February 17, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

*Submitted via* https://www.regulations.gov/document/CMS-2025-1823-0001

**Re: CMS-2451-P: Prohibition on Federal Medicaid and CHIP Funding for "Sex-Rejecting Procedures" Furnished to Children (RIN: 0938-AV73)**

Dear Administrator Oz:

GLBTQ Legal Advocates and Defenders ("GLAD Law"),[1] the National Center for LGBTQ Rights ("NCLR"),[2] and COLAGE[3] submit this comment opposing the Department of Health and Human Services' Notice of Proposed Rulemaking entitled "Prohibition on Federal Medicaid and CHIP Funding for 'Sex-Rejecting Procedures' Furnished to Children" ("Medicaid NPRM" or "proposed rule").[4] This proposed rule would prohibit federal financial participation for defined services when provided to minors for purposes associated with gender dysphoria and would require parallel amendments to State plans in Medicaid and the Children's Health Insurance Program ("CHIP"). CMS should withdraw the proposed rule in its entirety.

The proposed rule suffers from fundamental statutory, operational, and analytic flaws and must be withdrawn. The proposed prohibition conflicts with statutory Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") requirements by displacing individualized

[1] GLAD Law is a legal rights organization that works throughout New England and nationally to create a just society free of discrimination based on gender identity and expression, HIV status, and sexual orientation. We represent transgender youth and their families in access-to-care matters and regularly engage on Medicaid coverage, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) compliance, and nondiscrimination in health programs.
[2] NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, transgender and queer (LGBTQ) community, provides free legal assistance to LGBTQ people and their advocates, and conducts community education on LGBTQ issues since its founding in 1977.
[3] COLAGE is a national organization that unites people with one or more gay, bisexual, transgender and/or queer parents into a network of peers and supports them as they nurture and empower each other to be skilled, self-confident, and just leaders in our collective communities. For more than three decades, COLAGE has served individuals across generations and geographic regions, many of whom are transgender themselves, are parents of transgender children, or have transgender parents. Because our members and their families are directly affected by policies governing access to medically necessary transgender health care, COLAGE has a strong interest in this rulemaking.
[4] 90 Fed. Reg. 59441 (Dec. 19. 2025).

medical necessity determinations for minors;[5] it is irreconcilable with Medicaid's amount, duration, and scope rules and comparability protections;[6] it misaligns Medicaid and CHIP in ways that create significant operational disruption; and it rests on an economic analysis that treats denial of care as a benefit while ignoring predictable, offsetting costs.[7] The preamble concedes that the prohibition would apply even when a licensed clinician determines a service is medically necessary for an EPSDT-eligible youth[8] and that the policy may "prevent or delay" services.[9] Those concessions underscore the rule's incompatibility with the statutory text, settled EPSDT practice, and the real-world administration of State Medicaid and CHIP programs.[10]

## I. CMS's misguided interpretation of Medicaid State plan requirements does not provide requisite statutory authority for this rulemaking.

The proposed rule rests on a novel reading of general Medicaid State plan requirements that historically have guided program administration and rate setting, not categorical, nationwide clinical coverage exclusions. Section 1902(a)(19) of the Social Security Act (the Act) requires State Medicaid agencies to ensure that covered care and services will be provided in a manner consistent with "the simplicity of administration and the best interests of the recipients."[11] Section 1902(a)(30)(A) of the Act requires State programs to assure that, among other things, payment for covered care and services "are consistent with efficiency, economy, and quality of care."[12]

For decades, States have specified benefits and criteria, developed medical necessity standards, and submitted State plan amendments for CMS approval within the statutory benefit framework.[13] Indeed, the preamble itself notes that CMS has "long afforded State Medicaid agencies considerable flexibility" when implementing coverage standards under 42 C.F.R. § 440.230.[14] Yet the proposed rule would add a new subpart requiring that States declare within their Medicaid plans that no payment will be made for services defined as

[5] Pursuant to 42 U.S.C. § 1396d(r)(5), states participating in Medicaid must cover all medically necessary services for beneficiaries under 21 years of age.
[6] Under the Medicaid Act, "the medical assistance made available to any individual . . . shall not be less in amount, duration or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B)(i).
[7] 90 Fed. Reg. at 59458-59.
[8] *Id.* at 59451-52.
[9] *Id.* at 59459.
[10] *See U.S. Dep't of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs.*, EPSDT—A Guide for States [hereinafter CMS EPSDT Guide] (June 2014) (describing States' duty to furnish all § 1905(a) coverable, medically necessary services to correct or ameliorate a young person's conditions), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.
[11] 42 U.S.C. § 1396a(a)(19).
[12] *Id.* at § 1396a(a)(30)(A).
[13] 90 Fed. Reg. at 59451.
[14] *Id.* at 59450.

