

February 16, 2026

Attn: Robert F. Kennedy Jr., Secretary of Health and Human Services and Dr. Mehmet Oz,
Administrator for the Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted Electronically via Regulations.gov

Re: RIN 0938-AV73; CMS-2451-P Medicaid Program; Prohibition on Federal Medicaid Funding for Sex Trait Modification Procedures Furnished to Children and Youth

I. Introduction

The Center for Reproductive Rights (“Center”) respectfully submits the following comment in strong opposition to the Proposed Rule of the Centers for Medicare & Medicaid Services (“CMS” or “the Agency”) within the Department of Health and Human Services (“HHS” or “the Department”) to ban the use of federal Medicaid and Children’s Health Insurance Program (“CHIP”) funds for gender-affirming care¹ for young people.²

Since 1992, the Center has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 33 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to lifesaving obstetric care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether to get married; where access to quality reproductive health care is guaranteed; and where everyone can make these decisions free from coercion or discrimination. Additionally, the Center recognizes these values as they apply to gender-affirming care, supporting a world in which people are free to make decisions regarding their own bodies and access the quality health care they deserve.

As an organization committed to advancing policies that uphold bodily autonomy, we strongly oppose this Proposed Rule. If finalized as drafted, the Proposed Rule would be a violation of the Administrative Procedure Act (“APA”) and undoubtedly result in harmful outcomes for transgender youth. Further, as the largest federal health insurance program in the United States, the Medicaid program sets the standard for what type of care is covered by private insurance companies (and therefore offered by providers), and thus has an enormous influence

¹ For purposes of this comment letter, gender-affirming care refers to hormone therapy, puberty blockers, and surgical interventions for transgender youth, which are excluded from coverage in the Proposed Rule.

² *Prohibition on Federal Medicaid and Children’s Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children*, 90 Fed. Reg. 59463 (proposed December 19, 2025).

over the country’s health care system. By prohibiting federal Medicaid funds for gender-affirming care, the Proposed Rule may create a domino effect whereby gender-affirming care is less available to all patients, regardless of payor. For these reasons, we urge CMS to rescind the Proposed Rule in its entirety.

II. The Proposed Rule violates the APA.

Despite the well-documented, reliable evidence of both the safety and efficacy of gender-affirming care and the harms that result when transgender youth cannot access such care, CMS issued this Proposed Rule on December 19, 2025, banning federal Medicaid and CHIP funding for gender-affirming care.³ However, the Agency’s authority to promulgate rules is not limitless. Rulemaking must be guided by the underlying statute, the APA, and a balancing of interests that satisfies basic standards of rationality.⁴ If finalized as proposed, the Agency’s rule would be arbitrary and capricious, violating the APA.

a. The Proposed Rule is arbitrary and capricious because it runs counter to the substantial body of reliable scientific evidence showing that gender-affirming care is essential, safe, and effective.

An agency action under the APA is “arbitrary and capricious” where it “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.”⁵ The Proposed Rule violates this standard because it: runs counter to credible, reliable, and rigorous evidence demonstrating that gender-affirming care is safe, effective, and essential; summarily dismisses that evidence; and reaches conclusions that are so implausible that they cannot be ascribed to a difference in view of medical evidence.

Multiple leading studies and medical organizations recognize the benefits that come from providing gender-affirming care to transgender youth as well as the harms associated when transgender youth are unable to access such care.⁶ For instance, in 2025, health care experts in Utah submitted to the Utah Department of Health and Human Services a report entitled “Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria” (“Utah Report”).⁷ This report began as a result of the Utah legislature passing a ban on gender-affirming care for

³ *Id.*

⁴ 5 U.S.C. § 706(2)(A).

