February 17, 2026

Submitted electronically via regulations.gov

The Honorable Robert F. Kennedy Jr.
Health and Human Services Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Dr. Mehmet Oz
Administrator of the Center for Medicare & Medicaid Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: APHA and Public Health Deans and Scholars' Comments on the Centers for Medicare and Medicaid Services' "Medicaid Program; Prohibition on Federal Medicaid Funding for Sex-Rejecting Procedures Furnished to Children" (RIN 0938-AV73; CMS-2451-P)

Dear Secretary Kennedy and Administrator Oz:

The American Public Health Association (APHA), along with 123 public health and health policy deans, chairs, and scholars (in their individual capacities), file this comment on the Centers for Medicare & Medicaid Services' (CMS) December 2025 Notice of Proposed Rulemaking (NPRM), which would prohibit federal Medicaid funds from covering gender affirming care, including puberty-pausing medications, hormone therapy, and surgery, for transgender youth under the age of 18, and Children's Health Insurance Program (CHIP) funds from covering that care for transgender young people under the age of 19.[1] CMS proposes this rule in excess of its statutory authority, infringing on certain powers reserved to Congress and the States. If finalized as proposed, the rule would violate various aspects of federal Medicaid law, including the requirement to provide medically necessary care under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement and Medicaid's comparability requirement. CMS proposes this rule without sufficient evaluation of the significant negative impact that restricting access to this necessary, life-saving health care will have on individual and community health. For these reasons, we urge CMS to withdraw the proposed rule.

The individual signatories are distinguished deans, chairs, and scholars at the nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. They include individuals known for their expertise in health policy regarding Medicaid's role as the leading insurer for low-income people and other populations that face systemic barriers to essential health care services. The individual signatories join this comment in their individual capacities and not as representatives of their respective institutions. The complete list of individual signatories is included at the end of this letter.

[1] 90 *Fed. Reg.* 59441 (Dec. 19, 2025), https://www.federalregister.gov/d/2025-23464.

I. The proposed rule exceeds CMS' statutory authority, as CMS has no legal authority to restrict access to necessary, lawful medical care.

CMS proposes to prohibit federal Medicaid funds from covering gender affirming care, including puberty-pausing medications, hormone therapy, and surgery, for transgender youth under the age of 18. CMS also proposes to prohibit the use of CHIP funds to cover such care for transgender people under the age of 19. In proposing this rule, CMS exceeds its statutory authority, violates the EPSDT requirement to cover medically necessary services as determined by a child's treating provider, and violates Medicaid's comparability requirement.

CMS exceeds its authority, improperly relying on various provisions of the Social Security Act as justification for its power to propose and implement this NPRM.

CMS relies on three provisions of federal Medicaid and CHIP law as justification for its authority to make the changes proposed in the Notice of Proposed Rulemaking ("NPRM").[2] Two provisions of the Social Security Act ("the Act") cited by CMS require states to ensure that the health care Medicaid beneficiaries receive aligns with the professional standard of care in their states. Specifically, Section 1902(a)(19) of the Act requires that states ensure that care and services are provided in "the best interest of the recipients," while Section 1902(a)(30)(A) requires that states ensure that payments are consistent with "efficiency, economy, and quality of care."[3] Similarly, the CHIP provision upon which CMS relies requires that funds be provided in an effective and efficient manner.[4] Like the Medicaid provisions, this requirement is directed at program administration and fiscal oversight, but CMS cites it as a legal basis for interfering with state-governed health care practice.

The professional standard of care is a matter of state law. States license physicians and other health care professionals, define the scope of practice, and determine the standards against which clinical decisions are judged. These standards are typically informed by medical consensus, specialty guidelines, peer-reviewed evidence, and the reasonable judgment of similarly situated practitioners.[5] When a health care service is lawful under state law and consistent with accepted professional medical standards, it falls within the clinical judgment reserved to licensed health care professionals and is regulated by state authorities.

CMS' interpretation of these provisions in the NPRM is unprecedented. CMS has never before used these provisions to exclude clinical services that are consistent with professional medical recommendations and lawful under state law. Further, these provisions have never before been relied upon by CMS or found by a court to be an authority for CMS to substantively limit,

---

[2] *Id*. at 59442-43.
[3] 42 U.S.C. 1396(a)(19); 42 U.S.C. § 1396(a)(30)(A).
[4] 42 U.S.C. § 1397aa.
[5] Elpis Healthcare, What is Standard of Care: Its Legal and Medical Importance (2025), https://elpis-healthcare.com/blogs/standard-of-care-definition/.

condition, or redefine the underlying medical services that may be covered. For example, Section 1902(a)(30)(A) is typically invoked in litigation regarding the adequacy of Medicaid payment rates.[6] CMS exceeds its statutory authority by purporting to use these sections of the Act as it currently proposes. Federal administrative agencies cannot issue regulations beyond the authority delegated to them by Congress and cannot issue regulations that are inconsistent with the statute.[7] These provisions of federal law that CMS relies on are designed to ensure care is efficient, consistent with professional medical standards, and compliant with state law. These are not provisions that the agency can rely on to limit or eliminate Medicaid benefits.

These provisions do not authorize CMS to define or exclude categories of covered medical services that fall under mandatory and optional benefit categories, particularly where, as here, the services implicate the EPSDT mandate, as explained below; are lawful under state law; and are medically recognized and determined to be medically necessary by treating physicians. There is no federal medical necessity standard other than EPSDT that CMS can rely on. The authority to preempt state determinations rests solely with Congress. Congress has used this power sparingly to define what care is covered and medically necessary, including in the case of the Hyde Amendment, which prohibits states from using Medicaid funding for abortion except in very limited circumstances. Allowing CMS to commandeer this role would create a dangerous and unprecedented interpretation of these provisions of federal law that would allow CMS to limit access to any and all politically disfavored health care services, regardless of state medical laws and individual medical needs of Medicaid and CHIP beneficiaries.

Further, the statutory provisions on which CMS purports to rely on as authority for its proposal cannot be used to authorize new Medicaid funding prohibitions or conditions. Medicaid is a Spending Clause program, and any conditions or prohibitions on Medicaid payments must be clearly and unambiguously enacted by Congress. Under the Spending Clause of the Constitution, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."[8] Unlike Congress's unambiguous prohibition in the Hyde Amendment, the broad authorities on which CMS relies on to support its proposal here are anything but clear regarding a prohibition on federal funding for gender affirming care. In fact, the Social Security Act never once mentions "sex-rejecting procedures" or gender affirming care.

The NPRM violates the EPSDT requirement to provide medically necessary services as determined by the child's treating provider.

Transition-related health care is necessary, essential health care for transgender young people. EPSDT, enacted by Congress through the Social Security Amendments of 1967, is a mandatory

[6] *Armstrong v. Exceptional Child Care Center*, 135 S. Ct. 1378 (2015); *Douglas v. Independent Living Center of Southern Cal., Inc.*, 565 U.S. 606 (2012).
[7] *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).
[8] *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

benefit for children under age 21 who are enrolled in Medicaid.[9] Under EPSDT, state Medicaid programs must cover all medically necessary services to correct or ameliorate a child's physical or mental health condition, whether or not these services are covered for adult Medicaid beneficiaries, including diagnostic services, treatment, and other care.[10] Whether EPSDT requires coverage falling within a state's scope of practice laws entails a two-part determination: (1) the service must be within the scope of services recognized as a category of medical assistance, as defined in the statute; and (2) the treatment must be medically necessary as that term is defined for EPSDT purposes.[11] The medical necessity evaluation requires an individual determination on a case-by-case basis, "taking into account the particular needs of the child."[12] Decades of judicial precedent emphasize the importance of individualized determination and longstanding deference to the treating provider in EPSDT medical necessity determinations.[13]