"sex-rejecting procedures" for individuals under 18[15] and would categorically deny Federal Financial Participation (FFP) for State expenditures for those services.[16]

But reliance on administrative and rate-setting provisions does not allow the Department to regulate in contravention of statutory provisions that specifically dictate the scope and availability of care and services. The Act requires States to ensure that covered services are "sufficient in amount, duration, and scope to reasonably achieve [their] purpose,"[17] and prohibits a State Medicaid agency from reducing the amount, duration, or scope of a covered service "solely because of the diagnosis, type of illness, or condition."[18] The preamble asserts the exclusion of transgender care for minors is purpose-based and thus not a diagnosis-based limitation, yet it simultaneously explains that the targeted uses are those "associated with a *particular diagnosis*"[19] and would withdraw FFP whenever those uses arise in minors. Courts assessing categorical, diagnosis-based exclusions have held that plans may not deny coverage of services they otherwise cover when medically necessary for other conditions;[20] such exclusions effectively deprive the defined group of access to needed care and render any purported benefits illusory, particularly where the excluded modality or setting is the only clinically appropriate way to treat the condition or the only qualified providers able to furnish it. The denial of the same drugs or procedures

[15] Proposed 42 C.F.R. § 441.802(a).
[16] Proposed 42 C.F.R. § 441.802(b).
[17] 42 U.S.C. § 1396a(a)(10)(A); codified at 42 C.F.R. § 440.230(b).
[18] 42 U.S.C. § 1396a(a)(10)(B)(i); codified at 42 C.F.R. § 440.230(c).
[19] 90 Fed. Reg. at 59452 (emphasis added).
[20] *See, e.g., K.G. ex rel. Garrido v. Dudek*, 839 F. Supp. 2d 1254, 1276–78 (S.D. Fla. 2011) (rejecting State's argument that specific form of behavioral therapy was experimental and coverage was not required under Medicaid Act); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 588–93 (5th Cir. 2004) (holding Louisiana state agency violated Medicaid Act by denying plaintiff home health supplies consistent with his EPSDT screening); *Collins v. Hamilton*, 231 F. Supp. 2d 840, 848–49 (S.D. Ind. 2002) (holding Indiana's standing policy of refusing long-term residential psychiatric treatment to youth under 21 years old whose EPSDT screening showed the placement was medically necessary violated Medicaid law). Federal courts are currently grappling with how these principles apply to denials of medical services to transgender patients in the wake of the Supreme Court's decision in *United States v. Skrmetti*, 605 U.S. 495 (2025). *See, e.g., Lange v. Houston Cnty.*, 152 F.4th 1245, 1251–55 (11th Cir. 2025) (relying on *United States v. Skrmetti*, 605 U.S. 495 (2025), to hold that county health insurance plan's denial of coverage for transgender healthcare did not discriminate based on sex); *Kadel v. Folwell*, 100 F.4th 122 (4th Cir. 2025) (en banc) (holding West Virginia's and North Carolina's Medicaid programs violated the Medicaid Act, the Affordable Care Act, and the Equal Protection Clause), *vacated and ordered for reconsideration*, *Folwell v. Kadel*, 145 S. Ct. 1816 (2025). *See also Doe v. Snyder*, 28 F.4th 103, 114–15 (9th Cir. 2022) affirming district court's conclusion that plaintiffs did not meet the high standard to establish that a mandatory preliminary injunction forcing Arizona's Medicaid program to pay for his male chest reconstruction surgery was legally required); *Flack v. Wisc. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1019 (W.D. Wis. 2019) (holding state's categorical ban on medical treatment needs of those suffering from gender dysphoria violated the Availability and Comparability Provisions of the Medicaid Act); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997, 1002 (W.D. Wis. 2018) (holding Wisconsin's exclusion of "'[p]rocedures, services, and supplies related to surgery and sex hormones associated with gender reassignment'" from health insurance coverage for state employees violates Title VII of the Civil Rights Act of 1964, the Affordable Care Act, and the Equal Protection Clause).

for one diagnosis (here, gender dysphoria) while covering them for others is a textbook instance of prohibited diagnosis discrimination.

The proposed rule runs further afoul of the Medicaid Act's EPSDT benefit, which was added to the Medicaid Act in 1967 to ensure comprehensive pediatric care for Medicaid-eligible children under the age of 21.[21] The goal of EPSDT, as explained by CMS, "is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting."[22] States must cover screening and "[s]uch other necessary health care, diagnostic services, treatment, and other measures" described in Section 1905(a) of the Act[23] when needed to "correct or ameliorate" a condition.[24] Within this framework, physician services, inpatient and outpatient hospital services, and prescription drugs fall squarely within required benefit categories, and when such services are medically necessary for a young person, EPSDT requires coverage even if the same services are not covered for adults.[25]

The proposed rule's incompatibility with EPSDT is not abstract. The preamble states that the prohibition "includes circumstances in which a provider may determine that a sex-rejecting procedure is medically necessary for a child diagnosed with gender dysphoria," while asserting that EPSDT would remain "consistent" with the rule.[26] That position cannot be squared with EPSDT's text and operation.[27] By withdrawing FFP for every treatment recognized as medically necessary for minors experiencing gender dysphoria (except psychotherapy), the proposed rule would replace individualized medical necessity determinations with a categorical national exclusion, even when the treating clinician and multidisciplinary team determine that the service is necessary to correct or ameliorate the youth's condition. Against that backdrop, the claim that general plan clauses permit a national clinical exclusion of coverage of certain interventions for certain purposes even where a provider determines that a service is medically necessary cannot stand.

