From:	Oni K. Blair <oblair@aclutx.org>
To:	Evaluation Only. Created with Aspose.HTML. Copyright 2013-2020 Aspose Pty Ltd.up (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
CC:	Sarah Labowitz <slabowitz@aclutx.org>
Subject:	RE: Connecting with TX ACLU
Date:	2022/03/02 19:41:46
Priority:	Normal
Type:	Note

Thank you!

From: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Sent: Wednesday, March 2, 2022 6:39 PM
To: Oni K. Blair <oblair@aclutx.org>
Cc: Sarah Labowitz <slabowitz@aclutx.org>
Subject: RE: Connecting with TX ACLU

CAUTION: This message is from an external sender. Please be cautious of links &attachments.

Hi there,

Here is the release that went out. Let us know if you have questions.

Melanie

News Release

U.S. Department of Health and Human Services

202-690-6343
media@hhs.gov
www.hhs.gov/news
Twitter @HHSGov

FOR IMMEDIATE RELEASE
Wednesday, March 2, 2022

Statement by HHS Secretary Xavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth

Today, on the heels of a discriminatory gubernatorial order in Texas, Health and Human Services (HHS) Secretary Xavier Becerra released the following statement reaffirming HHS's commitment to supporting and protecting transgender youth and their parents, caretakers and families. Secretary Becerra also announced several immediate actions HHS is taking actions to support LGBTQI+ youth and further remind Texas and others of the federal protections that exist to ensure transgender youth receive the care they need:

"The Texas government's attacks against transgender youth and those who love and care for them are discriminatory and unconscionable. These actions are clearly dangerous to the health of transgender youth in Texas. At HHS, we listen to medical experts and doctors, and they agree with us, that access to affirming care for transgender youth is essential and can be life-saving.

"HHS is committed to protecting young Americans who are targeted because of their sexual orientation or gender identity, and supporting their parents, caretakers and families. That is why I directed my team to evaluate the tools at our disposal to protect trans and gender diverse youth in Texas, and today I am announcing several steps we can take to protect them.

"HHS will take immediate action if needed. I know that many youth and their supportive families are feeling scared and isolated because of these attacks. HHS is closely monitoring the situation in Texas, and will use every tool at our disposal to keep Texans safe.

"Any individual or family in Texas who is being targeted by a child welfare investigation because of this discriminatory gubernatorial order is encouraged to contact our Office for Civil Rights to report their experience."

New HHS Actions Announced by Secretary Xavier Becerra:

- • HHS is releasing guidance to state child welfare agencies through an Information Memorandum that makes clear that states should use their child welfare systems to advance safety and support for LGBTQI+ youth, which importantly can include access to gender affirming care;

- • HHS is also releasing guidance on patient privacy, clarifying that, despite the Texas government's threat, health care providers are not required to disclose private patient information related to gender affirming care;

- • HHS also issued guidance making clear that denials of health care based on gender identity are illegal, as is restricting doctors and health care providers from providing care because of a patient's gender identity;

- • The Secretary also called on all of HHS to explore all options to protect kids, their parents, caretakers and families; and

- • HHS will also ensure that families and health care providers in Texas are aware of all the resources available to them if they face discrimination as a result of this discriminatory gubernatorial order.

If you believe that you or another party has been discriminated against on the basis of gender identity or disability in seeking to access gender affirming health care, visit the OCR complaint portal to file a complaint online.

If you have questions regarding patient privacy laws, please reach out to the Office for Civil Rights email: OCRPrivacy@hhs.gov or call Toll-free: (800) 368-1019

Resources for kids, parents, caretakers and families:

- SAMHSA supports the Center of Excellence on LGBTQ+ Behavioral Health Equity, which provides behavioral health practitioners with vital information on supporting the population of people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities and expressions. The Center's website includes a recorded webinar on Gender Identity, Expression &Behavioral Health 101. Upcoming webinars will include topics such as: How to Signal to Youth that You are an LGBTQ+ Affirming Provider; How to Respond When a Young Person Discloses their SOGIE; Supporting Families of LGBTQ+ Youth; and Safety Planning for LGBTQ+ Students.

- A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children is a resource guide developed by SAMHSA that offers information and resources to help practitioners throughout health and social service systems implement best practices in engaging and helping families and caregivers to support their lesbian, gay, bisexual, and transgender (LGBT) children.

###

Connect with HHS and sign up for HHS email updates

Facebook Twitter Link to Youtube

If you would rather not receive future communications from U.S. Department of Health and Human Services (HHS), let us know by clicking here.
U.S. Department of Health and Human Services (HHS), 200 Independence Avenue, SW 6th Floor Room 647-D, Washington, DC 20201 United States

Melanie Fontes Rainer (she/her/ella)
Counselor to the Secretary
U.S. Department of Health and Human Services
Cell: (b)(6)
Melanie.Rainer@hhs.gov

From: Oni K. Blair <oblair@aclutx.org>
Sent: Wednesday, March 2, 2022 7:33 PM
To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Cc: Sarah Labowitz <slabowitz@aclutx.org>
Subject: RE: Connecting with TX ACLU

Melanie and Colleagues,

The President's mention of trans youth in the SOTU brought a breath of hope. Thank you for all you are doing to make sure this issue on everyone's radar and working to find solutions that protect trans gender youth. We understand there might be more info coming out tonight.

I am sharing the press release for the temporary restraining order, which was granted within the last hour:
https://www.aclutx.org/en/press-releases/texas-court-partially-blocks-gov-abbotts-anti-trans-directive-investigate-families

Do you have info on something happening tonight?

Oni

From: Oni K. Blair
Sent: Tuesday, March 1, 2022 2:30 PM
To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Pino, Lisa (HHS/OCR) <Lisa.Pino@hhs.gov>; Akpa, Stephanie (HHS/OCR) <Stephanie.Akpa@hhs.gov>; (b)(6) (HHS/OCR) <(b)(6)>; Rodriguez, Paul (HHS/OGC) <PaulR.Rodriguez@hhs.gov>; Wolff, Kate (ACF) <Kate.Wolff@acf.hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>
Cc: Clemencia, LaTanya (HHS/IOS) (CTR) <LaTanya.Clemencia@hhs.gov>; Wolff, Kate (OS/IOS) <Kate.Wolff@hhs.gov>; Sarah Labowitz <slabowitz@aclutx.org>
Subject: RE: Connecting with TX ACLU

Thank you all for taking the time to meet today. I've attached the brief we filed in Austin this morning. The NYT covered the filing and what's happening. You can find the link here. I'm also including the names and contact info of core coalition members in Texas, which the WH has also engaged:

Rebecca Marques, Human Rights Campaign rebecca.marques@hrc.org;
Ricardo Martinez, Equality Texas ricardo@equalitytexas.org;
Emmett Schelling, Transgender Education Network of Texas (TENT) emmett.schelling@transtexas.org
Shelly Skeen, Lambda Legal sskeen@lambdalegal.org;
Val Benavidez, Texas Freedom Network val@tfn.org
Sarah Labowitz, ACLU of Texas slabowitz@aclutx.org;
Adri Perez, ACLU of Texas aperez@aclutx.org;
Brian Klosterboer, ACLU of Texas bklosterboer@aclutx.org

Thank you,
Oni

Oni K. Blair
Pronouns: she/her
Executive Director
American Civil Liberties Union of Texas
P.O. Box 8306, Houston, TX 77288-8306
with offices in Austin, Brownsville, Dallas, and El Paso
713.942.8146 | oblair@aclutx.org
aclutx.org cidimage001.gif@01D6E8E6.5D680AB0 cidimage002.jpg@01D6E8E6.5D680AB0

cidimage003.png@01D6E8E6.5D680AB0

From: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, March 1, 2022 12:01 PM
To: Oni K. Blair <oblair@aclutx.org>; Sarah Labowitz <slabowitz@aclutx.org>; Pino, Lisa (HHS/OCR) <Lisa.Pino@hhs.gov>; Akpa, Stephanie (HHS/OCR) <Stephanie.Akpa@hhs.gov>; (b)(6) (HHS/OCR) <(b)(6)>; Rodriguez, Paul (HHS/OGC) <PaulR.Rodriguez@hhs.gov>; Wolff, Kate (ACF) <Kate.Wolff@acf.hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>
Cc: Clemencia, LaTanya (HHS/IOS) (CTR) <LaTanya.Clemencia@hhs.gov>; Wolff, Kate (OS/IOS) <Kate.Wolff@hhs.gov>
Subject: RE: Connecting with TX ACLU

CAUTION: This message is from an external sender. Please be cautious of links &attachments.

I am running 2 minutes late, will be on shortly.

Melanie Fontes Rainer (she/her/ella)
Counselor to the Secretary
U.S. Department of Health and Human Services
Cell: (b)(6)
Melanie.Rainer@hhs.gov

-----Original Appointment-----
From: Rainer, Melanie Fontes (OS/IOS)
Sent: Tuesday, March 1, 2022 8:08 AM
To: Rainer, Melanie Fontes (OS/IOS); Oni K. Blair; Sarah Labowitz; Pino, Lisa (HHS/OCR) (Lisa.Pino@hhs.gov); Akpa, Stephanie (HHS/OCR); (b)(6) (HHS/OCR); Rodriguez, Paul (HHS/OGC); Wolff, Kate (ACF); Pugh, Carrie (OS/IEA); Figueroa, Marvin (HHS/IEA)
Cc: Clemencia, LaTanya (HHS/IOS) (CTR); Wolff, Kate (OS/IOS)
Subject: Connecting with TX ACLU
When: Tuesday, March 1, 2022 1:00 PM-1:30 PM (UTC-05:00) Eastern Time (US &Canada).
Where: (b)(6)

Sender:	Oni K. Blair <oblair@aclutx.org>
Recipient:	Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>; Sarah Labowitz <slabowitz@aclutx.org>
Sent Date:	2022/03/02 19:41:14
Delivered Date:	2022/03/02 19:41:46

Subject:	Connecting on AAP letter DOJ regarding Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/13 16:00:19
Priority:	Normal
Type:	Note

Hi Johnathan,

We recently received the below letter, available online here, from multiple organizations urging the AG to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

(b)(5)

(b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b)(6) (b)(6) (HHS/OCR) <(b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>

Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

AMA
AMERICAN MEDICAL ASSOCIATION

CHILDREN'S HOSPITAL ASSOCIATION

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sent Date: 2022/10/13 16:00:23
Delivered Date: 2022/10/13 16:00:19
Message Flags: Unread Unsent

Subject:	Evaluation Only. Created with Aspose.HTML. Copyright 2013-2020 Aspose Pty Ltd.tals, Patients and Families from Violence
Date:	2022/10/13 15:04:34
Priority:	Normal
Type:	Note

Don't see anything for OCR, except for interruption of provision of care.

(b)(6), Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6)
Email: (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Tuesday, October 11, 2022 3:57 PM
To: (b)(6) (HHS/OCR) <(b)(6)>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

Let me know if you have a moment today or tomorrow to quickly touch base. Just spoke with AAP. Thanks so much!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
202-870-1811
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b)(6) (HHS/OCR) <(b)(6)>
Sent: Friday, October 7, 2022 1:08 PM
To: tharo (aap.org) <tharo@aap.org>
Cc: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar,

It turns out I will now be traveling on Tuesday. I am copying Cayla and Destiny here, so that you all can connect. They can fill me in – no need for me to be the hold up!

Best,
(b)(6)

(b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6)
Email (b)(6)

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Thursday, October 6, 2022 9:42 PM
To: (b)(6) (HHS/OCR) <(b)(6)
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Sounds great, (b)(6) Off to Anaheim for our annual meeting. Talk to you on Tuesday.

Best,
Tamar

From: (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 6, 2022 5:11 PM
To: Haro, Tamar Magarik <tharo@aap.org>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar,

Let's start small, and then I can make sure we have all the right HHS folks when we have a larger meeting. 4pm on Tuesday is perfect. I'll send an invite.

Safe travels to CA – I just got back from there yesterday!

Best,
(b)(6)

(b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6)
Email: (b)(6)

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Thursday, October 6, 2022 5:05 PM
To: (b)(6) (HHS/OCR) <(b)(6)

Subject: Re: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

I am sorry for the delay in responding. I would welcome the chance to connect. Unfortunately, I am on a plane all day tomorrow (to CA) for work but would Tuesday at 3 or 4 work for you?

Would you like me to invite CHA and AMA to the discussion too or did you want to start small?

Thanks,
Tamar

Sent from my iPhone

On Oct 6, 2022, at 3:40 PM, (b)(6) (HHS/OCR) <(b)(6) wrote:

Hi Tamar (moving others to BCC),

Thank you for reaching out. Are you free tomorrow (10/7) or Tuesday (10/11) do discuss?

Best,
(b)(6)

(b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

Image removed by sender.

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sent Date:	2022/10/13 15:04:52
Delivered Date:	2022/10/13 15:04:34
Message Flags:	Unread Unsent

From: Haro, Tamar Magarik <tharo@aap.org>

To: (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) -(b)(6)

Subject: Automatic reply: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Date: 2022/10/06 15:40:13

Priority: Normal

Type: Note

Thank you for writing. I will be attending an all-day work meeting on Thursday, October 6 so my response may be delayed. If you need to reach me urgently, please call or text (202) 904-6176 or email Madeline Curtis at mcurtis@aap.org.

Thanks,

Tamar

Sender: Haro, Tamar Magarik <tharo@aap.org>

Recipient: (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) -(b)(6)

Sent Date: 2022/10/06 15:40:01

Delivered Date: 2022/10/06 15:40:13

Message Flags: Unread

From:	Evaluation Only. Created with Aspose.HTML. Copyright 2013-2020 Aspose Pty Ltd.BOHF23SPDLT)/CN=RECIPIENTS/CN=ED17C98F1C6A4146AD81BF6122B23456-CAYLA.KAPLA <Cayla.Kaplan@hhs.gov>
To:	tharo (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=77ded6736adb42ff81723ab67493b11f-tharo <tharo@aap.org>; (b) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) (b)(6)
CC:	Gregg, Destiny (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7114a513d04411e9c829deb16da05ea-Gregg, Dest <Destiny.Gregg@hhs.gov>; Curtis, M (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ff5299260b8b4184a12f814f7854f3fc-mcurtis <mcurtis@aap.org>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/07 13:20:39
Priority:	Normal
Type:	Note

So glad it all went well!

Let's do 3:30PM on Tuesday. I will send over an invite now. Thank you so much!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Friday, October 7, 2022 1:18 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>; Curtis, M (aap.org) <mcurtis@aap.org>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Cayla,

Congratulations on a hugely success event yesterday. It was energizing and I think just the beginning of what these state partners may collaborate on. The Secretary is lucky to have you, Eden and the rest of the team. You guys are so terrific!

Would 3:30 or 4 pm on Tuesday work for you?

Tamar

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Friday, October 7, 2022 1:10 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6) Haro, Tamar Magarik <tharo@aap.org>
Cc: Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks so much, (b)(6)

Hi Tamar – it was so great to see you yesterday! And thank you so much for helping us put together such an amazing event.

Let's find a time on Tuesday for me, you, and Destiny (cc'd here) to touch base on this. We can determine who can/should be included in a larger conversation. What time works best for you? Happy to work around your schedule. Thank you so much – talk soon!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Friday, October 7, 2022 1:08 PM
To: tharo (aap.org) <tharo@aap.org>
Cc: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar,

It turns out I will now be traveling on Tuesday. I am copying Cayla and Destiny here, so that you all can connect. They can fill me in – no need for me to be the hold up!

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director

Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Thursday, October 6, 2022 9:42 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Sounds great, (b)(6) Off to Anaheim for our annual meeting. Talk to you on Tuesday.

Best,
Tamar

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 6, 2022 5:11 PM
To: Haro, Tamar Magarik <tharo@aap.org>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar,

Let's start small, and then I can make sure we have all the right HHS folks when we have a larger meeting. 4pm on Tuesday is perfect. I'll send an invite.

Safe travels to CA – I just got back from there yesterday!

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: dylan.dekervor@hhs.gov

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Thursday, October 6, 2022 5:05 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: Re: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

I am sorry for the delay in responding. I would welcome the chance to connect. Unfortunately, I am on a plane all day tomorrow (to CA) for work but would Tuesday at 3 or 4 work for you?

Would you like me to invite CHA and AMA to the discussion too or did you want to start small?

Thanks,
Tamar

Sent from my iPhone

On Oct 6, 2022, at 3:40 PM, (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)

Hi Tamar (moving others to BCC),

Thank you for reaching out. Are you free tomorrow (10/7) or Tuesday (10/11) do discuss?

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

Image removed by sender.

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	Kaplan, Cayla (HHS/IEA) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=ED17C98F1C6A4146AD81BF6122B23456-CAYLA.KAPLA <Cayla.Kaplan@hhs.gov>
Recipient:	tharo (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=77ded6736adb42ff81723ab67493b11f-tharo <tharo@aap.org>; (b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6) ; Gregg, Destiny (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7114a513d04411e9c829deb16da05ea-Gregg, Dest <Destiny.Gregg@hhs.gov>; Curtis, M (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ff5299260b8b4184a12f814f7854f3fc-mcurtis <mcurtis@aap.org>
Sent Date:	2022/10/07 13:20:38
Delivered Date:	2022/10/07 13:20:39
Message Flags:	Unread

From: Haro, Tamar Magarik <tharo@aap.org>

To: (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6)

Subject: Automatic reply: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Date: 2022/10/07 13:09:49

Priority: Normal

Type: Note

Thank you for writing. From Friday, October 7 until Tuesday, October 11, I will be attending AAP's National Conference &Exhibition so my response may be delayed. If you need to reach me urgently, please call or text (202) 904-6176.

Thanks, Tamar

Sender: Haro, Tamar Magarik <tharo@aap.org>

Recipient: (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) (b)(6)

Sent Date: 2022/10/07 13:08:23

Delivered Date: 2022/10/07 13:09:49

Message Flags: Unread

From:	Evaluation Only. Created with Aspose.HTML. Copyright 2013-2020 Aspose Pty Ltd.P (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-DEKERVOR, D>
To:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
CC:	Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>; Jee, Lauren (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dc5a273e16824884903f0d2afc8cb225-Jee, Lauren <Lauren.Jee1@hhs.gov>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/13 15:45:00
Priority:	Normal
Type:	Note

Perfect; will email Johnathan and keep you posted.

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Thursday, October 13, 2022 3:36 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

I think let's ping someone from Kristen's front office and see if they receive and can chat and Matthew Colangelo.

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 13, 2022 3:24 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Cc: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Yes; this is a separate letter that Cayla was also just sharing as an FYI on youth mental health.

Happy to connect with DOJ – is there someone in particular that you would like me to reach out to? I was planning on connecting Equality TX and TENT with Community Relations Services when I'm back home tomorrow.

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Thursday, October 13, 2022 3:22 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

This letter is different than what she sent in original email. I think we need to follow-up with DOJ on violence letter, esp given what we heard in Texas yesterday?

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 13, 2022 3:20 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Cc: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Subject: FW: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Melanie,

Cayla (IEA) was able to connect with Tamar and it sounds like there isn't a specific ask for OCR here. They believe the work we are doing around disruptions in care is very important, and mentioned our March 2022 Guidance. They welcomed future guidance, but did not provide specific details. I did mention to Cayla that this guidance has been vacated.

Cayla also shared letter as an FYI, with the below note from Tamar:

Here is the letter to President Biden that I mentioned to several of you was coming. In it, 134 national and state organizations who are dedicated to the mental health and well-being of infants, children, adolescents, and young adults, mark the one year anniversary of the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association's declaration of a National Emergency in Children's Mental Health. While much has been done by the federal government to address the crisis thanks in large part to all of you, the mental health of our nation's youth continues to deteriorate. The letter urges President Biden to treat the youth mental health crisis as the national emergency it continues to be and declare a federal National Emergency in children's mental health.

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b)(6) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

Image removed by sender.

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we

condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91(b)(6)
Recipient:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>; Jee, Lauren (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dc5a273e16824884903f0d2afc8cb225-Jee, Lauren <Lauren.Jee1@hhs.gov>
Sent Date:	2022/10/13 15:45:38
Delivered Date:	2022/10/13 15:45:00

From:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91(b)(6)
To:	Kaplan, Cayla (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ed17c98f1c6a4146ad81bf6122b23456-Cayla.Kapla <Cayla.Kaplan@hhs.gov>
CC:	Gregg, Destiny (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7114a513d04411e9c829deb16da05ea-Gregg, Dest <Destiny.Gregg@hhs.gov>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/07 13:03:00
Priority:	Normal
Type:	Note

Yup! (b)(6) I'm free until 1:30pm, and then again from 3-4pm.

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Friday, October 7, 2022 12:55 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

I think that makes sense! Can I give you a quick (b)(6) Let me know when's good for you. Thanks so much.

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Friday, October 7, 2022 12:12 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Cc: Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Absolutely!

I am wondering if it makes sense for you all to take the first call to identify who should be included on a larger call? I know that Tamar is hoping to have a call that includes CHA and AMA.

Let me know what you think.

Thanks,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Friday, October 7, 2022 11:56 AM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

Hope you're doing well! Is it possible for IEA to hop on this? It would be my portfolio and @Gregg, Destiny (OS/IEA). If not, we'll definitely need a read-out. Let me know if that works for you and/or if you have any flags. Thank you so much!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 6, 2022 3:40 PM
To: tharo (aap.org) <tharo@aap.org>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar (moving others to BCC),

Thank you for reaching out. Are you free tomorrow (10/7) or Tuesday (10/11) do discuss?

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

Image removed by sender.

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment

deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-(b)(6)
Recipient:	Kaplan, Cayla (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ed17c98f1c6a4146ad81bf6122b23456-Cayla.Kapla <Cayla.Kaplan@hhs.gov>; Gregg, Destiny (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7114a513d04411e9c829deb16da05ea-Gregg, Dest <Destiny.Gregg@hhs.gov>
Sent Date:	2022/10/07 13:03:10
Delivered Date:	2022/10/07 13:03:00

From:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-(b)(6)
To:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/06 15:37:00
Priority:	Normal
Type:	Note

Will do!

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: FW: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Please follow-up with her, and maybe bring Luis?

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

AMA
AMERICAN MEDICAL ASSOCIATION

CHILDREN'S HOSPITAL ASSOCIATION

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment

deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-(b)(6)
Recipient:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
Sent Date:	2022/10/06 15:37:09
Delivered Date:	2022/10/06 15:37:00

From:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91(b)(6)
To:	Kaplan, Cayla (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ed17c98f1c6a4146ad81bf6122b23456-Cayla.Kapla <Cayla.Kaplan@hhs.gov>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/12/06 17:55:00
Priority:	Normal
Type:	Note

Probably whenever folks would be available, since she's been asking for it for a while (oops!). But if January is best, we can go with that!

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Tuesday, December 6, 2022 5:16 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Sorry for the delay here!

Yes – happy to make this ask. When is she looking to have the call? This month or January? Let me know and I'll reach out – thank you!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Monday, December 5, 2022 1:41 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Cayla,

Melanie would like to pull together a call for her and Admiral Levine with AAP, AMA, and CHA on this topic.

I know it's a bit after our initial discussions on this topic, but we were trying to get DOJ Civil Rights on board too and it's just taking too long.

Given your relationships with these folks, would you be able to reach out to see if they would be open to having a call with the Director and Admiral Levine?

Thanks,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Friday, October 7, 2022 11:56 AM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

Hope you're doing well! Is it possible for IEA to hop on this? It would be my portfolio and @Gregg, Destiny (OS/IEA). If not, we'll definitely need a read-out. Let me know if that works for you and/or if you have any flags. Thank you so much!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 6, 2022 3:40 PM
To: tharo (aap.org) <tharo@aap.org>

Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar (moving others to BCC),

Thank you for reaching out. Are you free tomorrow (10/7) or Tuesday (10/11) do discuss?

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>;

Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

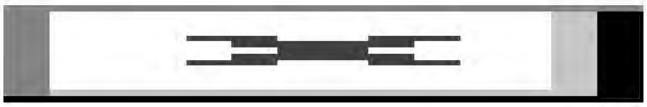


Image removed by sender.

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of

violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	(b) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-(b)(6)
Recipient:	Kaplan, Cayla (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ed17c98f1c6a4146ad81bf6122b23456-Cayla.Kapla <Cayla.Kaplan@hhs.gov>
Sent Date:	2022/12/06 17:55:59
Delivered Date:	2022/12/06 17:55:00

From:	Evaluation Only. Created with Aspose.HTML. Copyright 2013-2020 Aspose Pty Ltd.P (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-DEKERVOR, D>
To:	Kaplan, Cayla (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ed17c98f1c6a4146ad81bf6122b23456-Cayla.Kapla <Cayla.Kaplan@hhs.gov>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/12 18:03:00
Priority:	Normal
Type:	Note

Sorry about that – let me check and send you something.

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Wednesday, October 12, 2022 5:36 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

Tomorrow works! Looks like I can't view your schedule but I'm free before 10:30AM and I can make anytime after 1PM work. When is best? I'll send you a calendar hold. Thanks so much.

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, October 12, 2022 5:30 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Cayla,

Sorry for the delay. Are you free tomorrow? My schedule is up to date if you want to suggest a time! I'll be working remotely from Region 6. If Friday is better, just let me know and feel free to send an invite.

This issue came up today in our community meeting with Equality Texas and Transgender Education Network of Texas, so it is very timely.

Thanks!
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>
Sent: Tuesday, October 11, 2022 3:57 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) <(b)(6)
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

Let me know if you have a moment today or tomorrow to quickly touch base. Just spoke with AAP. Thanks so much!

Cayla Kaplan
U.S. Department of Health and Human Services
Office of the Secretary
External Affairs Specialist, Intergovernmental and External Affairs
(b)(6)
Cayla.kaplan@hhs.gov

To Receive Updates from HHS IEA Click Here!

From: (b) (b)(6) (b)(6) (HHS/OCR) <(b)(6)
Sent: Friday, October 7, 2022 1:08 PM
To: tharo (aap.org) <tharo@aap.org>
Cc: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar,

It turns out I will now be traveling on Tuesday. I am copying Cayla and Destiny here, so that you all can connect. They can fill me in – no need for me to be the hold up!

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Thursday, October 6, 2022 9:42 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Sounds great, (b)(6) Off to Anaheim for our annual meeting. Talk to you on Tuesday.

Best,
Tamar

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, October 6, 2022 5:11 PM
To: Haro, Tamar Magarik <tharo@aap.org>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Tamar,

Let's start small, and then I can make sure we have all the right HHS folks when we have a larger meeting. 4pm on Tuesday is perfect. I'll send an invite.

Safe travels to CA – I just got back from there yesterday!

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Thursday, October 6, 2022 5:05 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)

Subject: Re: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi (b)(6)

I am sorry for the delay in responding. I would welcome the chance to connect. Unfortunately, I am on a plane all day tomorrow (to CA) for work but would Tuesday at 3 or 4 work for you?

Would you like me to invite CHA and AMA to the discussion too or did you want to start small?

Thanks,
Tamar

Sent from my iPhone

On Oct 6, 2022, at 3:40 PM, (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)

Hi Tamar (moving others to BCC),

Thank you for reaching out. Are you free tomorrow (10/7) or Tuesday (10/11) do discuss?

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Senior Advisor to the Director
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:57 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Cc: Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thanks Rachel. I am adding (b)(6) here. It would be great to follow-up offline and get more specifics Tamir to see what OCR can do.

Thanks,
Melanie

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:21 PM
To: tharo (aap.org) <tharo@aap.org>; Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Boateng, Sarah (HHS/OASH) <Sarah.Boateng@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Thank you so much for flagging this. Adding a couple others.

Rachel

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

Image removed by sender.

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	(b)(6) (b)(6) (b)(6 (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0BDEC12AD0974EACABABE032F2B37C91-(b)(6)
Recipient:	Kaplan, Cayla (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ed17c98f1c6a4146ad81bf6122b23456-Cayla.Kapla <Cayla.Kaplan@hhs.gov>
Sent Date:	2022/10/12 18:03:10
Delivered Date:	2022/10/12 18:03:00

From:	Rainer, Melanie Fontes (OS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=9C7242F10A494D45BAB72C452ECD9F80-RAINER, MEL>
To:	Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>
Subject:	RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/04 13:30:00
Priority:	Normal
Type:	Note

Sounds good. Matthew Colangelo works for Vanita and I think would be most helpful.

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 1:21 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Subject: RE: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

(b)(5)

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, October 4, 2022 12:44 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Re: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

I could have our team look under 1557 or title ix and see if there is info here to investigate.

(b)(5)

Get Outlook for

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:22:09 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Subject: FW: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Have you had any conversations with the WH or OASH or anyone on this issue?

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM

To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

AMA
AMERICAN MEDICAL ASSOCIATION

CHILDREN'S HOSPITAL ASSOCIATION

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of

violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	Rainer, Melanie Fontes (OS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=9C7242F10A494D45BAB72C452ECD9F80-RAINER, MEL>
Recipient:	Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>
Sent Date:	2022/10/04 13:30:39
Delivered Date:	2022/10/04 13:30:00

From:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
To:	Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>
Subject:	Re: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence
Date:	2022/10/04 12:40:24
Priority:	Normal
Type:	Note

(b)(5)

Get Outlook for iOS

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Tuesday, October 4, 2022 12:22:09 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Subject: FW: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Have you had any conversations with the WH or OASH or anyone on this issue?

From: Haro, Tamar Magarik <tharo@aap.org>
Sent: Monday, October 3, 2022 1:15 PM
To: Kaplan, Cayla (HHS/IEA) <Cayla.Kaplan@hhs.gov>; Tesfaye, Eden (OS/IEA) <Eden.Tesfaye@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Subject: Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Hi Rachel, Cayla and Eden,

I wanted to make you saw the press release below, online here and attached that went out to media this morning. In it is a link to the letter our organizations sent to Attorney General Garland this morning urging him to investigate and prosecute all organizations, individuals, and entities responsible for coordinating, provoking, and carrying out bomb threat and threats of personal violence against children's hospitals and physicians across the U.S.

I wanted to make sure this was on your radar. Please feel free to share it within your teams.