⁵ *Motor Vehicle Manufacturers Ass’n of the United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

⁶ *See, e.g.*, Diana M Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5,2 [J]AMA 1, 7 (2022); *See* PEDIATRIC ENDOCRINE SOC’Y, *The Pediatric Endocrine Society Opposes Bills that Harm Transgender Youth*, <https://pedsendo.org/wp-content/uploads/2021/04/The-Pediatric-Endocrine-Society-Statement-TG.pdf> (last visited Jan. 30, 2026); *See* AM. ACAD. OF PEDIATRICS, *Why We Stand Up for Transgender Children and Teens*, <https://www.aap.org/en/news-room/aap-voices/why-we-stand-up-for-transgender-children-and-teens/> (last visited Jan. 30, 2026).

⁷ Joanne LaFleur et al., *Gender-Affirming Medical Treatments For Pediatric Patients With Gender Dysphoria*, COLL. OF PHARM. U. OF UTAH (2024).

transgender youth.⁸ The ban was referred to as a moratorium and directed the Utah Department of Health and Human Services to undertake this review and make a recommendation to the state legislature regarding this form of medical treatment.⁹ Notably, the report identified and extracted data from a significant number of studies reporting on over 28,000 pediatric gender dysphoria patients. This data was drawn from 277 publications representing 230 primary clinical studies reporting on the patient-level experience.¹⁰ The report made key findings demonstrating that gender-affirming care treatments are safe, including in relation to changes in bone density, cardiovascular risk factors, metabolic changes, and cancer.¹¹ The Utah Report also found that there are significant benefits to gender-affirming care; it was associated with improvements in psychological functioning, gender dysphoria, and global self-worth.¹² The report also found that hormone therapy in particular was an effective form of treatment for transgender and nonbinary youth because it significantly lowered rates of depression, anxiety, and social distress.¹³ The Proposed Rule does not address the Utah Report.

Additionally, in 2022 the Journal of the American Medical Association (“JAMA”) published a study investigating changes in mental health outcomes over the first year in which transgender and nonbinary youth received puberty blockers and gender-affirming hormones.¹⁴ This study, similar to the Utah Report, found that gender-affirming care was associated with lower rates of suicidality, self-harm, and depression.¹⁵ Further, in 2022 the Annual Review of Medicine published a review of studies on gender-affirming care for gender-diverse and transgender youth which found that, across both short and medium-term duration studies (meaning up to 6 years), gender-affirming care was beneficial, lifesaving care for transgender youth.¹⁶

The Proposed Rule also directly conflicts with expertise and evidence from numerous leading medical organizations. As the Proposed Rule recognizes, “guidelines from several major U.S. medical professional associations (American Medical Association, the American Academy of Pediatrics, and the American Psychological Association) . . . have issued statements deeming . . . ‘gender-affirming care,’ safe and effective.”¹⁷ These organizations have long been considered leading and reliable authorities, including by HHS in prior administrations.

⁸ See *id.* at 2.

⁹ See *id.*

¹⁰ *Id.* at 90.

¹¹ *Id.* at 90.

¹² *Id.* at 913.

¹³ *Id.* at 911.

¹⁴ Diana M Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5,2 [J]AMA 1, 7 (2022).

¹⁵ *Id.* at 7.

¹⁶ See Janet Y. Lee and Stephen M. Rosenthal, *Gender-Affirming Care of Transgender and Gender-Diverse Youth: Current Concepts*, 74 ANN. REV. OF MED. 112 (2023).

¹⁷ 90 Fed. Reg. at 59444 & nn. 30-33.

Nonetheless, the Proposed Rule summarily and incredibly dismisses this overwhelming weight of authority as “not trustworthy.”

CMS chiefly relies on a report the Department self-published in May of 2025 entitled “Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices”¹⁸ (“HHS Review”) to justify its Proposed Rule. However, the HHS Review is unreliable and has been repeatedly and widely criticized as such, and thus the Agency’s reliance on it is highly irrational.¹⁹ First, the HHS Review does not bear any indicia of reliability. The review was commissioned based on the direction of an Executive Order, which presupposed that “medical professionals are maiming and sterilizing a growing number of impressionable children under the radical and false claim that adults can change a child’s sex through a series of irreversible medical interventions,” and that evidence in support of gender-affirming care “lacks scientific integrity.”²⁰