CMS infringes on states' obligation to provide medically necessary health care to young people under age 21 and violates the medical necessity standard criteria by proposing a blanket exclusion of gender dysphoria treatment despite the fact that the services that come into play all fall within recognized medical assistance categories and despite the fact that under EPSDT, covered treatments can be denied only following an individualized determination. The NPRM outright states its intention to illegally override medical necessity, stating that "[t]his prohibition includes circumstances in which a provider may determine that a sex-rejecting procedure is medically necessary for a child diagnosed with gender dysphoria."[14]

This language in the NPRM violates the statutorily established EPSDT standard and ignores the longstanding deference to the child's treating medical provider. Emphasis on the deference to

---

[9] Public Law 90-248.
[10] 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(r)(5).
[11] 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(r)(5); S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 607 (5th Cir. 2004), aff'g No. 02-2164, 2002 WL 31741240 (E.D. La. Dec. 5, 2002) (holding that the state improperly imposed its own medical necessity determination, ignoring the provider's medical necessity determination and violating the EPDST statute).
[12] CMS, EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (2014), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_82.pdf.
[13] *See Q.H. v. Sunshine State Health Plan, Inc*., 307 So.3d 1 (Fla. Dist. Ct. App. 2020) (reversing denial of coverage for growth hormone therapy where state relied on preset criteria and disregarded both the treating physician's opinion and the child's individualized needs); *J.D. v. Dep't of Child. & Fams*., No. A-3411-17T4, 2020 WL 4811558 (N.J. Sup. Ct. Aug. 19, 2020) (vacating agency decision to reduce in-home behavioral services and remanding for development of record and consideration of whether services are medically necessary); *I.B. ex rel. R.B. v. State*, 87 So.3d 6 (Fla. Dist. Ct. App. 2012) (reversing decision to exclude personal care services and finding agency erroneously applied state medical necessity standard rather than EPSDT statute); *Urban v. Meconi*, 930 A.2d 860 (Del. 2007) (reversing denial of coverage for breast reduction surgery where state agency failed to consider treating physician's opinion); *Cook ex rel. Cook v. Agency for Pers. with Disabilities Dist.*, 967 So.2d 1002 (Fla. Dist. Ct. App. 2007) (prohibiting medical necessity definition more restrictive than "correct or ameliorate" but affirming decision approving less than requested personal care assistance); *C.F. v. Dep't of Child. & Fams*., 934 So.2d 1 (Fla. Dist. Ct. App. 2005) (reversing decision reducing personal care services because restrictive state policies were applied and insufficient weight was given to opinion of treating provider).
[14] 90 *Fed. Reg.* at 59451.

providers is clear in the legislative history of EPSDT, where the Senate report states that "[t]he physician is to be the key figure in determining utilization of health services. . . it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments."[15] Further, CMS' EPDST guide states that "[w]hile the treating health care provider has a responsibility for determining or recommending that a particular covered service is needed to correct or ameliorate the child's condition, both the state and a child's treating provider play a role in determining whether a service is medically necessary."[16] Nowhere, in statute or agency guidance, does CMS have the power to supplant its own EPSDT medical necessity determination over that of states or treating providers.

Lastly, CMS' EPSDT guide also advises states to "consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders."[17] For example, in determining medical necessity, providers should and do consider whether a service is necessary from a mental health standpoint, as well as a physical one, including engaging in age-appropriate activities.[18] Yet, this NPRM focuses on and overstates the few potential, long-term physical side effects of gender affirming care for young people, not taking into account the vast array of other positive health outcomes discussed in Section III below, including but not limited to decreased rates of depression and anxiety and increased body positivity.

The NPRM violates Medicaid's comparability clause by categorically prohibiting transgender young people from receiving services that are covered for cisgender Medicaid recipients.

Medicaid's comparability clause requires that "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."[19] This provision is a core feature of Medicaid, designed to prevent unequal access to covered benefits for beneficiaries with comparable medical needs. The comparability clause does not permit CMS to draw distinctions among beneficiaries based on politically disfavored diagnoses or populations when the services at issue fall within covered benefit categories and are medically necessary.

The proposed rule categorically prohibits transgender young people from receiving health care that is covered for other diagnoses and available to other Medicaid beneficiaries, such as hormone treatment for cisgender young people with precocious puberty or intersex young

---

[15] S. Rep. No. 404 89th Cong., 1st Sess. reprinted in 1965 USCCAN 1943, 1986.
[16] CMS, EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (2014), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_82.pdf.
[17] *Id.*
[18] *S.D. ex rel. Dickson v. Hood,* 391 F.3d 581, 607 (5th Cir. 2004), aff'g No. 02-2164, 2002 WL 31741240 (E.D. La. Dec. 5, 2002) ("Dr. Martin further opines, that "from a mental health standpoint" incontinence underwear is medically necessary, otherwise S.D. would be unable to live a normal life and engage in age appropriate activities.").
[19] 42 U.S.C. § 1396a(a)(10)(B)(i).

people.[20] Under this proposed rule, puberty-delaying medications, hormone treatments, and certain surgical procedures would otherwise be covered Medicaid services when deemed medically necessary for non-transgender patients. CMS claims that the different uses of the services – on its face a violation of the comparability requirements – is justified based on differing evidence bases and benefit/risk profiles, yet provides insufficient evidence to support this claim.

As discussed in more detail in Section II, CMS heavily relies on what they call the "HHS Report" to conclude that "the risk/benefit profile of medical and surgical interventions for children and adolescents diagnosed with gender dysphoria is unfavorable."[21] Not only has this report been heavily criticized by medical experts for its violations of scientific norms and misrepresentation of evidence,[22] but CMS in the NPRM and the HHS Report itself "acknowledges that systematic reviews offer limited evidence regarding the harms of sex-rejecting procedures in minors."[23] By singling out transgender young people and excluding coverage for medically necessary care solely on the basis of diagnosis and patient identity, CMS creates an impermissible coverage disparity that directly violates the comparability requirement.

II. The NPRM, if finalized as proposed, is arbitrary and capricious and will violate the Administrative Procedure Act.

The Administrative Procedure Act requires courts to "hold unlawful and set aside agency actions, findings, and conclusions found to be . . . arbitrary, capricious, [or] an abuse of discretion."[24] An agency action that "entirely fail[s] to consider an important aspect of the problem, offer[s] an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise" is arbitrary and capricious.[25] CMS' proposal, if finalized, is arbitrary and capricious for several reasons.

First, CMS has entirely failed to consider an important aspect of the problem the rule creates, including the importance of gender affirming care for transgender young people and the harms to patients and providers that would be caused should this rule be implemented. CMS wrongly claims that "evidence on the benefits of medical and surgical interventions to improve mental

---

[20] 90 *Fed. Reg.* at 59454-55.
[21] 90 *Fed. Reg.* at 59444.
[22] AAP Statement on HHS Report Treatment for Pediatric Gender Dysphoria. (2025, May 1). *American Academy of Pediatrics*. Retrieved February 3, 2026, from https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/; Jacobs, P. (2025, May 2). *Researchers slam HHS report on gender-affirming care for youth*. Science. https://www.science.org/content/article/researchers-slam-hhs-report-gender-affirming-care-youth.
[23] 90 *Fed. Reg.* at 59444.
[24] 5 U.S.C. § 706(2)(A).
[25] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983).

health or reduce symptoms of gender dysphoria is lacking."[26] As discussed below in Section III, decades of peer-reviewed research and clinical data show that transition-related health care for transgender young people is safe and effective. The agency also failed to adequately consider alternative policies and instead took the most drastic course of action cutting off all federal funding.[27]

Second, CMS' explanation for its decision runs counter to the evidence. CMS cherry-picked the evidence it relied on while failing to contend with the evidence that runs counter to its position. The agency must examine the relevant data and articulate a satisfactory explanation for its action,[28] including a "rational connection between the facts found and the choice made."[29] If CMS fails to give meaningful consideration to the body of evidence supporting gender affirming care for transgender young people in formulating its final policy that includes a rational connection between the evidence and its final policy, the final rule will be arbitrary and capricious.