A parallel CHIP amendment would bar federal CHIP payment for such services for individuals under 19.[28] The Department acknowledges the rights of States under Section 2110(a)(24) of the Act to cover "any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services" recognized by State law if provided under appropriate clinical circumstances,[29] and yet attempts to override this statutory permission via regulation. In providing the same justification for this novel

[21] Pub. L. No. 90–248, 81 Stat. 929, codified at 42 U.S.C. § 1396d(a)(4); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101–239, § 6403, 103 Stat. 2106, 2262–64; codified at 42 U.S.C. § 1396d(a)(4)(B), (r).
[22] *See* CMS EPSDT Guide, *supra* note 10, at 1.
[23] 42 U.S.C. § 1396d (defining "medical assistance").
[24] *Id.* at § 1396d(r)(5).
[25] *Id.*
[26] 90 Fed. Reg. at 59452.
[27] *See, e.g., Beal v. Doe,* 432 U.S. 438, 444 (1977) (indicating that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage").
[28] Proposed 42 C.F.R. § 457.476.
[29] 42 U.S.C. § 1397jj.

departure in the context of CHIP as it does for Medicaid, the Department similarly fails to provide sufficient legal justification for its proposed actions.

The Department also attempts to justify the CHIP restrictions by seeking to "align CHIP with Medicaid, the FEHB Program, and EHBs" in that the administration either has or has proposed to prohibit coverage of "sex rejecting procedures" in these programs.[30] However, discrimination in one (or many) programs does not justify its further extension and certainly does not create legal authority where none exists.

## II. Reliance on a deeply flawed, agency generated report is insufficient justification for this rulemaking.

Reliance on an agency-authored report, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*[31] ("HHS Report") cannot justify the proposed exclusions and funding restrictions. The HHS Report was commissioned under an Executive Order aimed at ending transgender health care for minors and defunding related research,[32] and its development departed from scientific norms.[33] The initial publication named no authors, and more than a fifth of its references were drawn from lay media and social media rather than peer-reviewed literature, undermining transparency and credibility.[34] Leading medical organizations, including the American Academy of Pediatrics (AAP), immediately objected that the report misrepresents medical consensus, cites AAP policy inaccurately, and prioritizes opinions over a comprehensive review of the evidence.[35]

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[30] 90 Fed. Reg. at 59453 (citing 2025 Marketplace final rule, 90 Fed. Reg. 27074 (June 20, 2025) (Essential Health Benefit requirements), U.S. Office of Personnel Management, Letter 2025-01A (Jan. 31, 2025) (Federal Employee Health Benefits Program and Postal Service Health Benefits).

[31] *U.S. Dep't of Health & Hum. Servs., Office of Population Affairs*, Treatment for Pediatric Gender Dysphoria, Review of Evidence and Best Practices (May 1, 2025), https://opa.hhs.gov/gender-dysphoria-report.

[32] Executive Order 14187, *Protecting Children from Chemical and Surgical Mutilation*, 90 Fed. Reg. 8771 (Jan. 28. 2025).

[33] Nadia Dowshen, et al., *A Critical Scientific Appraisal of the Health and Human Services Report on Pediatric Gender Dysphoria*, Journal of Adolescent Health (2025) at 1–2, https://www.jahonline.org/article/S1054-139X(25)00246-0/pdf.

[34] G. Nic Rider, et al., *Scientific Integrity and Pediatric Gender Healthcare: Disputing the HHS Review*, Sexuality Research and Social Policy (Oct. 13, 2025), https://link.springer.com/content/pdf/10.1007/s13178-025-01221-5.pdf.

