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MASSACHUSETTS

February 17, 2026

Submitted electronically via regulations.gov

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

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

RE: 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:

Health Law Advocates, Inc. (HLA) and Health Care For All (HCFA) submit this comment in strong opposition to the Centers for Medicare & Medicaid Services' (CMS) December 2025 Notice of Proposed Rulemaking (NPRM) entitled "Medicaid Program; Prohibition on Federal Medicaid Funding for Sex-Rejecting Procedures Furnished to Children." CMS's proposed rule, if finalized, would prohibit federal Medicaid and CHIP funding for gender-affirming care, including puberty-pausing medications, hormone therapy, and surgery-for transgender youth.[1] CMS lacks statutory authority for this rule. If finalized, the rule would also violate federal Medicaid law-including the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and comparability requirements. If finalized, the rule will be arbitrary and capricious and violate the Administrative Procedure Act. Finally, the rule will cause serious harms to transgender youth. We strongly urge CMS to withdraw this proposal.

HLA is a non-profit, public interest law firm headquartered in Boston that represents individuals with low incomes who face barriers to accessing health care and coverage. For the past 30 years, HLA has represented thousands of Massachusetts residents in cases involving access to necessary medical services, including those covered through private insurance and our state Medicaid system, as well as medical debt collections. While Massachusetts has made great progress toward improving access to health care and has achieved the highest rate of insurance coverage in the nation, HLA's work illustrates how gaps remain, especially among our most vulnerable residents.

[1] 90 Fed. Reg. 59441 (Dec. 19, 2025).

HCFA is Massachusetts' leading 501(c)(3) health care consumer advocacy organization. HCFA serves everyone in the Commonwealth, with a particular focus on those at the greatest risk of falling through the cracks of the current health care system including the uninsured, children, the elderly, immigrants, racial and ethnic minorities, and persons with disabilities. We provide direct service through our multilingual HelpLine, partner with community-based organizations on outreach and education campaigns, and advocate for systemic policy change.

This comment addresses the following issues:

1. CMS lacks statutory authority to impose this categorical coverage ban;

2. The rule, if finalized, is inconsistent with the EPSDT mandate;

3. The rule, if finalized, will violate Medicaid's comparability requirement;

4. The rule, if finalized, will be arbitrary and capricious in violation of the Administrative Procedure Act; and

5. The rule, if finalized, will cause serious harm.

I. CMS Lacks Statutory Authority to Impose This Rule

CMS cites three statutory provisions as authority for its proposal: Sections 1902(a)(19), 1902(a)(30)(A) and 2101 of the Social Security Act (the Act).[2] None authorizes what CMS proposes.

Sections 1902(a)(19) and 1902(a)(30)(A) require state Medicaid agencies to ensure that care is provided in the "best interest of recipients" and that payments are "consistent with efficiency, economy, and quality of care."[3] These provisions address Medicaid program administration and fiscal oversight; they do not authorize CMS to categorically exclude specific medical services from the Medicaid program.[4] That is Congress's job.

A federal administrative agency is not authorized to enact a categorial coverage ban on gender affirming care for transgender youth or any other care without express Congressional authority that is not present here. Without direct Congressional authority, CMS is attempting to rely on general provisions about Medicaid program administration and payment adequacy to prohibit coverage of medical services that are lawful under state law, consistent with professional medical standards, and determined to be medically necessary by treating physicians.[5] CMS has

[2] *Id.* at 59442-43.

[3] 42 U.S.C. §§ 1396a(a)(19), 1396a(a)(30)(A).

[4] The CHIP provision on which CMS relies similarly addresses program administration, not clinical service definitions. *See* 42 U.S.C. § 1397aa.

