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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

STATE OF OREGON, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as the Secretary of the Department of Health and Human Services, et al., Defendants.	No. 6:25-cv-02409-MTK REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT

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MEMORANDUM OF LAW

I. INTRODUCTION

Defendants seek to have it both ways—on the one hand wielding the Kennedy Declaration to terrorize providers into terminating the provision of transgender health care, and boasting when it has its intended effect—and on the other, insisting before this Court that it has no effect because it's just the opinion of one man who happens to disagree with that care. To agree with Defendants' litigation position, though, this Court would have to ignore that the one man is the Secretary of Health and Human Services, the "opinion" purports to set a national standard of care that by rule would supersede all other established standards of care, and the threatened consequence for ignoring the "opinion"—provider exclusion from Medicare and Medicaid—poses serious harms to States' provider networks. And this Court also would have to overlook the fact that the Secretary calls the Declaration a "clear directive" and that HHS has referred at least 17 hospitals and health centers for potential exclusion for violating that "opinion" and vowed that it won't stop "fighting" until "every single hospital system stops" providing transgender health care to youth.

While Plaintiff States would prefer the Declaration be the mere opinion of one man so they did not have to sue over it, it just isn't the case. The text of the Declaration, the legal consequences it spells out, and HHS's statements everywhere but in their legal brief force the Plaintiff States to seek relief. And this relief is desperately needed, notwithstanding Defendants' post hoc representations in litigation, as providers are being intimidated into stopping care at an alarming clip. Relief is also warranted; Defendants hardly defend the legality of the Declaration.

On jurisdiction, this case is ripe and the Kennedy Declaration is final agency action. Defendants have plainly exploited the Declaration to intimidate providers, including some of the leading children's hospitals in the nation, by publicly referring major hospitals and health centers to HHS-OIG for exclusion from Medicare and Medicaid solely because they provide—as a tiny fraction of the services they offer—transgender health care in contravention of the Declaration. Unsurprisingly, many institutions have taken Defendants at their word and complied with the

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Declaration's unequivocal command, causing harm to Plaintiff States' Medicaid provider networks and their authority to regulate the practice of medicine.

On the merits, Plaintiff States are entitled to summary judgment on their claims. Defendants ignore the plain text of the Declaration, which announces that it is setting a standard of care that supersedes established, professionally recognized standards of care in the Plaintiff States and purports to set a new substantive legal standard that could be used to categorically exclude providers for violating it. This goes well beyond a general statement of policy and thus would require notice and comment. Defendants point to no statutory authority to justify the Declaration, let alone the kind of unequivocal delegation of authority that would be necessary to intrude on the regulation of the practice of medicine. Defendants likewise offer no serious rebuttal to arguments that the Declaration violates the Medicaid Act because it violates the terms of States' Medicaid and CHIP plans and would devastate States' abilities to maintain adequate provider networks. On these grounds, this court should grant Plaintiff States' motion for summary judgment.

II. ADDITIONAL FACT SUMMARY

Since Plaintiff States filed their motion for summary judgment, HHS has continued referring prominent medical institutions within Plaintiff States to HHS-OIG for potential exclusion from Medicaid and Medicare based on their provision of transgender health care to youth.[1] In each

[1] HHS has referred at least 13 hospitals and 4 health centers to HHS-OIG for potential exclusion from Medicaid and Medicare, including: Seattle Children's Hospital, Children's Hospital Colorado, Children's Hospital Minnesota, Children's Hospital of Orange County, UCSF Hyde Hospital, Benioff Children's Hospital, Boston Children's Hospital, Doernbecher Children's Hospital, Lurie Children's Hospital of Chicago, Nemours Children's Hospital, New York University–Langone Health, Children's Hospital of Philadelphia, Johns Hopkins Hospital and Health System, Whitman-Walker Health Center, Callen-Lorde Community Health Center, Los Angeles LGBT Center, and the Institute for Family Health. Declaration of Lauryn K. Fraas (Fraas Decl.), Ex. 1, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Dec. 26, 2025, at 3:29 pm), https://x.com/HHSGCMikeStuart/status/2004695988242710776; *id.*, Ex. 2, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Dec. 30, 2025, at 1:08 pm), https://x.com/HHSGCMikeStuart/status/2006110061114851333; *id.*, Ex. 3, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Jan. 5, 2026, at 3:35 pm), https://x.com/HHSGCMikeStuart/status/2008321502765093348; *id.*, Ex. 4, Mike Stuart, HHS

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case, HHS's General Counsel cited the Kennedy Declaration as the basis for the referrals. For instance, in referring Johns Hopkins Hospital and Health System on February 3, 2026, the HHS General Counsel wrote:[2]

> @SecKennedy's declaration made clear that sex-rejecting procedures for children and adolescents are not safe and not effective. Far from it. Sex-rejecting procedures are incredibly damaging and contrary to acceptable standards of healthcare. @HHSGov, @SecKennedy, and @HHSOGC will continue to take all necessary actions to protect our children from "sea to shining sea." Our children deserve it.

Similarly on January 15, 2026, in referring six prominent children's hospitals for potential exclusion from Medicaid and Medicare, HHS's General Counsel posted:[3]

General Counsel (@HHSGCMikeStuart), X (Jan. 9, 2026, at 1:46 pm), https://x.com/HHSGCMikeStuart/status/2009743491186794620; *id.*, Ex. 5, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Jan. 15, 2026, at 3:40 pm), https://x.com/HHSGCMikeStuart/status/2011946547005833419; *id.*, Ex. 6, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Feb. 3, 2026, at 3:25 pm), https://x.com/HHSGCMikeStuart/status/2018828343144010025; *id.*, Ex. 7, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Feb. 11, 2026, at 10:16 am), https://x.com/HHSGCMikeStuart/status/2021649628639240524; *see also* ECF 32 at 18-19 & nn.6-7 (discussing initial three referrals). This Court may take judicial notice of statements made by government officials on social media and to the press. *See* *Nguyen v. Scott*, 796 F. Supp. 3d 703, 733 (W.D. Wash. 2025) (taking judicial notice of social media statements and videos); *Cnty. of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 520 n.4, n.6, n.7 (N.D. Cal. 2017) (taking judicial notice of press conference and interview statements).

[2] Fraas Decl., Ex. 6.

[3] Fraas Decl., Ex. 5; *see also id.*, Ex. 7 (social media post referring additional medical institutions and explaining that "@SecKennedy, @HHSGov, and legitimate medical professionals from across the nation have been exceedingly clear" that "[s]ex-rejecting procedures are not acceptable forms of healthcare" and that "@HHSGov, @SecKennedy, and @HHSOGC will continue to take all necessary actions to protect our children from life-altering, damaging and fake healthcare treatments").

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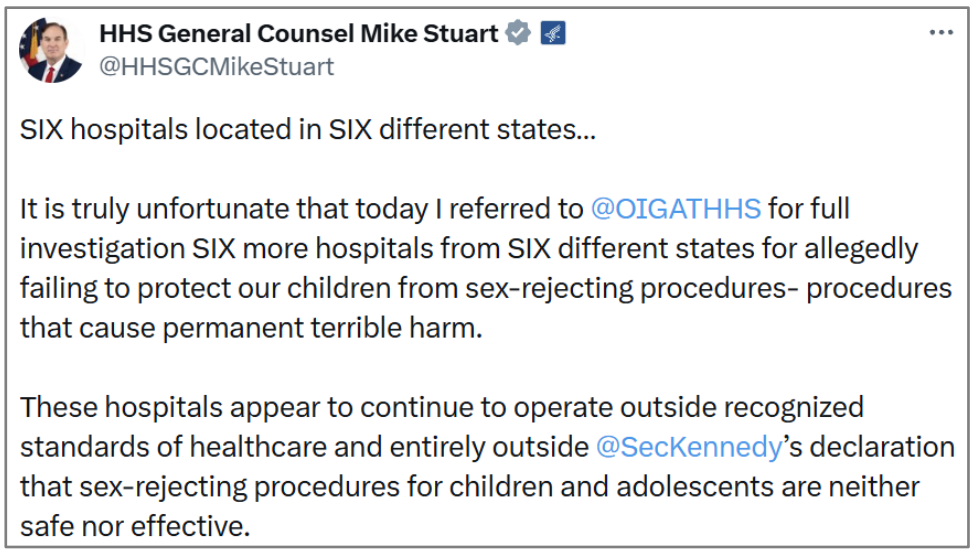
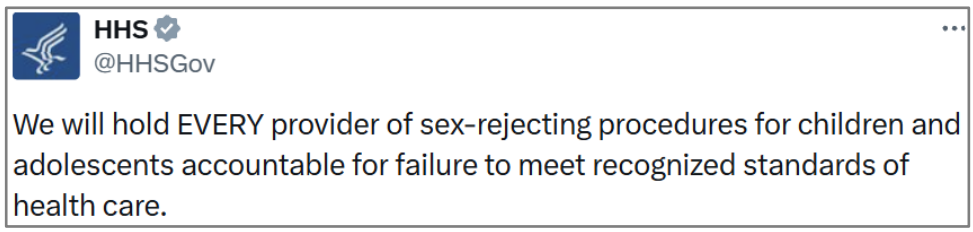


And on January 9, 2026, in referring three California hospitals, HHS's General Counsel explained that he was referring the hospitals for "full investigation" because the hospitals "continue to operate outside recognized standards of health care and entirely outside @SecKennedy's easy to understand declaration that sex-rejecting procedure for children and adolescents are not safe nor effective."[4]

HHS has also been clear in the goal of the referrals: to end transgender health care for adolescents, writing on January 5, 2026:



Indeed, HHS has celebrated the federal pressure currently being exerted on medical institutions to stop providing this care.[5]

[4] Fraas Decl., Ex. 4.

[5] Fraas Decl., Ex. 8, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Feb. 3, 2026, at 7:24 pm), https://x.com/HHSGCMikeStuart/status/2018888249104531523; *see also id.*, Ex. 11, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X, (Jan. 25, 2026, at 5:37 am), https://x.com/HHSGCMikeStuart/status/2015418646450090475?s=20.

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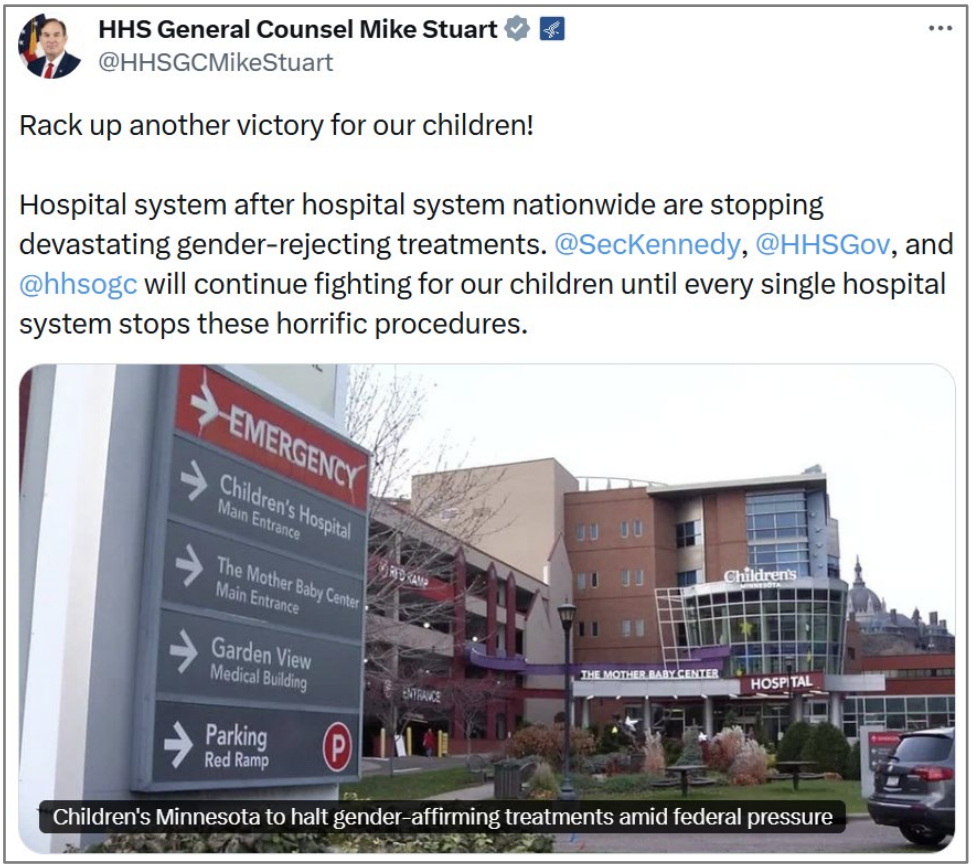

This federal pressure campaign has been effective. According to HHS, "dozens" of hospital systems across the country have stopped providing gender affirming care to young people "over the past few weeks."[6] These hospitals include three institutions that were referred to HHS-OIG for potential exclusion,[7] as well as institutions that fear referral to HHS-OIG or other retribution from the federal government based on the provision of transgender health care to youth, including

[6] Fraas Decl., Ex. 10, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Feb. 4, 2026, at 2:48 pm), https://x.com/HHSGCMikeStuart/status/2019181341158277378; *see also id*., Ex. 8.

[7] *See* ECF 59-6 (Children's Hospital Colorado, explaining in a press statement that it decided to suspend care "due to the threatened impact of the HHS investigation and the overall declaration"); Fraas Decl., Ex. 18, Joseph Goldstein, *Manhattan Hospital Ends Medical Treatment for Transgender Youth*, N.Y. Times (Feb. 17, 2026), https://www.nytimes.com/2026/02/17/nyregion/nyu-hospital-transgender-youth.html (NYU Langone stopping care, citing "the current regulatory environment" after being referred for possible exclusion); Fraas Decl., Ex. 20, Children's Minnesota, Gender Health, https://www.childrensmn.org/services/care-specialties-departments/gender-health/ (Children's Minnesota, explaining that it was pausing care due to "an increase in federal actions").

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Children's Hospital Wisconsin, Denver Health in Colorado, and Mary Bridge Children's Hospital in Washington.[8] As reflected in the statements of these institutions, they are unwilling to continue providing this care to minors amid the federal government's escalating threats. Looming large among these threats is the Kennedy Declaration, which poses an existential threat to institutions and individual providers of medically necessary health care for transgender minors because of the harsh consequences that flow from exclusion from federal programs.[9]

Excluding the referred pediatric hospitals from Medicaid would devastate pediatric health care delivery in many of the Plaintiff States. These hospitals provide critical pediatric services to multi-state regions and often serve as safety-net providers, supplying pediatric care to huge swaths

[8] Fraas Decl., Ex. 21, Joe Schulz, *Children's Wisconsin, UW Health stop providing gender-affirming treatments for minors*, Wisconsin Public Radio (Jan. 13, 2026), https://www.wpr.org/news/childrens-wisconsin-uw-health-stop-providing-gender-affirming-treatments-minors; *id.*, Ex. 19, Tony Gorman, *Youth gender affirming case suspended at Children's Hospital Colorado and Denver Health*, Colorado Public Radio (Jan. 2, 2026), https://www.cpr.org/2026/01/02/youth-gender-affirming-care-suspended-childrens-hospital-denver-health/; *id.*, Ex. 22, Becca Most, *Tacoma children's hospital closes gender-affirming care clinic*, The News Tribune (Jan. 27, 2026), https://www.thenewstribune.com/news/local/article314477495.html; *id.*, Ex. 23, Elise Takahama, *Mary Bridge leaders cite 2 federal threats behind gender clinic closure*, The Spokesman-Review (Feb. 4, 2026), https://www.spokesman.com/stories/2026/feb/04/mary-bridge-leaders-cite-2-federal-threats-behind-/; *see also id.*, Ex. 24 Theresa Gaffney, *Amid federal pressure, more hospitals stop gender-affirming care for minors*, STAT News (Feb. 5 2026), https://www.statnews.com/2026/02/05/hospitals-stop-gender-care-minors-trump-administration-pressure (cataloguing the health care institutions that have stopped providing transgender health care to minors since December 2025).

[9] *See, e.g.*, ECF 59-6 (statement by Children's Colorado explaining, "[t]his referral threatens Children's Colorado's Medicare and Medicaid funding, risking care for hundreds of thousands of children"); Fraas Decl., Ex. 22 ("Due to recent escalations at the federal level to eliminate medical interventions to treat gender dysphoria for minors nationwide, as well as investigations and significant penalizations of health care organizations that provide such care, MultiCare Health System has made the difficult choice to close the MultiCare Mary Bridge Children's Gender Health Clinic."); *id.*, Ex. 21 (citing "escalating legal and federal regulatory risk" and "recent federal actions" as the reason two major medical institutions in Wisconsin stopped providing gender affirming care to minors); *id.*, Ex. 19 (explaining that its decision to suspending gender affirming care on January 2, 2026 was "made necessary by the actions of HHS, [which] substantially affect access to critical health services").

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of low-income children in Plaintiff States.[10] For instance, Medicaid is a major payor to Seattle Children's Hospital—which provides specialized pediatric care (including cancer care, intensive cardiac care, and intensive neonatal care) to the sickest children in a five-state region—and is the *only* hospital in Washington approved to provide pediatric organ transplants. *See* ECF 62 ¶¶ 6, 7, 9, 10. Similarly, Children's Hospital of Colorado, which is the premier children's hospital in Colorado and the Rocky Mountain Region, has the only dedicated Level 1 trauma center in the region, and is the only hospital in Colorado approved to provide pediatric organ transplants. Flores-Brennan Suppl. Decl. ¶¶ 4-5. Boston Children's Hospital serves as the referral center for the sickest children in the New England region, providing specialized care for conditions such as congenital heart disease, childhood cancers, cerebral palsy, epilepsy, spina bifida, and stroke, and provided care to more than 86,500 MassHealth (Medicaid and CHIP) patients in 2025. Marqusee Suppl. Decl. ¶¶ 14, 17-18. Children's Hospital of Philadelphia, which has the largest pediatric oncology research program in the country as well as one of the largest pediatric cardiac centers in North America, is a critical provider of pediatric care in the mid-Atlantic region, and provided care to over 168,500 Medicaid patients in state fiscal year 2025. Kozak Suppl. Decl. ¶¶ 7-9, 17-19. Lurie Children's Hospital of Chicago is a leading pediatric provider in the Midwest region and served nearly 90,000 Medicaid and CHIP patients in state fiscal year 2025. *See* Phelan Suppl. Decl. ¶ 5. And Children's Minnesota, which is one of the largest freestanding pediatric health systems in the country, serves a five-state region, providing both a Level 1 Trauma Center and a Level 1 Children's Surgery Center to the more than 167,000 patients it served in 2024. Connolly Suppl. Decl. ¶¶ 3-4. Exclusion of these prominent entities from Medicaid would leave state health care

[10] Nearly half of the approximately 73 million children in the United States are on Medicaid or CHIP. *See* Fraas Decl., Ex. 25, *October 2025 Medicaid & CHIP Enrollment Data Highlights*, Medicaid.gov, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/october-2025-medicaid-chip-enrollment-data-highlights (last visited Feb. 24, 2026) (providing Medicaid data); *id.*, Ex. 26, *Children's Bureau: Child Welfare Outcomes Report Data, Child Population Data*, U.S. Dep't of Health & Hum. Servs., https://cwoutcomes.acf.hhs.gov/cwodatasite/population/index/ (last visited Feb. 24, 2026) (providing child population data).

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authorities scrambling to provide care for millions of incredibly sick children, particularly those requiring specialized cancer treatment, cardiac care and heart surgery, treatment for neurological disorders, as well as organ transplants. *See* ECF 62 ¶ 12 (explaining there would be no way to timely provide specialized care to many medically-complicated Medicaid patients in Washington if Seattle Children's Hospital was excluded); Flores-Brennan Suppl. Decl. ¶ 9 (same for Colorado if Colorado Children's Hospital was excluded); Phelan Suppl. Decl. ¶ 5 (same for Illinois if Lurie Children's Hospital was excluded); Kozak Suppl. Decl. ¶¶ 17, 20-21 (same for Pennsylvania if Children's Hospital of Pennsylvania was excluded); Marqusee Suppl. Decl. ¶¶ 16-18 (same for Massachusetts if Boston Children's Hospital was excluded); Connolly Suppl. Decl. ¶ 8 (same for Minnesota if Children's Minnesota was excluded).

III. ARGUMENT

A. The Kennedy Declaration Purports to Override Existing Standards of Care, and Defendants' Litigation Position to the Contrary Should be Disregarded

Ignoring both the plain text of the Kennedy Declaration and the fact that the HHS General Counsel has already deployed it against health care providers, Defendants now describe the Declaration as merely a "non-binding policy position" (ECF 73 at 17), "non-binding opinion" (*id.* at 21), and a "non-binding policy view" (*id.* at 23). On this basis, they demur on each and every substantive challenge Plaintiff States bring here.[11] The Kennedy Declaration isn't in excess of his statutory authority, they say, because *anyone*, including the Secretary, can express his opinion. *Id.* at 38. They didn't need to go through notice and comment, they say, because the Kennedy Declaration doesn't set or change any legal standard. *Id.* at 35-36. The Declaration isn't contrary to law, they say, because it is legally irrelevant. *Id.* at 40. And for these same reasons, they say, the Kennedy Declaration isn't even agency action, and the case isn't ripe. *Id.* at 23, 28. But contrary

[11] Defendants filed two nearly identical briefs. One is a motion to dismiss or, in the alternative, summary judgment. ECF 73. The other is an opposition to Plaintiff States' motion for summary judgment. ECF 74. This omnibus response and reply will cite to Defendants' motion (ECF 73), but all arguments respond to both of Defendants' filings.

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to Defendants' post-hoc litigation position, the plain language of the Secretary's Declaration purports to establish a standard of care that health care providers must follow or risk exclusion. And because of that basic fact, every argument that Defendants now make in litigation fails.

To begin with, Secretary Kennedy does not state that the Declaration was made in his personal capacity. To the contrary, the Declaration proclaims at the top that it is issued "pursuant to [Secretary Kennedy's] authority and responsibilities under federal law" and includes HHS's seal. Subsequently, section I.D. is labeled "Legal Authority for This Declaration" and it claims it is "issued pursuant to the authority vested in the HHS Secretary." Such language typically refers to distinct grants of regulatory or adjudicatory power that Congress has given to a federal official or agency. *See* *Kennedy v. Braidwood Mgmt., Inc.*, 606 U.S. 748, 779-80 (2025) (holding Congress "vested the Secretary of HHS with" certain powers in statute); *see also* U.S. Const. art. II, § 1, cl. 1 ("All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives."). By contrast, sharing an opinion requires no grant of authority, and the Secretary does not typically open press conferences or op-eds with similar language.

The Declaration also expressly invokes 42 C.F.R. § 1001.2, which Defendants acknowledge "addresses situations in which HHS or a component agency has exercised specific statutory authority to determine that a treatment modality is not safe and effective." ECF 75 ¶ 6. The Declaration uses § 1001.2 to definitively determine that transgender health care is not safe and effective. True, Defendants have now backpedaled and conceded that 42 C.F.R. § 1001.2 *does not* give Secretary Kennedy the unilateral legal authority to set nationwide standards of care. ECF 73 at 39. But the Department of Justice's (DOJ's) representations to this effect in a legal brief cannot retroactively rewrite the Declaration itself. Nor do such representations provide any assurance to providers threatened with exclusion from federal health care programs or prevent HHS-OIG from applying the Declaration in exclusion decisions.

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The remainder of the Declaration's language confirms that it purports to change substantive legal standards. For instance, after citing to and quoting from § 1001.2, the Declaration states: "As such" (that is, because it is issued under "authority vested in the HHS Secretary" and "informed by 42 CFR § 1001.2") "this declaration *supersedes* 'Statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practice or providing care within a State.'" Kennedy Decl. § I.D (emphasis added). On its face, therefore, the Declaration purports to definitively declare that transgender health care is below the standard of care as defined by States or professional organizations, and that this Declaration "supersedes"—that is "annul[s], make[s] void, or repeal[s]"—the otherwise generally applicable definition of "professionally recognized standards of care" in 42 C.F.R. § 1001.2. *See* Supersede, *Black's Law Dictionary* (12th ed. 2024).[12]

Further, contrary to the Response's insistence that the Declaration will be one of the "multiple sources" that HHS-OIG is free to weigh and consult in exclusion proceedings (*see* ECF No. 73 at 2), the Declaration by its terms leaves no room for other, competing evidence about the appropriate standard of care. Notably, at least one court has even denied preliminary relief to maintain the prohibited medical services for transgender patients and their families on grounds that the hospital's fear of triggering exclusion proceedings under the Declaration was legitimate. *See Boe v. Children's Hosp. Colo.*, Case No. 26CV30232, Order at 21 (Dist. Ct. City & Cnty. of

[12] Defendants' read of the Declaration also flies in the face of the interpretation of Plaintiff States' witnesses, many of whom have decades of experience in the administration of public health care systems at the state and federal levels. According to them, the Kennedy Declaration "makes clear that the provision of [gender-affirming medical care] is, *per se*, a basis to exclude providers from federal health care programs." ECF 33 ¶¶ 16-23 (Oregon's Medicaid Director); *see also* ECF 39 ¶¶ 10-16 (California); ECF 40 ¶¶ 14-20 (Colorado); ECF 41 ¶¶ 16-24 (Connecticut); ECF 42 ¶¶ 16-24 (Delaware); ECF 45 ¶¶ 14-20 (Hawai'i); ECF 46 ¶¶ 23-30 (Illinois); ECF 47 ¶¶ 16-25 (Maine); ECF 48 ¶¶ 15-23 (Maryland); ECF 49 ¶¶ 11-20 (Massachusetts); ECF 50 ¶¶ 10-13 (Michigan); ECF 51 ¶¶ 16-22 (Minnesota); ECF 53 ¶¶ 14-20 (New Jersey); ECF 54 ¶¶ 14-22 (New Mexico); ECF 55 ¶¶ 18-25 (Pennsylvania); ECF 56 ¶¶ 15-21 (Rhode Island); ECF 57 ¶¶ 14-19 (Vermont); ECF 58 ¶¶ 14-20 (Wisconsin). This natural reading of the Kennedy Declaration is also borne out by the multitude of providers who have stopped providing medically necessary transgender health care due to its explicit threat. Fraas Decl., Ex. 7.

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Denver Co. Feb. 13, 2026) (unpublished) (hereinafter Fraas Decl., Ex. 30) (denying preliminary injunction where it would require Children's Hospital Colorado to violate the Kennedy Declaration giving rise to "a very real threat of exclusion"). It strains credulity to think that both Plaintiff States—relying on the judgment of their seasoned Medicaid directors—and judges have fundamentally misunderstood the Declaration's import, as DOJ now insists.

Additionally, HHS has publicly treated the Kennedy Declaration as if health care providers were required to comply with it. In public post after public post, HHS's General Counsel has relied on the Declaration to refer hospitals and health centers to HHS-OIG for possible exclusion. *See supra* § II. According to HHS's General Counsel, they were referred because they "fail[ed] to meet professional recognized standards of health care as according to Secretary Kennedy's declaration" (ECF 59-2); (ECF 59-3) (same), "[t]he HHS [Secretary Kennedy] declaration made clear that sex-rejecting procedures for children and adolescents are neither safe nor effective" (ECF 59-4); (ECF 59-5) (same), and because medically necessary transgender health care is "entirely outside [Secretary Kennedy's] declaration" (Fraas Decl., Ex. 5).