[35] American Academy of Pediatrics (AAP), Press Release, AAP Statement on HHS Report Treatment for Pediatric Gender Dysphoria [hereinafter AAP Statement] (May 1, 2025), https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria ("Patients, their families, and their physicians—not politicians or government officials —should be the ones to make decisions together about what care is best for them based on evidence-based, age-appropriate care"); American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, American Psychiatric Association, Leading Physician Groups Oppose Infringements on Medical Care, Patient-Physician Relationship (May 1, 2025), https://www.acponline.org/sites/default/files/acp-policy-library/statements/joint_statement_on_hhs_gender_affirming_care_report_2025.pdf ("[A]ll patients must have access to evidence-based, comprehensive medical care, and that physicians must be able to practice medicine that is informed by their education, training, and experience without threat of criminalization.");

The report's methods and inferences are materially unsound.[36] It functions as an umbrella review that amplifies bias in prior contested reviews and over-relies on the Cass Review while failing to address detailed critiques of that review and even its own acknowledgment that medical interventions are appropriate for some adolescents.[37] It discounts longitudinal and cohort studies showing improvements in mental health, appearance congruence, life satisfaction, and reductions in depression, anxiety, and suicidality associated with transgender medical care, including multi-site health-system data demonstrating substantial reductions in suicidality-related hospital utilization among treated youth.[38] It grades benefits as "weak" largely because randomized trials do not exist, while disregarding the practical and ethical barriers to randomized control trials in this context and the fact that much of pediatrics relies on longitudinal and observational evidence of similar quality to guide care.[39] It also emphasizes hypothetical harms despite acknowledging "sparse" evidence of harm, even though puberty blockers and hormone therapies have long safety histories in other pediatric indications and are used within protocols that require individualized risk-benefit assessment and fertility counseling.[40]

The report mischaracterizes current standards of care and endorses practices at odds with ethical norms.[41] Contrary to the report's portrayal, established guidelines from specialty societies describe a cautious, multidisciplinary model in which comprehensive biopsychosocial assessment and ongoing mental health care are foundational, and medical interventions are reserved for a subset of adolescents with persistent, clinically significant dysphoria after rigorous evaluation.[42] This stands in stark contrast to the systematic medical evidence review conducted on behalf of the Utah Department of Health and Human Services, which resulted in a report finding that hormonal transgender healthcare can be safely provided to youth experiencing gender dysphoria.[43]

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American Medical Association (AMA) and AAP, Press Release, AMA and AAP Joint Statement on Evidence-Based Health Care [hereinafter AMA and AAP Joint Statement] (Nov. 19, 2025), https://www.aap.org/en/news-room/news-releases/aap/2025/ama-and-aap-joint-statement-on-evidence-based-health-care/ ("We reject characterizations of our approach to gender-affirming care as negligent or ideologically driven, and take particular issue with the false assertion that our members have committed 'malpractice' or betrayed their oath in any way. These claims, rooted in politics and partisanship, misrepresent the consensus of medical science, undermine the professionalism of physicians, and risk harming vulnerable young people and their families.").

[36] Dowshen, et al., *supra* note 33, at 1-2.

[37] Rider, et al., *supra* note 34, at 2.

[38] Dowshen, et al., *supra* note 33, at 1.

[39] Rider, et al., *supra* note 34, at 2.

[40] Dowshen, et al., *supra* note 33, at 1.

[41] *Id.* at 2; Ian D. Wolfe et al., *7 Pediatric Bioethicists: Proposed Ban on Medicaid Funding for Hospitals Providing Gender-Affirming Care for Minors Is Deeply Unethical*, STAT (Jan. 30, 2026), https://www.statnews.com/2026/01/30/gender-affirming-care-why-experts-oppose-proposed-ban/.

[42] Dowshen, et al., *supra* note 33, at 1.

[43] University of Utah College of Pharmacy, Drug Regimen Review Center, Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria (Aug. 6, 2024) (prepared for the Utah Department of

The report promotes a psychotherapy-only approach despite acknowledging there is no evidentiary base that psychotherapy alone resolves adolescent gender dysphoria. It further platforms "gender exploratory therapy," which experts have described as a conversion-style practice aimed at steering youth toward being not transgender identities.[44] Such practices are widely considered unethical and are restricted or banned in many jurisdictions, including the District of Columbia,[45] creating a direct conflict between the report's recommendations and prevailing legal and ethical standards.

Disallowing FFP for evidence-based treatments would substitute a contested and methodologically deficient synthesis for individualized, guideline-concordant clinical judgment.[46] The predictable result would be reduced access to medically necessary care, worsening mental health outcomes, and widening inequities for transgender adolescents.[47] The AAP and other professional bodies have made clear that decisions about care should be made by patients, families, and clinicians based on the totality of peer-reviewed evidence and prevailing clinical standards—not by blanket policy derived from a flawed report.[48]

Because the proposed rule rests on a report that lacks scientific independence, misstates the evidence base, mischaracterizes clinical standards, and promotes ethically problematic practices, HHS should not rely on it to support funding exclusions. At a minimum, HHS should withdraw or substantially revise the proposal, undertake a transparent and methodologically rigorous evidence review that meaningfully engages relevant specialty societies, and align program policy with the conservative, multidisciplinary, evidence-informed standards that currently govern pediatric care.

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Health and Human Services) (analyzing 134 primary clinical studies representing more than 28,000 transgender minors worldwide).