CMS relies on two main documents to support its proposed rule. Notably, the two documents – HHS Report and Cass Review – have both been widely criticized by medical experts for misrepresenting data and scientific evidence.[30] The HHS report, initially released in May 2025,

---

[26] 90 *Fed. Reg.* at 59449.

[27] *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 591 U.S. 1, 29 (2020) (finding that the Secretary's failure to consider an obvious alternative— retaining DACA's deferred-action component while terminating the associated benefits—rendered the agency's action arbitrary and capricious).

[28] "The task of a court reviewing agency action under the APA's arbitrary and capricious standard is to determine whether the agency has examined the pertinent evidence, considered the relevant factors, and articulate[d] a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co*., 463 U.S. 29, 43 (1983).

[29] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. at 43 (quoting *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962)).

[30] AAP Statement on HHS Report Treatment for Pediatric Gender Dysphoria. (2025, May 1). *American Academy of Pediatrics*. Retrieved February 3, 2026, from https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/; Jacobs, P. (2025, May 2). *Researchers slam HHS report on gender-affirming care for youth*. Science. https://www.science.org/content/article/researchers-slam-hhs-report-gender-affirming-care-youth; Moore, J. K., Rayner, C., Skinner, S. R., Wynne, K., Cavve, B. S., Fraser, B., Ganti, U., McAllister, C., Meyerowitz-Katz, G., Nguyen, T., Ravine, A., Ross, B., Russell, D. B., Saunders, L. A., Siafarikas, A., & Pang, K. C. (2025). Cass Review does not guide care for Trans Young People. *Medical Journal of Australia*, 223(7), 331–337. https://doi.org/10.5694/mja2.70035; Dowshen, N., Baker, K., Garofalo, R., Chen, D., Inwards-Breland, D. J., Sequeira, G., Mehringer, J. E., & McNamara, M. (2025). A critical scientific appraisal of the Health and Human Services Report on Pediatric Gender Dysphoria. *Journal of Adolescent Health*, 77(3), 342–345. https://doi.org/10.1016/j.jadohealth.2025.06.002; McNamara, M., Baker, K., Connelly, K., Janssen, A., Olson-Kennedy, J., Pang, K. C., Scheim, A., Turban, J., & Alstott, A. (2024). An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria. Retrieved February 3, 2026, from https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf.

claims to be a review of evidence and best practices for treating pediatric gender dysphoria.[31] Yet, the initial report omitted author names and did not go through a peer review process.[32] In November 2025, after widespread criticism, HHS released an updated report revealing the authors' names and adding a "peer review supplement."[33] One review of the HHS Report, published by medical experts in the Journal of Adolescent Health, details the violations of scientific norms, misrepresentation of scientific evidence, and mischaracterization of gender identity in young people and the standard of care.[34] For example, the authors state that the HHS Report "misrepresents and improperly appraises studies, often ignoring their primary conclusion" and "provides no evidence for its assertion that puberty-pausing medications and hormone therapy are harmful to TGD youth, and it even states that evidence of harms is 'sparse'."[35]

The Cass Review, published in 2024, purports to provide recommendations regarding transition-related care for young people in England; but, notably, none of the contributors have research or clinical experience in transgender health care.[36] Similar to the HHS Report, a group of medical experts published an article critiquing the Cass Review and "identified a high risk of bias in each of the systematic reviews driven by unexplained protocol deviations, ambiguous eligibility criteria, inadequate study identification."[37] The authors also "identified methodological flaws and unsubstantiated claims in the primary research."[38]

---

[31] U.S. Department of Health and Human Services. (2025, November 19). *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*. HHS Office of Population Affairs. https://opa.hhs.gov/gender-dysphoria-report.

[32] Jacobs, P. (2025, May 2). *Researchers slam HHS report on gender-affirming care for youth*. Science. https://www.science.org/content/article/researchers-slam-hhs-report-gender-affirming-care-youth; Dowshen, N., Baker, K., Garofalo, R., Chen, D., Inwards-Breland, D. J., Sequeira, G., Mehringer, J. E., & McNamara, M. (2025). A critical scientific appraisal of the Health and Human Services Report on Pediatric Gender Dysphoria. *Journal of Adolescent Health*, 77(3), 342–345. https://doi.org/10.1016/j.jadohealth.2025.06.002.

[33] *See* U.S. Department of Health and Human Services. (2025, November). Gender dysphoria report peer reviews and Responses. HHS Office of Population Affairs. Retrieved February 3, 2026, from https://opa.hhs.gov/gender-dysphoria-report-peer-reviews.

[34] Dowshen, N., Baker, K., Garofalo, R., Chen, D., Inwards-Breland, D. J., Sequeira, G., Mehringer, J. E., & McNamara, M. (2025). A critical scientific appraisal of the Health and Human Services Report on Pediatric Gender Dysphoria. *Journal of Adolescent Health*, 77(3), 342–345. https://doi.org/10.1016/j.jadohealth.2025.06.002

[35] *Id*.

[36] McNamara, M., Baker, K., Connelly, K., Janssen, A., Olson-Kennedy, J., Pang, K. C., Scheim, A., Turban, J., & Alstott, A. (2024). An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria. Retrieved February 3, 2026, from https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf.

[37] Noone, C., Southgate, A., Ashman, A., Quinn, É., Comer, D., Shrewsbury, D., Ashley, F., Hartland, J., Paschedag, J., Gilmore, J., Kennedy, N., Woolley, T. E., Heath, R., Biskupovic Goulding, R., Simpson, V., Kiely, E., Coll, S., White, M., Grijseels, D. M., … McLamore, Q. (2025). Critically appraising the cass report: Methodological flaws and unsupported claims. *BMC Medical Research Methodology*, 25(1). https://doi.org/10.1186/s12874-025-02581-7.

[38] *Id*.

Third, CMS argues that these transition-related services are harmful or unsafe for transgender young people, yet continues to allow them for cisgender young people with precocious puberty or for intersex young people.[39] Allowing the use of federal funding for the same services, just a different diagnosis, is inconsistent with CMS' claim that these services are harmful or unsafe. CMS' distinction for coverage of care based on diagnostic criteria, with no scientific or medical supporting evidence, is on its face arbitrary and capricious. If these services are truly categorically unsafe, as CMS wrongly claims, it could not plausibly permit their use for other pediatric populations. Allowing federal funding for identical hormone therapies or puberty-pausing medications, differing only in the diagnosis or patient population, contradicts CMS' claim that safety concerns motivate the proposed policy change and acts as a subterfuge for discrimination against transgender people. Moreover, the agency's diagnosis-based distinction risks substituting categorical exclusions for individualized medical judgment. Rather than deferring to the child's treating physician to determine whether a particular treatment is necessary for a particular patient, CMS imposes a blanket funding restriction unconnected to clinical standards. This approach not only contradicts CMS' stated concern for patient safety but also further underscores the arbitrary and capricious nature of the NPRM.

Lastly, CMS has proposed these changes to longstanding policy without adequate consideration of reliance interests. Providers structure their staffing, training, and more around the availability of federal funding for these services. By abruptly restricting federal funding for transition-related care, CMS threatens to destabilize existing care and force providers to stop providing services they have long offered in good faith reliance on prior agency policy and their own state's laws. Instead of meaningfully engaging with providers' concerns about the potential financial harm and reliance interest, CMS provides a conclusory statement that "these providers have other avenues to continue to receive compensation for providing medical care," with no further explanation or discussion.[40] CMS similarly minimizes the serious reliance interest of transgender young people and their families, stating that they "may look to obtain other health insurance or privately pay for these services."[41] This statement ignores the economic realities of Medicaid beneficiaries and the critical role that federal funding plays in ensuring medically necessary care is affordable and attainable. For many families, alternative insurance coverage is unavailable or not a meaningful option, meaning access to transition-related care would cease altogether. By failing to grapple with these reliance interests, CMS has not provided a reasonable explanation that is required when making changes to longstanding policy.

[39] 90 *Fed. Reg.* at 59454-55.
[40] *Id*. at 59448.
[41] *Id*. at 59449.