Defendants make much of the fact that no notices of intent to exclude nor notices to exclude have been issued in response to these referrals (*see*, *e.g.*, ECF 73 at 29). The absence of notices of intent to exclude and notices to exclude has nothing to do with whether the Kennedy Declaration purports to create a new legal standard of care, but instead, is the result of a stipulation in this case in which Defendants agreed to refrain from doing so while this motion gets decided. *See* ECF 43. They also ignore the HHS General Counsel's repeated use of the Declaration as a cudgel to bully providers out of offering transgender health care.[13] Defendants also strain to suggest that the Secretary's proclamation will have only the weight that it can bear in any decision HHS-OIG might

[13] *See* Fraas Decl., Exs. 8, 11; *id.*, Ex. 9, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X (Feb. 3, 2026, at 7:46 pm), https://x.com/HHSGCMikeStuart/status/2018893885791940712; *id.*, Ex. 12, Mike Stuart, HHS General Counsel (@HHSGCMikeStuart), X, (Jan. 31, 2026 at 1:29 pm), https://x.com/HHSGCMikeStuart/status/2017711840747516265.

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make regarding those referrals. *See* ECF 73 at 23. But that reading both contradicts the text of the Declaration itself and fails to address that HHS-OIG operates under authority delegated by the Secretary himself, rather than under authority granted independently by Congress. *See id.* at 14 (citing 76 Fed. Reg. 13618-19); 42 U.S.C. § 1320a-7(b) (granting power of exclusion to "[t]he Secretary"); *see also* 5 U.S.C. § 404 (independent "dut[ies] and responsibilit[ies]" of inspectors general do not include conducting exclusion or debarment proceedings).

To be sure, the Declaration does not exclude any specific provider from federal health care programs by its terms. But that is because exclusion requires administrative steps to be accomplished—not because OIG would treat the Declaration as anything other than superseding the Plaintiff States' standards of care in those proceedings.[14] *See* Kennedy Decl. § V (interpreting 42 U.S.C. § 1320a-7(b)(6)(B) to allow the secretary to "exclude individuals or entities . . . if the Secretary determines the individual or entity has furnished or caused to be furnished items or services to patients of a quality which fails to meet professionally recognized standards of health care."). For example, HHS-OIG must individually determine whether a particular provider has provided the prohibited services. But that does not make the Declaration any less final because, as Plaintiff States explained in the moving papers, the only thing left for HHS-OIG to do is to determine as a matter of fact that a provider "[f]urnished, or caused to be furnished, to patients" the prohibited services and begin exclusion proceedings. 42 C.F.R. §§ 1001.701(a)(2), 1001.2001, 1001.2002; *see also* ECF 32 at 22-23.

Defendants' attempt to walk back the clear import of the Kennedy Declaration is nothing more than a post hoc litigation position, transparently taken because the Declaration is indefensible on its face. The Court need give it no credence in assessing the legality of the action. *See* *Dep't of Homeland Sec. v. Regents of the Univ. of Calif.*, 591 U.S. 1, 22 (2020) (holding justifications for agency action were "impermissible *post hoc* rationalizations"); *Nw. Res. Info. Ctr., Inc. v. Nw.*

[14] Plaintiff States addressed this argument in their moving papers, *see* ECF 32 at 22-23, and Defendants' opposition offers no meaningful response.

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Power & Conservation Council, 730 F.3d 1008, 1019 (9th Cir. 2013) (same). Instead, this Court should read the Kennedy Declaration for what it is: a breathtakingly illegal attempt to wrest the regulation of the practice of medicine away from the states and "vest[] [it] in the HHS Secretary." Kennedy Decl. § I.D. And because Defendants make no attempt to defend the terms of the Kennedy Declaration, but instead rely on their mischaracterization to underlie each and every one of their arguments, this issue is dispositive of all others.[15]

B. This Case Is Ripe

The ripeness doctrine has both constitutional and prudential components. Defendants' arguments on both grounds depend entirely on their assertion that the Kennedy Declaration represents only the Secretary's "non-binding opinion." That assertion is baseless, for the reasons stated above. Further, to the extent Defendants argue that the Declaration would become ripe only after HHS-OIG has initiated exclusion proceedings, it is well-established that agency actions are ripe for purely legal challenges, even if enforcement actions have not yet commenced. *Abbott Labs. v. Gardner*, 387 U.S. 136, 151 (1967), *overruled on other grounds by Califano v. Sanders*, 430 U.S. 99, 105 (1977) (case was ripe for adjudication where challenged regulation was "made effective upon publication, and the Assistant General Counsel for [the agency] stated in the district court that compliance was expected"); *Freedom to Travel Campaign v. Newcomb*, 82 F.3d 1431, 1435 (9th Cir. 1996) (holding facial challenge to regulations ripe for judicial review); *Colwell v. Dep't of Health & Human Servs.*, 558 F.3d 1112, 1123 (9th Cir. 2009) (finding challenge to policy guidance ripe where enforcement had never moved beyond a voluntary compliance stage).

1. "The constitutional component of ripeness is synonymous with the injury-in-fact prong of the standing inquiry." *Twitter, Inc. v. Paxton*, 56 F.4th 1170, 1173 (9th Cir. 2022)

[15] By relying solely on their argument that the Kennedy Declaration is nothing more than a"public[] articulati[on] [of] views" (*see* ECF 73 at 10), Defendants have waived any argument that if it does purport to establish a standard of care, binding on HHS-OIG in exclusion proceedings, it is within the Secretary's statutory authority and compliant with the law. *See Lykins v. Hohnbaum*, No. CIV. 01-63-JO, 2002 WL 32783973, at *3 (D. Or. Feb. 22, 2002) (holding failure to defend a claim on motion for summary judgment concedes it).

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(quotation omitted). The Kennedy Declaration causes two concrete and imminent harms to the Plaintiff States' provider networks, one of which is already being felt. First, providers that refuse to comply with the Declaration risk exclusion from Medicaid, which would cause an unprecedented and alarming degree of disruption in the Plaintiff States' Medicaid provider networks, particularly in highly specialized areas like pediatric organ transplant, genetic disorders, and cancers. *See* ECF 62 ¶¶ 6-12; Flores-Brennan Suppl. Decl. ¶¶ 4-9; Kozak Suppl. Decl. ¶¶ 6-21; Phelan Suppl. Decl. ¶¶ 4-6; Marqusee Suppl. Decl. ¶¶ 11-20; Connolly Suppl. Decl. ¶¶ 3-8; Fraas Decl., Ex. 30 at 12. Providers that comply with the Declaration remove themselves from the network of practitioners available to deliver medically necessary transgender health care to State Medicaid clients, harming the Plaintiff States' proprietary interest in providing this care as a part of their Medicaid programs. *See*, *e.g.*, ECF 33 ¶¶ 20-23. A number of providers in the Plaintiff States have already sought to insulate themselves from the risk of exclusion by complying with the Declaration's command and ceasing provision of transgender health care to minors, a fact that Defendants trumpet at every opportunity. *See*, *e.g.*, ECF 59-6; Fraas Decl., Exs. 8, 11, 12, 17, 23. Defendants cannot claim credit for the Declaration having its intended effects while simultaneously asserting in this lawsuit that it is merely symbolic. The Declaration harms the Plaintiff States' Medicaid agencies in "the performance of [their] public function;" the Plaintiff States have Article III standing to challenge it. *See* *Biden v. Nebraska*, 600 U.S. 477, 494 (2023).

The Declaration also injures Plaintiff States' sovereign interest in the regulation of the practice of medicine. Medically necessary transgender health care is legal in each of the Plaintiff States and well within the standards of care under state law, yet the Kennedy Declaration says it "supersedes" Plaintiff States' standards. Kennedy Decl. § I.D. This impairs the Plaintiff States' interest in "the exercise of sovereign power over individuals and entities." *See* *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 601 (1982). "States have standing to vindicate their authority as sovereign entities with a governing prerogative that is separate from the federal government." *Washington v. FDA*, 108 F.4th 1163, 1176 (9th Cir. 2024). This is especially potent

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where regulation of the practice of medicine is concerned, which "is primarily, and historically, a matter of local concern." *Hillsborough Cnty., Fla. v. Auto. Med. Labs., Inc.*, 471 U.S. 707, 715 (1985) (citing *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218 (1947)); *see also Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (recognizing the state's powers to regulate medical professions from "time immemorial").

2. Plaintiff States' challenge is also prudentially ripe. Under the doctrine of prudential ripeness, the Court considers "the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." *Thomas v. Anchorage Equal Rights Comm'n*, 220 F.3d 1134, 1141 (9th Cir. 2000) (en banc). Plaintiff States seek summary judgment arguing that the Kennedy Declaration exceeds the Secretary's statutory authority, was issued without required notice and comment procedures, and is contrary to law. *See generally* ECF 32. As a general matter, purely legal challenges such as these are "more likely to be ripe." *Freedom to Travel Campaign*, 82 F.3d at 1434; *see also Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky. v. Labrador*, 122 F.4th 825, 840 (9th Cir. 2024). These purely legal challenges are ripe because they do not depend on any facts that could be developed in any specific exclusion proceeding brought against a particular hospital or doctor. Further, withholding judgment would subject Plaintiff States to serious hardship. Plaintiff States' Medicaid programs and sovereign interests are being impaired *right now*. As HHS itself recognizes "[a]lmost daily, another major hospital system is ending" the provision of transgender health care to minors, making it more difficult for the Plaintiff States to maintain adequate provider networks for this care.[16]

Defendants rely on the administrative remedies available to excluded providers to save them from the Declaration's immediate effect. *See* ECF 73 at 26. But those remedies confirm that withholding a judgment from the Plaintiff States is untenable. Under HHS's regulations, excluded providers do not have a right to a hearing before an ALJ before a notice of exclusion becomes effective. 42 C.F.R. § 1001.2002(b); *see also Erickson v. U.S. ex rel. Dep't of Health & Hum.*

[16] Fraas Decl., Ex. 9.

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Servs., 67 F.3d 858, 864 (9th Cir. 1995) (holding health care providers not entitled to pre-deprivation hearing to contest exclusion). Exclusions have a presumptive term of three years, and "[i]n no case may the period be shorter than 1 year." 42 C.F.R. § 1001.701(d)(1).

Moreover, exclusion is a harsh penalty that bars a provider from practicing medicine in any context where they might be, even tangentially, involved in the provision of care to a person covered by Medicare or Medicaid. *See* U.S. Dep't of Health & Hum. Servs. Off. of the Inspector Gen., Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs at 6-7 (May 8, 2013) (hereinafter Fraas Decl., Ex. 29). A hospital excluded from federal health care programs would have to close its doors. *See* ECF 34 ¶ 18 ("I am not aware of any hospital, for example, that could stay in business without participating in Medicaid and Medicare."). Exclusion also has "significant collateral consequences" for providers, such as being placed on a publicly available list of excluded providers, which creates significant "barriers when seeking malpractice insurance, admissions to hospitals, and maintaining the practice of medicine," even if patients are limited to the privately insured. ECF 35 ¶ 34; *see also* Fraas Decl., Ex. 30 at 11 (declaration of hospital's chief of medicine, stating that "[a]ll commercial insurance companies require that the hospital meet conditions of participation in order to be qualified for contracts and to bill for services."). The consequences are so severe that "exclusion from participation in federal health care programs, like those threatened by the Kennedy Declaration, constitutes a de facto bar on the practice of medicine." ECF 34 ¶ 19.

Defendants demand that Plaintiff States wait for these exclusion proceedings to run their course disregards the degree of this threat, which has already coerced providers to cease providing medically necessary transgender health care to adolescents, and ignores the ongoing injury both to Plaintiff States' Medicaid provider networks to provide this care and to their sovereign interest in the regulation of the practice of medicine. Defendants also completely fail to explain why the pure questions of law presented in this case require further factual development and cannot be decided

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on this record. There is no serious dispute that this case is ripe, and this Court should adjudicate the merits of Plaintiff States' summary judgment motion.

C. The Kennedy Declaration Is Final Agency Action

Defendants' response to Plaintiff States' argument that the Kennedy Declaration is final agency action is that, in their view, the Declaration is merely an opinion that "does not establish the standard of care," and a separate administrative process is required to exclude a provider. ECF 73 at 27-29; *but see* ECF 32 at 19-23. The Kennedy Declaration purports to do more than merely express the Secretary's opinion, for the reasons stated above. *Supra* § III.A. And the Kennedy Declaration is undoubtedly final agency action.

Finality has two prongs: the consummation of an agency's decisionmaking process and legal effect. *See* *Bennett v. Spear*, 520 U.S. 154, 178 (1997). The "core question" in determining finality is "whether the agency has completed its decisionmaking process, and whether the result of that process is one that will directly affect the parties." *Or. Nat. Desert Ass'n v. U.S. Forest Serv.*, 465 F.3d 977, 982 (9th Cir. 2006) (quoting *Indus. Customers of Nw. Utilities v. Bonneville Power Admin.*, 408 F.3d 638, 646 (9th Cir. 2005)). In making that determination, the Ninth Circuit examines "whether the action amounts to a definitive statement of the agency's position or has a direct and immediate effect on the day-to-day operations of the subject party, or if immediate compliance with the terms is expected." *Id.* (citation modified) (quoting *Indus. Customers of Nw Utilities*, 408 F.3d at 646).

The Declaration is a definitive statement of the agency's position because, as argued above, the Declaration's plain language shows that it purports to "supersede" all contrary standards of care. *Supra* § III.A. This Court should thus reject Defendants' arguments that the Declaration is merely an opinion that does not establish a standard of care. *See* ECF 73 at 27-29. Moreover, far from being a "merely tentative" indication of likely future action, the Declaration purports to have examined evidence, considered the issues, and reached a final decision on the safety and effectiveness of medically necessary transgender health care for adolescents. *Or. Nat. Desert Ass'n*,

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465 F.3d at 984. Specifically, the Secretary relies on the alleged "comprehensive evidence review published by [HHS], documented risks of significant harm, markedly weak evidence of benefit, unfavorable risk-benefit profiles, inadequate existing clinical guidelines, growing international consensus among countries conducting rigorous evidence reviews, and applicable medical ethics principles." Kennedy Decl. § I.A. Based on the Secretary's alleged consideration of those things, the Kennedy Declaration purports to establish a binding standard of care by declaring an entire treatment modality "not to be safe and effective." Kennedy Decl. §§ I.D., V. Last, nothing in the Kennedy Declaration indicates that Defendants intended the Declaration to be "tentative" or "interlocutory." *Or. Nat. Desert Ass'n*, 465 F.3d at 984. The Declaration contains no conditional, qualified, or equivocal language. Instead, on its face, it purports to constitute a final and definitive statement about the professional standard of care, that is, HHS's "last word on the matter[.]" *Id.*

The Declaration also has a legal effect. In determining the "legal effect" of agency action, courts look to "whether the [action] has the status of law or comparable legal force, and whether immediate compliance with its terms is expected." *Id.* at 987 (quoting *Ukiah Valley Med. Ctr. v. FTC*, 911 F.2d 261 (9th Cir. 1990)). As argued above, that test is obviously met here, because the Kennedy Declaration purports to render the exclusion of a provider a foregone conclusion—if a provider provides medically necessary transgender health care to minors, they have provided care that falls below the professional standard of care, a determination that HHS-OIG has no discretion to dispute. *Supra* § III.A. Because the Kennedy Declaration predetermines the result of an exclusion proceeding, it is final agency action. Critically, HHS's actions after it issued the Kennedy Declaration demonstrate that it expected hospitals and providers to immediately comply with the Kennedy Declaration's determination that the prohibited medical services fall below the standard of care. *See supra* § II (collecting social media posts of the HHS General Counsel); Fraas Decl., Exs. 1-16; *id*., Ex. 17, HHS Rapid Response (@HHSResponse), X (Jan 18, 2026, at 10:00 am), https://x.com/HHSResponse/status/2012948103117017172. Thus, the Kennedy Declaration was

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intended to—and did—have an immediate legal effect and constitutes final agency action. *See Or. Nat. Desert Ass'n*, 465 F.3d at 982.

D. The Kennedy Declaration Exceeds the Secretary's Statutory Authority

Because Defendants do not identify any statute permitting the challenged Declaration, summary judgment for Plaintiff States is warranted. Additionally, Defendants make no substantive response to Plaintiff States' arguments that States have primacy over the regulation of medicine unless unmistakably overridden by Congress; Congress did not delegate to the Secretary of HHS the authority to exercise control over the practice of medicine; and Congress went out of its way to state that no provision of the Social Security Act should be construed as authorizing the Secretary to exercise such control, *see* 42 U.S.C. § 1395. ECF 32 at 23-29. Defendants also fail to respond to, and thus concede, that the Declaration exceeds 42 U.S.C. §§ 1320a-7 and 1320c-5 because those statutes deal with the quality of health care services, rather than the category of care provided, and thus do not permit exclusion based solely on the provision of medically necessary transgender health care. ECF 32 at 28-31. These failures justify summary judgment for the Plaintiff States, for the reasons explained in their motion for summary judgment. *See id.* at 23-31.

Instead of making any substantive response to the Plaintiff States' motion, Defendants try to avoid the conclusion that Secretary Kennedy *used* (much less exceeded) his statutory authority in issuing the Declaration. Defendants again ask the Court to treat the Declaration like an op-ed criticizing gender-affirming care penned by an everyday citizen or a position statement from a professional organization. *See* ECF 73 at 38 ("The Secretary, just like anyone else, has the right to share his non-binding opinion on the safety and efficacy[.]"). "But this wolf comes as a wolf[,]" *Morrison v. Olson*, 487 U.S. 654, 699 (1988) (Scalia, J., dissenting), and, for substantially the same reasons as argued above (*supra* § III.A), this Court should reject Defendants' argument.

As described above, the face of the Declaration alone shows that Defendants do not regard the Declaration as a mere opinion. *See supra* III.A. The Court should take Secretary Kennedy at his word—that "this Declaration is a *clear directive* to providers to follow the science and the

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overwhelming body of evidence that these procedures hurt—not help—children."[17] Indeed, Defendants apparently tout the Declaration as authoritative in every setting but before this Court. For example, HHS's news release on the Declaration ran under the headline that HHS would bar hospitals from providing gender-affirming care, and announced, "Under the declaration, practitioners who perform sex-rejecting procedures on minors would be deemed out of compliance with those standards."[18]

Defendants also make the extraordinary argument that because the Declaration itself does not cite *any* specific statutory authority that could empower the Secretary to issue a dispositive declaration under 42 C.F.R. § 1001.2, *see* ECF 75 ¶¶ 6-7, the Declaration is lawful. But that argument gets it precisely backwards. *Cf.* *Career Colls. & Schs. of Tex. v. Dep't of Educ.*, 98 F.4th 220, 254 (5th Cir. 2024) ("The Department may not justify the Rule by stating that the Higher Education Act does not foreclose the Department's approach."), *cert. granted in part sub nom. Dep't of Educ. v. Career Colls. & Schs. of Tex.*, 145 S. Ct. 1039 (2025), *and cert. dismissed*, 146 S. Ct. 59 (2025). Under DOJ's theory, all agency action, including agency action that cites no authority, would be presumed lawful unless the agency made the mistake of affirmatively citing *incorrect* legal authority. Instead, because agencies are creatures of statute an agency "must identify statutory authority for any action it takes," *Nat'l Ass'n of Broadcasters v. FCC*, 39 F.4th 817, 819 (D.C. Cir. 2022), and that the "agency's burden is to establish that its governing statute *enables* its regulations," *Career Colleges & Schs. of Tex.*, 98 F.4th at 254. Where the regulation of the practice of medicine is concerned, this is doubly true. *See* *Gonzales v. Oregon*, 546 U.S.

[17] U.S. Department of Health and Human Services, *Protecting Children*, at 3:50-4:30 (YouTube, Dec. 18, 2025), https://www.youtube.com/watch?v=aY1XfN6Tt0Q (emphasis added) (attached as Fraas Decl., Ex. 27); *see also* Fraas Decl., Ex. 13, HHS Rapid Response (@HHSResponse), X (Dec. 18, 2025, at 8:35 am), https://x.com/HHSResponse/status/2001692812534788190 (social media post reflecting the same).

[18] Press Release, U.S. Department of Health and Human Services, HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children (Dec. 18, 2025), available at https://www.hhs.gov/press-room/hhs-acts-bar-hospitals-performing-sex-rejecting-procedures-children.html (attached as Fraas Decl., Ex. 28); *see also* Fraas Decl., Exs. 1-17.

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243, 274-75 (2006) ("background principles of our federal system [] belie the notion that Congress would use [] an obscure grant of authority to regulate areas traditionally supervised by the States' police power" like the practice of medicine). Defendants' concession that the Kennedy Declaration is untethered to any statutory authority is an independent basis to award summary judgment to Plaintiff States.

The Court should grant summary judgment to Plaintiff States because it is uncontested that Secretary Kennedy's Declaration exceeded his statutory authority. No statute grants Secretary Kennedy authority to unilaterally declare that a treatment modality is not safe and effective and use that declaration as the basis for exclusion from federal health care programs.

E. The Kennedy Declaration Violates Notice and Comment Requirements

1. The Medicare Act requires notice and comment

Defendants argue that the Kennedy Declaration is exempt from Medicare notice and comment rulemaking requirements because it "does not 'establish' or 'change' the 'substantive legal standard.'" ECF 73 at 34-35. To make this argument, Defendants again rest on the assertion that the Kennedy Declaration is a "non-binding statement that merely articulates the Secretary's policy view [that] cannot establish or change a substantive legal standard." ECF 73 at 36. But they ignore the plain language of the Declaration and its unambiguous attempt to establish a substantive legal standard to exclude providers from Medicare. *See supra* § III.A.

Even assuming Defendants correctly characterize the Declaration (they do not), its issuance would still have violated notice and comment requirements. Defendants are correct that Medicare's notice and comment requirements are not coextensive with the Administrative Procedure Act's (APA's)—Medicare's are, in fact, far broader. *See Azar v. Allina Health Servs.*, 587 U.S. 566, 573-79 (2019) (recognizing the Medicare Act requires notice and comment for interpretive rules and statements of policy that would not be required under the APA). Under the Medicare Act, an agency is required to conduct notice-and-comment rulemaking when promulgating any "rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing

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. . . the payment for services" or "the eligibility of individuals, entities, or organizations to furnish . . . services." 42 U.S.C. § 1395hh(a)(2). Here, the Declaration clearly establishes eligibility criteria to "furnish . . . services." *See id.* Thus, even accepting Defendants' characterization of the Kennedy Declaration as a mere statement of policy, Medicare's rulemaking requirements still apply.

Defendants attempt to avoid Medicare's rulemaking requirements by claiming the Kennedy Declaration does not establish or change a substantive legal standard. Defendants argue that prior to the Declaration, "individuals and entities were already subject to OIG's permissive authority to exclude them from federal healthcare programs if they furnished care falling below 'professionally recognized standards,'" and that "in the absence of the Declaration, individuals and entities would still be subject to OIG's permissive authority to exclude them from [federal health care programs] if they furnish care falling below 'professionally recognized standards.'" ECF 73 at 35. This argument fails because the Declaration purports to establish a treatment modality which, as a legal matter, HHS-OIG may (indeed, must) exclude providers for furnishing. The Kennedy Declaration's statement that gender-affirming medical treatments are "neither safe nor effective" for adolescents, and that providers of this care "will be deemed not to meet professionally recognized standards of health care" (Kennedy Decl. §§ I.D, V) unambiguously declares a legal standard. *See* *Allina Health Servs. v. Price*, 863 F.3d 937, 943 (D.C. Cir. 2017) (Kavanaugh, J.) (holding HHS action changed "a substantive legal standard" applying to Medicare providers because it "affect[ed] a hospital's right to payment"). As thoroughly shown above, the Kennedy Declaration declares that it establishes a standard of care, superseding all others. *See supra* § III.A.

In arguing to the contrary, Defendants rely primarily on *Agendia, Inc. v. Becerra*, 4 F.4th 896, 900 (9th Cir. 2021), *cert denied*, 142 S. Ct. 898 (2022). But that reliance is misplaced. In *Agendia*, the Ninth Circuit concluded that Medicare administrative contractors ("MACs") could make so-called "local coverage determinations," *i.e.*, determinations about whether Medicare would pay for the services in a particular geographic area, without going through notice-and-comment rulemaking. In explaining why local coverage determinations did not establish or change

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a substantive legal standard, the court explained that a local coverage determination "governs only the issuing MAC's claims adjudications" and "is not binding at the higher levels of administrative review conducted by the qualified independent contractor, an ALJ, or the [Medicare Appeals] Council." *Id.* at 898. Here, by contrast, the Kennedy Declaration purports to apply nationwide *and* in higher levels of administrative review. *See supra* § III.A. In *Agendia*, moreover, the statute itself created a special notice-and-comment process just for national coverage determinations that was less imposing than for the broader Medicare rulemaking process. 4 F.4th 896, 901-02. Accordingly, the Ninth Circuit reasoned that Congress excluding national coverage determinations from Medicare rulemaking under § 1395hh and creating a separate, less burdensome notice-and-comment process was evidence that it did not intend local coverage determinations to be subject to the ordinary Medicare rulemaking requirements. *Id.* at 900. There is no comparative statutory scheme here, where the Kennedy Declaration seeks to subject providers of medically necessary transgender health care to adolescents to exclusion without any legal authority whatsoever.

2. The APA requires notice and comment

Defendants contend that the Kennedy Declaration is likewise not subject to the APA's rulemaking requirements because it falls within the "general statement of policy exception," which applies to "statements issued by an agency to advise the public prospectively of the manner in which the agency proposes to exercise a discretionary power." ECF 73 at 30 (quoting *Lincoln v. Vigil*, 508 U.S. 182, 197 (1993)). Defendants assert that the Kennedy Declaration falls under this exception because it "operate[s] only prospectively," "does not evaluate past conduct, make findings about any specific entity or provider, apply facts to a regulatory standard, or trigger any enforcement consequences." ECF 73 at 31-32.

But whether a federal agency's directive is subject to APA notice-and-comment requirements does not depend on whether the directive is prospective, nor if it concerns future exercise of the agency's discretionary power. *Mada-Luna v. Fitzpatrick*, 813 F.2d 1006, 1013 (9th Cir. 1987). Indeed, nearly all federal rulemakings operate prospectively. Rather,

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> "[t]he critical factor to determine whether a directive announcing a new policy constitutes a rule or a general statement of policy is the extent to which the challenged directive leaves the agency, or its implementing official, free to exercise discretion to follow, or not to follow, the announced policy in an individual case."