[44] *Id.* at 1; Rider, et al., *supra* note 34, at 3; *U.S. Dep't of Health & Hum. Servs., Substance Abuse & Mental Health Servs. Admin.*, Moving Beyond Change Efforts: Evidence and Action to Support and Affirm LGBTQI+ Youth (2023), https://storage.googleapis.com/trevor-web-public/2025/11/f6b47c66-samhsa-lgbtqia-youth-report.pdf.

[45] Twenty-three states and the District of Columbia currently ban licensed mental health professionals from subjecting minors to conversion therapy, through either statutes or statewide professional-licensing rules. Movement Advancement Project, "Equality Maps: Conversion Therapy Laws," https://www.lgbtmap.org/equality-maps/conversion_therapy. *But see*, *Chiles v. Salazar*, No. 24-539 (argued Oct. 7, 2025) (challenging Colorado's conversion therapy ban); *Cath. Charities of Jackson, Lenawee, & Hillsdale Ctys. v. Whitmer*, 162 F.4th 686 (6th Cir. 2025) (preliminarily enjoining Michigan's conversion therapy ban).

[46] Rider, et al., *supra* note 34, at 1.

[47] *Id.* at 1.

[48] AAP Statement, *supra* note 35; AMA and APA Joint Statement, *supra* note 35.

## III. The impact analyses fail to adequately address harms and burdens caused by the proposed rule.

The analysis of economic effects of the proposed rule focuses on trivial government savings while failing to give any accounting for the costs associated with the follow-on harms that result from individuals being denied access to healthcare due to lack of Medicaid or CHIP coverage.

For example, the significant majority of the Regulatory Impact Statement (RIS) focuses on monetary savings yielded to federal and state government as a result of no longer providing payment to providers for prohibited care. Based on 2023 data, $31 million in Medicaid and CHIP spending was identified for claims with a diagnosis of gender dysphoria with a range of related claim categories.[49] Data from the CMS Office of the Actuary and the U.S. Census Bureau indicates that total Medicaid expenditures that year totaled $871.7 billion. Thus, the prohibited services represented less than 0.0036% of annual expenditures. This limited scope of analysis fails to capture what implementation entails in real programs, and the resulting harms to real people.

The RIS analysis of costs comprises of four sentences, two of which refer the reader to the Information Collection Analysis that addresses the administrative costs associated with revising State plans and associated policies. The balance of the "analysis" references that the rule may result in "several costs," one of which is preventing or delaying access to receipt of the prohibited healthcare.[50]

The failure of the RIS to address the foreseeable increased expenditures associated with untreated or abruptly discontinued care for minors who would otherwise receive physician-ordered services is a fatal flaw. The analysis fails to quantify in any way what these potential costs could be for either State Medicaid programs, hospitals themselves, or the young people and families involved. Further, it erroneously states that there is no "data or analysis on the impact of prohibitions on these procedures."[51] However, this is simply not true. Abruptly halting transgender healthcare for minors is associated with deterioration in mental health and increased suicidality, as youths who are unable to initiate or continue puberty blockers or hormones exhibit substantially higher odds of depression and suicidality than those who receive care.[52] Forced discontinuation is physically and psychologically destabilizing, often occurring without medical supervision or tapering, and is linked to worsened dysphoria, low mood, and care avoidance.[53]

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[49] 90 Fed. Reg. at 59463 (Table 13).
[50] *Id.* at 59459.
[51] *Id.* at 59458.
[52] Diana M. Tordoff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, JAMA Network Open (Feb. 2, 2022), https://pubmed.ncbi.nlm.nih.gov/35212746/.
[53] Kinnon R. MacKinnon, et al., *Health Care Experiences of Patients Discontinuing or Reversing Prior Gender-Affirming Treatments*, JAMA Network Open (July 25, 2022),

Withholding treatment through puberty also compels the development of irreversible secondary sex characteristics that exacerbate distress and may necessitate later invasive interventions that cannot undo years of suffering.[54] Access to pubertal suppression in adolescence is further associated with markedly lower odds of lifetime suicidal ideation in adulthood compared with those who wanted but could not obtain it, underscoring the harms of sudden withdrawal or denial of care.[55]

Further, the RIS does not account for the well-documented crisis services, emergency department utilization, inpatient behavioral health admissions, school and family disruptions, or other systems costs that arise when clinically indicated transgender care is withdrawn from (or initially denied to) youth experiencing gender dysphoria.[56] Rather than addressing this body of research, CMS explicitly declined to estimate whether there would be any additional Federal expenditures for other healthcare services related to gender dysphoria.[57] Ignoring predictable downstream costs when care is withdrawn departs from reasoned analysis and is contrary to OMB Circular A-4's emphasis on ancillary costs and countervailing risks.[58]

In addition to ignoring the foreseeable harm related to removing care, the preamble's suggestion that families seek other insurance or pay out of pocket[59] ignores the basic structure of Medicaid and CHIP as the primary coverage sources for low-income youth; for most affected families, alternative insurance is not an operationally realistic pathway. Indeed, the proposed rule acknowledges that Medicaid and CHIP beneficiaries may never begin—or be able to continue—this care at all if the rule is finalized,[60] thus making the harms of discontinuation of treatment that much more predictable.

