

United States Senate

WASHINGTON, DC 20510

February 17, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016 Baltimore, MD 21244-8016

RE: CMS-3481-P

Dear Administrator Oz,

We write today to urge the Centers for Medicare & Medicaid Services (CMS) not to finalize the notice of proposed rulemaking (NPRM) published on December 19, 2025, entitled “Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children.” Proposed rule CMS-3481-P would prohibit hospitals that receive Medicare and Medicaid funding from providing treatment for gender dysphoria to transgender youth. If finalized in its proposed form, this policy would mark an unprecedented intrusion of partisan politics and ideology into medical decision-making and severely restrict access to evidence-based, medically-necessary care.

This proposed rule would place the federal government directly between physicians, patients, and families by conditioning hospital participation in Medicare and Medicaid on the denial of individualized, clinician-directed care. The Conditions of Participation (CoPs) for hospitals have never before been used to compel providers to disregard their medical judgment or prevent patients from receiving care that clinicians, in consultation with patients and parents, determine to be medically appropriate. The proposed rule represents an unprecedented departure from the Congressional intent and the fundamental goals of the Medicare and Medicaid conditions of participation—to secure patients’ basic safety and quality care—and should be withdrawn.

The NPRM Unprecedentedly Regulates Clinical Judgment Instead of Safety

The proposed rule would amend the Medicare CoPs for hospitals, a set of health and safety regulations that hospitals must comply with to receive Medicare payments. Nearly all hospitals in the United States participate in and receive payment from the Medicare program and thus are subject to the CoPs.¹ The intent of the CoPs is to establish uniform national minimum standards “to assure the quality of medical care purchased for beneficiaries.”² From their inception, the CoPs have aimed to ensure hospitals have the basic capacity, systems, and safeguards in place to provide safe, high quality care. In short, CoPs aim to establish a safe environment to provide medical care.³ The CoPs address hospital administration, functions, and services; to date, they have not required or prohibited the provision of specific clinical treatments. For example, the CoP regulating hospital pharmaceutical services establishes basic operational safeguards to ensure that all drugs are stored securely and that expired medications are not available for patient

¹ Fact Sheet: Majority of Hospital Payments Dependent on Medicare or Medicaid, American Hospital Association (May 6, 2024), <https://www.aha.org/fact-sheets/2022-05-25-fact-sheet-majority-hospital-payments-dependent-medicare-or-medicaid>.

² John W. Cashman et al., “Medicare's Effect on Medical Care. The "Why" of Conditions of Participation in the Medicare Program,” Public Health Reports, vol. 83, no. 9 (1968), pp. 714-718, <https://pmc.ncbi.nlm.nih.gov/articles/PMC1891865/>.

³ 42 U.S.C. § 1395x(e)(9).

use.⁴ Similarly, the CoP established in 42 C.F.R. § 482.26 requires hospitals to maintain or have available diagnostic radiologic services and to implement safety precautions to manage radiation hazards, including periodic monitoring of staff radiation exposure and regular inspection of radiologic equipment. Another CoP, 42 C.F.R. § 482.42, requires hospitals to maintain a hospital-wide program for the surveillance, prevention, and control of hospital-acquired infections and other infectious diseases. The NPRM would be an unprecedented departure from the regulatory and statutory intent and history of the CoPs, which are a regulatory mechanism used to make sure that health care is delivered in a safe environment, not to dictate the specific health care that is delivered.

Although the CoPs are contained in Medicare regulations, they also apply to hospitals participating in Medicaid. Regulations at 42 C.F.R. §§ 440.10(a)(3)(iii) and 440.20(a)(3)(ii) require hospitals, among other providers, to meet the “requirements for participation in Medicare” to qualify for Medicaid payment.

Since the inception of the Medicare program, CoPs have been amended in statute or updated in regulation only in limited, targeted ways to advance patient health and safety and preserve flexibility for hospitals, rather than to prohibit specific clinical services or medical procedures. Compliance with CoPs is a condition for participation in federal health care programs and payment eligibility, not a determination of whether a specific service is covered or considered clinically appropriate. Early CoPs focused mainly on a hospital’s structure, such as its staffing, organization, facilities, and recordkeeping, rather than on how care should be delivered.⁵ This approach was intentional to allow hospitals with different resources, sizes, and community needs the flexibility to meet the standards in ways that made sense locally. In 1986, CMS updated the CoPs to further emphasize outcomes and performance, using broad expectations to require processes that ensure safety and quality rather than detailed, prescriptive rules, and explicitly aiming to “provide maximum flexibility” to hospitals.⁶

Today, the CoPs are organized into several sections that cover general requirements; hospital administration and patient rights; core hospital functions like nursing, pharmacy, infection control, and discharge planning; and standards for optional services such as surgical or obstetrical care. Hospitals aren’t required to provide "optional" services, but if they do, they must adhere to applicable CoPs. The CoPs address the required hospital services and optional services rather than limit or prohibit specific services or procedures. In practice, they serve as baseline health and safety standards that indicate whether a hospital is capable of providing quality care, rather than as rules that control clinical decision making.

Hospital CoPs Dictate the Context in Which People Get Care, Not the Specific Care They Receive

In a comprehensive review, we did not identify Medicare CoPs for hospitals that limit or prohibit hospitals from furnishing certain services or procedures. In every instance, CoPs have been used

⁴ 42 C.F.R. § 482.25

⁵ National Academies, Institute of Medicine, Medicare: A Strategy for Quality Assurance: Volume 1, 1990, <https://www.ncbi.nlm.nih.gov/books/NBK235462/>, p. 121.