[5] State law governs the professional standard of care. States license physicians, define scope of practice, and set the standards by which clinical decisions are judged, typically informed by medical consensus, specialty guidelines, and peer-reviewed evidence. *Medtronic, Inc. v. Lohr,* 518 U.S. 470, 475 (1996). CMS cannot override these state-

never before relied on these provisions to exclude services that are lawful, professionally recommended, and medically necessary. CMS typically relies on section 1902(a)(19) in conjunction with other authorities to require state agencies to administer their Medicaid programs according to programmatic safeguards.[6] Section 1902(a)(30)(A) has historically been invoked in litigation over Medicaid payment rate adequacy – not to restrict categories of covered care.[7]

When Congress intends to restrict Medicaid funding for specific services, it does so expressly. The Hyde Amendment, which statutorily prohibits Medicaid funding for most abortions, is one of the limited examples of Congress exercising its authority to regulate health care in this way.[8] Even the example that CMS highlights in its proposal—the requirement in 42 CFR § 441.253 prohibiting federal payment for sterilizations for persons under age 21— is rooted in the clear statutory requirement in the definition of family planning services in section 1905(a)(4)(C) that such services are furnished to individuals "who desire such services and supplies."[9] The regulatory requirement at 42 CFR § 441.253 was promulgated in response to forced and coerced sterilization abuses, against the backdrop of significant litigation intended to ensure sterilization was voluntary, and after significant agency deliberation regarding capacity to give informed consent to sterilization.[10] CMS's authority and regulatory efforts to ban sterilization services for individuals under age 21 is distinguishable from CMS' instant proposal because the sterilization requirements could be traced directly back to Congress's statutory directive. In both these examples, CMS's policy relied on explicit Congressional authority that it does not have here.

Moreover, under the Spending Clause, any condition on federal funds "must be [stated] unambiguously."[11] The Social Security Act never mentions "sex-rejecting procedures" or gender-affirming care.[12] The vague administrative provisions that CMS invokes cannot satisfy the

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regulated clinical determinations through a regulatory reinterpretation of general statutory provisions designed for entirely different purposes.

[6] See, e.g., 42 CFR 441.331(describing the reporting requirements for States for section 1915(c) waiver programs, "under the authority at section 1902(a)(6) and (a)(19) of the Act").

[7] *See Armstrong v. Exceptional Child Care Ctr*., 135 S. Ct. 1378 (2015); *Douglas v. Indep. Living Ctr. of S. Cal., Inc*., 565 U.S. 606 (2012).

[8] *See* Hyde Amendment (prohibiting federal Medicaid funding for abortion except in limited circumstances).

[9] 42 U.S.C. 1396d(a)(4)(C).

[10] *See* 42 Fed. Reg. 62718, 62719 (Dec. 13, 1977), available at 62678-62855.pdf ("There is general agreement that at some age an individual-is so immature and his/her judgment so uninformed that it is reasonable to presume that he/she is incapable of giving informed consent, and that therefore his/her assent to be sterilized cannot be said to be "voluntary" within the meaning of the family planning statutes. Moreover, minors have in the past been subject to sterilization abuse, ...").

[11] *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

[12] The Social Security Act contains no reference to "sex-rejecting procedures" or gender-affirming care.

Spending Clause's clear-statement requirement and certainly fall short of giving CMS the authority to ban gender affirming care in Medicaid.

As a general matter of administrative law, federal agencies cannot issue regulations that exceed their delegated authority or contradict the governing statute.[13] Allowing CMS to rely on these provisions to exclude politically disfavored care not only violates this fundamental principle, but it would also set a dangerous precedent by permitting the agency to override state medical licensing laws and individualized medical judgments at will.

II. The Rule Violates the EPSDT Mandate

EPSDT is a robust coverage requirement that applies to Medicaid coverage for children under age 21.[14] It requires state Medicaid programs to cover all medically necessary services to "correct or ameliorate" physical or mental health conditions, regardless of whether those services are covered for adults.[15] As CMS's guidance makes clear, "[t]hese services must be covered 'whether or not such services are covered under the state plan.'"[16] Medical necessity determinations under EPSDT require individualized, case-by-case assessment of each child's particular needs, with longstanding deference to treating providers.[17]

CMS's blanket prohibition on federal funding for gender-affirming services directly contravenes the EPSDT mandate. The proposed rule states that the ban applies even "in circumstances in which a provider may determine that a sex-rejecting procedure is medically necessary for a child diagnosed with gender dysphoria."[18] This admission reveals the rule's fundamental conflict with EPSDT's requirements, which reserves medical necessity determinations to treating physicians, not federal administrative agencies.

