



STATE OF WASHINGTON

February 17, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
United States Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Submitted via Federal Rulemaking Portal

RE: *Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children (90 FR 59463)*
Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children (90 FR 59441)

Dear Secretary Kennedy:

As Washington state leaders responsible for overseeing medical care, regulating insurance coverage, and protecting the rights and health of all Washingtonians, we write in unified opposition to the above-captioned Notices of Proposed Rulemaking. These proposed rules would undermine the availability of critical medical services in our state, including by recklessly meddling in the relationship between Washington doctors and their patients. Marked by a series of successive failures to consider basic facts, medical research, and the catastrophic harm they would inflict on patients, these proposals are the latest in a series of unlawful federal attacks on the rights, health, safety, and dignity of transgender and gender-diverse individuals. The provision of medically necessary, gender-affirming care to transgender youth is safe, evidence-based, and in many cases lifesaving. We urge you to rescind these harmful and discriminatory proposals immediately.

I. BACKGROUND

A. Washington state is an inclusive state that strives to ensure comprehensive coverage remains available for all LGBTQ+ individuals and communities.

Through Washington state's legal, administrative, and regulatory frameworks, the state has worked to create an environment in which all Washingtonians, including transgender youth, have access to the medically necessary care they need to live healthy and safe lives with dignity and pride. The proposed rules threaten to undermine those efforts.

1. Washington state’s Medicaid program covers gender-affirming care services.

In Washington state, the Medicaid program is known as “Apple Health,” an umbrella term referring to all of Washington state’s public benefit healthcare programs. Apple Health includes Medicaid and the Children’s Health Insurance Program (CHIP), which are governed by federal statutes, supported by federal funding, and administered by the state. “Apple Health” also includes separate programs administered and funded entirely by the state.

The Washington State Health Care Authority (HCA) is responsible for administering Washington’s Medicaid program. The program provides low-income individuals with access to comprehensive healthcare coverage at no or low cost. Medicaid’s coverage includes medical, dental, mental health, substance use disorder treatment, and long-term care. Notably, HCA is the largest healthcare purchaser in Washington, as Medicaid and other Apple Health programs cover about 20 percent of the state’s population. In total, Medicaid insures approximately 1.9 million people, including approximately 850,000 children.

By statute, Apple Health covers an array of services for transgender individuals, including gender-affirming interventions for gender dysphoria under Washington Administrative Code § 182-531-1675. Under Washington state law, HCA is required to cover gender-affirming care and “may not apply categorical cosmetic or blanket exclusions to gender-affirming treatment.” Washington Revised Code § 74.09.675(2). Gender-affirming interventions include, but are not limited to, puberty suppression therapy, hormone therapy, behavioral health services, and surgical procedures. Apple Health pays for these gender-affirming interventions when they are requested consistent with agency rules and determined medically necessary by HCA.

Importantly, HCA evaluates medical necessity on a case-by-case basis; in other words, for any gender-affirming care to be covered by Apple Health, it must be deemed medically necessary by HCA for the specific patient at issue.¹ In making these decisions, HCA considers a wealth of clinical evidence and individualized, patient-specific data, including “all available clinical information and credible evidence relevant to the client’s condition.”² Under Washington state law, a provider responsible for the patient’s diagnosis or treatment must submit—and HCA must review—individualized patient data and “credible evidence specifically related to the client’s condition.”³ This may include but is not limited to (1) a physiological description of the client’s condition; (2) relevant lab results; (3) pertinent X-rays or images; (4) individual patient records related to the case or request; (5) relevant videos or pictures; (6) objective medical or behavioral health information, such as findings or diagnoses resulting from patient-specific physical or behavioral health examinations; and (7) any other relevant and credible evidence relating to the request and the individual patient.⁴

¹ See WAC 182-501-0165 (3)-(5) (attached hereto as Exhibit A).

² *Id.*

³ *Id.*

⁴ *Id.*

For at least a decade now, HCA has claimed and received federal financial participation for gender-affirming interventions, including for clients younger than 18. These services are available to all transgender Apple Health clients, including clients under 21 years of age pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The gender-affirming interventions covered by HCA have been determined to be safe, effective, and evidence-based medical treatments, including by organizations such as the American Academy of Pediatrics, the American Medical Association, the Endocrine Society, and the World Professional Association for Transgender Health (WPATH), a globally recognized authority on gender-affirming care with standards of care that have been widely adopted by medical institutions worldwide.

2. Washington state law provides fundamental protections for individual rights and access to care.

Washington state law prohibits discrimination based on several protected factors, including but not limited to sexual orientation and gender identity.⁵ These fundamental legal protections for all Washingtonians extend into the state's healthcare framework, establishing important rights for LGBTQ+ community members and transgender youth seeking access to appropriate medical care.