Id. (citation modified). Only when a directive merely provides officials with guidance "while preserving their flexibility and their opportunity to make 'individualized determination[s],' [does] it constitute[] a general statement of policy" exempt from APA notice-and-comment requirements. *Id.*

Here, the Kennedy Declaration's mandatory language is a "powerful indication" that it purports to create a substantive legal standard, and is not merely guidance that leaves the discretion of agency officials intact. *See* *Alaska v. Dep't of Transp.*, 868 F.2d 441, 446 (D.C. Cir. 1989) (quoting *Cmty. Nutrition Inst. v. Young*, 818 F.2d 943, 947 (D.C. Cir. 1987)). As discussed in Plaintiff States' motion for summary judgment, courts have repeatedly found rules that have such an effect are legislative rules subject to notice-and-comment requirements. *See* ECF 32 at 36; *Hemp Indus. Ass'n v. DEA*, 333 F.3d 1082, 1084, 1088 (9th Cir. 2003) (DEA rule banning sale of particular hemp products was legislative because "the rule would force plaintiffs either to risk sanction or to forego the theretofore legal activity"); *Am. Mining Cong. v. Mine Safety & Health Admin*, 995 F.2d 1106, 1112 (D.C. Cir. 1993) (a rule is legislative when "in the absence of the rule there would not be an adequate legislative basis for enforcement action . . ."); *Alaska*, 868 F.2d at 445-47 (concluding that purported agency policy statement was a legislative rule, in part, because of binding nature of rule—which purported to "set forth bright-line tests to shape and channel agency enforcement"—and its impact on downstream agency discretion).

Defendants' claim that the Kennedy Declaration does not "establish a binding norm" or is not "finally determinative of the issues or rights it addresses" (ECF 73 at 32) ignores the plain language of the Declaration. Nothing in the text of the Declaration supports Defendants' claim that "OIG is 'free to exercise discretion to follow, or not to follow, the announced policy in an individual case.'" *See* ECF 73 at 32. Rather, the Declaration predetermines that a provider will be

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deemed to fall below the standards of care if they offer transgender health care to minors. Kennedy Decl. § V. And while the OIG ordinarily may consider various factors in determining whether a provider has failed to meet the professionally recognized standards of care, the Kennedy Declaration, by its terms, "supersedes" those factors. Kennedy Decl. § I.D.

Defendants also cannot accurately characterize the Kennedy Declaration as just a general statement of policy by arguing that "[b]efore the Declaration was issued, Congress had already empowered OIG to exclude providers for furnishing services that fail to meet professionally recognized standards of care." ECF 73 at 32. This argument ignores the nature of the Kennedy Declaration as compared to other sources of "professionally recognized standards of care." Without the Kennedy Declaration, OIG would have to consider exclusion for failure to meet professionally recognized standards of care by examining "Statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is at issue, recognize as applying to those peers practicing or providing care within a State." 42 C.F.R. § 1001.2. That is wholly different in nature from the Secretary of HHS declaring that gender-affirming medical care is categorically grounds for exclusion. And that is borne out by the fact that OIG has never excluded a provider for provision of gender-affirming medical care, or for provision of a specific type of care in general. *See* ECF 59-1. Prior to the Kennedy Declaration, neither CMS nor OIG had made a determination that these services warrant exclusion or that they fail to meet the requirements for reimbursement. Rather, CMS's historical reimbursement of this care is indicative that CMS previously considered that this care met the professionally recognized standards of care. The Kennedy Declaration is a stark departure from that practice.

F. The Kennedy Declaration Is Contrary to the Medicaid Act

Defendants also do not meaningfully respond to Plaintiff States' claims that the Kennedy Declaration violates the Medicaid Act. Because Defendants' failure to contest this issue renders it undisputed, summary judgment for the States on this point is appropriate.

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1. The Kennedy Declaration is contrary to the federally approved Medicaid and Children's Health Insurance Program (CHIP) plans of the Plaintiff States

Rather than responding to Plaintiff States' arguments that the Kennedy Declaration violates the terms of federally approved state Medicaid and CHIP plans that provide for transgender health care, *see* ECF 32 at 40-42, Defendants simply dance around the issue, arguing that "Plaintiffs' claim rests on a misunderstanding of the purpose and effect of the Kennedy Declaration." ECF 73 at 40-41. Not so. *See supra* § III.A. Instead, recognizing the very real purpose and impact of the Kennedy Declaration, Plaintiff States find themselves with no way to reconcile their Medicaid and CHIP plans, which provide coverage for gender-affirming care, with the Kennedy Declaration's newfound determination that providers of such care are now subject to exclusion from federal health care programs for providing such care. By unilaterally declaring that these covered services in Plaintiff States no longer meet professionally recognized standards, the Kennedy Declaration is contrary to the federally approved Medicaid and CHIP plans of the Plaintiff States.

2. The Kennedy Declaration is contrary to the Medicaid Act's free choice of provider requirement

Defendants' sole argument that the Kennedy Declaration is not contrary to the Medicaid Act's free choice of provider provision relies on a misreading of *Medina v. Planned Parenthood South Atlantic*, 606 U.S. 357 (2025). But *Medina* does not control here and instead supports Plaintiff States' position. *Medina* involved whether Medicaid beneficiaries could bring a class action against state officials under 42 U.S.C. § 1983 for their purported failure to comply with the free choice of provider provision, 42 U.S.C. § 1396a(a)(23)(A), by not allowing Planned Parenthood to participate in the State's Medicaid program. *Id.* Here, Plaintiff States are not private individuals asking the court to recognize an implied private right of action against state officials to enforce federal law. Instead, plaintiffs are States suing the federal government under the Administrative Procedure Act (APA)—a statute that expressly provides a cause of action—to enforce their rights under federal law. *See* ECF 28 at 28-35 (listing causes of action); *Biden v. Missouri*, 595 U.S. 87, 92 (2022) (States brought APA lawsuit to challenge HHS interim final

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rule). Defendants' protest that the "free-choice-of-provider provision does not impose any duties on the federal government" (ECF 73 at 41) ignores their general duty to conform their actions to congressional mandates, and the cause of action granted under the APA for failure to do so.

Moreover, in determining that Congress did not create an individually enforceable right against state officials in that provision, the Supreme Court recognized the important role that Congress gave the states in determining which providers are qualified to furnish services under Medicaid, and observed that if 42 U.S.C. § 1396a(a)(23)(A) conferred an individually enforceable right *against* the States, it would eviscerate the control over providers that the statute plainly vested *with* the states. *Medina*, 606 U.S. at 379; *see also id.* at 364 (recognizing that "[t]he provision does not define the term 'qualified,' perhaps because States have traditionally exercised primary responsibility over 'matters of health and safety,' including the regulation of the practice of medicine"). Here, as Plaintiff States have demonstrated, the Kennedy Declaration usurps the States' authority to determine which providers are qualified to provide Medicaid services. And their appeal to the general exclusion authority in 42 U.S.C. § 1320a-7 cannot save them because, as Defendants effectively concede, the Kennedy Declaration exceeds the Secretary's authority under that statute. *See supra* III.D.

As noted above, the Kennedy Declaration's mass disqualification of pediatric providers in Plaintiff States will also have a devasting impact on States' ability to maintain adequate provider networks, particularly in medically complex areas. For instance, disqualification of Children's Hospital Colorado would prevent Colorado (and states in the surrounding region) from determining that the more than 3,000 pediatric specialists at Children's Hospital Colorado are qualified to treat Medicaid or Medicare patients—impeding Colorado's ability to effectively operate a Medicaid system. *See* Flores-Brennan Suppl. Decl. ¶¶ 4-9; *see also infra* § III.H.3. When viewed in this context, there is simply no way to read a Declaration that is being used a basis to disqualify scores of major hospitals and their thousands of providers of pediatric care "in harmony" with a state's ability to run a functioning Medicaid system. ECF 73 at 33. Nor is there a way to

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read a Declaration that deems transgender health care as not meeting professionally recognized standards "in harmony" with state laws that declare just the opposite. *Id.*; *see also* ECF 32 at 12-13. By attempting to hijack the Plaintiff States' ability to determine whether hospitals and providers are qualified to provide Medicaid services within their borders, the Kennedy Declaration is contrary to the free choice of provider requirement.

G. Defendants' Arguments Still Lack Merit Under Their Post Hoc Litigation Position

Plaintiff States would still be entitled to summary judgment even if this Court were to reject the evidence of its eyes and ears—the plain text of the Kennedy Declaration and HHS's referrals of hospitals and health centers for violating the Declaration—and accept only the legal arguments of Defendants. As Defendants would have it, the Kennedy Declaration is just one opinion of many, which HHS-OIG may consider in exercising its discretionary authority in making case-by-case decisions about exclusion actions. *See* ECF 73 at 33 ("The Declaration does not trigger exclusion because it is not dispositive of the standard of care applicable in OIG exclusion proceedings and is instead only one piece of information OIG may consider."); ECF 75 ¶ 10 ("[T]he Declaration is only one factor that OIG may consider in any exclusion proceeding."). But, even if the Kennedy Declaration isn't "dispositive" in an exclusion proceeding (*but see supra* § III.A), Defendants never point to where Congress has given the Secretary the power to make a per se finding about treatment modalities to influence the professionally recognized standards under which exclusions are judged. Neither 42 U.S.C. § 1395 nor 42 U.S.C. §§ 1320a-7 and 1320c-5 give the Secretary that power. And a non-dispositive Declaration still would need to go through rulemaking because it would change substantive legal standards for providers' eligibility to participate in the Medicaid and Medicare programs if they provide transgender health care. *See supra* § III.E. Even under the most charitable view of Defendants' arguments, Plaintiff States are entitled to summary judgment.

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H. Plaintiff States Are Entitled to the Full Suite of Remedies

1. The Court should hold the Kennedy Declaration unlawful and set it aside

This Court should vacate the Kennedy Declaration because the APA directs that a "reviewing court shall . . . hold unlawful and set aside agency action" found to be unlawful. 5 U.S.C. § 706(2). "The Federal Government and the federal courts have long understood § 706(2) to authorize vacatur" of an unlawful agency action. *Corner Post, Inc. v. Bd. of Governors of Fed. Rsrv. Sys.*, 603 U.S. 799, 826-27 (2024) (Kavanaugh, J., concurring); *see also Mont. Wildlife Fed'n v. Haaland*, 127 F.4th 1, 50 (9th Cir. 2025) (vacatur is the "default remedy under the APA"). "When a federal court sets aside an agency action, the federal court vacates that order in much the same way that an appellate court vacates the judgment of a trial court." *Corner Post, Inc.*, 603 U.S. at 830 (Kavanaugh, J., concurring). The vacated "agency action is treated as though it had never happened." *Griffin v. HM Fla.-ORL, LLC*, 144 S. Ct. 1, 2 n.1 (2023) (Kavanaugh, J., respecting denial of stay). This means the parts of the agency action held unlawful are vacated as a whole—"not that their application to the individual petitioners is proscribed." *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998); see also *Corner Post, Inc.*, 603 U.S. at 830-31 (Kavanaugh, J., concurring) (collecting cases affirming decisions that "vacated the challenged agency rules rather than merely providing injunctive relief . . . [for] the specific plaintiffs").[19] This traditional APA remedy is appropriate here.

While courts "retain[] equitable discretion in limited circumstances to remand a decision without vacatur while the agency corrects its errors," *Mont. Wildlife Fed'n*, 127 F.4th at 50, those "limited circumstances" are not met here. In deciding whether to deviate from the usual remedy of vacatur, courts consider two factors: (1) "how serious the agency's errors are," and (2) "the disruptive consequences of an interim change that may itself be changed." *Cal. Cmtys. Against*

[19] *See also Trump v. CASA, Inc.*, 606 U.S. 831, 847 n.10 (2025) (stating that "[n]othing" in that decision "resolves the distinct question whether the Administrative Procedure Act authorizes federal courts to vacate federal agency action"); *Nat. Grocers v. Rollins*, 157 F.4th 1143, 1170 (9th Cir. Oct. 31, 2025) (holding Ninth Circuit precedent regarding vacatur of unlawful agency action is reconcilable with intervening Supreme Court precedent).

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Toxics v. EPA, 688 F.3d 989, 992 (9th Cir. 2012) (quoting *Allied-Signal, Inc. v. U.S. Nuclear Regul. Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993)). Here, both factors support vacatur.

First, as described above, the Kennedy Declaration wholly lacks any statutory authority, and Defendants have identified none. The Secretary of HHS simply does not have the power to override the standards of care applicable in the Plaintiff States by declaration or otherwise. The power to exclude providers in 42 U.S.C. §§ 13201-7(b)(6)(B) and 1320c-5(a)(2) does not extend to a general prohibition on the practice of medically necessary transgender health care for adolescents. As described in Plaintiff States' motion, HHS has no authority to dictate the content of "professionally recognized standards of health care." *See* ECF 32 at 20. Moreover, the statute permits the Secretary only to exclude providers for providing services that fail to meet a standard of *quality*, not for providing a certain category of medical services. *Id.* at 21. Because the Secretary has no authority to issue the Kennedy Declaration, or anything like it, the Secretary's failure to act within his statutory authority is a "fundamental flaw[]" that cannot be corrected on remand. *Nat. Grocers*, 157 F.4th at 1170 (quoting *Pollinator Stewardship Council v. EPA*, 806 F.3d 520, 532 (9th Cir. 2015)).

And there can be no dispute that the Declaration itself is massively disruptive, causing providers and provider systems across the country to change their practices, degrading the Plaintiff States' Medicaid provider networks, and infringing on Plaintiff States' sovereign right to regulate the practice of medicine. *See supra* § II; *see also* ECF 32 at 17-19. Vacating the Declaration, and making it clear that the Secretary cannot arrogate for himself the power to regulate medicine in the United States, would ease this disruption, not cause more of it. There is no basis to except the Declaration from the "default remedy" under the APA. *Mont. Wildlife Fed'n*, 127 F.4th at 51-52.

2. The Court should issue a declaratory judgment

Plaintiff States' requested declaratory relief is appropriate because this case presents an "actual controversy," thus vesting the Court with discretion to declare the parties' rights. 28 U.S.C. § 2201; *see, e.g.*, *Washington v. Dep't of Transp.*, No. 2:25-CV-00848-TL, 2026 WL 183584, at

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*26 (W.D. Wash. Jan. 23, 2026) ("In recent cases involving APA violations by executive agencies of the current administration, courts have granted declaratory relief without finding the need for extensive explanation."). Declaratory relief is appropriate where an agency expresses an intent to effectuate the same unlawful policy by some other means. *See* *Becerra v. Dep't of Interior*, 276 F. Supp. 3d 953, 960 (N.D. Cal. 2017) (holding declaratory relief was available where the likelihood that the agency was going to repeat its unlawful action through another mechanism was "not remote"); *Mansor v. Citizenship & Immigr. Servs.*, 685 F. Supp. 3d 1000, 1015 (W.D. Wash. 2023) (accepting argument that vacatur of agency action "would only address Defendants' current policy, whereas a declaratory judgment could affirmatively establish their rights.").

Here, in their revisionist account of the Declaration, Defendants insist that they maintain the authority to exclude providers from federal health care programs for the provision of medically necessary transgender health care to adolescents even if the Declaration is set aside. ECF 73 at 21 ("[E]ven in the absence of the Declaration, providers would still be subject to OIG's permissive authority to exclude them from [federal health care programs] if they furnished care falling below professionally recognized standards."). Because of this, and in light of Defendants' expansive overreach that is wholly untethered from the governing statutes, this Court should enter declaratory judgment to clarify that Defendants lack the authority to establish superseding standards of care to exclude providers from federal health care programs. This declaratory relief would alleviate the significant uncertainty caused by their conduct. *See* *Bilbrey by Bilbrey v. Brown*, 738 F.2d 1462, 1470-71 (9th Cir. 1984) (declaratory judgment appropriate to afford relief from uncertainty).

3. The Court should enjoin defendants from enforcing, implementing, or relying on the Kennedy Declaration

Defendants should be enjoined from enforcing, implementing, giving effect to, or relying on the Kennedy Declaration—or a materially similar policy which supersedes or purports to supersede the professionally recognized standards of care that exist in the Plaintiff States—against

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any provider in the Plaintiff States. *See* 5 U.S.C. § 703 (authorizing actions for "prohibitory or mandatory injunction" in addition to vacatur).

In APA cases, once a court concludes that a "rule was indeed illegal," there is "no separate need to show irreparable injury, as that is merely one possible 'basis for showing the inadequacy of the legal remedy.'" *Nat'l Min. Ass'n*, 145 F.3d at 1409 (quoting 11A Wright & Miller's Federal Practice & Procedure § 2944 (3d. ed. 1995)); *see also Illinois v. FEMA*, 801 F. Supp. 3d 75, 97 (D.R.I. 2025) (same). Indeed, given the "broad discretion in awarding injunctive relief" available to district courts, "express findings as to the elements necessary for a permanent injunction" are unnecessary to enjoin implementation of an illegal rule. *Nat'l Min. Ass'n*, 145 F.3d at 1408. As argued above, the Secretary of HHS does not have any legal authority to supersede the standards of care applicable in the Plaintiff States, and imposing such a standard of care via administrative fiat impairs the Plaintiff States' Medicaid provider networks as well as the Plaintiff States' sovereign interests in regulating the practice of medicine, and an injunction against it is entirely appropriate.

Applying the familiar test for injunctive relief yields the same result. *eBay Inc. v. MercExchange, LLC*, 547 U.S. 388, 391 (2006) (setting out the test for permanent injunction). The Plaintiff States are likely to suffer (and, in fact, many have already begun to suffer) irreparable injury to their proprietary interests in operating a viable Medicaid provider network. For instance, as the number of providers providing gender-affirming care continues to dwindle due to mounting fear of exclusion from federal health care programs, it is becoming increasingly difficult for Plaintiff States to provide such care to Medicaid patients in their states, notwithstanding their obligations to provide such medically-necessary care under state law and to maintain an adequate network of providers to meet the needs of enrollees under federal law. *See, e.g.*, ECF 33 ¶¶ 19-22 (discussing the Kennedy Declaration's irreparable damage to [Oregon Health Plan]'s network of medical providers; explaining that "even before [exclusion] occurs, some providers will likely choose to cease participating in those programs based on this threat," which will "make it very

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difficult if not impossible for OHP to find health care providers willing to provider gender affirming care to OHP clients"); ECF 34 ¶¶ 17-18, 21-22; ECF 39 ¶¶ 13-16; ECF 40 ¶¶ 18-19; ECF 41 ¶¶ 19-22; ECF 42 ¶¶ 18-22; ECF 44 ¶¶ 8-10; ECF 45 ¶¶ 17-19; ECF 46 ¶¶ 25-28; ECF 47 ¶¶ 18-22; ECF 48 ¶¶ 17-21; ECF 49 ¶¶ 14-20; ECF 50 ¶¶ 12-13; ECF 51 ¶¶ 19-22; ECF 53 ¶¶ 16-19; ECF 54 ¶¶ 16-19; ECF 55 ¶¶ 20-23; ECF 56 ¶¶ 17-20; ECF 57 ¶¶ 16-19; ECF 58 ¶¶ 16-19; *see also* Fraas Decl., Ex. 30 at 19 (recognizing that there were "limited options for alternate providers offering gender affirming care" in Colorado if Children's Hospital Colorado stopped providing such care).

These proprietary harms would be radically compounded if major providers of pediatric care in Plaintiff States are excluded from Medicaid and Medicare due to their provision of gender affirming care as Plaintiff States' would be unable to run a functioning Medicaid system. To date, at least 13 major hospitals have been referred to HHS OIG for potential exclusion from Medicaid and Medicare. *Supra* § II. If exclusion occurred, these hospitals could not treat *any* patients enrolled in Medicaid or Medicare—not just minor patients receiving transgender health care. And in these specialized hospitals often provide pediatric services that no other hospital in their state can provide. For instance, in Washington, Seattle Children's Hospital (referred for exclusion on December 26, 2025) is the only hospital in the state approved to provide pediatric organ transplants. ECF 62 ¶ 7. In Colorado, if Children's Hospital Colorado is excluded (referred on December 30, 2025), "[t]here is no other facility for pediatric Medicaid patients to receive certain care like heart and bone marrow transplants or neurosurgery." Fraas Decl., Ex. 30 at 12. And in Pennsylvania, if Children's Hospital of Philadelphia is excluded (referred on January 15, 2026), "some of Pennsylvania's most complex patients who are children and youth suffering a myriad of complex conditions, including pediatric genetic disorders and cancers, will have reduced access, and in some instances no access, to the treatment they need." Kozak Suppl. Decl. ¶ 21. There can be no doubt that exclusion of major pediatric hospitals would result in "potentially devastating public impact on public care" to patients in their regions and undermine impacted states' ability to

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run a functioning Medicaid system. Fraas Decl., Ex. 30 at 21; *see also, e.g.*, ECF 62 ¶ 12 (explaining there would be no way to timely provide specialized care to many medically-complicated Medicaid patients in Washington if Seattle Children's Hospital was excluded); Flores-Brennan Suppl. Decl. ¶ 9 ("If CHCO is lost as a Medicaid provider, some of Colorado's most complex patients who are children and youth suffering a myriad of complex conditions will have no other access to the treatment they need."); Connolly Suppl. Decl. ¶¶ 6-8 (explaining that because Children's Minnesota is a regional provider of specialized pediatric care, "there is no other facility or group of facilities that could take its place" and it would "undermine the state's pediatric healthcare system"); Phelan Suppl. Decl. ¶ 5 (explaining that if Lurie's Children's was unable to serve Medicaid patients, "some of Illinois's children and youth suffering a myriad of complex conditions may have no other access to the treatment they need"); Kozak Suppl. Decl. ¶¶ 17, 20-21 (exclusion of Children's Hospital of Philadelphia would "undermine the state's pediatric healthcare system in southeastern Pennsylvania . . . , where almost half a million children enrolled in Medicaid and CHIP reside" and leave some children with "complex conditions" with no or reduced access to the treatment they need); Marqusee Suppl. Decl. ¶ 18 ("If Boston Children's Hospital were no longer able to care for Medicaid clients, MassHealth would lose a trusted partner and provider for some of the highest acuity and most vulnerable pediatric patients in the Commonwealth.").

In addition, the impairment of the Plaintiff States' government interest in regulating the practice of medicine is straightforwardly irreparable injury. *Cf. Trump*, 606 U.S. at 859 (holding that the improper intrusion "on a coordinate branch of Government" constitutes irreparable harm (quoting *INS v. Legalization Assistance Project of L.A. Cnty. Fed'n of Labor*, 510 U.S. 1301, 1306 (1993) (O'Connor J., in chambers) (internal quotation marks omitted))). Here, as described above *(supra* § III.B.1*)*, the Kennedy Declaration infringes on the States' right to regulate the practice of medicine—including setting and enforcing the standards of care for physicians and hospitals within their states, a prerogative they have enjoyed since "time immemorial." *Dent*, 129 U.S. at

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122. And the balance of equities and public interest clearly favor an injunction here, where the Secretary's Declaration has no grounding in lawful authority whatsoever. *See Washington v. Trump*, 145 F.4th 1013, 1037 (9th Cir. 2025) (holding injunctive relief served the public interest where it enjoined government action that was "beyond its authority").

Accordingly, the Court should enjoin Defendants and their officers, agents, servants, employees, and attorneys, including those at HHS-OIG, from enforcing, implementing, giving effect to, or relying on the Kennedy Declaration—or a materially similar policy which supersedes or purports to supersede the professionally recognized standards of care that exist in the Plaintiff States—against any provider in the Plaintiff States.

IV. CONCLUSION

The Court should grant summary judgment to the Plaintiff States, deny Defendants' motion to dismiss, hold the Kennedy Declaration unlawful and set it aside, and enter a permanent injunction.

DATED this 24th day of February 2026.

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

STATE OF OREGON, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as the Secretary of the Department of Health and Human Services, et al.,

Defendants.

No. 6:25-cv-02409-MTK

SUPPLEMENTAL DECLARATION OF ADELA FLORES-BRENNAN

SUPPLEMENTAL DECLARATION OF ADELA FLORES-BRENNAN

I, Adela Flores-Brennan, declare as follows:

1. I am over 18 years of age, competent to testify, and make this declaration based on my personal knowledge.

2. I am the Medicaid Director for the Colorado Department of Health Care Policy and Financing (HCPF). This declaration incorporates and supplements my declaration dated December 29, 2025, submitted as ECF # 40.

Children's Hospital Colorado

3. I am aware that on December 30, 2025, the official Department of Health and Human Services (HHS) X account posted to the social media platform X an announcement that HHS General Counsel Mike Stuart referred Children's Hospital Colorado (CHCO) to the HHS Office of Inspector General "for failure to meet recognized standards of health care per the @HHSGov @SecKennedy declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective …."

4. CHCO is the premier children's hospital in Colorado and the Rocky Mountain Region for pediatric services. It is recognized as one of the top ten children's hospitals in the country for cardiology and heart surgery, diabetes and endocrinology, pulmonology and lung surgery, cancer treatment, and in treating gastroenterology and gastronomic issues. CHCO provides comprehensive pediatric care in Colorado at its hospital on Anschutz Medical Campus and at several locations throughout the region. It is 100% dedicated to caring for kids at all ages and stages of growth, with more than 3,000 pediatric specialists and more than 8,000 full-time employees helping to carry out CHCO's mission. CHCO is the only dedicated Level 1 trauma center in the region, handling the most challenging emergencies, and CHCO offers emergency

and urgent care at multiple locations, as well as numerous specialty care centers and clinics. It is also at the forefront of research in childhood disease with several nationally and internationally recognized medical and surgical programs. Together, with its partners, CHCO is responsible for virtually all of the pediatric research published in the Rocky Mountain region for at least a decade. Further, CHCO provides treatment to many Medicaid members who are following specific existing treatment pathways, such as treatment for cancer or neurological disorders. The timing of much of the care that CHCO provides is critical to the growth and development of children and youth with special health care needs such as autism spectrum disorder, cerebral palsy, type I diabetes, and heart disease.

5. As one specific example, CHCO is the only hospital in Colorado approved to provide pediatric organ transplants. If a child on Medicaid needed an organ transplant, and CHCO were excluded from that program, there would be no provider in Colorado capable of providing them with this medically necessary care.

6. In state fiscal year 2025, CHCO served 6,367 Medicaid members in an inpatient setting and received over $162 million in reimbursement for those members demonstrating the critical role they play in serving Colorado's pediatric population. CHCO served 113,346 Medicaid members in outpatient settings throughout Colorado, receiving over $175 million in reimbursement. In state fiscal year 2025, CHCO saw 114,373 unique Medicaid members total.

7. Colorado's Medicaid program (HCPF) relies on CHCO to provide this important care and would likely be unable to provide it in a timely way if CHCO were no longer able to care for Medicaid members. Federal law, including Early and Periodic Screening, Diagnostic, and Treatment, requires that HCPF provide for timely treatment of members age 21 and younger. If CHCO were unable to provide care to Medicaid members, HCPF's ability to comply with

these laws would be jeopardized. HCPF would likely need to send members out of state for necessary care, resulting in high transportation costs and out-of-state hospital rates. Moreover, necessary and critical care would likely be delayed since CHCO is a regional medical facility. If access to it were lost, there is no other facility or group of facilities that could take its place.