⁶ Health Care Financing Administration (HCFA), “Medicare and Medicaid Programs; Conditions of Participation for Hospitals,” 51 Federal Register 22010, June 17, 1986, <https://www.federalregister.gov/citation/51-FR-22042>, specifically p. 22010, https://archives.federalregister.gov/issue_slice/1986/6/17/22007-22052.pdf#page=4.

to improve the safety of medical care, not to prohibit the delivery of a particular treatment or service for a particular patient. CoPs establish institution-wide requirements to ensure a safe environment for care delivery, not to displace clinicians' independent medical judgment or regulate how providers make treatment decisions for patients, including those who receive care outside of the Medicare and Medicaid programs, as this NPRM proposes.

If the proposed rule is finalized, hospitals would be required to certify to CMS that they will not provide treatment for gender dysphoria to receive reimbursement under Medicare and Medicaid. This is an unprecedented use of CoPs to drive a political agenda that is not rooted in science or evidence. It is highly inappropriate to use CoPs to override medical consensus, interfere with the doctor-patient relationship, and weaponize and restrict access to health care to drive forward a social agenda.

Clinical decisions are governed by professional standards of care, state licensure, informed consent, and the treating provider's judgment based on an individual patient's circumstances. The proposed rule would eliminate individualized clinical assessment and replace it with a federal prohibition on decisions that have always resided within the doctor-patient relationship.

The proposed rule would also intrude into hospital operations in a manner inconsistent with the Medicare statute. Unlike existing CoPs, which afford hospitals flexibility in meeting regulatory requirements, this rule would directly dictate which services hospitals may offer. That level of control is inconsistent with federal statute and CMS's traditional regulatory role.

The Medicare statute prohibits "any federal officer or employee from exercising any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."⁷ This is commonly known as the "non-interference in the practice of medicine" requirement and embodies Congress' recognition that states – not the federal government – typically regulate the medical professions, including physicians, through licensing or other forms of recognition. The proposed CoP violates this fundamental statutory guardrail by attempting to dictate the care that hospitals can or cannot provide to patients, undermining state licensing authority, and directly regulating clinical practice.

Hospital COPs Should Not Restrict Access to Care. They Should Provide It.

Using the Medicare CoPs for hospitals to restrict access to treatment for gender dysphoria would be a blunt and inappropriate instrument, unsupported by evidence and inconsistent with the purpose and design of the CoPs.

CMS asserts that treatment for pediatric gender dysphoria is unsafe or insufficiently studied, however, decades of evidence do not support this conclusion. About 700,000 adolescents ages 13 to 17 in the U.S. identify as transgender.⁸ An even smaller subset of this population experiences gender dysphoria; approximately 0.08% of youth ages 6 to 17 experience clinically significant

⁷ SSA § 1801 [42 U.S.C. § 1395].

⁸ Jody L. Herman & Andrew R. Flores, *How Many Adults and Youth Identify as Transgender in the United States?* Williams Institute, UCLA School of Law (Aug. 2025), <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>.

gender dysphoria requiring medically necessary treatment.⁹ Gender dysphoria is a medically recognized condition characterized by clinically significant distress or impairment resulting from incongruence between one's gender identity and assigned sex. Gender dysphoria has been acknowledged by the medical community for more than half a century¹⁰ and formally classified in the Diagnostic and Statistical Manual of Mental Disorders for 45 years.

Left untreated, gender dysphoria is associated with markedly elevated rates of depression, anxiety, self-harm, and suicidality, especially among adolescents. Youth with gender dysphoria-related diagnoses are hospitalized for suicide attempts or self-harm at dramatically higher rates than their peers.¹¹ Studies further show that transgender people who are unable to access needed care face significantly higher levels of mental distress and suicide attempts.¹²

By contrast, access to evidence-based treatment for gender dysphoria is consistently associated with improved mental health outcomes. Transgender and nonbinary youth who receive puberty blockers or hormones experience a significant reduction in depression and suicidality over the following 12 months.¹³ Peer-reviewed studies further show that receipt of hormone therapy was associated with lower prevalence of depression, suicidal thoughts, and suicide attempts,¹⁴ and that adults who had access to puberty-suppression treatment in adolescence showed significantly lower lifetime suicidal ideation than those who wanted but could not access such care.¹⁵

These clinical findings are reinforced by comprehensive systematic reviews of the peer-reviewed medical literature, which consistently conclude that treatment for gender dysphoria is safe, effective, and associated with improvements in overall well-being, with no credible evidence of harm.¹⁶ Even more recently, a rigorous two-year systematic review conducted by experts at the University of Utah concluded that hormone therapy is safe and effective for transgender youth and that high-quality clinical guidelines exist to support pediatric care.¹⁷

The harms of denying coverage for medically-necessary treatment for gender dysphoria are therefore sadly predictable: increased psychological distress, more emergency mental-health crises, heightened risk of self-harm or suicide attempts, and avoidable suffering for a population already facing discrimination and disproportionate barriers to care. CMS cannot plausibly claim

⁹ Komodo Health, Inc. (2023). Prevalence of gender dysphoria diagnoses among U.S. youth, 2017–2021. (Summarized in Reuters investigative report). <https://www.reuters.com/investigates/special-report/usa-transyouth-data/>

¹⁰ Koh J. The history of the concept of gender identity disorder. *Seishin Shinkeigaku Zasshi*. 2012;114(6):673-80. Japanese. PMID: 22844818.

