February 5, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Daniel Brillman
Deputy Administrator and Director of
Medicaid & Children's Health Insurance
Program Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

RE: Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children (CMS-2451-P)

Dear Dr. Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, we appreciate the opportunity to comment on the proposed rule published in the Federal Register on December 19, 2025, regarding the provision of "sex-rejecting procedures" as an approach for gender dysphoria in the Medicaid and Children's Health Insurance Program (CHIP).

CMS is proposing to prohibit federal financial participation in Medicaid and CHIP for "sex-rejecting procedures" provided to individuals under age 18 in Medicaid and under age 19 in CHIP, regardless of a provider's clinical assessment of medical necessity. The proposed rule defines "sex-rejecting procedures" as pharmaceutical or surgical interventions intended to align a minor's physical development or appearance with an asserted identity different from the minor's sex, which CMS defines based on reproductive function. The definition excludes treatment for medically verifiable disorders of sexual development, interventions performed for unrelated medical reasons, and treatment of complications arising from prior procedures. If finalized, the FFP prohibition would take effect immediately. Federal funding would remain available for services outside the defined scope, including psychotherapy and mental health counseling under Medicaid's mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions and analogous benefits in CHIP programs. CMS also notes that states may continue to fund sex-rejecting procedures using state-only dollars. CMS estimates that 28 states and territories would need to revise their policies, and

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all states and territories would be required to submit State Plan Amendments confirming compliance with the rule, if finalized.

The AAFP encourages CMS to withdraw this proposed rule. While CMS argues that this proposed rule does not regulate provider-patient communication, **prohibiting federal reimbursement for any service effectively constrains family physicians' ability to provide comprehensive, evidence-based care and undermines the physician-patient relationship central to primary care.** Further, disruptions to longitudinal care delivery have been well-documented in driving poor health outcomes and higher downstream costs, including increased emergency department utilization, greater incidence of behavioral health crises, and heightened long-term care needs.[i, ii] These clinical impacts are compounded by significant administrative demands. If finalized, the rule will require physicians and practices to review the new coverage limitations, counsel families on shifting benefits, modify documentation workflows, and reconfigure billing processes to ensure compliance with the prohibition. Implementing and sustaining these changes will impose significant administrative burdens on physicians that divert scarce staff time away from patient care and toward ongoing compliance tasks. The burden will fall hardest on small and rural practices, community health centers, and other safety-net providers that operate with minimal infrastructure and already face workforce and financing constraints.

Further, this proposed rule risks causing significant patient and parent confusion across the healthcare ecosystem, including Medicaid, CHIP, and private payers. If finalized, the rule would block the use of federal financial participation for certain medical services, while allowing states to cover the same services with state only dollars. At the same time, the 2025 Hospital Conditions of Participation proposed rule released in concert with this proposed rule would bar Medicare and Medicaid participating hospitals from providing these services to minors altogether, regardless of payer. This combination of proposed rules produces a fragmented system in which families will have to parse variable plan policies, state only coverage exceptions, and facility-level restrictions, increasing the likelihood of patient confusion, unexpected out-of-pocket costs, and disruptions in care. Moreover, on December 3, 2025, the HHS Office for Civil Rights issued guidance reaffirming parents' rights to access their children's health information and underscoring HHS's priority of strengthening parental involvement in clinical decision-making. CMS's proposed prohibition appears in tension with HHS's broader policy priority, as it would limit parents' ability to participate fully in decisions affecting their children's treatment options.

This proposed rule would also impose significant operational and fiscal responsibilities on states. CMS estimates that the implementation of this rule will cost each state a one-time administrative cost of $5,468. This assumption underestimates the operational and fiscal realities states face. Complying with the rule would require states to revise their Medicaid and

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CHIP State Plans, reconfigure reimbursement systems, and conduct extensive provider and beneficiary communications. At the same time, states will need to determine whether, and how, to use limited state-only dollars to continue covering services previously supported through federal matching funds. State Medicaid and CHIP budgets already operate under considerable strain as states work to maintain eligibility, sustain provider networks, and ensure access to essential services.[iii] And most states lack the resources to replace federal matching funds for the services currently covered with federal financial participation.[iv]