8. Moreover, Colorado's Medicaid provider network relies on CHCO for other purposes. CHCO works with the University of Colorado School of Medicine to offer pediatric medical training programs including advanced practice student, medical student, residency, and fellowship programs, and internships. The training programs send medical providers to staff hospitals and clinics throughout the state of Colorado providing specialized pediatric care that would otherwise be unavailable. If CHCO were unable to continue operating and providing care to Medicaid members, it would undermine the state's pediatric healthcare system.

9. If CHCO is lost as a Medicaid provider, some of Colorado's most complex patients who are children and youth suffering a myriad of complex conditions will have no other access to the treatment they need. It would not be possible for Colorado to cover all of the care that CHCO provides to Medicaid members using state only funds.

Denver Health

10. I am aware that in response to the "Declaration of the Secretary of the Department of Health and Human Services Re: Safety, Effectiveness, and Professional Standards of Care for Sex-Rejecting Procedures on Children and Adolescents," as well as to the various posts on the official HHS X account announcing that HHS General Counsel Mike Stuart has referred a number of hospitals and institutions to the Office of Inspector General "for failure to meet professional recognized standards of health care," Denver Health made the decision in early January 2026 to suspend gender affirming care to youth.

11. Denver Health is Colorado's primary safety-net health system having been in operation since 1860. As a comprehensive, integrated health system, Denver Health provides hospital and emergency care to its patients and promotes continuity of care, assuring that health care is delivered in the most efficient, cost-effective setting. Denver Health cares for nearly 25% of Denver's population annually, delivering one in three babies in the Denver-area, and providing care to particularly vulnerable populations like people experiencing poverty, uninsured, pregnant teens, substance use issues, victims of violence and the unhoused population. Denver Health is nationally recognized for their high-quality Emergency and Clinical Care, Diabetes, Maternity, and Primary Care, Paramedic Services, and Nursing Staff.

12. In state fiscal year 2025, Denver Health served 10,748 Medicaid members in an inpatient setting and received over $104 million in reimbursement for those services. Denver Health served 112,046 Medicaid members in outpatient settings throughout the Denver Metro Area and Winter Park, receiving over $182 million in reimbursement demonstrating the critical role they play in serving Colorado's population. In state fiscal year 2025, Denver Health saw 112,183 unique Medicaid members total.

13. HCPF relies on Denver Health to provide this care and would likely be unable to provide it in a timely way if Denver Health were no longer able to care for Medicaid members. Federal law, including Early and Periodic Screening, Diagnostic, and Treatment, requires that HCPF provide for timely treatment of adult members, as well as members age 21 and younger. If Denver Health were unable to provide care to Medicaid members, HCPF's ability to comply with these laws would be jeopardized. HCPF would likely need to send members out of state for necessary care, resulting in high transportation costs. Moreover, necessary and critical care would likely be delayed since Denver Health is a regional medical facility and the only Level I

Trauma Center in the City and County of Denver. If access to it were lost, there is no other facility or group of facilities that could take its place.

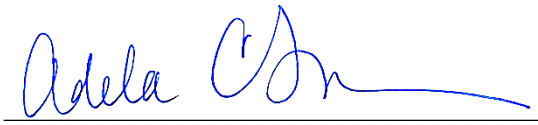
14. Moreover, Colorado's Medicaid provider network relies on Denver Health for other purposes. Denver Health is part of Denver Health and Hospital Authority (DHHA). DHHA is an integrated health care system which includes the hospital and several other pieces that are dependent upon the hospital. DHHA runs: Denver Health Medical Plan, a nonprofit health insurance plan; Rocky Mountain Poison and Drug Center, which handles more than 40,000 calls related to poisoning emergencies each year; Denver Health Paramedic Division, which provides 911 Advanced Life Support, Emergency Medical Services and ambulance transportation to the City and County of Denver, Denver International Airport, as well as several surrounding cities and counties; EMS Education Department which trains paramedics, EMTs, and first responders; Public Health Institute at Denver Health, which works with the Denver Department of Public Health and Environment to oversee medical investigations and disease control; Correctional Care Medical Facility, providing inpatient and outpatient care for justice involved populations through a guarded and locked unit within the hospital; Winter Park Medical Center, which provides emergency, urgent care, sports medicine and primary care at the base of Winter Park Resort; a hospital-based Federally Qualified Health Center, which is the 8th largest in the country by patient volume; and 19 School Based Health Centers, which provide healthcare access to the nearly 90,000 children in the Denver Public School system. If Denver Health were unable to continue operating and providing care to Medicaid members, it would undermine the state's healthcare system and the Denver Metro area's emergency response system.

15. If Denver Health is lost as a Medicaid provider, some of Colorado's most vulnerable and disenfranchised patients suffering from multifaceted healthcare challenges will

have no other access to the treatment they need. It would not be possible for Colorado to cover all of the care that Denver Health provides to Medicaid members using state only funds.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED this 23rd day of February, 2026.



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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
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v.

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Defendants.

No. 6:25-cv-02409-MTK

SUPPLEMENTAL DECLARATION OF LAURA PHELAN

SUPPLEMENTAL DECLARATION OF LAURA PHELAN

I, Laura Phelan, declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based either on personal knowledge, in consultation with agency staff, or from information that has been provided to and reviewed by me.

2. I am the Administrator of the Division of Medical Programs at the Illinois Department of Healthcare and Family Services ("HFS"). I am the designated State Medicaid Director for the Illinois State Medicaid program and the Illinois Children's Health Insurance Program ("CHIP").

3. HFS is the single designated state agency responsible for administering Illinois's Medical Assistance Program, which includes Illinois's Medicaid program and CHIP. HFS's mission is to improve access to quality healthcare for the individuals enrolled in its programs, while simultaneously containing costs and maintaining program integrity.

4. HFS is aware that the federal government has threatened to exclude certain healthcare providers and entities from participating in federal healthcare programs, including Medicaid. The Illinois Medical Assistance Program relies on Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's") to provide care to children covered by Medicaid and would be impacted if the federal government excluded Lurie Children's from participation in Medicaid.

5. Specifically, Lurie Children's is a leading pediatric Medicaid provider in the state, and in state fiscal year 2025, it served 89,178 Medical Assistance Program clients. The Illinois Medical Assistance Program would likely be unable to provide this same level of care in a timely manner if Lurie Children's were no longer able to care for Medicaid clients, and some of Illinois's

children and youth suffering a myriad of complex conditions may have no other access to the treatment they need.

6. Further, it would not be possible for Illinois to cover all the care that Lurie Children's provides to Medicaid clients using state only funds. In state fiscal year 2025 alone, Illinois paid over $386 million for the provision of care to Medical Assistance Program clients at Lurie Children's. Illinois requested federal reimbursement for over half of that amount.

7. These harms are compounded by the fact that, under 42 C.F.R. Part 438, the federal government requires states participating in Medicaid to maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Lurie Children's provides vital services in several specialty areas, some of which may not be available from other providers in the state. To the extent the federal government is threatening to exclude Lurie Children's from the Illinois Medical Assistance Program's provider network, it could also threaten to undermine the state's efforts to meet these federal requirements.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED this 20th day of February, 2026.

Laura Phelan

Laura Phelan

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Defendants.

No. 6:25-cv-02409-MTK

SUPPLEMENTAL DECLARATION OF JOANNE MARQUSEE

DECLARATION OF JOANNE MARQUSEE

I, Joanne Marqusee, declare as follows:

1. I am over 18 years of age, competent to testify, and make this declaration based on my personal knowledge.

Personal and Agency Background

2. I am the Assistant Secretary of the Massachusetts Executive Office of Health and Human Services (EOHHS). I have held this position since March 2023. I make this declaration as a representative of EOHHS, in part based on the business records of the Commonwealth of Massachusetts, in part based on publicly available information that I have reviewed, and in part based on my personal experience and knowledge. In my official capacity and based on my personal experience and knowledge, I am familiar with the facts and circumstances set forth herein and, if required to testify about them, would and could competently do so.

3. Prior to my current position at EOHHS, I spent 30 years in several community hospitals and academic medical centers in progressively more senior roles, including 17 years at Beth Israel Deaconess Medical Center, 5 years as a Chief Operating Officer of the Hallmark Health System (now called Melrose-Wakefield), and 7 years as Chief Executive Officer and President of Cooley Dickinson, a community hospital that is part of the Mass General Brigham health system. I have a master's degree in Public Policy from the Harvard Kennedy School and a Bachelor's degree in Linguistics from Cornell University.

4. EOHHS is the single state agency responsible for administering the Massachusetts Medicaid program. The agency's mission includes improving the overall health of this state's residents by promoting affordable access to medically necessary care.

5. EOHHS administers several publicly funded programs that enable qualifying Massachusetts residents to access free or low-cost health care coverage. These programs include

the Medicaid plan, Children's Health Insurance Program (CHIP), and the 1115 Demonstration Project—collectively known in Massachusetts as "MassHealth." Jointly funded by state and federal dollars, MassHealth provides coverage for a wide range of health care services to children, the elderly, families, and individuals with disabilities.

6. To be eligible for MassHealth, individuals must meet certain criteria, including residency, income and immigration status requirements. Massachusetts expanded Medicaid coverage under the Affordable Care Act in 2014, expanding the eligible population.

7. To be eligible to provide and bill for MassHealth services, an in-state provider must be an enrolled provider with MassHealth, meeting all required conditions of participation. Medicare certification is a required condition of participation for MassHealth acute hospitals.

8. In state fiscal year 2025, roughly 2 million Massachusetts residents or approximately 27-28% percent of the Commonwealth's population was covered by MassHealth, with an average caseload of over 730,000 children.

9. MassHealth provides low-income individuals with access to comprehensive healthcare coverage at no or low cost. MassHealth's coverage includes medical, dental, mental health, substance use disorder treatment and home and community-based services and supports.

Boston Children's Hospital

10. I am aware that on January 15, 2026, the official Department of Health and Human Services (HHS) General Counsel Mike Stuart X account posted to the social media platform X an announcement that Stuart "referred" Boston Children's Hospital, among others, to the HHS Office of Inspector General for "operat[ing] outside recognized standards of healthcare and entirely outside @SecKennedy's declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective."

11. Boston Children's Hospital is a premier children's hospital renowned worldwide for setting the standard in pediatric care. It is consistently ranked among the top children's and specialized hospitals in the world. It also has been named number 1 in specific service areas, including neonatology, nephrology, and urology.[1]

12. Boston Children's Hospital provides a multitude of specialized and high-acuity programs for children. These include but are not limited to advanced congenital cardiac surgery and interventional cardiology, pediatric organ transplantation, comprehensive inpatient pediatric oncology and cellular therapies, neonatal intensive care, high-volume pediatric critical care and extracorporeal membrane oxygenation (ECMO), a dedicated pediatric dialysis unit, fetal surgery, pediatric sleep program for sleep disorders, multidisciplinary programs for rare and complex disorders (for example, genetic, metabolic, craniofacial, and complex airway disorders), specialized developmental and behavioral pediatrics, and specialized pediatric trauma and emergency care that are difficult to replicate elsewhere in Massachusetts or the broader New England region.

13. As an example of Boston Children's Hospital's unparalleled service provision capabilities, Boston Children's Hospital's Benderson Family Heart Center has the largest pediatric cardiac and pediatric catheterization programs in the region, seeing patients with rare and genetic diseases and conditions.[2]

14. Boston Children's Hospital is the regional referral center for New England, receiving patients referred for congenital heart disease, childhood cancers, cerebral palsy, cerebrovascular surgery, congenital diaphragmatic hernia, epilepsy, spina bifida, stroke, and other rare diseases from facilities across New England.

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[1] https://www.childrenshospital.org/about-us/awards-accolades
[2] https://www.childrenshospital.org/services/heart-center

15. Boston Children's Hospital is a global leader in advancing pediatric research. According to Boston Children's Hospital, over 3,000 researchers work in Boston Children's Hospital's research arm. It reports that its research faculty publish over 80 research papers per week, including in the top 25 scientific journals. They have made advances in rare disease discovery, neurosciences, blood diseases, cancer, genetics and genomics, stem cell biology, bioinformatics, cardiac device development, and cell and gene therapies.

16. Boston Children's Hospital operates 477 inpatient beds at its Boston campus, demonstrating the critical role they play in serving children in the Commonwealth. Its capacity, especially, for extremely complex, rare, and acute pediatric cases, is unparalleled in the region and, as reported by Boston Children's Hospital, accounts for 69% of the Massachusetts average pediatric daily census.

17. In fiscal year 2024, Boston Children's Hospital had a public payer mix of 42.7%, with 32.5% of its patients enrolled in MassHealth or a MassHealth- contracted managed care entity. As a freestanding pediatric acute hospital, Boston Children's Hospital receives an increase in its base payment under the MassHealth adjudicated payment amount per discharge (APAD) methodology, and also is entitled to outlier payments for any infant and pediatric discharges with exceptionally high costs or exceptionally long lengths of stay. In total, the hospital served nearly 83,000 MassHealth members in 2024 and over 86,500 in 2025. It received $345.8 million and $374.6 million for services rendered to those members in 2024 and 2025, respectively.

18. As these numbers demonstrate, the MassHealth program relies on Boston Children's Hospital to provide care to its members. If Boston Children's Hospital were no longer able to care for Medicaid clients, MassHealth would lose a trusted partner and provider for some of the highest acuity and most vulnerable pediatric patients in the Commonwealth.

19. Federal law, including Early and Periodic Screening, Diagnostic, and Treatment, requires the Commonwealth's Medicaid program to provide for timely treatment of clients age 21 and younger. If Boston Children's Hospital were unable to provide care to Medicaid members, the program's ability to comply with these laws might be jeopardized. Members who would otherwise be seen by Boston Children's Hospital would need to seek care through other providers, but such providers may not have the capacity to provide the treatment needed. With a large percentage of pediatric beds in Massachusetts suddenly unavailable to MassHealth patients, the other hospitals with pediatric capacity could be overwhelmed by the increase in volume, risking delays in service or requiring out of state care for some highly specialized services.

20. Even with comparable and timely services at alternative hospital locations, MassHealth patients will face disruptions to their care team. As Boston Children's Hospital treats some of the most complex medical cases, including those requiring collaboration across many disciplines and significant case management, finding new care team members and starting from scratch can be time consuming and difficult, and may interrupt the member's continuity of care.

21. Furthermore, the Commonwealth's provider network relies on Boston Children's Hospital and its ability to participate in the MassHealth program. From a financial standpoint, losing Boston Children's Hospital as a MassHealth provider could increase other hospitals' financial needs as they work to absorb the patient volume or acuity capacity that Boston Children's Hospital currently serves. It could thus require additional state resources to be expended, to support the other hospitals in the Commonwealth that would need to absorb Boston Children's Hospital's current MassHealth caseload, or, in the event in-state hospitals are not equipped to serve some of that caseload, to pay increased costs of transportation and service provision for services that MassHealth members may need to obtain outside of Massachusetts.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED this 23rd day of February, 2026.

Joanne Marquesee
[NAME]

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Attorneys for State of Oregon

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

STATE OF OREGON, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as the Secretary of the Department of Health and Human Services, et al.,

Defendants.

No. 6:25-cv-02409-MTK

SUPPLEMENTAL DECLARATION OF JOHN CONNOLLY

SUPPLEMENTAL DECLARATION OF JOHN CONNOLLY

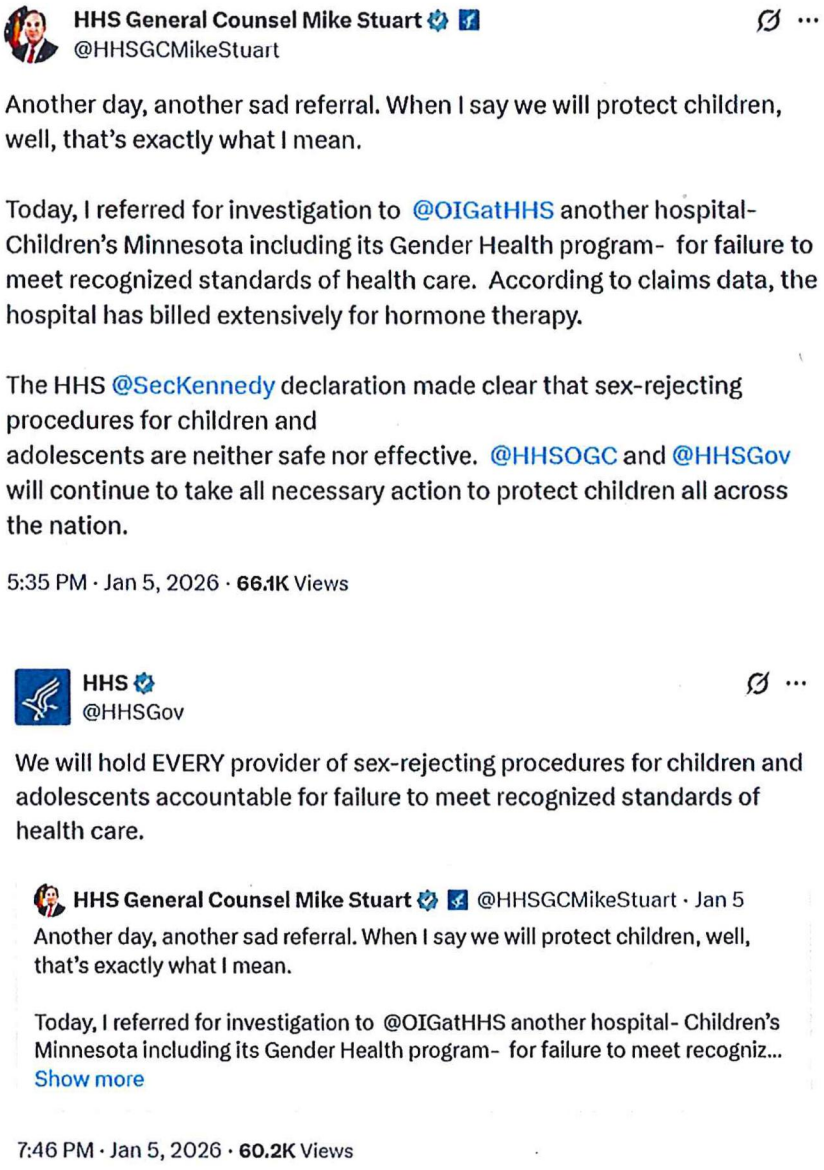
I, John Connolly, declare as follows:

1. I am over 18 years of age, competent to testify, and make this declaration based on my personal knowledge.

Personal and Agency Background

1. I am a Deputy Commissioner of the Minnesota Department of Human Services, which is referred to as DHS, and the State of Minnesota's Medicaid Director. I have been an employee of the State of Minnesota and have worked at DHS for a little over two years. I have overseen the state's Medicaid program and MinnesotaCare, described herein, the entire time of my employment with the State of Minnesota. I have served in state or county government in the area of health policy or public health for approximately ten years.

2. I am aware that on January 5, 2026, the official Department of Health and Human Services (HHS) X account posted to the social media platform X an announcement that HHS General Counsel Mike Stuart referred Children's Minnesota to the HHS Office of Inspector General "for failure to meet professional recognized standards of health care." The announcement included the statement that "The HHS @SecKennedy declaration made clear that sex-rejecting procedures for children and adolescents are neither safe nor effective. @HHSOGC and @HHSGOV will continue to take all necessary action to protect children all across the nation." True and correct screen captures of both Mike Stuart's X.com post, and HHS's re-post, are pasted below:



HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Another day, another sad referral. When I say we will protect children, well, that's exactly what I mean.

Today, I referred for investigation to @OIGatHHS another hospital- Children's Minnesota including its Gender Health program- for failure to meet recognized standards of health care. According to claims data, the hospital has billed extensively for hormone therapy.

The HHS @SecKennedy declaration made clear that sex-rejecting procedures for children and adolescents are neither safe nor effective. @HHSOGC and @HHSGov will continue to take all necessary action to protect children all across the nation.

5:35 PM · Jan 5, 2026 · **66.1K** Views

HHS
@HHSGov

We will hold EVERY provider of sex-rejecting procedures for children and adolescents accountable for failure to meet recognized standards of health care.

> **HHS General Counsel Mike Stuart** @HHSGCMikeStuart · Jan 5
> Another day, another sad referral. When I say we will protect children, well, that's exactly what I mean.
>
> Today, I referred for investigation to @OIGatHHS another hospital- Children's Minnesota including its Gender Health program- for failure to meet recogniz...
> Show more

7:46 PM · Jan 5, 2026 · **60.2K** Views

3. Children's Minnesota is the only health system in the state of Minnesota that cares exclusively for children from before birth through young adulthood. Children's Minnesota draws patients from Minnesota, Wisconsin, Iowa, North Dakota, South Dakota, and beyond, and offers a full range of pediatric specialty services, critical care, and clinics. Children's Minnesota holds the distinctions of being a Level 1 Trauma Center and a Level 1 Children's Surgery Center as ranked by the American College of Surgeons. According to Children's Minnesota's website,

Children's Minnesota is one of the largest freestanding pediatric health systems in the United States, with two hospitals, nine primary care clinics, seven rehabilitation care sites, and nine specialty care sites. Children's Minnesota operates as an independent not-for-profit health system.

4. According to Children's Minnesota's 2024 annual report (the most recent report available at the time of this declaration) Children's Minnesota served 167,610 total patients (excluding primary care patients) with 24,758 surgical procedures and 86,504 emergency department visits.

5. Also according to Children's Minnesota reported data, approximately half of their services are provided to patients who rely on medical assistance (including Minnesota's Medicaid plan, Medical Assistance). According to information provided by Children's Minnesota, and on information and belief, approximately 32 percent of its revenue comes from the Medicaid program. Its operating budget therefore relies heavily on Medicaid reimbursements to support the staffing and services it provides.

6. Minnesota's Medical Assistance program relies on Children's Minnesota to provide the specialized care that they do and would likely be unable to provide it in a timely way if Children's Minnesota were no longer able to care for Medicaid clients. Federal law, including requirements relating to early and periodic screening, diagnosis, and treatment, requires that Minnesota's Medicaid program provide for timely treatment of clients age 21 and younger. If Children's Minnesota were unable to provide care to Medicaid clients, Minnesota's ability to provide for these services would be jeopardized. Minnesota's MA program would likely need to send clients out of state for necessary care, resulting in high transportation costs. Moreover, necessary and critical care would likely be delayed since Children's Minnesota is a regional

medical facility. If access to it were lost, there is no other facility or group of facilities that could take its place.

7. Moreover, Children's Minnesota serves a critical educational and clinical training role in the medical community within Minnesota, providing education and training for medical and physician assistant students, residents, and fellows, as well as nursing and other graduate students, in all departments of Children's Minnesota. If Children's Minnesota were unable to continue operating and providing care to Medicaid clients, it would undermine the state's pediatric healthcare system.

8. If Children's Minnesota is lost as a Medicaid provider, some of Minnesota's most complex patients who are children and youth suffering a myriad of complex conditions will have no other access to the treatment they need. It would not be possible for Minnesota to cover all of the care that Children's Minnesota provides to Medicaid clients using state-only funds.

9. Based on public reporting, I am aware that Children's Minnesota became so concerned about its ability to continue treating Medicaid patients, and the threats against Children's Minnesota by HHS citing the Kennedy Declaration, that it has announced it will pause certain forms of gender affirming care on February 27, 2026. In their public announcement, Children's Minnesota wrote of HHS's threats: "These threats jeopardize the stability of Minnesota's only comprehensive pediatric health care system, and they threaten our clinicians' ability to practice medicine now and in the future." A spokesperson for the hospital wrote in the statement that this was not the decision Children's Minnesota wanted to make but felt it was necessary to protect its providers and the hospital.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED this 23rd day of February, 2026.

John Connolly

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

STATE OF OREGON, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as the Secretary of the Department of Health and Human Services, et al.,

Defendants.

No. 6:25-cv-02409-MTK

SUPPLEMENTAL DECLARATION OF SALLY A. KOZAK

SUPPLEMENTAL DECLARATION OF SALLY A. KOZAK

I, Sally A. Kozak, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a resident of the Commonwealth of Pennsylvania. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge.

2. I am the State Medicaid Director and the Deputy Secretary for the Office of Medical Assistance Programs for the Pennsylvania Department of Human Services ("PA DHS"). I have held that position since 2017. This declaration incorporates and supplements my declaration dated January 5, 2025, submitted as ECF # 55.

3. The Pennsylvania Medicaid Program provides children under the age of 21 access to all medically necessary Medicaid coverable health care, diagnostic services, treatment and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether or not such services are covered under the state's Medicaid State Plan. Pennsylvania's CHIP provides health coverage to uninsured children and teens under the age of 19 who are not eligible for or enrolled in Medicaid.

4. Both the Medicaid program and CHIP are mainly administered through agreements with managed care organizations in Pennsylvania. Managed care organizations administer Medicaid benefits to over 97 percent of Medicaid beneficiaries and 100 percent of CHIP beneficiaries.

5. I am aware that on January 15, 2026, the official Department of Health and Human Services (HHS) X account posted to the social media platform X an announcement that HHS General Counsel Mike Stuart referred The Children's Hospital of Pennsylvania to the HHS

Office of Inspector General "for failure to protect children from sex-rejecting procedures – procedures that cause permanent terrible harm. These hospitals appear to continue to operate outside recognized standards of healthcare and entirely outside Secretary Kennedy's declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective."[1]

6. The Children's Hospital of Philadelphia ("CHOP") is a premier children's hospital and was the first hospital in the United States dedicated to finding cures and treating illnesses and injuries specific to children. With its over 170-year history, CHOP is a nationally recognized pediatric research institution developing groundbreaking and life-changing treatments benefiting children in PA and around the world. According to CHOP's publicly available information, they are recognized as best-in-class from U.S. News and World Report as ranking as one of the best Children's Hospitals in the nation.