¹¹ Mitchell, H. K., et al. "Prevalence of gender dysphoria and suicidality and self-harm in a national database of pediatric inpatients in the USA: a population-based serial cross-sectional study." *The Lancet Child & Adolescent Health* (2022).

¹² Herman, J. L., & O'Neill, K. K. *Suicide Risk and Prevention for Transgender People: Summary of Research Findings*. Williams Institute, UCLA School of Law (2021).

¹³ Tordoff, D. M., et al. "Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care." *JAMA Network Open* 5(2): e220978 (2022).

¹⁴ Green, A. E., et al. "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 (2022).

¹⁵ Turban, J. L., et al. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." *Pediatrics* 145(2): e20191725 (2020).

¹⁶ What We Know Project, Cornell University, "What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?" (online literature review), 2018. <https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/>

¹⁷ Utah Department of Health and Human Services. (2024). *Review of medical evidence and best practices for the treatment of gender dysphoria in minors*. <https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636>

ignorance of these consequences. The elevated risk of suicide and self-harm among transgender youth denied medically-necessary care is not speculative, nor is it a conspiracy; it is well-documented in the medical literature and acknowledged by leading professional organizations. Finalizing a rule that knowingly limits coverage for – and essentially withholds – effective treatment from a population at high risk of suicide would represent a *profound departure* from CMS’s obligation to protect vulnerable beneficiaries and prevent avoidable harm.

As emphasized earlier, the Medicare statute prohibits federal officials from exercising supervision or control over the practice of medicine or the manner in which medical services are provided.¹⁸ In its proposed rule, CMS tries to assert that treatment for gender dysphoria in minors is “not healthcare.” This assertion is wholly inconsistent with the overwhelming consensus of specialized medical and mental health professionals. Every major U.S. medical and mental health organization,¹⁹ including the American Academy of Pediatrics,²⁰ the American Medical Association,²¹ the American College of Obstetricians and Gynecologists,²² the American Psychological Association,²³ and the American Academy of Family Physicians,²⁴ recognizes gender-affirming care as safe, effective, and medically necessary for treating gender dysphoria. These standards are grounded in decades of peer-reviewed evidence demonstrating that this treatment reduces depression, anxiety, and suicidality and improves overall quality of life. The proposed rule would therefore place CMS in direct opposition to every major U.S. medical organization and substitute partisan ideology for established clinical evidence and judgment—an extraordinary departure from evidence-based health policy and the administration of federal programs.

In the NPRM, CMS neither engages with nor rebuts the extensive peer-reviewed literature demonstrating that access to treatment for gender dysphoria improves mental health outcomes, despite claiming to have considered all evidence-based benefits and harms. Instead, the NPRM relies on the same ideological framework reflected in President Trump’s Executive Order 14187, “*Protecting Children From Chemical and Surgical Mutilation*,”²⁵ and the subsequent non-scientific report published by the U.S. Department of Health and Human Services, which, as directed by the Executive Order, asserted that gender-affirming care for minors carries significant risks and harms.²⁶ That HHS report has been widely discredited for mischaracterizing

¹⁸ https://www.ssa.gov/OP_Home/ssact/title18/1801.htm

¹⁹ U.S. House Committee on Education and the Workforce. (2024, May). *Professional organizations’ position statements on care for transgender people* (Hearing transcript). U.S. Government Publishing Office. <https://docs.house.gov/meetings/ED/ED00/20240515/117232/HHRG-118-ED00-20240515-SD002.pdf>

²⁰ Alyson Sulaski Wyckoff, “AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update,” *AAP News* (Aug. 4, 2023), <https://publications.aap.org/aapnews/news/25340>.

²¹ Board of Trustees, *American Medical Association*, “[Clarification of Evidence-Based Gender-Affirming Care H-185.927](#),” (Last Modified and Reaffirmed 2024).

²² Committee on Gynecologic Practice and Committee on Health Care for Underserved Women, *The American College of Obstetricians and Gynecologists*, “[Health Care for Transgender and Gender Diverse Individuals](#),” Comm. Op. No. 823 (Mar. 2021, Reaffirmed 2024).

²³ APA Council of Representatives, *American Psychological Association*, “[APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science](#),” (Feb. 2024).

²⁴ Congress of Delegates, *The American Academy of Family Physicians*, “[Care for Transgender and Gender Nonbinary Patient](#),” (Sept. 2024).

²⁵ [Exec. Order No. 14187](#), 90 F.R. 8771 (Jan. 28, 2025).

²⁶ Department of Health and Human Services, “[Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices](#),” (May 1, 2025).

the scientific literature, disregarding clinical evidence, selectively citing case reports, and substituting ideology for medical judgment.²⁷ Specifically, an *authentically* peer-reviewed scientific appraisal in the Journal of Adolescent Health identified substantial problems with the HHS report’s scientific rigor and treatment of evidence—raising concerns that the report departs from accepted standards for evidence synthesis and mischaracterizes the clinical literature and standard of care.²⁸ Among the “evidence” the HHS report cites to support the report’s pre-determined conclusion is the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology.²⁹ Yet the Administration ignores, both in the report and NPRMs, that the researcher who developed the GRADE methodology, Dr. Gordon Guyatt, explicitly condemned the misuse of GRADE to justify restricting gender-affirming care, calling it “egregious and unconscionable.”³⁰ Many accepted pediatric medical interventions have similar levels of evidence, yet CMS has not proposed categorical bans on those treatments.³¹