Best,
Tamar

For immediate release: October 3, 2022

Media contacts:

AAP: Jamie Poslosky (jposlosky@aap.org)
AMA: Robert J. Mills (robert.mills@ama-assn.org)
CHA: Elleni Almandrez (elleni.almandrez@childrenshospitals.org)

Leading Health Care Organizations Urge Action to Protect Physicians, Hospitals, Patients and Families from Violence

Groups call on Department of Justice investigation, technology platforms to address harassment and threats of violence against physicians and hospitals

Washington, DC—Today, the American Academy of Pediatrics (AAP), American Medical Association (AMA) and Children's Hospital Association (CHA) unite in support of physicians and hospitals who have been threatened and attacked in recent months.

The groups sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the increasing threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who work there.

"Whether it's newborns receiving intensive care, children getting cancer treatments or families accessing compassionate care for their transgender adolescents, all patients seeking treatment deserve to get the care they need without fear for their personal safety," said **AAP President Moira Szilagyi, MD, PhD, FAAP**. "We cannot stand by as threats of violence against our members and their patients proliferate with little consequence. We call on the Department of Justice to investigate these attacks and social media platforms to reduce the spread of the misinformation enabling them."

The AAP and AMA collectively represent more than 270,000 physicians and medical students and CHA represents more than 220 children's hospitals across the country. The groups wrote to Attorney General Garland urging "swift action to investigate and prosecute all organizations, individuals, and entities responsible."

"Individuals in all workplaces have the right to a safe environment, out of harm's way and free of intimidation or reprisal," said **AMA President Jack Resneck Jr., MD**. "As physicians, we condemn groups that promote hate-motivated intolerance and toxic misinformation that can lead

to grave real-world violence and extremism and jeopardize patients' health outcomes. The AMA will continue to work with federal, state and local law enforcement officials to develop and implement strategies that protect hard-working, law-abiding physicians and other health care workers from senseless acts of violence, abuse and intimidation."

In addition to the letter to the Department of Justice, the groups call on Twitter, TikTok and Meta, which owns Facebook and Instagram, to do more to prevent coordinated campaigns of disinformation. The organizations ask the platforms to take bolder action when false information is shared about specific institutions and physicians. They also urge social media companies to enforce safety and hateful conduct policies to stop the endangerment of patients, families, physicians and health care staff.

"We are committed to providing safe, supportive and inclusive health care environments for each and every child and family, and the clinicians and staff who are dedicated to caring for children," said **CHA President Amy Wimpey Knight**. "Threats and acts of violence are not a solution, nor a substitute, for civil dialogue about issues of a child or teen's health and wellbeing. At CHA, we are committed to working across sectors to prevent misleading and inflammatory comments that result in threats to those caring for patients."

The groups wrote in their letter to Attorney General Garland, "Our organizations are dedicated to the health and well-being of all children and adolescents. We are committed to the full spectrum of patient care—from prevention to critical care. We stand with the physicians, nurses, mental health specialists, and other health care professionals who provide evidence-based health care, including gender-affirming care, to children and adolescents."

###

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care. For more information, visit ama-assn.org.

About the Children's Hospital Association

Children's Hospital Association is the national voice of more than 220 children's hospitals, advancing child health through innovation in the quality, cost and delivery of care.

Sender:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
Recipient:	Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>
Sent Date:	2022/10/04 12:40:24

From:	Tannaz Rasouli <trasouli@aamc.org>
To:	Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>; Pugh, Carrie (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=600602937a904b288a2b2c0d1d75fc6a-Pugh, Carri <Carrie.Pugh@hhs.gov>
CC:	kfisher (aamc.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=bade5706c379443fa56e3962b2e1436e-kfisher.os <kfisher@aamc.org>
Subject:	RE: Texas Touch Base
Date:	2022/03/03 10:29:22
Priority:	Normal
Type:	Note

Very helpful, thank you!

From: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Sent: Thursday, March 3, 2022 10:12 AM
To: Tannaz Rasouli <trasouli@aamc.org>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Cc: Karen Fisher <kfisher@aamc.org>
Subject: RE: Texas Touch Base

Information Security Warning - External Email: Do not click on links or open attachments unless you trust the sender.

Thank you, this link has the statement and guidance if helpful--
https://www.hhs.gov/about/news/2022/03/02/statement-hhs-secretary-xavier-becerra-reaffirming-hhs-support-and-protection-for-lgbtqi-children-and-youth.html

Melanie Fontes Rainer (she/her/ella)
Counselor to the Secretary
U.S. Department of Health and Human Services
Cell: (b)(6)
Melanie.Rainer@hhs.gov

From: Tannaz Rasouli <trasouli@aamc.org>
Sent: Thursday, March 3, 2022 10:00 AM
To: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Cc: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; kfisher (aamc.org) <kfisher@aamc.org>
Subject: RE: Texas Touch Base

Hi Carrie – Following up on your request for statements during today's call, I've linked here to the statement AAMC President and CEO Dr. David Skorton issued in April 2021, when unfortunately, we felt the need to speak out about the importance of allowing doctors to provide gender-affirming care to

transgender youth. While we don't typically engage at the state level and have not issued a new statement, when the recent news out of Texas arose, we felt that it was important to reaffirm our commitment to the April statement through our various communications channels.

We will also share the guidance materials you shared on today's call with our members – I grabbed the two links below from the chat, but wanted to double check that I didn't miss any of the other resources the team mentioned? Or if you're planning to send a follow up email to the group with all the relevant links/information, I can just wait for that!

Thanks again for pulling us all together and for all your work!

Tannaz

https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf

https://www.acf.hhs.gov/cb/policy-guidance/im-22-01

Tannaz Rasouli
Senior Director, Public Policy &Strategic Outreach
Association of American Medical Colleges
655 K Street NW, Suite 100
Washington, DC 20001
p: 202.828.0057
t: @__tannaz
e: trasouli@aamc.org

From: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Sent: Wednesday, March 2, 2022 5:51 PM
To: shughes@aha.org; aimee.ossman@childrenshospitals.org; plargent@nasn.org; lbenson@naspweb.org; tharo (aap.org) <tharo@aap.org>; mstickel@napnap.org; sbutts.nasw@socialworkers.org; Karen Fisher <kfisher@aamc.org>; squinn@aafp.org; rtetlow@acog.org; sspeil (fah.org) <sspeil@fah.org>
Cc: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Ladjevardian, Sima (HHS/IEA) <Sima.Ladjevardian@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wolff, Kate (ACF) <Kate.Wolff@acf.hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: Texas Touch Base

Information Security Warning - External Email: Do not click on links or open attachments unless you trust the sender.

Hello all-

We would like to connect tomorrow morning at 9:00 AM with you to check in on Texas and the recent actions impacting transgender youth and their families.

We will follow up shortly with a zoom meeting link.

Thanks for your flexibility; we apologize for the short notice.

Best,

Carrie

Carrie Pugh
U.S. Department of Health and Human Services
Office of the Secretary
Director of External Affairs, Intergovernmental and External Affairs
Carrie.Pugh@hhs.gov
202-740-1814

Sender:	Tannaz Rasouli <trasouli@aamc.org>
Recipient:	Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>; Pugh, Carrie (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=600602937a904b288a2b2c0d1d75fc6a-Pugh, Carri <Carrie.Pugh@hhs.gov>; kfisher (aamc.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=bade5706c379443fa56e3962b2e1436e-kfisher.os <kfisher@aamc.org>
Sent Date:	2022/03/03 10:26:10
Delivered Date:	2022/03/03 10:29:22

From:	Pugh, Carrie (OS/IEA) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=600602937A904B288A2B2C0D1D75FC6A-PUGH, CARRI <Carrie.Pugh@hhs.gov>
To:	<shughes@aha.org>; <aimee.ossman@childrenshospitals.org>; <plargent@nasn.org>; <lbenson@naspweb.org>; tharo (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=77ded6736adb42ff81723ab67493b11f-tharo <tharo@aap.org>; <mstickel@napnap.org>; <sbutts.nasw@socialworkers.org>; kfisher (aamc.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=bade5706c379443fa56e3962b2e1436e-kfisher.os <kfisher@aamc.org>; <squinn@aafp.org>; <rtetlow@acog.org>; sspeil (fah.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9b823c18bb124b569da34cf53830800a-sspeil.os <sspeil@fah.org>; Curtis, M (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ff5299260b8b4184a12f814f7854f3fc-mcurtis <mcurtis@aap.org>
CC:	Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>; Ladjevardian, Sima (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=95f7e5f6b87f4544ba86a70c9ce17791-Ladjevardin <Sima.Ladjevardian@hhs.gov>; Doris-Pierce, Molly (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=319bffa9a39b432eb695810f0c3a7202-Doris-Pierc <Molly.Doris-pierce@hhs.gov>; Wolff, Kate (ACF) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=b507d714e0e040739beafa5879521e8a-Wolff, Kath <Kate.Wolff@acf.hhs.gov>; Figueroa, Marvin (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=4a287d28c5d248d2a21ad454649a7f7e-Figueroa, M <Marvin.Figueroa@hhs.gov>; Gregg, Destiny (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7114a513d04411e9c829deb16da05ea-Gregg, Dest <Destiny.Gregg@hhs.gov>; Akpa, Stephanie (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=3c984ba53af54d46b78d185808aee48c-Akpa, Steph <Stephanie.Akpa@hhs.gov>
Subject:	RE: Texas Touch Base
Date:	2022/03/03 08:00:13
Priority:	Normal
Type:	Note

Good morning - Just sent everyone the zoom link outlook calendar invite.

From: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Sent: Wednesday, March 2, 2022 5:51 PM
To: shughes@aha.org; aimee.ossman@childrenshospitals.org; plargent@nasn.org; lbenson@naspweb.org; tharo (aap.org) <tharo@aap.org>; mstickel@napnap.org; sbutts.nasw@socialworkers.org; kfisher (aamc.org) <kfisher@aamc.org>; squinn@aafp.org;

rtetlow@acog.org; sspeil (fah.org) <sspeil@fah.org>
Cc: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Ladjevardian, Sima (HHS/IEA) <Sima.Ladjevardian@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wolff, Kate (ACF) <Kate.Wolff@acf.hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Gregg, Destiny (OS/IEA) <Destiny.Gregg@hhs.gov>
Subject: Texas Touch Base

Hello all-

We would like to connect tomorrow morning at 9:00 AM with you to check in on Texas and the recent actions impacting transgender youth and their families.

We will follow up shortly with a zoom meeting link.

Thanks for your flexibility; we apologize for the short notice.

Best,

Carrie

Carrie Pugh
U.S. Department of Health and Human Services
Office of the Secretary
Director of External Affairs, Intergovernmental and External Affairs
Carrie.Pugh@hhs.gov
202-740-1814

Sender:	Pugh, Carrie (OS/IEA) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=600602937A904B288A2B2C0D1D75FC6A-PUGH, CARRI <Carrie.Pugh@hhs.gov>
Recipient:	<shughes@aha.org>; <aimee.ossman@childrenshospitals.org>; <plargent@nasn.org>; <lbenson@naspweb.org>; tharo (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=77ded6736adb42ff81723ab67493b11f-tharo <tharo@aap.org>; <mstickel@napnap.org>; <sbutts.nasw@socialworkers.org>; kfisher (aamc.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=bade5706c379443fa56e3962b2e1436e-kfisher.os <kfisher@aamc.org>; <squinn@aafp.org>; <rtetlow@acog.org>; sspeil (fah.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9b823c18bb124b569da34cf53830800a-sspeil.os <sspeil@fah.org>;

Curtis, M (aap.org) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ff5299260b8b4184a12f814f7854f3fc-mcurtis <mcurtis@aap.org>;
Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>;
Ladjevardian, Sima (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=95f7e5f6b87f4544ba86a70c9ce17791-Ladjevardin <Sima.Ladjevardian@hhs.gov>;
Doris-Pierce, Molly (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=319bffa9a39b432eb695810f0c3a7202-Doris-Pierc <Molly.Doris-pierce@hhs.gov>;
Wolff, Kate (ACF) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=b507d714e0e040739beafa5879521e8a-Wolff, Kath <Kate.Wolff@acf.hhs.gov>;
Figueroa, Marvin (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=4a287d28c5d248d2a21ad454649a7f7e-Figueroa, M <Marvin.Figueroa@hhs.gov>;
Gregg, Destiny (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7114a513d04411e9c829deb16da05ea-Gregg, Dest <Destiny.Gregg@hhs.gov>;
Akpa, Stephanie (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=3c984ba53af54d46b78d185808aee48c-Akpa, Steph <Stephanie.Akpa@hhs.gov>

Sent Date: 2022/03/03 08:00:12

Delivered Date: 2022/03/03 08:00:13

Message Flags: Unread

Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria

Ron DeSantis, Governor
Simone Marstiller, Secretary

Contents

Introductory Remarks and Abstract

Generally Accepted Professional Medical Standards

The Secretary of the Florida Agency for Health Care Administration requested that the Division of Florida Medicaid review the treatment of gender dysphoria for a coverage determination pursuant to Rule 59G-1.035, Florida Administrative Code (F.A.C.) (See Attachment A for the Secretary's Letter to Deputy Secretary Tom Wallace). The treatment reviewed within this report included "sex reassignment treatment," which refers to medical services used to obtain the primary and/or secondary physical sexual characteristics of a male or female. As a condition of coverage, sex reassignment treatment must be "consistent with generally accepted professional medical standards (GAPMS) and not experimental or investigational" (Rule 59G-1.035, F.A.C., see Attachment B for the complete rule text).

The determination process requires that "the Deputy Secretary for Medicaid will make the final determination as to whether the health service is consistent with GAPMS and not experimental or investigational" (Rule 59G-1.035, F.A.C.). In making that determination, Rule 59G-1.035, F.A.C., identifies several factors for consideration. Among other things, the rule contemplates the consideration of "recommendations or assessments by clinical or technical experts on the subject or field" (Rule 59G-1.035(4)(f), F.A.C.). Accordingly, this report attaches five assessments from subject-matter experts:

- **Attachment C:** Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.
- **Attachment D:** James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.
- **Attachment E:** Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.
- **Attachment F:** Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.
- **Attachment G:** G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

Abstract

Available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health.

Five clinical and technical expert assessments attached to this report recommend against the use of such interventions to treat what is categorized as a mental health disorder (See attachments):

- **Health Care Research:** Brignardello-Petersen and Wiercioch performed a systematic review that graded a multitude of studies. They conclude

that evidence supporting sex reassignment treatments is low or very low quality.

- **Clinical Psychology:** Cantor provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements.
- **Plastic Surgery:** Lappert provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest.
- **Pediatric Endocrinology:** Van Meter explains how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation.
- **Bioethics:** Donovan provides additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent.

Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational.

Health Service Summary

Gender Dysphoria

Frequently used to describe individuals whose gender identity conflicts with their natural-born sex, the term gender dysphoria has a history of evolving definitions during the past decades (Note: This report uses the term "gender" in reference to the construct of male and female identities and the term "sex" when regarding biological characteristics). Prior to the publication of the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the American Psychiatric Association (APA) used the diagnosis of gender identity disorder (GID) to describe individuals who sought to transition to the opposite gender. However, behavioral health clinicians sought a revision after determining that using GID created stigma for those who received the diagnosis. This is despite the APA having adopted GID to replace the previous diagnosis of transsexualism for the exact same reason (APA, 2017).[1]

When crafting its new definition and terminology, the APA sought to remove the stigma of classifying as a disorder the questioning of one's gender identity by focusing instead on the psychological distress that such questioning can evoke. This approach argues that individuals seeking behavioral health and transition services are doing so due to experiencing distress and that gender non-conformity by itself is not a mental health issue. This led to the adoption of gender dysphoria in 2013 when the APA released the DSM-V. In addition to using a new term, the APA also differentiated the diagnosis between children and adolescents and adults, listing different characteristics for the two age groups (APA, 2017).

According to the DSM-V, gender dysphoria is defined as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." As for the criteria to receive the diagnosis, the APA issued stricter criteria for children than adolescents and adults. For the former, the APA states that a child must meet six out of eight behavioral characteristics such as having "a strong desire to be of the other gender or an insistence that one is the other gender" or "a strong preference for cross-gender roles in make-believe or fantasy play." The criteria for adults and adolescents are less stringent with individuals only having to meet two out of six characteristics that include "a strong desire to be the other gender" or "a strong desire to be rid of one's primary and/or secondary sexual characteristics." The APA further notes that these criteria can also apply to young adolescents (DSM-V, 2013).

In 2021, the Merck Manual released a slightly different definition for gender dysphoria, citing that the condition "is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the

[1] The concept of gender being part of identity and disconnected from biological sex originated during the mid-twentieth century and was publicized by psychologist John W. Money. His research asserted that gender was a complete social construct and separate from biology, meaning that parents and/or caregivers could imprint on a young child (under three years) the identity of a boy or girl. In 1967, Money's theories led to a failed experiment on twin boys where physicians surgically transitioned one to appear as a girl. The twin that underwent sex reassignment never fully identified as a female. However, Money never publicly acknowledged this and reported the experiment as a success. Furthermore, he promoted his conclusions across the scientific community, concealing what actually unfolded. As a result, Money's ideas on gender fluidity served as a basis for performing procedures on children with hermaphroditic features or genital abnormalities. The case reveals how the understanding of a concept (e.g., gender) at any given time can lead to incorrect medical decisions with irreversible consequences (Gaetano, 2015).

sex assigned at birth." Additionally, the Merck Manual further states that "gender dysphoria is a diagnosis requiring specific criteria but is sometimes used more loosely for people in whom symptoms do not reach a clinical threshold" (Merck Manual, 2021). This definition is largely consistent with the DSM-V but does not emphasize the distress component to the same extent.[2]

Like other behavioral health diagnoses classified in the DSM-V, gender dysphoria has the following subtypes:

- **Early-Onset Gender Dysphoria:** This subtype begins during childhood and persists through adolescence into adulthood. It can be interrupted by periods where the individual does not experience gender dysphoria signs and may classify as homosexual (DSM-V, 2013).
- **Late-Onset Gender Dysphoria:** Occurring after puberty or during adulthood, this subtype does not begin until late adolescence and can emerge following no previous signs of gender dysphoria. The APA attributes this partially to individuals who did not want to verbalize their desires to transition (DSM-V, 2013).

Further studies have identified additional subtypes of gender dysphoria. In 2018, Lisa Littman introduced the concept of a rapid-onset subtype. Classified as rapid-onset gender dysphoria (ROGD), it features characteristics such as sudden beginnings during or following puberty. However, it differs from the DSM-V definitions because ROGD is associated with other causes such as social influences (e.g., peer groups, authority figures, and media). In other words, adolescents who had no history of displaying typical gender dysphoria characteristics go through a sudden change in identity following intense exposure to peers and/or media that heavily promotes transgender lifestyles (Littman, 2018). While more long-term studies are needed to confirm whether ROGD is a temporary or long-term condition, Littman's study has initiated discussions regarding potential causes of gender dysphoria as well as introduced a potential subtype.

Additionally, the frequent use of gender dysphoria in clinical and lay discourse has led to a fracturing of the definition. Studies on the topic frequently do not apply the DSM-V's criteria for the diagnosis and overlook certain key features such as distress. In a 2018 review by Zowie Davy and Michael Toze, the authors evaluated 387 articles that examine gender dysphoria and noted stark departures from the APA's definition. They further asserted that the APA intended to "reduce pathologization" by establishing a new definition for gender dysphoria in the DSM-V. This in turn would reduce diagnoses, although as Davy and Toze note, the tendency for the literature to diverge from the APA's definition may result in increased numbers of individuals classified as having gender dysphoria when they do not meet the DSM-V's criteria (Davy and Toze, 2018). This further raises the question of whether individuals are receiving potentially irreversible treatments for the condition when they might not actually have it.

The current usage of gender dysphoria is the result of discussions spanning across decades as demonstrated in the past editions of the DSM. Until 2013, the APA considered having gender identity issues a mental disorder by itself regardless of the presence of psychological distress. That perspective has since shifted to only consider the adverse psychological effects of questioning one's gender as a disorder. In addition, the APA considers gender as part of one's identity, which is not subject to a diagnosis. Whether the APA has shifted its terminology and criteria for gender identity issues due to

[2] Following the release of the Florida Department of Health's guidelines for treating gender dysphoria, Merck removed its definition for "gender dysphoria" from the Merck Manual (Fox News, 2022).

emerging clinical data or cultural changes is another question. In 1994, the APA replaced transsexualism with gender identity disorder as part of the "effort to reduce stigma" (APA, 2017). This raises questions about what influences decisions to revise definitions and criteria; is it social trends or medical evidence?

Behavioral Health Issues Co-Occurring with Gender Dysphoria

Because gender dysphoria pertains directly to the distress experienced by an individual who desires to change gender identities, secondary behavioral health issues can co-occur such as depression and anxiety. If left untreated, these conditions can lead to the inability to function in daily activities, social isolation, and even suicidal ideation. Studies do confirm that adolescents and adults with gender dysphoria report higher levels of anxiety, depression, and poor peer relationships than the general population (Kuper et al, 2019). Other associated conditions include substance abuse, eating disorders, and compulsivity. A significant proportion of individuals with gender dysphoria also have autism spectrum disorder (ASD) (Saleem and Rizvi, 2017). Although the number reporting secondary issues is increased, individuals diagnosed with gender dysphoria do not necessarily constitute the entire population that is gender non-conforming (i.e., does not identify with natal sex), and no information is available breaking down the percentage of those who are non-conforming with gender dysphoria and those who are non-conforming with no distress. Additionally, available research raises questions as to whether the distress is secondary to pre-existing behavioral health disorders and not gender dysphoria. This is evident in the number of adolescents who reported anxiety and depression diagnoses prior to transitioning (Saleem and Rizvi, 2017).

Furthermore, conventional treatments for secondary behavioral health issues are available. These include cognitive behavioral therapy, medication, and inpatient services. The APA reports that treatments for these are highly effective with 80% to 90% of individuals diagnosed with depression responding positively (APA, 2020). In addition, a high percentage of adolescents diagnosed with gender dysphoria had received psychiatric treatment for a prior or co-occurring mental health issue. A 2015 study from Finland by Kaltiala-Heino et al noted that 75% of children seeking sex reassignment services had been treated by a behavioral health professional (Kaltiala-Heino et al, 2015).

Diagnosing Gender Dysphoria

Prior to the publication of the DSM-V, diagnosing individuals experiencing gender identity issues followed a different process. Behavioral health clinicians could assign the diagnosis based on gender non-conformance alone. That has changed since 2013. Today, non-conforming to one's gender is part of personal identity and not a disorder requiring treatment. This change has led professional associations to shift the diagnostic criteria for gender dysphoria to focus on the distress caused by shifting identities (DSM-V, 2013).

For adolescents, the APA identifies "a marked incongruence between one's experienced/expressed gender and natal sex, of at least 6 months' duration" as the core component of gender dysphoria (DSM-V, 2013). What the APA does not elucidate is the threshold for "marked." This raises questions as to whether practitioners exercise uniformity when applying the diagnostic criteria or if they do so subjectively. For example, the WPATH's *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* provides guidance on the processes mental health practitioners should use when assessing for gender dysphoria but offers no benchmarks for meeting diagnostic criteria (WPATH, 2012).

Such processes include evaluating for gender non-conforming behaviors and other co-existing mental disorders like anxiety or depression. This involves not only interviewing the adolescent but also the family in addition to reviewing medical histories. WPATH also asserts that gender dysphoria assessments need to account for peer relationships, academic performance, and provide information of potential treatments. This last component is necessary because it might affect an individual's choices regarding transitioning, particularly if the information does not correspond to the desired outcome (WPATH, 2012).

The diagnosis of gender dysphoria is a relatively recent concept in mental health, being the product of decades of discussion and building upon previous definitions. Instead of treating gender non-conformity as a disorder, behavioral health professionals acknowledge it as part of one's identity and focus on addressing the associated distress. Considering the new criteria, this changes the dynamics of the population who would have qualified for a diagnosis before 2013 and those who would today. Given that desiring to transition into a gender different from natal sex no longer qualifies as a disorder, behavioral health professionals are treating distress and referring adolescents and adults to therapies that are used off-label and pose irreversible effects.

Current Available Treatments for Gender Dysphoria

At present, proposed treatment for gender dysphoria occurs in four stages, beginning with psychological services and ending with sex reassignment surgery. As an individual progresses through each stage, the treatments gradually become more irreversible with surgical changes being permanent. Because of the increasing effects, individuals must have attempted treatment at the previous stage before pursuing the next one (Note: late adolescents and adults have already completed puberty and do not require puberty blockers). Listed in order, the four stages are as follows:

- **Behavioral Health Services:** Psychologists and other mental health professionals are likely the first practitioners individuals with gender dysphoria will encounter. In accordance with clinical guidelines established by the World Professional Association for Transgender Health (WPATH)[3], behavioral health professionals are supposed to "find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment." WPATH further discourages services for attempting to change someone's gender identity. Instead, it instructs practitioners to assess for the condition and readiness for puberty blockers or cross-sex hormones while offering guidance to function in a chosen gender. WPATH does assert that the clinicians do need to treat any other underlying mental health issues secondary or co-occurring with gender dysphoria (WPATH, 2012). However, the organization provides conflicting guidance because it also advises practitioners to prescribe cross-sex hormones on demand (Levine, 2018).
- **Puberty Suppression:** Used only on individuals in the earliest stages of puberty (Tanner stage 2), preventing pubertal onset provides additional time to explore gender identities before the physical characteristics of biological sex develop. This treatment is intended to reduce distress and anxiety related to the appearance of adult sexual physical features. To suppress puberty, pediatric endocrinologists inject gonadotropin releasing hormone (Gn-RH) at specific intervals (e.g., 4 weeks or 12 weeks). The Gn-RH suppresses gonadotropin receptors that allow for the

[3] The World Professional Association for Transgender Health asserts that it is a professional organization. However, it functions like an advocacy group by allowing open membership to non-clinicians (WPATH, 2022).

development of primary and secondary adult sexual characteristics. Prior to receiving puberty suppression therapy, individuals must have received a diagnosis of gender dysphoria and have undergone a mental health evaluation (Kyriakou et al, 2020).

- **Cross-Sex Hormones:** For adults and late adolescents (16 years or older), the next treatment phase recommended is taking cross-sex hormones (e.g., testosterone or estrogen) to create secondary sex characteristics. In men transitioning into women, these include breast development and widening around the pelvis. Women who transition into men experience deeper voices, redistribution of fat deposits, and growing facial hair. According to the Endocrine Society, late adolescents who qualify for cross-sex hormones must have a confirmed diagnosis of gender dysphoria from a mental health practitioner with experience treating that population. Some physical changes induced by these hormones are irreversible (Endocrine Society, 2017).
- **Sex Reassignment Surgery:** Sometimes referred to as "gender affirming" surgery, this treatment does not consist of just one procedure but several, depending on the desires of the transitioning individual. Primarily, sex reassignment procedures alter the primary and secondary sexual characteristics. Men transitioning into women (trans-females) undergo a penectomy (removal of the penis), orchiectomy (removal of the testes), and vulvoplasty (creation of female genitals). Other procedures trans-females may undergo include breast augmentation and facial feminization. For women that transition into men (trans-males), procedures include mastectomy (removal of the breasts), hysterectomy (removal of the uterus), oophorectomy (removal of the ovaries), and phalloplasty (creation of male genitals). Because of the complexities involved in phalloplasty, many trans-males do not opt for this procedure and limit themselves to mastectomies. Additionally, the effects of sex reassignment surgery, such as infertility, are permanent (WPATH, 2012).

While some clinical organizations assert that they are the standard of care for gender dysphoria, the U.S. Food and Drug Administration (FDA) currently has not approved any medication as clinically indicated for this condition (Unger, 2018). Although puberty blockers and cross-sex hormones are FDA approved, the FDA did not approve them for treating gender dysphoria, meaning that their use for anything other than the clinical indications listed is off-label (American Academy of Pediatrics, 2014). As for surgical procedures, the FDA does not evaluate or approve them, but it does review all surgical devices (FDA, 2021). In addition, the Endocrine Society concedes that its practice guidelines for sex reassignment treatment does *not* constitute a "standard of care" and that its grades for available services are low or very low (Endocrine Society, 2017).[4]

[4] Disagreement over how to treat gender dysphoria, gender identity disorder, and transsexualism has persisted since sex reassignment surgery first became available in the 1960s. In a 2006 counterargument, Paul McHugh highlights how individuals seeking surgery had other reasons that extended beyond gender identity, including sexual arousal and guilt over homosexuality. In addition, he asserts that undergoing sex reassignment procedures did not improve a patient's overall behavioral health and that providing a "surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it" (McHugh, 2006).

Literature Review: Introduction

Currently, an abundance of literature and studies on gender dysphoria is available through academic journals, clinical guidelines, and news articles. Similar to other mental health issues, the material addresses a broad range of topics consisting of available treatments, etiology (i.e., causes), risks, benefits, and side effects. Although most stories reported by the media indicate that treatments such as cross-sex hormones and sex reassignment surgery are the most effective, research reveals that numerous questions still exist. These include what are the long-term health effects of taking cross-sex hormones, what are the real causes of gender dysphoria, and how many individuals that transition will eventually want to revert to their natal sex. Additionally, much of the available research is inconclusive regarding the effectiveness of sex reassignment treatments with multiple studies lacking adequate sample sizes and relying on subjective questionnaires. While much of the scientific literature leans in favor of cross-sex hormones and surgery as options for improving the mental health of individuals with gender dysphoria, it does not conclusively demonstrate that the benefits outweigh the risks involved, either short or long-term. What studies do reveal with certainty is that sex reassignment surgery and cross-sex hormones pose permanent effects that can result in infertility, cardiovascular disease, and disfigurement. All of this indicates that further research is necessary to validate available treatments for gender dysphoria. Thus, physicians, who recommend sex reassignment treatment, are not adhering to an evidence-based medicine approach and are following an eminence-based model.

The following literature review addresses the multiple facets of this condition and presents areas of ongoing debate and persisting questions. Beginning with the condition's etiology and continuing with evaluations of puberty blockers, cross-sex hormones, and surgery, the review explains each area separately and in context of gender dysphoria at large. Additionally, the review provides an analysis on available research on mental health outcomes as well as the condition's persistence into adulthood. Taken as a whole, the available studies demonstrate that existing gender dysphoria research is inconclusive and that current treatments are used to achieve cosmetic benefits while posing risky side effects as well as irreversible changes.