Washington health insurers and health plans are prohibited from discriminating in providing coverage for services based on a person's sexual orientation or gender identity. For example, Washington state law prohibits health insurers and fully insured health plans from denying or limiting coverage for gender-affirming care for persons of any age when that care is (1) prescribed as medically necessary; (2) consistent with the person's gender expression or identity; and (3) in accordance with accepted standards of care.⁶ Similarly, Medicaid managed care plans and health care providers delivering or administering services through HCA may not discriminate in providing gender-affirming care services based on the covered individual's gender identity or expression.⁷

Under Washington state law, denials or limitations of such gender-affirming care are generally prohibited unless a health care provider "with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination."⁸ Similarly, health carriers "may not apply categorical cosmetic or blanket exclusions to gender-affirming treatment."⁹ Of course, age may be one of several factors considered when determining whether a specific procedure is medically necessary and prescribed in accordance with accepted standards of care for a specific patient, but such determinations necessarily require individual, case-by-case reviews and are not appropriate for decision on a categorical basis for all patients.

⁵ See RCW 49.60.030 (defining the right to be free from discrimination based on "sexual orientation" in places of public accommodation); RCW 49.60.040 (defining sexual orientation to include gender expression or identity).

⁶ See, e.g., RCW [48.43.0128](#) (3)(c); WAC 284-43-5151.

⁷ RCW 74.09.675(1).

⁸ RCW [74.09.675](#) (2)(c).

⁹ RCW [74.09.675](#) (2)(a).

B. Although Washington state has made important efforts to ensure access to care, transgender individuals still face barriers in receiving medical services.

In 2023, Washington state’s LGBTQ Commission worked with a team of researchers to conduct a first-of-its-kind survey to study the experiences of LGBTQ+ Washingtonians relating to health, safety, and the economy.¹⁰ Over half of the survey participants reported having benefited from Washington’s robust policies and legal protections for LGBTQ+ individuals, and nearly half of participants stated they had benefited specifically from the state’s protections in medical settings. Given the large number of legal and administrative protections the state has put in place, over 85 percent of respondents reported feeling “safe” as a member of the LGBTQ+ community in Washington state.

Despite Washington state’s efforts to protect the availability of medical services for members of the LGBTQ+ community, however, the survey results also make clear that transgender and gender diverse individuals may still encounter significant challenges in accessing appropriate and necessary medical care:

- Almost one third (31.4 percent) of respondents had tried to access care but were unable to do so. Of that group, 22.8 percent were attempting to receive gender-affirming care, and 31.9 percent were seeking behavioral healthcare.
- Regarding insurance coverage specifically, 43.2 percent of participants reported encountering barriers to gender-affirming care.
- Approximately 27.6 percent of survey respondents reported their insurance as either Medicare or Medicaid (15.8 percent and 11.8 percent, respectively), compared to 62.3 percent that reported employer-provided insurance or private insurance. Only 2 percent reported having no insurance coverage at all.
- Even without the proposed rules at issue, there is a significant disparity in access to care for younger members of the LGBTQ+ population. Notably, 64.1 percent of respondents ages 17 and younger reported that they were unable to access care at least once in Washington state, compared to 30.6 percent for ages 18-64, and only 10.7 percent for ages 65 and older.
- Almost one out of ten (9.8 percent) participants responded that they tend to avoid seeking medical care because they expect to experience discrimination, with far more—approximately 38 percent of survey participants—reporting that they “sometimes” avoid seeking care for this reason.

¹⁰ See [WA LGBTQ+ Survey Report 2025](https://lgbtq.wa.gov/sites/default/files/2025-06/WA%20LGBTQ%2B%20Survey%20Report%202025_1.pdf), available at https://lgbtq.wa.gov/sites/default/files/2025-06/WA%20LGBTQ%2B%20Survey%20Report%202025_1.pdf (attached hereto as Exhibit B).

- When breaking the data down by age, adolescents were significantly more likely to have experienced discrimination in medical settings (78.5 percent), compared to adults (60 percent) and seniors (34.6 percent).

In communities where private or non-Medicare and Medicaid clinics are less readily accessible, such as in rural areas, the survey results describe even greater disparities in access to care. Notably, over 20 percent of the survey respondents stated they lived in rural areas, and their experiences are instructive:

- About half of survey respondents in north central Washington state (50.3 percent) reported being unable to access medical care at least once, compared to about one quarter of respondents from the Puget Sound (22.3 percent) who were unable to access medical care at least once.
- Nearly 80 percent of respondents living in north central Washington state (78.9 percent) have experienced discrimination in medical settings, compared to 53.4 percent of Puget Sound residents.

As these survey results make clear, and despite the many protections Washington state has put in place, access to gender-affirming care for transgender individuals and youth remains a challenge.

II. NOTICES OF PROPOSED RULEMAKING

The Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Services (CMS) have issued two related Notices of Proposed Rulemaking, both of which essentially seek to eliminate the provision of medically necessary, gender-affirming care for youth. The first proposed rule, titled “Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children” (or “the Conditions of Participation Proposed Rule”), would bar any hospital from participating in the Medicare and Medicaid programs if the hospital provides certain “sex-rejecting procedures” to youth, regardless of the source of payment for those medical services. The second proposed rule, titled “Prohibition on Federal Medicaid and [CHIP] Funding for Sex-Rejecting Procedures Furnished to Children” (or “the Reimbursement Proposed Rule”), would prohibit federal Medicaid and CHIP payments to states for the provision of so-called “sex-rejecting procedures” for youth.