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https://www.ovid.com/journals/janop/pdf/10.1001/jamanetworkopen.2022.24717~health-care-experiences-of-patients-discontinuing-or.

[54] Meredithe McNamara, et al., Yale Law School, The Integrity Project, *An Evidence-Based Critique of the "Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria* (April 2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf.

[55] Jack L. Turban, et al., *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, PLOS One (Jan. 12, 2022), https://pubmed.ncbi.nlm.nih.gov/35020719/; Jack L. Turban, et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, Pediatrics (Feb. 1, 2020), https://publications.aap.org/pediatrics/article-abstract/145/2/e20191725/68259/Pubertal-Suppression-for-Transgender-Youth-and?redirectedFrom=fulltext.

[56] *See, e.g.*, Wilson Y. Yee, et al., *State-Level Anti Transgender Laws Increase Past-Year Suicide Attempts Among Transgender and Non-Binary Young People in the USA*, Nature Human Behavior (Sept. 26, 2024), https://www.nature.com/articles/s41562-024-01979-5.

[57] 90 Fed. Reg. at 59459.

[58] *See Office of Management and Budget*, Circular A-4, at 26 (2003) ("Your analysis should look beyond the direct benefits and direct costs of your rulemaking and consider any important ancillary benefits and countervailing risks. … [A] countervailing risk is an adverse economic, health, safety, or environmental consequence that occurs due to a rule and is not already accounted for in the direct cost of the rule (e.g., adverse safety impacts from more stringent fuel-economy standards for light trucks)."), https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf.

[59] 90 Fed. Red. at 59449.

[60] *Id.*

The analysis also omits the costs that will be borne by States and managed care organizations resulting from required network redesign and contract amendments. Exclusion of previously covered services in hospital-centered pediatric programs triggers renegotiation of provider agreements, changes to utilization review protocols, redesign of formularies and medical policies, and retraining of clinical and administrative staff. Those changes touch legal, compliance, information technology, and clinical teams. They also require electronic health record updates, revisions to notice and appeal workflows, and new training on said changes.

By limiting the cost analysis of the rule to that covered by the Paperwork Reduction Act, and in so doing stating that the plan-amendment burden is merely a "simple recitation of the prohibition,"[61] does not reflect these downstream costs. This framing treats the change as a paperwork exercise, but the program consequences would be structural and systemwide for hospital-anchored pediatric care. State Medicaid agencies specify coverage criteria, administer managed care and fee-for-service networks, and bear responsibility for access standards, network adequacy, and timely care benchmarks.[62] It further fails to account for the administrative burden resulting from the discordance in the application of the proposed rule between Medicaid (individuals under the age of 18) and CIP (individuals under the age of 19). This creates friction in programs that are meant to coordinate coverage for low-income youth and increases the complexity of transitions between programs and providers at precisely the ages when continuity of care is critical.

## IV. Coordinated same-day HHS actions demonstrate impermissible animus rather than neutral program administration.

The proposed Medicaid and CHIP financing prohibition did not emerge in isolation. They are part of a concerted effort, rooted in animus, to marginalize transgender individuals and deny them – and only them – medically necessary healthcare.

On the very day the agency published this NPRM, HHS also issued a hospital Conditions of Participation proposed rule ("CoP NPRM") barring Medicare- and Medicaid-participating hospitals from performing the same defined set of procedures for minors,[63] and it advanced a separate civil-rights rulemaking under Section 504 of the Rehabilitation Act that would narrow disability protections by interpreting the statutory exclusion for "gender identity disorders not resulting from physical impairments" to encompass gender dysphoria.[64] The Conditions of Participation proposed rule grounds itself in the same

[61] *Id.* at 59457.
[62] *See* 42 C.F.R. § 431.10 (single state agency administration), 42 C.F.R. §§ 440.230 and 438.210 (coverage criteria and medical necessity), 42 C.F.R. §§ 438.206, 438.207, and 438.68 (managed care network adequacy and appointment wait-time standards), and 42 C.F.R. §§ 447.203 and 447.204 (fee-for-service access and public process).
[63] 90 Fed. Reg. 59463 (Dec. 19, 2025).
[64] 90 Fed. Reg. 59478 (Dec. 19, 2025).

executive directive, relies on the same departmental umbrella review, and declares the targeted interventions categorically inconsistent with patient health and safety in hospital settings.[65] The Section 504 proposed rulemaking, in turn, seeks to recalibrate nondiscrimination baselines in ways that diminish protections for the very population affected by these programmatic exclusions by explicitly excluding individuals with gender dysphoria from protections on the basis of disability.