In addition, the HHS report discounts the clinical guidelines and standards endorsed by major U.S. medical organizations while offering no persuasive scientific basis for deeming those guidelines “untrustworthy.” The American Academy of Pediatrics has stated that the report does not reflect the prevailing medical consensus or the realities of pediatric clinical practice.³² Concerns have also been raised regarding the report’s transparency and independence, including the presence of authors with documented ideological or financial conflicts of interest.³³

Even the “peer-review” process conducted and published by HHS reveals serious flaws in the report on which CMS relies.³⁴ For example, the American Psychiatric Association concluded that the report lacks sufficient transparency, fails to clearly explain how evidence was selected and evaluated, and does not meet the methodological standards required to guide clinical policy. Notably, reviewers criticized the report for failing to meaningfully assess the documented harms of withholding care—while emphasizing speculative harms of treatment—and for advancing conclusions that appear predetermined by Executive Order 14187 rather than derived from an impartial evaluation of the evidence. Far from validating the report, the peer-review record underscores that it is an inadequate and inappropriate foundation for a nationwide coverage ban.

²⁷ American Academy of Pediatrics. (2025, February). *AAP statement on HHS report on treatment for pediatric gender dysphoria*. <https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/>

²⁸ Dowshen, N., et al., *A Critical Scientific Appraisal of the U.S. Department of Health and Human Services Report on the Treatment of Pediatric Gender Dysphoria*, Journal of Adolescent Health (2025), [https://www.jahonline.org/article/S1054-139X\(25\)00246-0/fulltext](https://www.jahonline.org/article/S1054-139X(25)00246-0/fulltext).

²⁹ See 90 FR 59463, at 59468. See also 90 FR 59441, at 59446.

³⁰ Theresa Gaffney, Author of reviews of gender affirming care decries ‘egregious misuse’ of the findings to justify bans, STAT News (Sept. 22, 2025), <https://www.statnews.com/2025/09/22/evidence-based-medicine-gender-affirming-care-gordon-guyatt/>

³¹ Jennifer L Hudson et al., Interventions for Young Children’s Mental Health: A Review of Reviews. Clin Child Fam Psychol RE

³² American Academy of Pediatrics. (2025, February). *AAP statement on HHS report on treatment for pediatric gender dysphoria*. <https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/>

³³ Kekatos, M., (2025, November 20). HHS finalizes report on gender-affirming care for youth, medical groups push back. ABC News. <https://abcnews.go.com/Health/hhs-finalizes-report-gender-affirming-care-youth-medical/story?id=127685179>

³⁴ U.S. Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices—Peer Review Supplement* (Nov. 2025), <https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-supplement.pdf>.

By rejecting the guidance of every major U.S. medical organization and elevating a poorly-executed and politically-directed report over established clinical standards, CMS attempts to dictate medical practice—replacing individualized, collaborative, and evidence-based care with ideological decree.

The NPRM will Result in Clear Harms for Patients and Negative Impacts for the Health System

In its proposed rule, CMS estimates that nearly 10,000 transgender youth live in states where treatment for gender dysphoria remains lawful and are currently receiving care that would be affected by the proposed rule. CMS further estimates that approximately half of those receiving care in hospital settings would discontinue treatment entirely if the rule were finalized. However, this estimate significantly understates the likely impact. Nearly all hospitals participate in the Medicare program and therefore comply with the CoPs. As a result, hospitals would have little practical choice but to cease providing this care altogether, cutting off access for minors currently receiving treatment for gender dysphoria in hospital settings.

CMS does not adequately assess or acknowledge the consequences of patients losing access to care as a result of this proposed rule. As discussed above, untreated gender dysphoria is associated with increased risk of depression, anxiety, suicidality, substance use disorder, and other adverse health outcomes. This will lead to higher long-term health care costs for taxpayers and the Medicare and Medicaid programs.³⁵

CMS Must Withdraw the NPRM

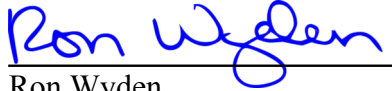
For nearly six decades, the CoPs have set baseline health and safety standards focused on hospital capacity, governance, and operational readiness. CMS has consistently refined or added new CoPs to ensure patient safety and quality of care while preserving flexibility for hospitals and respecting the statutory prohibition on federal interference in the practice of medicine. The proposed rule represents a dangerous and unprecedented departure from that history and intent.

Using the CoPs to restrict access to medically appropriate treatment for minors with gender dysphoria would override clinical judgment and deny evidence-based care to a vulnerable population. This proposed rule will cause harm to patients while imposing significant burdens on providers. These outcomes are inconsistent with the purpose of the CoPs.

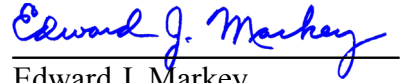
We strongly oppose this NPRM and any effort to restrict access to medically-necessary treatment for gender dysphoria. Gender-affirming care, when provided by qualified clinicians, is supported by decades of medical evidence and professional consensus, and denying access to such care will exacerbate mental health crises among transgender youth, with potentially fatal consequences. CMS should not repurpose a health and safety regulatory framework to advance a policy that is unsupported by evidence, inconsistent with Medicare statute, and contrary to the agency's obligation to protect beneficiaries from harm. For these reasons, we urge CMS to withdraw the proposed rule.

³⁵ Turban et al., *Access to Gender-Affirming Hormones and Mental Health Outcomes*, *American Journal of Preventive Medicine* (2022).