7. CHOP provides care for thousands of children every year from Pennsylvania, New Jersey, and other states in inpatient, outpatient, and primary care locations.[2] CHOP's network includes more than 30 primary care locations throughout Pennsylvania and New Jersey. In its 2025 fiscal year alone, CHOP had almost 1.7 million outpatient visits, of which more than 580,000 were for specialty care and roughly 800,000 were for primary care.[3] CHOP's specialized care for children includes 45 pediatric subspecialties.[4]

8. For example, the Cancer Center at CHOP provides innovative treatments for all types of childhood cancer, with the largest pediatric oncology research program in the country.[5] Each year, the CHOP Cancer Center treats more than 500 new patients and more than 4,000

[1] https://x.com/HHSGCMikeStuart/status/2011946547005833419
[2] CHOP, *Hospital and CHOP Care Network Statistics*, https://www.chop.edu/about-us/annual-report-of-our-financials/hospital-statistics (last visited Feb. 23, 2026).
[3] *Id.*
[4] CHOP, *Why Choose CHOP*, https://www.chop.edu/about-us/why-choose-chop (last visited Feb. 23, 2026).
[5] CHOP, *Cancer Center*, https://gps.chop.edu/medical-program/cancer-center (last visited Feb. 23, 2026).

existing patients.[6] CHOP's oncology programs include centers for cancer immunotherapy, proton therapy, blood and bone marrow transplant, neuro-oncology, and solid tumor cancer treatment.[7] CHOP also has one of the largest brain tumor centers in the United States, seeing more than 200 new patients annually.[8] CHOP led the clinical trials for the first form of CAR T-cell therapy to be approved by the FDA for the treatment of relapsed and refractory pediatric acute lymphoblastic leukemia.[9]

9. The Cardiac Center at CHOP is one of the largest pediatric cardiac centers in North America.[10] In a recent year, CHOP performed 898 cardiothoracic surgeries (528 of which were open heart), 1,676 cardiac catheterizations, and had almost 41,000 outpatient cardiology visits.[11] The Cardiac Center's programs include early diagnosis, monitoring and planning during pregnancy through its Fetal Heart Program, one of the largest in North America, and specialized programs to treat children with heart conditions such as advanced heart failure and pulmonary vein stenosis; and a wide range of congenital and acquired cardiac conditions.[12]

10. The CHOP Sickle Cell and Red Cell Disorders Curative Therapy Center offers cutting-edge care from multiple experts for children with sickle cell disease, beta thalassemia (Cooley's anemia), and other red cell disorders.[13] Clinical trials for gene therapy for the treatment of sickle cell disease took place at CHOP, which is one of the approved sites that offers

[6] CHOP, *Why Choose Us for Cancer Treatment*, https://www.chop.edu/centers-programs/cancer-center/why-choose-us (last visited Feb. 23, 2026).
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] CHOP, *Why Choose Us for Cardiac Care*, https://www.chop.edu/centers-programs/cardiac-center/why-choose-us (last visited Feb. 23, 2026).
[11] *Id.*
[12] CHOP, *Fetal Heart Program*, https://www.chop.edu/centers-programs/fetal-heart-program (last visited Feb. 23, 2026).
[13] CHOP, *Sickle Cell and Red Cell Disorders Curative Therapy Center (CuRED)*, https://www.chop.edu/centers-programs/sickle-cell-and-red-cell-disorders-curative-therapy-center-cured (last visited Feb. 23, 2026).

these new therapies.[14]

11. CHOP's Center for Fetal Diagnosis and Treatment is the largest and highest volume fetal program in the world, having cared for more than 35,000 expectant parents since opening in 1995, with over 7,402 deliveries in its Special Delivery Unit since June 2008.[15] The Center has cared for patient families from all 50 states and more than 70 countries.[16] The Center provides complete care for women carrying babies with known birth defects, from diagnosis and prenatal management through fetal surgery, to delivery and care after birth. This Center is one of few in the country that provides open fetal surgery before birth, having performed over 2,565 fetal surgeries for life-threatening conditions, as well as a range of other fetal interventions.[17]

12. CHOP's Newborn/Infant Intensive Care Units at two locations offer technology and teams that care for babies with health issues related to prematurity; birth defects; lung, heart and gastrointestinal conditions; and other disorders.[18] The Philadelphia campus treats more than 1,000 inpatients each year and is a Level IV NICU, able to provide the highest level of medical care.[19] The newer NICU at CHOP's King of Prussia campus provides Level III care for seriously ill newborns.[20]

13. CHOP's Center for Thoracic Insufficiency Syndrome is the first program in the nation devoted solely to treating children, teens and young adults with thoracic insufficiency

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[14] CHOP, *Gene Therapy for Sickle Cell Disease*, https://www.chop.edu/gene-therapy-sickle-cell-disease (last visited Feb. 23, 2026).
[15] CHOP, *Richard D. Wood Jr. Center for Fetal Diagnosis and Treatment*, https://www.chop.edu/centers-programs/center-fetal-diagnosis-and-treatment (last visited Feb. 23, 2026).
[16] CHOP, *Why choose the Wood Center for Fetal Diagnosis and Treatment*, https://www.chop.edu/centers-programs/center-fetal-diagnosis-and-treatment/why-choose-center-fetal-diagnosis-and-treatment (last visited Feb. 23, 2026).
[17] *Id.*
[18] CHOP, *Newborn/Infant Intensive Care Unit (N/IICU)*, https://www.chop.edu/centers-programs/newborn-infant-intensive-care-unit-niicu (last visited Feb. 23, 2026).
[19] CHOP, *Why choose us for neonatal intensive care*, https://www.chop.edu/centers-programs/newborn-infant-intensive-care-unit-niicu/why-choose-chop-neonatal-intensive-care (last visited Feb. 23, 2026).
[20] *Id.*

syndrome, a complex spine and chest wall condition that affects normal breathing and lung growth.[21] CHOP offers families individualized treatment plans which may include vertical expandable prosthetic titanium ribs, a treatment invented at CHOP.[22]

14. CHOP's Congenital Hyperinsulinism Center is the largest and most active hyperinsulinism center in the world, having treated more than 1,900 children.[23] The Center has set the standard for care worldwide and has a cure rate for focal hyperinsulinism of 97%.[24]

15. The Pediatric Transplant Center at CHOP manages some of the most complex pediatric cases, performing 40 to 50 organ transplants annually and exceeding national expected outcomes.[25] The Center cares for children of all ages, from the smallest infants through young adults.[26]

16. CHOP has been collaborative with the Pennsylvania Medicaid program and our Medicaid managed care organizations to address the needs of Medicaid-enrolled children. For example, CHOP has a contract with a Medicaid managed care organization to serve as a Patient Centered Ambulatory Intensive Care Center, particularly focusing on children with high acuity comorbid physical health and behavioral health needs. CHOP also serves as the Telephonic Psychiatric Services (TiPS) provider for the southeast area of the state, providing telephonic consultative services to pediatricians/primary care providers seeing patients who are exhibiting behavioral health symptoms when the pediatricians/primary care providers lack specific training

[21] CHOP, *Wyss/Campbell Center for Thoracic Insufficiency Syndrome*, https://www.chop.edu/centers-programs/center-thoracic-insufficiency-syndrome (last visited Feb. 23, 2026).
[22] *Id.*
[23] CHOP, *Congenital Hyperinsulinism Center*, https://www.chop.edu/centers-programs/congenital-hyperinsulinism-center (last visited Feb. 23, 2026).
[24] CHOP, *Why Choose CHOP for HI Treatment*, https://www.chop.edu/centers-programs/congenital-hyperinsulinism-center/why-choose-chop-hi-treatment (last visited Feb. 23, 2026).
[25] CHOP, *Why Choose the Transplant Center*, https://www.chop.edu/centers-programs/pediatric-transplant-center/why-choose-transplant-center (last visited Feb. 23, 2026).
[26] *Id.*

in pediatric behavioral health. CHOP's Center for Violence Prevention coordinates with at least one Medicaid managed care organization to provide wraparound and supportive services to children and youth who are the victims of interpersonal or community violence, especially gun violence.

17. CHOP is a critical provider of specialty services for children with medical complexities, who are served largely by Medicaid either as the primary or secondary form of coverage. Nearly half of its patients are covered by Medicaid. Without the participation of CHOP and their associated providers in the program, access to these specialty services would be adversely impacted to a significant extent, leaving many very vulnerable children and families either without resources or facing long waiting lists.

18. The Medicaid managed care organizations collaborate with CHOP by providing financial support for several special initiatives addressing social determinates of health to improve the health outcomes of children and families. With respect to these initiatives, CHOP runs the following programs:

a. CHOP's Community Asthma Prevention Program offers free education and support to Philadelphia children with asthma and their caregivers, with the goal of improving asthma-related outcomes and reducing emergency department visits and hospital stays. The program includes asthma prevention home visits, CHOP Care Network Primary Care Center physician education and school-based programs.

b. CHOP's CAPP+ Home Repairs Program is dedicated to creating healthier living environments for children with asthma by addressing significant structural housing issues. By collaborating with Philadelphia home repair agencies, CAPP+

invests an average of $25,000 per home to eliminate asthma triggers including mold, pest residue, and dust through repairs to roofs, plumbing leaks and other necessary improvements. The goal of CAPP+ is to ensure that every Medicaid child can grow up in a healthy home.

c. CHOP's Mobile Food Market involves a weekly mobile food truck that delivers produce, proteins and milk to families living in in the Cobbs Creek neighborhood of Philadelphia, a known food desert.

d. CHOP's youth summer employment program, which aims to improve teens' ability to obtain jobs, develop foundational finance skills and keep them safely engaged over the summer.

e. CHOP's Firearm Safety Initiative, which integrates firearm safety counseling and gun locking device distribution into clinical care to address mental health and community violence.

19. In state fiscal year 2025, CHOP served over 168,500 Medicaid patients and submitted approximately 841,000 claims to PA DHS or encounters to the Medicaid managed care organizations for services provided. CHOP received approximately $712,600,000 in reimbursement for Medicaid patients, which demonstrates the critical role CHOP plays in serving Pennsylvania children.

20. Moreover, CHOP is a network Medicaid and CHIP provider for all Pennsylvania Medicaid managed care plans and almost all CHIP managed care plans. For southeastern Pennsylvania, New Jersey and beyond, the CHOP hospitals and associated facilities operate out of over 50 locations. At the Philadelphia main campus, CHOP operates a Level 1 Trauma Center for the evaluation and treatment of children with life-threatening injuries. If CHOP were unable

to continue operating and providing care to Medicaid clients, it would undermine the state's pediatric healthcare system in southeastern Pennsylvania (which includes the city of Philadelphia and its surrounding counties), where almost half a million children enrolled in Medicaid and CHIP reside.

21. If CHOP is no longer a Medicaid and CHIP provider, some of Pennsylvania's most complex patients who are children and youth suffering a myriad of complex conditions, including pediatric genetic disorders and cancers, will have reduced access, and in some instances no access, to the treatment they need. They would likely lose access to the specialty care that CHOP provides. Families would need to find new providers and facilities for kids. Pennsylvania would be unable to cover all the care that CHOP provides to Medicaid-enrolled children using state only funds.

22. I declare under penalty of perjury under the laws of the State of Pennsylvania and the United States of America that the foregoing is true and correct.

DATED this 23rd day of February 2026, at Harrisburg, Pennsylvania.

/s/ Sally A. Kozak

Sally A. Kozak
State Medicaid Director
Pennsylvania Department of Human Services

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

STATE OF OREGON, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as the Secretary of the Department of Health and Human Services, et al., Defendants.	No. 6:25-cv-02409-MTK DECLARATION OF LAURYN K. FRAAS IN SUPPORT OF REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO DEFENDANTS' MOTION TO DISMISS, OR IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT

DECLARATION OF LAURYN K. FRAAS

I, Lauryn K. Fraas, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am an Assistant Attorney General at the Washington Attorney General's Office. I represent the State of Washington in this case.

Referrals to HHS-OIG by HHS General Counsel

2. Attached as **Exhibit 1** is a true and correct copy of a post from December 26, 2025, at 3:29 p.m. on the social media platform X by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. The post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2004695988242710776 on February 23, 2026.

3. Attached as **Exhibit 2** is a true and correct copy of a post from December 30, 2025, at 1:08 p.m. on the social media platform X by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. The post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2006110061114851333 on February 22, 2026.

4. Attached as **Exhibit 3** is a true and correct copy of a post from January 5, 2026, at 3:35 p.m. on the social media platform X by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. The post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2008321502765093348 on February 22, 2026.

5. Attached as **Exhibit 4** is a true and correct copy of a post from January 9, 2026, at 1:46 p.m. on the social media platform X by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. The post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2009743491186794620 on February 22, 2026.

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6. Attached as **Exhibit 5** is a true and correct copy of a post from January 15, 2026, at 3:40 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from URL: https://x.com/HHSGCMikeStuart/status/2011946547005833419 on February 22, 2026.

7. Attached as **Exhibit 6** is a true and correct copy of a post from February 3, 2026, at 3:25 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from URL: https://x.com/HHSGCMikeStuart/status/2018828343144010025 on February 22, 2026.

8. Attached as **Exhibit 7** is a true and correct copy of a post from February 11, 2026, at 10:16 a.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from URL: https://x.com/HHSGCMikeStuart/status/2021649628639240524 on February 22, 2026.

Other Official Social Media Posts by HHS General Counsel

9. Attached as **Exhibit 8** is a true and correct copy of a post from February 3, 2026, at 7:24 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from URL: https://x.com/HHSGCMikeStuart/status/2018888249104531523 on February 22, 2026.

10. Attached as **Exhibit 9** is a true and correct copy of a post from February 3, 2026, at 7:46 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2018893885791940712 on February 22, 2026.

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11. Attached as **Exhibit 10** s a true and correct copy of a post from February 4, 2026, at 2:48 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuarts's official account. This post was saved as a PDF from URL: https://x.com/HHSGCMikeStuart/status/2019181341158277378 on February 22, 2026.

12. Attached as **Exhibit 11** is a true and correct copy of a post from January 25, 2026, at 5:37 a.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2015418646450090475 on February 22, 2026.

13. Attached as **Exhibit 12** is a true and correct copy of a post from January 31, 2026, at 1:29 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services General Counsel Mike Stuart's official account. This post was saved as a PDF from the URL: https://x.com/HHSGCMikeStuart/status/2017711840747516265 on February 22, 2026.

Official Social Media Posts by HHS

14. Attached as **Exhibit 13** is a true and correct copy of a post from December 18, 2025, at 8:35 a.m. on the social media platform "X" by the U.S. Department of Health and Human Services Rapid Response's official account. This post was saved as a PDF from the URL: https://x.com/HHSResponse/status/2001692812534788190 on February 22, 2026.

15. Attached as **Exhibit 14** is a true and correct copy of a post from December 18, 2025, at 2:32 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services' official account. This post was saved as a PDF from the URL: https://x.com/HHSGov/status/2001782612021645725 on February 22, 2026.

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16. Attached as **Exhibit 15** is a true and correct copy of a post from December 22, 2025, at 9:51 a.m. on the social media platform "X" by the U.S. Department of Health and Human Services' official account. This post was saved as a PDF from the URL: https://x.com/HHSGov/status/2003161583879430349 on February 22, 2026.

17. Attached as **Exhibit 16** is a true and correct copy of a post from January 5, 2026, at 5:46 p.m. on the social media platform "X" by the U.S. Department of Health and Human Services' official account. This post was saved as a PDF from the URL: https://x.com/HHSGov/status/2008354412666740839 on February 22, 2026.

18. Attached as **Exhibit 17** is a true and correct copy of a post from January 18, 2026, at 10:00 a.m. on the social media platform "X" by the U.S. Department of Health and Human Services Rapid Response's official account. This post was saved as a PDF from the URL: https://x.com/HHSResponse/status/2012948103117017172 on February 22, 2026.

News Articles & Hospital Press Release

19. Attached as **Exhibit 18** is a true and correct copy of an article published February 17, 2026, by Joseph Goldstein at *The New York Times* titled "Manhattan Hospital Ends Medical Treatment for Transgender Youth." This article was saved as a PDF from URL: https://www.nytimes.com/2026/02/17/nyregion/nyu-hospital-transgender-youth.html on February 23, 2026.

20. Attached as **Exhibit 19** is a true and correct copy of an article published January 2, 2026, by Tony Gorman at *Colorado Public Radio News* titled "Youth gender affirming care suspended at Children's Hospital Colorado and Denver Health." This article was saved as a

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PDF from URL: https://www.cpr.org/2026/01/02/youth-gender-affirming-care-suspended-childrens-hospital-denver-health/ on February 23, 2026.

21. Attached as **Exhibit 20** is a true and correct copy of the Children's Minnesota Hospital's webpage titled "Gender Health." This webpage was saved as a PDF from URL: https://www.childrensmn.org/services/care-specialties-departments/gender-health/ on February 22, 2026.

22. Attached as **Exhibit 21** is a true and correct copy of an article published January 12, 2026, and updated on January 13, 2026, by Joe Schulz at *Wisconsin Public Radio* titled "Children's Wisconsin, UW Health stop providing gender-affirming treatments for minors." This article was saved as a PDF from URL: https://www.wpr.org/news/childrens-wisconsin-uw-health-stop-providing-gender-affirming-treatments-Minors on February 23, 2026.

23. Attached as **Exhibit 22** is a true and correct copy of an article published January 27, 2026, by Becca Most at *The News Tribune* titled "Tacoma children's hospital closes gender-affirming care clinic." This article was saved as a PDF from URL: https://www.thenewstribune.com/news/local/article314477495.html on February 21, 2026.

24. Attached as **Exhibit 23** is a true and correct copy of an article published February 4, 2026, by *The Spokesman-Review* titled "Mary Bridge leaders cite 2 federal threats behind gender clinic closure." This article was saved as a PDF from URL: https://www.spokesman.com/stories/2026/feb/04/mary-bridge-leaders-cite-2-federal-threats-behind-/ on February 23, 2026.

25. Attached as **Exhibit 24** is a true and correct copy of an article published February 5, 2026, by Theresa Gaffney at *Stat News* titled "Amid federal pressure, more hospitals

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stop gender-affirming care for minors." This article was saved as a PDF from URL: https://www.statnews.com/2026/02/05/hospitals-stop-gender-care-minors-trump-administration-pressure on February 23, 2026.

Federal Government Website Materials

26. Attached as **Exhibit 25** is a true and correct copy of the Centers for Medicare & Medicaid Services' webpage titled "October 2025 Medicaid & CHIP Enrollment Data Highlights". This webpage was saved as a PDF from URL: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/october-2025-medicaid-chip-enrollment-data-highlights on February 21, 2026.

27. Attached as **Exhibit 26** is a true and correct copy of the Children's Bureau of the U.S. Department of Health and Human Services webpage "Child Welfare Outcomes Report Data" section regarding "Child Population Data" for 2023. This webpage was saved as a PDF from URL: https://cwoutcomes.acf.hhs.gov/cwodatasite/population/index/ on February 21, 2026.

28. Attached as **Exhibit 27** is a true and correct copy of a screenshot of the U.S. Department of Health and Human Services YouTube video posted December 18, 2025 titled, "Protecting Children" at 3:50-4:30, available at URL: https://www.youtube.com/watch?v=aY1XfN6Tt0Q. This video screenshot was saved on February 21, 2026.

29. Attached as **Exhibit 28** is a true and correct copy of the U.S. Department of Health and Human Services Press Release dated December 18, 2025, titled "HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children." This webpage was saved as a PDF from

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URL: https://www.hhs.gov/press-room/hhs-acts-bar-hospitals-performing-sex-rejecting-procedures-children.html on February 22, 2026.

30. Attached as **Exhibit 29** is a true and correct copy of an excerpt from a Special Advisory Bulletin issued by U.S. Department of Health and Human Services Office of Inspector General entitled "UPDATED Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs" on May 8, 2013. An excerpt of the Special Advisory Bulletin was saved as a PDF from URL: https://oig.hhs.gov/exclusions/files/sab-05092013.pdf on February 23, 2026.

Unpublished State Court Decision

31. Attached as **Exhibit 30** is a true and correct copy of the Findings of Fact, Conclusions of Law and Order on Class Plaintiffs' Motion for Preliminary Injunction issued February 13, 2026, in *Boe, et al. v. Children's Hospital Colorado*, Case No. 26CV30232 (Dist. Ct. City & Cnty. of Denver Co. Feb. 13, 2026).

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

DATED this 24 day of February 2026, at Seattle, Washington.

s/ Lauryn K. Fraas
LAURYN K. FRAAS, WSBA #53238
Assistant Attorney General
Washington Attorney General's Office

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Exhibit 1

← **Post**

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Follow

Today I referred Seattle Children's Hospital to @OIGatHHS for failure to meet recognized standards of health care as according to Sec Kennedy's declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective. Our kids safety is critical!

3:29 PM · Dec 26, 2025 · **694** Views

2 10

Post your reply

Reply

Exhibit 2

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Today I again referred for investigation to @OIGatHHS another hospital for failure to meet recognized standards of health care per the @HHSGov @SecKennedy declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective - Children's Hospital Colorado. Sadly, it may not be the last referral.

@HHSOGC will always take every possible action to ensure children all across the nation are safe and protected.

1:08 PM · Dec 30, 2025 · **28.7K** Views

11 22 72 3

Read 11 replies

Exhibit 3

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Another day, another sad referral. When I say we will protect children, well, that's exactly what I mean.

Today, I referred for investigation to @OIGatHHS another hospital- Children's Minnesota including its Gender Health program- for failure to meet recognized standards of health care. According to claims data, the hospital has billed extensively for hormone therapy.

The HHS @SecKennedy declaration made clear that sex-rejecting procedures for children and adolescents are neither safe nor effective. @HHSOGC and @HHSGov will continue to take all necessary action to protect children all across the nation.

3:35 PM · Jan 5, 2026 · **66.2K** Views

29 111 697 22

Read 29 replies

Exhibit 4

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Today I referred to @OIGatHHS THREE California hospitals for full investigation – Children's Hospital of Orange County and the UCSF health system including its UCSF Hyde Hospital and Benioff Children's Hospitals.

California's Governor @GavinNewsom needs to do a better job protecting our kids from sex-rejecting procedures that cause permanent terrible harm. These California hospitals continue to operate outside recognized standards of health care and entirely outside @SecKennedy 's easy to understand declaration that sex-rejecting procedure for children and adolescents are not safe nor effective.

Children's Hospital of Orange County operates the Gender, Puberty, And Sex Development Program and advertises cross-sex hormones and puberty blockers for minors on its website, though it states it not does not provide sex change surgeries. However, claims data shows the hospital has billed for sex change surgeries for minors as recently as 2023, as well as for "hormones and puberty blockers."

Within the broader UCSF Health system, sex-rejecting procedures for minors is provided at the Child and Adolescent Gender Center at Benioff Children's Hospital.

Protecting our children is our solemn responsibility. This isn't that hard. @HHSGov is stepping up and Governor Newsom needs to do the same and stop life-altering procedures that harm our children.

We are not sitting idle. We will continue to protect our children from sex-rejecting procedures.

1:46 PM · Jan 9, 2026 · **1,769** Views

4 11 28

Exhibit 5

← **Post**

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

SIX hospitals located in SIX different states...

It is truly unfortunate that today I referred to @OIGATHHS for full investigation SIX more hospitals from SIX different states for allegedly failing to protect our children from sex-rejecting procedures- procedures that cause permanent terrible harm.

These hospitals appear to continue to operate outside recognized standards of healthcare and entirely outside @SecKennedy's declaration that sex-rejecting procedures for children and adolescents are neither safe nor effective.

The SIX hospitals referred for investigation are:

Nemours Alfred I. DuPont Hospital for Children (DE)

Ann & Robert H. Lurie Children's Hospital of Chicago (IL)

Boston Children's Hospital (MA)

The Children's Hospital of Philadelphia (PA)

New York University – Langone Health (NY)

Doernbecher Children's Hospital (OR)

There is no greater priority than protecting our children. It is our solemn responsibility. @HHSGov and this General Counsel will never stop doing all in our ability to protect our children from "sea to shining sea." We must be a nation that values our children. Life-altering procedures that do harm must end.

God Bless our children! God Bless them all!

3:40 PM · Jan 15, 2026 · **34.4K** Views

61 500 1.4K 41

Exhibit 6

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Today, I sadly made another major referral for investigation to @OIGatHHS- Johns Hopkins Hospital and Health System including, but not limited to, the Johns Hopkins Center for Transgender and Gender Expansive Health and the Johns Hopkins Emerge Gender and Sexuality Clinic- for failing to meet recognized standards of healthcare.

Over recent weeks, more than 30 hospitals and hospital systems including some of the largest in the nation have announced they are no longer performing sex-mutilating and sex-rejecting procedures for minors. Those hospital systems are to be commended for making the right decision after making irreversible terrible decisions that harmed and permanently damaged children. Sadly, other hospitals and hospital systems are continuing to perform heinous and horrific acts of intentional permanent harm to minors including, allegedly, Johns Hopkins Hospital and Health System. We will not stop until every single child is protected from the destruction of the integrity of God's chosen human body.

@SecKennedy's declaration made clear that sex-rejecting procedures for children and adolescents are not safe and not effective. Far from it. Sex-rejecting procedures are incredibly damaging and contrary to acceptable standards of healthcare. @HHSGov, @SecKennedy, and @HHSOGC will continue to take all necessary actions to protect our children from "sea to shining sea." Our children deserve it.

3:25 PM · Feb 3, 2026 · **193.8K** Views

190 1.3K 5.5K 172

Read 190 replies

Exhibit 7

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Healthcare system after healthcare system is changing course and stopping sex-rejecting procedures and gender mutilation of our children.

The @ASPS_News and AMA have made strong statements on this critical issue. The evidence is clear- sex rejecting procedures for children are not acceptable standards of healthcare.

In just the past few weeks, more than 40 hospital systems across the country have made the right decision to stop these heinous procedures. But there is far more work to do to protect our children.

Today, unfortunately, I made additional referrals for investigation to @OIGatHHS. These referrals are not for hospitals but, rather, for federally qualified health centers (FQHCs).

@HHSOGC referred for investigation the following FQHCs:

Whitman-Walker Health, Washington D.C.;

Community Health Project, Inc. (aka Callen-Lorde), Bronx, Brooklyn and New York, NY;

Los Angeles LGBT Center, Los Angeles, CA; and

The Institute for Family Health, Manhattan, Bronx, Brooklyn and Mid-Hudson Valley, NY.

@SecKennedy, @HHSGov, and legitimate medical professionals from across the nation have been exceedingly clear on this issue. Sex-rejecting procedures are not acceptable forms of healthcare.

@HHSGov, @SecKennedy, and @HHSOGC will continue to take all necessary actions to protect our children from life-altering, damaging and fake healthcare treatments.

10:16 AM · Feb 11, 2026 · **16.8K** Views

18 32 124 16

Exhibit 8

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Rack up another victory for our children!

Hospital system after hospital system nationwide are stopping devastating gender-rejecting treatments. @SecKennedy, @HHSGov, and @hhsogc will continue fighting for our children until every single hospital system stops these horrific procedures.

From kstp.com

7:24 PM · Feb 3, 2026 · **25.9K** Views

15 96 526 15

Read 15 replies

Exhibit 9

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Almost daily, another major hospital system is ending the tragic and irreversible practice of sex-rejecting procedures for minors. @ASPS_News is bravely standing with @HHSGov & @SecKennedy in courageously leading on this critical issue

From hhs.gov

7:46 PM · Feb 3, 2026 · **4,045** Views

13 39 168 9

Read 13 replies

Exhibit 10

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

It is time for Johns Hopkins to end the terrible practice of sex-rejecting procedures for minors and join the dozens of other hospital systems across the country that have stopped these horrific procedures over the past few weeks.

From wng.org

2:48 PM · Feb 4, 2026 · **15.9K** Views

19 55 311 9

Read 19 replies

Exhibit 11

Post

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

Proud of @HHSOGC's work to save and protect our children from the irreversible devastating trauma of sex-rejecting procedures. The investigations are sadly not done. @HHSGov and @SecKennedy will not stop until every child is safe and every hospital and doctor prioritizes "do no harm." The focus is clear- protect and nuture- not alter and butcher- our children.

> **Katie Miller** @KatieMiller · Jan 25
> 30 hospitals across the United States have stopped permanently altering children before their brains have even developed.
>
> This is now Los Angeles and Chicago this week.
> ...

