgender people, particularly those who rely on public coverage programs such as Medicaid.

CONCLUSION

70. The transgender population, at a steady 0.6% of the U.S. population, is a small and medically vulnerable population for whom decades of scientific research and medical practice have established a robust consensus on the appropriateness of gender-affirming care. Over the last 20 years, state regulators, Medicaid programs, insurance carriers, and employers have increasingly taken affirmative action to ensure that transgender people do not face barriers to coverage for the medically necessary treatment of gender dysphoria. The exclusion recently instituted at Fla. Admin. Code. R. 59G-1.050(7) thus is both out-of-step with expert medical standards used by both public and private health insurance programs and runs counter to prevailing nationwide trends in every form of insurance, including Medicaid, Medicare, and private coverage.

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 February 2023.

KELLAN E. BAKER, MA, MPH, PhD

EXHIBIT A

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EXHIBIT B

KELLAN E. BAKER, PhD, MPH, MA

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EDUCATION

Johns Hopkins Bloomberg School of Public Health 2016-2021
Doctor of Philosophy in Health Policy and Management
Concentration in Health Services Research and Policy
Dissertation: *Clinically Documented Social Risk Factors, Health Care Utilization, and Expenditures in a Commercially Insured Transgender Population*
Activities: Centennial Scholar, Health Policy Research Scholar, Gordis Teaching Fellow

Johns Hopkins Bloomberg School of Public Health 2016-2019
Certificate in Public Health Economics

Johns Hopkins Carey Business School 2018
Executive Certificate in Health Care Leadership and Management

University of the South School of Theology 2008-2012
Certificate in Theological Education

George Washington University School of Public Health and Health Services 2008-2011
Master of Public Health
Concentration in Global Public Health Policy
Thesis: *Transforming Health: International Rights-Based Advocacy for Transgender Health*
Activities: Delta Omega Public Health Honors Society

George Washington University Elliott School of International Affairs 2008-2011
Master of Arts in International Development
Thesis: *Security, Development, and Sexual and Gender-Based Violence in Conflict Settings*

Diplomatic Academy of Vienna 2007-2008
Graduate study in International Economics

University of Vienna 2007-2008
Certificate of Advanced Proficiency in German Language

Swarthmore College 2000-2004
Bachelor of Arts with High Honors in Astrophysics and Russian Literature
Activities: External Honors Program

PROFESSIONAL EXPERIENCE

Whitman-Walker Institute
Executive Director and Chief Learning Officer 2021-present

- Lead the research, policy, and education activities of Whitman-Walker, a community health system in Washington, DC that also includes Whitman-Walker Health, a Federally Qualified Health Center with 50+ years of experience serving diverse patient populations across the DC metro area, with a particular focus on people living with HIV and sexual and gender minority populations.
- Oversee daily operations for the Institute, including personnel, grants management, financial reporting and fiscal accountability, strategic planning, quality assurance for training and research activities, and development of internal and external partnerships.
- Oversee a 55-person team of researchers, policy analysts, and administrative staff in conducting epidemiologic, econometric, clinical, and policy research; translating research findings into policy, practice, and programming recommendations; and advancing methodology for research centering the impact of structural factors on individual and population health.
- Partner with clinicians and clinic management at Whitman-Walker on health services research using clinical data for quality assessment and practice improvement.
- Represent Whitman-Walker in interactions with media, government, academic institutions, public and private payers, professional societies, community members, and other stakeholders.

Johns Hopkins School of Public Health
Affiliate Faculty, Department of Health Policy and Management 2021-present

George Washington University School of Public Health and Health Services
Affiliate Faculty, Department of Health Policy and Management 2021-present

National Academy of Sciences, Division of Behavioral and Social Sciences and Education
Consultant 2019-2021

- Advised the Committee on Population on the development, funding, and coordination of a consensus study project on health and other domains of well-being in sexual and gender diverse populations.
- Authored and edited report components related to physical and mental health; health services access and use; health policy; data collection; and demography.
- Led report dissemination to policy, academic, medical, media, and community audiences.

Johns Hopkins Evidence-Based Practice Center
Research Associate 2018-2021

Designed and conducted systematic reviews to support the revision of the leading expert treatment guidelines in the field of transgender health.

Cornell University Center for the Study of Inequality
Senior Researcher 2017-2019

Designed and conducted systematic reviews of social inequality and health policy issues.

Johns Hopkins School of Public Health, Department of Epidemiology
Research Associate 2017-2018

Built economic models assessing the cost-effectiveness of integrating HIV testing, prevention, and treatment into primary care in low-resource settings.

Center for American Progress
Senior Fellow 2014-2017

- Designed and implemented strategies to advance policy goals around health equity, Affordable Care Act (ACA) implementation, health system transformation, health insurance reform, appropriations and budget, nondiscrimination, and data collection and research at all levels of government and with hospitals, health insurance carriers, and other private stakeholders.
- With Fenway Community Health, co-founded and directed a project that secured new data elements in the federal regulations governing the Meaningful Use of Electronic Health Records program.
- Coordinated and represented coalitions of diverse organizations focusing on civil rights, health care, and public health in regulatory and legislative policymaking activities with decisionmakers and staff at all levels of government.
- Developed and published original research, policy analyses, and policy and practice recommendations for audiences such as the White House, the federal agencies, the Presidential Advisory Council on HIV/AIDS, congressional and other legislative staff, state and local health departments, and state and federal insurance regulators.
- Regularly quoted and published in venues such as *Washington Post*, *New York Times*, *Reuters*, *Time*, *Scientific American*, *US News and World Report*, and National Public Radio.

Out2Enroll Founding Steering Committee Member 2013-2017

- Conceived and co-led Out2Enroll, a $1-million national communications, training, and policy partnership with the U.S. Department of Health & Human Services (HHS) and the White House to connect low-income sexual and gender minority people with insurance coverage under the ACA.
- Managed strategic and daily operations, including overseeing a coalition of more than 70 partners, developing communications strategies, fundraising, and grants management.
- Created the training "Reaching and Assisting LGBT Communities" (in-person and online) and trained more than 15,000 enrollment assisters in all 50 states, the US territories, and Washington, DC.
- At the request of the HHS Office for Civil Rights, created and presented trainings on the ACA and civil rights to the HHS Regional Offices.

Associate Director 2013-2014

- Led the health policy portfolio of the Federal Agencies Project, a national funder collaborative pursuing health reform and health equity objectives via federal regulatory policy.
- Managed a staff of research and policy analysts.

Senior Policy Analyst 2011-2013
- Conducted policy analyses and wrote reports, memos, regulatory comments, and media pieces on issues such as health reform, HIV/AIDS, health disparities, and health information technology.
- Created and oversaw the LGBT State Exchanges Project, a training and technical assistance partnership with five states to address coverage gaps through the implementation of the ACA.

Astraea Lesbian Foundation for Justice
Consultant 2014
Managed strategic planning activities of the Global Philanthropy Project, a group of 15 international funders supporting the human rights of sexual and gender minorities.

Kaiser Foundation Health Plan
Consultant 2013-2014
Advised on the development of Kaiser's industry-leading LGBTI Health Equity Program.

The Joint Commission
Consultant 2010
Co-authored "Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide."

Open Society Foundations
Consultant 2010-2013
Authored "Transforming Health: International Rights-Based Advocacy for Trans Health," featuring case studies from nine countries and the World Health Organization.

Danish Refugee Council
Fellow 2010
Conducted French-language focus group research in the Central African Republic and wrote a needs assessment about addressing sexual and gender-based violence in conflict situations.

National Coalition for LGBT Health
Policy Analyst 2009-2011
In coordination with 75 member organizations in 22 states and other stakeholders, developed and implemented a national policy strategy for advancing LGBT health equity.

The White House
Intern 2009
Staffed the Special Assistant to the President for Disability Policy.

Wonder Sprachinstitut (Vienna, Austria)
TOEFL Preparation Instructor 2007-2008
Taught beginning and advanced English.

Vienna University of Economics and Business (Vienna, Austria)
Executive MBA Program Tutor 2007-2008
Tutored students on English and economics topics.

***Kommersant* Newspaper (Moscow, Russia)**
Russian–English Translator 2006-2007
Translated international news, politics, business, and editorial content for a leading daily newspaper.

Nauka/Interperiodica (Moscow, Russia)
Russian–English Translation Editor 2004-2005
Edited translated scientific journal articles in the areas of physics, chemistry, geology, and biology under a contract with the Russian Academy of Sciences.

SERVICE TO PROFESSIONAL ORGANIZATIONS

National Institutes of Health 2022-present
Appointed Member, Sexual and Gender Minority Working Group of the NIH Council of Councils

Public Health AmeriCorps 2022-present
Member, Technical Working Group for National Process, Outcomes, and Impact Evaluation

AcademyHealth 2022-present
Member, Advisory Group on Health Services Research Innovation, Inclusion, and Impact

UnitedHealthcare 2022-present
Member, Ambassadors for the Community (health equity initiative focused on dual eligibles in DC)

Personalized Medicine Coalition 2022-present
Member, Health Equity Task Force

National Association of Insurance Commissioners 2022-present
Appointed Consumer Representative

California Health Interview Survey 2022-present
Member, Sexual Orientation and Gender Identity Working Group

National Academies of Sciences, Engineering, and Medicine 2021-present
Appointed Member, Consensus Study Committee on Measuring Sex, Gender Identity, and Sexual Orientation for the National Institutes of Health

Agency for Healthcare Research and Quality 2021-present
Invited Participant, AHRQ Health Equity Summits

National Institutes of Health, Inter-Society Coordinating Committee for Practitioner Education in Genomics 2021-present
Founder and Co-Chair, Project on LGBTQI+ Issues in Genomics and Genomics Education

European Research Council 2021-present
Grant Reviewer

National Academies of Sciences, Engineering, and Medicine 2021-present
Partner, Assessing Meaningful Community Engagement in Health & Health Care Leadership Consortium

AcademyHealth 2020-present
Appointed Member, National Advisory Group on Diversity, Equity, and Inclusion

Harvard Medical School 2020-present
Professional Advisory Council Member, Sexual and Gender Minority Health Equity Initiative

National Center for Transgender Equality 2019-present
Scientific Advisory Council Member, 2022 US Transgender Survey

National Institutes of Health 2016-present
Community Engagement Working Group Member, National Human Genome Research Institute

American Councils for International Education 2016-present
Flagship Program Orientation Facilitator (Russia, Kazakhstan, Azerbaijan, Tajikistan)

Equality Federation 2015-present
Board of Directors (current Immediate Past Chair, past Treasurer)

TEDMED 2020
Invited Health Equity Expert

Biden-Harris Presidential Campaign 2020
Equity Review Board Member, Health Policy Committee

Biden-Harris Presidential Campaign 2020
Co-Chair, LGBTQ Health Policy Committee

Congressional Tri-Caucus, Families USA, and UnidosUS 2016-2020
Steering Committee Member, Health Equity and Accountability Act

10.10.10 Cities: Health Social Entrepreneurship Program 2019
Health Start-Up Team "Ninja"

Community Catalyst and the Robert Wood Johnson Foundation 2017-2019
National Advisory Council Member, Consumer Advocacy for Health System Transformation

Gilead Sciences 2017-2019
Transgender Advisory Council Member

American Association for the Advancement of Science 2016-2019
Selection Committee Member, Executive Branch Science and Technology Policy Fellowship

Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services 2014-2019
Appointed Member, Advisory Panel on Outreach and Education

National Academies of Sciences, Engineering, and Medicine 2017-2018
Steering Committee Member, Project on Demography of Sexual and Gender Minority Populations

Johns Hopkins Bloomberg School of Public Health 2018
Member, Schoolwide Honors and Awards Committee