Literature Review: Etiology of Gender Dysphoria

What causes gender dysphoria is an ongoing debate among experts in the scientific and behavioral health fields. Currently, the research indicates that diagnosed individuals have higher proportions of autism spectrum disorder (ASD), history of trauma or abuse, fetal hormone imbalances, and co-existing mental illnesses. Also, experts acknowledge that genetics may factor into gender dysphoria. Another potential cause is social factors such as peer and online media influence. At the moment, none of the studies provides a definite cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative. However, the research does raise questions about whether treatments with permanent effects are warranted in a population with disproportionately high percentages of ASD, behavioral health problems, and trauma.

In a 2017 literature review by Fatima Saleem and Syed Rizvi, the authors examine gender dysphoria's numerous potential causes and the remaining questions requiring further research. In conclusion, the pair indicate that associations exist between the condition and ASD, schizophrenia, childhood abuse, genetics, and endocrine disruption chemicals but that more research is needed to improve understanding of how these underlying issues factor into a diagnosis. Throughout the review, Saleem and Rizvi identify the following as potential contributing elements to the etiology of gender dysphoria:

- **Neuroanatomical Etiology:** During fetal development, the genitals and brain develop during different periods of a pregnancy, the first and second trimesters respectively. Because the processes are separate, misaligned development is possible where the brain may have features belonging to the opposite sex. The authors identify one study where trans-females presented with a "female-like putamen" (structure at the base of the brain) when undergoing magnetic resonance imaging (MRI) scans.[5]
- **Psychiatric Associations:** Saleem and Rizvi identify multiple studies reporting that individuals with gender dysphoria have high rates of anxiety and depressive disorders with results ranging as high as 70% having a mental health diagnosis. In addition, the pair note that schizophrenia may also influence desires to transition. However, the review does not assess whether the mental health conditions are secondary to gender dysphoria.
- **Autism Spectrum Disorder:** Evidence suggests a significant percentage of individuals diagnosed with gender dysphoria also have ASD. The authors note that the available studies only establish a correlation and do not identify mechanisms for causation.
- **Childhood Abuse:** Like the above causes, Saleem and Rizvi note that those with gender dysphoria tended to experience higher rates of child abuse across all categories, including neglect, emotional, physical, and sexual.
- **Endocrine Disruptors:** Although this cause still requires substantial research, it is a valid hypothesis regarding how phthalates found in plastics can create an imbalance of testosterone in fetuses during gestation, which can potentially lead to gender dysphoria. The authors point to one study that makes this suggestion.

[5] Research on neuroanatomical etiology for gender dysphoria remains highly speculative due to limitations of brain imaging (Mayer and McHugh, 2016). In addition, neuroscience demonstrates that exposures to certain environments and stimuli as well as behaviors can affect brain changes (Gu, 2014). Furthermore, available research indicates that male and female brains have different physical characteristics but cannot be placed in separate categories due to extensive overlap of white/grey matter and neural connections (Joel et al, 2015).

Saleem and Rizvi's review reveal that gender dysphoria's etiology can have multiple factors, most of which require treatments and therapies not consisting of cross-sex hormones or surgery. (Saleem and Rizvi, 2017).

Out of the research on the condition's etiology, a large portion focuses on the correlation with ASD. One of the more substantial studies by Van der Miesen et al published in 2018 evaluates 573 adolescents and 807 adults diagnosed with ASD and compares them to 1016 adolescents and 846 adults from the general population. The authors' findings note that adolescents and adults with ASD were approximately 2.5 times more likely to indicate a desire of becoming the opposite sex. Although the methodology used to reach this conclusion consisted of surveys where respondents had a choice of answering "never," "sometimes," or "often," the results correspond with those of similar studies. Van der Miesen et al also indicate that most responses favoring a change in gender responded with "sometimes." Additionally, the authors do not state how many in their sample group actually had a gender dysphoria diagnosis. (Van der Miesen et al, 2018).

Another study by Shumer et al from 2016 utilizes a smaller sample size (39 adolescents) referred to an American hospital's gender clinic. Unlike Van der Miesen et al's research, Shumer et al evaluate subjects with a diagnosis of gender dysphoria for possible signs of ASD or Asperger's syndrome. Their findings revealed that 23% of patients presenting at the clinic would likely have one of the two conditions. Possible explanations for the high percentage are the methods used to gather the data. Shumer et al requested a clinical psychologist to administer the Asperger Syndrome Diagnostic Scale to the parents of the sample patients, four of whom already had an ASD diagnosis. The authors conclude that the evidence to support high incidence of gender dysphoria in individuals with ASD is growing and that further research is needed to determine the specific cause (Shumer et al, 2016).

Research indicating a strong correlation between ASD and gender dysphoria is not the only area where new studies are emerging. Discussions about the effects of prenatal testosterone levels are also becoming more prevalent. One such example is Sadr et al's 2020 study that looks at the lengths of the index and ring fingers (2D:4D) of both left and right hands of 203 individuals diagnosed with gender dysphoria. The authors used this method because prenatal testosterone levels can affect the length ratios of 2D:4D. By comparing the ratios of a group with gender dysphoria to a cohort from the general population, Sadr et al could assess for any significant difference. Their results indicated a difference in trans-females who presented with more feminized hands. For trans-males, the difference was less pronounced. The results for both groups were slight, and the meta-analysis that accompanies the study notes no statistically significant differences in multiple groups from across cultures. However, Sadr et al further assert that the evidence strongly suggests elevated prenatal testosterone levels in girls and reduced amounts in boys may contribute to gender dysphoria, requiring additional research (Sadr et al, 2020).

In addition to biological factors and correlations with ASD, researchers are exploring psychological and social factors to assess their role in gender dysphoria etiology. This literature examines a range of potential causative agents, including child abuse, trauma, and peer group influences. One such study by Kozlowska et al from 2021 explores patterns in children with high-risk attachment issues who also had gender dysphoria. The authors wanted to assess whether past incidents of abuse, loss, or trauma are associated with higher rates of persons desiring to transition. As a basis, Kozlowska et al cite John Bowlby's research on childhood brain development, noting that the process is not linear and depends

heavily on lived experiences. The study further acknowledges that biological factors combined with life events serve as the foundation for the next developmental phase and that early poor-quality attachment issues increase the risk for psychological disorders in adolescence and adulthood. Such disorders include mood and affective disorders, suicidal ideations, and self-harm. Kozlowska et al also cite other studies that indicate a high correlation between gender dysphoria and "adverse childhood events" and further assert that the condition "needs to be conceptualized in the context of the child's lived experience, and the many different ways in which lived experience is biologically embedded to shape the developing brain and to steer each child along their developmental pathway" (Kozlowska et al, 2021).

For their study, Kozlowska et al recruited 70 children diagnosed with gender dysphoria and completed family assessments going back three generations. This in-depth level was necessary to ascertain any and all events that could affect a child's developmental phases. Additionally, the researchers individually assessed the diagnosed children. To establish comparisons, Kozlowska et al performed assessments on a non-clinical group and a mixed-psychiatric group. Their results demonstrate that children with gender dysphoria have significantly higher rates of attachment issues as well as increased reports of "adverse childhood events" such as trauma (e.g., domestic violence and physical abuse). Furthermore, the authors indicate that a high proportion of families reported "instability, conflict, parental psychiatric disorder, financial stress, maltreatment events, and relational ruptures." These results led Kozlowska et al to conclude that gender dysphoria can be "associated with developmental pathways – reflected in at-risk patterns of attachment and high rates of unresolved loss and trauma – that are shaped by disruptions to family stability and cohesion." The study also cites that treatment requires "a comprehensive biopsychosocial assessment with the child and family, followed by therapeutic interventions that address, insofar as possible, the breadth of factors that are interconnected with each particular child's presentation" (Kozlowska et al, 2021).

This recent study raises questions regarding the medical necessity of gender dysphoria treatments such as puberty blockers and cross-sex hormones for adolescents. If high percentages of children diagnosed with gender dysphoria also have histories of trauma and attachment issues, should conventional behavioral health services be utilized without proposing treatments that pose irreversible effects? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects (i.e., the watchful waiting approach)?

Aside from the notion that childhood abuse and adversity can potentially cause gender dysphoria, other possible explanations such as social factors (e.g., peer influences and media) may be contributing factors. Research on rapid onset gender dysphoria (ROGD) links this phenomenon to peer and social elements. In an analysis utilizing parent surveys, Lisa Littman asserts that the rapid rise of ROGD is not associated with the traditional patterns of gender dysphoria onset (i.e., evidence of an individual's gravitation to the opposite sex documented over multiple years) but rather exposure to "social and peer contagion." Littman uses this term in the context of definitions cited in academic literature, stating that "social contagion is the spread of affect or behaviors through a population" and that "peer contagion is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially undermine their own development or harm others." Examples of the latter's negative effects include depression, eating disorders, and substance abuse. What prompted this study is a sudden increase of parents reporting their daughters declaring themselves to be transgender without any previous signs of gender dysphoria. Littman also indicates

that these parents cite that their daughters became immersed in peer groups and social media that emphasized transgender lifestyles (Littman, 2018).

In addition to identifying characteristics of ROGD, the study examines social media content that provides information to adolescents regarding how to obtain cross-sex hormones through deception of physicians, parents, and behavioral health professionals. Such guidance includes coaching on how to fit a description to correspond to the DSM-V and pressures to implement treatment during youth to avoid a potential lifetime of unhappiness in an undesirable body. Littman further states that "online content may encourage vulnerable individuals to believe that non-specific symptoms and vague feelings should be interpreted as gender dysphoria." The study also notes that none of the individuals assessed using the parental surveys qualified for a formal diagnosis using the DSM-V criteria (Littman, 2018).

The survey responses revealed similar data to Kozlowska et al's study with 62.5% of the adolescents having a mental health or neurodevelopmental disorder. Furthermore, the responses indicate a rapid desire to bypass behavioral health options and pursue cross-sex hormones. 28.1% of parents surveyed stated that their adolescents did not want psychiatric treatments. One parent even reported that their daughter stopped taking prescribed anti-depressants and sought advice only from a gender therapist. Littman's research further reveals that 21.2% of parents responded that their adolescent received a prescription for puberty blockers or cross-sex hormones at their first visit (Littman, 2018). These responses indicate that practitioners do not uniformly follow clinical guidelines when making diagnoses or prescribing treatment.

In the discussion, Littman proposes two hypotheses for the appearance of ROGD. The first states that social and peer contagion is one of the primary causes, and the second asserts that ROGD is a "maladaptive coping mechanism" for adolescents dealing with emotional and social issues. While the surveyed parents did not report early signs of gender dysphoria, a majority noted that their daughters had difficulty in handling negative emotions. Littman concludes that ROGD is distinct from gender dysphoria as described in the DSM-V and that further research is needed to assess whether the condition is short or long-term (Littman, 2018). What the study does not explore, but raises the question, is what proportion of those being treated for gender dysphoria are adolescents with ROGD.

Littman's study along with the others reveal that the causes of gender dysphoria are still a mystery and could have multiple biological and social elements. Because of this ongoing uncertainty, treatments that pose irreversible effects should not be utilized to address what is still categorized as a mental health issue. That allows adequate opportunity for individuals to receive treatment for co-existing mental disorders, establish their gender dysphoria diagnoses, and understand how cross-sex hormones and surgery will alter the appearance of their bodies as well as long-term health.

Literature Review: Desistance of Gender Dysphoria and Puberty Suppression

The World Professional Association for Transgender Health (WPATH) and the Endocrine Society both endorse the use of gonadotropin releasing hormones (Gn-RH) to suppress puberty in young adolescents who have gender dysphoria. Both organizations state that the treatment is safe and fully reversible. In addition, they state that delaying pubertal onset can provide extra time for adolescents to explore the gender in which they choose to live. The associations further state that puberty suppression is necessary to prevent the development of primary and secondary sexual characteristics that can inhibit successful transitions into adulthood (WPATH, 2012; Endocrine Society, 2017). Of the two groups, WPATH offers clinical criteria an individual should meet to qualify for puberty suppression such as addressing psychological co-morbidities and assessing whether gender dysphoria has intensified (WPATH, 2012).

Neither organization explains that the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects. Both organizations neglect to mention that using Gn-RH for gender dysphoria by altering the appearance is not an FDA-approved clinical indication. Furthermore, the research used to justify puberty suppression is low or very-low quality and little information is available on long-term effects (Hruz, 2019). Additionally, in his assessment, Quentin Van Meter explained that physical differences between central precocious puberty and natural onset puberty demonstrate that Gn-RH does not have permanent adverse effects for those treated for the former but can for the latter such as insufficient bone-mineral density and neural development (Van Meter, 2022). Also, as recently as May 17, 2022, during a U.S. Senate Committee on Appropriations hearing, Lawrence Tabak, acting director of the National Institutes of Health, responded to Senator Marco Rubio, acknowledging that no long-term studies are available evaluating the effects of puberty blockers when used for gender dysphoria (U.S. Senate Committee on Appropriations, 2022).

Currently, some studies provide weak support for this treatment but leave too many questions as to its effectiveness and medical necessity, especially considering how many children decide against transitioning. In addition, puberty blockers halt development of primary and secondary sexual characteristics and deny opportunities for adolescents to adapt and become comfortable with their natal sex. Instead, puberty blockers can serve as a potential "gateway drug" for cross-sex hormones by denying them the experience of physically maturing (Laidlaw et al, 2018).

A 2013 study by Steensma et al offers data on the percentage of children who opt not to transition after experiencing gender dysphoria. The authors follow 127 adolescents (mean age of 15 during the evaluation period) for four years who had been referred to a Dutch gender dysphoria clinic. Out of this cohort, 47 (37%; 23 boys and 24 girls) continued experiencing the condition and applied for sex reassignment treatment. The other 80 adolescents never returned to the clinic. Because this clinic was the only one that treated gender dysphoria in the Netherlands, Steensma et al assumed that those who did not return no longer desired transitioning. The study indicates one of the key predictors for persisting gender dysphoria was the age of first presentation. Older adolescents that started going to the clinic were more likely to persist, while younger adolescents tended not to follow through. Steensma et al provide further insight into other predicting factors, particularly on how each individual views his or her gender identity. The authors note that adolescents who "wished they were the other sex" were more likely to become desisters and that those who "believed that they were the other sex" persisted

and later sought sex reassignment treatment (Steensma et al, 2013). While the study focuses on factors that contribute to the condition's persistence or desistance, it raises the question as to whether puberty suppression is necessary when age plays such an important role regarding the decision to transition.

WPATH and the Endocrine Society state that the primary reason for initiating pubertal suppression is not to treat a physical condition but to improve the mental health of adolescents with gender dysphoria. However, available research does not yield definitive results that this method is effective at addressing a mental health issue. The "gold standard" for medical studies is the randomized-controlled trial (RCT). Because RCTs utilize large sample sizes, have blind testing groups (i.e, placebos), and use objective controls, they can offer concrete conclusions and shape the array of established treatments. In addition, RCTs require comparisons between cohort outcomes and ensure that participants are randomly assigned to each group. These measures further reduce the potential for bias and subjectivity (Hariton and Locascio, 2018).

Presently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available. Instead, the limited number of published studies on the topic utilize small sample sizes and subjective methods (Hruz, 2019). A 2015 article by Costa et al is one such example. The study asserts that "psychological support and puberty suppression were both associated with an improved global psychological functioning in gender dysphoric adolescents." To reach this conclusion, the authors selected 201 children diagnosed with the condition and divided them into two groups, one to receive psychological support only and the other to get puberty blockers in addition to psychological support. Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control. To assess whether puberty suppression is an effective treatment, the authors administered two self-assessments (Utrect Gender Dysphoria Scale and Children's Global Assessment Scale)[6] to the groups at 6-month intervals during a 12-month period. Because the study relies heavily on self-assessments, the conclusions are likely biased and invalid. Another problem that is also present and common throughout articles supporting puberty suppression is the short-term period of the study. Costa et al's conclusions may not be the same if additional follow-ups occurred three or five years later (Costa et al, 2015). This further raises the question whether low-quality studies like Costa et al's should serve as the basis for clinical guidelines advising clinicians to prescribe drugs for off-label purposes.

Aside from questionable research, information regarding the full physical effects of puberty suppression is incomplete. In a 2020 consensus parameter prepared by Chen et al, 44 experts in neurodevelopment, gender development, and puberty/adolescence reached a conclusion stating that "the effects of pubertal suppression warrant further study." The basis for this was that the "full consequences (both beneficial and adverse) of suppressing endogenous puberty are not yet understood." The participating experts emphasized that the treatment's impact on neurodevelopment in adolescents remains unknown. Chen et al explain that puberty-related hormones play a role in brain development as documented in animal studies and that stopping these hormones also prevents neurodevelopment in addition to sexual maturation. The authors further raise the question whether normal brain development resumes as if it had not been interrupted when puberty suppression ceases. Because this

[6] Behavioral health practitioners use the Children's Global Assessment Scale (CGAS) to measure child functioning during the evaluation process to determine diagnoses. Available evidence indicates that the CGAS is not effective for evaluating children who experienced trauma and presented with mental health symptoms (Blake et al, 2006).

question remains unanswered, it casts doubt on the veracity of organizations' assertions that puberty suppression is "fully reversible" (Chen et al, 2020).

In addition to the unanswered questions and low-quality research, puberty suppression causes side effects, some of which have the potential to be permanent. According to a 2019 literature review by De Sanctis et al, most side effects associated with Gn-RH are mild, consisting mostly of irritation around injection sites. However, clinicians have linked the drug to long-term conditions such as polycystic ovarian syndrome, obesity, hypertension, and reduced bone mineral density. While reports of these events are low and the authors indicate that Gn-RH is safe for treating central precocious puberty (Note: De Sanctis et al do not consider gender dysphoria in their analysis), the review raises questions about whether off-label use to treat a psychological condition is worth the risks (De Sanctis et al, 2019).

Furthermore, De Sanctis et al cite studies noting increased obesity rates in girls who take Gn-RH but that more research is needed to gauge the consistency. Additionally, the authors note that evidence is strong regarding reduced bone mineral density during puberty suppression but indicate that the literature suggests it is reversible following treatment (De Sanctis et al, 2019). While research leans toward the reversibility of effects on bone mineral density, the quantity of studies available on this subject are limited. Also, no long-term research has been completed on how puberty suppression affects bone growth. This is significant because puberty is when bone mass accumulates the most (Kyriakou et al, 2020). One example of a complication involving bone growth and Gn-RH is slipped capital femoral epiphysis. This condition occurs when the head of the femur (i.e., thighbone) can slip out of the pelvis, which can eventually lead to osteonecrosis (i.e., bone death) of the femoral head. Although the complication is rare, its link to puberty suppression indicates that the "lack of adequate sex hormone exposure" could be a cause (De Sanctis et al, 2019).

The current literature on puberty suppression indicates that using it to treat gender dysphoria is off-label, poses potentially permanent side effects, and has questionable mental health benefits. The limited research and lack of FDA approval for that clinical indication prompt questions about whether medications with physically altering effects should be used to treat a problem that most adolescents who experience it will later overcome by conforming to their natal sex. Additional evidence is required to establish puberty suppression as a standard treatment for gender dysphoria.

Literature Review: Cross-Sex Hormones as a Treatment for Gender Dysphoria

Currently, the debate surrounding the use of cross-sex hormones to treat gender dysphoria revolves around their ability to improve mental health without causing irreversible effects. It is not about whether taking cross-sex hormones can alter someone's appearance. The evidence demonstrating the effectiveness of cross-sex hormones in achieving the secondary sexual characteristics of the opposite sex is abundant. Also, the overall scientific consensus concludes that individuals who take cross-sex hormones will reduce the primary sexual function of his or her natal sex organs. What researchers continue evaluating are the short and long-term effects on mental health, impacts on overall physical health, and how the changes affect the ability to detransition. Of these, benefits to mental health overshadow the other discussions. Prescribers of cross-sex hormones focus so heavily on behavioral health outcomes that they de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death (Hruz, 2020). Some clinical guidelines such as WPATH's do not even indicate that some of the changes are irreversible.

Like puberty suppression, the Endocrine Society and WPATH provide guidance on administering cross-sex hormones to individuals with gender dysphoria. Both organizations state that this treatment should not be administered without a confirmed diagnosis of gender dysphoria and only after a full psychosocial assessment. In addition, behavioral health practitioners must ensure that any mental comorbidities are not affecting the individual's desire to transition. WPATH and the Endocrine Society further state that clinicians should administer hormone replacements such as testosterone and Estradiol (estrogen) in gradual phases, where the dose increases over several months. For trans-females, the organizations state that progesterone (anti-androgen) is also necessary to block the effects of naturally produced testosterone (WPATH, 2012; Endocrine Society, 2017). When taking cross-sex hormones, trans-males need increased doses for the first six months. After that, the testosterone's effects are the same on lower doses. Once started, individuals cannot stop taking hormones unless they desire to detransition (Unger, 2016).

Although the two groups provide similar guidance, they vary on statements that can have significant impact on long-term outcomes, particularly regarding age. According to WPATH's standards, 16 years is the general age for initiating cross-sex hormones, but the organization acknowledges that the treatment can occur for younger individuals depending on circumstances (WPATH, 2012). This differs from the Endocrine Society, which states no specific age for appropriateness and explains the disagreements in assigning a number. The group highlights that most adolescents have attained sufficient competence by age 16 but may not have developed adequate abilities to assess risk (Endocrine Society, 2017). This raises the question whether adolescents can make sound decisions regarding their long-term health. Additionally, the varying guidance raises an issue with WPATH not only using age 16 as a standard but also indicating that younger adolescents are capable of making that choice.

WPATH's guidance also does not stress the irreversible nature of cross-sex hormones, citing the treatment as "partially reversible" and not indicating which changes are permanent. Furthermore, parts of WPATH's information are misleading and directly conflict with guidance issued by clinics and other sources. One such example consists of WPATH stating that "hormone therapy *may* (emphasis added) lead to irreversible changes." This statement is misleading in light of existing research, which indicates that multiple physical changes are permanent. In addition, WPATH claims that certain effects of cross-

sex hormones such as clitoral enlargement can last one to two years when it is actually irreversible (UCSF, 2020). WPATH also does not explain the risks to male fertility, noting that lowered sperm count or sterility is "variable." The University of California at San Francisco (UCSF) provides starkly different information by stating that trans-females should expect to become sterile within a few months of starting cross-sex hormones. UCSF also advises trans-females to consult a sperm bank if they may want to father children after transitioning (WPATH, 2012; UCSF, 2020). Below is a chart that outlines the effects of cross-sex hormones and identifies which ones are reversible or permanent.

Physical Changes Effectuated by Cross-Sex Hormones	
Physical Changes in Trans-Males (Female-to-Male Transitions)	
Physical Change	**Reversible or Irreversible**
Oily Skin or Acne	Reversible
Facial and Body Hair Growth	Irreversible
Male-Pattern Baldness	Irreversible
Increased Muscle Mass	Reversible
Body Fat Redistribution	Reversible
Ceasing of Menstruation	Reversible
Enlarged Clitoris	Irreversible
Vaginal Atrophy	Reversible
Deepening of Voice	Irreversible
Physical Changes in Trans-Females (Male-to-Female Transitions)	
Body Fat Redistribution	Reversible
Decreased Muscle Mass	Reversible
Skin Softening or Decrease in Oiliness	Reversible
Lower Libido	Reversible
Fewer Spontaneous Erections	Reversible
Male Sexual Dysfunction	Possibly Irreversible
Breast Growth	Irreversible
Decrease in Testicular Size	Reversible
Decrease in Sperm Production or Infertility	Likely Irreversible
Slower Facial and Body Hair Growth	Reversible

Sources: UCSF, 2020; WPATH, 2012; Endocrine Society, 2017[7]

The above chart demonstrates that trans-males and trans-females experience different effects from cross-sex hormones that can cause myriad issues in later life. For example, trans-males who opt to detransition may face challenges related to permanent disfigurement (e.g., facial hair and deepened voices). Trans-females, on the other hand, may not endure the same issues pertaining to visible physical changes but might become despondent over being unable to reproduce. This can occur regardless of whether the transitioning individual is satisfied with sex reassignment. Given that the clinical guidelines do not provide uniform information on the permanent effects of cross-sex hormones, clinicians are unable to make sound recommendations to patients. This treatment can supposedly alleviate symptoms

[7] This chart consists of conclusions regarding physical changes made by three different clinical organizations. If one organization determined that a physical change was irreversible, that was sufficient to meet the criteria to be listed as "irreversible" in the chart.

of distress. However, cross-sex hormones' permanent effects also have the potential to cause psychological issues.

Arguments favoring cross-sex hormones assert that the desired physical changes can alleviate mental health issues in individuals with gender dysphoria but do not consider that hormones used in this manner, like puberty blockers, are off-label. While the FDA has approved estrogen and testosterone for specific clinical indications (e.g., hypogonadism), it has not cleared these drugs for treating gender dysphoria. Additionally, these arguments do not acknowledge that the U.S. Drug Enforcement Administration (DEA) lists testosterone as a Schedule III controlled substance, meaning that it has a high probability of abuse (DEA, 2022). Furthermore, evidence of psychological benefit from cross-sex hormones is low-quality and relies heavily on self-assessments taken from small sample groups (Hruz, 2020).

A 2019 study by Kuper et al seeks to demonstrate that adolescents desiring cross-sex hormones have elevated rates of depression, anxiety, and challenges with peer relationships. To make their findings, the authors provided questionnaires to 149 adolescents who presented at a gender clinic in Dallas, Texas and concluded that half of the sample group experienced increased psychological issues. One problem with the study is that it relies on parent or self-assessments such as the Youth-Self Report, Body-Image Scale, and the Child Behavior Checklist. While these assessments have strong reliability, the sample is cross-sectional, consisting of gender dysphoric individuals who presented for an initial visit at the clinic. Also, Kuper et al do not directly link these psychological symptoms to gender dysphoria but rather insinuate a strong connection. Without an analysis of the longitudinal histories of the participants, the study cannot demonstrate whether gender dysphoria was a direct cause of the psychological issues, which could possibly result from trauma, abuse, or family dysfunction. Kuper et al's study only presents weak correlation between adolescents who report symptoms of distress and gender dysphoria. While the authors do not claim that the participants' psychological problems caused the condition, they fail to explicitly state that no demonstrable relationship exists and explain that their findings are "broadly consistent with the previous literature" (Kuper et al, 2019).

Additionally, a more comprehensive literature review from 2019 by Nguyen et al evaluates the effect of cross-sex hormones on mental health outcomes. Although the authors argue that the evidence supports the treatment, they do note that available studies use "uncontrolled observational methods" and "rely on self-report." The review also asserts that "future research should focus on applying more robust study designs with large sample sizes, such as controlled prospective cohort studies using clinician-administered ratings and longitudinal designs with appropriately matched control groups." All of these are characteristics of RCTs. While Nguyen et al highlight flaws in the studies in their conclusion, they do not emphasize them in their analysis, opting to focus primarily on results. Another problem with the studies selected for the review is the short-term periods for evaluation. Out of 11 studies Nguyen et al discuss, only one tracks its participants for 24 months. The others only follow their cohorts for 6 or 12 months (Nguyen et al, 2019). Without long-term data to support assertions that cross-sex hormones substantially improve the mental health of individuals with gender dysphoria, the review cannot make definitive conclusions on the treatment's benefits.

Basing their stances on this low-quality evidence, clinical associations such as the American Academy of Pediatrics (AAP) and the American Psychology Association endorse the use of cross-sex hormones as treatments for gender dysphoria. In particular, the AAP discourages use of the term "transition" and

asserts that medical treatments used to obtain secondary characteristics of the opposite sex are "gender affirming." This decision mirrors the DSM-V's interpretation of gender being part of identity. The AAP further states that taking cross-sex hormones is an "affirmation and acceptance of who they (i.e., patient) have always been" (AAP, 2018). The American Psychological Association also takes a similar stance in its *Resolution on Gender Identity Change Efforts* by asserting that medical treatments such as puberty suppression, cross-sex hormones, and surgery improve mental health and quality of life and reinforce the notion that transitioning and seeking sex reassignment therapies do not constitute a psychological disorder (American Psychological Association, 2021). Stances like these can substantially influence practitioners and their treatment recommendations. Given that low-quality evidence serves as the basis for supportive positions, this raises questions about whether clinicians can make informed decisions for their patients that will promote the best outcomes.

James Cantor published a critique in 2020 of the AAP's endorsement of "gender affirming" treatments, arguing that the organization did not base its recommendations on established medical evidence. He asserts that the AAP's position is based on research that does not support intervention but rather supports "watchful waiting" because most transgender youths desist and identify as their natal sex during puberty. Cantor further argues that the AAP not only disregards evidence but also cites "gender affirming" interventions as the only effective method. To conclude, he states the organization is "advocating for something far in excess of mainstream practice and medical consensus" (Cantor, 2020).

Given those evidentiary problems, those who rely on the AAP's endorsement as a basis for "gender affirming" treatments are practicing eminence-based medicine as opposed to evidence-based medicine. Eminence-based medicine refers to clinical decisions made by relying on the opinions of prominent health organizations rather than relying on critical appraisals of scientific evidence (Nhi Le, 2016). While it is true that the AAP has more knowledge than a lay person and a degree of credibility in the medical community, the opinions of such organizations are not valid unless they are based on quality evidence.

Research on sex reassignment also does not adequately address the reasons for and prevalence of detransitioning. Although no definite numbers are available regarding the percentage of transgender people who decide to detransition, research indicates that roughly 8% decide to return to their natal sex. The reasons range from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria. In a 2020 study by Lisa Littman, 101 people who had detransitioned provided their basis for doing so. Out of the sample group, 96% had taken cross-sex hormones and 33% had sex reassignment surgery. The average age for transitioning was 22 years, and the mean duration for the transition was 4 years. This indicates that even allowing additional time beyond the recommended age of 16 years can still lead to regrets. The study also raises the question as to whether individuals who transitioned at 16 or younger wanted to detransition in greater numbers. The author further offers reasons why these individuals sought cross-sex hormones and surgery, which include having endured trauma (mental or sexual), homophobia (challenged to accept oneself as a homosexual), peer and media influences, and misogyny (applicable only to trans-males). To obtain the results, the participants responded to a survey that asked about their backgrounds (e.g., reasons for transitioning, mental health comorbidities), and motivations for detransitioning. Littman noted that half of the women (former trans-males) had a mental health disorder and/or had experienced trauma within a year of deciding to transition. Men (former trans-females) reported much lower numbers of behavioral health issues and trauma after de-transitioning. Additionally, 77% of men surveyed identified as the opposite gender prior to transition, whereas just 58% of women had (Littman, 2020).