The legislative history of EPSDT's authorizing statute reinforces this principle. The Senate report accompanying EPSDT's enactment 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."[19] CMS's own guidance affirms that

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[13] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024).

[14] Pub. L. 90-248 (Social Security Amendments of 1967). "The EPSDT requirements are a cornerstone of the Medicaid program and ensure robust health coverage for children. . . . The goal of EPSDT is to ensure that individual eligible children get the health care they need, when they need it, in the most appropriate setting." CMS, *Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* (2024).

[15] 42 U.S.C. §§ 1396a(a)(43), 1396d(r)(5).

[16] CMS, *Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* (2024).

[17] CMS, *EPSDT - A Guide for States* (2014); CMS, *Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements* (2024), *see also* S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 607 (5th Cir. 2004).

[18] 90 Fed. Reg. at 59451.

[19] S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986.

"both the state and a child's treating provider play a role in determining whether a service is medically necessary."[20] Nowhere does statute or guidance authorize CMS to supplant these determinations.

Finally, for decades courts have held that EPSDT prohibits states from imposing categorical exclusions that override individualized medical necessity determinations.[21] By extension, the federal government, which neither administers state Medicaid programs nor regulates the practice of medicine, certainly has no business engaging in this prohibited function without a clear Congressional directive.

III. The Rule Violates Medicaid's Comparability Requirement

Medicaid's comparability requirement mandates that medical assistance "shall not be less in amount, duration or scope" for any beneficiary compared to others.[22] Moreover, Medicaid agencies may not arbitrarily deny or decrease the amount, duration, or scope of a mandatory service solely because of a beneficiary's diagnosis, type of illness, or condition.[23] The proposed rule categorically prohibits transgender youth from receiving services like puberty-delaying medications, hormone treatments, and surgical procedures.[24] These exact procedures remain covered for other youth (i.e., cisgender youth) with other diagnoses, such as precocious puberty or differences of sex development. The only difference between those who can receive these services and those who cannot is that the transgender and gender expansive youth who this rule proposes to exclude have a medical diagnosis that is politically disfavored by some, including CMS.[25]

CMS claims this distinction is justified by differing evidence bases and risk-benefit profiles but provides no credible scientific support for this assertion. As discussed below, the documents CMS relies on have been widely criticized by medical experts. CMS itself acknowledges that systematic reviews "offer limited evidence regarding the harms" of these procedures.[26] Moreover, as discussed above, it is the states, not CMS that regulate the practice of

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[20] CMS, *EPSDT - A Guide for States* (2014).

[21] *See, e.g.*, *Q.H. v. Sunshine State Health Plan, Inc*., 307 So. 3d 1 (Fla. Dist. Ct. App. 2020); *Urban v. Meconi*, 930 A.2d 860 (Del. 2007); *C.F. v. Dep't of Child. & Fams*., 934 So. 2d 1 (Fla. Dist. Ct. App. 2005).

[22] 90 Fed. Reg. at 59444.

[23] 42 C.F.R. § 440.230(c).

[24] 90 Fed. Reg. at 59454-55.

[25] CMS attempts to rely on *United States v. Skrmetti*, 605 U.S. 495 (2025), which held that classifications based on age and medical use (but not the minor's sex) satisfy rational basis review under the Equal Protection Clause of the Fourteenth Amendment because "the law does not prohibit conduct for one sex that it permits for the other." CMS applies this reasoning to argue the proposed rule "would apply uniformly to all children regardless of the child's sex." 90 Fed. Reg. at 59451. The Equal Protection Clause has a different standard than Medicaid's comparability requirement, which specifically addresses discrimination based on "diagnosis, type of illness, or condition." In other words, the reliance on the Court's analysis in *Skrmetti* does not allow CMS to skirt Medicaid's comparability rules.

[26] 90 Fed. Reg. at 59444.

medicine; CMS lacks the authority to unilaterally declare that the risks of treatments licensed by state medical boards and provided by state-licensed physicians outweigh the medical benefits merely to avoid the Medicaid comparability requirements.[27] By singling out transgender youth and excluding medically necessary care solely based on diagnosis and patient identity, CMS creates an impermissible coverage disparity.