A. The Conditions of Participation Proposed Rule

The Conditions of Participation Proposed Rule would add a new section to 42 CFR part 482, subpart C to prohibit Medicare and Medicaid-participating hospitals from performing sex-rejecting procedures (SRPs) on any child (§ 482.46(a)). As set out in proposed § 482.46(a)(5), CMS proposes to define SRPs “as any pharmaceutical or surgical intervention that attempts to align an individual's physical appearance or body with a stated identity that differs from the individual's sex by either (1) intentionally disrupting or suppressing the development of biological functions, including primary or secondary sex-based traits or (2) intentionally altering an individual's physical appearance or body, including removing, minimizing, or permanently

impairing the function of primary or secondary sex-based traits such as the sexual and reproductive organs.”

The proposed rule defines “child” as any individual younger than 18 years of age; “female” as “an individual of the sex characterized by a reproductive system with the biological function of (at maturity, absent disruption or congenital anomaly) producing eggs (ova);” “male” as “an individual of the sex characterized by a reproductive system with the biological function of (at maturity, absent disruption or congenital anomaly) producing sperm”; and “sex” as “an individual's immutable biological classification as either male or female.”¹¹

To attempt to justify the rule’s prohibition against hospitals offering gender-affirming care for youth with gender dysphoria, CMS argues there is a “weak evidence base” to support safety and effectiveness but there is “plausible evidence of harm.” The proposed rule cites patient regret as one potential harm. Although regret is a possible outcome in any type of healthcare, studies demonstrate that it is exceedingly rare in cases of medically necessary transgender healthcare.¹² For example, one study showed patient rates of regret following gender-affirming surgeries at about 1 percent, noting that “[w]hen comparing regret after [gender-affirming surgery] to regret after other surgeries and major life decisions, the percentage of patients experiencing regret is extremely low.”¹³ Another study looked at a group of adolescents and families of adolescents who had received gender-affirming care, noting that “[a]mong the [youth] and their parents” the data showed “very high levels of satisfaction and low levels of regret with puberty blockers and gender-affirming hormones as well as high levels of continuation of care.”¹⁴ The study concluded that “youth accessing puberty blockers and hormones as part of gender-affirming care tend to be satisfied with and not regretful of that care several years later.”¹⁵

Perhaps most striking, then, is that beyond citing comparably rare instances of patient regret, CMS fails to identify *any* potential harm that would be unique to a patient undergoing gender-affirming care and would not also be present for patients receiving the same treatment for other conditions.¹⁶ Notably, the University of Utah College of Pharmacy’s Drug Regimen Review Center conducted a thorough review of the issue and concluded that “prevent[ing] access to and use of [gender-affirming hormone therapy] for treatment of [gender dysphoria] in pediatric patients cannot be justified based on ... concerns about potential regret in the future.”¹⁷

¹¹ Section 482.46(a)(1)-(4).

¹² See, e.g., Sarah M. Thornton et al., A Systematic Review of Patient Regret After Surgery—A Common Phenomenon in Many Specialties but Rare Within Gender-Affirmation Surgery, 234 *Am. J. of Surgery*, 68-73 (2024), available at <https://pubmed.ncbi.nlm.nih.gov/38688814/>.

¹³ *Id.*

¹⁴ See Olson, K.R., Raber, G.F., & Gallagher, N.M. (2024), *Levels of Satisfaction and Regret with Gender-Affirming Medical Care in Adolescence*. *JAMA Pediatrics*, 178 (12), 1354-1361, available at <https://pubmed.ncbi.nlm.nih.gov/39432272/>

¹⁵ *Id.*

¹⁶ 90 FR 59444

¹⁷ See Joanne LaFleur, Univ. of Utah College of Pharmacy, Drug Regimen Review Center, *Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria*, (2024), available at <https://www.transvitae.com/wp-content/uploads/2025/05/report.pdf>.

The Conditions of Participation Proposed Rule contains certain limited exceptions, such as permitting use of the procedures and prescriptions at issue “for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.”¹⁸ But these exceptions do little to address the proposed rule’s serious flaws. Instead, they suggest the proposal is motivated by discriminatory animus, as it would allow hospitals to use certain procedures and prescriptions to address a variety of conditions in cisgender youth while categorically barring the use of those same procedures and prescriptions to address gender dysphoria in all cases involving transgender or gender-diverse youth.

Evidence of the proposed rule’s discriminatory intent does not stop there. CMS concedes that the agency is barred from regulating the practice of medicine, but it waves away that important guardrail by declaring that so-called “SRPs” fall outside the practice of medicine when used to treat gender dysphoria in youth. In support of this striking assertion, CMS relies almost entirely on HHS’s own discredited research,¹⁹ while deliberately ignoring the many instances in which providing medically necessary, gender-affirming care has improved and even saved the lives of transgender and gender-diverse youth. The proposed rule’s one-sided presentation of evidence demonstrates that CMS has failed to engage meaningfully in the rulemaking process.