Second, the speed with which the HHS Review was created casts significant doubt on whether the review appropriately and fairly considered the available, reliable evidence in conducting its assessment.²¹ It was also conducted and published within a ninety-day period.²² Comparable reviews typically take years, which reflects the fact that conducting a thorough, complete review which appropriately considers and addresses the body of available research and evidence is a time-consuming and intensive process.²³ The HHS Review is also highly unusual in its refusal to originally disclose who compiled it, which prevents the public and experts from assessing the credibility, conflicts of interest, and potential bias of the authors and reviewers.²⁴ Further, major medical organizations who provide guidance on the provision of gender-affirming care report that they were not consulted during the drafting process.²⁵ After the HHS Review was issued, major medical associations denounced its findings. The American Academy of Pediatrics,

¹⁸ Evgenia Abbruzzese et al., *Treatment for Pediatric Gender Dysphoria*, U.S. DEP’T OF HEALTH AND HUM. SERV. (2025).

¹⁹ See Melissa Jenco, *AAP Speaks Out Against HHS Review on Gender Dysphoria, Infringement on Physician-Patient Relationship*, AM. ACAD. OF PEDIATRICS (May 1, 2025), <https://publications.aap.org/aapnews/news/32145/AAP-speaks-out-against-HHS-report-on-gender?autologincheck=redirected>; Selena Simmons-Duffin, *Healthcare for transgender children questioned in 400-page Trump administration report*, NAT’L PUB. RADIO (May 2, 2025), <https://www.npr.org/sections/shots-health-news/2025/05/01/nx-s1-5383599/transgender-gender-affirming-care-trump-hhs>; Phie Jacobs, *Researchers Slam HHS Review on Gender-Affirming Care For Youth*, SCI. INSIDER (May 2, 2025).

²⁰ See Exec. Ord. 14187, *Protecting Children from Chemical and Surgical Mutilation* §§ 1, 3 (Jan. 28, 2025).

²¹ See Selena Simmons-Duffin, *Healthcare for transgender children questioned in 400-page Trump administration report*, NAT’L PUB. RADIO (May 2, 2025), <https://www.npr.org/sections/shots-health-news/2025/05/01/nx-s1-5383599/transgender-gender-affirming-care-trump-hhs>.

²² See *id.* § 3(ii).

²³ See e.g. Joanne LaFleur et al., *Gender-Affirming Medical Treatments For Pediatric Patients With Gender Dysphoria*, COLL. OF PHARM. U. OF UTAH (2024); Janet Y. Lee and Stephen M. Rosenthal, *Gender-Affirming Care of Transgender and Gender-Diverse Youth: Current Concepts*, 74 ANN. REV. OF MED. (2023).

²⁴ Fenit Nirappil, *Gender affirming care for trans youth criticized in HHS Review that conceals authors*, WASH. POST (May 2, 2025), <https://www.washingtonpost.com/health/2025/05/01/trump-transition-care-trans-youth-hhs/>.

²⁵ *Id.*

as one example, stated that the HHS Review “misrepresents the current medical consensus”²⁶ and “repeatedly cited” its policies in “inaccurate and misleading” ways.²⁷

In fact, the HHS Review’s conclusions—on which the Proposed Rule relies—are not even supported by its own findings. While the review claims that gender-affirming care “interventions carry risk of significant harms,” it elsewhere acknowledges that “[e]vidence for harms associated with pediatric medical transition in systematic reviews is . . . sparse.”²⁸ Similarly, the HHS Review recommends explorative psychotherapy as an alternative to gender-affirming care, but acknowledges that “evidence regarding alternative approaches to [gender dysphoria] is sparse and inconclusive” and that “[t]he overview of systematic reviews... found a dearth of evidence for psychotherapeutic interventions for youth with [gender dysphoria].”²⁹ The Proposed Rule provides no rational explanation for why it allows coverage for exploratory psychotherapy,³⁰ but not hormone therapy and puberty blockers, when the HHS Review it relies on claims a lack of evidentiary basis for all of those services. Notably, the HHS Review states that it “is not intended to serve as a clinical practice guideline and does not aim to issue recommendations,” further confounding why the Department would choose to use it as the basis for the Proposed Rule.³¹