III. The proposed rule will have serious negative health impacts on transgender and gender diverse young people.

Peer-reviewed research and clinical data show that transition-related health care for transgender young people is safe and effective. CMS incorrectly claims that there is a lack of "rigorous scientific data" showing the safety and effectiveness of treatments for gender dysphoria in youth.[42] As discussed above, CMS relies on documents, including the HHS Report and Cass Review, that are rife with misrepresented data interpretations and methodological errors, to conclude that there is not a "favorable risk/benefit profile."[43] Further, CMS fails to consider and downplays the harm and lack of alternatives for transgender young people and families when access to this necessary health care is restricted.

These proposed restrictions on Medicaid and CHIP funding for transition-related health care for transgender young people will deprive them of necessary health care services proven to be safe and beneficial. The harmful effects of the current political climate and other restrictive policies on transgender and gender diverse individuals are well documented.[44] State-level anti-transgender laws have been associated with significant increases in suicide attempts among transgender and nonbinary youth.[45] Additionally, studies show that exposure to news about proposed bills restricting access to transition-related care contributes to worsening mental and physical health outcomes for transgender youth and young adults.[46]

A 2022 survey reported that 98% of respondents ages 18 or older who received gender-affirming hormone therapy, and 97% who received gender-affirming surgery, reported being happier and

---

[42] *Id.* at 59450.
[43] *Id.* at 59443-44.
[44] Dhanani, L. Y., & Totton, R. R. (2023). Have you heard the news? The effects of exposure to news about recent transgender legislation on transgender youth and young adults. *Sexuality Research and Social Policy, 20*(4), 1345–1359. https://doi.org/10.1007/s13178-023-00810-6; Horne, S. G., McGinley, M., Yel, N., & Maroney, M. R. (2022). The stench of bathroom bills and anti-transgender legislation: Anxiety and depression among transgender, nonbinary, and cisgender LGBQ people during a state referendum. *Journal of Counseling Psychology, 69*(1), 1–13. https://doi.org/10.1037/cou0000558; Lee, W. Y., Hobbs, J. N., Hobaica, S., DeChants, J. P., Price, M. N., & Nath, R. (2024). State-level anti-transgender laws increase past-year suicide attempts among transgender and non-binary young people in the USA. *Nature Human Behaviour, 8*(11), 2096–2106. https://doi.org/10.1038/s41562-024-01979-5
[45] Lee, W. Y., Hobbs, J. N., Hobaica, S., DeChants, J. P., Price, M. N., & Nath, R. (2024). State-level anti-transgender laws increase past-year suicide attempts among transgender and non-binary young people in the USA. *Nature Human Behaviour, 8*(11), 2096–2106. https://doi.org/10.1038/s41562-024-01979-5
[46] Dhanani, L. Y., & Totton, R. R. (2023). Have you heard the news? The effects of exposure to news about recent transgender legislation on transgender youth and young adults. *Sexuality Research and Social Policy, 20*(4), 1345–1359. https://doi.org/10.1007/s13178-023-00810-6; Horne, S. G., McGinley, M., Yel, N., & Maroney, M. R. (2022). The stench of bathroom bills and anti-transgender legislation: Anxiety and depression among transgender, nonbinary, and cisgender LGBQ people during a state referendum. *Journal of Counseling Psychology, 69*(1), 1–13. https://doi.org/10.1037/cou0000558

more satisfied with their lives.[47] Transgender individuals who transition report better health outcomes compared to those who do not.[48] These survey findings are supported by multiple comprehensive systematic literature reviews. A 2018 review conducted by researchers at Cornell University reviewed all peer-reviewed articles on transgender health care published between 1991 and mid-2017 and found that gender transition — including access to transition-related care — improves overall well-being.[49] Notably, no study over this twenty-six-year period concluded that gender transition causes overall harm.[50] Reported positive health outcomes include "improved quality of life, greater relationship satisfaction, higher self-esteem and confidence, and reductions in anxiety, depression, suicidality, and substance use."[51] A more recent 2024 comprehensive systematic review conducted by researchers at the University of Utah affirmed these findings, concluding that hormone therapy is safe and effective for transgender youth.[52] Many of the studies examined in these comprehensive reviews are discussed in more depth below.

Numerous studies report that hormone therapy and puberty-pausing medications in young people do not negatively impact other aspects of their physical health, or that any potential risks can be mitigated. Research has shown that girls who receive hormone therapy in childhood report normal bone density and ovarian function in early adulthood, with no notable impact on their final height.[53] The same study also reported no proven predisposition for polycystic ovary syndrome or menstrual irregularities connected with hormone therapy in young girls.[54] Additional studies show no negative impacts on liver enzymes or creatinine levels in transgender young people using puberty-pausing medications.[55] Further, a study found no adverse effects on

[47] Rastogi, A., Menard, L., Miller, G. H., Cole, W., Laurison, D., Caballero, J. R., Murano-Kinney, S., & Heng-Lehtinen, R. (2025, June). Health and wellbeing: A report of the 2022 U.S. Transgender Survey (pp. 10–11). *Advocates for Transgender Equality*. https://ustranssurvey.org/download-reports/
[48] *Id*. at 24.
[49] What We Know Project, Cornell University. (2018). *What does the scholarly research say about the effect of gender transition on transgender well-being?* https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/
[50] *Id*.
[51] *Id*.
[52] LaFleur, J., Heath, L., Gonzalez, V., et al. (2024). *Gender-affirming medical treatments for pediatric patients with gender dysphoria: A report of the University of Utah College of Pharmacy Drug Regimen Review Center (DRRC).* University of Utah. https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636
[53] Magiakou, M. A., Manousaki, D., Papadaki, M., et al. (2010). The efficacy and safety of gonadotropin-releasing hormone analog treatment in childhood and adolescence: A single center, long-term follow-up study. *The Journal of Clinical Endocrinology & Metabolism, 95*(1), 109–117. https://doi.org/10.1210/jc.2009-0793
[54] *Id*.
[55] Schagen, S. E. E., Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Hannema, S. E. (2016). Efficacy and safety of gonadotropin-releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *The Journal of Sexual Medicine, 13*(7), 1125–1132. https://doi.org/10.1016/j.jsxm.2016.05.004

cognitive functioning, behavioral, or social problems among young girls receiving puberty-pausing medications compared to their peers who do not receive this treatment.[56]

Transgender youth face a higher risk for lifetime substance use, depression, anxiety, and suicidality than their cisgender counterparts.[57] Transition-related care has been shown to improve mental health outcomes for transgender individuals, particularly youth, including reductions in suicidal ideation.[58] Compared to their cisgender peers, transgender youth are more likely to experience emotional distress, internalize and externalize problems, have high rates of suicidality, and psychiatric inpatient hospitalization.[59] Multiple studies report that young people who wanted, but did not receive, transition-related hormone therapy had higher chances of seriously considering suicide or attempting it as opposed to those who accessed the care they needed.[60] Importantly, even when controlling for psychiatric medication use and counseling, hormone therapy is independently associated with reductions in depression and suicidal ideation.[61] Multiple studies confirm that transgender and gender diverse youth who received

---

[56] Wojniusz, S., Callens, N., Sütterlin, S., Andersson, S., De Schepper, J., Gies, I., Vanbesien, J., De Waele, K., Van Aken, S., Craen, M., Vögele, C., Cools, M., & Haraldsen, I. R. (2016). Cognitive, emotional, and psychosocial functioning of girls treated with pharmacological puberty blockage for idiopathic central precocious puberty. *Frontiers in Psychology, 7*, 1053. https://doi.org/10.3389/fpsyg.2016.01053

[57] Coulter, R. W. S., Egan, J. E., Kinsky, S., et al. (2019). Mental health, drug, and violence interventions for sexual/gender minorities: A systematic review. *Pediatrics, 144*(3), e20183367. https://doi.org/10.1542/peds.2018-3367; McKenna, J. L., Anglemyer, E. T., & McGregor, K. (2024). Gender-affirming mental health care for transgender and gender diverse youth on pediatric inpatient psychiatry units. *Journal of the American Academy of Child & Adolescent Psychiatry, 63*(6), 576–580. https://doi.org/10.1016/j.jaac.2023.05.021