5:37 AM · Jan 25, 2026 · **55.4K** Views

59 141 769 20

Read 59 replies

Exhibit 12

← **Post**

HHS General Counsel Mike Stuart
@HHSGCMikeStuart

The fake sell of “gender affirming care” will soon be remembered as a Dark Age for American healthcare. Drilling a hole in your head in response to a headache now seems ludicrous but, there was a time, it was common practice. “Gender-rejecting” procedures for children are just as ludicrous and tragically damaging for a lifetime. @HHSGov, @SecKennedy and our entire team will always do all we can to protect our children and everything in our power to advance legitimate healthcare for all Americans.

> **Katie Miller** @KatieMiller · Jan 31
> “Gender affirming care” will go down in history as one of the worst medical atrocities ever.

1:29 PM · Jan 31, 2026 · **23.3K** Views

64 362 1.4K 48

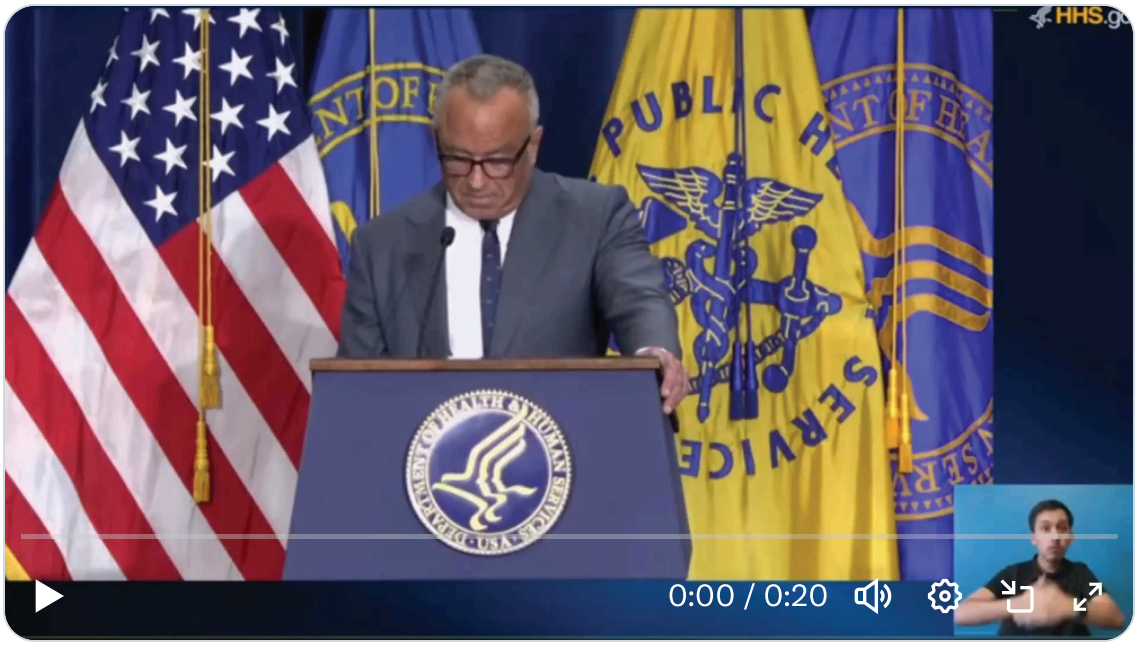
Read 64 replies

Exhibit 13

Post

HHS Rapid Response
@HHSResponse

.@SecKennedy: “Medical professionals or entities providing sex-rejecting procedures to children are out of compliance with these standards of health care. This declaration is a clear directive to providers to follow the science, and the overwhelming body of evidence that these procedures hurt — not help — children.”



8:35 AM · Dec 18, 2025 · **67.4K** Views

48 268 1.3K 30

Read 48 replies

Exhibit 14

Post

HHS
@HHSGov

Today, @SecKennedy signed a declaration stating that sex-rejecting treatments on children do not meet professionally recognized standards of health care.

2:32 PM · Dec 18, 2025 · **57.6K** Views

129 534 2.7K 51

Read 129 replies

Exhibit 15

Post

HHS
@HHSGov

Under the leadership of @POTUS and @SecKennedy, HHS announced actions to END sex-rejecting procedures for children.

Thank you to everyone who joined for the announcement: @HHS_Jim, @DrMakaryFDA, @DrOzCMS, @NIHDirector_Jay, @ADM_Christine, @RogerMarshallMD, @SenatorLankford, @RepBobOnder, @RepHarshbarger, @HHSOCR Director Paula Stannard, and @ChloeCole for bravely sharing her story.

9:51 AM · Dec 22, 2025 · **45.4K** Views

61 191 968 19

Read 61 replies

Exhibit 16

Post

HHS
@HHSGov

We will hold EVERY provider of sex-rejecting procedures for children and adolescents accountable for failure to meet recognized standards of health care.

> **HHS General Counsel Mike Stuart** @HHSGCMikeStuart · Jan 5
> Another day, another sad referral. When I say we will protect children, well, that's exactly what I mean.
>
> Today, I referred for investigation to @OIGatHHS another hospital- Children's Minnesota including its Gender Health program- for failure to meet recogniz...
> Show more

5:46 PM · Jan 5, 2026 · **60.2K** Views

73 302 2.2K 30

Read 73 replies

Exhibit 17

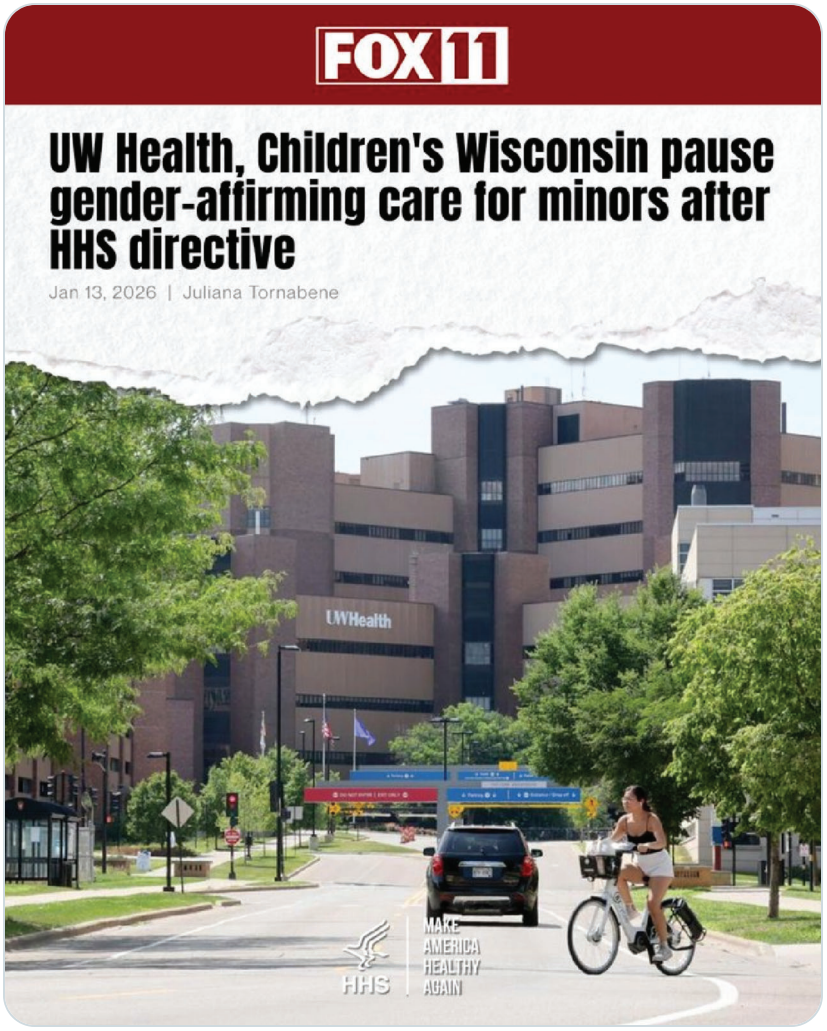
Post

HHS Rapid Response
@HHSResponse

It's working.

Hospitals across the country are ending irreversible medical interventions for minors.

At HHS, protecting children's health comes first.



10:00 AM · Jan 18, 2026 · **9,090** Views

24 59 351 7

Exhibit 18

Manhattan Hospital Ends Medical Treatment for Transgender Youth

NYU Langone Health cited the "current regulatory environment" in its decision to discontinue its gender medicine program for minors.

Listen to this article · 3:53 min Learn more

By Joseph Goldstein

Feb. 17, 2026

A major Manhattan hospital, faced with threats of losing federal funding, has closed its prominent medical program for treating transgender youth.

The move by the hospital, NYU Langone Health, comes after the Trump administration in December proposed rules that would pull federal dollars from any hospital that provides gender transition treatments for adolescents, such as puberty blockers, hormone therapy or surgery.

On Tuesday night, a spokesman for NYU Langone issued a statement citing "the current regulatory environment" as among the reasons the hospital had decided to discontinue its program for gender-related care for youth.

"Given the recent departure of our medical director, coupled with the current regulatory environment, we made the difficult decision to discontinue our Transgender Youth Health Program," according to the statement, which was provided by an NYU Langone spokesman, Steve Ritea.

In an interview, the Manhattan borough president, Brad Hoylman-Sigal, said that it was his understanding that NYU Langone would no longer provide hormone treatments and other gender-related care to transgender youth.

Mr. Hoylman-Sigal said he worried that some of NYU Langone's transgender patients would struggle to find doctors willing to continue their care.

"I'm horrified at the consequences that might result for some of these young people," he said. "It's crucial that they find alternative care as soon as possible, and I think it's the responsibility of the hospitals that are ending this treatment to make those arrangements."

In its statement, NYU Langone said that it was "committed to helping patients in our care manage this change." It noted that there would be no effect on the hospital's "pediatric mental health care programs, which will continue."

The announcement did not come out of the blue. Many families with transgender children who had been receiving gender treatments at major health systems have been trying to come up with backup plans. Some have sought to continue their care with doctors outside major hospital systems or at a clinic in Brooklyn where a doctor last year said that he was willing to risk jail to continue providing care to transgender youth.

A year ago, following an executive order by President Trump that took aim at gender-related treatment for minors, NYU Langone stopped accepting new patients into its transgender youth medicine program. It also canceled appointments for new patients who were scheduled to receive implants that release puberty-blocking medication. But patients who were already on puberty blockers or hormone therapy were able to continue with their treatments, according to interviews with parents of transgender youth.

During the past year, Mr. Trump has deployed the power of the federal government to try to put an end to gender-related care for minors across the United States. The Justice Department has sent more than 20 subpoenas to doctors and clinics that perform transgender medical procedures on minors, demanding confidential patient information.

The F.B.I. has asked the public to call its tip line with information about doctors "who mutilate" children "under the guise of gender-affirming care." And the Federal Trade Commission is examining whether "practitioners of 'gender-affirming care' may be actively deceiving consumers."

A number of clinics and hospitals across the country have responded by scaling back gender-related treatments.

NYU Langone isn't the only major Manhattan hospital with gender medicine programs for transgender youth. NYU Langone and another Manhattan health system, Mount Sinai, received subpoenas last year from federal agencies as part of inquiries into pediatric transgender medicine. Mount Sinai Health System did not respond to a request for comment regarding the status of its program.

Joseph Goldstein covers health care in New York for The Times, following years of criminal justice and police reporting.

Exhibit 19

Youth gender affirming care suspended at Children's Hospital Colorado and Denver Health

By Tony Gorman · Jan. 2, 2026, 5:52 pm

Kevin J. Beaty/Denverite

Children's Hospital Colorado on Aurora's Anschutz Medical Campus. Feb. 13, 2025.

Children's Hospital Colorado is suspending all gender-affirming care to patients under 18 years old amid an investigation by the U.S. Department of Health and Human Services.

On Friday, the hospital announced that it had notified patients' families and team members of the decision. Children's Colorado said that the HHS investigation threatens the hospital's Medicaid and Medicare funding.

"Following the Department of Health and Human Services' (HHS) announced referral of an investigation against Children's Hospital Colorado (Children's Colorado), the hospital must suspend all medical gender-affirming care for patients under 18 years old while we await federal court rulings and assess the rapidly evolving legal landscape," the hospital said in a statement.

Last week, HHS General Counsel Mike Stuart announced on social media that the referral for investigation into Children's Colorado was sent to the HHS Office of Inspector General under a declaration signed by HHS Sec. Robert F. Kennedy, Jr., because the procedures aren't safe or effective.

Children's Colorado said effective immediately, it will suspend writing new or renewing prescriptions for gender-affirming care for patients under 18 years old.

"We believe that families, in consultation with a trusted healthcare team, know what is best for their child, and that all families, including the families of gender diverse children, should have the ability to receive the expert medical care their child needs to thrive," the hospital said.

Children's Colorado has never provided gender-affirming surgical care for patients under the age of 18. Services will still be provided to patients over 18 years old.

Denver Health also announced on Friday that it will suspend gender-affirming care to youth in response to the Department of Health and Human Services' actions.

"These changes, which are made necessary by the actions of HHS, substantially affect access to critical health services," Denver Health said in a statement. "We also are concerned that the important relationships built between our providers and patients to help make informed decisions about their care are being disrupted. We are taking the appropriate steps to ensure our patients and families have the information they need at this time."

Denver Health stopped performing gender-affirming surgeries in early 2025.

The Department of Health and Human Services announced last month a series of proposed regulatory actions to carry out President Donald Trump's Executive Order to end the practice of gender-affirming procedures for children.

At the same time, Kennedy controversially signed a declaration finding that the procedures do not meet professionally recognized standards of health care.

Colorado has since joined 18 other states in suing to block the declaration.

Previous reporting

- Some Colorado hospitals are set to resume some gender-affirming care for youth after challenge to Trump order
- Protest outside Children's Hospital Colorado after sudden suspension of gender-affirming care
- Children's Hospital Colorado suspends gender affirming treatment, following White House executive order
- ACLU sues Children's Hospital on behalf of an 18-year-old seeking gender-affirming surgery

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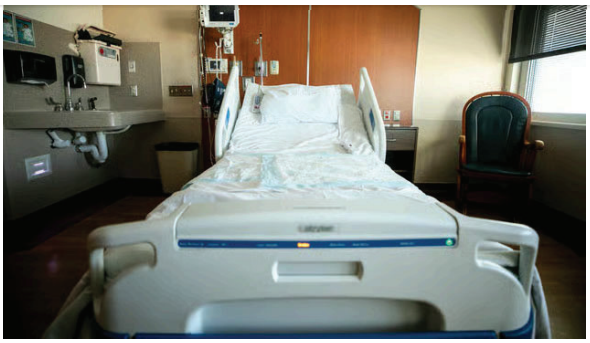

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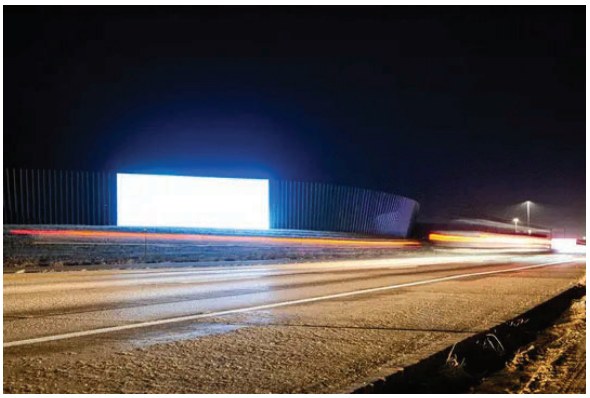

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Exhibit 20

Gender Health

Locations | Contact with questions | What to expect

Gender Health

- Gender Health Services
- Support and resources
- Locations & contact us
- What to expect
- For health professionals

A message to our community

As one of the leading pediatric providers of gender-affirming care in the region, we have recently experienced an increase in federal actions directed at health systems like ours that provide this care. These actions jeopardize the stability of Minnesota's only comprehensive pediatric health care system, and they threaten our clinicians' ability to practice medicine now and in the future. If conditions remain the same, we plan to temporarily pause prescribing puberty-suppressing medications and pubertal hormones (estrogen and testosterone) for patients under age 18 in our Gender Health program, effective Friday, Feb. 27, 2026.

Our Gender Health program is not closed. We continue to provide supportive care, mental health services and guidance regarding medical and non-medical treatment options. If you have an appointment with us, it is not canceled. Please keep your appointment to discuss any needed adjustments to your care plan. We will continue to follow our existing policies that protect private patient health information.

We understand this change will have a significant impact on our patients and families. If you have questions about your child's care, need more information, or require additional resources, please contact us.

Despite this difficult decision, Children's Minnesota remains committed to advocating for the patients and families and stand firmly behind the fact that gender affirming care is evidence-based and lifesaving for transgender and gender diverse youth.

Patient & family education materials

At Children's Minnesota, we know how important reliable information about conditions and illnesses is. Search any condition to learn more.

Search education materials

Comprehensive care for transgender and gender-diverse kids

Children's Minnesota is committed to providing evidence-based, high-quality and essential health care to all kids, including our transgender and gender diverse patients. Our Gender Health program partners with parents and our communities to improve kids' health now and for the future.

Patients currently being cared for in our Gender Health program (and/or children or teens on our waitlist) will continue to receive care unless they have received information directly from the Gender Health clinic or their care team.

At Children's Minnesota we provide a safe and accepting environment for transgender and gender diverse youth and their families to ask questions, seek support and access evidence-based mental health and medical care. We do not perform gender affirming surgeries.

Children's Minnesota Gender Health program is an exclusively pediatric, multidisciplinary gender health program, and includes pediatric gender health, endocrinology and gynecology physicians.

The Gender Health program provides compassionate and comprehensive care for transgender and gender-diverse youth. We're dedicated to serving as an essential medical partner and resource for transgender youth and families along their journey.

Learn more

Find out about what to expect at the Gender Health program.

What if our leaders really did put "kids first?"
February 17, 2026

Truly putting kids first means protecting them from trauma, investing in their health and safety, supporting families and valuing every child for who they are. Putting kids first is not a radical idea. It's our most basic responsibility.

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October 10, 2025

Dr. Kade Goepferd shares their heartfelt coming out story while offering practical lessons for parents, families and allies on supporting LGBTQ+ loved ones with empathy, love and understanding.

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Now more than ever our vibrant LGBTQ+ young people need to know they belong, they matter and they have a bright future. Nicki Hangsleben, founder of QUEERSPACE collective, is working to make that

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- Visiting hours & guidelines
- Directions & parking
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Children's Minnesota is registered as a 501(c)(3) non-profit organization. Our tax identification number is 41-1754276.

Exhibit 21

CHILDREN'S HEALTH, HEALTH, NEWS

Children's Wisconsin, UW Health stop providing gender-affirming treatments for minors

Both health systems cited recent changes at the federal level as motivating factors

BY JOE SCHULZ • JANUARY 12, 2026 • UPDATED JANUARY 13, 2026 at 12:02 PM

Listen

UW Health American Family Children's Hospital Thursday, Aug. 28, 2025, in Madison, Wis. *Angela Major/WPR*

Children's Wisconsin and UW Health have stopped providing gender-affirming care treatments to minors, citing recent federal policy changes.

Both are among the state's largest pediatric hospitals. Advocates fear the lack of access to gender-affirming treatments could lead to negative mental health effects for transgender youth.

The moves come after the **Trump administration last month** announced **plans** to block all Medicaid and Medicare funding for any services at hospitals that provide gender-affirming care to minors. They say it exposes young people to irreversible harm.

"Under my leadership, and answering President Trump's call to action, the federal government will do everything in its power to stop unsafe, irreversible practices that put our children at risk," Health and Human Services Secretary Robert F. Kennedy, Jr. said in the statement announcing the plan. "This Administration will protect America's most vulnerable. Our children deserve better — and we are delivering on that promise."

In a statement, Children's Wisconsin cited "escalating legal and federal regulatory risk" facing providers across the nation as the reason it is "currently unable to provide gender affirming pharmacologic care."

The health system also said it believes LGBTQ+ children should be treated with "support, respect, dignity and compassion" and stated that it will continue offering mental health services for patients and families.

Meanwhile, UW Health said in a statement that it is pausing prescribing puberty blockers and hormone therapy as part of gender affirming care for patients under 18 years old "due to recent federal actions." The system said it remains committed to providing "high-quality, compassionate" care to LGBTQ+ patients.

"We recognize the uncertainty faced by our impacted patients and families seeking this gender affirming care and will continue to support their health and well-being," UW Health said in a statement.

Steve Starkey, executive director for OutReach LGBTQ+ Community Center in Madison, said he believes the health systems' decisions will have

"For trans people of all ages, being able to express themselves in the gender that they feel that they are is important for their mental and physical health," he said. "By not allowing trans people to do that, to have the support, it just means that they are not able to be wholly who they are."

A **2023 study** by the Williams Institute at the UCLA School of Law found that more than 80 percent of trans adults had thought about suicide and more than 40 percent had attempted suicide.

Starkey said LGBTQ+ people in general tend to have higher rates of suicide and suicide ideation, especially in the trans community. He said youth tend to be more vulnerable than adults and losing access to gender affirming treatments isn't likely to help.

"It will definitely have a negative impact on the rates of suicide and and the mental health of trans community," he said. "It affects trans adults as well, because it's like an attack on all trans people."

Susan Neeley, director of family engagement and advocacy at GSAFE, a nonprofit advocating for LGBTQ+ youth, said the Trump administration's proposed rule changes are unfairly targeting the trans community.

"It's having a huge effect on everybody, physically, mentally, emotionally," she said. "There's just been so many attacks on trans people, and specifically trans youth and minors from this administration right now. It's taking a toll on people."

Neeley also said losing access to puberty blockers and hormone therapy could also have negative physical effects on trans youth.

"For example, if someone has been on estrogen and they're no longer (able) to refill that, that's going to have effects on their body if they aren't able to take it, and their body might make changes and revert into a body that the child doesn't feel fits who they are," she said.

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Exhibit 22

LOCAL

Tacoma children's hospital closes gender-affirming care clinic

By **Becca Most**

Updated January 27, 2026 4:10 PM

Join TNT reporter Becca Most as she delves into the recent changes at MultiCare Mary Bridge Children's Hospital in Tacoma. The hospital, the sole provider of youth gender-affirming care in Pierce County, will cease accepting new patients and prescriptions starting Sept. 12. Becca provides insights into the impact on local families. By Brian Hayes

Key Takeaways AI-generated summary reviewed by our newsroom.

Listen to this article

Several months after The News Tribune reported that the MultiCare Mary Bridge Children's Hospital in Tacoma had stopped accepting new gender-affirming care patients, MultiCare has closed its gender clinic and no longer will be offering gender-affirming medical treatment to any patients under the age of 18 after this week, according to a message sent to patients Monday.

Patients may still access behavioral health care at Mary Bridge Children's Hospital and MultiCare, according to the health system.

Mary Bridge Children's Hospital was one of the few places youth could receive such care in Pierce County, as previously reported by The News Tribune. The move comes despite Washington's Shield Law protecting access to gender-affirming care.

Gender-affirming care includes a variety of cosmetic or medical treatments, including puberty blockers and/or hormone therapy that can delay puberty or promote the development of masculine or feminine sex characteristics. Surgery is rarely provided to people under 18, according to the Association of American Medical Colleges. A vast majority of studies show that gender-affirming care is safe

and can significantly reduce suicidality in transgender and nonbinary youth under 18, in some cases by over 70%, according to the Human Rights Campaign.

In September, Mary Bridge declined to provide information about how many people have received gender-affirming care in Tacoma or how many people were on the waiting list for care.

"Due to recent escalations at the federal level to eliminate medical interventions to treat gender dysphoria for minors nationwide, as well as investigations and significant penalizations of health care organizations that provide such care, MultiCare Health System has made the difficult choice to close the MultiCare Mary Bridge Children's Gender Health Clinic," MultiCare said in an emailed response to The News Tribune on Tuesday. "Over the last year, we have worked to find options that would allow us to continue to care for this important group of patients. Unfortunately, continuing to provide gender-care-related medical treatment to minors puts our organization and our providers at too great a risk for government investigation and enforcement actions, including cutting off Medicare and Medicaid payments to MultiCare's entire health system."

A MultiCare spokesperson said nearly 75% of MultiCare's patients — and more than 62% of Mary Bridge Children's patients — depend on Medicare and Medicaid.

"Loss of this funding not only undermines MultiCare's ability to operate, but more critically, threatens patients' access to essential care in every region that MultiCare offers care," per the statement. "We have had conversations with local leaders including members of the LGBTQ+ community about our implementation plan and how we, as a community, can support these patients and families. This was an incredibly painful decision, and one that we wish that we did not have to make."

What will happen to current patients?

In a message sent to patients Monday, which was obtained by The News Tribune, MultiCare CEO Bill Robertson said without the Medicare and Medicaid payments, "our organization would cease to exist."

Robertson said, over the next few weeks, clinic operations will wind down and any future appointments will be cancelled. For patients who are under 18 and taking medications like puberty blockers and/or hormones, the gender health team "will make every effort to provide options ... though the current landscape may make that difficult," he said.

Patients under 18 who are not currently on medications "will not be able to add any medication treatment to their care plan," Robertson said.

Patients who are 18 and older will be transitioned to their current primary care provider, if they have one, and MultiCare staff "will be reaching out to discuss the best plan for your care, including any questions about your existing prescriptions," he said. "It may take some time to be seen, and if you are able to secure health care at another location on a shorter timeline, we encourage you to do so."

The Seattle Children's Hospital, which offers gender-affirming care, including hormone therapy, did not immediately respond to a request for comment from The News Tribune about care options on Tuesday.

In an interview Tuesday, Oasis Youth Center executive director Matthew Wilson said youth and their families can reach out to the center for help and guidance. More information will be released soon, he said.

"We are disappointed to learn that MultiCare is refusing care to transgender youth in contradiction to Washington state law," Wilson said. "This decision abruptly leaves hundreds of youth without care and contributes to the already tense atmosphere that transgender people are experiencing. We've already had concerned youth reach out to us."

This story was originally published January 27, 2026 at 3:43 PM.

Related Stories from Tacoma News Tribune

LOCAL

Ex-employee sues MultiCare, alleging denial of gender-affirming care coverage

October 20, 2025 10:28 AM

Becca Most | *The News Tribune* | 253-274-7322

Becca Most is a reporter covering the Pierce County Council and other issues affecting Tacoma residents. Originally from the Midwest, Becca previously wrote about city and social issues in Central Minnesota, Minneapolis and St. Paul. Her work has been recognized by Gannett and the USA Today Network, as well as the Minnesota Newspaper Association where she won first place in arts, government/public affairs and investigative reporting in 2023. Support my work with a digital subscription

Exhibit 23

THE SPOKESMAN-REVIEW

Washington Idaho

Mary Bridge leaders cite 2 federal threats behind gender clinic closure

Feb. 4, 2026 | Updated Wed., Feb. 4, 2026 at 3:48 p.m.

By Elise Takahama
Seattle Times

The decision to shutter a Tacoma pediatric gender clinic has drawn skepticism from some legal experts who say the hospital, though pressured by the Trump administration, acted prematurely.

But leaders at Mary Bridge Children's Hospital and its MultiCare Health System said the increasingly aggressive federal threats to all of their Medicare and Medicaid funding if gender-affirming care continued essentially forced them to close the clinic that sees hundreds of trans and nonbinary youth. If Mary Bridge did not halt care for those patients, and federal funding was pulled, the entire hospital would be at risk, they said.