IV. The Rule Is Arbitrary and Capricious

The Administrative Procedure Act requires courts to invalidate agency action that is "arbitrary, capricious, [or] an abuse of discretion."[28] Agency action is arbitrary and capricious when it "entirely fail[s] to consider an important aspect of the problem," offers an explanation "that runs counter to the evidence," or "is so implausible that it could not be ascribed to a difference in view."[29] CMS's rule fails on all three grounds.

A. CMS Failed to Consider the Established Benefits and Safety of Gender-Affirming Care

CMS wrongly claims that "evidence on the benefits of medical and surgical interventions to improve mental health or reduce symptoms of gender dysphoria is lacking."[30] Decades of peer-reviewed research and clinical data contradict this assertion.

A 2018 comprehensive review by Cornell University researchers examined all peer-reviewed articles on transgender health care published between 1991 and 2017. The review found that gender transition-including transition-related care-improves well-being, with no study concluding that transition causes overall harm.[31] Reported benefits include improved quality of life, greater relationship satisfaction, higher self-esteem, and reductions in anxiety, depression, suicidality, and substance use.[32]

A 2024 systematic review by the University of Utah confirmed that hormone therapy is safe and effective for transgender youth.[33] A 2022 survey found that 98% of respondents who

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[27] *See Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (citation omitted) ([W]e start with the assumption that the historic police powers of the State were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.); see also *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 518 (1992) (courts are to construe statutes narrowly due to the presumption against the pre-emption of state police power regulations).

[28] 5 U.S.C. § 706(2)(A).

[29] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

[30] 90 Fed. Reg. at 59449.

[31] What We Know Project, Cornell University, *What does the scholarly research say about the effect of gender transition on transgender well-being?* (2018).

[32] *Id.*

[33] LaFleur, J., et al., *Gender-affirming medical treatments for pediatric patients with gender dysphoria*, Univ. of Utah Coll. of Pharmacy DRRC (2024).

received gender-affirming hormone therapy, and 97% who received surgery, reported being happier and more satisfied with their lives.[34]

Gender-affirming care significantly reduces suicidality. Multiple studies report that youth who wanted but did not receive hormone therapy had higher odds of suicidal ideation and attempts.[35] One study found that receiving gender-affirming care was "associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality."[36] Even controlling for psychiatric medication and counseling, hormone therapy is independently associated with reductions in depression and suicidal ideation.[37]

Physical health outcomes are also favorable. Research demonstrates normal bone density and ovarian function in young adults who received hormone therapy in childhood, with no notable height impacts.[38] Studies show no adverse effects on cognitive functioning, behavioral or social problems, or liver and creatinine levels.[39]

Satisfaction rates with transition-related care are exceptionally high. A systematic review found regret following gender-affirming surgery is less than 1%-significantly lower than regret rates for breast augmentation (5.1-9.1%), body contouring (10.8-33.3%), having children (7%), or getting a tattoo (16.2%).[40]

B. CMS Cherry-Picked Flawed Evidence

CMS relies primarily on two evidentiary documents to support its proposal: the HHS Report and the Cass Review.[41] Both have been widely criticized by medical experts for methodological errors and misrepresentation of evidence.

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[34] Rastogi, A., et al., *Health and wellbeing: A report of the 2022 U.S. Transgender Survey* 10-11 (2025).

[35] Green, A.E., et al., *Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide*, J. Adolescent Health 70(4), 643-649 (2022); Turban, J.L., et al., *Pubertal suppression for transgender youth and risk of suicidal ideation*, Pediatrics 145(2) (2020).

[36] Tordoff, D.M., et al., *Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care*, JAMA Network Open 5(2) (2022).

[37] Achille, C., et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths*, Int'l J. Pediatric Endocrinology (2020).

[38] Magiakou, M.A., et al., *The efficacy and safety of gonadotropin-releasing hormone analog treatment in childhood and adolescence*, J. Clinical Endocrinology & Metabolism 95(1), 109-117 (2010).

