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Submitted electronically via www.regulations.gov

February 17, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2451-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Oz,

The AAMC welcomes this opportunity to comment on the proposed rule entitled "*Medicaid Programs; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children,* 90 Fed. Reg. 59441 (December 19, 2025), issued by the Centers for Medicare & Medicaid Services (CMS or the agency) that would prohibit federal financial participation (FFP) for gender-affirming care (referred to as "sex-rejecting procedures by CMS) for youth in Medicaid and the Children's Health Insurance Program (CHIP).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

Academic medical centers (AMCs) provide a significant volume of services to Medicaid beneficiaries so any changes to the Medicaid program impact teaching health systems and hospitals and the communities they serve. AAMC member teaching health-systems and hospitals account for 27 percent of Medicaid hospitalizations, while only accounting for 5 percent of all

U.S. hospitals.[1] Adequate funding and coverage for Medicaid services is essential to ensure access for the patients served by AAMC members.

We urge CMS to withdraw the proposed prohibition on FFP in the rule as it exceeds CMS's statutory authority, intrudes upon states' authority to determine the scope of coverage under Medicaid state plans and CHIP, interferes with the physician-patient relationship, and threatens access to care. We are deeply concerned that the proposed rule sets a precedent that would presage CMS limiting Medicaid and CHIP payment for other health care services that are lawful under state law and undermines the physician-patient relationship and the principle that physicians are best equipped to work with patients and their families to arrive at shared decision-making about their health care.

CMS Lacks Statutory Authority to Bar FFP for Specific Treatments on an Ad Hoc Basis in Medicaid

CMS proposes to prohibit FFP in Medicaid for "sex-rejecting" procedures for the purposes included in the proposed definition for individuals under the age of 18. Specifically, CMS proposes that State Medicaid plans must provide that the Medicaid agency will not make payment under the plan for "sex rejecting" procedures for children under 18, with three exceptions. For the purposes of this prohibition, CMS proposes to define the term "sex-rejecting procedure" to mean any pharmaceutical or surgical intervention that attempts to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

Congress has set forth detailed baseline requirements for state Medicaid plans in statute. Section 1902 (a)(19)[2] of the Social Security Act requires states to provide safeguards to ensure that eligibility decisions and services are administered "in a manner consistent with simplicity of administration and the best interest of" Medicaid enrollees. Additionally, section 1902(a)(30(A)[3] requires that states "assure that (provider) payments are consistent with efficiency, economy, and quality of care. The statute does not give CMS the authority to categorically ban FFP for specific types of treatment based on CMS's ad hoc weighing of the evidence.

In statute, Congress defined mandatory and optional benefits for which FFP is available under the Medicaid program and set forth express limitations on FFP for specific types of services.[4]

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[1] AAMC analysis of FY2023 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2024, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2024. Note: Data reflect short-term, general, nonfederal hospitals.

[2] 42 U.S.C. § 1396a(a)(19); *see also id.* § 1302 (enabling CMS to publish rules for oversight of state Medicaid programs).

[3] *Id.* § 1396a(a)(30)(A); *see also* 42 U.S.C. § 1302 (enabling CMS to publish rules for oversight of state Medicaid programs).

[4] *See, e.g., id.* §§ 1396a(a)(10) (identifying mandatory benefits), 1396b(i) (defining FFP exclusions), 1396d (defining various benefits under the state plan), 1396r-8(d) (defining permissible limits on coverage of prescription drugs).

CMS is required to approve any state plan amendment that complies with these federal requirements.

Under the Medicaid program, services fall within broad benefit categories, such as hospital inpatient, hospital outpatient, physician, or clinic services. Services, such as gender-affirming care, are not specifically defined as a benefit but rather fall within these broad benefit categories. The Supreme Court has stated that within these broad categories states have "substantial discretion to choose the proper mix of amount, scope and durations limitations on coverage," subject to compliance with federal requirements for minimum coverage and FFP limitations.[5] There are examples where Congress has expressly prohibited FFP for certain types of services, such as certain types of abortion services via the Hyde Amendment, as well as state spending on "roads, bridges and stadiums."[6]

While section 1902(a)(19) authorizes CMS to define procedural guardrails, it does not authorize CMS to exclude FFP for disfavored services. Additionally, section 1902(a)(30(A) establishes limits on fee-for-service provider payment levels and does not authorize CMS to specifically exclude services. The plain reading of the statute shows that Congress did not authorize CMS to exclude coverage for specific services on an ad hoc basis. We are deeply concerned that interpreting this statute so broadly would provide CMS with discretion to terminate Medicaid coverage for a wide array of treatments it views as "disfavored."

As the Supreme Court held in *Loper Bright Enterprises v. Raimondo*, courts should no longer defer to agency interpretations of statute, and should instead decide on a "single, best meaning."[7] In light of the statutory text, we do not believe that Congress intended to provide CMS with any authority to establish limits on FFP for coverage of specific services.

There are two other statutes pertaining to Early and Periodic Screening Diagnosis, and Treatment (EPSDT) and Covered Outpatient Drugs (described further below) that also clearly show that CMS may not restrict Medicaid coverage of specific services on an ad hoc basis.