In an interview, MultiCare CEO Bill Robertson said he doesn't think the hospital jumped the gun," though the closure is not something he and his team wanted.

"This has been distressing for us," Robertson said. "It's a sad time for us as an organization that is thought to be an important resource to these kids."

That being said, "we're responding to the real reality of a new enforcement regime," Robertson added. "There will be enforcement actions against us if we continue to provide this care."

Emily Brice, co-executive director of advocacy at Northwest Health Law Advocates, isn't so sure.

"I'm looking for the legal signal that tells me this is a decision that Mary Bridge needed to make at this time," Brice said. "I haven't yet been able to identify one."

She acknowledged it's possible the hospital is "aware of something I'm not." Still, her sense is the clinic's closure came too soon, given that gender care for minors remains legal in Washington state and proposed rules from the U.S. Department of Health and Human Services have not yet gone into effect.

Mary Bridge is not the only health organization to scale back gender-affirming medical services in the past year, as efforts to end this care from the Trump administration have intensified. Children's hospitals in Los Angeles and Washington, D.C. – where gender-affirming care for minors also remains legal – made similar announcements last year.

While the Mary Bridge gender clinic is the first in the state to close completely, other Washington health care providers have introduced new limitations. Kaiser Permanente, for example, still provides hormone treatment, puberty blockers and gender-affirming mental health care to minors, but no longer offers surgeries to patients under 19.

Mary Bridge confirmed in September its plans to cut its gender clinic waitlist of about 150 families, but said at the time it would continue to serve those who were already receiving gender-affirming medication.

With last week's news, about 320 patients who were still receiving care at the clinic will have to find a new provider. Of the remaining patients, about 180 are under 18, a hospital spokesperson said. About 130 patients are 18 and over, and will have the option of transferring their care to an adult provider within MultiCare's system, Robertson said.

"This is rather unprecedented in my experience in health care," he said.

Despite the closure, Dr. Barbara Thompson, Mary Bridge's medical director, said the hospital's gender-affirming care services have remained in line with guidance from all major medical groups in the U.S., including the Pediatric Endocrine Society, the World Professional Association for Transgender Health and the American Academy of Pediatrics.

“We still clinically stand behind our American societies for the care that we’ve provided,” Thompson said.

A pair of federal threats

When asked about the reasoning behind the decision to close Mary Bridge’s gender clinic, Robertson pointed to two federal approaches.

One is related to the regulatory actions Health and Human Services Secretary Robert F. Kennedy Jr. introduced in December that target gender care through the Centers for Medicare and Medicaid Services. The proposals are not final or legally binding.

The proposed rules would revise the requirements that Medicare- and Medicaid-certified hospitals must meet to receive CMS funding, prohibiting hospitals from providing gender-affirming care to patients under 18, Robertson said.

A period of public comment is open until Feb. 17. It’s not clear whether the proposals will go into effect immediately after that – but MultiCare leaders believe they will.

“We would not be viable if we lost Medicare and Medicaid,” Robertson said. “Mary Bridge would have to close or couldn’t operate, and MultiCare would have to cease operations.”

Mike Faulk, a spokesperson for state Attorney General Nick Brown’s office, said in an email Monday the proposed HHS rules are still subject to notice and comment by the public and have “no legal effect at this point.”

Any final agency rules that might eventually be issued would not apply retroactively, Faulk said.

A separate federal approach MultiCare is worried about is related to a declaration Kennedy signed Dec. 18 that proclaims pediatric gender-affirming care does “not meet professionally recognized standards of health care.”

Under the declaration, providers who offer gender-affirming care to patients under 18 would be considered out of compliance with those standards.

MultiCare is interpreting the declaration to mean that if a hospital bills the federal government for care considered to be "inappropriate" or "ineffective," it could become a target of other enforcement actions, Robertson said.

He believes the declaration is enforceable now, referencing the pediatric hospitals that have been referred to the HHS Office of the Inspector General for investigation, including Seattle Children's hospital.

Mary Bridge is not yet one of those hospitals, and has not received any direct communication from HHS on this topic, Robertson said.

However, he believes they're on the federal government's radar.

Brown's office is less certain about how or when Kennedy's declaration might be applied.

"We don't really know because what they are doing is unprecedented," Faulk wrote. His office believes the declaration took effect immediately under its own terms.

The state is currently a plaintiff in a multistate lawsuit, filed in Oregon, against Kennedy and HHS over the declaration, which the complaint argues is unlawful. Brown's office will likely know more about the declaration's application next week, when the federal government is expected to file its brief, Faulk said.

HHS press secretary Emily Hilliard declined to answer questions from The Seattle Times about how the agency interprets either of these federal actions. Instead, she wrote in a statement that HHS has a responsibility to "protect children and prevent taxpayers from footing the bill for chemical and surgical sex-rejecting procedures."

Questions from legal experts

The threats from the federal government are "very scary," said Omar Gonzalez-Pagan, senior counsel and health care strategist at Lambda Legal, a nonprofit legal aid group that advocates for LGBTQ+ rights.

Hospitals are "understandably risk-averse institutional players in the health care field" and facing a significant amount of pressure, said Gonzalez-Pagan, who's based in New York.

“It is a horrible choice that is being placed upon hospitals,” he said. “But hospitals don’t have to make that choice when that pressure point is unlawful. … They just need to stiffen up their spine.”

Gonzalez-Pagan reiterated that Kennedy’s proposals have not gone into effect and said the health secretary’s declaration is “on incredibly thin legal ice.” In addition, several courts have found evidence that the federal government’s attempts to restrict gender care for minors are illegal, he said.

Brice, of Northwest Health Law Advocates in Seattle, also said she can understand the concerns of health providers like Mary Bridge.

“But I also think that should be balanced against a concern for the patients who are losing their access,” she said. “I’m not certain why you would make a hasty decision on this when there are patients that you know for sure will not receive the services that they need.”

At MultiCare, which has locations in Washington, Oregon and Idaho, Robertson noted the importance of keeping medical decisions between patients and providers.

“There’s a lot of things about health care that we think should be left to the clinicians who take care of patients to sort through,” he said. “We believe in vaccines. We believe in making sure kids have the support for the journey of growing up.”

Robertson continued, “I think it’s important in a community to have a breadth and depth of opportunities available to us. The federal government is restricting some of that.”

He couldn’t say whether the gender clinic might reopen in the future.

“My crystal ball isn’t great these days,” he said. “As society changes and our legal environment changes, we’re always looking to find ways to take care of people. … But I would say that, you know, nothing’s permanent.

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WASHINGTON

Spokane woman gets 15 months in prison for hitting, killing aspiring chef downtown

A Spokane mother originally from England was detained by ICE over a prior felony. A local judge had praised her progress minutes before

Pedestrian killed in north Spokane

WA patients sue OB-GYN alleging medical and sexual abuse

When winter moves in, hydropower remains steady

It was January 2024, and Eastern Washington was in the grip of one of the coldest stretches in recent memory.

Exhibit 24

HEALTH

Amid federal pressure, more hospitals stop gender-affirming care for minors

Since January 2025, more than 40 hospitals have restricted treatments for young people

Jeff Roberson

By Theresa Gaffney Feb. 5, 2026

Morning Rounds Writer and Reporter

At least nine hospitals or health systems have stopped providing gender-affirming hormones and puberty blockers to young trans people since the start of the year, in the

wake of federal rules proposed in December that would withhold Medicare and Medicaid funding from clinics that continue pediatric care for transgender people.

A STAT analysis of news reports shows that more than 40 hospitals nationwide have paused or ceased to offer some type of gender-affirming care to young people since President Trump launched his first strike at the field one week into his second administration with an executive order that sought to use federal power to end such treatment for minors. Several clinics have cited increased federal pressure, including recent referrals for investigation by the Department of Health and Human Service's Office of Inspector General.

"We will not stop until every single child is protected from the destruction of the integrity of God's chosen human body," Mike Stuart, HHS general counsel, posted on X Tuesday as he announced the latest referral of a hospital for investigation for continuing to provide the care.

While STAT identified action from 42 hospitals and health systems since January 2025, Stuart asserted that more than 30 have stopped care "in recent weeks," though he didn't name the institutions.

Hospitals are stopping the services even though the proposed Centers for Medicare and Medicaid Services rules aren't final, and the executive order has been challenged multiple times in court and portions of it have been blocked while the cases proceed. Advocates and local communities have decried hospitals' decisions to preemptively comply with restrictions. Hospitals shuttering their offerings likely "don't want to be made the example to enforce the rule on day one," said Carmel Shachar, director of the Health Law and Policy Clinic at Harvard Law School. "Whether that's the right risk calculus is really difficult to say from the outside."

Many clinics have provided estrogen, testosterone, and puberty blockers to trans adolescents for years. Major medical organizations have historically recommended that surgeries be offered to transgender minors on a case-by-case basis, but few providers have ever performed them. As federal action continues, numerous hospitals have announced that they'll stop providing the medications to patients, including Rady Children's Health, a large California health system, and Children's Minnesota, a stalwart provider for

transgender patients in the Midwest. (Children's Minnesota, referred for investigation in early January, called the pause temporary in a statement to local media this week.)

Some facilities have stopped providing care only for new patients, like Lurie Children's in Chicago, which is one of many that have been referred for investigation. Fifteen stopped for all minors, and 14 stopped for anyone under 19, according to STAT's analysis. At least three major children's hospitals — which sometimes care for people into their early twenties — have closed to all patients, no matter the age. While a handful of hospitals reinstated the care after a short pause, that hasn't precluded some from suspending it again under further federal pressure, as Children's Hospital Colorado did last month.

Hospitals that discontinued gender-affirming care

More than 40 hospitals nationwide have stopped or paused some part of their gender-affirming care offerings since President Trump launched his first strike at the field in January 2025.

Page 1 of 5 ›

Clinic or health system	State	Patient population	Type of care	Date of Report	Has care been reinstated?	Link to coverage
Children's Minnesota	MN	Minors	Medication	Feb, 2026		Link
University of Utah	UT	Minors	Medication	Jan, 2026		Link
MultiCare Mary Bridge Children's Hospital	WA	Minors	Medication	Jan, 2026		Link
Rady's Children's Health	CA	Under 19	Medication	Jan, 2026		Link
Lurie Children's	IL	New patients under 18	Medication (Previously stopped surgery)	Jan, 2026		Link
Children's Hospital Wisconsin	WI	Minors	Medication	Jan, 2026		Link

UW Health	WI	Minors	Medication	Jan, 2026		Link
Children's Hospital Colorado	CO	Minors	Medication	Jan, 2026	Previously reinstated, but stopped again.	Link
Denver Health	CO	Minors	Medication (Previously stopped surgery)	Jan, 2026		Link
Sutter Health	CA	Under 19	Medication (Previously stopped surgery)	Dec, 2025	Pause reversed before implementation	Link

It's unclear how the proposed rules from the Centers for Medicare and Medicaid Services — available for public comment until Feb.17 — have played into hospital decisions. In a statement to the Colorado Sun, the Colorado children's hospital cited its referral for investigation as posing a risk to Medicare and Medicaid funding.

"It's been a really challenging year for hospitals, for the medical profession, for science," Shachar said. "That probably drives some of the risk analysis."

One of the proposed CMS rules ties participation in Medicare and Medicaid to a commitment not to provide young trans people with puberty blockers, hormones, or gender-affirming surgery. The announcement was accompanied by a far-reaching declaration from health secretary Robert F. Kennedy Jr. that the entire field does not meet medical standards of care, which legal experts believe could have far-reaching consequences.

"If I'm general counsel, I'm having a lot of heartburn about all of this," Shachar said about the variety of ways the administration is targeting transgender health care. "This is an issue that is absolutely a priority for the administration, in ways that even limiting access to abortion care has not been."

But other politicized health services — including mRNA vaccines and other reproductive care like contraception — could be targeted next if HHS successfully links the conditions of participation in Medicare and Medicaid to the provision of transgender care, Shachar said.

For now, young transgender patients — more than half of whom live in states that restrict their rights in some way — will find fewer doctors able to counsel them about medical care like hormones and surgery. And the field, which critics disparage for low-quality evidence of efficacy and inadequate standards of care, will have fewer opportunities to gather additional evidence and improve patient care.

Exhibit 25

October 2025 Medicaid & CHIP Enrollment Data Highlights

All states—including the District of Columbia—provide data each month about their Medicaid and Children's Health Insurance Programs (CHIP) eligibility and enrollment activity. These data reflect a range of indicators related to key Medicaid and CHIP application, eligibility, and enrollment processes. View the complete dataset on Data.Medicaid.gov.

CMS is releasing a new monthly Medicaid and CHIP Eligibility Operations and Enrollment Snapshot. The report provides current month and annual retrospective data on national and state-level Medicaid and CHIP eligibility and enrollment operations, as well as Marketplace and Basic Health Program enrollment. This new report streamlines the monthly Medicaid and CHIP eligibility and enrollment reports CMS released in the past.

Related Data Analysis

- Unwinding Data Reporting
- Medicaid and CHIP Eligibility Operations and Enrollment Snapshot

October 2025 Medicaid & CHIP Enrollment

76,790,559 people were enrolled in Medicaid and CHIP in the **50 states** and the District of Columbia that reported enrollment data for October 2025.

- **69,541,353 people** were enrolled in Medicaid.
- **7,249,206 people** were enrolled in CHIP.

36,639,540 people were enrolled in CHIP or were children enrolled in the Medicaid program in the **50 states** and the District of Columbia that reported child enrollment data for October 2025 representing **47.7%** of total Medicaid and CHIP program enrollment.

List Map

State	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Child Enrollment (Medicaid Child + CHIP Enrollment)	State Expanded Medicaid	State Notes
Alaska	199,110	12,744	211,854	85,271	Expanded	Not available
Alabama	749,334	190,930	940,264	672,491	Not Expanded	Not available
Arkansas	726,141	82,184	808,325	415,014	Expanded	Not available
Arizona	1,605,769	114,384	1,720,153	751,998	Expanded	Not available
California	11,826,775	1,238,553	13,065,328	4,835,377	Expanded	Not available
Colorado	1,051,871	139,176	1,191,047[1]	522,907[1]	Expanded	1. Includes Retroactive Enrollments
Connecticut	887,046	24,770	911,816	366,608	Expanded	Not available
District of Columbia	241,418	16,285	257,703	94,918	Expanded	Not available
Delaware	228,908	13,837	242,745	107,720	Expanded	Not available
Florida	3,485,075	163,016	3,648,091	2,355,956	Not Expanded	Not available
Georgia	1,684,015	188,012	1,872,027	1,322,796	Not Expanded	Not available
Hawaii	365,871	24,070	389,941[1]	153,532[1]	Expanded	1. Includes Retroactive

Hawaii	365,871	24,070	389,941[1]	152,533[1]	Expanded	Enrollments
Iowa	581,518	85,282	666,800	331,835	Expanded	Not available
Idaho	293,367	19,440	312,807	152,556	Expanded	Not available
Illinois	2,731,730	309,576	3,041,306	1,365,759	Expanded	Not available
Indiana	1,474,398	123,806	1,598,204	749,606	Expanded	Not available
Kansas	328,648	72,952	401,600	278,035	Not Expanded	Not available
Kentucky	1,212,561	135,337	1,347,898	619,007	Expanded	Not available
Louisiana	1,281,806	139,293	1,421,099	690,425	Expanded	Not available
Massachusetts	1,406,479	189,473	1,595,952	692,117	Expanded	Not available
Maryland	1,207,260	197,494	1,404,754	671,744	Expanded	Not available
Maine	312,151	27,538	339,689	139,804	Expanded	Not available
Michigan	2,122,659	166,570	2,289,229	894,501	Expanded	Not available
Minnesota	1,171,636	4,484	1,176,120	611,112	Expanded	Not available
Missouri	1,119,590	133,808	1,253,398	580,453	Expanded	Not available
Mississippi	506,720	84,096	590,816	394,291	Not Expanded	Not available
Montana	190,695	20,247	210,942[1]	91,101[2]	Expanded	1. Includes Individuals Enrolled At Any Time in Month (Not a Point-in-Time Count); Includes Retroactive Enrollments 2. Includes Individuals Enrolled At Any Time in Month (Not a Point-in-Time Count); Includes Limited-Benefit Enrollees; Includes Retroactive Enrollments
North Carolina	2,518,541	346,782	2,865,323	1,432,431	Expanded	Not available
North Dakota	100,154	5,327	105,481	51,519	Expanded	Not available
Nebraska	296,869	36,674	333,543	171,952	Expanded	Not available
New Hampshire	159,136	19,053	178,189[1]	87,666[1]	Expanded	1. Includes Retroactive Enrollments
New Jersey	1,486,782	259,018	1,745,800	805,777	Expanded	Not available
New Mexico	644,329	43,098	687,427	310,526	Expanded	Not available
Nevada	694,145	47,913	742,058	320,581	Expanded	Not available
New York	5,833,918	670,368	6,504,286	2,462,008	Expanded	Not available
Ohio	2,525,747	242,720	2,768,467[1]	1,192,630[1]	Expanded	1. Includes Individuals Enrolled At Any Time in Month (Not a Point-in-Time Count)
Oklahoma	919,727	69,333	989,060	516,707	Expanded	Not available
Oregon	1,120,199	183,553	1,303,752	472,211	Expanded	Not available
Pennsylvania	2,731,246	281,320	3,012,566	1,418,667	Expanded	Not available
Rhode Island	270,512	32,968	303,480	119,157	Expanded	Not available
South Carolina	883,061	111,098	994,159	614,984	Not Expanded	Not available

					Expanded	
South Dakota	122,794	14,125	136,919	76,908	Expanded	Not available
Tennessee	1,238,129	181,524	1,419,653	840,241	Not Expanded	Not available
Texas	3,802,894	345,714	4,148,608	3,169,115	Not Expanded	Not available
Utah	297,550	35,071	332,621	169,369	Expanded	Not available
Virginia	1,493,815	193,081	1,686,896	805,438	Expanded	Not available
Vermont	146,926	5,349	152,275	57,787	Expanded	Not available
Washington	1,724,759	63,105	1,787,864	821,362	Expanded	Not available
Wisconsin	1,025,688	99,058	1,124,746	538,125	Not Expanded	Not available
West Virginia	458,072	39,692	497,764[1]	197,772[1]	Expanded	1. Includes Individuals Enrolled At Any Time in Month (Not a Point-in-Time Count)
Wyoming	53,809	5,905	59,714	40,672	Not Expanded	Not available

Map represents data from October 2025, last updated January 29, 2026

Child Enrollment (Medicaid Child + CHIP Enrollment) - Child Enrollment (Medicaid Child + CHIP Enrollment) figures represent the number of children enrolled in the Medicaid program and the total enrollment for separate CHIP programs as of the last day of the reporting period. These figures are point-in-time counts of total program enrollment, and not solely counts of those newly enrolled during the reporting period. These figures include only people who are eligible for comprehensive benefits (for example, emergency Medicaid, family planning-only coverage and limited benefit dual eligible individuals are excluded). States use the definition of "child" as included in the state's Medicaid or CHIP state plan in reporting performance indicator data to CMS, which varies from state to state.

Total Medicaid and CHIP Enrollment - Total enrollment figures represent the total unduplicated number of people enrolled in Medicaid and CHIP as of the last day of the reporting period. These figures are point-in-time counts of total program enrollment, and not solely a count of those newly enrolled during the reporting period. These figures include only people who are eligible for comprehensive benefits (for example, emergency Medicaid, family planning-only coverage and limited benefit dual eligible individuals are excluded), except as indicated in the state-specific notes included with the tables.

Other Sources of Enrollment Data - CMS collects Medicaid and CHIP enrollment data from states through multiple reporting vehicles, such as Statistical Enrollment Data System (SEDS) and Medicaid Budget and Expenditure System. These enrollment data may not align with the data included in this report because of methodological differences. For example, in the most recent published SEDS annual enrollment report, CHIP enrollment was reported as more than 9.6 million. Unlike the point-in-time monthly enrollment counts included in this report, the SEDS CHIP enrollment figure represents the number of people ever enrolled in CHIP throughout the year. View the SEDS total and state-specific annual enrollment data on our CHIP Reports and Evaluations page.

Exhibit 26

CHILDREN'S BUREAU

Child Welfare Outcomes Report Data

Search Reports

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Child Population Data
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Data by State

Child Population Data

Displays demographic context data on the oveall child population, including the number of children under age 18, child poverty data, and data on the child population by race and ethnicity.

Filter Data

Compare By: State Year

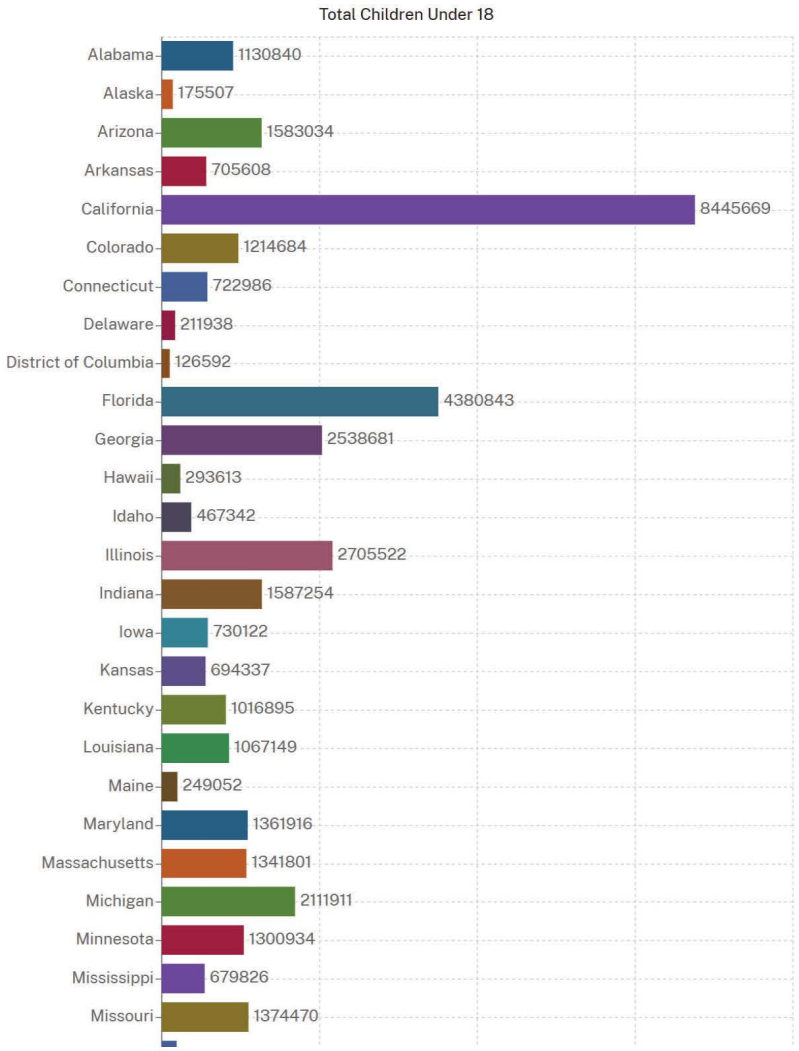
State: Select...

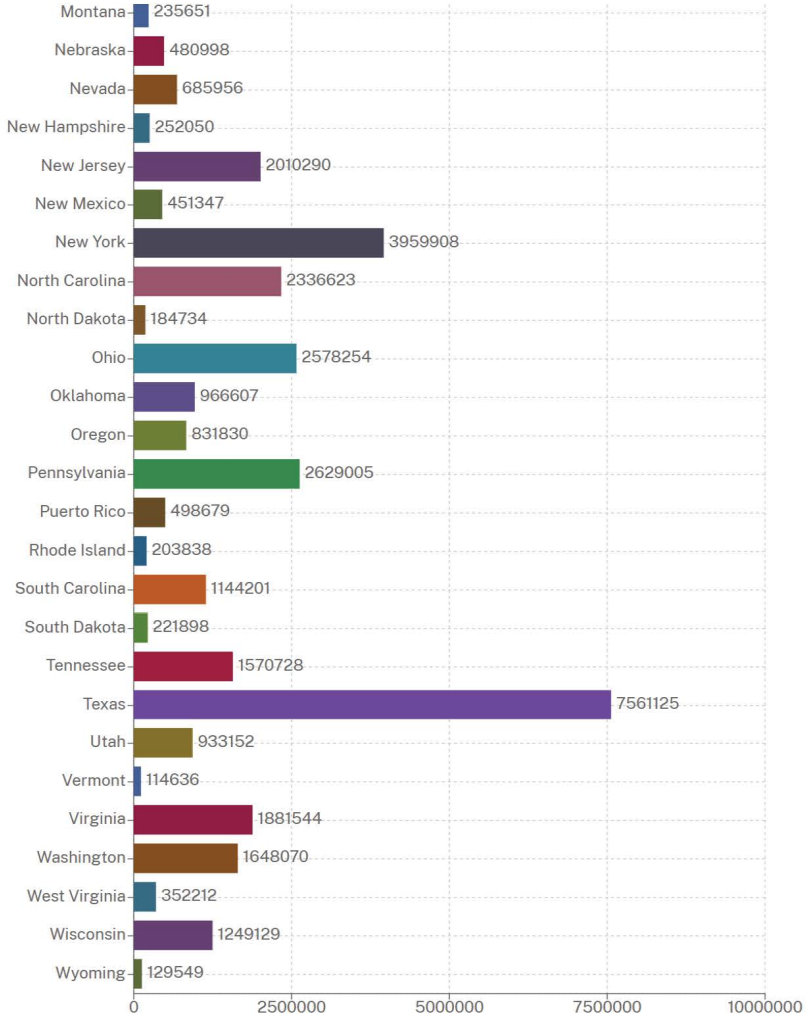
Year: 2023

Tabular View | Graph View

View: Total Child Population

Choose Attribute: Total Children Under 18





Notes

The total children under age 18 population data represent state estimates from the Census Bureau and are based on the calendar year. All other data on this site are based on the federal fiscal year (FY): October 1 through September 30.

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ADMINISTRATION FOR CHILDREN & FAMILIES

U.S. Department of Health & Human Services
330 C Street, S.W., Washington, D.C. 20201

Exhibit 27

Protecting Children

In this video

Timeline Transcript

sex-rejecting procedures to children are out of compliance with

4:17 these standards of health care. This declaration is a clear directive to providers to follow the science and the overwhelming body of evidence that these procedures hurt -- not help -- children.

4:32 Additionally, CMS is proposing two new rules. The first rule are hospitals that participate

4:38 in Medicare and Medicaid -- which is almost every hospital -- from performing these dangerous and

4:45 harmful procedures. The second rule prohibits the federal Medicaid dollars from funding the

4:51 sex-rejecting procedures on minors. The FDA is issuing warning letters to 12 manufacturers of

Live chat replay is not available for this video.