The Proposed Rule’s failure to meaningfully engage with the weight of credible evidence, which supports gender-affirming care as being in the best interest of transgender youth by reducing adverse health outcomes and improving quality of life, runs contrary to credible evidence and is therefore arbitrary and capricious.

b. The Proposed Rule is arbitrary and capricious because it conflicts with Medicaid’s statutory requirements and guidance under the mandatory Early and Periodic Screening, Diagnostic, and Treatment benefit for those under 21 years of age.

Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services are mandatory benefits for Medicaid beneficiaries under the age of 21 that are meant to “assure that

²⁶ AAP, *AAP Statement on HHS Review Treatment for Pediatric Gender Dysphoria*, (May 1, 2025), <https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/>.

²⁷ Fenit Nirappil, *Gender affirming care for trans youth criticized in HHS Review that conceals authors*, WASH. POST (May 2, 2025), <https://www.washingtonpost.com/health/2025/05/01/trump-transition-care-trans-youth-hhs/>.

²⁸ See HHS Releases *Comprehensive Review of Medical Interventions for Children and Adolescents with Gender Dysphoria*, U.S. DEP’T OF HEALTH & HUM. SERV. 1, 10, 13 (May 1, 2025).

²⁹ See HHS Releases *Comprehensive Review of Medical Interventions for Children and Adolescents with Gender Dysphoria*, U.S. DEP’T OF HEALTH & HUM. SERV. 1, 219, 251 (May 1, 2025).

³⁰ Notably, psychotherapy in this context may actually be “conversion therapy” by another name. The American Psychological Association has denounced this approach. *The Evidence Against “Conversion Therapy*, “AM. PSYCH. ASS’N. (OCT. 7, 2025), <https://www.apa.org/topics/lgbtq/evidence-against-conversion-therapy>. Further, in 2023, 28 medical and mental health associations signed a joint statement opposing similar practices. *United States Joint Statement Against Conversion Efforts* (August 23, 2023), <https://usjs.org/wp-content/uploads/2023/10/USJS-Final-Version.pdf>.

³¹ *Treatment for Pediatric Gender Dysphoria*, U.S. DEP’T OF HEALTH AND HUM. SERV. 1, 261 (May 1, 2025).

health problems are diagnosed and treated early, before they become more complex and their treatment more costly.”³² EPSDT services are defined in the statute as “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”³³ Under this requirement, state plans for medical assistance must “provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.”³⁴ As described below, gender-affirming medical care falls within the definition of EPSDT covered services and therefore should be provided when medically necessary to correct or ameliorate gender dysphoria.³⁵ The decision to carve this care out of Medicaid coverage is inconsistent with the statute.

Additionally, the Agency’s manual clarifies that EPSDT services are designed to assure that problems are diagnosed and treated before they become more complex and expensive, and that those needed services must be provided in a timely and efficient manner.³⁶ Evidence-based studies available to the Agency confirm that gender-affirming care meets this standard, because when gender-affirming care for transgender youth is delayed or unavailable, it can lead to adverse mental health outcomes. For example, the Utah Report found that transgender youth who had access to hormone therapy had significantly lower rates of anxiety, depression and social distress compared to their peers who did not have hormone therapy.³⁷ The 2022 JAMA study also found that transgender “youths who had initiated [puberty blockers] or [gender-affirming hormones] had 60% lower odds of moderate to severe depression and 73% lower odds of self-harm or suicidal thoughts compared with youths who had not yet initiated [puberty blockers] or [gender-affirming hormones].”³⁸

Moreover, if transgender youth are unable to access the gender-affirming care they need, it can lead to greater costs down the line, as EPSDT seeks to prevent.³⁹ A 2016 study from the *Journal of General Internal Medicine* showed that hormone therapy for gender-affirming care is cost-effective partially because patients with gender dysphoria who cannot access care are more likely to experience other negative health issues that are more costly, such as the care associated

³² Ctrs. for Medicare & Medicaid Servs., State Medicaid Manual § 5010.B.