[58] Rew, L., Young, C. C., Monge, M., & Bogucka, R. (2020). Puberty blockers for transgender and gender diverse youth—a critical review of the literature. *Child and Adolescent Mental Health, 26*(1), 3–14.https://doi.org/10.1111/camh.12437; Guss, C., & Gordon, C. M. (2022). Pubertal blockade and subsequent gender-affirming therapy. *JAMA Network Open, 5*(11), e2239763. https://doi.org/10.1001/jamanetworkopen.2022.39763; Rastogi, A., Menard, L., Miller, G. H., Cole, W., Laurison, D., Caballero, J. R., Murano-Kinney, S., & Heng-Lehtinen, R. (2025, June). *Health and wellbeing: A report of the 2022 U.S. Transgender Survey.* Advocates for Transgender Equality. https://ustranssurvey.org/download-reports/; Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics, 145*(2), e20191725. https://doi.org/10.1542/peds.2019-1725

[59] McKenna, J. L., Anglemyer, E. T., & McGregor, K. (2024). Gender-affirming mental health care for transgender and gender diverse youth on pediatric inpatient psychiatry units. *Journal of the American Academy of Child & Adolescent Psychiatry, 63*(6), 576–580. https://doi.org/10.1016/j.jaac.2023.05.021; van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health, 66*(6), 699–704. https://doi.org/10.1016/j.jadohealth.2019.12.018

[60] Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health, 70*(4), 643–649. https://doi.org/10.1016/j.jadohealth.2021.10.036; Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics, 145*(2), e20191725. https://doi.org/10.1542/peds.2019-1725

[61] Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths:

puberty-pausing medications present lower instances of internalizing their problems and are less likely to have suicidal thoughts.[62] Relatedly, evidence consistently shows that when young people receive transition-related care, including hormones, puberty-pausing medications, or surgery, there are notable reductions in rates of depression as well.[63] One study in particular found that among youth aged 13 to 20, receiving gender affirming care, including puberty-pausing medications and hormone therapy, was "associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality."[64]

Preliminary results. *International Journal of Pediatric Endocrinology, 2020*, 8. https://doi.org/10.1186/s13633-020-00078-2

[62] McGregor, K., McKenna, J. L., Williams, C. R., Barrera, E. P., & Boskey, E. R. (2024). Association of pubertal blockade at Tanner 2/3 with psychosocial benefits in transgender and gender diverse youth at hormone readiness assessment. *Journal of Adolescent Health, 74*(4), 801–807. https://doi.org/10.1016/j.jadohealth.2023.10.028; Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology, 7*(3), 302–311. https://doi.org/10.1037/cpp0000288; Croteau, T. A., Gelech, J., Morrison, M. A., & Morrison, T. G. (2025). Psychological and physical health outcomes associated with gender-affirming medical care for transgender and gender-diverse youth: A critical review. *Healthcare, 13*(14), 1659. https://doi.org/10.3390/healthcare13141659; Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics, 145*(2), e20191725. https://doi.org/10.1542/peds.2019-1725; Fisher, A. D., Ristori, J., Romani, A., Cassioli, E., Mazzoli, F., Cocchetti, C., Pierdominici, M., Marconi, M., Ricca, V., Maggi, M., Vignozzi, L., & Castellini, G. (2024). Back to the future: Is GnRHa treatment in transgender and gender diverse adolescents only an extended evaluation phase? *The Journal of Clinical Endocrinology & Metabolism, 109*(6), 1565–1579. https://doi.org/10.1210/clinem/dgad729; Almazan, A. N., & Keuroghlian, A. S. (2021). Association between gender-affirming surgeries and mental health outcomes. *JAMA Surgery, 156*(7), 611–618. https://doi.org/10.1001/jamasurg.2021.0952

[63] Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open, 5*(2), e220978. https://doi.org/10.1001/jamanetworkopen.2022.0978; McGregor, K., McKenna, J. L., Williams, C. R., Barrera, E. P., & Boskey, E. R. (2024). Association of pubertal blockade at Tanner 2/3 with psychosocial benefits in transgender and gender diverse youth at hormone readiness assessment. *Journal of Adolescent Health, 74*(4), 801–807. https://doi.org/10.1016/j.jadohealth.2023.10.028; Croteau, T. A., Gelech, J., Morrison, M. A., & Morrison, T. G. (2025). Psychological and physical health outcomes associated with gender-affirming medical care for transgender and gender-diverse youth: A critical review. *Healthcare, 13*(14), 1659. https://doi.org/10.3390/healthcare13141659; de Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134*(4), 696–704. https://doi.org/10.1542/peds.2013-2958; Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. *International Journal of Pediatric Endocrinology, 2020*, 8. https://doi.org/10.1186/s13633-020-00078-2; Fisher, A. D., Ristori, J., Romani, A., Cassioli, E., Mazzoli, F., Cocchetti, C., Pierdominici, M., Marconi, M., Ricca, V., Maggi, M., Vignozzi, L., & Castellini, G. (2024). Back to the future: Is GnRHa treatment in transgender and gender diverse adolescents only an extended evaluation phase? *The Journal of Clinical Endocrinology & Metabolism, 109*(6), 1565–1579. https://doi.org/10.1210/clinem/dgad729; Chelliah, P., Lau, M., & Kuper, L. E. (2024). Changes in gender dysphoria, interpersonal minority stress, and mental health among transgender youth after one year of hormone therapy. *Journal of Adolescent Health, 74*(6), 1106–1111. https://doi.org/10.1016/j.jadohealth.2023.12.024

[64] Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open, 5*(2), e220978. https://doi.org/10.1001/jamanetworkopen.2022.0978

Eating disorders are also a significant concern for transgender and gender-diverse youth. A study found that nearly one in four gender diverse young people reported various eating disorder symptoms, including those of anorexia and bulimia.[65] Research further indicates that improvements in body image in transgender young people following hormone therapy result in better mental health outcomes and enhanced overall well-being.[66]

The benefits of receiving transition-related care extend into adulthood as well. A 2022 study found that 98% of people who began gender-affirming medical treatment in adolescence continued treatment in adulthood.[67] Adults who accessed transition-related hormone therapy in their youth report lower odds of severe psychological distress, suicidal ideation, binge drinking, and lifetime illicit drug use when compared to those who desired such treatment but were unable to access it.[68] More broadly, evidence strongly shows that receiving gender-affirming hormone treatment in youth is associated with better mental health outcomes into adulthood.[69] Satisfaction rates for transition-related care are high, and rates of regret are notably low compared to many other medical and life decisions.[70] A systematic review found that regret following gender

---

[65] Kerr, J. A., Paine, J., Thrower, E., Hoq, M., Mollica, C., Sawyer, S. M., Azzopardi, P. S., & Pang, K. C. (2024). Prevalence of eating disorder symptoms in transgender and gender diverse adolescents presenting for gender-affirming care. *Journal of Adolescent Health*, *74*(4), 850–853. https://doi.org/10.1016/j.jadohealth.2023.11.396

[66] Becker, I., Auer, M., Barkmann, C., Fuss, J., Möller, B., Nieder, T. O., Fahrenkrug, S., Hildebrandt, T., & Richter-Appelt, H. (2018). A cross-sectional multicenter study of multidimensional body image in adolescents and adults with gender dysphoria before and after transition-related medical interventions. *Archives of Sexual Behavior, 47*(8), 2335–2347. https://doi.org/10.1007/s10508-018-1278-4; Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, *145*(4), e20193006. https://doi.org/10.1542/peds.2019-3006; Fisher, A. D., Ristori, J., Romani, A., Cassioli, E., Mazzoli, F., Cocchetti, C., Pierdominici, M., Marconi, M., Ricca, V., Maggi, M., Vignozzi, L., & Castellini, G. (2024). Back to the future: Is GnRHa treatment in transgender and gender diverse adolescents only an extended evaluation phase? *The Journal of Clinical Endocrinology & Metabolism*, *109*(6), 1565–1579. https://doi.org/10.1210/clinem/dgad729; Chelliah, P., Lau, M., & Kuper, L. E. (2024). Changes in gender dysphoria, interpersonal minority stress, and mental health among transgender youth after one year of hormone therapy. *Journal of Adolescent Health, 74*(6), 1106–1111. https://doi.org/10.1016/j.jadohealth.2023.12.024.

