CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Office of the Secretary

February 17, 2026

Submitted via Federal eRulemaking Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2451-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children – Proposed Rule, RIN 0938-AV73

To Whom It May Concern:

The California Health and Human Services Agency (CalHHS), along with the undersigned departments, submits the following comments for your consideration on the Proposed Rule entitled Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, RIN 0938-AV73, which was published on December 18, 2025. CalHHS urges the Centers for Medicare & Medicaid Services (CMS) to withdraw this proposed rule that seeks to eliminate access to evidence-based care and jeopardizes the health of California's youth.

The Proposed Rule uses a new and misleading term, "sex-rejecting procedures," to refer to gender-affirming care, a set of treatments that are proven to be safe and effective for the treatment of gender dysphoria in adolescents and adults (Coleman et al., 2022). The Proposed Rule would require that a State Medicaid plan specify that the Medicaid agency will not make payment under the plan for these services for individuals under age 18 and prohibit the use of Federal Medicaid dollars to fund gender-affirming care for individuals under age 18. In addition, it would require that a separate State Children's Health Insurance Program (CHIP) plan ensure that the CHIP agency will not make payment under the plan for gender-affirming care for individuals under age 19 and prohibit the use of Federal CHIP dollars to fund gender-affirming care for individuals under age 19.

California remains committed to safeguarding access to essential, lifesaving health care services and will continue to take decisive action against policies it views as harmful and inhumane. Accordingly, California has significant concerns with this Proposed Rule and the potentially devastating effects it will have on the lives of some Medi-Cal members and their families.

I. The Proposed Rule restricts access to medically necessary, evidence-based health care and would harm the health of Medi-Cal members.

California remains dedicated to ensuring that all Medi-Cal members have access to medically necessary, evidence-based health care services, including gender-affirming care services. The Notice of Proposed Rulemaking asserts that there is an absence of unbiased, evidence-driven clinical guidance on the benefits of gender-affirming care for youth. This assertion is false. On the contrary, there are ample nationally recognized, peer-reviewed, and evidence-based clinical practice guidelines that support the safe and effective use of gender-affirming care services for youth, including from the World Professional Association for Transgender Health (WPATH) (Coleman et al., 2022), the Endocrine Society (Hembree et al., 2017), the American Academy of Pediatrics (AAP) (Rafferty et al., 2018), the American Psychological Association (American Psychological Association, 2015), and other leading medical and mental health organizations. Additionally, in direct contrast to the findings in the 2025 federal HHS report, in May 2025, the Utah Department of Health (Utah DOH) and Human Services released a report commissioned by the Utah Legislature regarding medical treatment options for pediatric gender dysphoria, which found that "overall, there were positive mental health and psychosocial functioning outcomes" from gender-affirming care services. The report also found that "patients that were seen at the gender clinic before the age of 18 had a lower risk of suicide compared to those referred as an adult." (LaFleur, 2025).

The standard of care for pediatric gender dysphoria in the United States is shaped by guidelines from major medical organizations (e.g., American Academy of Pediatrics, Endocrine Society, World Professional Association of Transgender Health) and supports gender-affirming care (Coleman et al., 2022). This includes puberty blockers and hormone therapy for some adolescents under carefully monitored clinical protocols and informed parent or guardian consent (Dowshen et al., 2025). These guidelines are based on a body of clinical experience and research indicating that, for many youth, gender-affirming care, both social and medical, is associated with mental health benefits and reduced risk behaviors (APA, 2015; Ehrensaft, 2018; Ehrensaft et al., 2018; Malpas et al., 2018; Olson et al., 2016; Olson-Kennedy et al., 2019; Telfer et al., 2018).

The evidence base for pediatric gender dysphoria treatment includes observational studies, case-control methods, prospective cohort data, and some longitudinal follow-ups showing reduced gender dysphoria and suicidality after gender-affirming treatment (Ehrensaft, 2018; Ehrensaft et al., 2018; Malpas et al., 2018; Mehringer et al., 2021; Olson-Kennedy et al., 2018). Gender-affirming medicine has been critiqued for the lack of randomized control trials (RCTs), in which the researchers assign participants randomly to treatment and control groups. This is because RCTs for gender-affirming care are impractical and unethical in most cases. Where treatments, including gender-affirming care, are known or believed to alleviate the symptoms of a diagnosis (here, gender dysphoria), it is immoral to deny patients those treatments by assigning them to a control group. Additionally, RCTs can suffer from the same biases as observational studies. Frequently, results obtained in a laboratory fail to translate to the world outside the lab.

Critics of gender-affirming care point out the limitations in evidence quality in systematic reviews and clinical guidelines. However, it is important to note that these reviews and guidelines do not characterize the data as inadequate to support gender-affirming care interventions as treatment of gender dysphoria. Instead, authors of systematic reviews themselves acknowledge that “clinicians should work with patients to ensure that care reflects the experience, goals, and priorities of those needing care,” and that many commonly offered medical interventions are based on similar quality evidence. It is therefore “a clear violation of the principles of evidence-based shared decision-making” to outlaw an entire set of interventions on this basis (Guyatt et al., 2025).

