February 17, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2451-P and CMS-3481-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 (RIN 0938-AV73); and Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children (RIN 0938-AV87)

Dear Administrator Oz:

The undersigned organizations, united in protecting Medicaid and the Children's Health Insurance Program (CHIP) for our nation's children and youth, appreciate the opportunity to comment on two rules proposed on December 19, 2025, by the Centers for Medicare & Medicaid Services (CMS). [1] If finalized, these rules would restrict federal funds and prohibit hospitals from providing adolescents with medications or procedures for certain specified purposes, virtually eliminating access to a significant scope of the health care services widely known as gender-affirming care.[2] We strongly urge CMS to withdraw both proposed rules, which together represent extraordinary federal overreach and erosion of the statutory guarantee of medically necessary care for tens of millions of our low- and middle-income children and youth.

Medicaid and CHIP cover nearly half of the nation's children and youth. These programs are a critical lifeline for over 36 million infants, children, teens, and young adults, providing access to comprehensive preventive, diagnostic, and treatment services that are necessary to give kids a healthy start in life. Congress has repeatedly strengthened this broad, special coverage for children to ensure childhood illnesses and conditions are discovered early and addressed in time to avoid potentially lifelong consequences if left untreated. Medicaid and CHIP provide such important coverage and access to care for so many of our nation's children that any attempt to reduce or eliminate this coverage is gravely concerning.

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[1] CMS, Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, 90 Fed. Reg. 59441 (proposed Dec. 19, 2025) [hereinafter Medicaid Funding Rule]; CMS, Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children, 90 Fed. Reg. 59463 (proposed Dec. 19, 2025) [hereinafter Hospital CoP Rule]. Collectively, we refer to these two proposed rules as the proposals or rules.

[2] We use the term "gender-affirming care" to refer to the medications and surgical procedures that CMS calls "sex-rejecting procedures"—a vague term not recognized in medicine, science, or law. In addition, we refer to the population of individuals under age 18 as "children," "children and youth," or "young people;" nearly half of whom would be impacted by significant changes to Medicaid and CHIP. We use the term adolescents when referring to individuals who may receive the care targeted by the proposed rules.

These proposed rules would irreparably harm millions of children and youth by drastically restricting their coverage of and access to medically necessary care, despite protections enshrined in federal law that have been repeatedly strengthened on a bipartisan basis over the past 50 years in Medicaid and CHIP. In addition, by effectively imposing a nationwide ban on politically disfavored gender-affirming care, CMS threatens many hospitals, including children's hospitals and community hospitals, with financial ruin for any provision of prohibited care or even a simple paperwork mistake that could be misconstrued as providing prohibited care. This is extraordinary federal overreach, virtually eliminating access to this care for all adolescents in the country, regardless of whether they are covered by government programs, private insurance, or pay out of pocket. Moreover, these rules create conflicting federal requirements and unclear, unworkable standards for states, providers, and managed care entities to navigate, which burdens the efficient delivery of care for Medicaid and CHIP enrollees. Taken together, CMS' unauthorized regulation of the practice of medicine in these proposed rules would set an extremely dangerous precedent that future administrations could follow, rolling back federal coverage protections for children and politicizing their health care. Our nation's young people are legally and morally entitled to better.

I. The Medicaid Funding Rule

A. The Medicaid Funding Rule erodes the statutory guarantee of EPSDT by removing many medications and services from Medicaid and CHIP coverage, harming access to care for millions of children and youth nationwide.

EPSDT is a statutory guarantee that requires individualized determinations of medical necessity. Since its establishment in the Social Security Amendments of 1967, Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit, known as EPSDT, has recognized the importance of comprehensive coverage of and access to medically necessary care for children. The EPSDT benefit has been strengthened under President Richard Nixon and President George H.W. Bush and is widely considered the gold standard of care for children. The goal of EPSDT is more than mere coverage, but meaningful access to care without delay, which is summarized in the oft-repeated mantra of the right care, to the right child, at the right time, in the right setting. Specifically, sections 1902(a)(10)(A) and 1905(r) of the Social Security Act (the Act) entitle eligible enrollees under age 21 to a broad array of services, including any medically necessary Medicaid-coverable service listed in section 1905(a) of the Act, regardless of whether such service is otherwise mandatory, optional, or covered under the state plan.[3] This long-standing statutory guarantee is our nation's bedrock promise to our poorest children and youth, and it must be protected.