B. The Reimbursement Proposed Rule

The Reimbursement Proposed Rule would add a new subpart N to 42 CFR part 441 to prohibit any Medicaid reimbursements for the provision of SRPs to children under the age of 18. The proposed rule would also revise subpart D in 42 CFR part 457 to prohibit any CHIP payments to states for the provision of SRPs to any children under the age of 19.

As with the Conditions of Participation Proposed Rule, CMS offers limited exceptions for covering the procedures and prescriptions at issue, including when they are prescribed “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.” In other words, the proposal would permit federal reimbursement for these procedures and prescriptions when used to treat various conditions, but it would prohibit reimbursement for the same procedures and prescriptions for treating gender dysphoria and related conditions in transgender youth. It is unclear why any potential harms from these treatment options are acceptable in the first instance but are so dangerous in the second that CMS believes there cannot be *any* individual circumstances that would rise to the level of medical necessity. Put simply, the proposal discriminates against transgender youth and would undermine Washington state’s efforts to ensure all residents have access to the medically necessary care they need to enjoy safe and healthy lives.

The Reimbursement Proposed Rule also explains that it would not bar states from funding such procedures through state-only funds. Notably, this exception does not appear to take into consideration the simultaneously-issued Conditions of Participation Rule, which asserts that the

¹⁸ Section 482.46(b)(1).

¹⁹ See, e.g., Susan J. Kressly, M.D. “AAP Statement on HHS Report Treatment for Pediatric Gender Dysphoria” (May 1, 2025), available at <https://www.aap.org/en/news-room/news-releases/aap/2025/aap-statement-on-hhs-report-treatment-for-pediatric-gender-dysphoria/>.

provision of such care does not even constitute the practice of medicine. Similarly, neither proposal appears to consider a declaration issued by Secretary Kennedy just one day before the rules were published, claiming that certain “sex-rejection procedures for children and adolescents are neither safe nor effective as a treatment modality for gender dysphoria ... and, therefore, fail to meet professional recognized standards of health care.”²⁰ Apart from the dire harm that would result from implementing any of these unlawful rules or policies individually, accepting any combination of them would lead to chaos and contradiction.

III. THE PROPOSED RULES WILL LEAD TO DRAMATICALLY WORSE HEALTH OUTCOMES FOR WASHINGTONIANS

By prohibiting federal reimbursement for any so-called “sex-rejecting procedures” for individuals under age 18 and barring hospitals from providing any of these services regardless of the source of funding, the proposed rules will have severe and foreseeable public health consequences for Washingtonians, particularly transgender and gender-diverse youth. The proposed rules will disrupt access to evidence-based, medically necessary care, signaling discrimination and institutional rejection of an already-marginalized population.

A. The proposed rules threaten to increase and exacerbate behavioral health crises, leading to tragic and preventable deaths among vulnerable youth.

A substantial and growing body of peer-reviewed literature demonstrates that threats to transgender rights and restrictions on access to gender-affirming health care are independently associated with worse mental health outcomes, including depression, anxiety, self-harm, and suicidal ideation. In a cross-sectional study of 797 transgender individuals living in Washington State, researchers found that concerns about transgender rights being taken away were associated with 66 percent higher odds of depression and 167 percent higher odds of anxiety, while accurate knowledge of protective state policies was associated with significantly lower odds of these conditions.²¹

Evidence also shows that timely access to gender-affirming health care during adolescence is associated with substantially reduced suicide risk. A national study published in *JAMA Pediatrics* found that access to gender-affirming hormones during adolescence was associated with significantly lower odds of past-year suicidal ideation compared to individuals who first accessed such care in adulthood.²² Similarly, a large study of U.S. transgender adults found that those who

²⁰ See Declaration of the Secretary of the Department of Health and Human Services (Dec. 18, 2025), available at <https://www.hhs.gov/sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf>.

²¹ See Testa RJ, Hafeez H, Kroon S, et al. *Antitrans Policy Environment and Depression and Anxiety Symptoms in Transgender and Nonbinary Adults Living in Washington State* (2024), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2822715> (attached hereto as Exhibit C).

²² See Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care* (2022), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423>.

had received gender-affirming surgical care had 42 percent lower odds of recent psychological distress and 44 percent lower odds of suicidal ideation compared to those who had not.²³

Youth mental health indicators underscore the magnitude of risk. For example, the 2023 Washington Healthy Youth Survey showed that LGBTQ+ students were twice as likely as their peers to report depressive feelings, and one in three had contemplated suicide.²⁴ Similarly, according to the Trevor Project’s national survey, 41 percent of LGBTQ+ young people seriously considered attempting suicide in the past year, including 48 percent of transgender women and 56 percent of transgender men. More than one in ten LGBTQ+ youth attempted suicide in the past year.²⁵ The Trevor Project also reported that “39 [percent] of LGBTQ+ young people seriously considered attempting suicide in the past year — including 46 [percent] of transgender and nonbinary young people.” Further, “LGBTQ+ youth of color reported higher rates than White peers,” and “[m]ore than 1 in 10 LGBTQ+ young people attempted suicide in the past year.”²⁶ Policies that restrict or stigmatize access to medically indicated care for transgender youth, such as the proposed rules, only exacerbate these already alarming disparities. Indeed, a recent survey of information revealed a “surge” in deaths by suicide of transgender youth under age 18 in England following restrictions on accessibility to gender-affirming healthcare.²⁷

