

October 9, 2026

Steven Ford

Director, Department of Medical Assistance Services

Via email to steven.ford@dmass.virginia.gov

Dear Director Ford:

Thank you for taking the time to meet with Equality Virginia in August to discuss a final rule from the Centers for Medicare & Medicaid Services (CMS) prohibiting the use of federal Medicaid and CHIP funds for services such as puberty-delaying medications and hormone therapy when provided to transgender youth to treat gender dysphoria. *Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children*, 91 Fed. Reg. 52,406 (Aug. 13, 2026) (to be codified at 42 C.F.R. pts. 441, 457) ("the Rule"). It applies to enrollees under 18 for Medicaid and under 19 for CHIP, and is anticipated to go into effect October 13, 2026. As Equality Virginia discussed with you, the Rule repeatedly states that it does not prohibit coverage for the aforementioned services using state-only funds outside federally matched Medicaid or CHIP.

We write with serious concerns regarding DMAS' September 24, 2026 Medicaid Bulletin "Changes to Gender Dysphoria Coverage." The Bulletin purports to notify providers that "in accordance with a new federal final rule for dates of service on or after October 13, 2026, DMAS will no longer cover gender dysphoria services for Medicaid members under the age of 18, and CHIP members under the age of 19."

The Virginia Department of Medical Assistance Services Physician-Practitioner Manual, Chapter 12: Gender Dysphoria Supplement clearly states that these services are covered by Virginia Medicaid and contains no age limitations. To our knowledge, DMAS made no changes to this chapter of the manual following the Rule's publication on August 13. Further, implementing any such change would trigger a notice and comment period under the Virginia Administrative Process Act, Va. Code § 2.2-4007.04:01(B), including direct notice to stakeholders and a notice posted on Virginia Regulatory Town Hall. We have been unable to locate any notice posted to Town Hall, and none of the dozens of providers of youth gender affirming care that we are in regular communication with have received notice from DMAS of any such change.¹

¹ Only one provider that we're aware of has received any type of notice of this purported change, in the form of a phone call from a Medicaid managed care plan, as opposed to DMAS, notifying him that his patient's puberty delaying medication would no longer be covered as of next week.

We are alarmed that DMAS has issued a Medicaid Bulletin that directly conflicts with its obligations under the Physician-Practitioner Manual, without the required process intended to ensure that providers and their patients who rely on this care have advance notice of whether coverage will continue and of any operational changes. Nothing in the federal Rule dictates that outcome. The Rule repeatedly confirms that states retain authority to use state-only funds to provide these services to Medicaid and CHIP beneficiaries. Rule, 91 Fed. Reg. at 52,407, 52,428, 52,434-35, 52,442, 52,471 (. Many states have already preserved coverage for this care through allocation of state funding. Some states have set up Medicaid billing and coding guidelines that allow providers to flag claims for this care to be paid solely with state funds as opposed to the usual federal match.² Other states have appropriated funding to new freestanding funds and have instructed providers to bill these services to these new programs.³ Both of these options are available to Virginia, and determining a mechanism to continue coverage of this care is necessitated by the current Manual.

We encourage DMAS to either immediately begin the process of administratively establishing state-dollar-only Medicaid and CHIP billing codes or instruct providers to code these services in a manner that funnels reimbursement to a distinct state program. As Virginia works to establish this system, stakeholders such as providers, pharmacies, managed care organizations, beneficiaries, and relevant community groups should receive guidance that includes information on how to document services provided in the interim for retroactive payment once the system is established, and reiterates applicable nondiscrimination and equal access protections so providers, plans, and pharmacies do not apply the rule more broadly than required. Through either mechanism, Virginia maintains the ability—and obligation under its current DMAS manuals—to continue covering this care.

² See, e.g., Ill. Dep't of Healthcare & Fam. Servs., *Provider Notice: Federal Rule on Gender Affirming Care for Young People* (Oct. 6, 2026), <https://hfs.illinois.gov/medicalproviders/notices/notice.prn261006c.html>; N.Y. State Dep't of Health, *NYS Gender Affirming Care Guidance* (Oct. 2, 2026), https://www.emedny.org/ProviderManuals/communications/NYS_Gender_Affirming_Care_Guidance_-_2-26.pdf; Me. Dep't of Health & Hum. Servs., Off. of MaineCare Servs., *Clarification of Funding for Gender-Affirming Care* (Sept. 18, 2026), <https://www.maine.gov/dhhs/oms/providers/provider-bulletins/clarification-funding-gender-affirming-care-2026-09-18>.

³ See, e.g., Cal. Dep't of Health Care Access & Info., *Gender Affirming Care and Reproductive Health Programs*, HCAI, <https://hcai.ca.gov/workforce/initiatives/gender-affirming-care-and-reproductive-health-programs/> (last visited Oct. 8, 2026); Mass. Exec. Off. of Health & Hum. Servs., of Medicaid, *Continued Coverage of Gender-Affirming Care Services for MassHealth Members*, All Provider Bull. 420, at 1 (Sept. 2026), <https://www.mass.gov/doc/all-provider-bulletin-420-continued-coverage-of-gender-affirming-care-services-for-masshealth-members/download>;

Additionally, eliminating Medicaid and CHIP coverage for this care - even if the proper process were followed—would conflict with Virginia public policy. Virginia law requires private group health insurance and insurance plans sold on Virginia’s marketplace to cover medically necessary treatment for gender dysphoria, without limitations on the age of the insured. Va. Code § 38.2-3449.1(D) (“An individual shall not be subjected to discrimination under a health benefit plan on the basis of gender identity or being a transgender individual, *including by being denied coverage of medically necessary transition-related care.*” (emphasis added)); see also Va. Code § 38.2-3449.1(A) (“‘Medically necessary transition-related care’ means *any medical treatment prescribed by a licensed physician for treatment of gender dysphoria* and includes ...continuous hormone replacement therapy[.]” (emphasis added)). This commitment is also echoed in Virginia’s landmark nondiscrimination law, the Virginia Human Rights Act. See Va. Code § 2.2-3900(B)(1) (“It is the policy of the Commonwealth to [s]afeguard all individuals within the Commonwealth from unlawful discrimination because of... gender identity... in places of public accommodation[.]”).

Finally, this public policy position is reflected in Virginia’s choice to challenge this CMS rule in litigation. *State of Illinois v. Department of Health and Human Services*, 1:26-cv-14051 (U.S. D.Mass. Sept. 2, 2026). The complaint jointly filed by Virginia and twenty-one other states recognizes that “[t]he Rule discounts reputable, significant, evidence-based scientific studies and fails to address Plaintiff States’ determinations that the targeted healthcare constitutes safe, medically necessary care, including for adolescents.” Complaint at 161.

Because the Medicaid Bulletin conflicts with the requirements of the existing Physician-Practitioner Manual and Virginia’s clear statements of public policy, our organizations urge you to immediately rescind the Medicaid Bulletin and take the steps necessary to mitigate the harm caused by this improper notice. We further request that you meet with relevant stakeholders such as providers, pharmacies, MCOs, beneficiaries, and relevant community groups to identify a pathway to preserve access to gender affirming care for Virginia Medicaid and CHIP beneficiaries, either through the use of state-only funding within those programs or through a separate funding and reimbursement pathway.

While the final rule creates significant implementation challenges, it does not prevent Virginia from covering medically necessary services with state-only funds. We look forward to joining relevant stakeholders to discuss these matters with you as soon as possible.

Best,

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