[67] van der Loos, M. A. T. C., Hannema, S. E., Klink, D. T., den Heijer, M., & Wiepjes, C. M. (2022). Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: A cohort study in the Netherlands. *The Lancet Child & Adolescent Health, 6*(12), 869–875.https://doi.org/10.1016/s2352-4642(22)00254-1

[68] Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLOS ONE*, *17*(1), e0261039. https://doi.org/10.1371/journal.pone.0261039

[69] *Id*; Digitale, E. (2022, January 12). *Better mental health found among transgender people who started hormones as teens.* Stanford Medicine, News Center. https://med.stanford.edu/news/all-news/2022/01/mental-health-hormone-treatment-transgender-people.html

[70] Cavve, B. S., Bickendorf, X., Ball, J., et al. (2024). Reidentification with birth-registered sex in a Western Australian pediatric gender clinic cohort. *JAMA Pediatrics, 178*(5), 446–453. https://doi.org/10.1001/jamapediatrics.2024.0077; Thornton, S. M., Edalatpour, A., & Gast, K. M. (2024). A systematic review of patient regret after surgery: A common phenomenon in many specialties but rare within

affirming surgery was less than 1%, which is significantly lower than regret rates reported for procedures such as plastic surgery (5.1–9.1 % for breast augmentation and 10.82–33.3 % for body contouring), having children (7%), and getting a tattoo (16.2%).[71] Among the very few people who do choose to de-transition, most cite external factors that caused the decision, such as pressure from the community or societal stigma, rather than dissatisfaction with the medical care itself.[72]

Restricting access to necessary, transition-related care through this proposed rule will have devastating consequences on health outcomes for transgender young people. As detailed above, the peer-reviewed and scientifically backed evidence base for the positive impacts of access to transition-related care, specifically hormone-related treatments, is well documented and supported by extensive research. Any assertion to the contrary by CMS blatantly ignores the findings and reports from scholars and medical experts detailing the safety and efficacy of transition-related care for young people.

IV. The proposed rule has the potential to harm access to providers for all Medicaid beneficiaries and community health at large.

CMS states that it has "considered the concerns of States, providers, and beneficiaries who have relied on CMS making Federal Medicaid and CHIP payment for these services."[73] CMS provides a brief discussion stating that some states "may experience negative financial impacts" as a result of reliance on federal Medicaid and CHIP payments for transition-related care for youth.[74] But CMS concludes that the "harms" of transition-related care outweigh the "possible financial costs" without any discussion of how CMS arrived at that conclusion.[75] Additionally, CMS does not consider or discuss downstream effects on community health and access to providers for Medicaid beneficiaries at large that stem from the loss of federal Medicaid and CHIP payments.

---

gender-affirmation surgery. *The American Journal of Surgery, 234*, 68–73. https://doi.org/10.1016/j.amjsurg.2024.04.021

[71] Thornton, S. M., Edalatpour, A., & Gast, K. M. (2024). A systematic review of patient regret after surgery: A common phenomenon in many specialties but rare within gender-affirmation surgery. *The American Journal of Surgery, 234*, 68–73. https://doi.org/10.1016/j.amjsurg.2024.04.021

[72] Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. LGBT Health. 2021 May-Jun;8(4):273-280 https://doi.org/10.1089/lgbt.2020.0437; McNamara, M., Baker, K., Connelly, K., Janssen, A., Olson-Kennedy, J., Pang, K. C., Scheim, A., Turban, J., & Alstott, A. (2024). An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria. Retrieved February 3, 2026, from https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf.

[73] 90 *Fed. Reg.* at 59452.

[74] *Id*. at 59448.

[75] *Id*. at 59448.

Young people and their families are already seeing a chilling effect as a result of threats from the federal government, causing providers to stop offering this medically necessary care.[76] As a result of this NPRM, providers may voluntarily leave the Medicaid program rather than choosing between restricting medically necessary care to their patients or risking professional consequences. As discussed above, transition-related care is necessary health care for transgender young people; this NPRM would force providers to know that this care is medically necessary, know the immense risk of negative physical and mental health outcomes, and still deny that care to their patients. CMS concedes that "[t]his prohibition includes circumstances in which a provider may determine that a sex-rejecting procedure is medically necessary for a child diagnosed with gender dysphoria."[77] The integrity of the states' health care system at large is harmed when health care professionals are barred from providing services consistent with professional standards of care.

For many of these providers, providing transition-related care to transgender young people is a small part of their work. They provide many other essential health care services to the community, and the loss of these providers from the Medicaid program could impact access to these services. For example, endocrinologists may help manage hormone therapy for transgender young people, but endocrinologists also help diagnose and treat a wide array of other hormone-related conditions, such as diabetes and thyroid disorders.[78] The potential loss of providers in the Medicaid program will particularly harm rural and other geographic areas that already face provider shortages and threats of hospital closure.[79]

Conclusion

For all the foregoing reasons, APHA and the individual public health deans and scholars listed below urge CMS to withdraw the NPRM. If finalized, the proposed rule will lead to significant individual health, community health, and economic harms, will be arbitrary and capricious, and violate the law.

---

[76] Restar, A. J., Layland, E. K., Davis, B., Thompson, H., & Streed, C. (2024). The Public Health Crisis State of Transgender Health Care and Policy. *American Journal of Public Health*, 114(2), 161–163. https://doi.org/10.2105/ajph.2023.307523; Smallens, Y. (2025, June 3). *"They're Ruining People's Lives" Bans on Gender-Affirming Care for Transgender Youth in the US*. Human Rights Watch. https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-on-gender-affirming-care-for-transgender-youth; Dhanani, L. Y., & Totton, R. R. (2023). Have You Heard the News? The Effects of Exposure to News About Recent Transgender Legislation on Transgender Youth and Young Adults. *Sexuality Research and Social Policy*, 20(4), 1345–1359. https://doi.org/10.1007/s13178-023-00810-6.

[77] 90 *Fed. Reg.* at 59451.

[78] *What is an endocrinologist?.* Cleveland Clinic. (2025, February 20). https://my.clevelandclinic.org/health/articles/22691-endocrinologist.

[79] Euhus, R., Cervantes, S., Burns, A., & Rudowitz, R. (2025, June 26). *5 Key Facts About Medicaid Coverage for People Living in Rural Areas*. KFF. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-living-in-rural-areas/.

We also respectfully request that the full text of our comments, as well as the full text of each of the individual studies, reports, and other supporting materials that we have cited and made available through active links in our comments, be considered part of the formal administrative record on this NPRM for purposes of the Administrative Procedure Act. Please let us know if CMS is unable for any reason to include our linked materials, so we will have the chance to otherwise submit copies of the supporting documents into the administrative record.

Thank you for your consideration of our comments. If you need any additional information, please contact Allyson Crays at a.crays@gwu.edu.