National Institutes of Health 2018
Invited Participant, Expert Workshop on Methods in Sexual & Gender Minority Health Research

Johns Hopkins Medicine and Harvard University School of Medicine 2013-2018
Member, EQUALITY Study Stakeholder Advisory Board

Robert Wood Johnson Foundation 2017
Application Reviewer, Culture of Health Program

U.S. Professional Association for Transgender Health 2016-2017
Scientific Program Committee Member, Inaugural USPATH Scientific Conference

AcademyHealth 2015-2017
Advisory Council Member and Grant Reviewer, Community Health Peer Learning Program

Center for Consumer Information & Insurance Oversight, U.S. Department of Health & Human Services 2015
Grant Reviewer, HealthCare.gov Enrollment Navigator Program

Robert Carr Civil Society Networks 2015
Grant Reviewer

University of California at San Francisco Center of Excellence for Transgender Health 2013, 2015
Policy Track Co-Chair, National Transgender Health Summit

National Action Alliance for Suicide Prevention 2012
Member, LGBT Task Force

The Fenway Institute 2011-2016
Affiliated Faculty for LGBT Health Policy

U.S. Department of State 2009-2013
National Security Language Initiative for Youth Program Orientation Facilitator (Russia)

The DC Center for the LGBT Community 2009-2011
Board of Directors (DC for Marriage Campaign Co-Chair)

OTHER PROFESSIONAL ACTIVITIES

Ad Hoc Journal Reviews

- *New England Journal of Medicine*
- *Journal of the American Medical Association*
- *JAMA Psychiatry*
- *JAMA Internal Medicine*
- *Health Affairs*
- *American Journal of Public Health*
- *Journal of the American Medical Informatics Association*
- *Medical Informatics*
- *Milbank Quarterly*
- *Journal of Official Statistics*
- *Social Science & Medicine*
- *American Journal of Epidemiology*
- *American Journal of Preventive Medicine*
- *Preventive Medicine*
- *Quality of Life Research*
- *Sexuality Research and Social Policy*
- *Sexual and Reproductive Health Matters*
- *Journal of Homosexuality*
- *Journal of Public Health Dentistry*
- *Frontiers in Oncology*
- *Psychology of Sexual Orientation and Gender Diversity*
- *LGBT Health*
- *Transgender Health*
- *BMC Health Services Research*
- *Family Practice*
- *Journal of Patient Safety and Risk Management*
- *Progress in Community Health Partnerships: Research, Education, and Action*
- *Media and Communication*
- *Patient Education & Counseling*
- *The Physician and Sports Medicine*

Memberships

- DC Center for AIDS Research (2021-present)
- Johns Hopkins Center for AIDS Research (2020-present)
- Association for Public Policy Analysis and Management (2018-present)
- International Society for Pharmacoeconomics and Outcomes Research (2018-present)
- World Professional Association for Transgender Health (2018-present)
- Society for Medical Decision Making (2017-present)
- AcademyHealth (2012-present)
- American Public Health Association (2009-present)

Conference Abstract Reviews

- International Society for Pharmacoeconomics and Outcomes Research
- AcademyHealth (theme reviewer for "Disparities and Health Equity" track)
- American Public Health Association
- Society for Medical Decision Making
- U.S. Professional Association for Transgender Health

HONORS AND AWARDS

First Place, Research and Translation Virtual Ideas Exchange Competition 2020
OptumLabs

Golden Apple Award for Excellence in Teaching 2020
Public Health Studies Program, Johns Hopkins University
Awarded for the class "Policy, Politics, and Power in Health Equity," designed through the Gordis Teaching Fellowship

Alice S. Hersh Scholarship 2020
AcademyHealth

Victor P. Raymond Memorial Fund Award 2019
Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health

Delta Omega Policy and Practice Scholarship Award 2019
Johns Hopkins Bloomberg School of Public Health

Out to Innovate Award 2019
National Organization of Gay & Lesbian Scientists and Technical Professionals

Distinguished Service Award 2019
10.10.10 Cities: Health

Science Writing Fellowship 2019
Johns Hopkins Bloomberg School of Public Health

Gordis Teaching Fellowship 2018
Public Health Studies Program, Johns Hopkins University

Health Policy Research Scholarship 2017
Robert Wood Johnson Foundation
Health Policy Research Scholars is a national leadership program that invests in scholars from populations traditionally underrepresented in graduate programs whose work will inform and influence policy for building a Culture of Health

Featured Speaker 2017
National March for Science (Washington, DC)

Centennial Scholarship 2016
Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
Awarded to the outstanding entering doctoral student in each department to mark the school's centennial in 2016

Achievement Award 2015
GLMA: Health Professionals Advancing LGBT Equality

Andrew Cray Memorial Transgender Health Advocacy Award 2015
National Center for Transgender Equality

LGBTQ Leadership Fellowship 2011-2012
The Rockwood Institute

Delta Omega Public Health Honors Society 2010
George Washington University School of Public Health and Health Sciences

Eric Rofes Memorial Scholarship 2009
National Gay & Lesbian Task Force

High Honors 2004
Swarthmore College Honors Program

PUBLICATIONS

Journal Articles (Peer-Reviewed)

Baker KE, Restar A. (2022). Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population. *J Law Med Ethics, 50*, 456–470.

Baker KE, Compton D, Fechter-Leggett ED, Grasso C, Kronk CA. (2022). Will clinical standards not be part of the choir? Harmonization between the HL7 gender harmony project model and the NASEM measuring sex, gender identity, and sexual orientation report in the United States. *JAMIA*, *30*(1), 83–93.

Restar A, Dusic E, Garrison-Desany H, Lett E, Everhart A, **Baker KE**, Scheim A, Beckham SW, Reisner S, Rose A, Mimiaga M, Radix A, Operario D, Hughto J. (2022) Gender Affirming Hormone Therapy Dosing Behaviors among Transgender and Nonbinary Adults. *Humanit Soc Sci Commun, 9*(304).

Tran NK, **Baker KE**, Lett E, Scheim AI. (2022). State-level heterogeneity in associations between structural stigma and individual healthcare access: A multilevel analysis of transgender adults in the United States. *J Health Serv Res Policy*. doi:10.1177/13558196221123413.

Scheim AI, **Baker KE**, Restar AJ, Sell RL. (2021). Health and Health Care Among Transgender Adults in the United States. *Annual Review of Public Health*. doi:10.1146/annurev-publhealth-052620-100313

Restar A, Garrison-Desany HM, **Baker KE**, Adamson T, Howell S, Baral SD, Operario D, Beckham W. (2021). Prevalence and associations of COVID-19 testing in an online sample of transgender and non-binary individuals. *British Medical Journal - Global Health*, *6*, e006808.

Baker KE, Durso LE, Streed CG. (2021). Ensuring that LGBTQI+ People Count: Collecting Data on Sexual Orientation, Gender Identity, and Intersex Status. *New England J Med, 384*, 1184–1186.

Baker KE, Wilson LM, Sharma R, Dukhanin V, McArthur K, Robinson KA. (2021). Hormone Therapy, Mental Health, and Quality of Life among Transgender People: A Systematic Review. *J Endocr Soc, 5*(4), bvab001.

Wiegmann AL, Young EI, **Baker KE**, Khalid SI, Shenaq DS, Dorafshar AH, Schechter LS. (2021). The Affordable Care Act and Its Impact on Plastic and Gender-Affirmation Surgery. *Plastic Reconstr Surg, 147*(1), 135e–153e.

Baker KE, Harris AC. (2020). Terminology should accurately reflect complexities of sexual orientation and identity. *Am J Public Health, 110*(11), 1668–1669.

Lett E, Dowshen NL, **Baker KE**. (2020). Intersectionality and Health Inequities for Gender Minority Blacks in the U.S. *Am J Prev Med*, *59*(5), 639–647.

Wilson LM, **Baker KE**, Sharma R, Dukhanin V, McArthur K, Robinson KA. (2020). Effects of antiandrogens on prolactin levels among transgender women on estrogen therapy: A systematic review. *Int J Transgend Health*, *21*(4), 391–402.

Baker KE. (2019). Findings from the Behavioral Risk Factor Surveillance System on Health-Related Quality of Life among U.S. Transgender Adults, 2014-2017. *JAMA Intern Med, 179*(8), 1141–1144.

Tabaac AR, Sutter ME, Wall CSJ, **Baker KE**. (2018). Gender Identity Disparities in Cancer Screening. *Am J Prev Med, 54*(3), 385–393.

Baker KE. (2017). The Future of Transgender Coverage. *New England J Med, 376*(19), 1801–1804.

Padula WV, **Baker KE**. (2017). Coverage for Gender Affirmation: Making Health Insurance Work for Transgender Americans. *LGBT Health, 4*(4), 244–247.

Cahill S, **Baker KE**, Deutsch MB, Keatley J, Makadon HJ. (2016). Inclusion of Sexual Orientation and Gender Identity in Stage 3 Meaningful Use Guidelines: A Huge Step Forward for LGBT Health. *LGBT Health, 3*(2), 100–102.

Reisner SL, Conron KJ, Scout Nfn, **Baker KE**, et al. (2015). Counting transgender and gender nonconforming adults in health research: Recommendations from the Gender Identity in U.S. Surveillance (GenIUSS) Group. *Transgender Studies Quarterly, 2*(1), 34–57.

Cahill S, Singal R, Grasso C, King D, Mayer K, **Baker KE**, Makadon H. (2014). Do ask, do tell: High levels of acceptability by patients of routine collection of sexual orientation and gender identity data in four diverse American community health centers. *PLoS ONE, 9*(9), e107104.

Baker KE, Minter S, Wertz K. (2012). Nondiscrimination in Insurance: The Case of California's Insurance Gender Nondiscrimination Act. *Harvard University LGBTQ Policy Journal, 2*.

Baker KE. (2012). Where Do We Go from Here: LGBT-Inclusive Health Policy in Affordable Care Act Implementation. *Harvard University LGBTQ Policy Journal,* 2.

Baker KE, Krehely J. (2011). How Health Care Reform Will Help LGBT Elders. *Public Policy & Aging Report, 21*(3), 19–23.

Book Chapters

Baker KE. (2019). The Politics of LGBT Health. In: Schneider JS and V Silenzio, eds. *Gay & Lesbian Medical Association Handbook on LGBT Health*. Washington, DC: ABC-CLIO Press.

Bau I and **Baker KE**. (2016). Legal and Policy Issues in LGBTI Health. In: Ehrenfeld J and K Eckstrand, eds. *Lesbian, Gay, Bisexual, Transgender, and Intersex Healthcare: A Clinical Guide to Preventative, Primary, and Specialist Care*. Nashville: Vanderbilt University Press.