The proposed rules fail to address the significant mental, emotional, behavioral, and physical harm they would inflict on youth in Washington state, including transgender and gender diverse youth who are already undergoing medically necessary treatment regimens and would stand to lose access to the care they depend on for their health and stability. Significant disruptions in care and forced withdrawal from treatment have been shown to cause dramatic increases in anxiety, depression, and suicidal ideation in transgender youth.²⁸ Given CMS’s failure to consider these dire harms, the proposed rules are fundamentally flawed and must be withdrawn.

B. The Conditions of Participation Proposed Rule threatens to deter transgender youth from seeking necessary emergency medical services.

The Conditions of Participation Proposed Rule would bar hospitals from providing certain medications during an individual’s inpatient stay, so transgender youth hospitalized for any reason, including trauma or behavioral health crises, may be unable to continue their previously

²³ See Almazan AN, Keuroghlian AS. Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA Surg.* 2021;156(7):611–618, available at <https://jamanetwork.com/journals/jamasurgery/fullarticle/2779429>.

²⁴ See The Washington State Healthy Youth Survey, available at <http://www.askhys.net>.

²⁵ See The Trevor Project, *2023 U.S. National Survey on the Mental Health of LGBTQ+ Young People* (2023), available at <https://www.thetrevorproject.org/survey-2023/>.

²⁶ See The Trevor Project, *2024 National Survey on LGBTQ+ Youth Mental Health* (2024), available at <https://www.thetrevorproject.org/survey-2024/#access-to-care>.

²⁷ See Good Law Project, [New data shows surge in trans kids’ suicides following healthcare rollbacks | Good Law Project](https://goodlawproject.org/new-data-shows-surge-in-trans-kids-suicides-following-healthcare-rollbacks/?utm_source=substack&utm_medium=email) (Feb. 2026), available at https://goodlawproject.org/new-data-shows-surge-in-trans-kids-suicides-following-healthcare-rollbacks/?utm_source=substack&utm_medium=email (“This spike [in suicides] follows the decision by NHS England to pull down the shutters on gender affirming healthcare for young trans people...”).

²⁸ See, e.g., *Massachusetts v. Trump, et al.*, 1:25-cv-12162-AK, Doc. 87-21, ¶ 30 (noting that patients who have experienced abrupt terminations in their care have suffered “more acute symptoms of gender dysphoria” and “had worsening dysphoria and mental health”).

prescribed puberty blockers or hormone therapy during hospitalization. Any abrupt discontinuation of these medications has the potential to exacerbate gender dysphoria and psychological distress, and the deterrent effect of the proposed rule would likely lead to worse health outcomes and untreated conditions. For example, a transgender teen involved in a car accident might elect to forgo an emergency room evaluation out of fear that if they were to be admitted, they would be unable to receive their necessary puberty blockers or hormones, even if those medications had been prescribed to them by a physician at a private clinic.

These concerns are especially urgent considering the barriers already in place regarding access to emergency room treatment.²⁹ Over half of the respondents to the LGBTQ+ Commission's survey reported that they had previously used an emergency room in Washington state, but as many as 15 percent of those who had been unable to access some form of care reported encountering challenges in accessing emergency care.³⁰ The proposed rules would dramatically enhance those challenges for LGBTQ+ individuals throughout Washington state, undermining their ability to access critical care in emergency situations and leading to worse health outcomes.

C. The proposed rules are likely to result in significantly higher numbers of transgender youth turning to illicit substances

The proposed rules will likely lead to more young adults turning to illicit substances to deal with the increased emotional and mental health challenges from being unable to access medically necessary health care. For example, studies have shown that “substance use is common among LGBTQ+ youth, with over half of the respondents having used alcohol and a third having used marijuana in the last year, both of which are higher than rates among the general population of US high school students.”³¹ Regular substance use was reported more among LGBTQ+ youth who experienced challenges in their efforts to change their sexual orientation and/or gender identity, and among those who had experienced physical harm due to their LGBTQ+ identity. These findings suggest that youth in these communities may use illicit substances to cope with negative experiences in unsupportive and discriminatory environments, such as those created by the proposed rules. These concerns are particularly urgent given the risk that the proposed rules will have a chilling effect on the availability of therapy and other critical behavioral health supports for transgender and gender-diverse youth.

IV. THE PROPOSED RULES WILL REDUCE ACCESS TO LAWFUL, MEDICALLY NECESSARY CARE AND WILL INTERFERE WITH DOCTOR-PATIENT RELATIONSHIPS

The proposed rules would decrease access to specialty and primary care, resulting in delayed care and a broad range of unmet medical needs. If these proposals were to be implemented, Washington state agencies, including HCA, will experience significant challenges in identifying

²⁹ The proposed rules' effects would be further compounded by other federal efforts to limit access to care, including for example recent restrictions on the provision of care to veterans through TRICARE and related services.