[3] 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(r). Eligible enrollees include children under the age of 21 enrolled in Medicaid through the categorically needy pathway. Although EPSDT is not required in separate CHIP programs, several states provide Medicaid-based Secretary-approved coverage, which includes EPSDT, to separate CHIP enrollees. *See* KFF, Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations (Apr. 1, 2025), 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.

EPSDT requires individualized determinations of whether a service is medically necessary for a particular patient. CMS has consistently affirmed that the EPSDT statute requires states to cover all Medicaid-coverable services deemed medically necessary for a particular child or youth.[4] While this principle may require states to provide additional services that are not specified in the state plan when they are medically necessary for a particular child or youth, it is also a limiting principle—no service may be covered unless it is medically necessary for that individual.[5] Thus, coverage hinges on the critical determination of medical necessity, which is necessarily an individualized one, particular to the needs of the individual patient. However, in the Medicaid Funding Rule, CMS removes this determination from the patient, their family, and their trusted medical providers. Rather, CMS proposes to exclude from Medicaid and CHIP coverage of medications and surgical interventions when prescribed for certain politically disfavored purposes for *all* patients under the age of 18 in Medicaid and—inexplicably—to all patients under the age of 19 in CHIP. By making a one-size-fits-all determination for the nation's Medicaid- and CHIP-enrolled children and youth, including some young adults, CMS's proposal is antithetical to EPDST's fundamental principle of medical necessity.

Excluding gender-affirming care from Medicaid and CHIP coverage denies important care to adolescents and promotes a potentially harmful alternative.

- **Adolescents with gender dysphoria for whom gender-affirming care is appropriate need access to that care through EPSDT.** While CMS asserts that evidence supporting gender-affirming care for adolescents with gender dysphoria is limited and uncertain, it does not assert there is no clinical evidence supporting that care.[6] Indeed, there are decades of medical evidence supporting the safety of the targeted medications and services for various patient populations and circumstances.[7] Moreover, CMS acknowledges that 18 states including the District of Columbia have laws or policies protecting or even requiring the coverage of gender-affirming care.[8] CMS' rule would prohibit that care, regardless of medical necessity, state laws protecting that care, or decisions properly made by patients together with their clinicians and families. Furthermore, if implemented, the rule would take

[4] *See* CMS, EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (June 2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf [hereinafter EPSDT Guide]; CMS, State Health Official Letter # 24-005 RE: Best Practices for Adhering to EPSDT Requirements (2024).
[5] EPDST Guide, at 12.
[6] Medicaid Funding Rule, at 59444.
[7] See evidence discussed in examples of peer-reviewed articles during the past four decades: Guss C, Gordon CM. Pubertal Blockade and Subsequent Gender-Affirming Therapy. JAMA Netw Open. 2022 Nov 1;5(11):e2239763. doi: 10.1001/jamanetworkopen.2022.39763. Quigley CA, Wan X, Garg S, Kowal K, Cutler GB Jr, Ross JL. Effects of low-dose estrogen replacement during childhood on pubertal development and gonadotropin concentrations in patients with Turner syndrome: results of a randomized, double-blind, placebo-controlled clinical trial. J Clin Endocrinol Metab. 2014 Sep;99(9):E1754-64. doi: 10.1210/jc.2013-4518. Mansfield MJ, Beardsworth DE, Loughlin JS, Crawford JD, Bode HH, Rivier J, Vale W, Kushner DC, Crigler JF Jr, Crowley WF Jr. Long-term treatment of central precocious puberty with a long-acting analogue of luteinizing hormone-releasing hormone. Effects on somatic growth and skeletal maturation. N Engl J Med. 1983 Nov 24;309(21):1286-90. doi: 10.1056/NEJM198311243092104.
[8] Medicaid Funding Rule, at 59448.

that care away from individuals who are currently receiving it, causing immeasurable harm. In the preamble to the proposed rule, CMS admits "[t]his prohibition includes circumstances in which a provider may determine that [gender-affirming care] is medically necessary for a child diagnosed with gender dysphoria."[9] CMS provides no justification for denying coverage in particular cases where the benefits and risks are known and care is determined to be medically necessary on an individualized basis, as required under EPSDT. Prohibiting the provision of this care when it is evidence-based and medically necessary for EPSDT-eligible adolescents runs afoul of the plain language, the longstanding implementation, and the entire goal of the federal EPSDT statute.