Baker KE. (2011). Data Collection and Use. In: The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide*. Oakbrook Terrace, IL: The Joint Commission. Available at: www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf

Reports, Issue Briefs, Articles, and Editorials

Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. (2022). Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202202c

Frank NF, **Baker KE**. (2019). Anti-LGBT Discrimination Has a Huge Human Toll. Research Proves It. *Washington Post*. Available at: www.washingtonpost.com/outlook/2019/12/19/anti-lgbt-discrimination-has-huge-human-toll-research-proves-it/

What We Know Project. (2019). What Does the Scholarly Research Say About the Effects of Discrimination on the Health of LGBT People? Cornell University Center for the Study of Inequality. Available at: https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-scholarly-research-say-about-the-effects-of-discrimination-on-the-health-of-lgbt-people/

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Baker KE, Keisling MR. (2018). Two Transgender Advocates Explain Why They're Marching for Science. *Scientific American*. Available at: https://blogs.scientificamerican.com/voices/2-transgender-activists-explain-why-theyre-marching-for-science/

Baker KE. (2017). Trans People in the Health Reform Fight: What's at Stake. *TheBody.com*. Available at: www.thebody.com/content/80046/trans-people-in-the-health-reform-fight-whats-at-s.html

Calsyn M, **Baker KE**, Spiro T. (2017). For the Insurance Lobby, Old Habits Are Hard to Break. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/healthcare/news/2017/02/15/415237/for-the-insurance-lobby-old-habits-are-hard-to-break/

Baker KE, Durso LE. (2017). Why Repealing the Affordable Care Act Is Bad Medicine for LGBT Communities. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/news/2017/03/22/428970/repealing-affordable-care-act-bad-medicine-lgbt-communities/

Baker KE, Singh S, Mirza SA, Durso LE. (2017). The Senate Health Care Bill Would Be Devastating for LGBTQ People. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/news/2017/07/06/435452/senate-health-care-bill-devastating-lgbtq-people/

Baker KE. (2016). LGBT Protections in Affordable Care Act Section 1557. *Health Affairs Blog.* Available at: http://healthaffairs.org/blog/2016/06/06/lgbt-protections-in-affordable-care-act-section-1557

Baker KE, McGovern A, Gruberg S, Cray A. (2016). The Medicaid Program and LGBT Communities: Overview and Policy Recommendations. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/report/2016/08/09/142424/the-medicaid-program-and-lgbt-communities-overview-and-policy-recommendations/

Mirza SA, **Baker KE**. (2016). The Impact of the Affordable Care Act on LGBTQ Youth Experiencing Homelessness. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/reports/2016/08/31/143226/the-impact-of-the-affordable-care-act-on-lgbtq-youth-experiencing-homelessness/

Baker KE, Durso LE, Ridings AM. (2016). How to Collect Data about LGBT Communities. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/report/2016/03/15/133223/how-to-collect-data-about-lgbt-communities/

Baker KE, Hughes M. (2016). Sexual Orientation and Gender Identity Data Collection in the Behavioral Risk Factor Surveillance System. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/report/2016/03/29/134182/sexual-orientation-and-gender-identity-data-collection-in-the-behavioral-risk-factor-surveillance-system/

Baker KE. (2015). Open Doors for All: Sexual Orientation and Gender Identity Protections in Health Care. Washington, DC: Center for American Progress. Available at: www.americanprogress.org/issues/lgbt/report/2015/04/30/112169/open-doors-for-all/

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GRANT SUPPORT

DC Center for AIDS Research 2022-2023
Developing Best Practices for Integrating HIV Prevention into Gender-Affirming Care for Transgender Adults
Amount: $49,961
Role: Principal Investigator

Wellspring Advisors 2015-2017
Conducting nationwide outreach and enrollment activities through the Out2Enroll campaign
Amount: $200,000
Role: Project Co-Director

Robert Wood Johnson Foundation 2015-2016
Conducting nationwide outreach and enrollment activities through the Out2Enroll campaign
Amount: $199,472
Role: Project Co-Director

Robert Wood Johnson Foundation 2014-2015
Building the Out2Enroll online enrollment assistance tool
Amount: $148,800
Role: Project Co-Director

Wellspring Advisors 2014-2015
Conducting nationwide outreach and enrollment activities through the Out2Enroll campaign
Amount: $100,000
Role: Project Co-Director

Arcus Foundation 2014-2015
Conducting nationwide outreach and enrollment activities through the Out2Enroll campaign
Amount: $100,000
Role: Project Co-Director

Robert Wood Johnson Foundation 2014-2015
Establishing the "Do Ask, Do Tell" project
Amount: $84,000
Role: Co-Principal Investigator

Wellspring Advisors 2013-2016
Impact of the Affordable Care Act on LGBT Communities
Amount: $600,000
Role: Co-Principal Investigator

Palette Fund 2013-2014
Launching the Out2Enroll campaign
Amount: $10,000
Role: Project Co-Director

Nathan Cummings Foundation 2013-2014
Launching the Out2Enroll campaign
Amount: $10,000
Role: Project Co-Director

Open Society Foundations 2013-2014
Transgender Medical Policy Reform in Russia and the Former Soviet Union
Amount: $88,000
Role: Co-Principal Investigator

Elliott School of International Affairs 2010
Investigating sexual- and gender-based violence in conflict situations
Amount: $10,000
Role: Co-Principal Investigator

TEACHING

Classes Taught

Issues in LGBTQ Health Policy Fall 2021, Fall 2022
Johns Hopkins School of Public Health (Baltimore, MD)

Policy, Politics, and Power in Health Equity Fall 2019, Spring 2020
Johns Hopkins University (Baltimore, MD)
Upper-division undergraduate seminar designed and taught through the Gordis Teaching Fellowship

Guest Lectures

Sexuality, Gender Identity, & The Law 02/2022
American University Washington College of Law (Washington, DC)

Epidemiology of LGBTQIA Health 02/2022
George Washington University (Washington, DC)

O'Neill Institute for National and Global Health Law Colloquium 11/2021
Georgetown Law Center (Washington, DC)

Health Equity Policy 10/2021
Georgetown University (Washington, DC)

Social Epidemiology 10/2021
Temple University College of Public Health (Philadelphia, PA)

Advanced Topics in Health Promotion and Behavioral Sciences 04/2021
University of Louisville (Louisville, KY)

LGBT Health Law and Policy 03/2021
Georgetown Law School (Washington, DC)

Health Policy and Advocacy 02/2021
SUNY Upstate Medical College (Syracuse, NY)

Issues in LGBTQ Health Policy 12/2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Epidemiology of LGBT Health 11/2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Issues in LGBTQ Health Policy 11/2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

LGBTQ Politics and Policy 10/2020
American University (Washington, DC)

Research Ethics and Integrity 03/2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

LGBT Health Policy 03/2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

LGBT Health Law and Policy 02/2020
Georgetown Law School (Washington, DC)

LGBT Health Policy 02/2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Epidemiology of LGBT Health 12/2019
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Economic Evaluation II 12/2018
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Epidemiology of LGBT Health 12/2018
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Public Health Policy 11/2018
SUNY Upstate Medical College (Syracuse, NY)

LGBTQI Health: Research, Policies, and Best Practices 05/2018
Mt. Sinai Icahn School of Medicine (New York, NY)

Epidemiology of LGBT Health 12/2017
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

LGBTQ Issues in Public Policy 11/2017
New York University Wagner School of Public Service (New York, NY)

Health Policy and Public Health 10/2017
Baldwin Wallace University (Berea, OH)

LGBT Health Law and Policy 09/2017
Georgetown Law School (Washington, DC)

Epidemiology of LGBT Health 12/2016
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

LGBT Health Policy and Practice Graduate Certificate Program 01/2016
George Washington University (Washington, DC)

Epidemiology of LGBT Health 12/2015
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

LGBT Health Policy and Practice Graduate Certificate Program 01/2015
George Washington University (Washington, DC)

Health Policy and Public Health 10/2014
Baldwin Wallace University (Berea, OH)

Teaching Assistant Positions

Teaching Assistant, Department of Health Policy and Management 2017-2020
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

- Economic Evaluation I and II
- Health Economics for Managers

- Fundamentals of Health Policy and Management
- Introduction to Bioethics in Public Health Practice and Research
- Research Ethics and Integrity: U.S. and International Issues
- Science of Patient Safety
- The Political Economy of Social Inequalities and Its Consequences for Health and Quality of Life

MPH Capstone Teaching Assistant 2019
Johns Hopkins Bloomberg School of Public Health (Baltimore, MD)

Teaching Assistant, Pfizer Executive Program in Economic Evaluation 2018
University of Chicago (New York, NY)

Trainings

"Reaching and Assisting LGBT Communities" – in-person and online training developed for Out2Enroll and presented to Health Insurance Marketplace Navigators and other enrollment assisters

Arkansans for Coverage	12/2015
Alaska Primary Care Association	11/2015
Cognosante, Cleveland, OH	11/2015
Cognosante, Miami, FL	11/2015
Cognosante, Philadelphia, PA	11/2015
Enroll Virginia Coalition	11/2015
Council on Aging of Buncombe County, Asheville, NC	11/2015
Navigators for a Healthy Louisiana, Shreveport, LA	10/2015
Navigators for a Healthy Louisiana, Baton Rouge, LA	10/2015
Navigators for a Healthy Louisiana, New Orleans, LA	10/2015
Covered California University, Sacramento, CA	09/2015
HealthCare.gov	09/2015
Nebraska Primary Care Association	08/2015
Michigan Primary Care Association	08/2015
Florida Association of Community Health Centers	07/2015
Get Covered Arkansas Coalition, Little Rock, AR	06/2015
Kentuckiana Regional Planning and Development Agency, Louisville, KY	05/2015
Kentucky Primary Care Association, Hazard, KY	05/2015
Cognosante, Cleveland, OH	01/2015
Cognosante, Philadelphia, PA	01/2015
Utah Health Policy Project, Salt Lake City, UT	12/2014
Cognosante, New Orleans, LA	12/2014
Cognosante, Miami, FL	11/2014
Planned Parenthood Federation of America	10/2014
United Way Worldwide	10/2014
Nebraska Primary Care Association	07/2014
HealthCare.gov	07/2014

"Opening the Door: Assisting LGBT People"

U.S. Department of Health and Human Services Office for Civil Rights Region IV Office, Atlanta, GA	10/2015
U.S. Department of Health and Human Services Office for Civil Rights Region II Office, New York, NY	10/2015

U.S. Department of Health and Human Services Office for Civil Rights Region VIII Office, Denver, CO 10/2015
U.S. Department of Health and Human Services Office for Civil Rights Region IX Office, San Francisco, CA 09/2015
U.S. Department of Health and Human Services Office for Civil Rights Region III Office, Philadelphia, PA 08/2015
U.S. Department of Health and Human Services Office for Civil Rights Region I Office, Boston, MA 06/2015
U.S. Department of Health and Human Services Office for Civil Rights Region VI Office, Dallas, TX 05/2015

PRESENTATIONS

Oral Abstracts and Issue Panels

Baker, KE, Segal J. Clinically Documented Social Risk Factors and Mental and Behavioral Health Diagnoses in a Commercially Insured Transgender Population. American Public Health Association Conference (online) 10/2021

Wolfson D, **Baker KE**, Platt J, Fields C, Ramiah K. Rebuilding Trust in Health Care: What We Know and What We Need to Know. AcademyHealth Annual Research Meeting (online) 06/2021

Baker KE, Badgett MVL, Gates G, Patterson C, Russell S, Umberson D, White J. The Health of LGBTQI+ Populations: Findings from a New National Academy of Sciences Report. Population Association of America Annual Meeting (online) 05/2021

Baker KE, Russell S. The Health of LGBTQI+ Populations: Findings from a New National Academy of Sciences Report. American Educational Research Association Annual Meeting (online) 04/2021

Terndrup CP, Siegel J, Streed C, Ufomata E, **Baker KE**. Transforming General Internal Medicine for Improved LGBTQ Healthcare: Strategies from the Bedside to the Legislature. Society for General Internal Medicine Annual Meeting (online) 04/2021

Hedian H, Terndrup CP, Siegel J, McNamara M, **Baker KE**. Teaching about Transgender Health: How to Navigate Challenging Small Group Discussions. Society for General Internal Medicine Meeting (online) 04/2021

Baker KE, Reisner SL, Dalke K, Harris AC. The Health of LGBTQI+ Populations: Findings from a New National Academy of Sciences Report. National Health Policy Conference (online) 02/2021

Badgett MVL, Flores AR, Dibner K, **Baker KE**. Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report. Association for Public Policy Analysis and Management Conference (online) 11/2020