Of the reasons cited for detransitioning, the majority (60%) noted that they became more comfortable with their natal sex. Other reasons included concerns over complications from the treatments, primarily cross-sex hormones, and lack of improved mental health. Other less-cited explanations include concerns about workplace discrimination and worsening physical health. The study also notes that approximately 36% of participants experienced worse mental health symptoms. Based on the findings, Littman concludes that more research is needed in tracking the transgender population to obtain accurate percentages of those who decide to detransition and that men and women reported varying reasons for deciding to transition and later return to their natal sex. The author notes that higher rates of trauma and peer group influences might have contributed to women's decisions, which Littman attributes partially to rapid onset gender dysphoria (Littman, 2020). What the study also indicates is that cross-sex hormones are not a validated treatment for gender dysphoria. Nearly all of the participants had taken them and decided against maintaining the physical changes. Given that the majority of surveyed detransitioners cited that they were comfortable with their biological sex, the study indicates that gender dysphoria is not necessarily a lifelong issue. This necessarily raises doubts about whether cross-hormones, which cause permanent physical damage, is justified.

In addition to the psychological factors, cross-sex hormones pose significant long-term health risks to transitioning individuals. Currently, little information is available given that researchers have not had adequate time to study the effects in this population. However, use of hormones for other conditions has yielded data on how these drugs can affect the body and the cardiovascular system in particular. Because of the high dosages required to achieve physical change and the need to continuously take the drugs, cross-sex hormones can potentially harm quality of life and reduce life expectancy for transitioning individuals. According to Dutra et al, trans-females are three times more likely to die from a cardiovascular event than the general population. In their 2019 literature review, Dutra et al examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that use of estrogen or testosterone can increase risks for cardiovascular disease. Throughout their review, Dutra et al cite examples of trans-females having higher triglyceride levels after 24 months of cross-sex hormones and how researchers halted a study on estrogen due to an increase in heart attacks among participants. Another article the authors reference indicates a higher risk for thromboembolisms (i.e., blood clots) in trans-females. For trans-males, Dutra et al explain that research shows significant increased risk for hypertension, high cholesterol, obesity, and heart attacks. One study noted that trans-males have a four times greater risk of heart attack compared to women identifying as their natal sex. Dutra et al conclude that most transgender individuals are younger than 50 and that more studies are needed as this population ages. They do note that available studies indicate that cross-sex hormones pose dangers to long-term cardiovascular health (Dutra et al, 2019).

In sum, the literature reveals that the evidence for cross-sex hormones as a treatment for gender dysphoria is weak and insufficient. Between the permanent effects, off-label use, and consequences to long-term health, cross-sex hormones are a risky option that does not promise a cure but does guarantee irreversible changes to both male and female bodies. Additionally, the inadequate studies serving as the basis for recommendations by clinical associations can lead to providers making poorly informed decisions for their patients. Research asserting that taking cross-sex hormones improves mental health is subjective and short-term. More studies that utilize large sample sizes and appropriate

methods is required before the medical profession should consider cross-sex hormones as one of gender dysphoria's standard treatments.

Literature Review: Sex Reassignment Surgery

The final phase of treatment for gender dysphoria is sex reassignment surgery. This method consists of multiple procedures to alter the appearance of the body to resemble an individual's desired gender. Some procedures apply to the genitals (genital procedures) while others affect facial features and vocal cords (non-genital procedures). While the surgery creates aesthetical aspects, it does not fully transform someone into the opposite biological sex. Transgender persons who undergo the procedures must continue taking cross-sex hormones to maintain secondary sexual characteristics. Additionally, all physical changes are irreversible, and the success rate of a surgery varies depending on the procedure and the population. For example, surgeries for trans-females have much better results than those for trans-males. Complications such as post-operative infections can also arise with the urinary tract system. However, sex reassignment surgery supposedly can provide drastic, if not complete, relief from gender dysphoria (Endocrine Society, 2017). The following is a list of procedures (both genital and non-genital) for trans-females and trans-males that create physical features of the desired sex.

Procedures for Trans-Females

- **Genital Surgeries:** These consist of penectomy (removal of the penis), orchiectomy (removal of the testicles), vaginoplasty (construction of a neo-vagina), clitoroplasty (construction of a clitoris), and vulvoplasty (construction of a vulva and labia). To perform, a surgeon begins by deconstructing the penis and removing the testicles. The penile shaft and glans are repurposed to serve as a neo-vagina and artificial clitoris (Note: These are not actual female genitalia but tissue constructed to resemble female anatomy). If the shaft tissue is insufficient, the surgeon may opt to use a portion of intestine to build a neo-vagina. The scrotum serves as material for fashioning a vulva and labia. In addition to constructing female genitalia, the surgeon reroutes the urethra to align with the neo-vagina. Genital surgeries for trans-females result in permanent sterility (Bizic et al, 2014).
- **Chest Surgery:** To attain full breasts, trans-females can undergo enlargement. The procedure is similar to breast augmentation for women where a surgeon places implants underneath breast tissue. Prior to surgery, trans-females need to take cross-sex hormones for roughly 24 months to increase breast size to get maximum benefit from the procedure (Endocrine Society, 2017).
- **Cosmetic and Voice Surgeries:** Designed to create feminine facial features, fat deposits, and vocal sounds, these procedures are secondary to genital procedures and intended to alter trans-females' appearances to better integrate into society as a member of the desired gender (WPATH, 2012).

Procedures for Trans-Males

- **Mastectomy:** This is the most performed sex reassignment surgery on trans-males because cross-sex hormones and chest-binding garments are often insufficient at diminishing breasts. To remove this secondary sexual characteristic, trans-males can undergo a mastectomy where a surgeon removes breast tissue subcutaneously (i.e., under the skin) and reconstructs the nipples to appear masculine. The procedure can result in significant scarring (Monstrey et al, 2011).
- **Genital Surgeries:** Unlike the procedures for trans-females, genital surgeries for trans-males are more complex and have lower success rates. Consisting of hysterectomy, oophorectomy

(removal of the ovaries), vaginectomy (removal of the vagina), phalloplasty (construction of a penis), and scrotoplasty (construction of prosthetic testicles), a team of surgeons must manufacture a penis using skin from the patient (taken from an appendage) while removing the vagina and creating an extended urethra. The functionality of the artificial penis can vary based on how extensive the construction was. Attaining erections requires additional surgery to implant a prosthesis, and the ability to urinate while standing is often not achieved. Genital procedures for trans-males result in irreversible sterility (Monstrey et al, 2011).

- **Cosmetic Surgeries:** Similar to trans-females, these procedures create masculine facial features, fat deposits, and artificial pectoral muscles. They aid trans-males with socially integrating as their desired gender. Surgery to deepen voices is also available but rarely performed (WPATH, 2012).

Because sex reassignment surgery is irreversible, the criteria for receiving these procedures is the strictest of all gender dysphoria treatments. WPATH and the Endocrine Society suggest rigorous reviews of patient history and prior use of other therapies before approving. Furthermore, the two organizations recommend that only adults (18 years old) undergo sex reassignment surgery.[8] WPATH and the Endocrine Society also recommend ensuring a strongly documented diagnosis of gender dysphoria, addressing all medical and mental health issues, and at least 12 months of cross-sex hormones for genital surgeries. Although the organizations agree on most criteria, they differ on whether hormones should be taken prior to mastectomies. WPATH asserts that hormones should not be a requirement, whereas the Endocrine Society advises up to 2 years of cross-sex hormones before undergoing the procedure (WPATH, 2012; Endocrine Society, 2017). What this indicates is that trans-males might undergo breast removal without having first pursued all options if their clinician adheres to WPATH's guidelines, which can lead to possible regret over irreversible effects.

As with cross-sex hormones, sex reassignment surgery's irreversible physical changes can potentially show marked mental health improvements and prevent suicidality in people diagnosed with gender dysphoria. In April 2022, the chair of the University of Florida's pediatric endocrinology department, Dr. Michael Haller, advocated for the benefits of "gender affirming" treatments (WUSF, 2020). However, the available evidence calls such statements into question. Recent research assessing both cross-sex hormones and sex reassignment surgery indicate that the effects on "long-term mental health are largely unknown." In studies regarding the benefits of surgery, the results have the same weaknesses as the research for the effectiveness of cross-sex hormones. These include small sample sizes, self-report surveys, and short evaluation periods, all of which are insufficient to justify recommendations for irreversible treatments (Bränström et al, 2020).

Two studies conducted in Sweden provide insight on the effectiveness of sex reassignment surgery in improving the behavioral health of transgender persons. Because Sweden has a nationalized health system that collects data on all residents, this country can serve as a resource to assess service utilization and inpatient admissions. Both studies, one by Dhejne et al from 2011 and another by Bränström et al published in 2020, assessed individuals who had received sex reassignment surgery and examined outcomes over several decades. Dhejne et al's findings indicate that sex reassignment

[8] Although practice guidelines indicate the minimum age to undergo sex reassignment surgery is 18, available evidence demonstrates that mastectomies have been performed on adolescent girls as young as 13 who experience "chest dysphoria" (Olson-Kennedy et al, 2018).

procedures do not reduce suicidality. The authors explained that individuals who underwent sex reassignment surgery were still more likely to attempt or commit suicide than those in the general population. This study is unique because it monitored the subjects over a long period of time. Dhejne et al note that the transgender persons tracked for the study did not show an elevated suicide risk until ten years after surgery (Dhejne et al, 2011). Given that a high proportion of research follows sex reassignment patients for much shorter timeframes, this evidence indicates that surgery might have little to no effect in preventing suicides in gender dysphoric individuals over the long run.

In addition to having an increased suicide risk, Dhejne et al discuss how individuals who underwent sex reassignment procedures also had higher mortality due to cardiovascular disease. The authors do not list the specific causes but establish the correlation. Given that cross-sex hormones can damage the heart, the increased risk could be related to the drugs and not the surgery. Furthermore, the study explains that the tracked population had higher rates of psychiatric inpatient admissions following sex reassignment. Dhejne et al established this by examining the rates of psychiatric hospitalizations in these individuals prior to surgery and noted higher utilization in the years following the procedures. These results are in comparison to the Swedish population at large. While the study contradicts other research emphasizing improvements in mental health issues, it has its limitations. For example, the sample size is small. Dhejne et al identified only 324 individuals who had undergone sex reassignment surgery between 1973 and 2003. In addition, the authors noted that while the tracked population had increased suicide risks when compared to individuals identifying as their natal sex, the rates could have been much higher if the procedures were not available (Dhejne et al 2011). What this study postulates is that sex reassignment surgery does not necessarily serve as a "cure" to the distress resulting from gender dysphoria and that ongoing behavioral health care may still be required even after a complete transition.

Bränström et al's study evaluating the Swedish population used a larger sample (1,018 individuals who had received sex reassignment surgery) but tracked them for just a ten-year period (2005 to 2015).[9] Unlike Dhejne et al, the authors did not track suicides and focused primarily on mood or anxiety disorder treatment utilization. Their results indicate that transgender persons who had undergone surgery utilized psychiatric outpatient services at lower rates and were prescribed medications for behavioral health issues at an annual decrease rate of 8%. Bränström et al also did not limit comparisons to Sweden's overall population and factored in transgender persons who take cross-sex hormones but have not elected to have surgery. Those results still presented a decrease in outpatient mental health services. However, Bränström et al note that individuals only on cross-sex hormones showed no significant reduction in that category, which calls into question claims regarding effectiveness of cross-sex hormones in ameliorating behavioral issues.

The Bränström et al study prompted numerous responses questioning its methodology. The study lacked a prospective cohort or RCT design, and it did not track all participants for a full ten-year period (Van Mol et al, 2020). These criticisms resulted in a retraction, asserting that Bränström et al's conclusions were "too strong" and that further analysis by the authors revealed that the new "results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related

[9] Although Bränström et al claim to follow individuals for a ten-year period, peer reviews of the research revealed that this was not the case, noting the authors had varying periods of tracking, ranging from one to ten years (Van Mol et al, 2020).

health care visits or prescriptions or hospitalizations following suicide attempts in that comparison" (Kalin, 2020).

There are multiple explanations for why the Bränström et al study reached different results than the Dhejne et al study. For starters, Bränström et al tracked a larger sample group over a later period (2005 to 2015 as opposed to 1973 to 2003) during which gender dysphoria underwent a dramatic shift in definition. Also, Dhejne et al did not see elevated suicides until after ten years, raising the question as to whether sex reassignment surgery has temporary benefits on mental health rather than long-term or permanent benefits. Like the other Swedish study, Bränström et al's findings are a correlation and do not specifically state that the procedures cause reduced psychiatric service utilization (Bränström et al, 2020).

A 2014 study by Hess et al in Germany evaluated satisfaction with sex reassignment procedures by attempting to survey 254 trans-females on their quality of life, appearance, and functionality as women. Out of the participants selected, only 119 (47%) returned completed questionnaires, which Hess et al indicate is problematic because dissatisfied trans-females might not have wanted to provide input. The results from the collected responses noted that 65.7% of participants reported satisfaction with their lives following surgery and that 90.2% indicated that the procedures fulfilled their expectations for life as women. While these results led Hess et al to conclude that sex reassignment surgery generally benefits individuals with gender dysphoria, the information is limited and raises questions (Hess et al, 2014). Such questions include whether the participants had mental health issues before or after surgery and did their satisfaction wane over time. Hess et al only sent out one questionnaire and not several to ascertain consistency over multiple years. Questions like these raise doubts about the validity of the study. Although Hess et al's research is just one study, numerous others utilize the same subjective methods to reach their conclusions (Hruz, 2018).

In his assessment, Patrick Lappert contributes additional insight on the appropriate clinical indications for mastectomies, noting that removal of breast tissue is necessary following the diagnosis of breast cancer or as a prophylactic against that disease. He cites that this basis is verifiable through definitive laboratory testing and imaging, making it an objective diagnosis, whereas gender dysphoria has no such empirical methods to assess and depends heavily on the patient's perspective. Also, Lappert notes that trans-males who make such decisions are doing so on the idea that the procedure will reduce their dysphoria and suicide risk. However, they are making an irreversible choice based on anticipated outcomes supported only by weak evidence, and thus cannot provide informed consent (Lappert, 2022).

The literature is inconclusive on whether sex reassignment surgery can improve mental health for gender dysphoric individuals. Higher quality research is needed to validate this method as an effective treatment. This includes studies that obtain detailed participant histories (e.g., behavioral diagnoses) and track participants for longer periods of time. These are necessary to evaluate the full effects of treatments that cause irreversible physical changes. In addition, sex reassignment procedures can result in severe complications such as infections in trans-females and urethral blockage in trans-males. Health issues related to natal sex can also persist. For example, trans-males who undergo mastectomy can still develop breast cancer and should receive the same recommended screenings (Trum et al, 2015). Until more definitive evidence becomes available, sex reassignment surgery should not qualify as a standard treatment for gender dysphoria.

Literature Review: Quality of Available Evidence and Bioethical Questions

Quality of Available Evidence

Clinical organizations that have endorsed puberty suppression, cross-sex hormones, and sex reassignment surgery frequently state that these treatments have the potential to save lives by preventing suicide and suicidal ideation. The evidence, however, does not support these conclusions. James Cantor notes that actual suicides (defined as killing oneself) are low, occur at higher rates for men, and that interpretations of available research indicate a blurring of numbers between those with gender dysphoria and homosexuals (Cantor, 2022). Although information exists that contradicts certain arguments, media outlets continue to report stories emphasizing the "lifesaving" potential of sex reassignment treatment. A May 2022 story by NBC announced survey results under the headline "Almost half of LGBTQ youths 'seriously considered suicide in the past year'" (NBC, 2022). This is a significant claim that can have a sensational effect on patients and providers alike, but how strong is the evidence supporting it? Almost all of the data backing this assertion are based on surveys and cross-studies, which tend to yield low-quality results (Hruz, 2018). In addition, how many gender dysphoric individuals are seeing stories in the media and not questioning the narrative? Because research on the effectiveness of treatments is ongoing, a debate persists regarding their use in the adolescent and young-adult populations, and much of it is due to the low-quality studies serving as evidence.

In their assessment, Romina Brignardello-Petersen and Wojtek Wiercioch examined the quality of 61 articles published between 2020 and 2022 (Note: See Attachment A for the full study). They identified research on the effectiveness of puberty blockers, cross-sex hormones, and sex reassignment surgery and assigned a grade (high, moderate, low, or very low) in accordance with the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. Out of the articles reviewed, all with a few exceptions received grades of low or very low quality when demonstrating outcomes regarding improvements in mental health and overall satisfaction with transitioning. For puberty blockers, Brignardello-Petersen and Wiercioch identified low quality evidence for alleviating gender dysphoria and very low quality for reducing suicidal ideation. The authors also had nearly identical findings for cross-sex hormones. However, they noted moderate quality evidence for the likelihood of cardiovascular side effects. Regarding surgery, Brignardello-Petersen and Wiercioch graded articles that examined overall satisfaction and complication rates. None of the studies received grades higher than low quality. These findings led the authors to conclude that "there is great uncertainty about the effects" of sex reassignment treatments and that the "evidence alone is not sufficient to support" using such treatments. Among the studies graded was one the U.S. Department of Health and Human Services cited in its information on "gender affirming" treatments. The authors noted this research had a "critical risk of bias" and was of low quality (Brignardello-Petersen and Wiercioch, 2022).

For his part, James Cantor provided a review of available literature, which addresses studies on etiology, desistance, effectiveness of puberty blockers and cross-sex hormones, suicidal behaviors, and clinical association and international guidelines. Throughout his analysis, Cantor cites weak evidence, poor methodologies (e.g., retrospective versus prospective studies), and lack of professional endorsements in research that indicates the benefits of sex reassignment treatment. Additionally, he notes that improvements in the behavioral health of adolescents who take cross-sex hormones can be attributed to the counseling they receive concurrently and that suicidality is not likely to result from gender

dysphoria but from co-occurring mental disorders. The reasoning behind the third point is based on the blending of suicide and suicidality, which are two distinct concepts. The former refers specifically to killing oneself, and the second regards ideation and threats in attempts to receive help. Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males. His other conclusions indicate that young children who experience gender identity issues will most likely desist by puberty, that multiple phenomena can cause the condition, and that Western European health services are not recommending medical intervention for minors. The basis for these statements is the paucity of high to moderate quality evidence on the effectiveness of sex reassignment treatments and numerous studies demonstrating desistance (Cantor, 2022).

Despite the need for stronger studies that provide definitive conclusions, many practitioners stand by the recommendations of the AAP, Endocrine Society, and WPATH. This is evident in a letter submitted to the *Tampa Bay Times*, which was a rebuttal to the Florida Department of Health's (DOH) guidance on treatment for gender dysphoria (Note: The guidance recommends against using puberty blockers, cross-sex hormones, or surgery for minors) (DOH, 2022). The authors, led by six professors at the University of Florida's College of Medicine, state that recommendations by clinical organizations are based on "careful deliberation and examination of the evidence by experts." However, evaluations of these studies show otherwise. Not only does the available research use cross-sectional methods such as surveys, but it provides insufficient evidence based on momentary snapshots regarding mental health benefits. These weak studies are the foundation for the clinical organizations' guidelines that the University of Florida professors tout as a gold standard. In addition, the letter's authors state that DOH's guidance is based on a "non-representative sample of small studies and reviews, editorials, opinion pieces, and commentary" (Tampa Bay Times, 2022). That statement misses the point when it comes to evidence demonstrating whether treatments with irreversible effects are beneficial because the burden of proof is on those advocating for this treatment, not on those acknowledging the need for further research. This raises the question concerning how much academic rigor these professors are applying to practice guidelines released by clinical organizations and whether they also apply the same level of rigor to novel treatments for other conditions (e.g., drugs, medical devices).

Another example of a lack of rigor is a 2019 article by Herman et al from the University of California at Los Angeles (UCLA) that evaluated responses to a 2015 national survey on transgender individuals and suicide. Unlike other studies, this one utilized a large cohort with 28,000 participants from across the U.S. responding. However, the researchers used no screening criteria and did not randomly select individuals. In addition, responses consisted entirely of self-reports with no supporting evidence to even prove a diagnosis of gender dysphoria. Although Herman et al conclude that the U.S. transgender population is at higher risk for suicidal behaviors, the authors' supporting evidence is subjective and serves as a weak basis. Additionally, the survey results do not establish gender dysphoria as a direct cause of suicide or suicidal ideation. The questions required participants to respond about their overall physical and mental health. Out of those that indicated "poor" health, 77.7% reported suicidal thoughts or attempts during the previous year, whereas just 29.1% of participants in "excellent" health had. These percentages indicate that causes beyond gender dysphoria could be affecting suicidal behaviors. Other reasons cited include rejection by family or religious organizations and discrimination. The authors also acknowledge that their findings are broad, not nationally representative, and should serve as a basis for pursuing future research (Herman et al, 2019).

Yet another example is a study published in 2022 by Olson et al tracks 300 young children that identify as transgender over a 5-year period, and asserts low probabilities for detransitioning, while supporting interventions such as puberty blockers. The authors found that children (median age of 8 years) who identified as a gender that differed from their natal sex were unlikely to desist at a rate of 94% and conclude that "transgender youth who socially transitioned at early ages" will continue "to identify that way." While this appears to contradict earlier studies that demonstrate most young adolescents who change gender identities return to their "assigned gender at birth," the authors note differences and limitations with the results. For example, Olson et al notes that they did not verify whether the participants met the DSM-V's diagnostic criteria for gender dysphoria and that the children's families supported the decisions to transition. Instead, the authors relied on a child's chosen pronouns to classify as transgender. Also, Olson et al acknowledged that roughly 66% of the sample was biologically male. This is particularly significant considering that the majority of transitioning adolescents in recent years were natal females. Another issue with the study includes the median age at the end of follow-up (13 years), which is when boys begin puberty. Furthermore, the authors cite that the participants received strong parental support regarding the transitions, which constitutes positive reinforcement (Olson et al, 2022). Other research demonstrates that such feedback on social transitioning from parents and peers can prevent desistance following pubertal onset (Zucker, 2019). Despite these limitations, the New York Times announced the study's publication under the headline "Few Transgender Children Change Their Minds After 5 Years" (New York Times, 2022). Such a title can add to the public's perception that gender dysphoria requires early medical intervention to address.

Bioethical Questions

The irreversible physical changes and potential side effects of sex reassignment treatment raise significant ethical questions. These questions concern multiple bioethical principles including patient autonomy, informed consent, and beneficence. In a 2019 article, Michael Laidlaw, Michelle Cretella, and Kevin Donovan argue that prescribing puberty blockers or cross-sex hormones on the basis that they will alleviate psychological symptoms should not be the standard of care for children with gender dysphoria. Additionally, the three authors assert that such treatments "constitute an unmonitored, experimental intervention in children without sufficient evidence of efficacy or safety." The primary ethical question Laidlaw, Cretella, and Donovan pose is whether pushing physical transitioning, particularly without parental consent, violates fully informed consent (Laidlaw et al, 2019).

In accordance with principles of bioethics, several factors must be present to obtain informed consent from a patient. These consist of being able to understand and comprehend the service and potential risks, receiving complete disclosure from the physician, and voluntarily providing consent. Bioethicists generally do not afford the ability of giving informed consent to children who lack the competence to make decisions that pose permanent consequences (Varkey, 2021). Laidlaw, Cretella, and Donovan reinforce this point regarding sex reassignment treatment when they state that "children and adolescents have neither the cognitive nor the emotional maturity to comprehend the consequences of receiving a treatment for which the end result is sterility and organs devoid of sexual function" (Laidlaw et al, 2019). This further raises the question whether clinicians who make such treatment recommendations are providing full disclosure about the irreversible effects and truly obtaining informed consent.

Another issue is the conflict between consumerism and the practitioner's ability to provide appropriate care. Consumerism refers to patients learning about treatments through media/marketing and requesting their health care provider to prescribe it, regardless of medical necessity. Considering that social media is rife with individuals promoting "gender affirmative" drugs and surgeries, children are making self-assessments based on feelings they may not understand and that can lead to deep regret in the future (Littman, 2018). This can contribute to patients applying pressure on their doctors to prescribe medications not proven safe or effective for the condition. Consumerism can also affect bioethical compliance because it constrains clinicians from using their full "knowledge and skills to benefit the patient," which is "tantamount to a form of patient abandonment and therefore is ethically indefensible" (Varkey, 2021).

In his assessment, G. Kevin Donovan explains the bioethical challenges related to sex reassignment treatment, emphasizing the lack of informed consent when administering these services. He asserts that gender dysphoria is largely a self-diagnosis practitioners cannot verify with empirical tests (e.g., labs and imaging) and that providing such treatments is experimental. Because of the lack of consent and off-label use of puberty blockers and cross-sex hormones, Donovan raises the question as to how "experienced and ethical physicians so mislead others or be so misled themselves?" He further attributes this phenomenon to societal and peer pressures that influence self-diagnosis and confirm decisions to transition. As a result, these pressures lead to individuals wanting puberty blockers, cross-sex hormones, and surgery. Donovan goes on to identify several news stories where embracing sex reassignment treatment is a "cult-like" behavior. To conclude, he links these factors back to the failure to obtain informed consent from transgender patients and how that violates basic bioethical principles (Donovan, 2022).

Coverage Policies of the U.S. and Western Europe

U.S. Federal Level Coverage Policies

Medicare: In 2016, the Centers for Medicare and Medicaid Services (CMS) published a decision memo announcing that Medicare Administrative Contractors (MACs) can evaluate sex reassignment surgery coverage on a "case-by-case" basis. [10] CMS specifically noted that the decision memo is not a National Coverage Determination and that "no national policy will be put in place for the Medicare program" (CMS, 2016). This memo was the result of CMS reviewing over 500 studies, reports, and articles to the validity of the procedures. Following its evaluation, CMS determined that "the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . small sample sizes, lack of validated assessment tools, and considerable (number of participants in the studies) lost to follow up." In 2017, CMS reinforced this position with a policy transmittal that repeated the 2016 memo's criteria (CMS, 2017).

The basis for Medicare's decision is that the "clinical evidence is inconclusive" and that "robust" studies are "needed to ensure that patients achieve improved health outcomes." In its review of available literature, CMS sought to answer whether there is "sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria." After evaluating 33 studies that met inclusion criteria, CMS's review concludes that "not enough high-quality evidence" is available "to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively." Additionally, out of the 33 studies, just 6 provided "useful information" on the procedures' effectiveness, revealing that their authors "assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies" that "did not demonstrate clinically significant changes or differences in psychometric test results" following sex reassignment surgery (CMS, 2016).

U.S. Department of Defense – Tricare: Tricare does not cover sex reassignment surgery, but it will cover psychological services such as counseling for individuals diagnosed with gender dysphoria and cross-sex hormones when medically necessary (Tricare, 2022).[11]

U.S. Department of Veterans Affairs: The U.S. Department of Veterans Affairs (VA) does not cover sex reassignment surgery, although it will reimburse for cross-sex hormones and pre- and post-operative care related to transitioning. Because the VA only provides services to veterans of the U.S. armed forces, it cannot offer sex reassignment treatment to children (VA, 2020).[12]

---

[10] The Centers for Medicare and Medicaid Services is part of the U.S. Department of Health and Human Services. Its primary functions are to administer the entire Medicare system and oversee federal compliance of state Medicaid programs. In addition, CMS sets reimbursement rates and coverage criteria for the Medicare program.
[11] Tricare is the insurance program that covers members of the U.S. armed forces and their families. This includes children of all ages.
[12] The U.S. Department of Veterans Affairs oversees the Veterans Health Administration (VHA), which consists of over 1,000 hospitals, clinics, and long-term care facilities. As the largest health care network in the U.S., the VHA provides services to veterans of the U.S. armed forces.

State-Level Coverage Policies

Florida: In April 2022, DOH issued guidance for the treatment of gender dysphoria, recommending that minors not receive puberty blockers, cross-sex hormones, or sex reassignment surgery. [13] The justification offered for recommending against these treatments is that available evidence is low-quality and that European countries also have similar guidelines. Accordingly, DOH provided the following guidelines:

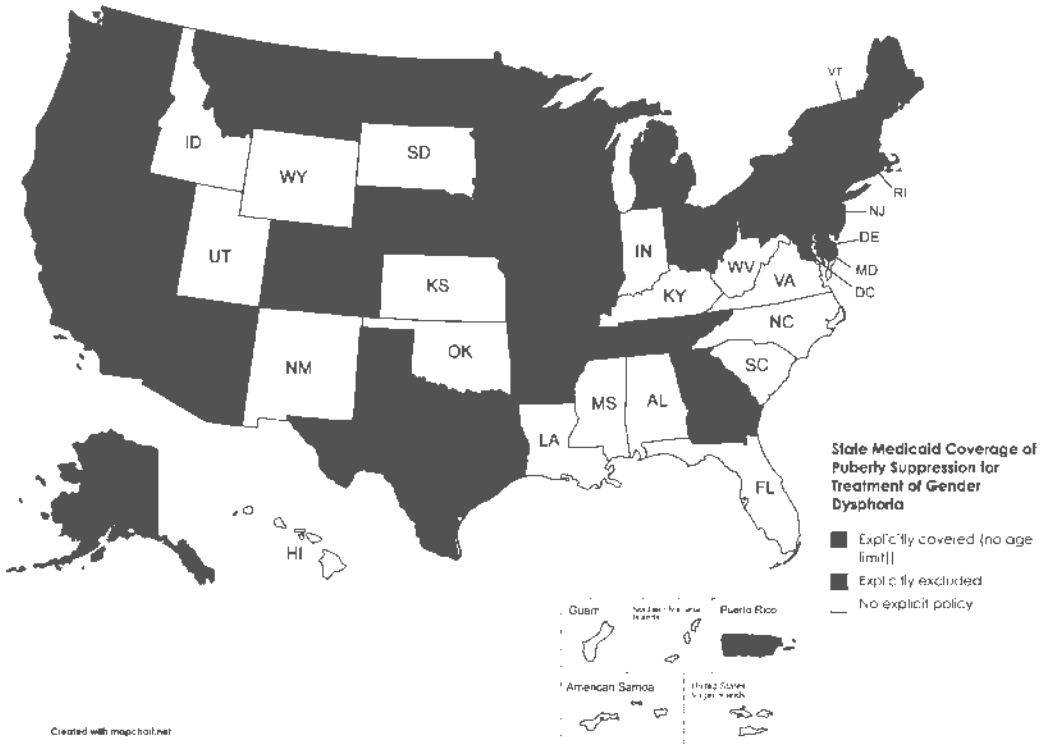
- "Social gender transition should not be a treatment option for children or adolescents."
- "Anyone under 18 should not be prescribed puberty blockers or hormone therapy."
- "Gender reassignment surgery should not be a treatment option for children or adolescents."
- "Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider."