³⁰ See Exhibit B.

³¹ See The Trevor Project, *Substance Use and Suicide Risk Among LGBTQ Youth* (2022), available at <https://doi.org/10.70226/TIEZ5246> (citing Johns et al., 2020).

health care providers willing to offer gender-affirming care to Apple Health clients, even if such services were entirely state-funded. The proposed rules will also recklessly and unlawfully interfere with the relationships between Washington state doctors and their patients.

A. Many Apple Health providers depend on their participation in the Medicaid and Medicare programs as a condition for providing medical care.

Many of the providers who accept Apple Health depend on Medicaid and Medicare for fiscal solvency. We are not aware of any hospital that could stay in business without participating in the Medicaid and Medicare programs. Notably, HCA has already received reports from health care providers that, in response to federal actions such as the Kennedy Declaration³² (which neither of the proposed rules appears to even acknowledge), some providers have already ceased to provide or are reconsidering offering gender-affirming care services. Further, HCA is also aware that some patients have experienced delays in accessing these services, contributing to heightened anxiety and uncertainty within transgender and gender-diverse communities.

By threatening to exclude participation in the Medicaid and Medicare programs, the proposed rules will dramatically erode Washington state's network of Medicaid providers. A recent report from the Washington State Insurance Commissioner found 5,641 distinct Medicaid providers offering gender-affirming care in Washington state.³³ Currently, these providers are present in every corner of the state, including in rural areas where access to medical care is more challenging. If such providers were excluded from participating in Medicaid, as the proposed rule threatens to do with certified hospitals, then Apple Health would likely be unable to ensure that their clients could continue to have access to readily available, medically necessary services.

These concerns are particularly acute for certain specialties, such as pediatrics or endocrinology, that are already difficult to access for Apple Health clients due to a shortage of providers willing to take Medicaid. Further, exclusion from participation in the Medicare and Medicaid programs constitutes a de facto bar on the practice of medicine for many providers, as it is significantly more difficult for excluded providers to obtain employment or malpractice insurance. Facing the threat of potential exclusion from these programs, many Washington state providers will simply choose to provide no care at all for this population because of the fear of exclusion and the dramatic consequences exclusion carries.

B. The proposed rules will undermine the ability of issuers to comply with Washington state's network adequacy requirements.

In the Reimbursement Proposed Rule, CMS explains that its proposal would not "prevent States from providing coverage for sex-rejecting procedures with State-only funds outside of the

³² See Declaration of the Secretary of the Department of Health and Human Services (Dec. 18, 2025), available at <https://www.hhs.gov/sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf>.

³³ See Washington State Office of the Insurance Commissioner, Gender Affirming Treatment (GAT) Study at 15 (November 2024), available at <https://www.insurance.wa.gov/sites/default/files/2024-12/waoic-gender-affirming-treatment-report-11272024.pdf> (attached hereto as Exhibit D).

Federally-matched Medicaid program or CHIP.”³⁴ The Washington State Legislature, however, requires that Medicaid managed care organizations and fully-insured commercial health plans cover gender-affirming care.³⁵ But the restriction on Medicaid and CHIP payments for gender-affirming care, in combination with the prohibition on hospitals performing these procedures,³⁶ could render those benefits largely illusory and unenforceable. Children may have coverage for services, but there will be very few, if any, providers available to offer them. In fact, CMS concedes that there will be “difficulty in identifying in-network providers that have available space” and that patients will experience “longer commute times to these providers.”³⁷

The prohibition against hospitals offering these procedures may reduce the number of participating hospitals and cause insurers to be in violation of network adequacy requirements. Under Washington state law, an insurer must maintain a provider network that “is sufficient in numbers and types of providers and facilities to assure that to the extent feasible...all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition.”³⁸ Washington state law also prohibits health insurers from denying or limiting coverage of gender-affirming care when care is medically necessary and prescribed pursuant to accepted standards of care.³⁹ If Washington hospitals terminate their provision of gender-affirming care procedures in response to the proposed rules, it would be extremely difficult for any issuer to maintain a provider network sufficient in number and type of health care providers to ensure timely access and meet Washington’s state network adequacy requirements. And if issuers are unable to meet those requirements, patients in Washington state will experience worse health outcomes.

C. Washington state health care providers are already reducing access to gender-affirming care in response to the chilling effect of the NPRMs and related federal policies.

The Conditions of Participation Proposed Rule purports to exclude only those hospitals that provide so-called “SRPs” to children under the age of 18, but the penalty of exclusion is so severe that hospitals and related providers will likely stop providing a broad range of gender-affirming care to avoid a finding of noncompliance. Mary Bridge Children’s Hospital in Tacoma, Washington, is an example of the dangerous chilling effect of these proposed rules.