Baker KE, Russell S, Reisner SL, Dalke K, Harris AC. Violence and the Well-Being of LGBTQI+ People: A Role for Public Health. American Public Health Association Conference (online) 10/2020

Baker KE. Leveraging the Behavioral Risk Factor Surveillance System for Transgender Health Research. American Public Health Association Conference, Philadelphia, PA 11/2019

Baker KE. Cracking the Code: Using Machine Learning to Identify Transgender People in Medical Claims Data. American Public Health Association Conference, Philadelphia, PA 11/2019

Pardo S, **Baker KE**, Wilkinson W. Advancing Sexual Orientation and Gender Identity Cultural Humility in Public Health Care: Policy, Research, and Practice Strategies. National Trans Health Summit, Oakland, CA 04/2019

Gorton N, **Baker KE**, Tescher J, Jaffe JM. Transgender Health Insurance Reform. World Professional Association for Transgender Health Inaugural USPATH Scientific Conference, Los Angeles, CA 01/2017

Baker KE, Cahill SR. Sexual Orientation and Gender Identity Data in EHRs. Critical Conversation, America's Essential Hospitals VITAL 2016 Conference, Boston, MA 06/2016

Baker KE. Role of Public Health Policy in Gender Affirmation and Health Equity for Trans/Gender-Variant People in the U.S. American Public Health Association Conference, Chicago, IL 11/2015

Baker KE. Do Ask, Do Tell: Collecting and Using LGBT Data. AcademyHealth Annual Research Meeting, San Diego, CA 04/2014

Allensworth-Davies D, Badgett MVL, **Baker KE**, Bean-Mayberry B, Bowleg L, Mattocks K. The Role of Health Services Research and Policy in Addressing the Health and Health Care Needs of LGBT Individuals. AcademyHealth Annual Research Meeting, Baltimore, MD 06/2013

Cain VS, Miller KS, **Baker KE**, Pearlman AJ. Understanding LGBT Health: Overview, Methodological Challenges, and Policy Implications. National Conference on Health Statistics, Washington, DC — 08/2012

Baker KE. Not Waving, But Drowning? Barriers and Challenges in Access to Sexual Health Services for MSM. Centers for Disease Control and Prevention National STD Conference, Minneapolis, MN — 03/2012

Baker KE. LGBT Health as a Tool for Social Justice. American Public Health Association Conference, Denver, CO — 11/2010

Poster Abstracts

Hindorff L, Madden E, Jackson A, Akintobi T, **Baker KE**, et al. (2022). Advancing Health Equity in Genomics: Reflections and Recommendations for Future Research Directions from an NHGRI Workshop. American Society of Human Genetics, Los Angeles, CA — 10/2022

Baker KE, Segal J. Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population. AcademyHealth Annual Research Meeting (online) — 06/2021

Kasaie P, Weir B, Dowdy D, **Baker KE**, Holmes L, Labossiere S, Beyrer C. Mobile Multi-Disease Screening at Scale: Modelling the Effects in Kenya, Nigeria, and India. 22nd International AIDS Conference, Amsterdam, Netherlands — 07/2018

Baker KE, Chidambaram P, Colrick I, Padula WV. Implications of Health Insurance Coverage for Care Related to Gender Transition for Transgender Adolescents. Society for Medical Decision Making Annual Meeting, Pittsburgh, PA — 10/2017

Fox RF, **Baker KE**. LGBT Inclusion in Health Care Reform. American Public Health Association Conference, Philadelphia, PA — 11/2009

Interviews and Recordings

"Dr. Kellan Baker and Health Equity for the LGBTQ+ Community," Inside Health Care #79, National Committee on Quality Assurance. Available at: https://www.ncqa.org/blog/inside-health-care-79-dr-kellan-baker-health-equity-for-the-lgbt-community/ — 05/2022

"Patient Story: Kellan Baker," American Board of Internal Medicine Foundation Forum. Available at: https://abimfoundation.org/video/patient-story-kellan-baker — 10/2021

"Core to Who I Am," *Tradeoffs* Podcast, University of Pennsylvania. Available at: https://tradeoffs.org/2020/07/14/core-to-who-i-am/ — 07/2020

"A Conversation with Kellan Baker," Health Policy Research Scholars. Available at: www.youtube.com/watch?v=trLC992Q7bc — 09/2019

"Meet the Scholars: Kellan Baker," Health Policy Research Scholars. Available at: https://healthpolicyresearch-scholars.org/meet-the-scholars-kellan-baker/ — 06/2019

"Transgender Health Care Access and Policy," HealthLink on Air, SUNY Upstate Medical University. Available at: www.upstate.edu/hloa/2018/1127-transgender-people-face-health-care-challenges-of-both-access-and-policy.php — 11/2018

"The Future of Transgender Coverage," *New England Journal of Medicine*. Available at: https://www.nejm.org/doi/full/10.1056/NEJMp1702427 — 05/2017

National March for Science Speech, Washington, DC. Available at: https://www.youtube.com/watch?v=Qin3q4dp7DQ — 04/2017

"A New Era of Inclusion: How to Address LGBT and HIV/AIDS Issues in Health Reform Implementation," Center for American Progress. Available at: www.c-span.org/video/?311574-1/lgbt-health-advocates-examine-afforable-care-act — 03/2013

"Queery: Kellan Baker." *Washington Blade*. Available at: www.washingtonblade.com/2010/05/20/queery-kellan-baker/ — 05/2010

Testimony

Hearing on Trans Health Equity Act of 2022 (House Bill 746), Public Health and Minority Health Disparities Subcommittee, Health and Government Operations Committee, Maryland General Assembly	03/2022
Hearing on Trans Health Equity Act of 2022 (House Bill 746), Health and Government Operations Committee, Maryland General Assembly	03/2022
Hearing on Trans Health Equity Act of 2022 (Senate Bill 682), Senate Finance Committee, Maryland State Senate	03/2022
DC Health Benefit Exchange Authority Performance Oversight Hearing, Committee on Health and Human Services, Council of the District of Columbia	02/2016

Invited Lectures, Presentations, Keynotes, and Plenaries

Public Health and Health Systems Policy for Federal Policymakers

"Addressing Structural Factors Needed to Support Health Equity Research," Future Directions in Genomics and Health Equity Research Workshop, National Human Genome Research Institute (online)	03/2022
"Collecting Sex, Gender Identity, and Sexual Orientation Data: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," White House Office of Personnel Management (online)	03/2022
"Sexual and Gender Minority Health: Evidence and Recommendations," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (online)	06/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," U.S. Department of Justice (online)	06/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," Civil Rights Division, U.S. Department of Justice (online)	06/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," National Institutes of Health Bioethics Interest Group (online)	02/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," National Institutes of Health Committee on Sexual and Gender Minority Research (online)	12/2020
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," Federal Committee on Statistical Methodology (online)	12/2020
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," U.S. Department of Health and Human Services LGBT Coordinating Committee (online)	11/2020
"Access to Care for the LGBT Community," Centers for Disease Control and Prevention National STD Conference (online)	09/2020
"LGBT Populations in Cancer Clinical Trials," U.S. Food and Drug Administration (online)	06/2020
"LGBT Issues in Public Health and Genomics," National Human Genome Research Institute (online)	06/2020
Health Equity and Accountability Act Congressional Briefing, Washington, DC	04/2018
"LGBT Communities in Genomics Research and Outreach," National Institutes of Health, Bethesda, MD	03/2018
"LGBT Federal Health Policy," White House LGBT Summit, Dearborn, MI	04/2016
"Two-Spirit and Native LGBT Communities," Indian Health Service (online)	12/2015
"Enrollment Resources for LGBTQ Youth," Centers for Medicare & Medicaid Services (online)	12/2015
"Transgender Issues in Federal Policy," Health Resources and Services Administration Special Projects of National Significance Meeting, Washington, DC	10/2015
"LGBT Data Collection," White House LGBT Summit, St. Louis, MO	10/2015
"New Frontiers in Health Disparities: Medicare and Medicaid in a Post-*Heckler* World," Centers for Medicare & Medicaid Services Health Equity Conference, Baltimore, MD	09/2015

"LGBT Outreach and Enrollment under the Affordable Care Act," The White House, Washington, DC	07/2014
Health Equity and Accountability Act Congressional Briefing, Washington, DC	07/2014
"The ACA and LGBT Individuals: Delivering Culturally Competent Quality Care in Clinical Settings," Health Resources and Services Administration, Washington, DC	05/2014
"The Out2Enroll Initiative and LGBT Priorities in Health Reform," The White House, Washington, DC	09/2013
"What Health Reform Means for LGBT Communities," U.S. Government Accountability Office, Washington, DC	06/2013
"Policy Approaches for Addressing Transgender Health Disparities," Presidential Advisory Council on HIV/AIDS, Washington, DC	02/2013
"LGBT Health Policy," White House Summit on LGBT Health, Philadelphia, PA	02/2012
"Sexual Orientation and Gender Identity Data Collection in the Youth Risk Behavior Surveillance System," Federal LGBT Youth Summit, Washington, DC	06/2011
"If You Don't Count Us, We Don't Count: Using Data for Advocacy," Federal LGBT Youth Summit, Washington, DC	06/2011

Health Disparities Research and Policy

Measuring Sex, Gender Identity, and Sexual Orientation," Sexual and Gender Minority Interest Group, National Cancer Institute Cohort Consortium (online)	03/2022
"Measuring Sex, Gender Identity, and Sexual Orientation," Sexual and Gender Minority Task Force, American Society of Clinical Oncology (online)	03/2022
"Health Policy for Transgender and Gender-Diverse Youth," Policy & Issues Forum, National Association of Community Health Centers (online)	02/2022
"End Stigma, End HIV: World AIDS Day 2021," Smithsonian Natural History Museum (online)	12/2021
"The State of Trans Men and Transmasculine Community," Brothers Obtaining and Navigating Dynamic Solidarity (online)	11/2021
"The Impact of COVID-19 on Trans Men and Transmasculine Communities," Brothers Obtaining and Navigating Dynamic Solidarity (online)	11/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," American Medical Association LGBTQ Committee (online)	11/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," American Medical Association LGBTQ and Allies Caucus	11/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," University of Minnesota Ethics Grand Rounds (online)	10/2021
Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," LGBTQIA Health Conference (online)	10/2021
"The Health of Sexual and Gender Diverse Populations: Addressing Inequities at the Intersections," National Academies of Sciences, Engineering, and Medicine (online)	07/2021
"LGBTQI+ Communities in the COVID-19 Pandemic," National Academies of Sciences, Engineering, and Medicine (online)	06/2021
"Advancing the Well-Being of LGBTQI+ Populations," Hauser Policy Fund Webinar Series, National Academies of Sciences, Engineering, and Medicine (online)	06/2021
"Understanding the Well-Being of LGBTQI+ Populations: Findings from a New National Academies of Sciences, Engineering, and Medicine Report," American Educational Research Association Presidential Session (online)	04/2021
"2021 Opportunities for Strengthening HIV Programs and Improving Health Equity," O'Neill Institute at Georgetown School of Law (online)	02/2021
"LGBT Health Research and Policy," LGBT Litigators Roundtable (online)	12/2020
"Cancer in LGBT Populations: Differences, Disparities, and Strategies for Change," American Association for Cancer Research Conference (online)	10/2020