A. Public Health Organizations

1. American Public Health Association

B. Public Health Deans

1. Chandler, G. Thomas, MS, PhD, Distinguished Dean Emeritus, Professor, Environmental Health Sciences, Arnold School of Public Health, University of South Carolina
2. El-Mohandes, Ayman, MBBCh, MD, MPH, Dean, CUNY Graduate School of Public Health & Health Policy
3. Goldman, Lynn R., MD, MPH, MS, Dean Emerita, Milken Institute School of Public Health, The George Washington University
4. Gusmano, Michael K., PhD, Iacocca Chair, Professor of Health Policy, Associate Dean of Academic Affairs, College of Health, Lehigh University
5. Hyder, Adnan A., MD, MPH, PhD, Dean & Robert A. Knox Professor, Boston University School of Public Health
6. Jeffries, Pamela R., PhD, RN, FAAN, ANEF, FSSH, Dean, Vanderbilt School of Nursing, Valere Potter Distinguished Professor of Nursing, RWJF Nurse Executive Fellow Alumna, Vanderbilt School of Nursing
7. LaVeist, Thomas A., PhD, Dean and Weatherhead Presidential Chair in Health Equity, Professor Tulane University School of Public Health and Tropical Medicine
8. Lu, Michael C., MD, MS, MPH, Dean, UC Berkeley School of Public Health

9. Lushniak, Boris, MD, MPH, Professor and Dean, University of Maryland School of Public Health

10. Parker, Edith A., MPH, DrPH, Dean, Professor, Community and Behavioral Health, The University of Iowa College of Public Health

11. Rimer, Barbara K., DrPH, Professor Emerita, Department of Health Behavior, Dean Emerita, UNC Gillings School of Global Public Health

12. Thorpe, Jane, JD, Professor and Sr. Associate Dean for Academic, Student & Faculty Affairs, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

13. Vermund, Sten H., MD, PhD, Dean, Distinguished University Health Professor of Public Health and Pediatrics, College of Public Health, University of South Florida

14. Wilensky, Sara E., JD, PhD, Assistant Dean for Undergraduate Education, Director, Undergraduate Program in Public Health, Special Services Faculty for Undergraduate Education, Milken Institute School of Public Health, The George Washington University

C. Health Professions, Public Health, Health Law and Policy Scholars

15. Akman, Jeffrey S., MD, Professor and Leon M. Yochelson Chair, Department of Psychiatry and Behavioral Sciences, School of Medicine and Health Sciences, The George Washington University

16. Baird, Sarah, PhD, Professor and Vice Chair, Department of Global Health, Milken Institute School of Public Health, The George Washington University

17. Barkoff, Alison, JD, Harold and Jane Hirsh Associate Professor of Health Law and Policy, Director, Hirsh Health Law and Policy Program, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

18. Beckerman, Julia Zoe, JD, MPH, Teaching Professor and Vice Chair of Academics, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

19. Blanchard, Janice, MD, PhD, Professor, Chief of Health Policy Section, Department of Emergency Medicine, School of Medicine and Health Sciences, The George Washington University

20. Blatt, Benjamin, MD, CHSE, Professor of Medicine, School of Medicine and Health Sciences, The George Washington University

21. Blewett, Lynn A., PhD, MA, Professor, Division of Health Policy and Management, University of Minnesota School of Public Health

22. Bonar, Robert, DHA, Gordon A. Friesen Professor of Healthcare Administration, Director of Master of Health Administration Program, Milken Institute School of Public Health, The George Washington University

23. Borden, William B., MD, FACC, FAHA, Chief Quality and Population Officer, Professor of Medicine and Health Policy, The George Washington University Medical Faculty Associates

24. Borkowski, Liz, MPH, Senior Research Scientist, Managing Director, Jacobs Institute of Women's Health, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

25. Braaten, Kari P., MD, MPH, Assistant Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School

26. Braffett, Barbara H., PhD, Associate Research Professor, Department of Epidemiology, Co-PI, DCCT/EDIC Data Coordinating Center, Co-I, TODAY Coordinating Center, The George Washington University

27. Brindis, Claire D., DrPH, Distinguished Professor, Departments of Pediatrics and Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, Emerita Director, Philip R. Lee Institute for Health Policy Studies

28. Burke, Taylor, JD, LLM, Adjunct Professor of Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

29. Burris, Scott, JD, James E. Beasley Professor of Law, Director, Center for Public Health Law Research, Temple University Beasley School of Law

30. Burroughs, Thomas E., PhD, MS, MA, Professor of Health Management & Policy, Biostatistics, and Epidemiology, College for Public Health and Social Justice, Saint Louis University

31. Byrnes, Maureen, MPA, Teaching Instructor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

32. Cartwright-Smith, Lara, JD, MPH, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

33. Casoni, Maria, MPH, MSL, Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

34. Chang, Aileen, MD, MSPH, Associate Professor of Medicine, The George Washington University School of Medicine and Health Sciences

35. Chernoby, Kimberly, MD, JD, Assistant Clinical Professor of Emergency Medicine, The George Washington University School of Medicine and Health Sciences, Chief Legal Officer, FemInEM

36. Cleary, Sean, MPH, PhD, Associate Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

37. Cohen, Alan B., Sc.D., Research Professor (Retired), Markets, Public Policy and Law, Boston University Questrom School of Business, and Professor of Health Law, Policy and Management (Retired), Boston University School of Public Health

38. Crays, Allyson, JD, Public Health Law and Policy Analyst, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

39. Diemert, David, MD, FRCP(C), Professor, Depts. of Medicine and Microbiology, Immunology & Tropical Medicine, The George Washington University School of Medicine & Health Sciences

40. Dutta, Elizabeth Arend, DrPH, MPH, Professorial Lecturer, The George Washington University

41. Ecker, Jeffrey L., MD, Joe V. Meigs Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Chair Emeritus, Department of Obstetrics and Gynecology, Massachusetts General Hospital

42. Erikson, Clese, MPAff, Deputy Director, Health Workforce Research Center, Fitzhugh Mullan Institute for Health Workforce Equity, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

43. Evans, Scott, PhD, MS, Director, The Biostatistics Center, Professor and Founding Chair, Department of Biostatistics and Bioinformatics, Milken Institute School of Public Health, The George Washington University

44. Feder, Judith, PhD, Professor, McCourt School of Public Policy, Georgetown University

45. Frankford, David M., JD, Professor of Law, Rutgers Law School

46. Freed, Salama, PhD, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

47. Friedman, Leonard H., PhD, MPH, FACHE, Professor and Director, MHA@GW Program, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

48. Gaba, Nancy D., MD, FACOG, Oscar I. and Mildred S. Dodek Professor and Chair, Department of Obstetrics and Gynecology, School of Medicine and Health Science, The George Washington University

49. Ganguli, Ishani, MD, MPH, Associate Professor of Medicine, Harvard Medical School

50. Ghosh, Mimi, PhD, MS, Associate Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

51. Goldstein, Melissa M., JD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

52. Grogan, Colleen M., PhD, Deborah R. and Edgar D. Jannotta Professor, Crown Family School of Social Work, Policy, and Practice, The University of Chicago

53. Hamilton, Bethany, JD, Director, National Center for Medical-Legal Partnership, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

54. Heinrich, Janet, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

55. Hoffman, Allison K., JD, William Maul Measey Professor of Law and Health Sciences, Professor of Medical Ethics & Health Policy, University of Pennsylvania Carey Law School

56. Holtz, Timothy H., MD, MPH, FACP, FACPM, RDML (ret) US PHS, Redstone Chair & Director, Sumner M. Redstone Global Center for Prevention and Wellness, Professor, Department of Global Health & Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

57. Horton, Katherine, RN, MPH, JD, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

58. Huberfeld, Nicole, Edward R. Utley Professor of Health Law, Co-Director, BU Program on Reproductive Justice, Chair, BU Health Law Program, Boston University School of Law and School of Public Health

59. Imershein, Sara, MD, MPH, FACOG, Clinical Professor, OB-GYN, School of Medicine and Health Sciences, The George Washington University

60. Jacobs, Feygele, DrPH, MS, MPH, Professor and Director, Geiger Gibson Program in Community Health, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

61. Jordan, Jeanne A., PhD, HCLD(ABB), MT(ASCP), Professor Emerita, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

62. Jost, Timothy Stoltzfus, JD, Professor Emeritus, Washington and Lee University School of Law

63. Katz, Ingrid, MD, MHS., Director, Yale Institute for Global Health

64. Ku, Leighton, PhD, MPH, Professor, Department of Health Policy and Management, Director, Center for Health Policy Research, Milken Institute School of Public Health, The George Washington University