- **By eliminating coverage of gender-affirming medications and surgical procedures, CMS abandons adolescents needing this care, leaving few options for intervention and no additional support.** Adolescents experiencing gender-dysphoria need—and, as described above, many are entitled to—access to the full spectrum of generally accepted care, including access to medications, surgical procedures, and mental health care. However, the Medicaid Funding Rule seeks to eliminate coverage for all but psychotherapy for the treatment of adolescents diagnosed with gender dysphoria. The rule does not define psychotherapy, describe the evidence, benefits, or harms of psychotherapy, or explain the distinction between mental health counseling and psychotherapy.[10] Despite the rule's reliance on the availability of this one treatment option, the rule would do nothing to provide added psychological support to young people experiencing the trauma of care denials. Access to mental health services for Medicaid enrollees is already a concern. For example, in September 2025, the Department of Health and Human Services (HHS) Office of the Inspector General issued an alarming report that most children in Medicaid did not receive timely suicide-related follow up care after hospitalization or an emergency department visit.[11] The rule's reliance on psychotherapy alone, without additional support for mental health coverage, providers, or youth, abandons adolescents who need care.

  In addition, we fear that CMS' proffered alternative of psychotherapy may be interpreted by some as an implicit endorsement for the discredited practice known as conversion therapy—the pseudoscientific practice of attempting to change an individual's sexual orientation or gender identity to align with heterosexual or cisgender norms.[12] Conversion therapy has been proven ineffective and harmful, with evidence indicating that individuals who experience attempted conversion therapy had nearly twice the odds of lifetime suicidal ideation, 75% increased odds of planning to attempt suicide, and 88% increased odds of a suicide attempt with minor injury compared with individuals who did not experience

[9] *Id*. at 59451.
[10] Medicaid Funding Rule, at 59449.
[11] HHS, Office of the Inspector General, Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Follow up Care, OEI-07-23-00510 (Sept. 2025), https://oig.hhs.gov/documents/evaluation/10940/OEI-07-23-00510.pdf.
[12] *See* American Psychological Association, APA Resolution on Gender Identity Change Efforts (Feb. 2021) https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

conversion therapy.[13] For these reasons, 20 states including Puerto Rico and the District of Columbia ban or limit the practice, but CMS does not weigh any of the clear, well-documented evidence of the ineffectiveness and considerable harm conversion therapy is known to cause before eliminating other treatment options.

The rule's chilling effect would reduce children's access to permissible care. The immense operational difficulties that this rule would create are likely to have a chilling effect and reduce access to care even for permissible purposes, such as to treat children and youth with precocious puberty or another medically verifiable disorder of sexual development.[14] CMS states that no pharmaceutical is solely indicated for gender-affirming care but is rather approved for other indications.[15] CMS' proposals, therefore, would require states to approve medical claims for treatments prescribed for some purposes but not for others. To properly approve or deny claims, states would need to ascertain the purpose of every prescribed medication or service impacted by the rule. It is unclear how states, managed care plans, and providers would be able to operationalize this directive, but it would certainly create additional cost and administrative burden in providing care to children and youth. Faced with the hassle and scrutiny of prescribing a medication for a permissible purpose or indication that also may be used for an impermissible purpose may well cause clinicians to stop prescribing these medications and services altogether, not just for adolescents with gender dysphoria, but for children and youth suffering from other medical conditions. In sum, the operational difficulty is likely to have a chilling effect on the provision of these medications and services for permissible purposes, exacerbating access challenges children and youth already face, in contravention of EPSDT's broad mandate.

B. The Medicaid Funding Rule's conflicting, unclear, and unworkable requirements would would hamper the efficient administration of Medicaid and CHIP.

Excluding drugs from Medicaid coverage creates a confusing conflict of laws for states and providers to navigate, undermining access protections for outpatient prescription drugs. CMS proposes to prohibit states from covering medications that federal law, in fact, requires states to cover under the Medicaid Drug Rebate Program (MDRP). Specifically, section 1927 of the Act requires any state that opts to provide prescription drug coverage (which all states, the District of Columbia, and Puerto Rico do) to cover all FDA-approved outpatient drugs for all of their

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[13] *See* HHS, Substance Abuse and Mental Health Services Administration, Moving Beyond Change Efforts: Evidence and Action to Support and Affirm LGBTQI+ Youth, Publication No. PEP22-03-12-001 (2023). *See also* Blosnich, J. R., Henderson, E. R., Coulter, R. W. S., Goldbach, J. T., & Meyer, I. H. (2020, July). Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016–2018. *American Journal of Public Health*, *110*(7), 1024-1030. doi: 10.2105/AJPH.2020.305637.