In a separate fact sheet released simultaneously with the guidance, DOH further asserts that the evidence cited by the federal government cannot establish sex reassignment treatment's ability to improve mental health (DOH, 2022).

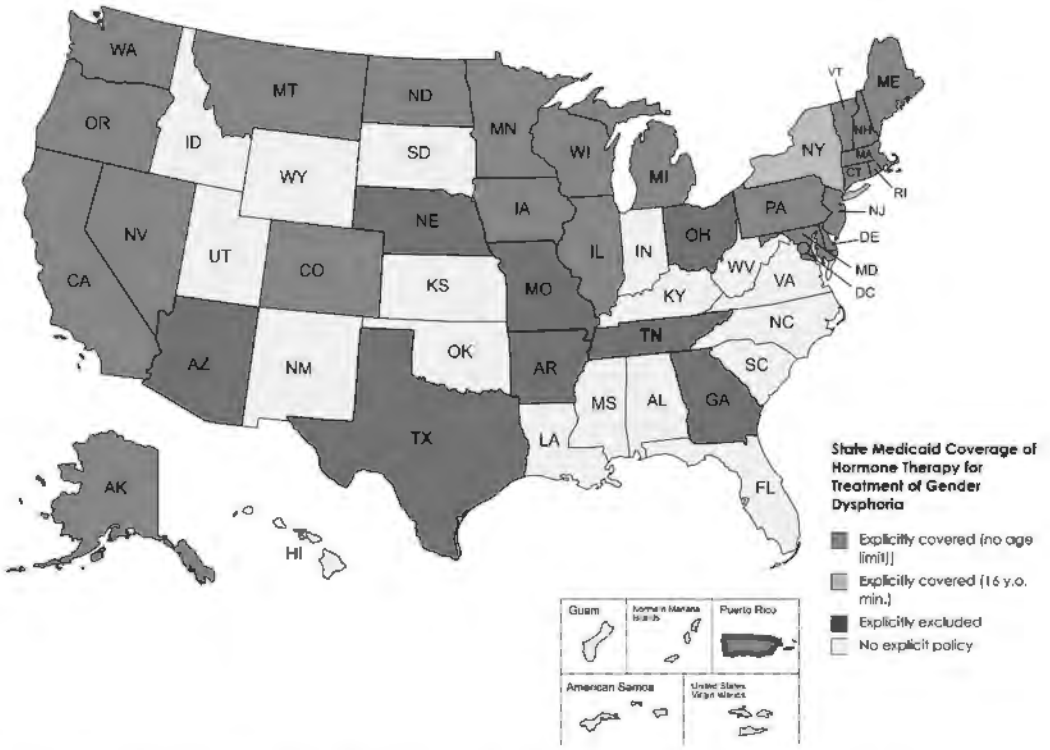
State Medicaid Programs: Because individual states differ in health services offered, Medicaid programs vary in their coverage of sex reassignment treatments. The following maps identify states that cover sex reassignment treatments, states that have no policy, and states that do not cover such treatments.

[13] Unlike the federal government, the State of Florida delegates responsibilities for Medicaid and health care services to five separate agencies (Agency for Health Care Administration, Department of Health, Department of Children and Families, Department of Elder Affairs, and Agency for Persons with Disabilities). Each agency has its own separate head (secretary or surgeon general), which reports directly to the Executive Office of the Governor. As Florida's public health agency, DOH oversees all county health departments, medical professional boards, and numerous health and welfare programs (e.g., Early Steps and Women, Infants, and Children). Because it oversees the boards, DOH has authority to release practice guidelines.

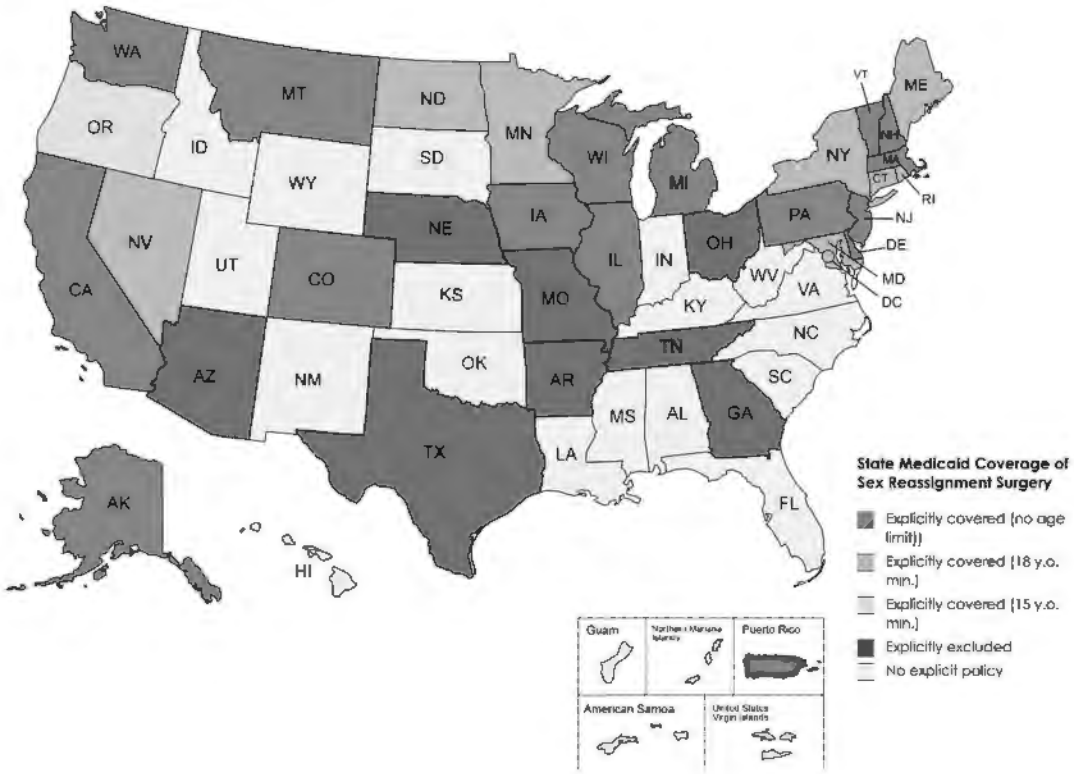
State Medicaid programs with coverage decisions regarding puberty blockers:



State Medicaid programs with coverage decisions regarding cross-sex hormones:



State Medicaid programs with coverage decisions regarding sex reassignment surgery:



Western Europe

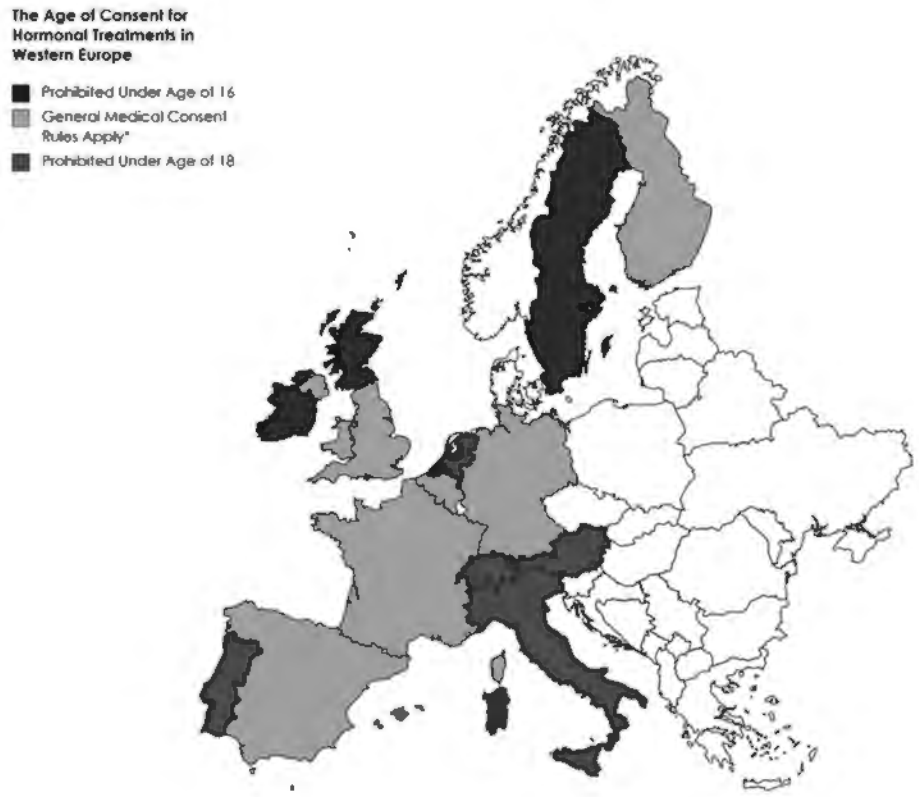
Scandinavian countries such as Sweden and Finland have released new guidelines on sex reassignment treatment for children. In 2022, the Swedish National Board of Health stated that "the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits." With the exception of youths who exhibited "classic" signs of gender identity issues, adolescents who present with the condition will receive behavioral health services and gender-exploratory therapy (Society for Evidence Based Gender Medicine, 2022).

In Finland, the Palveluvalikoima issued guidelines in 2020 stating that sex reassignment in minors "is an experimental practice" and that "no irreversible treatment should be initiated." The guidelines further assert that youths diagnosed with gender dysphoria often have co-occurring psychiatric disorders that must be stabilized prior to prescribing any cross-sex hormones or undergoing sex reassignment surgery (Palveluvalikoima, 2020).

The United Kingdom (U.K.) is also reassessing the use of irreversible treatments for gender dysphoria due the long-term effects on mental and physical health. In 2022, an independent interim report commissioned by the U.K.'s National Health Service (NHS) indicates that additional research and systematic changes are necessary to ensure the safe treatment of gender dysphoric youths. These include reinforcing the diagnosis process to assess all areas of physical and behavioral health, additional training for pediatric endocrinologists, and informing parents about the uncertainties regarding puberty blockers. The interim report is serving as a benchmark until the research is completed for final guidelines (The Cass Report, 2022).

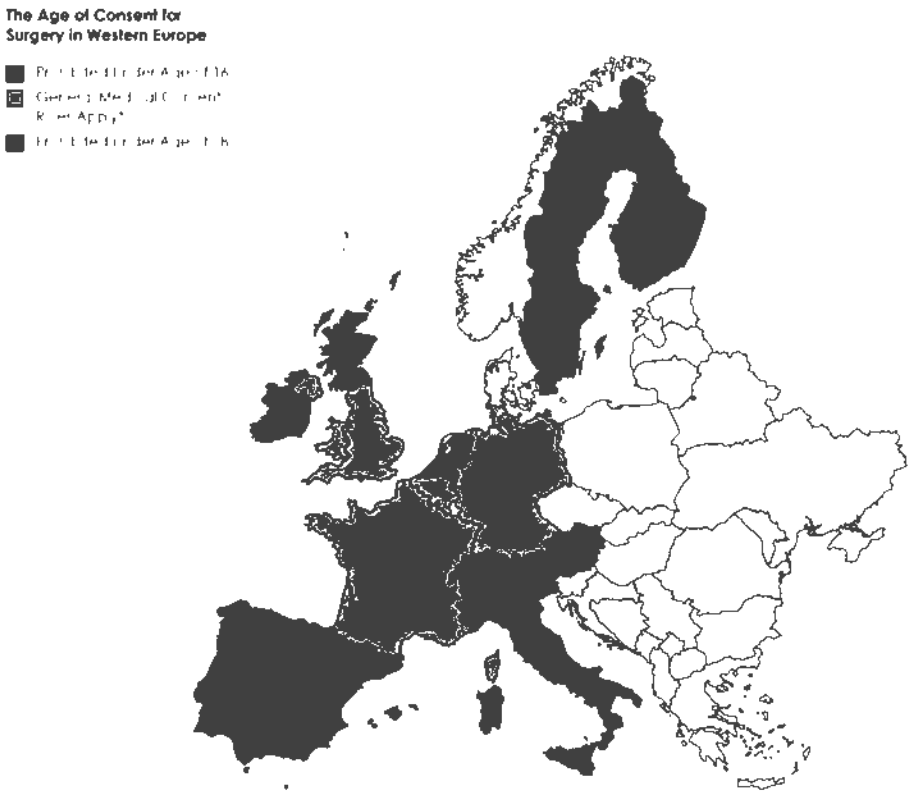
Like state Medicaid programs, health systems across Western Europe also vary in their coverage of sex reassignment treatment.

Western European nations' requirements for cross-sex hormones:



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Western European nations' requirements for sex reassignment surgery:



In this context, the oge requirement for access to ony medical treotment without consent of parents or of a public authority. This age may range from 16 to 18 yeors depending on each country's laws.

Generally Accepted Professional Medical Standards Recommendation

This report does not recommend sex reassignment treatment as a health service that is consistent with generally accepted professional medical standards. Available evidence indicates that the services are not proven safe or effective treatments for gender dysphoria.

Rationale

The available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. As this report demonstrates, the evidence favoring "gender affirming" treatments, including evidence regarding suicidality, is either low or very low quality:

- **Puberty Blockers:** Evidence does not prove that puberty blockers are safe for treatment of gender dysphoria. Evidence that they improve mental health and reduce suicidality is low or very low quality.
- **Cross-Sex Hormones:** Evidence suggesting that cross-sex hormones provide benefits to mental health and prevents suicidality is low or very low quality. Rather, evidence shows that cross-sex hormones cause multiple irreversible physical consequences as well as infertility.
- **Sex Reassignment Surgery:** Evidence of improvement in mental health and reduction in suicidality is low or very low quality. Sex reassignment surgery results in irreversible physical changes, including sterility.

While clinical organizations like the AAP endorse the above treatments, none of those organizations relies on high quality evidence. Their eminence in the medical community alone does not validate their views in the absence of quality, supporting evidence. To the contrary, the evidence shows that the above treatments pose irreversible consequences, exacerbate or fail to alleviate existing mental health conditions, and cause infertility or sterility. Given the current state of the evidence, the above treatments do not conform to GAPMS and are experimental and investigational.

✓ **Concur** ____ **Do not Concur**

Comments:

_____

_____

_____

Tom Wilkes
Deputy Secretary for Medicaid (or designee)

6/2/22
Date

Works Cited

Almost Half of LGBTQ Youths 'Seriously Considered' Suicide in Past Year, Survey Says. *NBC News*. 4 May 2022.

American Academy of Pediatrics. Policy Statement: Off-Label Use of Drugs in Children. *Pediatrics*. 2014. 133(3).

American Psychiatric Association. *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders*. 2013.

American Psychiatric Association. *Gender Dyspharia Diagnosis*. 2017.

American Psychiatric Association. *What Is Depression*. 2020.

American Psychological Association. *APA Resolution on Gender Identity Change Efforts*. 2021.

Baker GM, Guzman-Arocho YD, Bret-Mounet VC, Torous VF, Schnitt SJ, Tobias AM, Bartlett RA, Fein-Zachary VJ, Collins LC, Wulf GM, Heng YJ. Testosterone Therapy and Breast Histopathological Features in Transgender Individuals. *Mod Pathol*. 2021. 34(1).

Blake K, Cangelosi S, Johnson-Brooks S, Belcher HME. Reliability of the GAF and CGAS with Children Exposed to Trauma. *Child Abuse and Neglect*. 2007. 31: 909-915.

Bizic MR, Jeftovic M, Pusica S, Stojanovic B, Duisin D, Vujovic S, Rakic V, Djordjevic ML. Gender Dysphoria: Bioethical Aspects of Medical Treatment. *BioMed Research International*. 2018: 9652305.

Bizic M, Kojovic V, Duisin D, Stanojevic D, Vujovic S, Milosevic A, Korac G, Djordjevic ML. An Overview of Neovaginal Reconstruction Options in Male to Female Transsexuals. *The Scientific World Journal*. 2014. 638919.

Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American Journal of Psychiatry*. 2020. 177(8).

Brignardello-Petersen R, Wiercioch W. Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. Unpublished: Commissioned by the Florida Agency for Health Care Administration. 2022.

Bruggeman BS, Dayton K, Diaz A, Evans J, Haller MJ, Hudak ML, Mathews CA, Shapiro M. We 300 Florida Health Care Professionals Say the State Gets Transgender Guidance Wrong. *Tampa Bay Times*. 27 April 2022.

Cantor J. Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *Journal of Sex and Marital Therapy*. 46(4).

Cantor J. *Science of Gender Dysphoria and Transsexualism*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Cass H. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People, Interim Report*. 2022.

The Centers for Medicare and Medicaid Services. Decision Memo: Gender Dysphoria and Gender Reassignment Surgery. 30 August 2016.

The Centers for Medicare and Medicaid Services. Pub 100-03 Medicare National Coverage Determinations. 3 March 2017.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, Steinberg L, Sisk CL, Roth J, Paus T, Mueller SC, McCarthy MM, Micevych PE, Martin CL, Kreukels BPC, Kenworthy L, Herting MM, Herlitz A, Heraldsen RJH, Dahl R, Crone EA, Chelune GJ, Burke SM, Berenbaum SA, Beltz AM, Bakker J, Eliot L, Vilain E, Wallace GL, Nelson EE, Garofalo R. Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth. *Transgender Health*. 2020. 5(4).

Claahsen-van der Grinten H, Verhaak C, Steensma T, Middelberg T, Roeffen J, Klink D. Gender Incongruence and Gender Dysphoria in Childhood and Adolescence – Current Insights in Diagnostics, Management, and Follow-Up. *European Journal of Pediatrics*. 2020. 180: 1349-1357.

Costa R, Colizzi M. The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review. *Neuropsychiatric Disease and Treatment*. 2016. 12: 1953-1966.

Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. 2015. 12(11).

Davy Z, Toze M. What Is Gender Dysphoria? A Critical Systematic Narrative Review. *Transgender Health*. 2018. 3(1).

De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: A Brief Review of Literature. *Acta Biomed*. 2019. 90(3).

De Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment. *Pediatrics*. 2014. 134(4).

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, Landen M. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS One*. 6(2).

Donovan GK. *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Dutra E, Lee J, Torbati T, Garcia M, Merz CNB, Shufelt C. Cardiovascular Implications of Gender-Affirming Hormone Treatment in the Transgender Population. *Maturitas*. 2019. 129: 45-49.

Few Transgender Children Change Their Minds After 5 Years, Study Finds. *New York Times*. 4 May 2022.

Gaetano P. David Reimer and John Money Gender Reassignment Controversy: The John/Joan Case. *The Embryo Project Encyclopedia*. 2017.

Geffen S, Horn T, Smith KJ, Cahill S. Advocacy for Gender Affirming Care: Learning from the Injectable Estrogen Shortage. *Tronsgender Heolth*. 2018. 3(1).

Go JJ. Should Gender Reassignment Surgery Be Publicly Funded? *Bioethical Inquiry*. 2018. 15: 527-534.

Gu J, Kanai, R. What contributes to individual differences in brain structure. *Front Hum Neurosci*. 2014. 8:262.

Hariton E, Locascio JJ. Randomised Controlled Trials – The Gold Standard for Effectiveness Research. *BJOG: An International Journal of Obstetrics and Gynecology*. 2018. 125(13).

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinological Metabolism*. 2017. 102(11).

Herman JL, Brown TNT, Haas AP. *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. University of California at Los Angeles School of Law Williams Institute. 2019.

Hess J, Neto RR, Panic L, Rubben H, Senf W. Satisfaction with Male-to-Female Gender Reassignment Surgery. *Deutsches Arzteblatt International*. 2014. 111: 795-801.

Hruz PW. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *Catholic Medical Association*. 2020. 87(1).

James HA, Chang AY, Imhof RL, Sahoo A, Montenegro MM, Imhof NR, Gonzalez CA, Lteif AN, Nippoldt TB, Davidge-Pitts CJ. A Community-Bases Study of Demographics, Medical and Psychiatric Conditions, and Gender Dysphoria/Incongruence Treatment in Transgender/Gender Diverse Individuals. *Biology of Sex Differences*. 2020. 11(55).

Jensen RK, Jensen JK, Simons LK, Chen D, Rosoklija I, Finlayson C. Effect of Concurrent Gonadotropin-Releasing Hormone Against Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. *Transgender Health*. 2019. 4(1).

Joel D., Berman Z., Tavor L. Sex beyond the Genitalia: The Human Brain Mosaic. *Proceedings of the National Academy of Sciences of the United States of America*. 2015. 112(50).

Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals after Gender-Affirming Surgeries: A Comment by the Editor on the Process (Letter). *American Journal of Psychiatry*. 2020. 177:765.

Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*. 2015. 9(9).

Kozlowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR. Attachment Patterns in Children and Adolescents with Gender Dysphoria. *Frontiers in Psychology*. 2021. 11: 582688.

Kuper LE, Mathews S, Lau M. Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy. *Journal of Developmental Behavior Pediatrics*. 2019. 40(8).

Kyriakou A, Nicolaides NC, Skordis N. Current Approach to the Clinical Care of Adolescents with Gender Dysphoria. *Acta Biomed*. 2020. 91(1).

Laidlaw M, Cretella M, Donovan K. The Right to Best Care for Children Does Not Include the Right to Medical Transition. *The American Journal of Bioethics*. 2019. 19(2).

Laidlaw M, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: Endocrine Treatment of Gender-Dsyphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *Journal of Clinical Endocrinological Metabolism*. 2018.

Lappert P. *Surgical Procedures and Gender Dysphoria*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Lee JY, Finlayson C, Olson-Kennedy J, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. *Journal of the Endocrine Society*. 2020. 4(9).

Levine SB. Informed Consent for Transgendered Patients. *Journal of Sex & Maritol Therapy*. 2018. 10:1080.

Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*. 2021. S0: 3353-3369.

Littman L. Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports. *PLOS One*. 2018. 13(8).

Mayer L, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *The New Atlantis*. 2016. Fall Edition. 103.

McHugh PR. *The Mind Has Mountains: Reflections an Society and Psychiatry*. The Johns Hopkins University Press. 2006.

Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida. *Fox News*. 8 May 2022.

Merck Pharmaceuticals. *Merck Manual: Professional Version*. 2021.

Monstrey SJ, Ceulemans P, Hoebeke P. Sex Reassignment Surgery in the Female-to-Male Transsexual. *Seminars in Plastic Surgery*. 2011. 25(3).

Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. *Curr Psychiatry Rep*. 2019. 20(12).

Nhi Le HP. *Eminence-Based Medicine vs. Evidence-Based Medicine*. Students 4 Best Evidence. 12 January 2016. https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine,appraisal%20of%20scientific%20evidence%20available

Olson KR, Durwood L, DeMeules M, McLaughlin KL. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*. 2015. 137(3).

Olson KR, Durwood L, Horton R, Gallagher NM, Devor A. Gender Identity 5 Years After Social Transition. *Pediatrics*. 2022; doi: 10.1542/peds.2021-056082.

Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*. 2018. 172(5).

Palveluvalikoima of Finland. Recommendation of the Council for Choices in Health Care in Finland (Palko/Cohere Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020.

Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018. 142(4).

Sadr M, Korashad BS, Talaei A, Fazeli N, Honekopp J. 2D:4D Suggests a Role of Prenatal Testosterone in Gender Dysphoria. *Archives of Sexual Behavior*. 2020. 49: 421-432.

Saleem F, Rizvi SW. Transgender Associations and Possible Etiology: A Literature Review. *Cureus*. 9(12).

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

Society for Evidence Based Gender Medicine. Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW). 2022.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2013. 52(6).

Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Open Network*. 2022; 59(2).

Trum H, Hoebeke P, Gooren L. Sex Reassignment of Transsexual People from a Gynecologist's and Urologist's Perspective. *Acta Obstetrica et Gynecologica*. 2016. 94: 563-567.

Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Method Analysis *LGBT Health*. 2021. 8(4).

UF Doctor Says Gender-Affirming Care Works for Kids Who Need It, and Can Even Save Lives. *Health News Florida*. 26 April 2022.

Unger CA. Hormone Therapy for Transgender Patients. *Translational Andrology and Urology*. 2016. 5(6).

University of California at San Francisco Health System. *Overview of Feminizing Hormone Therapy*. 2020.

University of California at San Francisco Health System. *Overview of Masculinizing Hormone Therapy*. 2020.

U.S. Department of Defense, Tricare. *Gender Dysphoria Services*. 2022.

U.S. Department of Health and Human Services: Office for Civil Rights. HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy. 2 March 2022.

U.S. Drug Enforcement Administration. *Drug Fact Sheet: Steroids*. 2020.

A Review of the President's FY 2023 Funding Request and Budget Justification for the National Institutes of Health. U.S. Senate Committee on Appropriations. Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 17 May 2022. https://www.appropriations.senate.gov/hearings/a-review-of-the-presidents-fy-2023-funding-request-and-budget-justification-for-the-national-institutes-of-health

Van Meter QL. Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Van der Miesen AIR, Hurley H, Bal AM, de Vries ALC. Prevalence of the Wish to Be of the Opposite Gender in Adolescents and Adults with Autism Spectrum Disorder. *Archives of Sexual Behavior*. 2018. 47: 2307-2317.

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *American Journal of Psychiatry*. 2020. 177:765.

Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Medical Principles and Practice*. 2021. 30: 17-28.

World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 2012.

Zhao JJ, Marchaim D, Palla MB, Bogan CW, Hayakawa K, Tansek R, Moshos J, Muthusamy A, Kotra H, Lephart PR, Wilson AN, Kaye KS. Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984-2008. *Surgical Infections*. 2014. 15(2).

Zucker K. Debate: Different strokes for different folks. *Child and Adolescent Mental Health*. 2019. doi.org/10.1111/camh.12330.

Attachments

Attachment A: Secretary for the Florida Agency for Health Care Administration's Letter to Deputy Secretary Thomas Wallace. 20 April 2022.

Attachment B: Complete text of Rule 59G-1.035, F.A.C.

Attachment C: Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluatian of the Best Available Evidence*. 16 May 2022.

Attachment D: James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.

Attachment E: Quentin Van Meter, MD: *Cancerns about Affirmation af an Incangruent Gender in a Child or Adolescent*. 17 May 2022.

Attachment F: Patrick Lappert, MD: *Surgical Pracedures and Gender Dyspharia*. 17 May 2022.

Attachment G: G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

From:	Huggins, Michael (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=9597596B8C4D4B8D9FAF4922101A611B-HUGGINS, MI <Michael.Huggins@hhs.gov>
To:	Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
CC:	Jee, Lauren (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dc5a273e16824884903f0d2afc8cb225-Jee, Lauren <Lauren.Jee1@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) (b)(6)
Subject:	RE: 9/26 Clearance Items
Date:	2022/09/26 21:58:42
Priority:	Normal
Type:	Note

Great! Thanks so much!

Michael Huggins, Esq., M.P.P. (he/him/his)
Senior Advisor to the Director
Office for Civil Rights
U.S. Department of Health and Human Services

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Monday, September 26, 2022 9:58 PM
To: Huggins, Michael (HHS/OCR) <Michael.Huggins@hhs.gov>
Cc: Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: 9/26 Clearance Items

Ok, good here

From: Huggins, Michael (HHS/OCR) <Michael.Huggins@hhs.gov>
Sent: Monday, September 26, 2022 7:36 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Cc: Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: 9/26 Clearance Items

Hi Melanie,

I hope you're doing well! I confirm that OASH took CRFD's suggested language. I highlighted here their two comments. The edit at the very top is in response to your comment. Does that sound good? I would be happy to clear this as soon as possible.

<< File: (b)(5) >>
Thanks again!

Michael Huggins, Esq., M.P.P. (he/him/his)
Senior Advisor to the Director
Office for Civil Rights
U.S. Department of Health and Human Services

From: Huggins, Michael (HHS/OCR)
Sent: Friday, September 23, 2022 6:39 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Cc: Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6) 'McLean, Rogelyn (CMS/CCIIO)' <rogelyn.mclean@cms.hhs.gov>; Clemencia, LaTanya (HHS/OCR) <LaTanya.Clemencia@hhs.gov>
Subject: 9/26 Clearance Items

Hi Melanie,

I hope you're doing well! Please see the attached items for your review. If you have any additional questions or concerns, then feel free to contact us.

Thanks so much!

Michael

<< OLE Object: Picture (Device Independent Bitmap) >> MFR Clearance Tracker.xlsx

(b)(5)

(b)(5)

(b)(5)

(b)(5)

(b)(5)

(b)(5)

(b)(5)

Michael Huggins, Esq., M.P.P. (he/him/his)
Senior Advisor to the Director
Office for Civil Rights
U.S. Department of Health and Human Services

Sender: Huggins, Michael (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=9597596B8C4D4B8D9FAF4922101A611B-HUGGINS, MI <Michael.Huggins@hhs.gov>

Recipient: Rainer, Melanie Fontes (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>;
Jee, Lauren (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dc5a273e16824884903f0d2afc8cb225-Jee, Lauren <Lauren.Jee1@hhs.gov>;
(b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6)

Sent Date: 2022/09/26 21:58:40

Delivered Date: 2022/09/26 21:58:42

Message Flags: Unread

From: Rainer, Melanie Fontes (OS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=9C7242F10A494D45BAB72C452ECD9F80-RAINER, MEL <Melanie.Rainer@hhs.gov>

To: Huggins, Michael (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9597596b8c4d4b8d9faf4922101a611b-Huggins, Mi <Michael.Huggins@hhs.gov>

CC: Jee, Lauren (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dc5a273e16824884903f0d2afc8cb225-Jee, Lauren <Lauren.Jee1@hhs.gov>;
(b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6)
(b)(6)
McLean, Rogelyn (CMS/CCIIO) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=930d79f4ebde4ab1ac67dbf1fed783a8-rogelyn.mcl <Rogelyn.McLean@cms.hhs.gov>;
Clemencia, LaTanya (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ddcb1a258a28428e80db417c431ed29d-Clemencia, <LaTanya.Clemencia@hhs.gov>

Subject: RE: Updated - 9/20 Clearance Items

Date: 2022/09/20 08:54:37

Priority: Normal

Type: Note

I think I am caught minus the FL letter for (b)(6)

A couple of things here-

(b)(5)

Thanks,
Melanie

(b)(5)

(b)(5)

From: Huggins, Michael (HHS/OCR) <Michael.Huggins@hhs.gov>
Sent: Monday, September 19, 2022 8:29 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Cc: Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; (b)(6) (b)(6) (HHS/OCR) (b)(6) McLean, Rogelyn (CMS/CCIIO) <Rogelyn.McLean@cms.hhs.gov>; Clemencia, LaTanya (HHS/OCR) <LaTanya.Clemencia@hhs.gov>
Subject: Updated - 9/20 Clearance Items

Hi Melanie,

I hope you're doing well! Here are some items for your review. Unfortunately, IT is still working on fixing our Sharepoint sites, but as soon as that is fixed we can move this over to Sharepoint. In the meantime, I have made a few changes to the chart below to make it more of a tracker. If you have any additional questions, concerns, or adjustments, then I would be happy to address them.