Thus, under this proposed rule, the impetus of access to these services will shift from clinical need to state financial capacity. Shifting coverage for these services to state-only financing will likely trigger uneven availability, longer wait times, and broader care disruptions across states. Research shows that federal Medicaid financing changes can shift costs to states by more than 10% of their own-source revenues. Because states must balance their budgets, they often respond with service cuts, lower provider rates, and other measures that widen cross-state disparities in access.[v] These fiscal pressures mean that the effects of the prohibition will extend beyond the targeted services into adjacent areas of care, including behavioral health supports such as psychotherapy and counseling that CMS maintains would remain federally matchable under this proposed rule. In practice, children's treatment plans rely on coordinated, integrated care so prohibiting one component affects the entire care continuum. As a result, the proposed prohibition risks hindering physicians' ability to deliver timely and coordinated treatment, and places children's access to care increasingly at the mercy of their state's fiscal capacity.

CMS grounds this proposed rule in authority established under §1902(a)(19) and §1902(a)(30)(A) of the Social Security Act. These provisions relate to the best interests of beneficiaries and the efficiency and quality of care, but they do not grant CMS authority to define categories of medical services that states are prohibited from covering. By prohibiting federal financial participation, the proposed rule would functionally prevent states from covering these services for Medicaid beneficiaries, despite CMS's assertion that states may use state-only funds. And as stated above, states are limited in their ability to absorb a categorical shift of this magnitude given structural budget constraints. **As a result, CMS is at risk of exceeding its statutory authority and entering the physician's scope of practice and state plan jurisdiction.**

Also, CMS cites the 2025 HHS Review on Gender Dysphoria as the basis for the proposed prohibition. While the Review critiques the evidentiary basis for several clinical guidelines and identifies methodologically constrained research, its conclusions about risks and benefits are drawn from a body of evidence it acknowledges is limited and inconsistent. This inherent uncertainty makes the Review an atypical foundation for a categorical federal funding prohibition. Historically, in areas where evidence is evolving or incomplete, Medicaid policy

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has relied on individualized medical-necessity determinations, adherence to professional standards of care, and state plan authority, rather than diagnosis-based exclusions.[vi] Consistent with 42 CFR §440.230, Medicaid services must be provided in sufficient amount, duration, and scope to achieve their intended purpose, and mandatory services cannot be denied solely because of a beneficiary's diagnosis, type of illness, or condition. In this context, the limitations identified in the HHS Review reinforce the need for continued, individualized clinical discretion, improved data collection, and ongoing evaluation, and not a categorical federal prohibition.

We therefore recommend that CMS withdraw the proposed rule. Doing so would reaffirm the role of physicians and families in making individualized medical decisions, respect state authority within statutory parameters, and ensure that Medicaid and CHIP continue to facilitate access to evidence-based, patient-centered care as the evidence base develops.

For additional questions, please contact David Tully, Vice President, Government Relations, AAFP at dtully@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

[i] Burch, P., Walter, A., Stewart, S. *et al.* Patient reported measures of continuity of care and health outcomes: a systematic review. *BMC Prim. Care* **25**, 309 (2024). https://doi.org/10.1186/s12875-024-02545-8
[ii] Goodwin JS. Continuity of Care Matters in All Health Care Settings. *JAMA Netw Open.* 2021;4(3):e213842. https://doi:10.1001/jamanetworkopen.2021.3842
[iii] Clemens, J., & Ippolito, B. (2018). Implications of Medicaid financing reform for state government budgets. *Journal of Law and Economics*, 61(3), 525–560. https://doi.org/10.1086/697140
[iv] Pew Charitable Trusts. (2026, January 13). *New federal Medicaid policies compound state budget pressures*. The Pew Charitable Trusts. https://www.pew.org/en/research-and-analysis/articles/2026/01/13/new-federal-medicaid-policies-compound-state-budget-pressures
[v] Clemens, J., & Ippolito, B. (2018). Implications of Medicaid financing reform for state government budgets. *Journal of Law and Economics*, 61(3), 525–560. https://doi.org/10.1086/697140

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[vi] Centers for Medicare & Medicaid Services. (2014). *EPSDT – A guide for states: Coverage in the Medicaid benefit for children and adolescents*. Medicaid.gov. https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf

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