[14] On its face, the proposed rule would allow coverage of otherwise excluded medications and procedures when undertaken for any of three specified purposes: 1) to treat a child with a medically verifiable disorder of sexual development, 2) 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 3) to treat complications, including any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of sex-rejecting procedure(s). *See* Medicaid Funding Rule, at 59463 (to be codified at 42 C.F.R. § 441.801).

[15] *Id*. at 59455.

medically accepted indications, including supported off-label uses, when those drugs are made by any manufacturer that participates in the MDRP, with only very limited exceptions as outlined in federal law.[16] In return, participating drug manufacturers agree to rebate a portion of the price of each covered drug to the state, which is shared with the federal government. Through regulatory action, CMS's proposal would require states to exclude coverage of certain drugs for certain medically accepted indications, even if the drug's manufacturer participates in the MDRP, in which case the drug's coverage would be mandatory under federal law. CMS addresses this conflict simply by asserting states will cover *other* indications of the drugs to comply with MDRP requirements.[17] However, the MDRP statute does not permit CMS or states to selectively exclude some medically accepted indications of covered drugs. Rather, the law only permits states—not CMS—to exclude a drug from coverage in highly limited circumstances that are expressly detailed in statute and do not apply here.[18] In addition to upending an important incentive for drug manufacturers to provide discounted drugs to Medicaid programs and an important access protection for Medicaid, CMS fails to resolve how states and providers should navigate these clearly conflicting requirements. In sum, CMS has proposed a rule that is directly contrary to federal law, creating operational difficulties for states and providers to navigate, and sets a dangerous precedent that undermines Medicaid enrollees' access to outpatient prescription drugs.

<u>The Medicaid Funding Rule creates unworkable, unclear exclusion criteria for states, managed care entities, and providers to navigate, substantially burdening the efficient delivery of care for Medicaid and CHIP enrollees.</u>

- **Purpose standard.** CMS proposes to exclude medications and procedures from coverage when prescribed for a purpose that CMS disfavors and defines in the proposed rule. Specifically, CMS would prohibit financial federal participation for "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," whereas CMS would permit federal funds for those same services provided for any other purpose.[19] Thus, in order to pay a claim properly, the state or managed care entity would need to ascertain whether the pharmaceutical or surgical intervention was made in an "attempt" to align an adolescent patient's gender and sex. It is not clear how a payor could ascertain the "attempt" behind a provider's submission of a claim, or how payors could operationalize such an inquiry with any efficiency, and CMS fails to clarify this unworkable standard in the preamble to the rule.

- **Income standard.** Moreover, CMS repeatedly attempts to justify its proposed gender-affirming care funding ban to "protect children," yet inexplicably extends that ban to 18-year-

[16] 42 U.S.C. § 1396r-8.
[17] Medicaid Funding Rule, at 59455.
[18] In general, these circumstances include when the drug: 1) is *not* used for a medically accepted indication, 2) falls within a specified class of drugs that may be excluded, such as for weight loss or hair growth, 3) is subject to restrictions agreed to by the manufacturer, or 4) is excluded from the state's formulary because it does not have a significant clinical advantage over another drug in the formulary. *See* 42 U.S.C. § 1396r-8(d).
[19] Medicaid Funding Rule, at 59463 (to be codified at 42 C.F.R. § 441.801).

old enrollees of CHIP.[20] In doing so, CMS fails to explain why or how providers should distinguish 18-year-old separate CHIP enrollees from 18-year-old Medicaid enrollees—only the latter of whom would be eligible for gender-affirming care coverage under CMS' proposal. In many states, it would be nearly impossible for a provider to make this distinction because the provider would need to know the patient's family income level to determine whether the patient is covered by Medicaid or CHIP. For example, to determine whether a claim might be paid for providing gender-affirming care to an 18-year-old enrollee of Mississippi Health Benefits (which is the name of both the Medicaid and separate CHIP programs in Mississippi), a provider would need to determine that the patient's family income falls below 133% of the federal poverty level, which would mean the patient is a Medicaid enrollee and therefore eligible for coverage. In contrast, if the patient's family income were to fall between 133% and 209% of the federal poverty level, then in Mississippi an 18-year-old patient would be a CHIP enrollee, and therefore ineligible for gender-affirming care coverage.[21] Clearly, this distinction based on family income is as unworkable as it is unjustified.

II. The Hospital CoP Rule

The Hospital CoP Rule represents extraordinary federal overreach, threatening critical pediatric providers and reducing access to care for all children and youth in the country.