Sincerely,



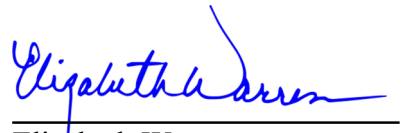
Ron Wyden
United States Senator
Ranking Member, Committee
on Finance



Edward J. Markey
United States Senator



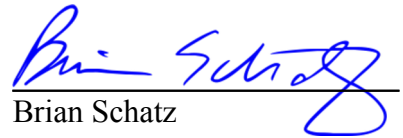
Jeffrey A. Merkley
United States Senator



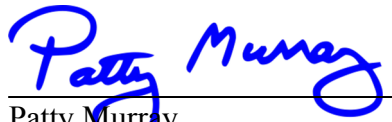
Elizabeth Warren
United States Senator



Tammy Baldwin
United States Senator



Brian Schatz
United States Senator



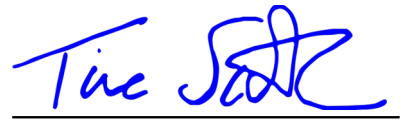
Patty Murray
United States Senator



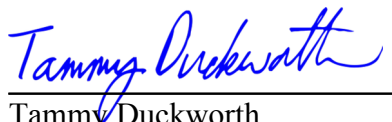
Mazie K. Hirono
United States Senator



Adam B. Schiff
United States Senator



Tina Smith
United States Senator



Tammy Duckworth
United States Senator

United States Senate

WASHINGTON, DC 20510

February 17, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2451-P

Dear Administrator Oz,

We write to express grave concern regarding the administration's notice of proposed rulemaking (NPRM) that would restrict or prohibit the use of federal Medicaid funds for the coverage of gender-affirming care in state Medicaid programs and the Children's Health Insurance Program (CHIP). Proposed rule CMS-2451-P would result in significant disruption and severe limits on coverage of evidence-based medical treatments for gender dysphoria—including puberty blockers, hormone therapy, and gender-affirming surgeries—for both children under age 18 enrolled in Medicaid and under age 19 enrolled in CHIP.

If finalized, this rule would mark an unprecedented intrusion of partisan politics and ideology into medical decision-making and a direct violation of long-standing statute and clinical standards of care. In proposing this rule, CMS moves beyond its traditional role as an administrator of health coverage and into the role of a national arbiter of the practice of medicine—displacing the judgment, experience, and expertise of physicians, patients, families, and states in favor of a one-size-fits-all federal mandate that lacks an evidence base. This approach is fundamentally inconsistent with Congress's clear directive in Section 1801 of the Medicare statute, which expressly prohibits federal officials from exercising supervision or control over the practice of medicine or the manner in which medical services are provided.¹ Such an approach represents a sharp departure from long-standing principles of limited federal interference in medical decision-making and the primacy of state regulation of the practice of medicine.

Prevalence of Transgender Identity & Gender Dysphoria

Transgender people—those whose gender identity differs from the sex assigned to them at birth—make up less than 1% of the U.S. population, including roughly 700,000 adolescents ages 13 to 17.² An even smaller subset of this population, approximately 0.08% of youth ages 6 to 17, experiences clinically significant gender dysphoria requiring medically-necessary treatment.³ Gender dysphoria is a medically-recognized condition characterized by clinically significant

¹ 42 U.S.C. § 1395 (Medicare Act § 1801)

² Jody L. Herman & Andrew R. Flores, *How Many Adults and Youth Identify as Transgender in the United States?* Williams Institute, UCLA School of Law (Aug. 2025), <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>.

³ Komodo Health, Inc. (2023). *Prevalence of gender dysphoria diagnoses among U.S. youth, 2017–2021*. (Summarized in Reuters investigative report). <https://www.reuters.com/investigates/special-report/usa-transyouth-data/>

distress or impairment resulting from incongruence between one's gender identity and assigned sex.⁴ Gender dysphoria has been acknowledged by the medical community for more than half a century,⁵ and formally classified in the Diagnostic and Statistical Manual of Mental Disorders for 45 years.

Risks of Untreated Gender Dysphoria and Benefits of Treatment to Resolve Gender Dysphoria

Left untreated, gender dysphoria is associated with markedly elevated rates of depression, anxiety, self-harm, and suicidality, particularly among adolescents. Youth with gender-dysphoria-related diagnoses are hospitalized for suicide attempts or self-harm at dramatically higher rates than their peers.⁶ Studies further show that transgender people who are unable to access needed care face significantly higher levels of mental distress and suicide attempts.⁷

By contrast, access to evidence-based treatment for gender dysphoria is consistently associated with improved mental health outcomes. Transgender and nonbinary youth who receive puberty blockers or hormones experience significant reductions in depression and suicidality over the following 12 months.⁸ Peer-reviewed studies further show that receipt of hormone therapy is associated with lower prevalence of depression, suicidal thoughts, and suicide attempts,⁹ and that adults who had access to puberty-suppression treatment during adolescence report significantly lower lifetime suicidal ideation than those who wanted but could not access such care.¹⁰

These clinical findings are reinforced by comprehensive systematic reviews of the peer-reviewed medical literature, which consistently conclude that treatment for gender dysphoria is safe, effective, and associated with improvements in overall well-being, with no credible evidence of harm.¹¹ Even more recently, a rigorous two-year systematic review conducted by experts at the University of Utah concluded that hormone therapy is safe and effective for transgender youth and that high-quality clinical guidelines exist to support pediatric care.¹²

The harms of denying coverage for medically-necessary treatment for gender dysphoria are therefore sadly predictable: increased psychological distress, more emergency mental-health crises, heightened risk of self-harm and suicide attempts, and avoidable suffering for a

⁴ American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.; DSM-5-TR). <https://doi.org/10.1176/appi.books.9780890425787>

⁵ Koh J. The history of the concept of gender identity disorder. *Seishin Shinkeigaku Zasshi*. 2012;114(6):673-80. Japanese. PMID: 22844818.