[39] Schagen, S.E.E., et al., *Efficacy and safety of gonadotropin-releasing hormone agonist treatment*, J. Sexual Medicine 13(7) (2016); Wojniusz, S., et al., *Cognitive, emotional, and psychosocial functioning of girls treated with pharmacological puberty blockage*, Frontiers in Psychology 7 (2016).

[40] Thornton, S.M., et al., *A systematic review of patient regret after surgery*, Am. J. Surgery 234, 68-73 (2024).

[41] 90 Fed. Reg. at 59443-44.

The HHS Report was initially released without author names and without peer review.[42] Medical experts publishing in the *Journal of Adolescent Health* documented its "violations of scientific norms, misrepresentation of scientific evidence, and mischaracterization of gender identity."[43] The authors found 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 . . . and it even states that evidence of harms is 'sparse.'"[44]

The Cass Review has similarly been criticized. Researchers identified "a high risk of bias in each of the systematic reviews driven by unexplained protocol deviations, ambiguous eligibility criteria, [and] inadequate study identification," along with "methodological flaws and unsubstantiated claims in the primary research."[45] Notably, none of the Cass Review's contributors have research or clinical experience in transgender health care.[46]

C. CMS's Rationale Is Internally Inconsistent

CMS asserts that these treatments are harmful or unsafe for transgender youth, yet permits the identical treatments for cisgender youth with precocious puberty or for intersex youth.[47] This distinction is arbitrary. If puberty-delaying medications and hormones were truly categorically unsafe, CMS could not plausibly permit their use for any pediatric population. Allowing federal funding for identical treatments based solely on diagnosis – with no scientific justification – constitutes arbitrary discrimination.

D. CMS Failed to Consider Reliance Interests

CMS proposes to upend longstanding policy without adequate consideration of reliance interests. Providers have structured staffing, training, and care models around the availability of federal funding for these services.[48] Families have relied on Medicaid coverage to access medically necessary care.

CMS dismisses these concerns with the conclusory statement that providers "have other avenues to continue to receive compensation."[49] It similarly tells affected families they "may

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[42] Jacobs, P., *Researchers slam HHS report on gender-affirming care for youth*, Science (May 2, 2025).

[43] Dowshen, N., et al., *A critical scientific appraisal of the HHS Report on Pediatric Gender Dysphoria*, J. Adolescent Health 77(3), 342-345 (2025).

[44] *Id.*

[45] Noone, C., et al., *Critically appraising the Cass Report: Methodological flaws and unsupported claims*, BMC Medical Research Methodology 25(1) (2025).

[46] McNamara, M., et al., *An Evidence-Based Critique of "The Cass Review"*, Yale Law School (2024).

[47] 90 Fed. Reg. at 59454-55.

[48] *See* Restar, A.J., et al., *The Public Health Crisis State of Transgender Health Care and Policy*, Am. J. Public Health 114(2), 161-163 (2024).

[49] 90 Fed. Reg. at 59448

look to obtain other health insurance or privately pay."[50] This ignores the economic reality of Medicaid beneficiaries, for whom alternative insurance is often unavailable. When changing longstanding policy, agencies must "grapple with" reliance interests, yet CMS has not done so.[51]

V. The Rule Will Cause Serious Health Harms

The evidence demonstrates that restricting access to gender-affirming care causes significant harm to transgender youth. State-level anti-transgender laws have been associated with significant increases in suicide attempts among transgender and nonbinary youth.[52] The United State Supreme Court highlighted in the first paragraph of its opinion in in *United States v. Skrmetti* that "[l]eft untreated, gender dysphoria may result in severe physical and psychological harms."[53] Even exposure to news about proposed restrictive legislation contributes to worsening mental and physical health outcomes.[54]

Transgender youth already face disproportionately high rates of depression, anxiety, suicidality, and psychiatric hospitalization compared to cisgender peers.[55] Denying evidence-based treatment will exacerbate these disparities. Nearly one in four gender-diverse young people report eating disorder symptoms; hormone therapy improves body image and associated mental health outcomes.[56]

All of HLA's minor clients who have sought gender-affirming care have experienced debilitating psychological anguish due to gender dysphoria. One HLA client had identified as the opposite gender since they were four-years-old, and made a full social transition, supported by their parents, during elementary school. In their late teens, they experienced barriers to getting gender-affirming care and wrote the following reflections:

> "While I feel that I have made great progress in managing my gender dysphoria, I fear that the stress and anxiety I am currently experiencing will cause me to get worse. The ongoing delay and uncertainty around receiving necessary medical services are triggering my feelings of loss of control, anxiety, depression and disillusionment. While I have strong support from my family and my therapist, I want to do whatever I can to limit my

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[50] *Id.* at 59449.