On this same day, the Department also issued a declaration that transgender healthcare for minors does not meet professionally recognized standards of healthcare, the Food and Drug Administration announced it had issued warning letters to 12 manufacturers and retailers for "illegal marketing of breast binders to children for the purposes of treating gender dysphoria," and the Assistant Secretary for Health signed a public health message stating that evidence shows transgender healthcare for minors is "dangerous."[66] Taken together, these actions form a coordinated suite that restricts coverage, constrains provider participation, and narrows civil-rights protections, all focused on the same defined group on the same day.

The internal cross-references within the proposed rules cement that impression that this is targeted campaign against transgender individuals. The CoP NPRM expressly notes that its attributed effects "might be lower" if the Medicaid and CHIP financing prohibition is finalized first, a candid acknowledgment that the two rules are intended to work in tandem to eliminate access through overlapping pathways.[67] The Medicaid preamble likewise frames its prohibition as part of a sequence of agency steps begun earlier in the year, including letters to State Medicaid Directors and to hospitals signaling skepticism about the clinical evidence and demanding policy changes.[68] The Medicaid NPRM emphasizes that it will halt FFP immediately upon effectiveness[69] and though it repeatedly reassures that States may still pay for the same care with State-only funds,[70] the Department has simultaneously referred multiple healthcare entities to the Office of the Inspector General for Investigation for the act of providing transgender healthcare for minors.[71] These

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[65] *See generally*, 90 Fed. Reg. 59463 (Dec. 19, 2025).
[66] *U.S. Dep't of Health & Hum. Servs., Press Release*, HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children (Dec. 18, 2025), https://www.hhs.gov/press-room/hhs-acts-bar-hospitals-performing-sex-rejecting-procedures-children.html.
[67] 90 Fed. Reg. 59475.
[68] *Id.* at 59450.
[69] *Id.* at. 59456.
[70] *Id.* at 59443, 59454, 59459.
[71] HHS (@HHSGov), X (Dec. 26, 2025, at 2:47 PM EST), https://x.com/HHSGov/status/2004640322580578440; Michael B. Stuart, General Counsel, HHS (@HHSGCMikeStuart), X (Dec. 30, 2025, at 4:08PM EST), https://x.com/HHSGCMikeStuart/status/2006110061114851333; *id.* (Jan. 5, 2026, at 6:35PM EST), https://x.com/HHSGCMikeStuart/status/2008321502765093348; *id.* (Jan. 9, 2026, at 4:46PM EST), https://x.com/HHSGCMikeStuart/status/2009743491186794620; *id.* (Jan. 15, 2026, at 6:40 PM EST), https://x.com/HHSGCMikeStuart/status/2011946547005833419; *id.* (Feb. 3, 2026, at 6:35 PM EST), https://x.com/HHSGCMikeStuart/status/2018828343144010025; *id.* (Feb. 11, 2026, at 1:16pm EST), https://x.com/HHSGCMikeStuart/status/2021649628639240524.

referrals suggest that even where States cover this healthcare, they still may be subject to government investigation and enforcement. This underscores that the goal is to remove federal support precisely when the purpose of care is to treat gender dysphoria.

The choice to rename the targeted services as "sex-rejecting procedures" also signals animus. The Medicaid and CoP NPRM preambles define that term to single out pharmacologic and surgical interventions when used to align a minor's body "physical appearance or body with an asserted identity that differs from the child's sex," while embracing the very same drugs and procedures as covered, safe, or acceptable when used for other diagnoses or when perceived to conform to birth sex.[72] That asymmetry, reinforced by carveouts for other pediatric uses and by categorical statements that clinician determinations of medical necessity do not matter when the purpose is treatment of gender dysphoria, functions as a diagnostic proxy while denying that any diagnosis-based exclusion exists. Rebranding the targeted care in pejorative terms, while maintaining coverage and participation for the same modalities in other contexts, reflects hostility to a particular population rather than a neutral safety concern applicable across indications.

The Section 504 Notice of Proposed Rulemaking published the same day further evidences intent to erode protections for the same population targeted by the Medicaid and CoP proposed rules. By proposing to interpret disability law to exclude gender dysphoria from protection for recipients of HHS funding, the Department simultaneously reduces avenues to challenge discriminatory denial of services and narrows remedies available to affected minors within health programs. That move sits alongside the Medicaid NPRM preamble's reliance on litigation developments to discount nondiscrimination concerns in Medicaid and CHIP and to cabin the reach of existing protections under Section 1557 of the Affordable Care Act, which prohibits both sex and disability discrimination in health programs receiving federal financial assistance and administered by the Department.[73] In combination with the hospital and financing proposals, this civil-rights narrowing completes a coordinated regulatory triad: withdraw federal coverage, bar hospital provision, and constrain civil-rights recourse, all targeted at the same adolescents.