³³ 42 U.S.C. §§ 1396d(r)(5).

³⁴ 42 U.S.C. § 1396a(a)(43)(C).

³⁵ See 42 U.S.C. §§ 1396d(r)(5).

³⁶ See Ctrs. for Medicare & Medicaid Servs., State Medicaid Manual § 5010.B.

³⁷ See Joanne LaFleur et al., *Gender-Affirming Medical Treatments For Pediatric Patients With Gender Dysphoria*, COLL. OF PHARM. U. OF UTAH 911 (2024);

³⁸ Diana M Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5,2 [J]AMA 1, 6 (2022).

³⁹ See Abigail Coursolle, *Cuts to Gender-Affirming Care for Low-Income Youth Come With Real Costs*, NAT’L HEALTH L. PROGRAM (May 20, 2025), <https://healthlaw.org/cuts-to-gender-affirming-care-for-low-income-youth-come-with-real-costs/>.

with attempted suicide, HIV, as well as drug and substance abuse disorders.⁴⁰ Further, other studies indicate that early intervention for people with gender dysphoria helps prevent more expensive and invasive care in the future. For example, a 2020 study published by the American Academy of Pediatrics found that transgender youth who were able to access puberty blocking medication during their adolescence were less likely to need surgical interventions in the future to help treat their gender dysphoria.⁴¹

CMS attempts to distinguish gender-affirming care from EPSDT requirements by claiming that this care may not benefit the long-term needs of transgender youth.⁴² However, CMS fails to consider or address the evidence supporting the long-term health benefits of gender-affirming care for transgender youth. For example, as a part of the Utah Report, the research focused on long-term outcomes based on patients who had received at least five years of hormone treatment.⁴³ These patients had significantly lower rates of anxiety, depression, and social distress compared to their transgender and nonbinary peers who did not receive hormonal treatments.⁴⁴ Further, the studies reviewed in the Annual Review of Medicine included studies of up to six years and found that gender-affirming care was associated with lower rates of gender dysphoria and improved rates of psychological functioning.⁴⁵

The weight of available evidence shows that gender-affirming care is medically necessary, has long-term benefits, and ensures transgender patients' health needs are treated before becoming more complex and expensive. By the very terms of the Medicaid statute and CMS guidance, gender-affirming care should be required under EPSDT. Yet, CMS now claims an entirely new standard of care which runs counter to the evidence, and common sense, and is thus arbitrary and capricious.

⁴⁰ William V. Padula et al., *Societal Implications of Health Insurance Coverage For Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31 J. OF GEN. INTERNAL MED. 394, 398 (2016).

⁴¹ Tim C. Van de Grift et al., *Timing of Puberty Suppression and Surgical Options for Transgender Youth*, AM. ACAD. OF PEDIATRICS (Nov. 1 2020), <https://publications.aap.org/pediatrics/article-abstract/146/5/e20193653/75321/Timing-of-Puberty-Suppression-and-Surgical-Options?redirectedFrom=fulltext>.

⁴² 90 Fed. Reg. at 59452.

⁴³ Joanne LaFleur et al., *Gender-Affirming Medical Treatments For Pediatric Patients With Gender Dysphoria*, COLL. OF PHARM. U. OF UTAH 1, 899 (2024).

⁴⁴ *Id.* at 911.

⁴⁵ See Janet Y. Lee and Stephen M. Rosenthal, *Gender-Affirming Care of Transgender and Gender-Diverse Youth: Current Concepts*, 74 ANN. REV. OF MED. (2023).

