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CENTER FOR CHILDREN
AND FAMILIES

February 17, 2026

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS–2451–P, RIN 0938–AV73
Proposed Rulemaking: Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS–2451–P, the proposed rule to prohibit federal financial participation for gender-affirming care for youth in Medicaid and CHIP (hereinafter referred to as "the NPRM").

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for children and families. As part of the McCourt School of Public Policy, CCF provides research, develops strategies, and offers solutions to improve the health of children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA).

CCF's expertise is rooted in deep understanding of Medicaid and CHIP law and policy, including the federal statutory and regulatory frameworks and subregulatory guidance and state-level program implementation. Many of our faculty have decades of experience in drafting, analyzing and explaining Medicaid and CHIP law. Our expertise is routinely sought by state and federal policymakers, the media, and key Medicaid and CHIP stakeholders such as clinicians, advocacy organizations, and parents whose families are covered by Medicaid/CHIP.

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Our comments include numerous citations to supporting research for the benefit of the Centers for Medicare & Medicaid Services (CMS). We direct CMS to each of the studies cited and made available through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

I. Summary of Comments

The NPRM would inflict serious harm on vulnerable youth by prohibiting federal financial participation (FFP) for gender-affirming care in Medicaid and the Children's Health Insurance Program (CHIP). The NPRM imposes politically-motivated decisions on patients, families, and clinicians without reasonable justification and in contravention of the Medicaid and CHIP statutes, as outlined below. If finalized as proposed, the NPRM would be burdensome to implement, imposing costs on states, managed care organizations (MCOs) and clinicians; the NPRM does not adequately account for these costs. For these reasons, we urge CMS to withdraw the NPRM immediately.

II. The NPRM Would Harm Vulnerable Adolescents and Their Families

Transgender and questioning youth make up a small, but disproportionately at-risk group. In 2023, the Centers for Disease Control and Prevention's national Youth Risk Behavior Survey found that 3.3 percent of U.S. high school students identified as transgender, and 2.2 percent identified as questioning. This small group experienced a higher prevalence of violence, poor mental health, suicidal thoughts and behaviors, unstable housing, and a lower prevalence of school connectedness, compared to their cisgender peers.[1] Such distress, stigma and violence can have lasting impacts on youth and must be prevented.

Yet, the NPRM would do just the opposite. By targeting adolescents with gender dysphoria and limiting their access to care, the NPRM would expose this already vulnerable group to greater risks of harm. Research published in the journal Nature Human Behavior and conducted by the Trevor Project found that state laws targeting transgender people made trans and nonbinary young people more likely to attempt suicide in the past year.[2] The

[1] N.A. Suarez, et al., "Disparities in School Connectedness, Unstable Housing, Experiences of Violence, Mental Health, and Suicidal Thoughts and Behaviors Among Transgender and Cisgender High School Students — Youth Risk Behavior Survey, United States, 2023," *MMWR Suppl 2024*, 73(Suppl-4): 50–58. DOI: http://dx.doi.org/10.15585/mmwr.su7304a6

[2] W.Y. Lee, 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* 8, (Nov 2024): 2096-2106. https://doi.org/10.1038/s41562-024-01979-5

preamble does not address these likely harms but rather asserts that a blanket ban on FFP for gender-affirming care is necessary to protect the "best interests" of recipients without providing sufficient evidence to support such a ban or considering any alternatives. Patients, along with their families and clinicians, are best suited to determine what is in their own best interests, as Medicaid's pediatric benefit requires.