The conclusions of the report "Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices" (HHS Report), published by the United States Department of Health and Human Services and relied on to justify this proposed rule, stand in clear conflict with positions held by major professional medical associations, which support access to gender-affirming care based on existing evidence that it can improve psychological outcomes for transgender and gender diverse youth when provided within established clinical frameworks guided by WPATH. In response to the release of the HHS report, the AAP issued a statement rejecting characterizations of gender-affirming care as negligent or driven by political ideology, emphasizing that such claims “misrepresent the consensus of medical science, undermine the professionalism of physicians, and risk harming vulnerable young people and their families” (Walker, 2025).

The divergence from prominent major medical associations highlight the report's willingness to not reflect a unified scientific consensus or standard of care.
If the HHS Report is used to justify clinical guidelines, laws, or regulations, as is the case with the proposed rule, its methodological flaws and contested conclusions will have negative public health consequences. Restrictive policies shaped by the report have already begun to limit access to medically necessary, evidence-informed care for transgender youth, leading to worsened mental health outcomes, including anxiety, depression, and suicidality, which are already well documented at higher rates in this population (Bhatt et al., 2022). Although the report emphasizes potential harms of medical interventions for gender dysphoria, it does not account for harms associated with withholding appropriate care, a point raised by clinicians and stakeholders in the field (de Vries et al., 2021; Green et al., 2022).

Research shows:

- Access to gender-affirming care reduces health disparities such as HIV/AIDs, STI infection, suicidality, mental health distress, drug use, and other risk behaviors for transgender and gender diverse populations in the United States (Bhatt et al., 2022).
- Access to gender-affirming care is positively linked with the mental health of transgender youth, lowering their risk of depression and suicide (Bauer et al., 2015; Green et al., 2022).
- Transgender youth who have access to gender-affirming medical care experience improvements in mental health and often show mental health comparable to their cisgender peers (Toomey et al., 2022).
- A study of 104 youths aged 13-20 years old observed 60% lower odds of depression and 73% lower odds of suicidality among youth who had initiated puberty blockers or gender-affirming hormones compared with youths who had not (Tordoff et al., 2022).

Not only does banning gender-affirming care for individuals under the age of eighteen neglect scientific research, but it also impedes the relationship between physicians, youth, and their families, and their ability to engage in shared decision-making. This rule, if adopted, will limit the availability of treatment for adolescents experiencing gender dysphoria and put them at risk for long-term complications, including worsening mental health, increased distress, and higher risks of self-harm or suicide (Green et al., 2022).

II. The proposed rule relies on misinterpreted evidence and makes conclusions that are not scientifically verified.

The proposed rule relies on the HHS Report, as well as the "Independent review of gender identity services for children and young people" by Dr. Hilary Cass (known as the Cass Review) to justify its ban on pediatric gender-affirming care. Both of these reports are based on unsound science and misinterpreted evidence. While the HHS Report frames itself as evidence based and peer reviewed, significant concerns about transparency, methodology, author expertise, and alignment with scientific consensus limit its scientific validity and integrity. It is not currently equivalent to the rigor expected in systematic academic and medical reviews used to guide clinical practice (Dowshen et al., 2025). The report's influence on federal policy changes warrants scrutiny due to the serious implications for adolescent health.

The HHS report uses questionable citation practices. Independent critics and media reports note inclusion of studies published in non-traditional journal and citations of controversial or withdrawn concepts including rapid-onset gender dysphoria (ROGD), raising concerns about evidence selection bias (Manto, 2025). ROGD is a widely influential but unvalidated research hypothesis. It describes adolescents and young adults who, from their parents' perspective, did not meet the gender dysphoria diagnostic criteria as children but as adolescents "suddenly" claim to be gender dysphoric or transgender, as though "out of the blue," disregarding the commonality of other seemingly sudden changes that may occur in the transition from childhood to adolescence. No psychological, pediatric, or health professional organization, in the United States or abroad—or any established professional organization—recognizes "ROGD" as a diagnosis or mental disorder. Nor does the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or any other clinical guidelines list ROGD as a diagnosis. The person who coined the phrase "ROGD" has herself acknowledged that "[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis" (Littman, 2019).

Major medical organizations such as the American Psychiatric Association (APA) have also explicitly criticized the report for lacking transparency, noting that it "fails to clearly articulate how the studies it reviewed were selected, what criteria governed inclusion or exclusion, or how their quality was assessed," and therefore, its conclusions cannot be accepted "at face value" (see, APA Peer Review). Observers have also noted that many of the report's authors are public critics of gender-affirming care who lack clinical research and treatment delivery experience in transgender youth and adults, which limits their ability to weigh clinical evidence effectively (Gaffney & Merelli, 2025).