III. This new rule will detrimentally impact the health and well-being of transgender youth across the country by denying them the health care they need.

a. *The Proposed Rule mirrors the effects of the Hyde Amendment by prohibiting federal funds for politically disfavored health care and disproportionately causes harm to low-income communities.*

For decades, the Hyde Amendment has prohibited most federal health insurance programs from covering the cost of abortion care except in the limited circumstances of rape, incest, or life endangerment. This federal funding ban has created dangerous and discriminatory outcomes for pregnant individuals across the country and has had a disproportionate impact on communities of color and low-income communities.⁴⁶ The Proposed Rule seeks to impose similar barriers to access for gender-affirming care; if finalized it will exacerbate existing disparities in health care access and have the greatest impact on low-income transgender youth.

The Hyde Amendment has reportedly left 7.8 million women enrolled in Medicaid ages 15-49 without abortion coverage.⁴⁷ Without health insurance to cover the costs of their care, Medicaid enrollees have been forced to delay care or divert money from other urgent needs, potentially pushing them further into poverty.⁴⁸ Similarly, without access to critical gender-affirming care, low-income transgender youth and their families enrolled in these federal programs will be forced to pay for care out of pocket, delay their care, or forego the care altogether. As referenced above, if transgender youth are not able to access certain types of gender-affirming care, they may experience adverse mental health outcomes such as anxiety, depression, and suicidality.⁴⁹ As of last year, nearly 37 million young people were enrolled in either Medicaid or CHIP, and none of these enrollees will be able to access gender-affirming care based on their transgender status under the new rule.⁵⁰

b. *This new rule will interfere with providers' expert medical judgment.*

The majority of physicians in the United States accept Medicaid patients and, if finalized, this rule would jeopardize their ability to provide the health care they determine their patients to

⁴⁶ *On Hyde Amendment's 44th Anniversary, Center and Allies Call for its End*, CTS. FOR REPROD. RTS. (Sept. 25, 2020), <https://reproductiverights.org/news/on-hyde-amendments-44th-anniversary-center-and-allies-call-for-its-end/>.

⁴⁷ *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*, GUTTMACHER INST. (May 2021), <https://www.guttmacher.org/fact-sheet/hyde-amendment>.

⁴⁸ *40 Years Is Enough: Let's End the Harmful and Unjust Hyde Amendment*, GUTTMACHER INST. (September 2016), <https://www.guttmacher.org/article/2016/09/40-years-enough-lets-end-harmful-and-unjust-hyde-amendment>.

⁴⁹ See Joanne LaFleur et al., *Gender-Affirming Medical Treatments For Pediatric Patients With Gender Dysphoria*, COLL. OF PHARM. U. OF UTAH 1, 911 (2024).

⁵⁰ *August 2025: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot*, CTR. FOR MEDICARE & MEDICAID SERV. (Nov. 28, 2025), <https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-aug2025.pdf>.

need.⁵¹ Gender-affirming care for transgender youth is provided through medical professionals,⁵² after the patient, their family, and their provider have made an informed decision that a certain treatment plan is in the best interest of the patient. By contradicting the best medical judgment of providers, the Proposed Rule seeks to curb the type of care provided to transgender patients, where providers and reputable evidence-based studies should be leading. This rule may cause providers to stop providing lifesaving care against their best medical judgment.

IV. Conclusion

For the reasons set forth above, we urge the Department to withdraw the Proposed Rule entirely. If finalized, this Proposed Rule will violate the APA and its impact will be devastating for transgender youth across the country.

For additional information about the issues raised in this letter, please contact Liz McCaman Taylor, Senior Federal Policy Counsel, at ltaylor@reprorights.org.

Signed,

Center for Reproductive Rights

⁵¹ Julia Paradise, *Data Note: A Large Majority of Physicians Participate in Medicaid*, KFF (May 10, 2017), <https://www.kff.org/medicaid/data-note-a-large-majority-of-physicians-participate-in-medicaid/>.

⁵² See *Gender-Affirming Care Fact sheet*, PHYSICIANS FOR REPROD. HEALTH (June 2025), <https://prh.org/wp-content/uploads/2025/06/policy-gender-affirming-care-fact-sheet.pdf>.