III. The NPRM Lacks Sufficient Statutory Justification and Undermines Medicaid/CHIP through Alarming Administrative Overreach

Federal law describes the services for which federal financial participation (FFP) is not available under Medicaid at section 1903(i) of the Social Security Act (hereinafter referred to as "the Act"). There is no provision prohibiting FFP for gender-affirming care. Under CHIP, states have even more flexibility; states must provide the benefits described under section 2103 of the Act and may provide coverage for "categories of additional services" under section 2103(c), even beyond the categories listed (see 2103(c)(3)). Some Medicaid FFP prohibitions are incorporated into CHIP by cross reference at 2107(e), but none relate to gender-affirming care. Congress attempted to add statutory limitations on FFP for gender-affirming care in Medicaid and CHIP during the debate around last year's budget reconciliation law, H.R. 1 (known as the "One, Big, Beautiful Bill," P.L. 119-21), but such provisions were not included in the final legislation.[3] Thus, Congress recognizes FFP is available for gender-affirming care in Medicaid and CHIP under current law, and CMS does not have the authority to impose these new limitations on federal funding on its own.[4]

For Medicaid, the NPRM relies on two statutory provisions as the bases for administrative action: (1) section 1902(a)(19) of the Act regarding simplicity of administration and the best interests of the recipients[5] and (2) section 1902(a)(30)(A) of the Act regarding utilization review and payment sufficiency.[6] In no way do these provisions justify the

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[3] See the original House-passed version of H.R. 1, section 44125, available at https://www.congress.gov/bill/119th-congress/house-bill/1/text/eh.

[4] U.S. Const., art. 1, § 9, cl. 7.

[5] Section 1902(a)(19) provides: "1902(a) A State plan for medical assistance must— …(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;" available at https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

[6] Section 1902(a)(30)(A) provides: "1902(a) A State plan for medical assistance must— …(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;" available at https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

NPRM. Section 1902(a)(19) is only serving as the basis of current regulations to support basic program administration, such as determining eligibility and verifying income (see 42 CFR 435.911 and 435.940). Section 1902(a)(30)(A) only serves as the basis of current regulations intended to ensure payment sufficiency, such as reviewing payment rate reductions to ensure ongoing access (42 CFR 447.203), implementing upper payment limits (42 CFR 447.250(b), referencing 447.253(a)(2), and 42 CFR 447.300, referencing 447.302 through 447.325), and reviewing proposed payment rate changes for the ingredient costs or professional dispensing fees for prescription drugs (42 CFR 447.500(a)(5) and 42 CFR 447.518(c)).

Sections 1902(a)(19) and 1902(a)(30)(A) are also serving as the basis of current regulations regarding the prohibition on payment for provider-preventable conditions but this is easily distinguished from the NPRM because section 2702 of the Affordable Care Act (P.L. 111-148) required the Secretary to exercise authority to prohibit federal payment of certain provider preventable conditions and health care acquired conditions (see 42 CFR 447.26). There is no such statutory authority to limit federal payment for gender-affirming care in Medicaid.

For CHIP, the NPRM relies on section 2101(a) regarding the purpose of the Children's Health Insurance Program.[7] Section 2101(a) is the basis of current regulations to support strategic planning, reporting, and evaluation (42 CFR 457.700) and documentation such as the kinds of records a state must maintain, the minimum retention period for such records, and the conditions under which those records must be made available (42 CFR 457.965). As with Medicaid, there is no statutory authority to limit federal payment for gender-affirming care in CHIP.

Thus, relying on sections 1902(a)(19), 1902(a)(30)(A) and 2101(a) to justify banning federal funds for a particular set of services is a clear departure from and wholly inconsistent with the meaning of the statutory provisions themselves and how they have served as the basis for existing regulations. CMS plainly lacks the statutory authority to make the changes outlined in the NPRM – as Congress itself has made clear – and so it is misusing basic program governance authority to eliminate access to care for a particularly vulnerable group of adolescents. This sets an alarming and dangerous precedent.

[7] Section 2101(a) provides: "2101 (a) Purpose.—The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through—(1) obtaining coverage that meets the requirements of section 2103, or (2) providing benefits under the State's Medicaid plan under title XIX, or a combination of both." available at https://www.ssa.gov/OP_Home/ssact/title21/2101.htm.