Until recently, Mary Bridge Children’s Hospital provided youth in Tacoma and surrounding areas with gender-affirming care, including access to medication and behavioral health care. On January 26, 2026, the hospital notified patients that it would be closing its gender-affirming care clinic for fear of being excluded from the Medicaid and Medicare programs, just as the Condition of Participation Proposed Rule threatens.⁴⁰ The notice states in part:

³⁴ 90 FR 59443.

³⁵ See, e.g., RCW 48.43.0128.

³⁶ 90 FR 59463, 59441.

³⁷ 90 FR 59474.

³⁸ WAC 284-170-200.

³⁹ RCW 48.43.0128.

⁴⁰ See Correspondence re: Mary Bridge Children’s Hospital (attached hereto as Exhibit E).

It is with a heavy heart that I write to share that MultiCare and Mary Bridge Children's will no longer be offering gender-health-related medical care to minors, effective the week of January 26, 2026.

This was an incredibly painful decision, and one that we wish we did not have to make. We recognize how important this care is to our gender health clinic patients and have a sense of the impact this will have on you and your family.

Over the last year we have worked to find options that would allow us to continue to care for this important group of patients. But recent developments at the Federal level now threaten to cut off Medicare and Medicaid payments to MultiCare's entire health system if we continue offering these services.

Without those payments, our organization would cease to exist...⁴¹

The closure of Mary Bridge's gender-affirming-care clinic abruptly terminated patients' access to important care and medication. Unfortunately, the closure also disrupted patients' access to therapy and behavioral health care, demonstrating that the chilling effect of these proposed rules extends far beyond the specific treatment options they purport to target.

D. The Conditions of Participation Proposed Rule unlawfully seeks to regulate the practice of medicine.

One of the most striking and baseless claims in the Conditions of Participation Proposed Rule is that banning hospitals from offering medically necessary, gender-affirming care to transgender youth would not amount to "regulat[ing] the practice of medicine." This is false, and the proposed rule is a reckless attempt to meddle in the relationship between doctors and their patients. The Tenth Amendment to the United States Constitution establishes the states' fundamental right to regulate the practice of medicine, licensing, and public health within their borders, a basic principle of federalism that the Supreme Court has repeatedly upheld. Given the states' plain authority to govern the practice of medicine within their borders, it cannot be that CMS is able to prohibit them from authorizing coverage and delivering appropriate, medically necessary care to their residents. Such unlawful federal overreach would deprive patients and their families of the opportunity to access important health care, even where a physician has determined that the care is medically necessary based on an individual patient's circumstances.

Despite CMS's efforts to interfere with doctor-patient relationships, gender-affirming care is evidence-based medical care and is appropriate for the treatment of gender dysphoria in transgender youth. The extensive list of major U.S. medical associations supporting this treatment includes the American Academy of Pediatrics (AAP), American Medical Association (AMA), American Psychological Association (APA), Endocrine Society, Pediatric Endocrine Society, American Academy of Child and Adolescent Psychiatry (AACAP), American

⁴¹ *Id.*

Psychiatric Association (APA), the American Nurses Association (ANA), and the World Professional Association for Transgender Health (WPATH), all of which are better positioned and more capable of making these determinations than either HHS or CMS.

By unilaterally declaring the practice of gender-affirming care for youth as outside “the practice of medicine,” CMS creates a dangerous precedent. For example, the proposed rule asserts that treating a person’s body to affirm their gender identity “is not health care.” The only way CMS can make such a baseless assertion, however, is by willfully disregarding the many young people for whom such services have amounted to affirming and in many cases lifesaving care. Decisions about a young person’s health and safety should be made by the young person, their family, and their medical team, not by a federal agency with no lawful authority to direct medical care or regulate the practice of medicine.

E. The proposed rules would have harmful effects on Washington state’s workforce and the availability of healthcare workers in specialty fields.

The Conditions of Participation Proposed Rule would also have significant negative implications for Washington state’s health care workforce. By conditioning Medicare and Medicaid participation on the categorical exclusion of certain pediatric services, CMS would place hospitals and affiliated clinicians in untenable positions that may drive providers out of pediatric care, adolescent medicine, endocrinology, psychiatry, and related behavioral health practice areas.

Washington state already faces workforce shortages in pediatric subspecialties and behavioral health care, particularly in rural and underserved areas. Only about 7 percent of Washington state’s health care providers practice in rural communities, and most of Washington state is designated a Health Professional Shortage Area for primary care and mental health.⁴² Policies that increase regulatory risk, professional stigma, or legal uncertainty for providers treating transgender youth are likely to accelerate provider attrition, service consolidation, and early retirement, further reducing access to care for all children, not only those seeking gender-affirming services. In addition, the proposed rule will likely deter some trainees from entering or remaining in pediatric and adolescent health fields, undermining the state’s long-term workforce sustainability and capacity to meet growing pediatric behavioral health needs.

V. THE PROPOSED RULES WOULD FRUSTRATE WASHINGTON STATE’S ABILITY TO COMPLY WITH ITS LEGAL OBLIGATIONS

Washington state has important state and federal legal obligations regarding the provision of coverage and access to services for gender-affirming care. The proposed rules fail to address these obligations in any meaningful way and would interfere with the state’s ability to comply with its legal requirements and ensure timely and effective access to care.