Thanks so much!

Michael

(b)(5)

(b)(5)

(b)(5)

(b)(5)

Michael Huggins, Esq., M.P.P. (he/him/his)
Senior Advisor to the Director
Office for Civil Rights
U.S. Department of Health and Human Services

Sender:	Rainer, Melanie Fontes (OS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=9C7242F10A494D45BAB72C452ECD9F80-RAINER, MEL <Melanie.Rainer@hhs.gov>
Recipient:	Huggins, Michael (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9597596b8c4d4b8d9faf4922101a611b-Huggins, Mi <Michael.Huggins@hhs.gov>; Jee, Lauren (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dc5a273e16824884903f0d2afc8cb225-Jee, Lauren <Lauren.Jee1@hhs.gov>; (b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6) McLean, Rogelyn (CMS/CCIIO) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=930d79f4ebde4ab1ac67dbf1fed783a8-rogelyn.mcl <Rogelyn.McLean@cms.hhs.gov>; Clemencia, LaTanya (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ddcb1a258a28428e80db417c431ed29d-Clemencia, <LaTanya.Clemencia@hhs.gov>
Sent Date:	2022/09/20 08:54:35
Delivered Date:	2022/09/20 08:54:37
Message Flags:	Unread

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

AUGUST DEKKER, legally known as KORI DEKKER; BRIT ROTHSTEIN; SUSAN DOE, a minor, by and through her parents and next friends, JANE DOE and JOHN DOE; and K.F., a minor, by and through his parent and next friend, JADE LADUE, *Plaintiffs*, v. SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	Civil Action No. **COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND OTHER RELIEF**

Plaintiffs AUGUST DEKKER, legally known as KORI DEKKER;[1] BRIT ROTHSTEIN; SUSAN DOE, a minor, by and through her parents and next friends, JANE DOE and JOHN DOE;[2] and K.F., a minor, by and through his parent and next

[1] Although Plaintiff's legal name is Kori Dekker, he is known by and uses the name August Dekker in accordance with his male gender identity. Accordingly, this Complaint refers to Plaintiff as August and uses male pronouns to refer to him.

[2] As set forth in the motion to proceed pseudonymously, Plaintiff Susan Doe, and her parents and next friends, Jane Doe and John Doe, seek to proceed pseudonymously in order to protect Susan Doe's right to privacy given that she is a

friend JADE LADUE,[3] by and through the undersigned counsel, bring this lawsuit against Defendants SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration, and the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION ("AHCA") to challenge the adoption of a rule, Florida Administrative Code 59G-1.050(7), prohibiting Medicaid coverage of services for the treatment of gender dysphoria and to seek declaratory and injunctive relief.

INTRODUCTION

1. A person's access to health care should not be contingent on their sex, gender identity, or whether they are transgender. Yet, that is exactly the situation in Florida. AHCA has made access to medically necessary health care for Medicaid beneficiaries contingent on whether they are transgender.

2. Empirical evidence and decades of clinical experience demonstrate that medical care for the treatment of gender dysphoria, also known as gender-affirming care, is medically necessary, safe, and effective for both transgender adolescents and adults with gender dysphoria. Gender-affirming care is neither experimental nor

---

minor and the disclosure of her identity "would reveal matters of a highly sensitive and personal nature, specifically [Susan Doe]'s transgender status and [her] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019).

[3] Because he is a minor, Plaintiff K.F. is proceeding under his initials pursuant to Federal Rule of Civil Procedure 5.2(a).

investigational; it is the prevailing standard of care, accepted and supported by every major medical organization in the United States.

3. Under newly adopted Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion"), transgender Medicaid beneficiaries are denied coverage for gender-affirming care to treat gender dysphoria, without regard to the actual generally accepted professional medical standards that govern such care or the particular medical needs of any Medicaid beneficiary. Specifically, any health care service that "alter[s] primary or secondary sexual characteristics" is ineligible for Medicaid coverage, though only when that service is being used to treat gender dysphoria. These same health care services, however, are routinely covered by Medicaid when they are for medically necessary purposes other than the treatment of gender dysphoria.

4. The Challenged Exclusion represents dangerous governmental action that threatens the health and wellbeing of transgender Medicaid beneficiaries.

5. The purpose of Medicaid is to provide health care coverage to individuals who have low income and cannot otherwise afford the costs of necessary medical care. By denying coverage for gender-affirming care, Defendants effectively *categorically* deny access to medically necessary care to thousands of Floridians who lack other means to pay for such care.

6. Defendants' actions not only come within the context of a series of measures the State has adopted targeting transgender people for discrimination, but they stand in sharp contrast not just to the well-established evidence and widely accepted view of the medical and scientific community in the United States, but also to the policies of the vast majority of states, which provide Medicaid coverage for gender-affirming care.

7. If allowed to remain in effect, the Challenged Exclusion will have immediate dire physical, emotional, and psychological consequences for transgender Medicaid beneficiaries.

8. These consequences need not occur, however, as the Challenged Exclusion is unlawful in multiple respects and therefore should be preliminarily and permanently enjoined.[4]

9. First, the Challenged Exclusion, which Defendant Marstiller enforces, violates the United States Constitution's guarantee of equal protection of the laws. Under the Fourteenth Amendment's Equal Protection Clause, Defendants are prohibited from discriminating against persons based on sex and transgender status.

[4] Blanket bans like the Challenged Exclusion have been repeatedly found to be unlawful and unconstitutional forms of discrimination. *See, e.g.*, *Fain v. Crouch*, 3:20-cv-00740, Dkt. #271 (S.D.W.V. Aug. 2, 2022) (granting summary judgment in favor of plaintiffs on causes of action also brought in this Complaint); *Flack v. Wis. Dep't. of Health Services*, 3:18-cv-00309-wmc, Dkt. #217 (W.D. Wis. Aug. 16, 2019) (same).

10. Second, the Challenged Exclusion violates Section 1557 of the Patient Protection and Affordable Care Act (the "ACA"), 42 U.S.C. § 18116, which prohibits discrimination on the basis of sex by health programs or activities, any part of which receives federal funding, such as Medicaid.

11. Third, the Challenged Exclusion violates the Medicaid Act's Early and Periodic Screening, Diagnostic, and Treatment provisions, which require Defendants to affirmatively arrange for services that are necessary to "correct or ameliorate" a health condition for Medicaid beneficiaries under 21 years of age, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r) ("EPSDT Requirements"), as well as the Medicaid Act's requirement for Defendants to ensure comparable coverage to every Medicaid beneficiary, 42 U.S.C. § 1396a(a)(10)(B)(i) ("Comparability Requirements").

12. Accordingly, Plaintiffs seek relief related to Defendants' adoption and enforcement of the Challenged Exclusion, including declaratory and preliminary and permanent injunctive relief, as well as compensatory damages, attorney's fees, and costs.

PARTIES

A. Plaintiffs

Plaintiff August Dekker

13. Plaintiff August Dekker is a 28-year-old transgender man. August, who has been diagnosed with gender dysphoria, is enrolled in and receives his health care coverage through Florida's Medicaid program. At the recommendation of his health care providers, August receives medically necessary hormone therapy to treat his gender dysphoria, which Florida's Medicaid program has covered until now. August has been enrolled in Medicaid at all times relevant to this complaint. August lives in Hernando County, Florida.

Plaintiff Brit Rothstein

14. Plaintiff Brit Rothstein is a 20-year-old transgender man. Brit, who has been diagnosed with gender dysphoria, is enrolled in and receives his health care coverage through Florida's Medicaid program. At the recommendation of his health care providers, Brit receives medically necessary hormone therapy to treat his gender dysphoria, which Florida's Medicaid program has covered until now, and is scheduled to obtain chest surgery as treatment for his gender dysphoria in December 2022, which Medicaid had pre-authorized. Brit has been enrolled in Medicaid at all times relevant to this complaint. As he is college student, Brit lives in Orange

County, Florida while he is in school, and lives in Broward County, Florida, along with his family, when he is out of school.

Plaintiff Susan Doe

15. Plaintiff Susan Doe is a 12-year-old transgender adolescent girl. Susan Doe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her next friends and parents, Jane Doe and John Doe. Susan, who has been diagnosed with gender dysphoria, is enrolled in and receives her health care coverage through Florida's Medicaid program. At the recommendation of her health care providers, Susan receives medically necessary puberty delaying medication to treat her gender dysphoria, which Florida's Medicaid program has covered until now. Susan has been enrolled in Medicaid at all times relevant to this complaint. Susan, Jane, and John live in Brevard County, Florida.

Plaintiff K.F.

16. Plaintiff K.F. is a 12-year-old transgender adolescent boy. K.F. sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his next friend and parent, Jade Ladue. K.F., who has been diagnosed with gender dysphoria, is enrolled in and receives his health care coverage through Florida's Medicaid program. At the recommendation of his health care providers, K.F. receives medically necessary puberty delaying medication to treat his gender dysphoria, which Florida's Medicaid

program has covered until now. K.F. has been enrolled in Medicaid at all times relevant to this complaint. Jade and K.F. live in Sarasota County, Florida.

B. Defendants

17. Defendant Simone Marstiller is sued in her official capacity as Secretary of AHCA, the "single state agency authorized to manage, operate, and make payments for medical assistance and related services under Title XIX of the Social Security Act [Medicaid]." Fla. Stat. §§ 409.902, 409.963 (2022); *see also* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10. Defendant Marstiller is responsible for the enforcement of the Challenged Exclusion. Defendant Marstiller is responsible for ensuring that the operation of Florida's Medicaid program complies with the United States Constitution and the Medicaid Act and its implementing regulations. Defendant Marstiller's official place of business is located in Tallahassee, Leon County, Florida.

18. Defendant AHCA is the "single state agency authorized to manage, operate, and make payments for medical assistance and related services under Title XIX of the Social Security Act [Medicaid]." Fla. Stat. §§ 409.902, 409.963 (2022). As such, AHCA receives federal funding to support the Florida Medicaid Program. AHCA uses the funds it receives from the federal government in part to cover health care services for persons enrolled in the Florida Medicaid Program. Moreover, AHCA oversees the promulgation of all Medicaid rules, fee schedules, and coverage

policies into the Florida Administrative Code. Fla. Stat. § 409.919 (2022). Defendant AHCA is based and headquartered in Tallahassee, Leon County, Florida.

JURISDICTION AND VENUE

19. The Court has jurisdiction over the claims asserted herein pursuant to 28 U.S.C. §§ 1331, 1343(a)(3)-(4).

20. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201, 2202, 42 U.S.C. § 1983, and Rules 57 and 65 of the Federal Rules of Civil Procedure.

21. Under 28 U.S.C. § 1391(b), venue is proper in the U.S. District Court for the Northern District of Florida because all Defendants reside within this District and a substantial part of the events or omissions giving rise to the claims alleged herein occurred in this District. Venue is proper in the Tallahassee Division of the Northern District of Florida under N.D. Fla. Loc. R. 3.1(B) because it is where the Defendants reside and where a substantial portion of the acts or omissions complained of herein occurred.

22. This Court has personal jurisdiction over Defendants because they are domiciled in Florida and/or have otherwise made and established contacts with Florida sufficient to permit the exercise of personal jurisdiction over them.

FACTUAL BACKGROUND

A. Gender Identity and Gender Dysphoria

23. A person's sex is multifaceted, and comprised of a number of characteristics, including but not limited to chromosomal makeup, hormones, internal and external reproductive organs, secondary sex characteristics, and most importantly, gender identity.

24. Gender identity is a person's internal sense of their sex. It is an essential element of human identity that everyone possesses, and a well-established concept in medicine. Gender identity is innate; immutable; has significant biological underpinnings, such as the sex differentiation of the brain that takes place during prenatal development; and cannot be altered.

25. Gender identity is the most important determinant of a person's sex. Everyone has a gender identity.

26. A person's sex is generally assigned at birth based solely on a visual assessment of external genitalia. External genitalia, however, are only one of several sex-related characteristics that comprise a person's sex, and as a result, are not always indicative of a person's sex.

27. For most people, their sex-related characteristics are aligned, and the visual assessment performed at birth serves as an accurate proxy for that person's sex.

28. The term "sex assigned at birth" is the most precise terms to use because not all of the physiological aspects of a person's sex are always in alignment with each other as typically male or typically female.

29. For these reasons, the Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.[5]

30. When a person's gender identity does not match that person's sex assigned at birth, gender identity is the critical determinant of that person's sex.

31. Individuals whose sex assigned at birth aligns with their gender identity are referred to as cisgender. Transgender people, on the other hand, have a gender identity that differs from the sex assigned to them at birth. A transgender boy or man is someone who was assigned a female sex at birth but has a male gender identity. A transgender girl or woman is someone who was assigned a male sex at birth but has a female gender identity.

---

[5] *See* Wylie C. Hembree, *et al.*, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3875 (2017), https://perma.cc/FM96-L228 (hereinafter "Endocrine Society Guidelines").

32. The health and wellbeing of all people, including those who are transgender, depends on their ability to live in a manner consistent with their gender identity.

33. Scientific and medical consensus recognizes that attempts to change an individual's gender identity to bring their gender identity into alignment with their sex assigned at birth are ineffective and harmful. Attempts to force transgender people to live in accordance with their sex assigned at birth, a practice often described as "conversion," or "reparative" therapy, is universally known to cause profound harm and is widely considered unethical and, in some places, unlawful.

34. For transgender people, the incongruence between their gender identity and sex assigned at birth can result in clinically significant stress and discomfort known as gender dysphoria.

35. Gender dysphoria is a serious medical condition recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The World Health Organization's International Classification of Diseases, which is the diagnostic and coding compendia used by medical professionals, refers to the condition as "gender incongruence." Gender dysphoria is also recognized by the leading medical and mental health professional groups in the United States, including the American Academy of Pediatrics,

American Medical Association, the American Psychological Association, American Psychiatric Association, and the Endocrine Society, among others.

36. If left untreated, gender dysphoria can result in debilitating anxiety, severe depression, self-harm, and even suicidality. Untreated gender dysphoria often intensifies with time. The longer an individual goes without or is denied adequate treatment for gender dysphoria, the greater the risk of severe harms to the person's health.

37. The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have published widely accepted guidelines for treating gender dysphoria.[6] The goal of medical treatment for gender dysphoria is to eliminate clinically significant distress by helping a transgender person live in accordance with their gender identity. This treatment is sometimes referred to as "gender transition," "transition related care," or "gender-affirming care."

38. WPATH is an international and multidisciplinary association whose mission is to promote evidence-based health care protocols for transgender people. WPATH publishes the Standards of Care based on the best available science and expert professional consensus.

---

[6] Endocrine Society Guidelines; World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th Version, 2012), https://perma.cc/62K5-N5SX (hereinafter, "WPATH Standards of Care").

39. The WPATH Standards of Care and Endocrine Society Guidelines are widely accepted as best practices guidelines for the treatment of adolescents and adults diagnosed with gender dysphoria and have been recognized as authoritative by the leading medical organizations.

40. The WPATH Standards of Care and Endocrine Society Guidelines recognize that puberty delaying medication, hormone therapy, and surgery to align a person's primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring) with their gender identity are medically necessary services for many people with gender dysphoria.

41. The precise treatment of gender dysphoria for any individual depends on that person's individualized needs. The guidelines for medical treatment of gender dysphoria differ depending on whether the treatment is for an adolescent (minors who have entered puberty) or an adult. No pharmaceutical or surgical intervention is recommended or necessary prior to the onset of puberty, however. The individualized steps that many transgender people take to live in a manner consistent with their gender identity are known as "a transition" or "transitioning." The precise steps involved in transitioning are particular to the individual but may include social, medical, and legal transition. Determinations regarding medically necessary care are made on an individualized basis between by the medical professional and the patient.

42. Social transition entails a transgender individual living in accordance with their gender identity in all aspects of life. Social transition can include wearing attire, following grooming practices, and using pronouns consistent with that person's gender identity. The steps a transgender person can take as part of their social transition help align their gender identity with all aspects of everyday life.

43. Many transgender individuals also pursue legal transition, which involves taking steps to formally amend their legal identification documents to align with their gender identity, such as changing one's name through a court ordered legal name change and updating the name and gender marker on their driver's license, birth certificate, and other identification documents.

44. Medical transition, a critical part of transitioning for many transgender people, includes gender-affirming care that brings the sex-specific characteristics of a transgender person's body into alignment with their identity.

45. Gender-affirming care can involve counseling, hormone therapy, surgery, or other medically necessary treatments for gender dysphoria.

46. The most effective treatment for transgender adolescents and adults with gender dysphoria, in terms of both their mental and medical health, contemplates an individualized approach. Medical and surgical treatment interventions are determined by the health care team (usually involving medical and

mental health professionals) in collaboration with the patient, and the patient's parents/guardians, if the patient is an adolescent.

47. Under the WPATH Standards of Care, medical interventions may become medically necessary and appropriate after transgender youth reach puberty. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

48. For many transgender adolescents, going through puberty as the sex assigned to them at birth can cause extreme distress. Puberty delaying medication allows transgender adolescents to pause puberty, thus minimizing and potentially preventing the heightened gender dysphoria and permanent physical changes that puberty would cause.

49. Puberty delaying treatment is reversible. When the adolescent discontinues treatment, puberty will resume. Puberty delaying treatment does not cause infertility.

50. For some transgender adolescents and adults, it is necessary to undergo hormone therapy, which involves taking hormones for the purpose of bringing their secondary sex characteristics into alignment with their gender identity (testosterone for transgender males, and estrogen and testosterone suppression for transgender females). Secondary sex characteristics are bodily features not associated with

external and internal reproductive genitalia (primary sex characteristics). Secondary sex characteristics include, for example, hair growth patterns, body fat distribution, and muscle mass development. Hormone therapy can have significant masculinizing or feminizing effects and can assist in bringing transgender people's secondary sex characteristics into alignment with their gender identity, and therefore is medically necessary care for transgender people who need it to treat their gender dysphoria.

51. Gender-affirming surgery might be sought by transgender people after puberty to treat symptoms of gender dysphoria by better aligning their primary or secondary sex characteristics with their gender identity. Though not all transgender people require or seek gender-affirming surgical care, such care can be medically necessary when determined to be in the best interests of the patient and supported by empirical evidence.

52. Gender-affirming medical care can be lifesaving treatment and has been shown to positively impact the short and long-term health outcomes for transgender people of all ages.

53. All of the treatments used to treat gender dysphoria are also used to treat other diagnoses or conditions. These treatments are not excluded from Medicaid coverage under the Challenged Exclusion when used to treat any diagnosis or condition other than gender dysphoria, yet they carry comparable risks and side

effects to those that can be present when treating gender dysphoria. Thus, the use of these treatments for gender dysphoria are not any more risky than for other conditions and diagnoses for which the same treatments are regularly used.

54. The consequences of untreated, or inadequately treated, gender dysphoria, however, are dire, as untreated gender dysphoria is associated with both clinically significant anxiety, depression, self-harm, and suicidality and higher levels of stigmatization, discrimination, and victimization, contributing to negative self-image and the inability to function effectively in daily life.

55. When transgender people are provided with access to appropriate and individualized gender-affirming care in connection with treatment of gender dysphoria, its symptoms can be alleviated and even prevented.

56. As such, the American Medical Association, American Psychological Association, American Psychiatric Association, Endocrine Society, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, and other major medical organizations have recognized that gender-affirming care is medically necessary, safe, and effective treatment for gender dysphoria, and that access to such treatment improves the health and well-being of transgender people. These groups and others have explicitly advocated against blanket bans on gender-affirming care like the Challenged Exclusion.

57. The medical procedures for the treatment of gender dysphoria are not "cosmetic" or "elective" or for the mere convenience of the patient, but instead are medically necessary for the treatment of the diagnosed medical condition. They are not experimental or investigational, because decades of both clinical experience and medical research show that they are essential to achieving well-being for transgender patients with gender dysphoria.

B. The Medicaid Act and Florida's Medicaid Program

i. Medicaid Coverage

58. The Medicaid Act, Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396-1396w-6, creates a joint federal-state program that provides health care services to specified categories of low-income individuals.

59. Medicaid is designed to "enabl[e] each State, as far as practicable...to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence and self-care...." 42 U.S.C. § 1396-1.

60. States are not required to participate in the Medicaid program—but all states do. States that choose to participate must comply with the Medicaid Act and its implementing regulations. In return, the federal government reimburses each

participating state for a substantial portion of the cost of providing medical assistance. *See id.* §§ 1396b(a), 1396d(b), 1396(c).

61. The Medicaid Act requires each participating state to designate a single state agency charged with administering or supervising the state's Medicaid program. *Id.* § 1396a(a)(5). While a state may delegate certain responsibilities to other entities, such as local agencies or Medicaid managed care plans, the single state agency is ultimately responsible for ensuring compliance with all aspects of the Medicaid Act. *See, e.g.*, 42 C.F.R. §§ 438.100(a)(2), 438.100(d).

62. Each participating state must maintain a comprehensive state plan for medical assistance, approved by the Secretary of the U.S. Department of Health and Human Services. 42 U.S.C. § 1396a.

63. The state plan must describe how the state will administer its Medicaid program and affirm the state's commitment to comply with the Medicaid Act and its implementing regulations. *Id.*

64. Under the Medicaid Act, a participating state must provide medical assistance to certain eligibility groups. *Id.* § 1396a(a)(10)(A)(i). One such group is children and adolescents under age 18 whose household income is below 133% of the federal poverty level. *Id.* §§ 1396a(a)(10)(A)(i)(VI)-(VII), 1396a(l). Another mandatory eligibility category is individuals with a disability who receive Supplemental Security Income or meet separate disability and financial eligibility

standards established by the state. *Id.* §§ 1396a(a)(10)(A)(i)(II), 1396a(f). States have the option to cover additional eligibility groups. *Id.* §§ 1396a(a)(10)(A)(ii).

65. States must administer Medicaid in "the best interests of recipients." 42 U.S.C. § 1396a(a)(19).

ii. The Medicaid EPSDT Requirements

66. The Medicaid Act requires each participating state to cover certain health care services, including inpatient and out-patient hospital services and physician services, when medically necessary. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d. States have the option to cover additional services, including prescription drugs, when medically necessary. *Id.*

67. One mandatory benefit under Medicaid is Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for beneficiaries under age 21. *Id.* §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

68. The fundamental purpose of the EPSDT Requirements is to "[a]ssure that health problems are diagnosed and treated early, before they become more complex and their treatment more costly." Ctrs. for Medicare & Medicaid Servs., State Medicaid Manual § 5010.B.

69. Pursuant to the EPSDT requirements, states must cover four specific, separate categories of screening services: medical, vision, dental, and hearing. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r)(1)-(4).

70. States also must cover "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." *Id.* § 1396d(r)(5). In other words, states participating in Medicaid must cover all medically necessary services for beneficiaries under age 21, even when those services are not covered for adults.

71. Services that fall under 42 U.S.C. § 1396d(a) include inpatient and outpatient hospital services, physician services, and prescription drugs. *Id.* § 1396d(a)(1), (2), (5)(A), (12).

72. Gender-affirming medical treatments, including puberty delaying medication, hormone therapy, and surgery come within the services described in section § 1396d(a) and, thus, are EPSDT services when they are necessary to correct or ameliorate gender dysphoria. *Id.* § 1396d(r)(5) (incorporating services listed in § 1396d(a)).

73. States must "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by" screening services. *Id.* § 1396a(a)(43)(C).

74. States must initiate EPSDT services in a timely manner, as appropriate to the individual needs of the beneficiary, and absolutely no later than 6 months from the date of the request. 42 C.F.R. § 441.56(e).

iii. The Medicaid Comparability Requirements

75. Under the Medicaid Act, "the medical assistance made available to any individual ... shall not be less in amount, duration or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B)(i).

76. "Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b).

77. A state "Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c).

iv. Florida's Medicaid Program

78. The State of Florida participates in the federal Medicaid program. Fla. Stat. §§ 409.901-409.9205. AHCA is the single state agency in Florida that is responsible for administering and implementing Florida's Medicaid program consistent with the requirements of federal law. *See* Fla. Stat. § 409.902; 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

79. AHCA contracts with private managed care plans to provide health care services to most Medicaid beneficiaries. Fla. Stat. § 409.964.

80. The federal government reimburses Florida for approximately 60% of the cost of providing medical assistance through its Medicaid program. *See* U.S. Dep't of Health & Hum. Servs., Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2022 Through September 30, 2023, 86 Fed. Reg. 67479, 67481 (Nov. 26, 2021).

81. Florida regulations require AHCA to cover health care services that are medically necessary within the scope of Fla. Admin. Code R. 59G-1.035(6), 59G-1.010. To qualify as medically necessary, a service must meet several conditions. *See* Fla. Admin. Code R. 59G-1.010, incorporating by reference AHCA, Definitions Policy at 2.83 (2017) (defining medically necessary care).

82. For one, the service must be consistent with generally accepted professional medical standards and not experimental or investigational. *Id.*; Fla. Admin. Code R. 59G-1.035. To determine whether a particular service is consistent with generally accepted professional medical standards, AHCA must consider: "(a) Evidence-based clinical practice guidelines. (b) Published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical

community or practitioner specialty associations). (c) Effectiveness of the health service in improving the individual's prognosis or health outcomes. (d) Utilization trends. (e) Coverage policies by other creditable insurance payor sources. (f) Recommendations or assessments by clinical or technical experts on the subject or field." *Id.* § 59G-1.035(4).

83. After considering those factors, AHCA must submit a report with recommendations to the Deputy Secretary for Medicaid for review, and the Deputy Secretary makes a final determination as to whether the health service is consistent with generally accepted professional medical standards and not experimental or investigational. *Id.* § 59G-1.035(5).

84. Until August 21, 2022, Florida Medicaid covered the full range of gender-affirming treatments, including puberty delaying medication, hormone therapy, and surgical care.

85. Effective August 21, 2022, Florida excluded the coverage without any intervening change in federal Medicaid laws or the standard of care for gender dysphoria, as recognized by the medical community.

C. Defendants Adopt the Challenged Exclusion and Target Transgender Medicaid Beneficiaries for Discrimination.

86. On April 20, 2022, Florida's Department of Health ("FDOH") issued a misleading and factually inaccurate set of guidelines titled "Treatment of Gender

Dysphoria for Children and Adults" (hereinafter "FDOH Guidelines").[7] FDOH issued the FDOH Guidelines in direct response to the fact sheet from the U.S. Department of Health & Human Services regarding "Gender-Affirming Care and Young People."[8]

87. The FDOH Guidelines, which are non-binding in nature, directly contradicted the guidance from HHS, as well as the established medical guidelines supported by the country's largest and leading medical organizations.

88. The FDOH Guidelines stated that:

- Social gender transition should not be a treatment option for children or adolescents.
- Anyone under 18 should not be prescribed puberty delaying medication or hormone therapy.
- Gender reassignment surgery should not be a treatment option for children or adolescents.

89. Under the WPATH Standards of Care and Endocrine Society Guidelines, no one is provided pharmaceutical treatment for gender dysphoria until *after* the onset of puberty. No surgical interventions are recommended for

---

[7] *See Treatment of Gender Dysphoria for Children and Adults*, FLORIDA DEP'T OF HEALTH (April 20, 2022), https://perma.cc/W33H-6P5Q.

[8] *See Gender-Affirming Care and Young People*, U.S. Dep't of Health & Human Servs. (March 2022), https://perma.cc/399W-T6AC.

transgender adolescents prior to the age of 18, *except* for limited reconstructive surgery for adolescents who have reached Tanner Stage 5 and for whom it is deemed medically necessary by qualified mental and medical health care professionals.

90. The FDOH Guidelines were criticized by, among others, a group of more than 300 Florida health care professionals who care for transgender and gender diverse youth. This group denounced the FDOH Guidelines for citing "a selective and non-representative sample of small studies and reviews, editorials, opinion pieces and commentary to support several of their substantial claims" and misrepresenting "high-quality studies" by making "conclusions that are not supported by the authors of the articles."[9]

91. The 300 Florida health care professionals further stated that the FDOH Guidelines "contradict[] existing guidelines from the American Academy of Pediatrics, the Endocrine Society, the American Academy of Child and Adolescent Psychiatry and the World Professional Association for Transgender Health," and that "[t]hese national and international guidelines are the result of careful deliberation and examination of the evidence by experts including pediatricians, endocrinologists, psychologists and psychiatrists."

---

[9] Brittany S. Bruggeman, *et al.*, *Opinion: We 300 Florida health care professionals say the state gets transgender guidance wrong | Open letter*, TAMPA BAY TIMES (Apr. 27, 2022), https://perma.cc/5UWE-LURH.

92. On April 20, 2022, based on the publication of the FDOH Guidelines, Secretary Marstiller sent a letter to Tom Wallace, AHCA's Deputy Secretary for Medicaid, requesting that AHCA determine if the treatments addressed in the FDOH Guidelines "are consistent with generally accepted professional medical standards and not experimental or investigational."[10]

93. The request from Secretary Marstiller to Deputy Secretary Wallace was highly unusual, as AHCA does not generally draft a GAPMS report for services that it is already covering.

94. While AHCA purported to go through its required rule-making process, it was clear the outcome was predetermined: to restrict access to medically necessary gender-affirming care for transgender people in Florida.