⁶ Mitchell, H. K., et al. "Prevalence of gender dysphoria and suicidality and self-harm in a national database of pediatric inpatients in the USA: a population-based serial cross-sectional study." *The Lancet Child & Adolescent Health* (2022).

⁷ Herman, J. L., & O'Neill, K. K. *Suicide Risk and Prevention for Transgender People: Summary of Research Findings*. Williams Institute, UCLA School of Law (2021).

⁸ Tordoff, D. M., et al. "Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care." *JAMA Network Open* 5(2): e220978 (2022).

⁹ Green, A. E., et al. "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 (2022).

¹⁰ Turban, J. L., et al. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." *Pediatrics* 145(2): e20191725 (2020).

¹¹ What We Know Project, Cornell University, "What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?" (online literature review), 2018. <https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/>

¹² Utah Department of Health and Human Services. (2024). *Review of medical evidence and best practices for the treatment of gender dysphoria in minors*. <https://le.utah.gov/AgencyRP/reportingDetail.jsp?rid=636>

population already facing discrimination and disproportionate barriers to care.¹³ CMS cannot plausibly claim ignorance of these consequences. The elevated risk of suicide and self-harm among transgender youth denied medically-necessary care is not speculative, nor is it a conspiracy; it is well-documented in the medical literature and acknowledged by leading professional organizations. Finalizing a rule that knowingly limits coverage for – and essentially withholds – effective treatment from a population at high risk of suicide would represent a *profound departure* from CMS’s obligation to protect vulnerable beneficiaries, prevent avoidable harm, and administer Medicaid and CHIP in compliance with federal law. Finalizing the proposed rule would substitute the federal government’s judgment for that of medical professionals who are ethically and professionally trained and obligated to act in their patients’ best interests, in consultation with the patients themselves and their families.

CMS Departure from Medical Consensus and Evidence-Based Standards of Care

Despite this extensive and consistent body of evidence, the proposed rule departs sharply from established medical consensus. Every major U.S. medical and mental health organization¹⁴—including the American Academy of Pediatrics,¹⁵ the American Medical Association,¹⁶ the American College of Obstetricians and Gynecologists,¹⁷ the American Psychological Association,¹⁸ and the American Academy of Family Physicians¹⁹—recognizes gender-affirming care as safe, effective, and medically-necessary for treating gender dysphoria. These standards are grounded in decades of peer-reviewed evidence demonstrating that this treatment reduces depression, anxiety, and suicidality and improves overall quality of life. The proposed rule would therefore place CMS in *direct opposition* to every major U.S. medical organization and substitute partisan ideology for established clinical evidence and judgement—an extraordinary departure from evidence-based health policy and the administration of federal programs.

In the NPRM, CMS neither engages with nor rebuts the extensive peer-reviewed literature demonstrating that access to treatment for gender dysphoria improves mental-health outcomes, despite claiming to have considered all evidence-based benefits and harms. Instead, the NPRM relies on—and advances—the same ideological framework reflected in President Trump’s

Executive Order 14187, “*Protecting Children From Chemical and Surgical Mutilation*,”²⁰ and the subsequent non-scientific report published by the U.S. Department of Health and Human

¹³ Macedo, D., et al. “Self-harm and suicidality among trans and gender diverse people: A systematic review.” *International Journal of Mental Health Nursing* (2024).

¹⁴ U.S. House Committee on Education and the Workforce. (2024, May). *Professional organizations’ position statements on care for transgender people* (Hearing transcript). U.S. Government Publishing Office. <https://docs.house.gov/meetings/ED/ED00/20240515/117232/HHRG-118-ED00-20240515-SD002.pdf>

¹⁵ Alyson Sulaski Wyckoff, “AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update,” *AAP News* (Aug. 4, 2023), <https://publications.aap.org/aapnews/news/25340>.

¹⁶ Board of Trustees, *American Medical Association*, “[Clarification of Evidence-Based Gender-Affirming Care H-185.927](#),” (Last Modified and Reaffirmed 2024).

¹⁷ Committee on Gynecologic Practice and Committee on Health Care for Underserved Women, *The American College of Obstetricians and Gynecologists*, “[Health Care for Transgender and Gender Diverse Individuals](#),” Comm. Op. No. 823 (Mar. 2021, Reaffirmed 2024).

¹⁸ APA Council of Representatives, *American Psychological Association*, “[APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science](#),” (Feb. 2024).

¹⁹ Congress of Delegates, *The American Academy of Family Physicians*, “[Care for Transgender and Gender Nonbinary Patient](#),” (Sept. 2024).

²⁰ [Exec. Order No. 14187](#), 90 F.R. 8771 (Jan. 28, 2025).