"Transgender Patient Narratives," American Board of Internal Medicine Foundation Forum (online)	08/2020
"Influencing LGBT Health Policy," Columbia University Program for the Study of LGBT Health (online)	07/2020
"Challenges and Barriers in Closing the Evidence Gap for Underrepresented and Vulnerable Populations in Clinical Research," Conquer Cancer Council Meeting, Alexandria, VA	12/2019
"Public Health Issues Before the U.S. Supreme Court: LGBT Rights, Reproductive Rights, and Firearms," Johns Hopkins School of Public Health, Baltimore, MD	11/2019
"How Patients' Identities Impact Trust," National Patient Advocate Foundation Policy Consortium, Washington, DC	11/2019
"Federal LGBTQ Health Policy in the Trump Administration," US Professional Association for Transgender Health, Washington, DC	09/2019
"Barriers and Solutions to Access to Genomic Medicine: Realizing the Benefits of Genomic Medicine for All," National Patient Advocate Foundation Policy Consortium, Washington, DC	05/2019
"Challenges and Opportunities in Trans Health Policy," SUNY Upstate Medical College, Syracuse, NY	11/2018
"Challenges and Opportunities in Advancing Federal LGBTQ Health Policy in the Trump Administration," GLMA: Health Professionals Advancing LGBT Equality Conference, Las Vegas, NV	10/2018
"Together Ahead: Accelerating Progress to End HIV," US Conference on AIDS, Orlando, FL	09/2018
"Research Ethics and Policy Intersections," National Transgender Health Summit, Oakland, CA	11/2017
"SOGI Data Collection," National Transgender Health Summit, Oakland, CA	11/2017
"United States of Trans Health Policy," National Transgender Health Summit, Oakland, CA	11/2017
"Ethical Issues in the Care of LGBTQ Youth and Families," American Academy of Pediatrics National Conference, Chicago, IL	10/2017
"Rollback of Protections Impacting the Quality of Hospice and Palliative Care for LGBTQ Patients and Families," GLMA: Health Professionals Advancing LGBT Equality Conference, Philadelphia, PA	10/2017
"The Assault on Federal LGBT Health Policy in the Trump Administration," GLMA: Health Professionals Advancing LGBT Equality Conference, Philadelphia, PA	10/2017
"Sexual Orientation and Gender Identity Data Collection," National Alliance of State and Territorial AIDS Directors National Prevention and Care Technical Assistance Meeting, Arlington, VA	07/2017
"Health Privacy in the LGBTQIA Community, Electronic Health Records Systems and Sensitive Data," Health Privacy Summit, Washington, DC	06/2017
"LGBTQ Health Policy Update," Health Action, Washington, DC	02/2017
"Transgender Health Policy and Research Ethics," World Professional Association for Transgender Health Inaugural USPATH Scientific Conference, Los Angeles, CA	01/2017
"Deep Dive: What the Affordable Care Act Means for LGBT People," The Fenway Institute (online)	07/2016
"LGBT Outreach and Enrollment: New Developments," Cognosante National Training, Phoenix, AZ	07/2016
"LGBT Health under the Affordable Care Act," Equality Federation Leadership Conference, Portland, OR	07/2016
"Times of Change: The Latest Dynamics in LGBT Outreach, Enrollment, and Coverage," Enroll America National Conference, Washington, DC	05/2016
"Beyond HIV/AIDS: Reporting on the LGBT Community," American Health Journalists Association Conference, Cleveland, OH	04/2016
"SOGI Data Collection and LGBT Health," National Association of State and Territorial AIDS Directions Midwestern Regional Meeting, Detroit, MI	04/2016
"Cultural Competency and the ACA: Maximizing Outreach," American Federation of Teachers Professional Issues Conference, Washington, DC	04/2016
"LGBT Health Policy: Current Landscape and Latest News," The Fenway Institute (online)	03/2016
"Cutting Edge Issues in LGBT Health Research and Policy," Johns Hopkins Bloomberg School of Public Health LGBT Public Health Research Day, Baltimore, MD	03/2016

"Affirmatively Transgender: The Role of Law and Policy," O'Neill Institute Colloquium at Georgetown Law School, Washington, DC	09/2015
"Transgender Health Insurance Policy," Stanley Biber Memorial Lecture, GLMA: Health Professionals Advancing LGBT Equality Conference, Portland, OR	09/2015
"Transgender Health Insurance Coverage," Pride at Work Conference, Orlando, FL	08/2015
"Effective LGBT Outreach," Cognosante National Training, Baltimore, MD	07/2015
"Culturally Competent Outreach and Enrollment Assistance," Enroll America State of Enrollment Conference, Washington, DC	06/2015
"What LGBT Communities Need to Know about the Affordable Care Act," Equal Care for Equal Lives LGBT Health Summit, Little Rock, AR	06/2015
"LGBT Outreach and Enrollment," Southern Health Partners Meeting, Atlanta, GA	06/2015
"Healthcare Hallelujah: Trans Health and the ACA," Black Trans Advocacy Conference, Dallas, TX	05/2015
"Transgender Health Issues," Rutgers University Law School, Newark, NJ	04/2015
"Data Collection to Advance Transgender Health," National Transgender Health Summit, Oakland, CA	04/2015
"Winning Access to Trans Health Coverage and Care," National Transgender Health Summit, Oakland, CA	04/2015
"The ACA and LGBT Communities," EverThrive Illinois	03/2015
"Using Data to Advance Public Policy," Creating Change Conference, Denver, CO	02/2015
"Top Issues in LGBT Health Policy," Harvard School of Public Health LGBTQ Conference, Boston, MA	02/2015
"LGBT Health Disparities," Thomson Reuters, New York, NY	01/2015
"Update on LGBTQ People of Color: Focus on Transgender Health," Health Action, Washington, DC	01/2015
"LGBT Enrollment Challenges," Get Covered Illinois LGBT Marketing Campaign Launch, Chicago, IL	01/2015
"LGBT Health: Challenges and Opportunities," Diversity, Inc. Healthcare Event, New York, NY	10/2014
"LGBT People in Health System Transformation," Consumer Voices for Coverage, Philadelphia, PA	09/2014
"LGBTI Health Policy," LGBTI Health Research Conference, Cleveland, OH	08/2014
"LGBT Health Disparities and ACA Enrollment," Cognosante National Meeting, Baltimore, MD	07/2014
"Do Ask, Do Tell: LGBT Data Collection in Electronic Health Records," The Center for LGBTQ Studies at the City University of New York Graduate Center, New York, NY	06/2014
"Understanding LGBT Health," University of Pennsylvania, Philadelphia, PA	04/2014
"Introduction to Transgender Healthcare," Medical College of Wisconsin, Milwaukee, WI	04/2014
"The Affordable Care Act: Implications for Trans Consumers," FORGE, Inc., Milwaukee, WI	04/2014
"Access to Health Care," Civil Liberties and Public Policy Conference, Amherst, MA	04/2014
"Reaching and Assisting LGBT Communities," Rutgers School of Nursing, Newark, NJ	03/2014
"Connecting with Coverage: LGBT Communities and the ACA," Pennsylvania Health Access Network	03/2014
"The Affordable Care Act and the LGBT Community," Oklahoma Equality, Tulsa, OK	03/2014
"The Affordable Care Act and the LGBT Community," The Dallas Resource Center, Dallas, TX	03/2014
"Connecting with Coverage: LGBT Communities and the ACA," Black AIDS Institute (online)	03/2014
"LGBT Federal Health Policy," National Summit on Cancer in the LGBT Communities, Memorial Sloane Kettering Cancer Center, New York, NY	01/2014
"LGBT Health Policy and Advocacy," Creating Change Conference, Houston, TX	01/2014
"Enrollment 2.0: Effective Strategies for Specific Populations," Health Action, Washington, DC	01/2014
"Implementing the Affordable Care Act," International Gay & Lesbian Leadership Conference, Denver, CO	12/2013
"Out2Enroll: The Affordable Care Act and the LGBT Community," The Johns Hopkins Center for Health Disparities Solutions (online)	11/2013
"The LGBT Community and the Affordable Care Act," Marquette University, Milwaukee, WI	11/2013

"Connecting with Coverage: LGBT Communities and the ACA," AIDS Resource Center of Wisconsin, Milwaukee, WI	11/2013
"Connecting LGBT Communities to Benefits under the ACA," Children's Hospital Los Angeles (online)	10/2013
"Nondiscrimination under the Affordable Care Act," Consumer Voices for Coverage, Philadelphia, PA	10/2013
"Outreach, Engagement and Enrollment into ACA Coverage," U.S. Conference on AIDS, New Orleans, LA	09/2013
"LGBT Community Benefits from the ACA," Q Health Initiative Conference, Salt Lake City, UT	09/2013
"Leading on Meaningful Use: Next Steps in SO/GI Data Policy," Gay & Lesbian Medical Association Conference, Denver, CO	09/2013
"Enrollment for LGBT Communities," Gay & Lesbian Medical Association Conference, Denver, CO	09/2013
"The Promise of Reform: How Obamacare Affects LGBT Communities," Federal AIDS Policy Partnership, Washington, DC	08/2013
"Optimizing LGBT Health under the ACA," National LGBT Health Education Center (online)	08/2013
"Building a Healthy and Inclusive Society," Young Elected Officials National Convening, Washington, DC	07/2013
"Transgender Health Issues in Health Care Reform," National Transgender Health Summit, Oakland, CA	04/2013
"Transgender Diagnoses in ICD-11," Global Action for Transgender Equality Strategy Meeting, Buenos Aires, Argentina	04/2013
"Organizing LGBT Communities around the ACA," Fair Wisconsin Leadership Conference, Milwaukee, WI	02/2013
"The Affordable Care Act and LGBT Consumers," Michigan Consumers for Healthcare and Equality Michigan, Kalamazoo, MI	02/2013
"LGBT Legal and Policy Issues in the Affordable Care Act," Eastern Michigan University, Ypsilanti, MI	02/2013
"LGBT Legal and Policy Issues in the Affordable Care Act," University of Michigan, Ann Arbor, MI	02/2013
"LGBT Community Health Center Advocacy and Policy," Gay & Lesbian Medical Association Conference, San Francisco, CA	09/2012
"LGBT Health in Health Care Reform," Gay & Lesbian Medical Association Conference, San Francisco, CA	09/2012
"Closing the LGBT Health Disparities Gap through Electronic Health Records," Gay & Lesbian Medical Association Conference, San Francisco, CA	09/2012
"The LGBT State Exchanges Project: Building Community and Advocacy Tools for LGBT Health," Equality Federation Summer Institute, Portland, ME	08/2012
"Transgender Health," Johns Hopkins School of Nursing, Baltimore, MD	04/2012
"LGBT Health Disparities," National Health Law Program Health Advocates Conference, Washington, DC	12/2011
"The Picture of Health: How Statistics Will Change LGBT Health Care," International Gay & Lesbian Leadership Conference, Houston, TX	12/2011
"International Transgender Health," World Professional Association for Transgender Health Conference, Atlanta, GA	11/2011
"No Data, Big Problem: LGBT Health Equity at Kaiser Permanente," Kaiser Permanente Diversity Conference, San Francisco, CA	10/2011
"2011 Federal LGBT Health Initiatives," Gay & Lesbian Medical Association Conference, Atlanta, GA	09/2011
"Transgender Health Policy Advocacy," National Transgender Health Summit, San Francisco, CA	04/2011
"Advancing LGBT Health through Health Care Reform Implementation," Gay & Lesbian Medical Association Conference, San Diego, CA	10/2010
"Health as a Social Justice Issue," Creating Change Conference, Dallas, TX	02/2010
"LGBT Federal Youth Policy," Creating Change Conference, Dallas, TX	02/2010
"Transgender Issues in Russia," Transgender Europe Conference, Berlin, Germany	05/2008

Philanthropy

"Protections and Barriers in Access to Care," AIDS Philanthropy Summit, Washington, DC	12/2016

"LGBT Health Policy Opportunities," OutGiving Funders Meeting, Dallas, TX 05/2015

"Expanding Coverage and Access," LGBT Health Funding Summit, New York, NY 01/2015