The Hospital CoP Rule threatens nearly all hospitals, including children's hospitals and community hospitals, with a dire penalty if they provide medically necessary care for prohibited purposes. CMS' proposal would prohibit hospitals, as a condition of their participation in Medicare and Medicaid, from providing medically necessary gender-affirming medications or procedures for any patient under 18 years of age when provided for certain purposes the agency disfavors that are specified in the rule.[22] As a result, hospitals would face an untenable choice – either deny patients medically necessary care or lose all Medicare and Medicaid funding. This amounts to an excessive, unbearable penalty for nearly all hospitals in the country, especially for hospitals that serve a high-volume of Medicaid patients, like many children's hospitals and community hospitals. For example, at a typical children's hospital, more than 50% of the patients are covered by Medicaid/CHIP; at some hospitals, the figure is closer to 75%.

Faced with eliminating this care from their facilities or shutting their doors, hospitals are left with no choice but to stop providing gender-affirming care, and we expect many hospitals would comply. However, even hospitals that make every effort to comply with the proposal could face financial ruin in the event that even one mistake is made and care is provided in violation of the rule. For example, hospitals could be penalized if the rule's unclear coverage exclusions are misapplied and prohibited care is provided to an 18-year-old adult CHIP enrollee, or a trauma patient arrives for emergency care who has been on hormone therapy that cannot be abruptly

[20] *See, e.g.,* Medicaid Funding Rule, at 59449, 59454.
[21] *See* Mississippi Division of Medicaid, Mississippi Medicaid Health Benefits (Feb. 11, 2026), https://medicaid.ms.gov/medicaid-coverage/who-qualifies-for-coverage/mississippi-medicaid-health-benefits/.
[22] Medicaid CoP Rule, at 59477 (to be codified at 42 C.F.R. § 482.46).

terminated, or a provider's "attempt" to provide care is misconstrued from the notes on a patient's chart. The rule's excessive penalty, that could be levied even against hospitals intending to comply, threatens the existence of life-saving, essential services, such as cancer care, asthma care, prosthetics care, rural obstetrics, trauma centers, burn units, and neonatal intensive care at children's hospitals and other hospitals all over the country. If CMS threatens hospitals with financial ruin, patients will pay the price.

The Hospital CoP Rule would strip away critical care for *all* children and youth, despite assurances in the Medicaid Funding Rule, leaving no safe place for medically necessary gender-affirming care. In the Medicaid Funding Rule, CMS addresses the concern that providers may face "financial harm" from the loss of revenue from the proposed coverage exclusions, arguing "providers may continue to receive payment for [excluded] pharmaceutical or surgical interventions . . . from sources other than Medicaid or CHIP."[23] However, this argument is flatly refuted by CMS' proposal in the Hospital CoP Rule to prohibit hospitals from performing such care on *any* patient under the age of 18 or face exclusion from Medicare and Medicaid. As a result, most hospitals will have no choice but to withhold gender-affirming care from all patients under the age of 18, regardless of whether they are Medicaid or CHIP enrollees, are commercially insured, or pay out of pocket—and regardless of whether that care is clinically appropriate or medically necessary in the patient's individual circumstances. This is a stunning, unprecedented use of the hospital conditions of participation, which until now have been limited to establishing structural and safety standards, such as that hospitals maintain appropriate nursing services and an emergency preparedness plan.[24] If no Medicare- or Medicaid-participating hospital can provide gender-affirming care for any patient under the age of 18, very few providers will be left to furnish this care, rendering gender-affirming care virtually inaccessible—a sweeping outcome with devastating impacts for young patients in need of care all across the country.

III. Both Rules Constitute the Unauthorized Regulation of the Practice of Medicine

The proposed rules constitute an unwarranted intrusion into the patient-clinician relationship and would exceed CMS' authority by regulating medical care.

By asserting that gender-affirming care for adolescents "is not health care and hence [is] not subsumed under the term 'the practice of medicine'," [25] CMS is seeking to establish regulatory authority that is explicitly disavowed in federal law. [26] Specifically, section 1801 of the Act states "[n]othing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services

[23] Medicaid Funding Rule, at 59448.
[24] 42 C.F.R. §§ 482.15 (emergency preparedness), 482.23 (nursing services).
[25] Hospital CoP Rule, at 59471.
[26] Similar disavowals are expressly included in other statutes such as the Social Security Amendments of 1954, the Fertility Success Rate and Certification Act of 1992, the Food and Drug Administration Modernization Act of 1997, the Drug Addiction Treatment Act of 2000, and the Food and Drug Administration Amendments Act of 2007. Congress has made clear that it does not intend to authorize federal interference in the practice of medicine.