IV. The NPRM is in Direct Violation of Longstanding Medicaid Law

Not only do the statutory bases cited in the NPRM not justify the proposal and therefore constitute an alarming Administrative overreach of Congressional authority, the proposal would also clearly violate *at least* three other provisions of Medicaid law: Medicaid's pediatric benefit known as EPSDT (Early and Periodic Screening, Diagnostic and Treatment), the Medicaid drug rebate program, and Medicaid rules regarding the amount, duration, and scope of services.

A. EPSDT Requires Coverage of Medically Necessary Care

States are required to provide EPSDT to children and youth under age 21 covered by Medicaid and children and youth under age 19 covered by Medicaid expansion CHIP programs (known as M-CHIP).[8] States with separate CHIP programs (known as S-CHIP) can also choose to offer EPSDT or EPSDT-like services to separate CHIP enrollees, and 15 of 21 states with S-CHIP programs chose to do so as of 2025.[9] Under EPSDT, states are required to furnish all section 1905(a) Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, even if the state does not otherwise cover such services under the state plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.[10]

In the preamble to the NPRM, CMS underscores previous EPSDT coverage guidance that emphasized the requirement on states to take into account the particular needs of the child, including the child's long-term needs, not just what is required to address the immediate situation (90 FR 59452). Moreover, under EPSDT, states are not allowed to impose any "hard" limits or caps on care, though they can impose "soft" or tentative limits for utilization management. In the 2014 EPSDT Implementation Guide, CMS writes, "because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements,"

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[8] See sections 1902(a)(43) and 1905(r) of the Act for applicability of EPSDT to Medicaid enrollees. EPSDT is also required for children and youth enrolled in M-CHIP programs by virtue of being enrolled in Medicaid, see section 2101(a)(2) of the Act.

[9] T. Brooks, et al., "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision," (Washington, DC: KFF, April 2025), available at https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/#table-2

[10] Centers for Medicare & Medicaid Services, "Early and Period Screening, Diagnostic, and Treatment" (Baltimore, MD: Centers for Medicare & Medicaid Services), available at https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment.

citing guidance dating back to 1990.[11] And yet, the NPRM would impose a blanket ban on gender-affirming care; a ban, by its very nature, is a hard cap that does not take into account the particular needs of the child or the child's long-term needs.

B. Prescription Drugs Used for Gender-Affirming Care Cannot be Excluded from Medicaid Coverage and Payment

Under section 1927 of the Act, in order for federal Medicaid payment to be available for their covered outpatient drugs, a manufacturer must enter into a rebate agreement with the Secretary of Health and Human Services (HHS), known as a National Drug Rebate Agreement, under which it must pay certain rebates to the federal government and to states. In turn, state Medicaid programs must generally cover all FDA-approved outpatient drugs produced by the manufacturer for any medically accepted indication, which is defined as "any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in" certain drug compendia.[12]

Section 1927(d)(1)(B) provides a very limited number of exceptions to this requirement. For example, a state "may exclude or otherwise restrict coverage of a covered outpatient drug" if under subparagraph (d)(1)(B)(i) the prescribed use is *not* for a medically accepted indication or if under subparagraph (d)(1)(B)(ii), the drug is contained in a list of drugs subject to exclusion under paragraph (d)(2).[13] Paragraph (d)(2) states that the "following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted" and then lists drugs used for a small number of indications.[14]

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[11] Centers for Medicare & Medicaid Services, "EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" (Baltimore, MD: Centers for Medicare & Medicaid Services, June 2014), available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.

[12] Section 1927(k)(6) of the Act.

[13] There are only two other exceptions. Under subparagraph (d)(1)(B)(iii), the drug is subject to restrictions under a separate rebate agreement between a manufacturer and a state authorized by the Secretary in lieu of a federal rebate agreement (which no state currently has). Under subparagraph (d)(1)(B)(iv), the state has excluded coverage of the drug from its formulary under paragraph (d)(4). But such a formulary must be an open formulary as states are required under subparagraph (d)(4)(D) to permit coverage of a drug excluded from the formulary pursuant to a prior authorization process.