65. Lantz, Paula, PhD, Associate Director, International Policy Center, James B. Hudak Professor of Health Policy, Director of BA Undergraduate Programs, Gerald R. Ford School of Public Policy, Professor of Health Management and Policy, University Professor of Diversity and Social Transformation, School of Public Health, University of Michigan

66. LaPuma, Peter, PhD, CIH, PE, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University

67. Law, Sylvia A., JD, Elizabeth K. Dollard Professor Emerita of Law, Medicine and Psychiatry, NYU Law School

68. Levi, Jeffrey, PhD, Professor Emeritus, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

69. Lewis-O'Connor, Annie, PhD, NP, MPH, Instructor in Medicine, Harvard Medical School, Founder and Director, C.A.R.E. Clinic, Brigham and Women's Hospital

70. Lillie-Blanton, Marsha, DrPH, Adjunct Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

71. Magnus, Manya, PhD, MPH, Professor and Chair, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

72. Mariner, Wendy K., JD, LLM, MPH, Professor of Health Law, Ethics and Human Rights Emerita, Boston University School of Public Health

73. Markus, Anne R., PhD, MHS, JD, Professor and Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

74. Mason, Diana J., RN, PhD, FAAN, Senior Policy Service Professor, Center for Health Policy and Media Engagement, School of Nursing, The George Washington University

75. McCarthy, Melissa L., ScD, MS, Professor of Health Policy and Emergency Medicine, Milken Institute School of Public Health, The George Washington University

76. McDonnell, Karen A., PhD, Associate Professor, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

77. Michaels, David, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University

78. Michener, Jamila, PhD, Associate Professor of Government, Cornell University

79. Monroe, Anne K., MD, MSPH, Associate Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

80. Murphy, Caitlin, MPP, Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

81. Musumeci, MaryBeth, JD, Associate Teaching Professor, Milken Institute School of Public Health, The George Washington University

82. Newcomer, Kathryn, PhD, MA, Professor of Public Policy and Public Administration, Trachtenberg School of Public Policy and Public Administration, The George Washington University

83. Oberlander, Jonathan, PhD, Professor, Department of Social Medicine, Professor, Department of Health Policy & Management, University of North Carolina at Chapel Hill

84. Parmet, Wendy E., JD, Matthews University Distinguished Professor of Law, Northeastern University

85. Perreira, Krista M., PhD, Professor, Department of Social Medicine, UNC School of Medicine

86. Perrin, James M., MD, Professor of Pediatrics Emeritus, Harvard Medical School, John C. Robinson Distinguished Chair in Pediatrics, MassGeneral for Children

87. Peterson, Mark A., PhD, Professor of Public Policy, Political Science, Health Policy and Management, and Law, UCLA Meyer and Renee Luskin School of Public Affairs

88. Pittman, Patricia, PhD, Professor of Health Policy and Management, Director of Health Workforce Research Center, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

89. Pollack, Harold, PhD, Helen Ross Distinguished Services Professor, Associated Faculty, Public Health Sciences, Crown Family School of Social Work, Policy, and Practice, Administration, University of Chicago

90. Poteat, Tonia, PhD, MPH, PA-C, Professor, Duke University School of Nursing, Research Professor of Global Health, Duke Global Health Institute

91. Price, Olga Acosta, Associate Professor and Vice Chair, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

92. Reeves, Matthew, MD, MPH, FACOG, Chief Executive Officer, DuPont Clinic; Clinical Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine and Health Sciences; Adjunct Clinical Associate Professor of Obstetrics and Gynecology, Stanford University School of Medicine; Adjunct Associate Professor of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

93. Regenstein, Marsha, PhD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

94. Rempe, Shannon, JD, MPH, Program Director, Advancing Public Health and Health Equity in the Courts, Northeastern University

95. Ricciardi, Richard, PhD, CRNP, FAAP, FAAN, Executive Director, Center for Health Policy and Media Engagement, Professor, School of Nursing, The George Washington University

96. Rich-Edwards, Janet, ScD, MPH, Associate Professor of Medicine, Harvard Medical School, Associate Professor in Epidemiology, Harvard T.H. Chan School of Public Health

97. Richards, Adam K., MD, PhD, MPH, DTM&H, Senior Associate, Department of International Health, Johns Hopkins Bloomberg School of Public Health

98. Rittenberg, Eve, MD, Assistant Professor of Medicine, Harvard Medical School

99. Rocco, Philip, PhD, Associate Professor of Political Science, Marquette University

100. Rosenbaum, Sara, JD, Professor Emerita, Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

101. Schneider, Andy, JD, Research Professor of the Practice, McCourt School of Public Policy, Georgetown University

102. Seiler, Naomi, JD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

103. Silberman, Pam, JD, DrPH, Professor Emerita, Director, Executive Doctoral Program in Health Leadership, Department of Health Policy and Management, UNC Gillings School of Global Public Health

104. Silverman, Hannah, MPH, Senior Research Associate, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

105. Siminoff, Laura A., PhD, Laura H. Carnell Professor of Public Health, Department of Social and Behavioral Sciences, Temple University

106. Skinner, Daniel, PhD, Professor of Health Policy, Department of Social Medicine, Heritage College of Osteopathic Medicine, Ohio University

107. Slifkin, Becky, PhD, Professor Emerita, Department of Health Policy and Management, UNC Gillings School of Global Health

108. Smith, Emily R., ScD, MPH, Associate Professor, Global Health & Nutrition Sciences, Director, PhD in Global Health Sciences, Interim Chair, Department of Global Health, Milken Institute School of Public Health, The George Washington University

109. Sparer, Michael, JD, PhD, William Henry Welch Professor of Public Health, Department of Health Policy and Management, Columbia University Mailman School of Public Health

110. Strasser, Julia, DrPH, MPH, Assistant Research Professor, Department of Health Policy and Management, Director, Reproductive Health Workforce & Policy Research Center, Fitzhugh Mullan Institute for Health Workforce Equity, Milken Institute School of Public Health, The George Washington University

111. Suter, Sonia M., JD, MS, Professor of Law, The Kahan Family Research Professor of Law, Co-Director, Health Law & Policy Program, The George Washington University Law School

112. Swartz, Katherine, PhD, MS, Professor of Health Policy and Management, Emerita, Harvard T.H. Chan School of Public Health, Harvard University

113. Tavrow, Paula, Ph.D., Adjunct Professor, Department of Community Health Sciences, University of California Los Angeles Fielding School of Public Health

114. Vichare, Anushree, PhD, MBBS, MPH, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

115. Vyas, Amita N., PhD, MHS, Professor, Director, Maternal & Child Health Program, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University

116. Waldman, Ronald, MD, MPH, Professor Emeritus of Global Health, Milken Institute School of Public Health, The George Washington University

117. Wasserman, Alan G., MD, MACP, Eugene Meyer Emeritus Professor of Medicine, Department of Medicine, The George Washington School of Medicine and Health Sciences

118. Watson, Sidney D., JD, Jane and Bruce Robert Professor of Law, Center for Health Law Studies, Saint Louis University School of Law

119. Westmoreland, Timothy M., JD, Professor from Practice, Emeritus, Georgetown University School of Law

120. Wise, Paul H., Richard E. Behrman Professor of Child Health and Society, Senior Fellow, Freeman Spogli Institute for International Studies, Core Faculty, Center on Democracy, Development and the Rule of Law, Affiliated faculty at the Center for International Security and Cooperation, Stanford University

121. Wisner, Katherine L., MD, MS, DLFAPA, Professor of Psychiatry and Pediatrics, Developing Brain Institute, Children's National Hospital, Professor of Obstetrics and Gynecology, George Washington University School of Medicine

122. Yang, Y. Tony, DSc, LLM, MPH, Endowed Professor of Health Policy, The George Washington University

123. Young, Heather A., PhD, MPH, Vice Chair/Professor/MPH Epidemiology Co-Director/PhD Epidemiology Director, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University