"International Transgender Health Priorities," Advancing Transgender Movements Worldwide Funders Conference, Berlin, Germany 12/2013

"LGBT Health Reform Priorities," Health Care for All New York and the New York State Health Foundation, New York, NY 06/2013

"The Promise of Reform: How Obamacare Affects LGBTQ Communities," LGBTQ Grantmakers Retreat, Albuquerque, NM 03/2013

"Transforming Health: International Rights Based Advocacy for Trans Health," Open Society Foundations, New York, NY 02/2013

"LGBT Health Issues in U.S. Health Reform," Rockefeller Foundation, Bellagio, Italy 05/2012

Education and Career Development

"Health Science Policy," Health Science Communications and Policy Workshop, Office of Intramural Training and Education, National Institutes of Health (online) 03/2022

"Living Intersectionality in Academia: Emerging Scholars," Davis Center for Russian and Eurasian Studies, Harvard University (online) 01/2022

Postbac Career Exploration Series: Careers in Public Health, Office of Intramural Training and Education, National Institutes of Health (online) 10/2021

"LGBTQI+ Health Disparities: Research, Interventions, and Policy," Amgen Scholars Health Disparities Seminar, National Institutes of Health (online) 06/2021

Professional Advisory Panel on Sexual and Gender Minority Health in Medical Education, Harvard Medical School (online) 05/2021

"Innovations in Cancer Disparities Research," San Diego State University (online) 04/2021

Russian Tea, Swarthmore College (online) 04/2021

Summer Social Justice Institute, Swarthmore and Haverford Colleges, Swarthmore, PA 08/2018

"Science Outside the Lab: Science and Technology Policy Careers," Arizona State University Honors College, Washington, DC 06/2018

"Gay for Pay: Swarthmore Alumni in Queer Careers," Swarthmore College, Swarthmore, PA 03/2017

"Science Outside the Lab: Science and Technology Policy Careers," Arizona State University Honors College, Washington, DC 05/2016

VOLUNTEER ACTIVITIES

Co-Founder 2008-present
FtM Phoenix (Moscow, Russia)
FtM Phoenix (https://www.transsovetnik.com) advocates for the health and human rights of transgender people in Russia and Eurasia. In 2013-2014, we hosted the 1st and 2nd Eurasian Trans Health Conferences in Moscow, which brought together health care providers, advocates, and government officials from 8 countries in the former Soviet Union.

HIV/AIDS Peer Support Program Developer 2008-2009
Whitman-Walker Health (Washington, DC)

Community Clinics Campaign Coordinator 2006
FTM Alliance of Los Angeles (Los Angeles, CA)

Recreational Therapist 2005
Baskakov Center for Children with Special Needs (Moscow, Russia)

English–Russian Translator and Program Assistant 2004-2005
Special Olympics Russia (Moscow, Russia)

Certified Coach and Unified Team Player (basketball, bocce, long-distance running) 1997-2004
Special Olympics USA (Thousand Oaks, CA and Philadelphia, PA)

SKILLS AND PROFICIENCIES

Software/Programs: R, SQL, Stata, DbVisualizer, Mplus, TreeAge, heRo3, DistillerSR, AHRQ Systematic Data Review Repository, Covidence, ArcGIS, WordPress, Quickbooks, Microsoft Office
Languages: Russian (fluent), German (working proficiency), French (working proficiency), Spanish (basic proficiency)

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

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

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

I, Dan H. Karasic, 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 am over the age of 18. 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. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae ("CV"). A true and correct copy of my CV is attached as **Exhibit A**.

Pl. Trial Ex. 007

4. I am a Professor Emeritus of Psychiatry at the University of California – San Francisco (UCSF) Weill Institute for Neurosciences. I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

5. 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 (UCLA) Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a training program in mental health services for persons living with AIDS at UCLA.

6. For over 30 years, I have worked with patients with gender dysphoria. I am a Distinguished Life Fellow of the American Psychiatric Association and currently 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.

7. 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. The clinic treats trans youth 12-25 years old.

8. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of WPATH's *Standards of Care for the Health of Transsexual, Transgender, and Gender*

Nonconforming People, Versions 7 and 8, which are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. For the Version 8, I was the lead author on the Mental Health chapter.

9. 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 care providers.

10. 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.

11. I have also worked with the San Francisco Department of Public Health, having helped develop and implement their program 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.

12. 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 am currently a consultant for the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people.

13. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive other medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*, I am and must be familiar with additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

14. 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*.

15. Since 2018, I have performed over 100 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

B. Compensation

16. 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.

C. Previous Testimony

17. Over the past four years, I have given expert testimony at trial or by deposition in the following cases: *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); *Fain v. Crouch*, 3:20-cv-00740 (S.D.W. Va.); and *Brandt v. Rutledge*, No. 4:21-cv-00450 (E.D. Ark.). To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

II. BASES FOR OPINIONS

18. In preparing this report, 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, as documented in my curriculum vitae, which is attached hereto as **Exhibit A**.

19. I have also reviewed the materials listed in the bibliography attached hereto as **Exhibit B**. 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.

20. Additionally, I have reviewed Florida's Administrative Rule governing the determination of generally accepted professional medical standards under Florida Medicaid coverage (Fla. Admin. Code R. 59G-1.035); the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022, along with its attachments, including the reports of Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch (Attachment C), Dr. James Cantor (Attachment D), Dr. Quentin Van Meter (Attachment E), Dr. Patrick Lappert (Attachment F), and Dr. G. Kevin Donovan (Attachment G) (hereinafter, "GAPMS Memo"); and Fla. Admin. Code. R. 59G-1.050(7) which prohibits Medicaid coverage of puberty-delaying medications (commonly referred

to as "puberty blockers"), hormone and hormone antagonists, "sex reassignment" surgeries, and any other procedures that alter primary or secondary sexual characteristics, on the basis that the services do not meet Florida's definition of "medical necessity" for purposes of its Medicaid program.

21. The materials I have relied upon in preparing this report 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.

III. EXPERT OPINIONS

A. Gender Identity

22. Sex assigned at birth refers to the sex assigned to a person at the time of their birth, typically based on the appearance of external genital characteristics. While the terms "male sex" and "female sex" are sometimes used in reference to a person's genitals, chromosomes, and hormones, 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 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).

23. Gender identity is "a person's deeply felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; or an alternative gender" (American Psychological Association, 2015, at 834). Gender identity does not always align with 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., 2022).

B. Gender Dysphoria

24. 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.

25. The diagnosis of Gender Dysphoria in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) (DSM-5 released in 2013 and DSM-5-TR released in 2022), involves two major diagnostic criteria for adolescents and adults:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as

manifested by at least two of the following (one of which must be Criterion A1):

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics.
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

26. Given that gender dysphoria can cause such distress, many transgender individuals face depression, anxiety, and higher rates of suicidality than cisgender people. This is noted both in adults and adolescents. However, gender dysphoria is a condition that is highly amenable to treatment, and the prevailing treatment for it is highly effective. These risks decline when transgender individuals are supported and live according to their gender identity. And with access to medically indicated care, transgender people can experience significant and potentially complete relief from their symptoms of gender dysphoria. Not only is this documented in scientific literature and published data, but I witness this each time I see my patients being supported by their community, family, school, and medical providers.

C. Evidence-Based Guidelines for Treatment of Gender Dysphoria

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

28. The SOC 8 is based upon a more rigorous and methodological evidence-based approach than previous versions. (Coleman, et al., 2022). This

evidence is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion. Its recommendations are evidence-based, informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. The process for development of the 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 methodology (Guyatt, et al., 2011), considering the available evidence supporting interventions, risks and harms, and feasibility and acceptability.

29. While SOC 8 includes important updates, it does not change the substance of any of the opinions I expressed in my previous declaration. Indeed, SOC 8 continues to recommend the provision of medical interventions, such as puberty blockers, hormone therapy, and surgery, as medically appropriate and necessary treatments for gender dysphoria, based on an individual patient's needs.

30. WPATH SOC 8 also states, "Gender identity change efforts (gender reparative or gender conversion programs aimed at making the person cisgender) are widespread, cause harm to TGD people, and (like efforts targeting sexual orientation) are considered unethical." (Coleman, et al., 2022).

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

32. Guidelines from other organizations, including those developed by the UCSF Center of Excellence for Transgender Care, also list similar protocols for the medically necessary treatment of gender dysphoria.

33. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

34. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guidelines are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others.

35. To be sure, being transgender is widely accepted as a variation in human development and is not considered a mental illness. People who are transgender have no impairment in their ability to be productive, contributing members of society simply because of their transgender status.

a. The American Psychiatric Association's DSM 5 states: Gender dysphoria "is more descriptive than the previous DSM-IV term 'gender identity disorder' and focuses on dysphoria as the clinical problem, not identity per se." (APA, 2013).

b. WPATH SOC 8 states: "The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. … It should be recognized gender diversity is common to all human beings and is not pathological. However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions." (Coleman, et al. 2022).

c. The American Psychological Association states: "Whereas diversity in gender identity and expression is part of the human experience and transgender and gender nonbinary identities and expressions are healthy, incongruence between one's sex and gender is neither pathological nor a mental health disorder." (American Psychological Association, 2021).

d. The World Health Organization states: "Gender incongruence has thus broadly been moved out of the 'Mental and behavioural disorders' chapter and into the new 'Conditions related to sexual health' chapter. This reflects evidence that trans-related and gender diverse identities are not conditions of mental ill health, and classifying them as such can cause enormous stigma." (WHO Europe).

36. Thus, the overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender people not only results in the prolonging of their gender dysphoria, but 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).

37. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. The American Psychological Association states that gender identity change efforts provide no benefit and instead do harm. (American Psychological Association, 2021).

38. 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, 2020; American College of Obstetricians and Gynecologists, 2021; American Academy of Family Physicians, 2020).

D. Treatment of Gender Dysphoria

39. The WPATH SOC 8 and the Endocrine Society Guidelines establish authoritative protocols for the treatment of gender dysphoria.

40. In accordance with the WPATH SOC 8 and the Endocrine Society Guidelines, medical interventions to treat gender dysphoria may include treatment with pubertal suppression and/or hormones, and treatment with surgery.

41. No medical or surgical treatment for gender dysphoria is provided to pre-pubertal children.

42. Once a patient enters puberty, treatment options include pubertal suppression therapy and gender-affirming hormones. Pubertal blocking involves methods of temporarily suppressing endogenous puberty to alleviate gender dysphoria and give the patient more time to work with their mental health providers to assess treatment needs. These blockers are reversible medications and once

stopped, a patient returns to the stage of pubertal development that had begun when the treatment was initiated.

43. If a patient is assessed to have a medical need for hormone therapy, gender-affirming hormone therapy involves administering steroids of the experienced sex (i.e., their gender identity), such as testosterone in transgender male individuals and estrogen in transgender female individuals, to treat gender dysphoria later in puberty. The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to their gender identity. For adolescents, this treatment allows patients to have pubertal changes and development consistent with their gender identity. Gender-affirming hormone therapy is a partially reversible treatment in that some of the effects produced by the hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice, decreased testicular mass).

44. Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include, *inter alia*, vaginoplasty and orchiectomy for transgender female individuals, and chest reconstruction and hysterectomy for transgender male individuals.

45. According to WPATH SOC 8, "Chest masculinization surgery can be considered in minors when clinically and developmentally appropriate as determined

by a multidisciplinary team experienced in adolescent and gender development" (Coleman, et al. 2022).

46. The treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions. Indeed, these or similar procedures are provided for cisgender people with other diagnoses.