are provided."[27] CMS asserts that the prohibited services are not health care while referencing the HHS Review, which describes the same services as medical interventions. Bafflingly, CMS also purports that services provided for one purpose are not health care while an identical set of services provided for a different purpose are health care. Medical care does not cease to be medical care merely because CMS declares it so. The practice of medicine is defined by states and overseen by state medical boards. The standard of care, or generally accepted standards of practice, is ever evolving and reflects credible scientific evidence that is recognized by the relevant medical community or practitioner specialty society's recommendations.

IV. Conclusion

Taken together, the Medicaid Funding Rule and Hospital CoP Rule endanger the future of children's health care by rolling back coverage and access to critical care for young people—particularly adolescents with gender dysphoria who are covered by Medicaid or CHIP, but the proposed rules don't stop there. In an act of unprecedented federal overreach, the nationwide ban proposed in the Hospital CoP Rule would effectively eliminate access to this care for all adolescents in the country, regardless of whether they are covered by government programs or commercial insurance. To achieve these ends, CMS levies a penalty against hospitals that is so excessive it threatens the existence of many pediatric health care providers, such as children' s hospitals that depend on Medicaid funds to operate. This, in turn, irresponsibly threatens all children's access to the essential care these hospitals provide for all patients—from cancer care to well-child care, and everything in between.

If CMS finalizes these rules, in the face of conflicting statutory requirements, it would set a dangerous precedent, politicizing children and youth's health care in a way that could allow any future administration to restrict or eliminate access to any politically unpopular or disfavored benefit based on the agency's own weighing of the clinical evidence. Political interference in clinical decision-making undermines evidence-based care, destabilizes long-standing medical standards, and places patients at risk. Politically driven restrictions on evidence-based care compromise patient safety, erode trust in clinicians, and interfere with clinicians' ethical responsibilities. In sum, the politicization of children's health care results in poorer health outcomes for children and youth. This political attack on adolescents' access to medically necessary health care is unlikely to be any exception.

Our nation's young people deserve better. For these reasons, we strongly urge CMS to withdraw these rules.

Sincerely,

[27] 42 U.S.C. § 1395.

AAP California Chapter 1

Academic Pediatric Association

AFL-CIO

AFT: Education, Healthcare, Public Services

American Academy of Pediatrics

American Association of Child and Adolescent Psychiatry

American College of Physicians

American Pediatric Society

American Psychiatric Association

Amida Care

Association of Medical School Pediatric Department Chairs

Autistic People of Color Fund

Autistic Self Advocacy Network

Center for Law and Social Policy (CLASP)

Center for the Study of Social Policy (CSSP)

Coalition of Texans with Disabilities

Coalition on Human Needs

Community Catalyst

DC Action

Detroit Disability Power

Eating Disorders Coalition for Research, Policy & Action

End Child Poverty California

Fallon Health

Families USA

Family Voices National

First Focus on Children

Florida Chapter of American Academy of Pediatrics, Inc.

Florida Policy Institute

Georgetown University Center for Children and Families

Georgia ADAPT NDN

Harrier Hancock Center

HIV Medicine Association

Illinois Chapter, American Academy of Pediatrics

Kansas AAP

Kansas Chapter, American Academy of Pediatrics

Legal Action Center

Legal Aid Justice Center

Mental Health America

Michigan Poverty Law Program

Michigan's Children

National Alliance on Mental Illness

National Association of Pediatric Nurse Practitioners

National Center for Youth Law

National Partnership for Women and Families

Nebraska Appleseed

Nebraska Chapter of the American Academy of Pediatrics

Nevada Chapter, American Academy of Pediatrics

New Mexico Pediatric Society

New Mexico Voices for Children

PA Chapter, American Academy of Pediatrics

Planned Parenthood Action Fund

PUBLIC ADVOCACY FOR KIDS (PAK)

Public Justice Center

REDC Consortium

Rogan's List

Santa Clara Family Health Plan

SEIU

Society for Adolescent Health and Medicine

South Carolina Appleseed Legal Justice Center

Tennessee Chapter of the America Academy of Pediatrics

Tennessee Justice Center

The Children's Partnership

The Ford & Ford Group

The National Alliance to Advance Adolescent Health

Voices for Vermont's Children

Washington Chapter of the American Academy of Pediatrics

Women’s Rights and Empowerment Network