The convergence of timing, terminology, and interlocking regulatory mechanisms is powerful evidence that the Medicaid NPRM embodies animus toward transgender youth rather than a lawful, even-handed exercise of program administration. Further, the proposed rule's alleged permissive posture in allowing states to continue coverage of transgender healthcare for minors via Medicaid is patently illusory when read together with the CoP proposed rules, which would prohibit hospitals that provide that very care from participating in the Medicaid program altogether. Indeed, the CoP NPRM itself exemplifies the coercive federal overreach the Supreme Court invalidated in *National Federation of Independent Business v. Sebelius*, which held that Congress cannot employ financial

[72] Proposed 42 C.F.R. § 441.801 (Medicaid NPRM); Proposed 42 C.F.R. § 482.46 (CoP NPRM).
[73] 90 Fed. Reg. 59450-51 (citing *State of Tennessee v. Kennedy*, --F. Supp. 3d---,1:24CV161-LG-BWR, 2025 WL 2982069 (S.D. Miss. Oct. 22, 2025); *United States v. Skrmetti*, 145 S. Ct. 1816 (2025)).

pressure "so coercive as to pass the point at which pressure turns into compulsion."[74] The Court in *South Dakota v. Dole*,[75] similarly recognized that permissible conditions must amount to "relatively mild encouragement" rather than threats to essential funding streams.

Furthermore, HHS's actions reflect the administration's animus against transgender individuals and its coordinated effort across the federal government to end transgender healthcare for minors. For example, all of the federal district courts that have reviewed administrative subpoenas issued by the Department of Justice (DOJ) to healthcare providers seeking personal health information of minor patients receiving transgender healthcare have rebuked DOJ's attempts to enforce those subpoenas.[76] Several courts have held that these subpoenas were issued for the improper purpose of "pressuring providers to cease offering gender-affirming care rather than to investigate specific unlawful conduct,"[77] and that "the government's demand for deeply private and personal patient information carries more than a whiff of ill-intent."[78]

**Conclusion**

The proposed rule is not a neutral program amendment — it is a categorical exclusion that will strip low-income transgender youth of coverage for medically necessary care, violate EPSDT's core mandate, and predictably drive worse mental health outcomes, crises, and avoidable systems costs if finalized. The preamble admits the policy would block care even when clinicians deem it necessary, replacing individualized judgment with a blanket ban that conflicts with Medicaid's amount, duration, and scope requirements and comparability protections, as well as CHIP's statutory flexibilities. The Department leans on an agency-authored report whose methods have been widely criticized by major medical organizations and scholars, while discounting longitudinal evidence showing transgender care is associated with improved mental health and reduced suicidality among adolescents. Its economic analysis tallies trivial "savings" while ignoring foreseeable costs from untreated or abruptly discontinued care, contrary to OMB's

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[74] 567 U.S. 519 (2012).
[75] 483 U.S. 203 (1987).
[76] *See In re Subpoena Duces Tecum No. 25-1431-016*, No. 2:25-mc-00041-JHC, 2025 WL 3562151, at *12 (W.D. Wash. Sept. 3, 2025); *Queerdoc PLLC v. U.S. Dep't of Just.*, No. 2:25-mc-00042, 2025 WL 3013568, at *7 (W.D. Wash. Oct. 27, 2025), *appeal docketed*, No. 25-7384 (9th Cir. Nov. 24, 2025); *In re Admin. Subpoena No. 25-1431-019*, No. 1:25-MC-91324-MJJ, 2025 WL 2607784, at *6 (D. Mass. Sept. 9, 2025), *appeal docketed*, No. 25-2092 (1st Cir. Nov. 14, 2025); *In re Subpoena No. 25-1431-014*, No. MC 25-39, 2025 WL 3252648, at *13 (E.D. Pa. Nov. 21, 2025); *In re 2025 UPMC Subpoena*, No. 2:25-mc-01069-CB, 2025 WL 3724705, at *2 (W.D. Pa. Dec. 24, 2025). *See also In re: Dep't of Just. Admin. Subpoena No. 25-1431-030*, No. 25-MC-00063-SKC-CYC, 2026 WL 33398, at *4 (D. Colo. Jan. 5, 2026) (magistrate judge recommendation to the federal district court stating "the Subpoena never attempts to satisfy its burden as to limited scope" and that the subpoena's requests "which seek personal health data … are not, therefore, relevant in purpose to an [Federal Food, Drug, and Cosmetic Act] investigation").
[77] *Queerdoc*, 2025 WL 3013568, at *7.
[78] *In re 2025 UPMC Subpoena*, 2025 WL 3724705, at *2.

direction to account for ancillary costs and countervailing risks. The harms are not speculative: denial or disruption of indicated treatment is linked to deteriorating mental health, increased suicide risk, and destabilization that reverberates across families, schools, and health systems. And the same-day, interlocking HHS actions — barring hospital provision, narrowing civil-rights baselines, and renaming targeted care in pejorative terms — underscore impermissible animus, not patient safety. For these reasons, and to prevent profound and avoidable harm to young people and their families, CMS must withdraw the proposed rule in full.