DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

RE: Puberty blockers, cross-sex hormones, and surgery related to gender dysphoria

April 11, 2025

Dear State Medicaid Director:

The purpose of this letter is to ensure that state Medicaid agencies are aware of growing evidence regarding certain procedures offered to children, and to remind states of their responsibility to ensure that Medicaid payments are consistent with quality of care and that covered services are provided in a manner consistent with the best interest of recipients.

In recent years, medical interventions for gender dysphoria in children have proliferated. These interventions include surgical procedures that attempt to transform an individual's physical appearance to align with an identity that differs from his or her sex or that attempt, for purposes of treating gender dysphoria, to alter or remove an individual's sexual organs to minimize or destroy their natural biological functions. These interventions also include the use of puberty blockers, including GnRH agonists and other interventions, to delay the onset or progression of normally timed puberty for purposes of treating gender dysphoria, as well as the use of sex hormones, such as estrogen, progesterone, or testosterone, and androgen blockers to align an individual's physical appearance with an identity that differs from his or her sex.

For example, one study estimated in 2023 that nearly 3,700 children with gender dysphoria between the ages of 12 to 18 from 2016-2020 underwent surgical procedures, including over 3,200 children who had breast or chest surgery and over 400 children who had genital surgery resulting in permanent alterations to reproductive organs and impaired sexual function.[1] Another study found that between 2017 to 2021, more than 100,000 children ages 6 to 17 were diagnosed with gender dysphoria and, of that group, more than 17,000 started taking puberty blockers or hormonal therapy.[2] A database composed of claims data estimated that nearly 14,000 minors underwent such treatments between 2019 and 2023.[3]

Initiated with an underdeveloped body of evidence, these interventions lack reliable evidence of long-term benefits for minors, and for some children, these interventions are now known to cause long-term and irreparable harm.

Several developed countries have recently diverged from the U.S. in the way they treat gender dysphoria in children. The United Kingdom, Sweden, and Finland have recently issued restrictions on the medical interventions for children, including the use of puberty blockers and hormone treatments, and now recommend exploratory psychotherapy as a first line of treatment and reserve hormonal interventions

[1] Wright, J.D., Chen, L., Suzuki, Y., et al., "National Estimates of Gender-Affirming Surgery in the US," *Jama Network Open. August 23, 2023, 6(8),* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808707.
[2] Respaut R. & Terhune, C., "Putting numbers on the rise in children seeking gender care," *Reuters*, October 6, 2022, https://www.reuters.com/investigates/special-report/usa-transyouth-data/.
[3] Do No Harm, "Stop the Harm Database," https://stoptheharmdatabase.com/about/. Accessed March 4, 2025.

only for exceptional cases.[4] [5] [6] In particular, the "Cass Review," an independent review of the evidence in the United Kingdom, noted that despite the considerable research in the field of gender dysphoria in children, "systematic evidence reviews demonstrated the poor quality of the published studies, meaning there is not a reliable evidence base upon which to make clinical decisions, or for children and their families to make informed choices."[7]

As such, we remind states of the following federal Medicaid requirements.

State Medicaid programs have a responsibility to ensure that payments are consistent with "efficiency, economy, and quality of care" under Section 1902(a)(30)(A) of the Social Security Act. Furthermore, Section 1902(a)(19) of the Social Security Act requires that states provide such safeguards as may be necessary to ensure covered care and services are provided in a manner consistent with the best interests of recipients. The language from federal statute reflects a basic obligation of state Medicaid agencies to take steps to help ensure the quality of Medicaid-covered care and to ensure that such care is provided in a manner consistent with the best interest of beneficiaries.

Additionally, for certain populations, including children, longstanding federal Medicaid regulations prohibit federal funding for coverage of services whose purpose is to permanently render an individual incapable of reproducing. Federal financial participation (FFP) is strictly limited for procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing and, under 42 C.F.R. 441.253(a), is specifically prohibited for such procedures performed on a person under age 21.[8]

Furthermore, in order for federal financial participation to be made available for prescribed drugs, states must have a drug utilization program that complies with Section 1927 of the Act.[9] In particular, Section 1927(g) requires each state to develop a drug utilization review (DUR) program to assure that prescribed drugs are appropriate, medically necessary, and are not likely to result in adverse results. We encourage states to review their DUR programs to ensure alignment with current medical evidence and federal requirements, including the evidence outlined above. States are required to report annually relevant drug monitoring. Additional guidance on DUR approaches is forthcoming.

CMS is committed to following the highest standards of care and to adhering closely to the foundational principles of medicine, especially as it comes to doing no harm to America's children. CMS is also committed to supporting states as they work to keep their coverage and payment policies up to date, consistent with applicable law. For additional questions, please email us at Medicaid.gov@cms.hhs.gov.

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[4] NHS England, "Children and young people's gender services: implementing the Cass Review recommendations," August 29, 2024, *https://www.england.nhs.uk/long-read/children-and-young-peoples-gender-services-implementing-the-cass-review-recommendations/*.

[5] Socialstyrelsen, "Care of children and adolescents with gender dysphoria," December 2022, *https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf*.

[6] Society for Evidence Based Gender Medicine, "One Year Since Finland Broke with WPATH 'Standards of Care,'" July 2, 2021, *https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors*

[7] Cass, H., "Independent review of gender identity services for children and young people: Final report," April 2024, https://cass.independent-review.uk/home/publications/final-report/.

[8] Cheng, PJ, Pastuszak AW, Myers JB, Goodwin IA, Hotaling JM. Fertility concerns of the transgender patient. Transl Androl Urol. 2019 Jun; 8(3):209-218, available at https://pubmed.ncbi.nlm.nih.gov/31380227/. Accessed March 5, 2025.

[9] *See* Section 1902(a)(54); 42 CFR 456.703

Sincerely,

/s/

Drew Snyder
Deputy Administrator and Director