[14] These include agents used for anorexia, weight loss, or weight gain; agents used for fertility; agents used for cosmetic purposes or hair growth; agents used for the symptomatic relief of coughs and colds; prescription vitamins and minerals except for prenatal vitamins and fluoride; nonprescription drugs except for tobacco cessation for pregnant women; drugs for which manufacturers requires tests or monitoring services purchased from the manufacturer as a condition of sale; and agents used for the treatment of sexual or erectile dysfunction. Agents used for smoking cessation and two classes of drugs — barbiturates and benzodiazepines — are also listed in subparagraph (d)(2). But subparagraph (d)(7) separately prohibits states from excluding coverage of these three uses or classes.

The preamble to the NPRM states that prohibiting coverage of certain covered outpatient drugs used for gender-affirming care does not conflict with the requirements of section 1927 because those drugs will still be covered for other indications. However, such a prohibition clearly violates section 1927. Drug compendia referenced in section 1927 — listed in subparagraph (g)(1)(B)(i) — support, for example, evidence-based medical indications for hormone replacement therapy and puberty blockers used in gender-affirming care. In addition, as noted, paragraph (d)(2) lists several medical uses of covered outpatient drugs that states may elect to exclude. But use for gender-affirming care is not included in that list and therefore drugs used for such care cannot be excluded from Medicaid coverage and payment. Finally, there is no authority granted to the Secretary in section 1927 for a blanket *federal* prohibition of coverage of outpatient drugs used for gender-affirming care even if there is an applicable exclusion (which there is not). Section 1927(d) only permits *states*, at their option, to exclude or restrict a limited number of drugs, drug classes, or their medical uses. For example, while drugs used for weight loss may be excluded by states and most do, some states voluntarily cover GLP-1 drugs for a weight loss indication.[15] (States are required to cover GLP-1 drugs for other medically accepted indications such as for the treatment of diabetes.)

C. Medicaid Services May Not Be Denied Based on Diagnosis, Type of Illness or Condition

Under section 1902(a)(10)(B), states are required to ensure that services are sufficient in amount, duration and scope to reasonably achieve their purpose, and under 42 CFR 440.230(c), states are expressly prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service to an otherwise eligible beneficiary solely because of the *diagnosis, type of illness, or condition*. Yet, under the rubric laid out in the NPRM, the same services would be allowable under certain circumstances (e.g., medically verifiable disorder of sexual development) and not under others (e.g., gender dysphoria). The NPRM is therefore a clear violation of the plain reading of Medicaid's amount, duration and scope standard, and the mere assertion to the contrary in the preamble does not change this (90 FR 59451).

V. The NPRM is in Direct Violation of Longstanding CHIP Law and Would Extend the Ban on Gender-Affirming Care to Adults

Not only does the statutory basis cited in the NPRM not justify the proposal and therefore constitute an alarming Administrative overreach of Congressional authority, the proposal

[15] Elizabeth Williams, "Medicaid Coverage and Spending on GLP-1s" (Washington, DC: KFF, January 2026), available at https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s/

would also clearly violate CHIP's benefit structure and extend the ban on gender-affirming care to 18-year-olds with CHIP coverage, despite describing the ban as only applicable to minors.