E. Assessments of Patients with Gender Dysphoria.

47. WPATH SOC 8 recommends that health care professionals working with transgender and non-binary adolescents be licensed, hold a postgraduate degree in relevant clinical field, have received training and developed expertise in working with children and adolescents, including those with autism spectrum disorder, and have received training and developed expertise in gender identity and diversity in youth, and in the ability of youth to assent/consent to care (Coleman, et al., 2022).

48. WPATH SOC 8 recommends a "comprehensive biopsychosocial assessment" for adolescents "prior to any medically necessary medical or surgical intervention" for gender dysphoria. The assessment should include gender identity development, social development and support, diagnostic assessment of co-occurring mental health or developmental concerns, and capacity for decision-making (Coleman, et al., 2022).

49. For assessing an adult for gender-affirming medical care, WPATH SOC 8 states that the health professional should be licensed and trained in identifying

gender dysphoria as well as co-existing mental health and psychosocial concerns, and that medical or surgical treatment should only be recommended when "gender incongruence is marked and sustained," when there is capacity for consent, when other conditions that might affect outcomes have been assessed, and when diagnostic criteria for Gender Dysphoria of DSM 5-TR (in the US) or Gender Incongruence of ICD-11(outside the US) are met.

50. Before gender affirming care is provided, WPATH SOC 8 recommends that impacts on fertility of care, and fertility preservation options be discussed thoroughly with the patient, and in the case of a minor, with parents or guardians.

51. 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 (Ehrensaft, 2017). WPATH SOC 8 states, "We recommend health professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particularly in favored." (Coleman, et al., 2022). WPATH SOC 8 states "For some youth, obtaining gender-affirming medical care is important while for others these steps might not be necessary." (Coleman, et al., 2022). In my clinical experience, some adolescent patients have a critical need for medical interventions at or at some point after the onset of puberty

and others do not. As with all medical interventions, it is highly individualized and responsive to the particular medical and mental health needs of each patient.

52. The Endocrine Society Guidelines state 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, et al., 2017, at 3877). 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.*, at 3876. 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.*

F. Gender-Affirming Medical and Surgical Care Is Safe and Effective.

53. Gender-affirming medical and surgical interventions in accordance with the WPATH SOC and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many transgender people 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; WPATH, 2016).

54. There is substantial evidence that gender-affirming medical and surgical care is effective in treating gender dysphoria. This evidence includes scientific studies assessing mental health outcomes for transgender people who are treated with these interventions, including adolescents, and decades of clinical experience.

55. The research and studies supporting the necessity, safety, and effectiveness of medical and surgical care for gender dysphoria are the same type of evidence-based data that the medical community routinely relies upon when treating other medical conditions.

56. 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. (Aldridge et al., 2021; Almazan, et al., 2021; Baker et al., 2021; Murad, et al., 2010; Nobili et al., 2018; Pfafflin & Junge, 1998; T'Sjoen et al. 2019; van de Grift et al., 2018; White Hughto and Reisner, 2016; Wierckx et al., 2014).

57. A systematic review of 20 studies showed improved quality of life, decreased depression, and decreased anxiety with hormonal treatment in transgender people. (Baker, et al., 2021). Another systematic review showed improvement in mental health and quality of life measures in transgender people with hormonal treatment (White Hughto and Reisner, 2016). In the United Kingdom, one study demonstrated that depression and anxiety were substantially reduced over 18 months of gender-affirming hormonal treatment. (Aldridge, et al., 2021). In a secondary analysis of data from the US Transgender Survey, having had genital surgery was associated with decreased psychological distress and suicidal ideation. (Almazan, et al., 2021). In transgender patients followed 4-6 years after surgery, satisfaction was very high (over 90%) and regret was low. (van de Grift et al., 2018). The Cornell "What We Know" systematic review of 55 studies from 1991-2017 strongly supported that gender-affirming hormone and surgical treatment improved the well-being of transgender individuals. (What We Know, 2018).

58. Transgender people have been benefiting from gender-affirming medical and surgical care for decades. Researchers interviewed fifteen transgender people 40 years after they had received gender-affirming surgical care at University of Virginia. Participants reported continued benefits over 40 years from gender affirming care, including improved mental health, reduced suicidality, reduced

gender dysphoria, and high patient satisfaction, with no reported cases of regret (Park, et al. 2022).

59. The studies on gender-affirming medical care for treatment of 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, I have seen the benefits of gender-affirming medical care on my patients' health and well-being. I have seen many patients show improvements 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.

60. Accordingly, treatments for gender dysphoria are not considered elective or cosmetic. Indeed, as WPATH (2016) states, "The medical procedures attendant to gender-affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense but are understood to be medically necessary for the treatment of the diagnosed condition. In some cases, such surgery is the only

effective treatment for the condition, and for some people genital surgery is essential and life-saving."

61. As part of the treatment process for gender dysphoria, patients provide informed consent to their care. In addition, a treating doctor will not offer gender-affirming medical treatments unless they have concluded after weighing the risks and benefits of care for the specific patient that treatment is appropriate. The risks and benefits of care are discussed with the transgender patient, who must consent or assent, as appropriate. This process is no different than the informed consent process for other medical treatments. However, for gender-affirming medical care, there is the additional safeguard of the recommended assessments by a health care professional, who must not only be experienced in the assessment of gender dysphoria, but also in the assessment of a patient's capacity to consent/assent to treatment and ability to understand the risks and benefits of treatment. Indeed, SOC 8 notes that mental health professionals are the best positioned practitioners to conduct these assessments for adolescents and also recommends, for all patients, that a mental health professional address any mental health issues that may interfere with a patient's ability to consent prior to the initiation of gender-affirming care.

62. 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-delaying treatment, hormones, and surgery, and were 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."

63. A study of 209 gender-affirming mastectomies in transmasculine adolescents aged 12-17, performed at Kaiser Permanente Northern California from 2013 to 2020, showed a regret rate of 1%. (Tang, et al 2022).

64. 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).

65. For all the reasons above, I am aware of no basis in medicine or science for categorical exclusion of coverage for gender-affirming care.

66. One misperception is that puberty-delaying medications and hormone therapy are experimental because they are not FDA-approved for the specific application of treating Gender Dysphoria. Medications very commonly are prescribed for off-label uses. All gender-affirming hormone treatments are approved

for treatment of other conditions and have been used to treat those conditions, as well as for gender-affirming care, for many years, supporting their safety and efficacy. The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality states, "[Off-label prescribing] is legal and common. In fact, one in five prescriptions written today are for off-label use."[1]

67. Finally, the cost of providing coverage for gender-affirming care is generally very low. To begin, transgender people constitute a small percentage of the overall population, approximately 0.5%. (Crissman, et. al., 2017). Furthermore, the fraction of the population receiving clinical care for Gender Dysphoria is much smaller, well under one in a thousand patients (Zhang, et al., 2020). As a result, one study estimated an average cost of $0.016 cents per member per month to provide gender-affirming care (Padula, et al., 2016). A study by Herman (2013) similarly found low costs to providing health coverage for gender-affirming care. Additionally, when a form of treatment is covered for cisgender people under an insurance plan, it is generally not disproportionately costly to cover the same treatment for transgender people simply because it is provided to treat gender dysphoria.

[1] See https://www.ahrq.gov/patients-consumers/patient-involvement/off-label-drug-usage.html.

G. Harms of Denying Gender-Affirming Care

68. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, posttraumatic stress disorder, and suicidality. The prevalence of these mental health conditions is also thought to be a consequence of minority stress, the chronic stress from coping with societal stigma and discrimination because of one's identity, including gender identity and gender expression. (American Medical Association, 2019). 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).

69. Accordingly, major medical organizations, such as the American Medical Association, American Psychiatric Association, and American College of Obstetricians and Gynecologists, 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, 2019).

70. Denial of this appropriate care for transgender adolescents is also opposed by mainstream 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.

71. Familial and social support and the provision of gender-affirming medical treatment have been associated with dramatically less suicidal ideation in transgender people. (Bauer, et al., 2015). Provision of puberty blockers and gender-affirming hormones for transgender youth likewise decreases suicidality (Tordoff, et al., 2022; Turban, et al., 2020; Green, et al., 2022; Allen, et al., 2019). The American Academy of Child and Adolescent Psychiatry states, "Research consistently demonstrates that gender diverse youth who are supported to live and/or explore the gender role that is consistent with their gender identity have better mental health outcomes than those who are not." (AACAP, 2019).

72. In a multicenter NIH-funded study, 315 transgender and nonbinary youth followed over two years showed a decrease in anxiety and depression and an improvement in appearance congruence and life satisfaction with gender affirming medical treatment. (Chen, et al., 2023).

73. In a University of Washington study of 104 transgender and nonbinary youth, treatment with puberty blockers or hormones was associated with 60% less moderate to severe depression and 73% less suicidal ideation over 12 months, compared to youth not treated. (Tordoff, et al. 2022).

74. In a University of Texas Southwestern study, treatment with gender-affirming hormones in transgender youth was associated with a substantial reduction in body dissatisfaction, as well as improvement on measures of depression and anxiety. (Kuper, et al., 2020).

75. In a University of Southern California and Children's Hospital Los Angeles study of 136 transgender male youth, the half that had received chest masculinizing surgery had far less gender dysphoria than those who had not yet had surgery. (Olson-Kennedy, et al., 2018).

76. In a University of Pennsylvania and University of Rochester study, transgender male youth aged 13-21 suffered substantial emotional distress and functional impairment from dysphoria related to their chest. Chest dysphoria resolved with surgery. Youth reported improvement functionally and in quality of life (Mehringer, et al., 2021).

77. In the past 10 years, there has been a reversal in longstanding coverage policies that had excluded reimbursement of gender-affirming care for transgender people. There are many more clinics providing care to transgender youth and adults in academic medical centers than a decade ago, because funding is now available. This change is allowing clinical researchers to expand the body of research in the United States, as well as increasing access to care.

H. The GAPMS Memo and AHCA's Decision to Prohibit Medicaid Coverage of Gender-Affirming Care

78. According to criteria of the Florida Administrative Code 59G-1.035, the Agency for Health Care Administration (AHCA) makes coverage determinations based on "Generally accepted professional medical standards—standards based on reliable scientific evidence published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations' recommendations." It is my understanding that AHCA purports to have used the standards set forth in this rule to reach the conclusion set forth in its June 2022 GAPMS Memo that gender-affirming care, including puberty blockers, hormone replacement therapy, and gender-affirming surgery does not meet generally accepted professional medical standards and is therefore, experimental and investigational.

79. To craft the GAPMS Memo (which served as the basis for AHCA's decision to ban gender-affirming care in accordance with Fla. Admin. Code R. 59G-1.050(7)), AHCA enlisted Drs. Romina Brignardello-Petersen and Wojtek Wiercioch. Dr. Brignardello-Petersen is a dentist who is an assistant professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University in Canada. Dr. Wiercioch is a post-doctoral research fellow in the same department as Dr. Brignardello-Petersen. Both authors report no academic interests in the care of people with gender dysphoria.

80. Drs. Brignardello-Petersen and Wiercioch performed a manual search of websites that includes only one non-governmental organization site: the Society for Evidence-Based Gender Medicine (SEGM). The fact that SEGM was chosen instead of much larger and more established organizations representing the mainstream of care, e.g., the American Psychological Association, the American Medical Association, or the American Psychiatric Association, raises a concern for bias, as SEGM is a small group founded recently specifically in opposition to gender-affirming care.