95. On June 2, 2022, Defendants published their report, "Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" (hereinafter "GAPMS Memo").[11] The publication of the GAPMS Memo was accompanied by the publication of a political webpage within AHCA's website titled "Let Kids Be Kids"

[10] *Letter from AHCA Secretary Marstiller to Deputy Secretary Wallace* (April 20, 2022), https://perma.cc/YS7S-DFAX.

[11] AHCA, *Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria* (June 2, 2022), https://perma.cc/SUB9-V7DW.

(https://ahca.myflorida.com/lctkidsbckids/) that included graphics, misleading "fact-checking" of HHS's guidance, and false assertions about social media's alleged influence on experiences of gender dysphoria.

96. The GAPMS Memo wrongly concluded that gender-affirming medical treatments, including puberty blockers, hormone therapy, and surgery, "do not conform to GAPMS [("generally accepted professional medical standards")] and are experimental and investigational." Deputy Secretary Wallace signed the GAPMS Memo and noted his concurrence.

97. To support this conclusion, the GAPMS Memo cited to, and relied upon, five non-peer-reviewed, unpublished "assessments" that Defendants commissioned. The "assessments" are the following:

- Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. 16 May 2022.
- James Cantor, PhD: Science of Gender Dysphoria and Transsexualism. 17 May 2022.
- Quentin Van Meter, MD: Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. 17 May 2022.

- Patrick Lappert, MD: Surgical Procedures and Gender Dysphoria. 17 May 2022.
- Kevin Donovan, MD: Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children. 16 May 2022.

98. These "assessments" illustrate how the GAPMS Memo is the product of bias and was engineered to achieve a particular result.

99. For example, although the GAPMS Memo presents Dr. Quentin van Meter as an expert in medical treatment for gender dysphoria, at least one court in Texas barred him from providing expert testimony on the on the "question of whether an adolescent transgender child should be administered puberty blockers and whether affirmation of an incongruent gender in a child is harmful or not."[12] Dr. Van Meter is the president of the American College of Pediatricians (not to be confused with the American Academy of Pediatrics). The American College of Pediatricians is not a professional association but instead a political group that, among other things, opposes marriage equality for same-sex couples, supports the

[12] Stephen Caruso, *A Texas judge ruled this doctor was not an expert. A Pennsylvania Republican invited him to testify on trans health care*, PENNSYLVANIA CAPITOL-STAR (Sept. 15, 2020), https://perma.cc/P8AU-3RFC.

provision of conversion therapy, and describes childhood gender dysphoria as "confusion."

100. The GAPMS Memo also cites to Dr. James Cantor as an expert on gender dysphoria. However, Dr. Cantor admitted in court to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving medical or surgical treatments for gender dysphoria.[13]

101. AHCA's GAPMS Memo also cites to an "assessment" authored by Dr. Romina Brignardello-Petersen and a post-doctoral fellow purporting to review the scientific literature regarding gender dysphoria and its treatment. Dr. Brignardello-Petersen has no particular expertise regarding gender dysphoria and is a member of the Society for Evidence Based Gender Medicine ("SEGM"), a group that opposes standard medical care for gender dysphoria, has no publications or conferences, and, upon information and belief, consists solely of a website created by a small group of people.

102. AHCA cites to an "assessment" by Dr. Patrick Lappert, a non-board-certified plastic surgeon. A federal court recently noted that there is evidence that calls Dr. Lappert's "bias and reliability [to testify regarding gender dysphoria] into

[13] In *Eknes-Tucker v. Marshall*, No. 2:22-CV-184-LCB, 2022 WL 1521889, at *5 (M.D. Ala. May 13, 2022), based on Dr. Cantor's lack of experience in providing this type of care, "the Court gave his testimony regarding the treatment of gender dysphoria in minors very little weight."

serious question" and that Dr. Lappert "is not qualified to render opinions about the diagnosis of gender dysphoria, its possible causes, … the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on [] non-surgical treatments," and that his views "do not justify the exclusion" of gender-affirming medical care.[14]

103. On June 17, 2022, AHCA issued a Notice of Proposed Rule seeking to amend Florida Administrative Code 59G-1.050 to prohibit Florida Medicaid from covering "services for the treatment of gender dysphoria," including: "1. Puberty blockers; 2. Hormones and hormone antagonists; 3. Sex reassignment surgeries; and 4. Any other procedures that alter primary or secondary sexual characteristics." The Proposed Rule also stated that, "For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)," the aforementioned services "do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C."[15]

[14] *Kadel v. Folwell*, No. 1:19CV272, 2022 WL 3226731, at *12-13, 32 (M.D.N.C. Aug. 10, 2022).

[15] https://www.flrules.org/gateway/View_Notice.asp?id=25979915.

104. The Proposed Rule sought to prohibit Medicaid coverage of medical treatment for gender dysphoria for both transgender adolescents and adults, going beyond the FDOH Guidance.

105. During the 21 days following the issuance of the Proposed Rule, from June 17, 2022 to July 8, 2022, thousands of comments were submitted by individuals, organizations, and medical professionals across Florida in opposition to the rule.

106. On July 8, 2022, AHCA held a public hearing on the proposed rule.

107. The hearing, which was set for 3:00pm on a Friday afternoon, featured a "panel of doctors," none of whom had any clinical experience treating gender dysphoria, to respond to any substantive comments from the audience. The panel of doctors included: Dr. Andre Van Mol; Dr. Quentin Van Meter; and Dr. Miriam Grossman.

108. The panel highlighted AHCA's singular focus on prohibiting coverage of and access to medically necessary gender-affirming care.

109. Dr. Andre Van Mol is a board member of Moral Revolution (https://www.moralrevolution.com/), an organization that believes that "[t]he multitude of possible gender identities and the normalization of same-sex sexual behavior points to a society that has abandoned the desire to accurately define and socialize humanity as a reflection of God's image," and that "[s]ome people

experience same-sex attraction and gender dysphoria … not because they were 'born that way,' but because they were born human into a fallen world, and because society has disrupted and confused how we teach children who they are."

110. In reference to transgender youth, Dr. Miriam Grossman has stated that "conditioning children into believing that a lifetime of impersonating someone of the opposite sex, achievable only through chemical and surgical interventions, is harmful to youths."

111. The public hearing was also characterized by participants who were flown in from out of state, who did not profess to be Florida Medicaid participants, or who were opponents of transgender rights bussed in to testify in support of the rule. Many of them were carrying signs and shirts reflecting the "Let Kids Be Kids" slogan that appears on AHCA's webpage regarding the GAPMS Memo. AHCA allowed stickers containing their slogan to be passed out at the front door and at the sign-in table as attendees entered.

112. Notwithstanding the seemingly biased nature of the proceedings, thousands of commenters submitted written comments and many testified at the hearing in opposition to the Proposed Rule. The range of comments highlighted, among other things: the significant and immediate harms that transgender Medicaid beneficiaries in Florida would suffer; the flaws of the GAPMS Memo; the well-documented evidence base for gender-affirming care, including that it is safe and

effective for the treatment of gender dysphoria; and that the Proposed Rule was unlawful.

113. Among the comments submitted to Defendants in opposition to the Proposed Rule was a comment by a team of legal and medical experts from Yale Law School, the Yale School of Medicine's Child Study Center and Departments of Psychiatry and Pediatrics, University of Texas Southwestern, and University of Alabama at Birmingham that identifies and refutes the many unscientific claims behind the GAPMS Memo.[16]

114. The comment by the team of experts indicated that:

- **The GAPMS Memo falsely claims that the scientific evidence does not support medical treatment for gender dysphoria.** In fact, medical care for gender dysphoria is supported by a robust scientific consensus. The specific medical services at issue have been used worldwide for decades, meet generally accepted medical standards, and are not experimental.
- **The GAPMS Memo urges a discriminatory policy that violates the federal and state constitutions and federal and state law.** AHCA offered the report to justify the denial of Medicaid coverage for medical

[16] *Letter from Anne L. Alstott et al. to AHCA Secretary Marstiller* (July 8, 2022), https://perma.cc/E432-YUQ7.

care for gender dysphoria. But this discriminatory policy illegally targets transgender people. Neither the June 2 GAPMS Memo nor the AHCA proposal would apply to similar treatments routinely offered to cisgender people.

- **The GAPMS Memo repeatedly and erroneously dismisses solid medical research studies as "low quality," demonstrating a faulty understanding of statistics, medical regulation, and scientific research.** The GAPMS Memo makes unfounded criticisms of robust and well-regarded clinical research, while disregarding other relevant studies altogether. If Florida's Medicaid program applied the June 2 GAPMS Memo's approach to all medical procedures equally, it would have to deny coverage for widely used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.
- **The GAPMS Memo cites sources that have no scientific merit.** The GAPMS Memo relies on pseudo-science, particularly purported expert "assessments" that are biased and full of errors. The "assessments" are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups. The GAPMS

Memo's unfounded claims come from unqualified sources, which include a blog entry, letters to the editor, and opinion pieces.

115. The comment by the team of experts was accompanied by the publication of a report, "A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria," that represents the first comprehensive examination of Florida's GAPMS Memo. The authors of this report contend that the GAPMS Memo is a misleading document intended to justify denying Florida Medicaid coverage for gender dysphoria treatment.[17]

116. In its comment, the American Academy of Pediatrics noted: "[T]he mental and physical health and well-being of transgender children and adolescents often rely on their abilities to access much needed mental and physical health care—care that is in keeping with the widely recognized evidence-based standards of care for gender dysphoria. In proposing this rule, Florida ignores broad consensus among the medical community as to what those evidence-based standards of care are, and instead seeks, for its own discriminatory reasons, to impose alternate standards and

[17] *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022), https://perma.cc/XZV3-PBEA.

an outright ban of specific treatments for transgender adolescents in the state's Medicaid program."[18]

117. Similarly, the Endocrine Society submitted a comment stating: "The proposed rule would deny Medicaid beneficiaries with gender dysphoria access to medical interventions that alleviate suffering, are grounded in science, and are endorsed by the medical community. The medical treatments prohibited by the proposed rule can be a crucial part of treatment for people with gender dysphoria and necessary to preserve their health. … [R]esearch shows that people with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life. In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk."[19]

118. In addition, interviews with researchers whose studies were cited within the FDOH Guidelines and GAPMS Memo have expressed alarm at how Defendants

---

[18] *Letter from the American Academy of Pediatrics and the Florida Chapter of the AAP to AHCA Deputy Secretary Tom Wallace* (July 7, 2022), https://perma.cc/ND5M-TGYJ.

[19] *Letter from the Endocrine Society to AHCA* (July 8, 2022), https://perma.cc/F5TX-J3JY.

have misinterpreted and misrepresented their studies to justify the Challenged Exclusion.[20]

119. Notwithstanding the thousands of comments submitted to AHCA in opposition to the Proposed Rule, as well as the substantive evidence and extensive commentary submitted by leading medical and legal experts and organizations, Defendants filed the Challenged Exclusion as a final rule for adoption on August 1, 2022, a mere three weeks after the close of the public comment period and without having responded in writing to material or timely written comments, as required by Fla. Stat. § 120.54(3)(e)(4).

120. Notice of the Final Adopted Version of the Challenged Exclusion was published on FLRules.com on August 10, 2022 and stated that the Challenged Exclusion would become effective on August 21, 2022.[21]

121. The Challenged Exclusion, in its final adopted form within Florida Administrative Code 59G-1.050, states as follows:

> (7) Gender Dysphoria.
>
> (a) Florida Medicaid does not cover the following services for the treatment of gender dysphoria:

---

[20] Sam Greenspan, *How Florida Twisted Science to Deny Healthcare to Trans Kids*, VICE NEWS (Aug. 3, 2022), https://perma.cc/GZ6P-W2WN.

[21] https://www.flrules.org/gateway/View_Notice.asp?id=26157328.

1. Puberty blockers;

2. Hormones and hormone antagonists;

3. Sex reassignment surgeries; and

4. Any other procedures that alter primary or secondary sexual characteristics.

(b) For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

122. Coverage for the four services listed within the Challenged Exclusion is still available when those services are medically necessary for the treatment of conditions other than gender dysphoria.

123. The Challenged Exclusion ignores the established scientific and medical consensus that the four specified services are frequently medically necessary, safe, and effective for treating gender dysphoria.

124. The Challenged Exclusion results in AHCA refusing to cover medically necessary treatments for gender dysphoria.

125. In addition, the Challenged Exclusion is one of a series of measures the State has taken targeting transgender people, and LGBTQ people more broadly, for discrimination.

126. For example, surrounding the GAPMS Memo's release and the adoption of the Challenged Exclusion:

a. The FDOH issued its factually inaccurate April 2022 guidelines titled "Treatment of Gender Dysphoria for Children and Adults";[22]

b. Florida enacted its infamous "Don't Say Gay" law, Fla. Stat. § 1001.42(8)(c) (2022);[23]

c. Governor DeSantis removed a state attorney from office for, in part, saying he would refuse to enforce any laws criminalizing gender-affirming care;[24]

d. The FDOH sent the Florida Board of Medicine ("FBOM") a "Petition to Initiate Rulemaking," asking it to, among other things, adopt a categorical ban on the provision of gender-affirming medical care to people under 18 years of age and, with respect to adults, to adopt a 24-hour waiting period;[25]

---

[22] *Treatment of Gender Dysphoria for Children and Adults*, FLORIDA DEP'T OF HEALTH (April 20, 2022), https://perma.cc/W33H-6P5Q.

[23] Enacted July 1, 2022, the law seeks to erase LGBTQ people and related content from Florida public schools. The widely used "Don't Say Gay" moniker fails to recognize the harms this law intentionally inflicts upon transgender people and others who identify as members of the LGBTQ community.

[24] Florida Executive Order No. 22-176 (Aug. 4, 2022), https://perma.cc/VSG9-2SUJ.

[25] *Petition to Initiate Rulemaking Setting the Standard of Care for Treatment of Gender Dysphoria* (July 28, 2022), https://perma.cc/3PP7-N6WW.

e. The FBOM initiated a rulemaking process for a proposed rule to, among other things, ban gender-affirming care for people under the age of 18;[26]

f. The Florida Department of Business and Professional Regulation lodged a public nuisance complaint against a bar catering to transgender people when that bar had a drag queen reading event;[27] and

g. Florida officials and their spokespersons made a litany of statements denigrating transgender people.[28]

127. The discriminatory animus by Defendants toward transgender people is clearly evident by their actions, as the adoption of the Challenged Exclusion deliberately targets transgender people for discrimination in Florida.

---

[26] *Meeting Minutes*, FLORIDA BOARD OF MED. (Aug. 5, 2022), https://perma.cc/52A3-2E5V.

[27] *Fla. Dep't of Bus. and Prof. Reg., Div. of Alcoholic Beverages and Tobacco v. R House, Inc.*, Case No. 2022-035976, Admin. Complaint (July 26, 2022), https://perma.cc/8DRL-KVWY.

[28] Jeremy Redfern (@JeremyRedfernFL), Twitter (Aug. 14, 2022), https://tinyurl.com/2p8vajvw; Governor Ron DeSantis (@GovRonDeSantis), Twitter (Aug. 16, 2022), https://tinyurl.com/yckkuh32; Christina Pushaw (@ChristinaPushaw), Twitter (Aug. 19, 2022), https://tinyurl.com/2p8r5r6c.

D. The Plaintiffs

Plaintiff August Dekker

128. August Dekker is a 28-year-old transgender man.

129. August is unemployed and receives Supplemental Security Income due to disability, as he lives with debilitating rheumatoid arthritis. He has been a Medicaid beneficiary in Florida since 2014.

130. August experiences and has been diagnosed with gender dysphoria.

131. As a child, even as early as 5 years of age, August felt uncomfortable being perceived as a girl. For example, he would always choose to play a male character when he was roleplaying with his brothers and would also play male characters when he would play "house."

132. Around the age of 13, August was extremely distraught when he got his first period. He ran to his mom crying and wondering what was happening because he did not feel that he was a girl.

133. However, because of his family's religious beliefs, August felt forced to suppress his gender identity as a child and adolescent, which caused him great distress and anxiety.

134. Once he graduated high school, August felt freer to explore his gender expression and come to terms with his gender identity as a man. By 2015, August began to socially transition and live openly as the man that he is.

135. Not long after, August decided to seek out medical care. It took him a while to find a provider who would be qualified and with whom he felt comfortable. Once he found a provider at Metro Inclusive Health in Tampa, August began working with a therapist before starting hormone therapy. The therapist diagnosed August with gender dysphoria in 2017.

136. Following the diagnosis of gender dysphoria and working with and under the care of his medical and mental health providers, August began undergoing hormone therapy as medically necessary treatment for his gender dysphoria in 2017.

137. August has since worked with different medical and mental health providers, who continue to recommend hormone therapy as medically necessary treatment for his gender dysphoria. He now sees a therapist at Solace Behavioral Health in Tampa and receives his hormone therapy through Planned Parenthood in Tampa.

138. At present, at the recommendation of his medical and mental health providers, August is being prescribed testosterone hormone therapy as treatment for his gender dysphoria. The prescription must be written every month. Up until now, Medicaid has covered August's testosterone hormone therapy.

139. In addition, in consultation with and under the care of his medical and mental health providers, August obtained chest surgery as treatment for his gender dysphoria in April 2022. This surgical treatment, which was covered by Medicaid,

was recommended by his providers as medically necessary treatment for August's gender dysphoria. And it was covered by Medicaid.

140. Medicaid has always covered August's medically necessary gender-affirming medical care as recommended by his medical and mental health providers to treat his gender dysphoria.

141. Being able to receive hormone therapy in the form of testosterone injections and to have chest surgery has allowed August to bring his body into alignment with who he is, provided a great deal of relief to August, and relieved some of the clinically significant distress underlying his gender dysphoria. It has given August the ability to not hate himself or his body and has brought great comfort to his life.

142. Having access to this medically necessary care has allowed August to be the version of himself that he pictured growing up. For August, it feels natural and normal to be able to live as the man that he is.

143. Following his chest surgery, August was able to celebrate his birthday with some friends outdoors in a state park. Having a more masculine chest that conformed with his identity allowed August to be shirtless in public for the first time ever, just like any other man. It was an afternoon full of joy and laughter for August, and he had never felt more euphoric about his body than he did in that moment.

144. AHCA's adoption of the Challenged Exclusion has caused August a great deal of distress and anxiety. When August first learned of the new regulation, he felt a great sense of dread. August is now fearful of the future.

145. August's only source of income is his monthly Supplemental Security Income payments of $841. He uses this limited income to pay for rent, food, and necessities, and simply cannot afford his medically necessary hormone therapy without Medicaid, which would cost $60-65 per month.

146. While August could ask some family and friends for money in order to afford his medically necessary care, that is neither guaranteed nor sustainable. It also feels dehumanizing and shameful to August to have to ask for help all the time, especially when his hormone therapy is medically necessary health care recommended by his doctors and which Medicaid has covered until now.

147. August also has experienced the physical effects of having to stop hormone therapy for a period of time. That experience caused him to lose muscle mass, have a higher pitched voice, and lose some of his body and facial hair such that it caused him distress and to a degree that people started perceiving him as a woman instead of the man that he is. It caused August great discomfort and anguish to be perceived as such, and he does not want to ever have to experience that again.

148. The adoption of the Challenged Exclusion, along with other actions taken by Florida's current administration targeting transgender people, have shaken

August and caused him to lose hope. August no longer feels safe to be an out transgender person in Florida. Because of the discrimination he sees stoked by Florida's policy decisions to target transgender people, August often worries that someone will perceive him as transgender and decide they want to hurt him. He is frightened about the possibility that losing access to his medically necessary gender-affirming care will cause physical changes that will make it more likely for someone to perceive him as transgender or more feminine. If someone perceives him as transgender or more feminine, August is afraid that they will verbally or physically assault him.

149. It is incredibly stressful and debilitating for August to have to worry about whether he will be able to get the medical care that he needs, or whether in its absence, he will be incorrectly perceived as female.

150. The Challenged Exclusion threatens the health and wellbeing of transgender Medicaid beneficiaries like August.

Plaintiff Brit Rothstein

151. Brit Rothstein is a 20-year-old transgender man.

152. Brit is a junior in at the University of Central Florida (UCF), where he is studying digital media and minoring in information technology. Brit has a full scholarship to attend UCF, which is the only way that he is able to go to college as his family is low-income and could not otherwise afford tuition and living expenses.

Brit worked hard to obtain a Florida Bright Futures scholarship so that he would be able to attend college. He also received a Top Ten Knights Scholarship from the UCF. In addition, Brit participates in a federal work study program, which provides part-time jobs for students with financial need, while taking 15 credits this semester.

153. Given his and his family's very limited income, as well as his age, Brit receives his health care coverage through Florida's Medicaid program, as administered through Sunshine Health.

154. A transgender man, Brit was incorrectly assigned the sex female at birth, but his gender identity is male.

155. Brit experiences gender dysphoria in relation to the disconnect between his sex assigned at birth and his gender identity.

156. Since the third grade, Brit has been aware of his male gender identity. When he was younger, Brit's mom would try to force him to wear dresses to church but he hated dresses and would only want to wear slacks. He also did not understand why he could not have short hair. Even as a child, stereotypical assumptions and expectations regarding his sex assigned at birth did not make sense to him.

157. In the sixth grade, as he approached puberty, Brit's anxiety and depression surrounding his sex assigned at birth was exacerbated, and he would become physically ill when he had to go into the girls' locker room for P.E. Fortunately, there was a guidance counselor who understood the discomfort that Brit

experienced in the locker room and the manifesting anxiety and distress it caused him, so she helped him transfer out of P.E.

158. While he was in the seventh grade, Brit was seeing a therapist due to unrelated issues. His therapist saw how much Brit was struggling with not being able to live his life as a boy and, through his sessions with his therapist, Brit became more comfortable with how he was feeling and came to understand that he was a boy. Brit's therapist also helped Brit navigate how to talk to others about his gender identity.

159. After a lot of research about how to explain to his family how he felt and that he was transgender, Brit came out to his dad in 2015, at age 13, and asked that he be treated in accordance with his male gender identity. Brit's parents are divorced, and he came out only to his dad at first. Brit's dad was very supportive and allowed Brit to wear a binder (a garment that helps to give the appearance of a flatter chest) at his house and live as his true authentic self when he was there.

160. Unfortunately, Brit was not able to do the same at his mother's house because she disapproved of him. For example, when Brit came out to his mother as transgender in 2016, she called him an "abomination" and disowned him. Brit has not had any contact with his mother or her side of the family since then.

161. Around July 2015, when Brit was 14 years old, Brit began seeing a psychologist, and continued therapy with her until he went to college. Brit's

psychologist diagnosed him with gender dysphoria and, after a couple of years of counseling, the psychologist referred Brit to Joe DiMaggio Children's Hospital to meet with a pediatric endocrinologist.

162. Because Brit's mother objected to the medical care for Brit's gender dysphoria recommended by Brit's mental health and medical providers, Brit's dad had to go to court, where he was granted by the court sole decision-making authority as it related to issues involving Brit's gender identity.

163. Thereafter, when Brit was 17 years old, he began to see a pediatric endocrinologist at Joe DiMaggio. By then, Brit had been diagnosed with gender dysphoria approximately four years prior and had been in consistent and regular counseling since that time. Brit was also living in accordance with his male gender identity to the maximum extent possible, given his family situation.

164. Brit's pediatric endocrinologist determined that it was medically necessary for Brit to begin hormone blockers, which she prescribed for him, and oversaw his treatment. Months later, Brit also began testosterone hormone therapy as medically necessary treatment for his gender dysphoria at his pediatric endocrinologist's recommendation. Medicaid has covered Brit's gender-affirming health care needs, including therapy, blood tests, office visits, and his prescriptions for hormone blockers and testosterone.

165. Hormone therapy, in the form of testosterone, has impacted Brit's life in many positive ways, including the changes to his physical body, his mental and emotional health, and even the self-confidence he has gained through existing in a body that feels more like his own.

166. When he was 18, Brit was able to obtain a court order for legal name change, changing his legal name to Brit Andrew Rothstein, which aligned with his gender identity and who he knows himself to be. Brit also amended his legal government-issued identification documents to reflect his new legal name and correct gender marker as male.

167. Still, however, Brit continues to experience significant dysphoria related to his chest. Ever since his chest developed, Brit has hated the way it looks and feels, and has long known that he needs to have chest surgery to bring his body into alignment with who he is.

168. Brit wears a binder almost every day, usually for 10-12 hours per day, depending on his schedule. His binder causes him discomfort, leaves skin indentations, and sometimes causes bruising on his ribcage. In 2018, Brit had to go to the emergency room for chest contusions caused by wearing his binder for too long. Having top surgery would allow Brit to no longer wear a restrictive binder just to navigate his daily life. Unfortunately, there are very few medical providers in

Florida who are both competent in performing gender-affirming chest surgery, and even fewer who also take Medicaid.

169. Brit finally found a surgeon at the University of Miami who accepts Medicaid for chest surgeries in January 2022. Brit had his consultation with the surgeon in May and the surgeon recommended that Brit undergo gender-affirming chest surgery, which was pre-authorized by Medicaid. When Brit received his pre-authorization on August 11, 2022, he felt blessed to finally have the chance to obtain the gender-affirming care he needed.

170. Brit was elated to learn that he would finally be getting the surgery that he needed and had long awaited, and he even had a date scheduled: December 22, 2022. For Brit, it would be an understatement to say that he was looking forward to the surgery. The surgery would allow Brit to bring his body into alignment with who he is. It would also eliminate the need for Brit to wear a restrictive and painful binder to hide that part of his body.

171. However, the very next day after Brit learned his surgery had been pre-authorized, Brit learned that AHCA adopted a rule that prohibited Medicaid coverage for Brit's medically necessary gender-affirming chest surgery. To Brit, it was a punch to the gut to learn that the state of Florida had decided to strip coverage for medically necessary medical care from him and other transgender Floridians on Medicaid. It was the highest of highs followed by the lowest of lows.

172. What is worse, without Medicaid, Brit cannot afford to pay for his testosterone prescription or for his surgery, which is still scheduled for December 22, 2022. Because of the Challenged Exclusion, Brit is unable to access to the medical care for his gender dysphoria that his medical providers have determined is medically necessary for his health and wellbeing.

173. Brit's family is also of very limited income, and he does not have family members who can pay for his care. Brit's dad is a single parent, who has arranged his entire life around being the sole-caretaker for Brit's twin sister, who lives with cerebral palsy and other disabilities. Brit's dad needs to have the same schedule as his sister because she requires around the clock care and attention. As such, Brit's has worked as a teachers' assistant for students with special education needs in the Broward County School District, a job which pays approximately $21,000 per year. Brit's dad is thus barely able to make ends meet and cannot afford to financially help Brit access the medical care he needs.

174. Brit has spent a long time fighting to become the man that he knows himself to be. He has overcome obstacles and worked hard to get an education and have access to the medical care his providers have deemed medically necessary to treat his gender dysphoria, yet Defendants have created an unnecessary additional barrier blocking Brit from the medical care that he needs, and which would allow him to feel like his body is in alignment with who he truly is.

175. Even though Brit is legally male in the eyes of the state and federal government, has testosterone circulating through his body, and has grown facial hair, Brit still lives in fear every day that he will be misperceived as female or perceived as transgender due to his chest.

176. In high school, Brit recognized how fortunate he was to have a supportive parent who loved him for who he is. Not everyone has that. There were multiple students at Brit's high school who attempted or died by suicide, so Brit decided that he needed to advocate for those who did not have the support that he had from his dad. As a result, Brit was invited to join the Broward County Superintendent's LGBTQ+ Advisory Council, and Brit was the President of his school's Gay/Straight Alliance (GSA) Club. Brit supported his fellow transgender classmates the best that he could, because Brit believes that everyone deserves to feel accepted for who they are.

177. For Brit, the State's decision to deny transgender people, like himself, of access to medically necessary health care and being treated differently than others solely for being transgender is unthinkable and wrong.

Plaintiff Susan Doe

178. Susan Doe is the daughter of Jane and John Doe.

179. Jane Doe is a full-time mom and homemaker. John Doe works for the federal government. He has worked there for 19 years.

180. Along with their two children, Jane and John live in Brevard County, Florida.

181. Jane and John adopted Susan, their 12-year-old daughter, out of medical foster care in Florida when she was 2 years old.

182. Susan is transgender.

183. When Jane and John adopted Susan out of foster care, Susan had several medical issues. She was originally placed in regular foster care and was then moved into the medical foster care program after an incident where she stopped breathing as an infant. At the time she came into the Does' care, she had severe acid reflux that needed treatment and was barely meeting developmental milestones.

184. Because Jane and John adopted Susan out of foster care, she is eligible for Medicaid coverage until she turns 18. Susan has thus been eligible for and enrolled in Florida's Medicaid program since she entered Florida's foster care system as an infant. Jane and John have kept Susan on Medicaid in order to ensure continuity of care with her existing providers and to ensure that her medical needs are properly met.

185. Although Susan was assigned male at birth, she has known that she is a girl from a very young age. When she was 3 years old, Susan first told her parents that she was a girl. Jane and John allowed Susan to explore her gender expression in deliberate and gradual steps. For example, Susan liked to wear ribbons in her hair

and pink bracelets to school, even when she still wore typical boy clothes and had not yet grown out her hair. Jane and John kept princess dresses for Susan at home, and she would often change into a dress as soon as she came home from school.

186. When Susan was in first grade, she became extremely unhappy with her assigned gender. Before that time, she had mostly been a very happy-go-lucky child, but starting in first grade she began getting angry and frustrated easily, and then would become incredibly sad, often crying for 20 minutes or more.

187. Jane and John consulted resources online and researched gender dysphoria in children, and as Susan's parents, had to acknowledge that the discrepancy between Susan's sex assigned at birth and how she felt inside was causing her to suffer.

188. The Does looked for a therapist for Susan. Ultimately, Susan and Jane were able to go to one session with a therapist when Susan was 6, and the therapist advised Jane on how to best support Susan. The therapist told Jane to keep listening to Susan and to allow her to express herself, as Jane and John had been doing. The therapist also suggested buying clothes from the girls' department that were gender neutral so Susan could wear them to school without attracting attention about her gender presentation.

189. Susan had her last short haircut when she was 6 years old, and when she saw how it looked, she started crying because she felt like the short haircut did not reflect her identity. After that, she started growing out her hair.

190. Around the same time, Jane found out that Susan had started to introduce herself to people with her chosen name, which has since become her legal name, and is more typically feminine.