As noted earlier, states may choose to set up their CHIP programs in one of three ways: M-CHIP, S-CHIP, or a combination. States with M-CHIP programs must provide Medicaid's EPSDT benefit to CHIP children and youth, therefore the comments above related to the NPRM's clear violation of EPSDT are also applicable to children enrolled in M-CHIP. Under section 2103(a), S-CHIP programs must include a minimum set of statutorily required benefits (e.g., well-baby and well-child visits, dental, behavioral health, and vaccines) and adhere to one of three basic structures: benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. Benchmark coverage includes benefits that are substantially equal to the health benefits in the federal employee health benefit (FEHB) plan, the state employee plan, or the largest commercial health maintenance organization (HMO) in the state, as outlined under section 2103(b). Benchmark-equivalent coverage has an aggregate actuarial value that is at least equivalent to the coverage under one of the benchmark plans and must include inpatient and outpatient hospital services, physicians' surgical and medical services, and laboratory and X-ray services as described in section 2103(a)(2). Finally, states may choose Secretary-approved coverage under section 2103(a)(4), which is coverage the Secretary of HHS has determined would provide appropriate coverage for the children and youth covered under the program. Most states that have selected the Secretary-approved coverage option have done so in order to make S-CHIP benefits the same or very similar to Medicaid's EPSDT benefit (15 of 21 states with S-CHIP programs include EPSDT, via the Secretary-approved option).[16]

If a state selects a benchmark that includes gender-affirming care, the state could also include such care in S-CHIP, or the state could alter the benefit package to exclude gender-affirming care so long as the package still meets the actuarial equivalency standard. However, there is no authority for CMS to exclude gender-affirming care in a state that has selected a benchmark with such coverage and has chosen to include it. Also, if a state selects a benchmark that does not include gender-affirming care and the state chooses to add such services, the Secretary cannot prevent the state from doing so. Section 2103(c)(3) of the Act reads: "Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) [related to the categories of basic, required services such as inpatient hospital described above] or (2) [related to categories of additional services such as prescription drugs, vision, and hearing services]." Thus, in states with M-CHIP, states and the federal government must comply with EPSDT and provide gender-affirming care when

[16] Brooks, op. cit.

medically necessary. In states with S-CHIP, states can choose whether to provide gender-affirming care and CMS may not prevent them from doing so.

The CHIP ban is also unjustifiably broader than described. While the preamble to the NPRM goes to great lengths to describe the proposal as banning gender-affirming care out of a purported concern for minors (see lengthy discussion of the "HHS Review" which includes this limitation, "Treatment of adults constitutes a separate topic and is not addressed in this Review" on page 11), the CHIP ban extends to 18-year-olds.[17]

VI. Implementing the NPRM Would Be Incredibly Complex for States

By banning gender-affirming care for certain purposes but allowing FFP for the same services to be delivered for different purposes, the NPRM sets up an impossible standard to implement. States and managed care organizations would have to distinguish between permissible and impermissible purposes of care, which may not be possible from current data sources. The NPRM also proposes different age standards for Medicaid (ban under 18 years old) and CHIP (ban under 19 years old), meaning that, in some cases, providers would need to know the adolescent's family income level before determining whether such care is permissible.[18] These and other administrative complexities directly contradict the very statutory reference the NPRM purports to implement, section 1902(a)(19) which, among other requirements, emphasizes the *simplicity of administration*.

VII. Conclusion

The NPRM is an unjustified administrative overreach, violating longstanding Medicaid and CHIP statutory requirements. Left unchecked, this Administration and future Administrations could continue to erode Medicaid and CHIP based on political decision-making. Moreover, the rule unfairly targets a small, vulnerable group of adolescents who are already at high risk for adverse physical and mental health outcomes. For these reasons, CMS should immediately withdraw the NPRM.

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[17] U.S. Department of Health and Human Services, "Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices" (Washington, DC: HHS, November 2025), available at https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report.pdf.

[18] Consider Mississippi, where an 18-year-old enrollee of Mississippi Health Benefits (the name of both the Medicaid and separate CHIP programs in the state) would be eligible for gender-affirming care if the patient's family income falls below 133 percent of the federal poverty level (and thus enrolled in Medicaid) but would be ineligible for the same care if the patient's family income were to fall between 133 and 209 percent of the federal poverty level (making the 18-year-old a CHIP enrollee). See https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/#table-1.

Please direct any questions about our comments to Kelly Whitener at kelly.whitener@georgetown.edu or Joan Alker at joan.alker@georgetown.edu.

Sincerely,

Joan Alker
Research Professor
Executive Director