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT**). To ensure that Medicaid provides comprehensive coverage for children and youth under 18, Congress required states to cover all "necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physician and mental illnesses and conditions."[8] In accordance with these provisions, CMS has taken the position that states must cover all services deemed medically necessary for an individual child or youth, subject to the Medicaid program's overarching limitations on FFP for excluded services. CMS has historically directed each state to establish its own process for assessing medical necessity, emphasizing the importance of individualized clinical assessments. By declaring in this proposed rule that certain gender affirming services are never medically

[5] Pharm. Rsch. & Mfrs. of Am. v. Walsh, 538 U.S. 644, 665 (2003).
[6] 42 U.S.C. 1396b (i)(12), (17), (21).
[7] 603 U.S. 369, 400 (2024).
[8] 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(4)(B) & (r).

necessary for any young person, CMS is acting in conflict with the EPSDT statutes requirement for individualized determinations of medical necessity.

- **Covered Outpatient Drugs**
  Subject to certain limited exceptions, section 1927 of the Social Security act requires state Medicaid programs to cover all "medically accepted indications" for covered outpatient drugs.[9] These indications include all drug uses listed on the drug label as approved by the FDA and all off-label indications "supported by one more citations included or approved for inclusion" in a list of published compendia of evidence-based drug use.[10] CMS states in the proposed rule that there is "no pharmaceutical that is solely indicated" for gender-affirming care. However, the statutorily enumerated compendia include certain evidence-based indications for hormone replacement therapy and puberty blockers. CMS lacks authority to over-ride the requirement in section 1927 to cover "medically accepted indications" for covered outpatient drugs.

The statutory text, statutory structure, and historical agency interpretation clearly show that Congress did not give CMS the authority to categorically exclude FFP for specific types of services based on an ad hoc clinical review of the evidence.

CMS Lacks Statutory Authority to Bar FFP for Specific Treatments on an Ad Hoc Basis in CHIP

Additionally, CMS proposes to revise the regulations to prohibit Federal CHIP payments to states for sex-rejecting procedures provided to children under the age of 19. The prohibition would apply for CHIP in the same manner proposed for Medicaid.

Similar to Medicaid, under the CHIP program CMS does not have statutory authority to bar FFP for specific treatments based on ad hoc clinical assessments. CHIP was established by Congress in 1997 to support states in providing health coverage to uninsured children about the Medicaid income threshold. States can either use the CHIP funds to expand eligibility under Medicaid or create a separate CHIP program that is subject to some of the same federal requirements as Medicaid. States with separate programs have more flexibility around benefit package design.[11] While the Medicaid statute includes a list of mandatory and optional benefits, Congress authorized separate CHIPs to cover "any other (medical services) recognized by State law," beyond those enumerated in the CHIP statute.[12] Under this provision, CMS is prohibited from excluding FFP for any medical services "recognized by state law" unless CMS can identify a basis for exclusion elsewhere in the CHIP statute. There is no language elsewhere in statute that would support this exclusion for separate CHIPs. As under Medicaid, we do not believe that CMS has cited any authority that would permit ad hoc FFP exclusions in separate CHIPs.

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[9] 42 U.S.C. 1396r-8(d)(1) & (4).
[10] [10] *Id.* § 1395r-8(k)(6) (cross-referencing the compendia at *id.* § 1396r-8(g)(1)(B)).
[11] Medicaid & CHIP Payment & Access Comm'n, *Overview of the State Children's Health Insurance Program*, in REPORT TO THE CONGRESS ON MEDICAID AND CHIP (Mar. 2011), https://www.macpac.gov/wp-
[12] 42 U.S.C. § 1397jj(a)(24).

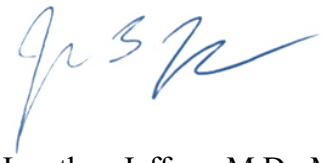
The Proposed Changes Improperly Interfere with the Physician-Patient Relationship

Additionally, the proposal represents a harmful intrusion into the patient-physician relationship. Medical decisions are best made by patients and their families, in consultation with their physicians, based on clinical evidence, professional judgment, and the individual needs and values of the patient. Federal agencies, such as CMS are not positioned to determine what constitutes appropriate medical care for individual patients. Determinations about appropriate diagnosis and treatment should fall squarely within the professional judgment of licensed physicians, guided by evidence-based standards of care and ethical obligations to their patients. It is inappropriate for government policies (such as this proposal that would prohibit funding for an entire class of services) to intrude into the physician-patient relationship – undermining both quality of care and patient trust**.** Further, clinical standards are developed through rigorous scientific processes led by medical professionals and specialty societies and should not be done through administrative rulemaking.

CONCLUSION

The AAMC is committed to ensuring access to high-quality care that treats all people, equally and with respect, and providing training to physicians and other health care professionals that is consistent with those values. We urge CMS to withdraw this proposed rule as it exceeds CMS's statutory authority, undermines the physician-patient relationship, and threatens access to care. If you have any questions regarding our comments, please feel free to contact Gayle Lee (galee@aamc.org).

Sincerely,



Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
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cc: David Skorton, M.D., AAMC President and Chief Executive Officer