191. During the summer of 2017, which was the summer before Susan started second grade, Susan told Jane and John unequivocally: "I need to be a girl." To ensure that they were properly supporting Susan, Jane and John took Susan to see a therapist as a family. The therapist diagnosed Susan with gender dysphoria. The therapist also made clear to the Does that Susan knows exactly who she is and that any problems stemmed from when people question Susan's identity. The therapist thus recommended Jane and John continue to support Susan in her social transition.

192. Following the therapist's advice, Jane and John followed Susan's lead and bought her more traditionally feminine clothes, including dresses and skirts to wear to school. Jane and John also worked with the principal and teachers at Susan's school to try to make sure that they used the appropriate name and pronouns for Susan. In addition, the therapist shared with Jane and John, and the Does in turn

shared with Susan's school, the latest research on helping children with gender dysphoria adjust well at school, in addition to in the home.

193. After Susan was able to socially transition and live in accordance with her firmly asserted female gender identity, Jane and John observed Susan feeling a sense of joy. Susan was happy and comfortable in her own skin.

194. In addition, the therapist further recommended that Susan see a pediatric endocrinologist, who could monitor her hormone levels for the onset of puberty and assist with any future medical needs.

195. Jane and John looked for a pediatric endocrinologist that was close to them, but ultimately began working with a pediatric endocrinologist at Joe DiMaggio Children's Hospital in south Florida. Susan has been seeing her pediatric endocrinologist since 2019. The Does drive three hours there and three hours back for every appointment. Initially, the pediatric endocrinologist closely monitored Susan's hormone levels to determine the onset of puberty. Susan had visits approximately every three months.

196. Jane and John have been very deliberate in their approach to supporting Susan. Their goal has always been to support their daughter while following the advice and recommendations of medical and health professionals experienced in dealing with gender identity and gender dysphoria.

197. In July 2020, after Susan began the onset of puberty, the pediatric endocrinologist started Susan on a puberty delaying medication called Lupron as medically necessary treatment for Susan's gender dysphoria. The medication, which Medicaid has been covering, prevents Susan from developing secondary sex characteristics consistent with male puberty. According to the pediatric endocrinologist, it is medically necessary for Susan to receive a Lupron injection every three months in order for her to live authentically in a manner consistent with her gender identity and to treat her gender dysphoria. By preventing the physical manifestations that accompany male puberty, Susan is also able to avoid negative social and emotional consequences associated with her being forced to develop the characteristics aligned with a gender with which she does not identify.

198. When Susan learned that the puberty delaying medication was necessary to suppress male puberty, she was happy at the prospect. There is nothing worse in Susan's mind than male puberty; she describes it as a "nightmare."

199. Susan's pediatric endocrinologist is currently monitoring Susan to determine when it would be medically appropriate for her to begin hormone therapy. Susan is very eager to go through female puberty. At this point, the pediatric endocrinologist thinks that Susan could be ready to start hormone therapy in a year or two.

200. In August 2021, the Does' therapist retired from her practice. In November 2021, Susan began seeing another therapist, who is a Licensed Clinical Social Worker. Like the first therapist, the second therapist diagnosed Susan with gender dysphoria. The second therapist has further supported Susan in managing the symptoms of her dysphoria.

201. In light of Defendants' adoption of the Challenged Exclusion, the Does understand that Florida's Medicaid program will no longer cover Lupron for Susan as treatment for her gender dysphoria. The Challenged Exclusion will also prohibit Medicaid from covering hormone therapy as treatment for Susan's gender dysphoria when Susan is ready to begin the treatment, per the medical guidance of her pediatric endocrinologist.

202. Susan is due to have her next Lupron injection on October 3, 2022. Due to the Challenged Exclusion, Medicaid will refuse to pay for the medically necessary Lupron injection when it is needed.

203. Jane and John worry about the potential physical and mental health consequences of depriving Susan of the medically necessary treatment recommended by her doctors. Not providing such treatment is not an option for them. For Jane and John, providing Susan with the medical treatment for gender dysphoria that she requires is necessary to ensure her health and well-being.

204. If Susan had to stop taking Lupron and go through male puberty as a result of the Challenged Exclusion, she would be devastated. Susan has been living as a girl in every aspect of her life since 2017. Her legal name was changed to her current affirmed name in 2018, and in 2020, her birth certificate was amended to reflect that she is female.

205. If Susan were no longer able to access the medical care that she needs to align her body with her gender identity, Susan's mental health would suffer tremendously. Susan would not want to leave the house, and Jane and John fear that she might engage in self-harm. Going through male puberty would be torture for Susan. It would also be agony for Jane and John to watch Susan suffer needlessly when this could be easily eliminated with what they understand to be effective medical care for treating their daughter's gender dysphoria.

206. Through their experience with Susan's medical treatment and extensive conversations with her medical providers over the past five years, Jane and John understand that gender-affirming treatment is medically necessary, safe, and effective treatment for Susan's gender dysphoria.

207. Unlike Susan, Jane and John receive their health coverage through John's employer-provided health plan.

208. While the Does can add Susan to John's health plan, they cannot do so until the open enrollment period near the end of the year, and Susan's coverage

would not start before January 1, 2023. Thus, given her need for her next Lupron shot in early October 2022, this is not a feasible solution.

209. In any event, as a child adopted out of foster care, Susan is entitled to have her medical needs covered by Medicaid and Jane and John should not have to move Susan to John's employer-provided health plan in order for her to continue receiving medically necessary care.

210. With Medicaid no longer covering Susan's Lupron treatment, Jane and John will have no choice but to try to pay for her upcoming three-month Lupron injection out of pocket. Based on their research, the retail price for a single Lupron shot is roughly $11,000. As the parents of two children with only one income, Jane and John do not have sufficient resources to provide this care without sacrifice. Jane and John would have to take on debt to pay for Susan's puberty delaying medication and it would be a hardship for them.

211. Even if the Does are able to add Susan to John's health plan, Susan's health care would be more expensive for them, as they would have a $300 annual deductible for Susan and higher cost-sharing for Susan's gender-affirming care. These are costs they did not have prior to the Challenged Exclusion due to Medicaid's coverage of the medical treatment for Susan's gender dysphoria.

212. Jane and John not only worry about the multitude of harms that would be imposed on their family by the Challenged Exclusion, but also about the effect that Defendants' actions will have on other transgender people and their families.

213. The Does have begun considering moving out of state in order to protect their daughter from state-sponsored discrimination. Jane and John do not wish to move if it can be avoided, as, among other things, it could mean John having to switch jobs and separating Susan and their son from their long-term health care providers, friends, and family. That said, the health and wellbeing of their adolescent children are paramount to them.

214. The Does consider Defendants' decision to stop covering medically necessary gender-affirming medical care through Medicaid to be tragic and dehumanizing. They are concerned about the message the State of Florida is sending by excluding transgender people from Medicaid coverage to which they otherwise would be entitled simply because they are transgender.

215. Jane and John keep in touch with other families in the LGBTQ+ affirming foster care community and are concerned for the ability of some children to find foster and adoptive families because of the state's hostility toward LGBTQ+ people and concerns about being able to meet the health care needs of those children through Medicaid.

Plaintiff K.F.

216. K.F. is the 12-year-old son of Jade Ladue and stepson of Joshua Ladue.

217. Joshua has raised K.F. since he was three years old and K.F. considers and calls Joshua "dad."

218. Jade is a patient coordinator at a dental office, while Joshua receives Social Security Disability Insurance because he is diagnosed with venous malformation, a type of vascular condition that results from the veins in his leg having developed abnormally.

219. K.F., Jade, and Joshua all live in Sarasota County along with K.F.'s four siblings, ranging in age from five to sixteen years old. They moved to Florida from Massachusetts as a family in August 2020.

220. K.F. is transgender.

221. Because of K.F.'s age and the Ladue family's income, he is eligible for Medicaid. He has been eligible for and enrolled in the program since he and his family moved to Florida. Prior to the Ladue family's move, K.F. was enrolled in Massachusetts's Medicaid program.

222. Although K.F. was assigned female at birth, he has known he was a boy from a very young age. When he was 7 years old, he came out to his grandparents during a camping trip, telling them that he has known since he was four years old that he is a boy and was born in the wrong body. In looking back on K.F.'s

childhood, both Jade and Joshua see that K.F. was showing them that he was a boy well before that conversation K.F. had with his grandparents. K.F. always wanted to wear traditional boy clothes (no dresses or skirts), insisted on his hair being kept short, and loved to play shirtless with other boys in their neighborhood.

223. K.F. has never wavered about his gender identity.

224. As with all of their children before their pre-teen years, Joshua and Jade established strict limitations on K.F.'s consumption of television, movies, videos, and video games. At the age of seven, when K.F. came out as transgender, he had never heard of the concept of gender dysphoria, or transgender people, beyond his own experience, which he described first to his grandparents, and then to Jade and Joshua, as simply "being a boy."

225. After K.F. confided in his parents, Jade decided the next best step would be to locate a therapist who specializes in gender dysphoria. Soon after, K.F. had his first appointment with a Licensed Mental Health Counselor. After thorough evaluation, the therapist was the first to diagnose K.F. with gender dysphoria and made sure that Jade and Joshua understood K.F.'s diagnosis and walked them carefully through what they should expect as K.F. got older.

226. After K.F. began therapy, Jade joined a local PFLAG group, an organization which is dedicated to supporting, educating, and advocating for

LGBTQ+ people and their families. She joined the group because it was important to her and Joshua that they demonstrate to K.F. their commitment to supporting him.

227. K.F. was living fully in accordance with his male gender identity in every aspect of his home life and he wanted to be treated accordingly at school. Thus, when K.F. entered the second grade, K.F.'s therapist helped facilitate a meeting between Jade and his school administrators and teachers to talk about K.F.'s gender identity and what actions the school should take to ensure he was fully affirmed and supported as a boy with his classmates in the school environment.

228. Once K.F.'s licensed mental health provider gave her professional recommendation that it was appropriate for K.F. to begin seeing a pediatric endocrinologist, she referred K.F. to the Gender Multispecialty Service (GeMS) Program at Boston Children's Hospital, the first pediatric and adolescent transgender health program in the United States. K.F. had his first appointment with the GeMS Program on September 13, 2015. That first appointment was incredibly thorough, lasting over two hours, and was overall a very happy occasion. It was clear to Jade that K.F. would be receiving the best possible care and the team of providers confirmed everything that K.F.'s therapist had told them: that K.F. is a transgender boy and that his parents and extended family supporting him in his affirmation of his male gender identity was the best decision for his health and well-being.

229. GeMS continued K.F.'s therapy and started him with pediatric nurse practitioner. The nurse practitioner's role was to monitor K.F.'s hormone levels for the onset of puberty and assist with any future gender-affirming health care needs. K.F.'s care with GeMS continued until the family moved to Florida in August 2020.

230. Before the Ladue family moved, in the summer of 2020, K.F.'s medical providers determined that based on the onset of K.F.'s puberty, it was medically necessary for K.F. to receive his first puberty delaying medication. At the recommendation of K.F.'s medical providers, K.F. received a Supprelin implant, a form of puberty delaying medication which would prevent the onset of secondary sex characteristics typical of girls and women. K.F. received the implant on August 8, 2020, and it was fully covered by Massachusetts' Medicaid program.

231. According to K.F.'s former and current medical providers, it is medically necessary for K.F. to receive puberty delaying medication so that K.F. can live authentically in a manner consistent with his gender identity and to treat his gender dysphoria. By preventing the physical manifestations that would accompany the puberty of his sex assigned at birth, K.F. is also able to avoid negative social and emotional consequences associated with his being forced to develop secondary sex characteristics that do not align with his male gender identity.

232. As his parent, it is also important to Jade and Joshua that K.F. be able to choose with whom to disclose this deeply personal, private information about

himself. Because of the puberty delaying medication, K.F. has that option, and the inherent protection and privacy that it provides.

233. When Jade and Joshua decided to move their family to Florida, Jade researched programs in the state that offered the same or similar level of care afforded by GeMS. Finding a program that offers high quality gender-affirming care and that accepts Medicaid can be challenging. Fortunately, through that research, Jade found the Emerge Gender & Sexuality Clinic for Children, Adolescents and Young Adults based at Johns Hopkins All Children's Hospital (Johns Hopkins Gender Clinic) located in St. Petersburg, Florida.

234. Once they moved, K.F. initiated care with a doctoral-level pediatric nurse practitioner specializing in endocrinology at the Johns Hopkins Gender Clinic. In April 2022, K.F. received his second Supprelin implant which was fully covered by his Florida Medicaid plan.

235. K.F. typically visits the Johns Hopkins Gender Clinic every six months. Recently, however, K.F. has had more frequent visits because his medical provider is monitoring whether K.F.'s second implant is adequately suppressing puberty and there is a possibility that K.F. may need a different type of puberty delaying medication to suppress puberty and successfully continue his medical transition. K.F. has another appointment scheduled at the end of October 2022 to check in with K.F.'s medical provider.

236. K.F. is adamant that he does not want breasts and would eventually like to have facial hair and muscles. The idea of developing typically female secondary sex characteristics makes K.F. extremely anxious; he prays every night that his puberty delaying medication will be successful. Since K.F. came to understand and express the dysphoria he experienced resulting from his sex assigned at birth at an early age, Jade and Joshua were able to get him the mental health and medical treatment that was necessary, and as a result K.F. is perceived as and accepted by other people as male and very few people know he is transgender. Developing secondary sex characteristics typically associated with girls and women, instead of those aligned with his male gender identity, would be tremendously emotionally and physically painful for K.F.

237. In the event K.F.'s current implant is not effective, and because Florida Medicaid now excludes coverage of puberty delaying medication when used to treat gender dysphoria, the Ladues would have to pay out of pocket for Lupron Depot shots, the treatment K.F.'s medical provider has indicated would be the next step for K.F. Those monthly shots would cost between $1,000 to $2,000 per shot out of pocket. The Ladue family has limited income, and they are very worried because they would not be able to afford these treatments without Medicaid coverage.

238. K.F.'s medical providers have also told the Ladues that likely within the next year, when K.F. is fourteen years old, that it will be medically indicated for

him to begin hormone therapy (testosterone) at a dose appropriate to his age and body composition. K.F. is very excited about starting testosterone therapy. K.F. usually hates receiving shots but he told Jade he would be happy to take a monthly shot if it meant that he would experience the male puberty that is aligned with his gender identity, such as his voice deepening and growing facial hair.

239. Jade and Joshua are so grateful that K.F. was confident enough and felt safe to come out to them at such a young age. His identifying his gender dysphoria at a young age combined with a loving and supportive immediate and extended family means that they were able to ensure that K.F. received the health care appropriate for him as soon as possible. As a result, his gender dysphoria has been well managed.

240. While K.F. has always dealt with anxiety, before he came out, it was much worse. He experienced what Jade would describe as "night terrors" and had a persistent stomachache. The Ladues would get calls from K.F.'s school that he was not doing well and was often in the nurse's office. The Ladues went to doctors to determine the source of K.F.'s distress, but no one could identify what was causing the problem. After he had firmly established gender-affirming care with GeMS, K.F. became a completely different child; it was like night and day. He had a smile on his face, a light in his eye, and even a glow about him. His performance and

attendance in school improved, as did his peer relationships. Like any parent, Jade and Joshua were relieved to see their child happy and thriving.

241. K.F. has also begun the process of legal transition. He has legally changed his name and the family is currently in the process of having his gender marker changed on his birth certificate and records with the Social Security Administration.

242. Under the Challenged Exclusion, Medicaid will no longer cover puberty delaying medications for K.F. as treatment for his gender dysphoria. The Challenged Exclusion will also prohibit Medicaid from covering hormone therapy as a medically necessary treatment for K.F.'s gender dysphoria when K.F., pursuant to the medical expertise and recommendations of his physicians, is ready to begin that treatment.

243. Jade and Joshua are incredibly worried about the potential physical and mental health consequences of depriving K.F. the medically necessary treatment recommended by his health care providers. K.F. has been living as a boy in every aspect of his life--medically, legally, and socially--since 2016.

244. If he were no longer able to access the medication that aligns his body with his gender identity, K.F.'s mental health would suffer tremendously, and he would be devastated. Jade and Joshua fear that K.F., and the whole family with him, would go down a dark and scary road fast. For example, they fear that K.F. would

not leave his bedroom and he would refuse to go to school, or that he would cut off his communications with his friends, teammates, and teachers. Given how much his gender-affirming care has improved his life and mental health, Jade and Joshua can only assume that reversing that course of treatment would result in the unthinkable happening.

245. Because of these concerns, K.F. going without treatment is simply not an option for the Ladue family. They believe providing K.F. with the medical treatment for gender dysphoria that he requires is necessary to ensure his health and well-being.

246. The Ladue family is under 138% of the federal poverty limit; that is why their children, including K.F., qualify for Florida's Medicaid program. Whether it be paying for a different puberty delaying medication if K.F.'s provider determines the current implant is not working or beginning K.F.'s course of hormone therapy in the next year, the Ladue family simply does not have sufficient resources to provide K.F. the gender-affirming care he requires. They simply could not pay out of pocket for the cost of K.F.'s care.

247. Joshua receives his health insurance through Medicare. He cannot add K.F. to his health insurance. Jade has access to health care coverage for family members because of her job, but the cost of adding K.F. is unaffordable for their family.

248. While Florida is their home, ultimately, the Ladue family will be forced to move if necessary to protect their son's access to medication that is necessary for his health and well-being. Doing so would mean Jade would have to find a new job, Joshua would have to establish his Social Security payment through a new field office, and the kids would be uprooted and forced to start at new schools and make new friends.

249. In addition, the Ladues are Christian and just joined a church that they attend every Sunday. So far, they have felt very welcome and would be sad to break a tie with this faith community and the other communities and relationships they have established in South Florida.

250. For K.F., this would be a particularly difficult and painful transition. K.F. is doing well academically, socially, and athletically. He is on the golf team at his school and he is looking forward to upcoming tryouts out for the basketball team in their town. It is awful for Jade and Joshua to even think that K.F. would have to end this participation and leave his teammates because Florida refuses to provide him with coverage for the medical treatment that he needs to live and thrive, medical treatment that is available to many other cisgender young people, simply because K.F. is transgender.

CLAIMS FOR RELIEF

COUNT I
Deprivation of Equal Protection in Violation of the Fourteenth Amendment of the U.S. Constitution

(All Plaintiffs Against Defendant Simone Marstiller)

251. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

252. The Fourteenth Amendment to the United States Constitution, enforceable pursuant to 42 U.S.C. § 1983, provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. Amend. XIV, § 1.

253. Plaintiffs state this cause of action against Defendant Marstiller, in her official capacity, for purposes of seeking declaratory and injunctive relief, and to challenge her adoption and enforcement of the discriminatory Exclusion both facially and as applied to Plaintiffs.

254. Defendant Marstiller is a person acting under color of state law for purposes of 42 U.S.C. § 1983 and has acted intentionally in denying Plaintiffs equal protection of the law.

255. Under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, discrimination based on sex is presumptively unconstitutional and subject to heightened scrutiny.

256. Discrimination on the basis of nonconformity with sex stereotypes, transgender status, gender, gender identity, gender transition, and sex characteristics are all forms of discrimination on the basis of sex.

257. A person is defined as transgender precisely because of the perception that they contradict gender stereotypes associated with the sex they were assigned at birth. When a transgender person affirms their authentic gender, it inherently contradicts standard gender stereotypes expected of the individual based on their sex assigned at birth.

258. In addition, under the Equal Protection Clause of the Fourteenth Amendment, discrimination based on transgender status is presumptively unconstitutional and subject to strict, or at least heightened, scrutiny. Indeed, transgender people have suffered a long history of discrimination in Florida and across the country and continue to suffer such discrimination to this day; they are a discrete and insular group and lack the political power to protect their rights through the legislative process; they have largely been unable to secure explicit state and federal protections to protect them against discrimination; their transgender status bears no relation to their ability to contribute to society; and gender identity is a core, defining trait so fundamental to one's identity and conscience that a person cannot be required to abandon it as a condition of equal treatment.

259. By adopting and enforcing the Challenged Exclusion categorically excluding "services for the treatment of *gender* dysphoria," including "*[s]ex* reassignment surgeries" and any "procedures that alter primary or secondary *sexual* characteristics," Defendant Marstiller is engaging in constitutionally impermissible discrimination based on sex, including, *inter alia*, discrimination based on nonconformity with sex stereotypes and transgender status.

260. Through her duties and actions to design, administer, and implement the Challenged Exclusion, Defendant Marstiller has unlawfully discriminated—and continues to unlawfully discriminate—against Plaintiffs based on sex-related considerations.

261. The Challenged Exclusion treats Plaintiffs differently from other persons who are similarly situated.

262. Under the Challenged Exclusion, transgender Medicaid beneficiaries who require gender-affirming care are denied coverage for that medically necessary care, while other Medicaid participants can access the same care as long as it is not required for the treatment of gender dysphoria, i.e., gender transition.

263. The Challenged Exclusion on its face and as applied to Plaintiffs deprives transgender Medicaid beneficiaries of their right to equal protection of the laws and stigmatizes them as second-class citizens, in violation of the Equal Protection Clause of the Fourteenth Amendment.

264. Defendants' promulgation and continued enforcement of the Challenged Exclusion did not, and does not, serve any rational, legitimate, important, or compelling state interest. Rather, the Challenged Exclusion serves only to prevent Plaintiffs and other transgender Medicaid beneficiaries from obtaining medically necessary medical care and services to treat their gender dysphoria, complete their gender transition, and live as their authentic selves.

265. As a direct and proximate result of the discrimination described above, Plaintiffs have suffered injury and damages, including mental pain and suffering and emotional distress. Without injunctive relief from Defendants' discriminatory Challenged Exclusion of coverage for gender-affirming care, Plaintiffs will continue to suffer irreparable harm in the future.

COUNT II
Discrimination on the Basis of Sex in Violation of Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § I8116
(All Plaintiffs Against AHCA)

266. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

267. Section 1557 of the ACA, 42 U.S.C. § 18116, provides, in relevant part that, "an individual shall not, on the ground prohibited under … title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681, et seq.)"—which prohibits discrimination "on the basis of sex"—"be excluded from participation in, be denied

the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance."

268. Discrimination on the basis of nonconformity with sex stereotypes, transgender status, gender, gender identity, gender transition, and sex characteristics are all forms of discrimination encompassed by the prohibition of discrimination on the basis of sex under Section 1557.

269. Defendant AHCA receives federal financial assistance such that it is a "covered entity" for purposes of Section 1557 of the ACA. The Centers for Medicare & Medicaid Services ("CMS"), operating within HHS, provide federal financial assistance to AHCA for the state's participation in the Medicaid program. Indeed, Defendant AHCA has a published Notice of Nondiscrimination Policy on its website, stating that the "This Notice is provided as required by … Section 1557 of the Affordable Care Act and implementing regulations."

270. A covered entity, such as Defendant AHCA, cannot provide or administer health care coverage which contains a categorical exclusion of coverage for gender-affirming health care, or otherwise impose limitations or restrictions on coverage for specific health services related to gender transition if such limitation or restriction results in discrimination on the basis of sex.

271. Plaintiffs have a right under Section 1557 to receive Medicaid coverage through AHCA free from discrimination on the basis of sex, sex characteristics, gender, nonconformity with sex stereotypes, transgender status, or gender transition.

272. By categorically excluding "services for the treatment of *gender* dysphoria," including "*[s]ex* reassignment surgeries" and any "procedures that alter primary or secondary *sexual* characteristics," Defendant AHCA has discriminated against Plaintiffs on the basis of sex in violation of Section 1557 and has thereby denied Plaintiffs the full and equal participation in, benefits of, and right to be free from discrimination in a health program or activity.

273. As a result of the Challenged Exclusion, Plaintiffs have and will continue to suffer harm. By knowingly and intentionally offering coverage to Plaintiffs that discriminates on the basis of sex, Defendant AHCA has intentionally violated the ACA, for which Plaintiffs are entitled to injunctive relief, compensatory and consequential damages, and other relief.

274. Without injunctive relief from Defendants' discriminatory Challenged Exclusion of coverage for gender-affirming care, Plaintiffs will continue to suffer irreparable harm in the future.

COUNT III
Violation of the Medicaid Act's EPSDT Requirements,
42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5)
(Plaintiffs Brit Rothstein, Susan Doe, and K.F. Against Defendant Marstiller)

275. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

276. The Medicaid Act mandates that states provide Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") services, which include all services necessary to "correct or ameliorate" a physical or mental health condition, to Medicaid beneficiaries under age 21. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), 1396d(r)(5).

277. The Challenged Exclusion, and Defendants' refusal, based on the Challenged Exclusion, to provide coverage for services for the treatment of gender dysphoria to Plaintiffs Brit Rothstein, Susan Doe, and K.F., and transgender Medicaid beneficiaries under age 21, violates the Medicaid Act's EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5), which are enforceable by Plaintiffs under 42 U.S.C. § 1983.

COUNT IV
Violation of the Medicaid Act's Comparability Requirements,
42 U.S.C. § 1396a(a)(10)(B)(i)

(All Plaintiffs Against Defendant Marstiller)

278. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

279. The Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B)(i), require that the "medical assistance made available to [eligible individuals] shall not be less in amount, duration, or scope than the medical assistance made available to" other eligible individuals.

280. The Challenged Exclusion, and Defendants' refusal, based on the Challenged Exclusion, to provide coverage for services for the treatment of gender dysphoria to Plaintiffs and other transgender Medicaid beneficiaries, while covering the same services for other Florida Medicaid beneficiaries with different diagnoses, violate the Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B)(i), which is enforceable by Plaintiffs under 42 U.S.C. § 1983.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court enter judgment in their favor and against Defendants on all claims, as follows:

A. Issue preliminary and permanent injunctions prohibiting Defendants from any further enforcement or application of the Challenged Exclusion and directing Defendants and their agents to provide Medicaid coverage for the medically necessary care for the treatment of gender dysphoria without regard to the Challenged Exclusion;

B. Enter a declaratory judgment that the Challenged Exclusion, which categorically excludes coverage for medically necessary care for the treatment of gender dysphoria, both on its face and as applied to Plaintiffs:

i. Violates the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex, including transgender status, nonconformity with sex stereotypes, sex characteristics, gender, gender identity, sex assigned at birth, and gender transition;

ii. Violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex (including transgender status, nonconformity with sex stereotypes, sex characteristics, gender, gender identity, sex assigned at birth, and gender transition);

iii. Violates the Medicaid Act's EPSDT Requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5); and

iv. Violates the Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B)(i);

C. Waive the requirement for the posting of a bond of security for the entry of temporary and preliminary relief;

D. Award the declaratory and injunctive relief requested in this action against Defendants' officers, agents, servants, employees, and attorneys, as well as any other persons who are in active concert or participation with them;

E. Award compensatory and consequential damages to Plaintiffs in an amount that would fully compensate each of them for: (1) the harms to their short- and long-term health and well-being from being denied access to medically necessary health care as a result of the Challenged Exclusion and its application to them; (2) their economic losses; and (3) all other injuries that have been caused by Defendants' acts and omissions alleged in this Complaint;

F. Award Plaintiffs their reasonable attorneys' fees, costs, and expenses under 42 U.S.C. § 1988 or other applicable statutes; and

G. Award such other and further relief as the Court may deem just and proper.

* * * * *

Respectfully submitted this 7th day of September 2022.

PILLSBURY WINTHROP SHAW PITTMAN, LLP

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

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

Joe Little*
500 Capitol Mall, Suite 1800
Sacramento, CA 95814
(916) 329-4700
joe.little@pillsburylaw.com

NATIONAL HEALTH LAW PROGRAM

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

Catherine McKee*
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27541
(919) 968-6308
mckee@healthlaw.org

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

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

Carl S. Charles*
1 West Court Square, Suite 105
Decatur, GA 30030
(404) 897-1880
ccharles@lambdalegal.org

SOUTHERN LEGAL COUNSEL, INC.

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

FLORIDA HEALTH JUSTICE PROJECT

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

** Application for admission pro hac vice forthcoming.*
*** Application for admission to the Northern District Court forthcoming.*

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

August Dekker, legally known as Kori Dekker; Brit Rothstein; Susan Doe, a minor by and through her parents and next friends, Jane Doe and John Doe; and K.F., a minor, by and through his parent and next friend, Jade Ladue

(b) County of Residence of First Listed Plaintiff Hernando County
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Simone Chriss and Chelsea Dunn, Southern Legal Counsel, 1229 NW 12th Ave. Gainesville, FL 32601, (325) 271-8690; Katy DeBriere, Florida Health Justice Project, 3900 Richmond St., Jacksonville, FL 32205, (352) 278-6059; Jennifer Altman, Shani Rivaux, Pillsbury Winthrop Shaw Pittman, LLP ("Pillsbury"), 600 Brickell Ave., Ste. 3100, Miami, FL 33131, (786) 913-4900; William C. Miller, Gary J. Shaw, Pillsbury, 1200 17th St. N.W., Washington, D.C., 20036, (202) 664-8000; Joe Lillie, Pillsbury, 500 Capitol Mall, Ste. 1800, (916) 329-4700; Abigail Coursolle, National Health Law Program ("NHeLP"), 3701 Wilshire Blvd., Ste. 315, Los Angeles, CA, 90010, (310) 736-1652; Catherine McKee (NHeLP), 1512 E. Franklin St., Chapel Hill, N.C., (919) 968-6308; Omar Gonzalez-Pagan, Lambda Legal Defense and Education Fund, Inc. ("Lambda Legal"), 120 Wall St., 19th Floor, New York, NY 10005, (212) 809-8585; Carl S. Charles, Lambda Legal, West Court Square, Ste. 105, Decatur, GA 30030, (404) 697-1880

DEFENDANTS

Simone Marstiller, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and Florida Agency for Health Care Administrration

County of Residence of First Listed Defendant Leon County
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☑ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

CIVIL RIGHTS
- ☑ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

V. ORIGIN *(Place an "X" in One Box Only)*

☑ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
42 U.S.C. 1983; 42 U.S.C. 18116

Brief description of cause:
Challenging Defendant's exclusion of Medicaid coverage for gender affirming care

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☑ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE Honorable Mark E. Walker DOCKET NUMBER 4:20-cv-00020

DATE 9/7/2022

SIGNATURE OF ATTORNEY OF RECORD /s/ Jennifer Altman

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE 000210