81. To support the conclusions provided to AHCA, Drs. Brignardello-Petersen and Wiercioch preferentially relied on studies that only included participants under age 25. Drs. Brignardello-Petersen and Wiercioch do not provide a basis to support their selection of only these studies, or of leaving out a multitude of other studies that include participants that are over age 25. In my experience working with patients with gender dysphoria, many of those who seek gender-affirming surgery are over 25. The average age of 7,905 transgender patients who had gender-affirming surgery in the US from 2009-2015, identified by insurance data, was 29.8 years old (Lane, et al., 2018). Thus, reliance on studies related preferentially to those under age 25 does not accurately capture the full body of scientific evidence pertaining to this form of care. This is especially important given

that the GAPMS memo concludes that gender-affirming care is not a generally accepted professional medical standard for individuals at any age.

82. Brignardello-Petersen and Wiercioch excluded from consideration the vast majority of studies on transgender health. They state, "After screening 1854 records found through our searches, we found 10 eligible studies."

83. Drs. Brignardello-Petersen and Wiercioch relied on an overview of a very small sample of systematic reviews of studies of transgender care (they looked at only 10 of 61 systematic reviews), for which they purported to rank the quality of evidence using GRADE criteria. GRADE criteria assigns low quality scores to studies not performed by randomized, blinded clinical trials. However, randomly selecting people to receive or not receive gender-affirming medical or surgical interventions is impossible, for practical and ethical reasons. Notably, many treatments for other conditions are in widely accepted use without having been studied through randomized, controlled clinical trials. Many drugs for cancer and hematologic disorders have been FDA approved without a randomized controlled trial (Hatswell, et al., 2016). Many other drugs have been FDA approved with randomized controlled trials for one indication but are commonly used for another condition or in a different population than the one for which it was approved (Wittich, et. al., 2012).

84. People have been receiving gender-affirming medical and surgical treatment for well over half a century, with very low regret rates (Dhejne, et al., 2014), and there is substantial research and clinical experience that supports gender-affirming care as treatment for gender dysphoria. The scientific evidence "published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations" led the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, and other mainstream medical organizations to conclude that the provision of gender-affirming medical and surgical interventions falls within generally accepted professional medical standards.

85. Another person enlisted to provide an opinion to AHCA in drafting its GAPMS memo is James Cantor, PhD, a forensic psychologist in Toronto, Canada. Dr. Cantor's report indicates that his work at the University of Toronto from 1998 to 2018 was limited to its adult forensic program, that is, Dr. Cantor worked with people with paraphilias,[2] and in particular with pedophiles. Dr. Cantor is well known for this work, but not for his work with transgender people. In testimony in *Eknes-Tucker v. Marshall*, Dr. Cantor stated that he had not personally diagnosed any child or

[2] Paraphilias are persistent and recurrent sexual interests, urges, fantasies, or behaviors of marked intensity involving objects, activities, or even situations that are atypical in nature. Being transgender is not a paraphilic disorder.

adolescent with gender dysphoria, and that he had personally never treated any child or adolescent for gender dysphoria.

86. Dr. Cantor agrees that transgender adults "adjust well to life as the opposite sex" if they are otherwise mentally healthy. Dr. Cantor is also correct to report that regret rates are low.

87. Dr. Cantor focuses on desistance rates of prepubertal children brought into clinics in Toronto and Amsterdam. However, given that these prior longitudinal studies included gender nonconforming children who were not transgender due to the broad criteria for the since-abandoned "gender identity disorder in children" diagnosis, or who did not qualify even for the gender identity disorder in children diagnosis, these studies shed little light into questions of persistence and desistance of gender dysphoria in pre-pubertal children. In fact, a more recent study, which is the only large American prospective study that has been published in the past 35 years, showed much lower desistance rates (Olson, et al., 2022). Specifically, only 2.5% of the youth studied identified with their sex assigned at birth.[3]

88. In any event, longitudinal studies show that gender dysphoria in adolescence usually persists (DeVries, et al., 2011; van der Loos, et al., 2022). And

[3] Of these, youth with cisgender identities were more common among youth whose initial social transition occurred before age 6 years; their retransitions often occurred before age 10 years. And, again, no medical treatment is recommended for any transgender person prior to the onset of puberty.

no medical treatment, let alone irreversible medical and surgical interventions, is used prior to puberty. Even in the clinics with higher desistance rates for *pre-pubertal* children upon which Dr. Cantor relies, puberty blockers and hormones were used when gender dysphoria persisted after the onset of puberty. In sum, the desistance statistics of *pre-pubertal* children do not inform the decision whether to initiate these treatments in adolescents and adults.

89. The WPATH Standards of Care and the American Psychiatric Association each recommend that transgender people who also suffer from depression, anxiety, and other mental health symptoms should seek out treatment for these symptoms. However, in most cases, having a history of mental illness should not prevent people from receiving gender-affirming medical and surgical treatment. (Coleman, et al., 2022; Byne, et al., 2018).

90. Dr. Cantor's uses the term "affirmation on demand" as a straw man. The WPATH Standards of Care require a comprehensive mental health assessment for patients who are minors, and clinical assessments are also required for adults. (Coleman, et al., 2022).

91. Dr. Cantor cites a Finnish study as evidence for his conclusion that adolescents should not be prescribed gender-affirming hormones because they are supposedly not effective in the treatment of gender dysphoria. (Kaltiala, et al., 2020). However, in that study, the need for treatment for depression dropped from 54% of

the youth to 15%; the need for treatment for anxiety dropped from 48% of the youth to 15%; and the need for treatment for suicidality/self-harm dropped from 35% to 4%. All of these were statistically highly significant changes.

92. Dr. Cantor states that the study by Kuper, et al. 2020 did not show benefit from treatment. This statement is misleading at best. The article concludes, "Youth reported large improvements in body dissatisfaction ($P < .001$), small to moderate improvements in self-report of depressive symptoms ($P < .001$), and small improvements in total anxiety symptoms ($P < .01$)." Dr. Cantor further states that the study by Achille et al. does not show that those studied benefitted from endocrine treatment. Again, Cantor's characterization of this study's conclusion is misleading. The results of the paper show that, "Mean depression scores and suicidal ideation decreased over time while mean quality of life scores improved over time. When controlling for psychiatric medications and engagement in counseling, regression analysis suggested improvement with endocrine intervention. This reached significance in male-to-female participants."

93. In reviewing the international health care consensus regarding gender-affirming care, Dr. Cantor refers to an interim report on care of transgender youth in the United Kingdom's National Health System which is currently being compiled by Dr. Hilary Cass. The interim report states that the final report will synthesize published evidence with expert opinion and stakeholder input. Notably, the interim

report recommends increasing the number of health providers, shortening wait times, and increasing the number of centers across the country providing care to transgender youth.

94. Swedish and Finnish national health authorities, which Dr. Cantor also references, have recommended caution and more research but have not banned care for transgender youth. In these countries, gender-affirming care for adults and for youth who qualify is fully paid for by the national health system of each country.

95. There remains strong international support for the continued provision of gender-affirming medical and surgical care. Experts from the around the world collaborated on the new WPATH Standards of Care Version 8. I was chapter lead of the Mental Health chapter of this version, and the authors of that chapter included psychiatrists who are leaders of transgender health programs in Belgium, Sweden, and Turkey. There is broad agreement in philosophy of care, including support for gender-affirming care and opposition to conversion therapy.

96. The ethics of providing transgender care are discussed by one expert, Dr. G. Kevin Donovan. Dr. Donovan ignores the larger ethical question raised by Florida's actions to terminate Medicaid coverage of gender-affirming care for those who were previously approved for that same coverage. Florida's actions amount to forced detransition. As Dr. Donovan states, the principles of ethical care include autonomy, beneficence, and justice. There has been little research on those forced to

detransition, but abruptly terminating Medicaid coverage for low-income and disabled Floridians will force these Medicaid recipients into detransition, an experiment to which they did not consent. Autonomy, beneficence, and justice are entirely ignored in this experiment, with no respect for the autonomy of the individual to decide their course, no concern for "do no harm" or maximizing benefits and minimizing harm, and no justice—fairness in distribution of risks and benefits—as the poor and those with disabilities will be forced into this detransition experiment while those with resources will be spared.

97. I have only had a few patients over the years who have been forced to detransition, because of incarceration or institutionalization, or other circumstances, and results have been uniformly disastrous, with suicide and self-harm attempts, depression, and deterioration of functioning. Some of my patients forced to detransition were receiving intensive mental health care at the time, on psychiatric wards. But no amount of psychotherapy could counter the deleterious effects of forced detransition and the withholding of needed gender-affirming medical and surgical care.

IV. CONCLUSION

98. The categorical exclusion of coverage for gender-affirming medical care adopted by Florida's Agency for Health Care Administration, which bars coverage for medical treatments for gender dysphoria, is contrary to widely accepted

medical protocols for the treatment of transgender people with gender dysphoria that are recognized by major medical and mental health professional associations in the United States.

99. The accepted protocols for the treatment of transgender people with gender dysphoria provide for mental health assessments, including of co-occurring conditions; criteria for eligibility for each treatment; and an informed consent process before medical interventions are initiated.

100. Decades of medical research and clinical experience have demonstrated that the medical treatments AHCA has barred from Medicaid coverage are safe, effective, and medically necessary to relieve gender dysphoria for transgender people. AHCA's conclusion otherwise is not supported by medical evidence or consensus.

101. Denying gender-affirming medical care to transgender people for whom it is medically indicated puts them at risk of significant harm to their health and wellbeing, including heightened risk of depression and suicidality.

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

Executed this 15th day of February 2023.

Dan H. Karasic, M.D.

Exhibit A

Curriculum Vitae

University of California, San Francisco

CURRICULUM VITAE

Name: Dan H. Karasic, MD

Position: Professor Emeritus
Psychiatry
School of Medicine

Voice: 415-935-1511
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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; Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	UCLA
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 Center	Psychiatrist Clinic	Dimensions Dimensions
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	National Institute of Mental Health

	AIDS (1990-1991)	
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 Professional Achievement	Occidental College

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 Psychiatrists	Chair Lesbian
1994 - 1995	Educational Program, Association of Gay and Lesbian 1995 Annual Meeting	Director Psychiatrists,
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 Issues, Northern California Psychiatric Society	Chair
1998 - 2002	City of San Francisco Human Rights Commission, Lesbian, Gay Bisexual Transgender Advisory Committee	Member
2000 - 2004	Association of Gay and Lesbian Psychiatrists. for the organization's educational programs	Vice President Responsible
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 Professional Association for Transgender Health	Member
2014 - 2018	Public Policy Committee, World Professional Association for Transgender Health	Chair
2014 - 2018	WPATH Global Education Initiative: Training providers 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, Bangkok, Thailand	Track Chair
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, Aviv	Invited Speaker Tel
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, Amsterdam	Invited Speaker

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, Buenos Aires	Invited Speaker
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 Symposium	Invited Speaker
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, Toronto	Media Session 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 Symposium, New Orleans	Chair
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	Chair Conference
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 Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	Invited Speaker

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 Biennial Conference, Atlanta, GA	Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	Invited Speaker

		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	Invited Speaker York
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

		Invited Speaker
1996	Psychopharmacology for the Primary Care AIDS/Clinician, series of four lectures, UCSF Department of Medicine	Invited Lecturer
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 Rounds	Invited Speaker Grand
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, Santa Rosa	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	University of California, Davis, Department of Psychiatry Rounds	Invited Speaker Grand
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 Grand Rounds	Invited Speaker Psychaitry
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 - present HIV/AIDS Task Force Member

1992 - 1993 HIV Research Group Member

1992 - 1997 Space Committee Member

1992 - present 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 - present 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 Gender-Confirming 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. 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

1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.
2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: The AIDS Knowledge Base, Third Edition. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams &Wilkens, Philadelphia, 1999, pp. 577-584.
3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH.** The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
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.)

2022 Expert, C.P. v. Blue Cross Blue Shield of Illinois, No. 3:20-cv-06145-RJB (W.D. Wash.)

Exhibit B

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