⁴² See, e.g., Tableau Public, Rural Health Insights for Each State & Congressional District, Workforce, available at <https://public.tableau.com/app/profile/stroudwater.associates/viz/shared/KHY2NR9HZ>.

A. The Reimbursement Proposed Rule would undermine Washington state's compliance with the Early and Periodic Screening, Diagnostic, and Treatment Program.

Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT)⁴³ requires states to ensure access to certain comprehensive, preventative, and medically necessary treatment services for recipients under the age of 21. "It is the responsibility of states to determine medical necessity on a case-by-case basis,"⁴⁴ and states must provide coverage for medically necessary procedures, even if those services are not covered under the state plan. Indeed, even the Reimbursement Proposed Rule recognizes that states like Washington "may only include tentative limits on services and must take into account the individual needs of the child." Unfortunately, the proposal itself fails to take those same individual needs into consideration and instead attempts to impose a discriminatory, categorical ban on providing certain treatment options only for transgender youth under the program.

The Reimbursement Proposed Rule concedes it would "limit States' longstanding flexibility to develop State-specific processes for determining when a service is medically necessary for an EPSDT-eligible beneficiary." But even this concession is a gross understatement: the proposal both violates EPSDT and would fundamentally undermine Washington state's legal obligations, prohibiting the state from offering appropriate gender-affirming care services under the program, even if there were a determination of medical necessity in an individual patient's case.

Notably, CMS attempts to explain away this conflict by asserting that so-called SRPs "may pose a risk of harm to children." Such rank speculation, however, is insufficient to justify a categorical ban on these critical treatment options, particularly where CMS has chosen to ignore the wealth of evidence showing the treatments are safe, effective, and often lifesaving. This is particularly true considering the proposed rules would still inexplicably permit the same treatment options "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," suggesting that CMS's true concerns are less about any speculative harm and more about its attempt to deny care to the specific patient population at issue. Further, CMS's discriminatory conclusion that these important treatment options "may cause harm" and must be categorially banned for transgender youth runs directly counter to the evidence and the law, which permits states to conduct individualized determinations of medical necessity for their residents' medical care.

B. The proposed rules would violate Washington state's legal obligations under the Medicaid Drug Rebate Program.

Like every other state, Washington participates in the Medicaid Drug Rebate Program (MDRP). As a result, and subject to certain limited exceptions, Section 1927 of the Social Security Act requires Washington (and every other state) to provide Medicaid coverage for all FDA-approved drugs for their "medically accepted indications." Under the relevant regulatory framework, a

⁴³ 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43).

⁴⁴ See "[Early and Periodic Screening, Diagnostic, and Treatment | Medicaid](https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment)," available at <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment>.

drug’s “medically accepted indications” include any indications that appear on the drug’s FDA-approved label as well as any indications identified for the drug in certain pharmaceutical compendia.⁴⁵ The pharmaceutical compendia at issue identify both “on-label” and “off-label” uses for FDA-approved drugs, and states like Washington are required to cover those drugs for all their identified uses.

The pharmaceutical compendia have long identified the treatment of gender dysphoria as one of the “medically accepted indications” for prescription medications that are often deemed medically necessary for providing gender-affirming care. Pursuant to its participation in the MDRP, therefore, Washington state has a legal obligation under Section 1927 to provide coverage for these prescriptions for their “medically accepted indications,” which include treating gender dysphoria in transgender youth where such treatment is deemed medically necessary based on the specific facts of any individual patient’s unique medical history.

Claiming that “there is no pharmaceutical that is solely indicated” for gender-affirming care and that these pharmaceuticals will still be covered for their non-transgender-related indications, however, CMS attempts an end-run around Washington state’s Section 1927 legal obligations. But CMS’s explanation is a plain misstatement of the law, as it ignores Washington state’s obligations under the MDRP to cover these prescriptions for *all* their medically accepted indications. Put simply, there is no exception to Section 1927 that would allow a state to deny coverage merely because the federal government seeks to discriminate against a specific patient population that might tend to use a group of prescription drugs for a particular medically approved indication. By prohibiting Washington state from providing Medicaid coverage for these prescriptions for treating gender dysphoria—clearly one of their “medically accepted indications”—CMS’s interpretation would not only subject Washington state to potential liability for failing to abide by its obligations under the MDRP but would also undermine the state’s efforts to provide appropriate and lawful prescription coverage for all Washington state residents.

⁴⁵ 42 U.S.C. 1395r-8(k)(6).

VI. CONCLUSION

For the reasons set forth above, and for the health of all Washingtonians, we urge you to withdraw these proposed rules.

Sincerely,



Governor
Washington State



Patty Kuderer
Washington State Insurance Commissioner



Ryan Moran
Director
Washington State Health Care Authority



Dennis Worsham
Secretary of Health
Washington State Department of Health



Lisa Keating
Executive Director
Washington State LGBTQ Commission



Tana Senn
Secretary
Washington State Department of Children, Youth,
and Families



Megan Matthews
Director
Washington State Office of Equity