In addition to the HHS Report, the Cass Review fails to meet standards for scientific rigor and does not support the ideological position of the Federal administration. Researchers have found that the Cass Review:

- Does not follow established standards for evaluating evidence and evidence quality.
- Fails to contextualize the evidence for gender-affirming care with the evidence base for other areas of pediatric medicine.
- Misinterprets and misrepresents its own data.
- Levies unsupported assertions about gender identity, gender dysphoria, standard practices, and the safety of gender-affirming medical treatments and repeats claims that have been disproved by sound evidence.
- Has serious methodological flaws, including the omission of key findings in the extant body of literature.

Researchers found that the Review's relationship with and use of the York systematic reviews violates standard processes that lead to clinical recommendations in evidence-based medicine (McDeavitt et al, 2025, p.4). Reliance on the Cass Review as scientific evidence is inappropriate, and it should not form the basis of health policy or regulations.

In fact, the Cass Review makes statements that are consistent with the models of gender-affirming medical care described by WPATH and the Endocrine Society. The Cass Review does not recommend a ban on gender-affirming medical care.

The proposed rule's divergence from prominent major medical associations' roles, conclusions, and guidance demonstrates a disregard for the unified scientific consensus and standard of care for gender diverse youth.

III. The terminology in the Proposed Rule is vague, ambiguous, and confusing and would be unworkable to implement.

The definitions in the Proposed Rule are vague and confusing from a clinical perspective and leave significant uncertainty as to how state Medicaid agencies and providers should comply with the Proposed Rule's requirements. The Proposed Rule defines "sex-rejecting procedures" as "any pharmaceutical or surgical intervention that attempts to align a child's physical appearance or body with an asserted identity that differs from the child's sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based

traits; or (2) intentionally altering a child's physical appearance or body, including amputating, minimizing, or destroying primary or secondary sex-based traits such as the sexual and reproductive organs". The Proposed Rule also excludes from the definition of "sex-rejecting procedures" procedures undertaken: (i) to treat a child with a medically verifiable disorder of sexual development; (ii) for purposes other than attempting to align a child's physical appearance or body with an asserted identity that differs from the child's sex; or (iii) to treat complications, including any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of these procedures.

As currently written, the Proposed Rule would be administratively burdensome and impracticable – if not impossible – to implement. The inclusion of the term "intentionally" in the definition of "sex-rejecting procedures" introduces the unrealistic requirement that state Medicaid agencies divine the specific state of mind of a provider when providing a particular medical treatment to a patient. Further, the term "natural biological functions" is extremely vague and overbroad, potentially applying to anything from neurological processes to immune responses to hair and nail growth. Finally, both the prohibitions and the exclusions listed in the Proposed Rule do not correspond to specific diagnosis or treatment codes, and the Proposed Rule lacks clarity as to coverage of medications that may be used for treatment of a wide array of conditions (e.g. GnRH agonists for precocious puberty, oncology, IVF). Given the ever-evolving nature of medical science and clinical practice, any attempt to resolve the above uncertainties by introducing greater specificity into the Proposed Rule would be impractical at best, and at worst, would chill the provision of a host of medically necessary services outside the realm of gender-affirming care, causing further harm to the health of Medicaid recipients.

IV. The Proposed Rule would create an unlawful categorical exclusion from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

The longstanding federal Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit has been historically recognized by both CMS and courts[1] as a broad, affirmative entitlement, not a discretionary benefit subject to categorical exclusions. Therefore, the federal EPSDT statute does not allow CMS to carve out an entire class of services (i.e., gender-affirming care services) for children based on policy disagreement or generalized assertions regarding clinical efficacy or appropriateness. By replacing individualized medical necessity determinations with a nationwide categorical exclusion, the proposed rule violates federal law, would require an act of Congress to change, and

[1] See *Collins v. Hamilton* (2003) 349 F.3d 371 and *Chisholm v. Hood* (2001) 133 F. Supp 2d 894.

would prevent State Medicaid programs from fulfilling their statutory EPSDT obligations by substituting federal policy judgments for the case-specific assessments required by the Medicaid Act.

CalHHS and our departments are committed to advancing health equity and ensuring access to medically necessary, evidence-based care for all Medi-Cal members consistent with federal EPSDT statutory requirements. To this end, CalHHS urges CMS to withdraw the Proposed Rule. Thank you again for the opportunity to provide this feedback.

Sincerely,

Kim Johnson
Secretary
California Health and Human Services Agency

Michelle Baass
Director
Department of Health Care Services

Erica Pan, MD, MPH, FIDSA, FAAP
California State Public Health Officer
Director, Public Health

Mary Watanabe
Director
Department of Managed Health Care

Elizabeth Landsberg
Department of Health Care Access and Information

Jessica Altman
Executive Director
Covered California

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