Services (HHS), which, as directed by the Executive Order, asserted that gender-affirming care for minors carries significant risks and harms.²¹ That HHS report has been explicitly criticized by medical experts and peer-reviewed scientific commentary for violating basic norms of evidence synthesis, mischaracterizing the existing literature, selectively emphasizing isolated case reports over population-based data, and discounting established clinical guidelines without scientific justification. Specifically, an *authentically* peer-reviewed scientific appraisal in the Journal of Adolescent Health identified substantial problems with the HHS report’s scientific rigor and treatment of evidence—raising concerns that the report departs from accepted standards for evidence synthesis and mischaracterizes the clinical literature and standard of care.²² Among the “evidence” the HHS report cites to support its pre-determined conclusion is the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology.²³ Yet, the Administration ignores, both in the Report and NPRMs, that the researcher who developed the GRADE methodology, Dr. Gordon Guyatt, explicitly condemned the misuse of GRADE to justify restricting gender-affirming care, calling it “egregious and unconscionable.”²⁴ Many accepted pediatric medical interventions have similar levels of evidence, yet CMS has not proposed categorical bans on those treatments.²⁵

In addition, the HHS report discounts the clinical guidelines and standards endorsed by major U.S. medical organizations while offering no persuasive scientific basis for deeming those guidelines “untrustworthy.” The American Academy of Pediatrics has stated that the report does not reflect the prevailing medical consensus or the realities of pediatric clinical practice.²⁶ Concerns have also been raised regarding the report’s transparency and independence, including the presence of authors with documented ideological or financial conflicts of interest.²⁷

Even the “peer-review” process conducted and published by HHS reveals serious flaws in the report on which CMS relies.²⁸ For example, the American Psychiatric Association concluded that the report lacks sufficient transparency, fails to clearly explain how evidence was selected and evaluated, and does not meet the methodological standards required to guide clinical policy. Notably, reviewers criticized the report for failing to meaningfully assess the documented harms of withholding care—while emphasizing speculative harms of treatment—and for advancing conclusions that appear predetermined by Executive Order 14187 rather than derived from an

²¹ Department of Health and Human Services, “[Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices](#),” (May 1, 2025).

²² Dowshen, N., et al., *A Critical Scientific Appraisal of the U.S. Department of Health and Human Services Report on the Treatment of Pediatric Gender Dysphoria*, Journal of Adolescent Health (2025), [https://www.jahonline.org/article/S1054-139X\(25\)00246-0/fulltext](https://www.jahonline.org/article/S1054-139X(25)00246-0/fulltext).

²³ See 90 FR 59463, at 59468. See also 90 FR 59441, at 59446.

²⁴ Theresa Gaffney, *Author of reviews of gender affirming care decries ‘egregious misuse’ of the findings to justify bans*, STAT News (Sept. 22, 2025), <https://www.statnews.com/2025/09/22/evidence-based-medicine-gender-affirming-care-gordon-guyatt/>.

²⁵ See, e.g., Jennifer L Hudson et al., *Interventions for Young Children's Mental Health: A Review of Reviews*. Clin Child Fam

²⁶ American Academy of Pediatrics. (2025, February). *AAP statement on HHS report on treatment for pediatric gender dysphoria*. <https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/>

²⁷ Kekatos, M., (2025, November 20). HHS finalizes report on gender-affirming care for youth, medical groups push back. *ABC News*. <https://abcnews.go.com/Health/hhs-finalizes-report-gender-affirming-care-youth-medical/story?id=127685179>

²⁸ U.S. Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices—Peer Review Supplement* (Nov. 2025), <https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-supplement.pdf>.

impartial evaluation of the evidence. Far from validating the report, the peer-review record underscores that it is an inadequate and inappropriate foundation for a nationwide coverage ban.

By rejecting the guidance of every major U.S. medical organization and elevating a poorly-executed and politically-directed report over established clinical standards, CMS attempts to dictate medical practice—replacing individualized, collaborative, and evidence-based care with ideological decree.

This proposed rule does not exist in isolation. It is part of a broader, coordinated effort across multiple federal agencies, including HHS and the U.S. Department of Justice, to discourage or prevent providers from offering medically-necessary care for transgender youth. This includes actions by the Secretary,²⁹ the Office for Civil Rights,³⁰ and other HHS components taken expressly to carry out Executive Order 14187. This context further underscores that the proposed rule reflects a predetermined ideological objective rather than a neutral, evidence-based reassessment of Medicaid and CHIP policy.

Taken together, these actions reflect an unprecedented effort by the federal government to centrally control medical decision-making for a specific population—using funding threats, regulatory pressure, and administrative declarations to override clinicians and intimidate patients and providers. The federal government should not be exercising control over the private decisions of American families and their health care providers.

Conflicts Between the NPRM and Federal Medicaid Requirements

The proposed rule introduces a first-of-its-kind definition of “sex” in Medicaid regulation and would severely limit coverage of a wide range of medically-necessary care for transgender youth while allowing those same services, such as puberty blockers, to address other conditions like precocious puberty. This selective and discriminatory approach underscores the rule’s true intent: to target transgender Americans, not to promote sound policy.

As you know, federal Medicaid law requires that states provide medically-necessary care to all categorically eligible beneficiaries on a comparable basis.³¹ Under Medicaid’s Comparability Provision, states are responsible for ensuring that services are furnished in sufficient amount, duration, and scope to reasonably achieve their purpose, and states may not deny a mandatory service solely because of the diagnosis, type of illness, or condition.³² The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit further requires states to cover medically-necessary services whether or not such services are covered under the State plan to correct or ameliorate a medical condition for enrollees under 21.³³ These statutory protections have repeatedly been interpreted by federal courts to include medically-necessary treatment for

²⁹ Kennedy, R. F., Jr., Secretary of the U.S. Department of Health and Human Services. (2025). *Declaration regarding pediatric sex-rejecting procedures*. U.S. Department of Health and Human Services. <https://www.hhs.gov/sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf>

³⁰ U.S. Department of Health and Human Services. (2025, December 19). *Nondiscrimination on the basis of disability in programs or activities receiving federal financial assistance*. *Federal Register*, 90, 59478–59483. <https://www.federalregister.gov/documents/2025/12/19/2025-23484/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial>

³¹ 1902(a)(10)(B).