[51] *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 591 U.S. 1, 29 (2020).

[52] Lee, W.Y., et al., *State-level anti-transgender laws increase past-year suicide attempts*, Nature Human Behaviour 8(11), 2096-2106 (2024).

[53] *United States v. Skrmetti*, 605 U.S. 495 (2025).

[54] Dhanani, L.Y. & Totton, R.R., *The effects of exposure to news about recent transgender legislation*, Sexuality Research & Social Policy 20(4), 1345-1359 (2023).

[55] McKenna, J.L., et al., *Gender-affirming mental health care for transgender and gender diverse youth*, J. Am. Academy of Child & Adolescent Psychiatry 63(6), 576-580 (2024).

[56] Kerr, J.A., et al., *Prevalence of eating disorder symptoms in transgender and gender diverse adolescents*, J. Adolescent Health 74(4), 850-853 (2024); Becker, I., et al., *Multidimensional body image in adolescents and adults with gender dysphoria*, Archives of Sexual Behavior 47(8), 2335-2347 (2018).

> risk of having to endure this additional stress for an extended period of time. Also, with every passing day, I continue to suffer from gender dysphoria. My need to have my body align with my gender identity is real and intense…any delay in care is harmful for me."

This young person's experience is emblematic of the stories HLA has heard from our minor clients: inability to access gender-affirming care prescribed by their medical team and supported by their parents caused substantial psychological harm. Every single one of HLA's clients who have been able to receive gender-affirming care have reported improved psychological well-being and other positive differences in their lives. For example, one young client who HLA helped to access needed care, wrote:

> "At the time I first contacted HLA about my case, I could not have imagined how much my life would change for the better…the difference of where I am now and where I might be is vast, and owes much to the advocacy and conviction of folks like yourselves. From the bottom of my heart, thank you!"

In HLA's experience, access to needed gender-affirming care – helping people become who they know themselves to be – is crucial to ensuring people can fully participate in their communities and broader society. We have even seen access to gender-affirming care as a life-or-death proposition for some clients who have engaged in self-harm or attempted suicide when they were unable to live as the person they knew themselves to be. Access to gender-affirming care for young people can literally save lives.

The harms extend beyond individual patients. Providers may leave the Medicaid program rather than deny medically necessary care to their patients, reducing access to all health services-including diabetes management, thyroid treatment, and other endocrine care-for Medicaid beneficiaries broadly.[57] This effect will be particularly acute in rural areas already facing provider shortages.[58]

VI. Conclusion

HLA and HCFA vigorously oppose the Proposed Rule. CMS must withdraw the rule because the agency lacks statutory authority to impose it. If finalized, the rule would violate the EPSDT mandate and Medicaid's comparability requirements. The rule is arbitrary and capricious-based on cherry-picked, widely criticized evidence while ignoring decades of peer-reviewed research demonstrating safety and efficacy. It would also cause devastating harm to vulnerable youth and their families.

Please do not hesitate to contact us regarding any of the matters discussed above.

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[57] Endocrinologists who provide hormone therapy for transgender youth also treat diabetes, thyroid disorders, and other conditions. *See* Cleveland Clinic, *What is an endocrinologist?* (2025).

[58] *See* Euhus, R., et al., *5 Key Facts About Medicaid Coverage for People Living in Rural Areas*, KFF (June 26, 2025).

Respectfully submitted,

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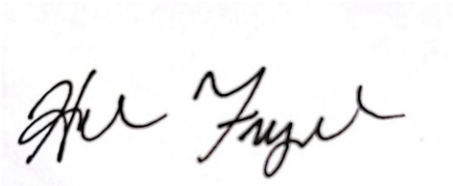

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