³² 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)(17); 42 C.F.R. § 440.230.

³³ 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

gender dysphoria.³⁴ Denying coverage or limiting care based solely on a person's transgender status would therefore contradict the Medicaid statute, longstanding CMS policy, and the requirement that all medically-necessary care must be available to all qualified beneficiaries.³⁵

Medicaid has long rested on a balance between federal oversight and state administration, with clinical decisions left to licensed providers operating within state-regulated standards of care. The proposed rule upends this precedent by asserting federal control over medical judgments that Congress deliberately left to states and clinicians.

Anticipated Harms and Impacts of the Proposed Rule

The real-world harms of this policy would be devastating. The loss of federal Medicaid and CHIP funds for medically-necessary treatment for gender dysphoria would increase mental health crises and suicide attempts among transgender youth and adults,³⁶ while driving up uncompensated-care costs in emergency departments and behavioral-health systems. At the same time, the loss of these funds by definition targets low-income children and their families who will face much higher health care costs as a result - exacerbating the current health care affordability crisis faced by millions of families. Limiting access to medically-necessary care does not eliminate need; it shifts care into emergency and inpatient settings, where treatment is more costly, less effective, and often uncompensated. For Medicaid beneficiaries experiencing mental health crises, this predictable shift increases emergency department utilization and strains hospital systems while undermining both efficiency and patient outcomes. Yet, CMS did not even attempt to quantify, or otherwise grapple with, these direct harms to this vulnerable population.

Even in its proposed form, the rule has already contributed to a chilling effect, with some providers scaling back or discontinuing care in response to federal threats and uncertainty, forcing families to scramble for treatment or forgo care altogether.³⁷ This chilling effect is not incidental—it is the foreseeable consequence of a regulatory regime that uses federal authority and the threat of the loss of federal funds to pressure providers into abandoning lawful, medically-necessary care, even before any final rule has taken effect. The stark cost of this pressure will be the health, well-being, and lives of transgender Americans.

We urge CMS to withdraw this rule to ensure that state Medicaid and CHIP programs can continue to cover medically-necessary treatment for gender dysphoria, consistent with statutory requirements and medical standards of care. Protecting access to evidence-based medical care is not only a legal obligation but a moral imperative. Transgender people—like all Americans—deserve health care free from political interference. We demand that CMS rescind this NPRM that is already producing harm for vulnerable youth across the country.

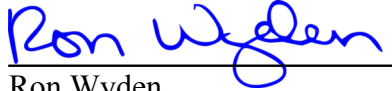
³⁴ See *Flack v. Wisc. Dept' of Health Servs.*, No. 18-cv-309-wmc (W.D. Wisc. Aug. 16, 2019); *Fain v. Crouch*, _ F. Supp. 3d __, 2022 WL 3051015 (S.D. W. Va. 2022).

³⁵ *Cruz v. Zucker*, 195 F. Supp. 3d 554, 570 (S.D.N.Y. 2016).

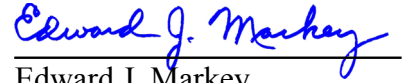
³⁶ Jody L. Herman & Kathryn K. O'Neill, *Suicide Risk and Prevention for Transgender People: Summary of Research Findings*, Williams Institute, UCLA School of Law (Sept. 2021), <https://williamsinstitute.law.ucla.edu/publications/trans-suicide-risk-prevention/>.

³⁷ Simmons-Duffin, S. (2025, August 1). *Gender-affirming health care for minors is becoming harder to get*. NPR. <https://www.npr.org/2025/08/01/nx-s1-5482866/gender-affirming-healthcare-for-minors-is-becoming-harder-to-get>

Sincerely,



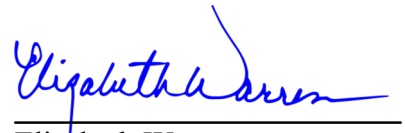
Ron Wyden
United States Senator
Ranking Member, Committee
on Finance



Edward J. Markey
United States Senator



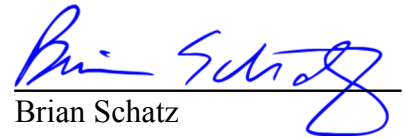
Jeffrey A. Merkley
United States Senator



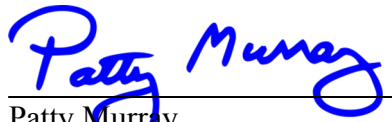
Elizabeth Warren
United States Senator



Tammy Baldwin
United States Senator



Brian Schatz
United States Senator



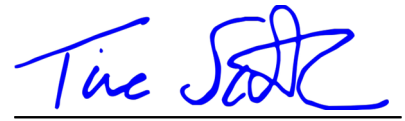
Patty Murray
United States Senator



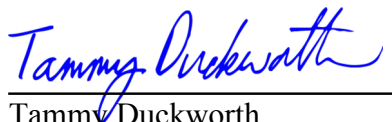
Mazie K. Hirono
United States Senator



Adam B. Schiff
United States Senator



Tina Smith
United States Senator



Tammy Duckworth
United States Senator