Exhibit 28

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

← Press Room </press-room/index.html>

Navigate to:

FOR IMMEDIATE RELEASE
December 18, 2025

Contact: HHS Press Office
202-690-6343
Submit a Request for Comment

HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children

WASHINGTON — DECEMBER 18, 2025 — The U.S. Department of Health and Human Services (HHS) today announced a series of proposed regulatory actions to carry out President Trump's Executive Order <https://www.whitehouse.gov/presidential-actions/2025/01/protecting-children-from-chemical-and-surgical-mutilation/> directing HHS to end the practice of sex-rejecting procedures on children that expose young people to irreversible harm. These procedures include pharmaceutical or surgical interventions of specified types that attempt to align a child's physical appearance or body with an asserted identity different from their sex.

The Centers for Medicare & Medicaid Services (CMS) will release a notice of proposed rulemaking to bar hospitals from performing sex-rejecting procedures on children under age 18 as a condition of participation in Medicare and Medicaid programs. Nearly all U.S. hospitals participate in Medicare and Medicaid and this action is designed to ensure that the U.S. government will not be in business with organizations that intentionally or unintentionally inflict permanent harm on children. CMS is proposing this rulemaking pursuant to its longstanding authority in sections 1861(e)(9), 1871, and 1905(a) of the Social Security Act, which authorize the agency to establish standards necessary to protect patient health and safety in Medicare- and Medicaid-participating hospitals.

CMS will release an additional notice of proposed rulemaking to prohibit federal Medicaid funding for sex-rejecting procedures on children under age 18. The same prohibition would apply to federal Children's Health Insurance Program (CHIP) funding for these procedures on individuals under age 19. Currently, 27 states do not provide Medicaid coverage of sex-rejecting procedures on children.

Sex-rejecting procedures on children — which include puberty blockers, cross-sex hormones, and surgical operations — expose them to irreversible damage, including infertility, impaired sexual function, diminished bone density, altered brain development, and other irreversible physiological effects.

Health and Human Services Secretary Robert F. Kennedy, Jr. today signed a declaration, based on an HHS peer-reviewed report <https://opa.hhs.gov/gender-dysphoria-report>, finding that these procedures do not meet professionally recognized standards of health care. Under the declaration, practitioners who perform sex-rejecting procedures on minors would be deemed out of compliance with those standards.

"Under my leadership, and answering President Trump's call to action, the federal government will do everything in its power to stop unsafe, irreversible practices that put our children at risk," **Secretary Kennedy said.** "This Administration will protect America's most vulnerable. Our children deserve better—and we are delivering on that promise."

“Children deserve our protection, not experimental interventions performed on them, that carry life-altering risks with no reliable evidence of benefit,” **said CMS Administrator Dr. Mehmet Oz**. “This proposal seeks to clarify that hospitals participating in our programs cannot conduct these unproven procedures on children. CMS will ensure that federal program standards reflect our responsibility to promote the health and safety of children.”

The U.S. Food and Drug Administration (FDA) is issuing warning letters to 12 manufacturers and retailers for illegal marketing of breast binders to children for the purposes of treating gender dysphoria. Breast binders are Class 1 medical devices used for purposes such as assistance in recovery from cancer-related mastectomy. The warning letters will formally notify the companies of their significant regulatory violations and how they should take prompt corrective action.

“Illegal marketing of these products for children is alarming, and the FDA will take further enforcement action such as import alerts, seizures, and injunctions if it continues,” **said FDA Commissioner Marty Makary, M.D., M.P.H.**

HHS is also moving to reverse the Biden administration’s attempt to include gender dysphoria within the definition of a disability. The Office for Civil Rights’ newly proposed revision to Section 504 of the Rehabilitation Act of 1973 clarifies that the definitions of “disability” and “individual with a disability” exclude “gender dysphoria” not resulting from physical impairments. The rule would reassure recipients of HHS funding that policies preventing or limiting sex-rejecting procedures do not violate Section 504’s disability nondiscrimination requirements.

“The Biden administration abused a law that was never intended to require health care providers or health programs to support transgender surgeries for minors,” **said Health and Human Services Deputy Secretary Jim O’Neill**. “Our rule would restore regulatory clarity and ensure that organizations receiving federal funds can set evidence-based policies without fear of violating federal civil rights requirements.”

Last month, HHS published </press-room/hhs-releases-peer-reviewed-report-discrediting-pediatric-sex-rejecting-procedures.html> *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, its peer-reviewed study of the medical dangers posed to children from attempts to change their biological sex. According to claims data, nearly 14,000 minors received sex-rejecting procedures between 2019 and 2023.

Assistant Secretary for Health and Head of the United States Public Health Service Commissioned Corps Admiral Brian Christine, M.D., today signed a public health message [PDF] <https://health.gov/sites/oash/files/message_pediatric_gender_dysphoria_treatment.pdf> to inform health care providers, families, and policymakers that current evidence does not support claims that puberty blockers, cross-sex hormones, and surgeries are safe and effective treatments for pediatric gender dysphoria. “Children’s health and well-being guide our every move,” **said ADM Christine**. “Evidence shows sex-rejecting puberty blockers, cross-sex hormones, and surgeries are dangerous. Providers have an obligation to offer care grounded in evidence and to avoid interventions that expose young people to a lifetime of harm.”

View the Declaration of the Secretary of the Department of Health and Human Services Re: Safety, Effectiveness, and Professional Standards of Care for Sex-Rejecting Procedures on Children and Adolescents [PDF, 315 KB] </sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf>.

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Note: All HHS press releases, fact sheets and other news materials are available in our Press Room </press-room/index.html>.
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Last revised: December 18, 2025

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Content created by Assistant Secretary for Public Affairs (ASPA)
Content last reviewed December 18, 2025

Exhibit 29

UPDATED

Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs

Issued May 8, 2013

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

EXCLUSION FROM FEDERAL HEALTH CARE PROGRAMS

The effect of an OIG exclusion is that no Federal health care program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person.[8] The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one health care profession to another while excluded.[9] This payment prohibition applies to all methods of Federal health care program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system or other bundled payment, or other payment system and applies even if the payment is made to a State agency or a person that is not excluded. For example, no payment may be made to a hospital for the items or services furnished by an excluded nurse to Federal health care program beneficiaries, even if the nurse's services are not separately billed and are paid for as part of a Medicare diagnosis-related group payment received by the hospital. Also, the excluded nurse would be in violation of her exclusion for causing a claim to be submitted by the hospital for items or services the nurse furnished while excluded.

---

[8] An excluded provider may refer a patient to a non-excluded provider if the excluded provider does not furnish, order, or prescribe any services for the referred patient, and the non-excluded provider treats the patient and independently bills Federal health care programs for the items or services that he or she provides. Covered items or services furnished by a non-excluded provider to a Federal health care program beneficiary are payable, even when an excluded provider referred the patient.

[9] For example, the prohibition against Federal health care program payment for items and services would continue to apply to a person who was excluded while a pharmacist even after the person earns his or her medical degree and becomes a licensed physician.

The prohibition on Federal health care program payment for items or services furnished by an excluded individual includes items and services beyond direct patient care. For instance, the prohibition applies to services performed by excluded individuals who work for or under an arrangement with a hospital, nursing home, home health agency, or managed care entity when such services are related to, for example, preparation of surgical trays or review of treatment plans, regardless of whether such services are separately billable or are included in a bundled payment. Another example is services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs that are billed to a Federal health care program. Also, excluded individuals are prohibited from providing transportation services that are paid for by a Federal health care program, such as those provided by ambulance drivers or ambulance company dispatchers.

Excluded persons are prohibited from furnishing administrative and management services that are payable by the Federal health care programs. This prohibition applies even if the administrative and management services are not separately billable. For example, an excluded individual may not serve in an executive or leadership role (e.g., chief executive officer, chief financial officer, general counsel, director of health information management, director of human resources, physician practice office manager, etc.) at a provider that furnishes items or services payable by Federal health care programs. Also, an excluded individual may not provide other types of administrative and management services, such as health information technology services and support, strategic planning, billing and accounting, staff training, and human resources, unless wholly unrelated to Federal health care programs.

In addition, any items and services furnished at the medical direction or on the prescription of an excluded person are not payable when the person furnishing the items or services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to a State agency or a provider that is not excluded. Many providers that furnish items and services on the basis of orders or prescriptions, such as laboratories, imaging centers, durable medical equipment suppliers, and pharmacies, have asked whether they could be subject to liability if they furnish items or services to a Federal program beneficiary on the basis of an order or a prescription that was written by an excluded physician. Payment for such items or services is prohibited.[10] To avoid liability, providers should ensure, at the point of service, that the ordering or prescribing physician is not excluded.[11]

VIOLATION OF OIG EXCLUSION BY AN EXCLUDED PERSON

An excluded person violates the exclusion if the person furnishes to Federal health care program beneficiaries items or services for which Federal health care program payment is sought. An excluded person that submits a claim

[10] See Act § 1862(e)(1)(B). Some excluded practitioners will have valid licenses or Drug Enforcement Agency (DEA) numbers. Therefore, it is important not to assume that because a prescription contains a valid license number or DEA number, the practitioner is not excluded.

[11] In some cases, pharmacies and laboratories rely on Medicare Part D plans and/or State agencies to ensure that prescribers are not excluded through, for example, computer system edits. These alternative screening mechanisms may effectively identify excluded individuals and prevent the pharmacies or laboratories from submitting claims for services ordered or prescribed by excluded individuals. However, pharmacies and laboratories that rely on a third party to determine whether prescribers are excluded should be aware that they may be responsible for overpayments and CMPs relating to items or services that have been ordered or prescribed by excluded individuals.

Exhibit 30

DISTRICT COURT, CITY & COUNTY OF DENVER, COLORADO 1437 Bannock Street Denver, Colorado 80202	DATE FILED February 13, 2026 6:20 PM CASE NUMBER: 2026CV30232 ▲ **COURT USE ONLY** ▲
Plaintiff: BELLA BOE, by and through her mother Becky Boe; CHLOE COE, by and through her father Clark Coe; DANIELLE DOE, by and through her mother Denisha Doe; GABRIELLA GOE, by and through her mother Grace Goe; All of whom are minor patients and their parents, as representatives of a class of similarly situated individuals, v. **Defendant**: CHILDREN'S HOSPITAL COLORADO.	**Case Number**: 26CV30232 **Courtroom**: 424

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ON CLASS PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

This case came on for a hearing to the Court February 4 and 5, 2026. The Court, having considered the evidence, the briefs, and the applicable legal authority, makes the following findings of fact and conclusions of law and issues the following order.

I. PROCEDURAL BACKGROUND

1. On January 20, 2026, Plaintiffs filed their Complaint, alleging two counts of violations of the Colorado Anti-Discrimination Act ("CADA") pursuant to section 24-34-601, C.R.S. Plaintiffs allege discrimination in a place of public accommodation based on disability, sex, and gender identity.

2. Also on January 20, 2026, Plaintiffs filed Class Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction.

3. On January 21, 2026, Defendant filed its Memorandum in Opposition to Motion for Temporary Restraining Order.

4. Also on January 21, 2026, the Court held a hearing on the Motion for Temporary Restraining Order. The Court denied the Motion for Temporary Restraining Order and set a hearing on the Motion for Preliminary Injunction.

5. On January 30, 2026, Defendants filed their Opposition to Plaintiffs' Motion for Preliminary Injunction.

6. Plaintiffs filed their Reply in Support of Motion for Preliminary Injunction on February 4, 2026.

7. On February 4 and 5, 2026, the Court held a hearing on the Motion for Preliminary Injunction.

8. At the hearing, Plaintiffs were represented by counsel Paula Greisen and John McHugh. Defendant was represented by counsel Stanley Garnett, Patrick O'Rourke, Leah Regan-Smith, and Kristin Arthur. The Court admitted exhibits 1-3, 5-7, A, B, E, and F.

9. On February 5, 2026, Defendant filed its Supplemental Brief Regarding Availability of Class-Wide Relief.

10. Also on February 5, 2026, Plaintiffs filed Class Plaintiffs' Statement of Additional Authorities in Response to Defendant's Supplemental Brief.

II. FINDINGS OF FACT

The Court finds the following facts were proven by a preponderance of the evidence for the purposes of the hearing on preliminary injunction:[1]

11. Plaintiffs are a group of individuals who identify as transgender youth. Each has sought care from the TRUE Center at Children's Hospital Colorado ("CHC"). The Plaintiffs filed under pseudonyms with the Court's permission.

12. Defendant CHC is a hospital that provides primarily pediatric care in the Colorado region.

A. Stipulations

13. The provision of medical gender-affirming care is lawful in the State of Colorado, and the American Medical Association ("AMA") and American Academy of Pediatrics ("AAP") have endorsed gender-affirming care to be both safe and effective. CHC provides all care in compliance with Colorado law, and consistent with posted recommendations provided by the AMA and AAP.

14. CHC and, since its founding, the TRUE Center, has followed the World Professional Association for Transgender Health's ("WPATH") internationally-accepted medical

[1] All findings of fact and conclusions of law made in this order are based on what the Court finds to be a preponderance of the admissible, credible, persuasive evidence. Since the Court sat as the factfinder in this case, in assessing credibility, the Court has applied the same standards that jurors are permitted to apply as set forth in CJI-Civ. 3:16.

standards of care, including the medical standards of care regarding adolescents who experience gender dysphoria.

15. The TRUE Center only prescribes medical gender-affirming care (including puberty blockers and hormone therapy) when it has been determined to be medically necessary for the treatment of gender dysphoria.

16. The TRUE Center saw 1140 patients under 18 in 2025. Of those, 257 patients were prescribed puberty blockers and 549 patients were prescribed hormone therapy. In 2024, the TRUE Center saw 1203 patients under 18. Of those, 260 were prescribed puberty blockers and 549 were prescribed hormone therapy.

17. On January 20, 2025, the President issued Executive Order 14,168 (the "Gender Ideology EO"), announcing that "[i]t is the policy of the United States to recognize two sexes, male and female[.]" The Gender Ideology EO declares the lived experience of transgender individuals to be a "false claim" under the moniker of "gender ideology" and purports to deny the reality that transgender people exist.

18. On January 28, 2025, the President issued Executive Order 14,187 (the "Medical Services EO"), announcing that "it is the policy of the United States that it will not fund, sponsor, promote, assist, or support the so-called 'transition' of a child from one sex to another, and it will rigorously enforce all laws that prohibit or limit these destructive and life-altering procedures." This EO uses the term "chemical and surgical mutilation" to reference the use of puberty blockers and sex hormones.

19. On February 5, 2025, CHC announced it would cease providing all medical gender-affirming care to minor patients. At that time, CHC stated it would provide current patients with a one-time prescription for six months of medication.

20. On February 19, 2025, CHC announced it was resuming providing medical gender-affirming care for minors previously treated by CHC in the State of Colorado.

21. On December 18, 2025, the Secretary of Health and Human Services ("HHS") Robert F. Kennedy, Jr., issued a declaration, known as the "Kennedy Declaration," claiming that "[s]ex rejecting procedures for children and adolescents are neither safe nor effective as a treatment modality for gender dysphoria[.]"

22. The legality of that declaration was promptly challenged in *Oregon v. Kennedy*, No. 6:25-cv-02409-MTK (D. Or.). Plaintiffs, including Colorado, have subsequently moved for summary judgment.

23. On December 30, 2025, HHS's General Counsel announced he was referring CHC "for investigation" to the Office of Inspector General ("OIG") at HHS for providing gender affirming care in violation of the Kennedy Declaration.

24. On or about January 6, 2026, HHS agreed to not issue notices of intent to exclude (42 C.F.R. § 1001.2001) or notices of exclusion (42 C.F.R. § 1001.2002) to CHC until the earlier

of the court's decision on the motion for summary judgment or 30 days after the hearing on the motion for summary judgment in *Oregon v. Kennedy*.

25. Oral argument on the plaintiff's motion for summary judgment as to the legality of the Kennedy Declaration in *Oregon v. Kennedy* is set for March 19, 2026.

B. Dr. Daniel Reirden

26. The Court heard testimony from Dr. Daniel Reirden. Dr. Reirden is the interim medical director for Rensselaer Polytechnic Institute. Dr. Reirden was accepted by the Court as an expert in the provision of medical gender affirming care.

27. Gender identity is defined as the experience of gender by the self. Sex is a biological finding based on reproductive organs.

28. Gender dysphoria may be diagnosed when an individual has extreme distress due to the difference between gender identity and the gender or sex assigned at birth.

29. Gender affirming care has an expansive definition. It ranges from the choice of pronouns and preferred name to hormonal treatment and surgery.

30. Puberty blockers are a type of gender affirming medical care in which medical hormones are used to block the natural onset of puberty. Puberty blockers temporarily pause sexual development. Youth may take puberty blockers to allow themselves time to explore their identity. When puberty blockers are stopped, puberty proceeds in accordance with biology.

31. Going through puberty causes irreversible physical changes that are difficult to reverse. Some changes may require surgery to reverse.

32. Puberty blockers are often administered by implant. The implant is replaced every twelve months until the patient decides to allow puberty to proceed.

33. A patient will work with a medical provider to determine when puberty is beginning and then start the blockers within a couple of weeks. The medical provider typically needs to physically observe the patient for changes. This is not easily accomplished by telehealth.

34. After some time on puberty blockers, the patient may undergo hormone therapy to allow puberty of the chosen gender. The decision is made with the medical provider, patient, and parents. This usually occurs in middle teens.

35. A medical provider providing gender affirming care needs a level of expertise, including regarding growth patterns, what is involved in puberty, and family treatment.

36. Puberty blockers and hormones are considered medically necessary gender affirming care.

37. From 2007-2023, Dr. Reirden was a physician at CHC, providing gender affirming care. He helped start the TRUE Center at CHC. The TRUE Center was designed to be a multi-

disciplinary medical practice, including doctors, psychiatrists, social workers, among others, providing care to adolescents to young adults. The TRUE Center treats patients from all over Colorado and the Rocky Mountain region, including Wyoming, New Mexico, Kansas, Montana, and other states. Patients come from across the country and internationally.

38. The TRUE Center had 1000 to 1200 unique patient visits per year.

39. Physicians need to develop a personal relationship with their patients. The relationship develops over time, not just one visit. This is a stressful period of time for patients. It would cause lots of psychological stress on patients if they were not able to receive care.

40. The TRUE Center and gender affirming care have helped many patients who are now living happy lives as another gender. Medical gender affirming care is lifesaving and lifechanging.

41. If puberty blockers are stopped, the body will start producing gonadotrophins within months. Puberty will resume. If hormone therapy is stopped, there may be irreversible changes to the body.

42. For each named Plaintiff, Dr. Reirden has not met the patient, the patients' parents, nor reviewed any medical records. He opined that each Plaintiff would experience the negative effects of stopping medical gender affirming care, including irreversible physical and psychological harm.

43. Doctors must make their own independent medical decisions, including what to prescribe to an individual patient. The doctor will make decisions specific to the patient.

44. One-half of CHC's patients are Medicaid recipients. When Dr. Reirden was at CHC, he recalled that the percentage of patients at the TRUE Center on private pay was approximately two-thirds, which is more than the hospital in general.

45. Dr. Reirden currently has no hospital privileges. When he did have privileges, he, like all doctors, had to certify that he was not excluded from being a Medicaid provider.

C. Dr. Dan Karasic

46. The Court heard testimony from Dr. Dan Karasic. Dr. Karasic provides mental health care to transgender youth and adults. He was previously employed by the University of California San Franciso as a professor of psychology. From 2003 to 2020, Dr. Karasic was a psychologist for transgender youth ages twelve to twenty-five at Dimensions Clinic. Some of his patients at Dimensions were on Medicaid.

47. Dr. Karasic co-authored WPATH standards.

48. Dr. Karasic was accepted by the Court as an expert in the mental health needs of individuals with gender dysphoria.

49. Dr. Karasic currently sees patients in his private practice. None of his current patients are on Medicaid.

50. Dr. Karasic has no question that gender affirming care is safe and effective. No reputable medical association has found otherwise. No reputable research supports the Kennedy Declaration.

51. Gender identity is the deep-seated sense of gender a person has. Cisgender refers to individuals whose gender identity aligns with their birth sex. Transgender refers to individuals who do not experience such alignment.

52. To be diagnosed with gender dysphoria, an individual needs to experience two of approximately seven symptoms of discomfort and distress. If the distress is severe, the patient needs mental and medical health treatment.

53. Severe psychological symptoms can be disabling. Gender dysphoria can cause disability by affecting life activities such as learning, reading, concentrating, ability to socialize, and going to school.

54. As a clinician, Dr. Karasic completes disability forms.

55. A goal of medical gender affirming care is to bring the body more in congruence with gender identity to relieve stress.

56. Cisgender youth may also need puberty blockers or hormones.

57. Medical providers need education and training to develop expertise regarding gender affirming care. Most general pediatricians do not provide gender affirming care.

58. Youth are not typically on puberty blockers for long. They can usually start after age ten. They might start on hormones younger than age fifteen. There may be a period of overlap with puberty blockers and hormones.

59. A study showed that in states where gender affirming care has been banned for youth, the number of youth who attempted suicide increased at a rate of between thirty-three and forty-nine percent in the last year.

60. A recent article in the United Kingdom studied a period in which the country restricted access to gender affirming care and the percentage of suicides for transgender youth was higher than the percentage of the population that identifies as transgender.

61. Many transgender youth need mental health treatment. Gender affirming care assists in alleviating mental health issues.

62. It is Dr. Karasic's opinion that the Kennedy Declaration is flawed. The drafters are not experts but activists. The Declaration is based on politics and ideology, not a rational, clinical basis.

63. The mental health of youth who go through puberty of the sex with which they do not identify can suffer.

64. Dr. Karasic opined that it is more likely than not that when a patient is forced to stop gender affirming care abruptly, immediate and irreparable harm will result.

65. Dr. Karasic agreed that medical care is intertwined with state and federal funding and insurance in a complex system.

66. Dr. Karasic noted that increasingly, gender affirming care is being done outside the reimbursement system and/or in other countries.

D. The Plaintiffs

67. The Court heard testimony from Jessica Joe, the mother of Jacob (all pseudonyms). Jacob is not a named plaintiff. Jacob is fourteen and lives in Durango. Jacob identifies as a boy and has since he was a very young age. Jacob has been diagnosed with gender dysphoria.

68. Jacob received gender affirming care from the TRUE Center. He is now on puberty blockers. His current implant was placed in November 2024. His current implant expired in November 2025. Jacob had an appointment for January 2, 2026 but the hospital cancelled.

69. Jacob's puberty blockers are medically necessary because he does not want to go through girl puberty. Ms. Joe understands the maximum amount of time on puberty blockers is three years.

70. Jacob and his family are on Medicaid. There are restrictions on where they can get care. For example, they cannot go to Albuquerque for care even though it would be more convenient in terms of location.

71. Jacob was able to get a one-time pro bono appointment from another provider for gender affirming care for three weeks. Ms. Joe testified they could not go back to the provider while on Medicaid. It was not clear from her testimony whether Medicaid forbade going to another provider or if she meant they could not see another provider because it was not covered by Medicaid.

72. If Jacob cannot obtain gender affirming care, he will develop breasts, have a period, and his body will not look how he has expected. Jacob is researching other countries where he can get gender affirming care. He has said he does not want to go to school. Stopping gender affirming care will cause him irrevocable harm.

73. The Court heard testimony from Grace Goe, mother of Gabriella (all pseudonyms).

74. Gabriella is nine years old. Gabriella was born with male sex traits. When Gabriella was young, she asked if she could cut off her penis. At that point, she began seeing a psychologist and her parents began reading books on the topic.

75. By her fourth birthday, Gabriella transitioned to living as female. Gabriella is female at school with peers.

76. Gabriella has been diagnosed with gender dysphoria. She began working with the TRUE Center when she was six. She had been meeting with a pediatric endocrinologist. She is expecting to be able to use puberty blockers to allow her more time to decide. She is expecting that she can start puberty blockers in March or April 2026.

77. Ms. Goe has not informed Gabriella that the TRUE Center will not provide Gabriella care. Ms. Goe does not want to explain that the government thinks Gabriella is wrong.

78. If Gabriella cannot get gender affirming care and has a testosterone-led puberty, she will be devastated. She will not be what she wants to be. It would be distressing.

79. The Court heard testimony from Becky Boe, mother of Bella (all pseudonyms). Bella lives in Denver. She is fourteen. She received care at the TRUE Center. Bella was in foster care before being adopted by Ms. Boe. In foster care, Bella lived in a chaotic situation, with drugs, abuse, and missed medical care.

80. When Bella was ten in 2022, she came out. Bella asked to change her name and began presenting socially as a girl.

81. Bella has often had suicidal ideation. At one point, she was admitted to the hospital for suicidal ideation. The hospital put her with boys, who sexually assaulted her.

82. Soon after her hospital stay, Bella started on puberty blockers with the TRUE Center. At TRUE, Bella has had the same doctor since 2022 and she trusts the doctor. The doctor has helped Bella with mental health issues.

83. Bella's last puberty blocker was implanted in December 2024. At age fourteen, Bella expected to start hormone therapy. She had an appointment a couple of weeks ago. The provider explained that the TRUE Center was unable to prescribe hormones. Bella is currently not scheduled to receive another implant.

84. Bella is frustrated, angry, distraught, and suicidal. She now wishes she had not come out and is considering de-transitioning. Bella really wants to start hormone therapy because it will be hard to go to school as a boy.

85. Bella is on Medicaid; she is not allowed to go to non-Medicaid providers. The TRUE Center said it could not give referrals.

86. The Court heard testimony from Denisha Doe, mother of Danielle (all pseudonyms). Danielle lives in Denver. She is a twin. She and her family lived in Texas prior to Colorado.

87. From the time Danielle could express herself, she said she was a girl. Unlike her twin, Danielle liked all things feminine. Danielle was very persistent.

88. Danielle first asked her parents when her penis would fall off. She then asked if she could cut it off. Her parents were alarmed, and saw a counselor in Texas.

89. As early as age three, Danielle presented as a girl.

90. Danielle has been diagnosed with gender dysphoria. She started on puberty blockers at age twelve.

91. Danielle's family moved to Colorado in 2023 because they wanted a place with robust protections.

92. Currently, Danielle is on an oral protocol. She takes her medication every other day.

93. Danielle is undergoing a procedure to extract sperm to cryofreeze for future use. Her hormones need to be monitored for the procedure.

94. Over time, Danielle has grown to trust the providers at the TRUE Center.

95. In early 2025, Danielle got notices that the TRUE Center was ceasing and then resuming care. The family became scared and worried during that time.

96. The family received the January 2026 notice from the TRUE Center about stopping care after the Kennedy Declaration. Danielle had an appointment on January 14, 2026 for blood work and measurements. The TRUE Center told Danielle it could not do the care.

97. Danielle is currently hospitalized at CHC in the psychiatric ward for a depressive episode. Danielle wrote her mother a letter that included suicidal ideation, she said she dreamt of de-transitioning, and said, "If I don't see you again, I love you." Danielle is looking for new coping skills.

98. Currently, CHC is administering Danielle gender affirming medication that the family brings in. CHC will not prescribe the medication.

99. Danielle's mental health has worsened. There is no doubt she will experience irreversible harm.

100. Danielle's doctor wrote in MyChart that gender affirming care would be helpful to Danielle.

E. Dr. David Brumbaugh

101. The Court heard testimony from Dr. David Brumbaugh, a pediatric gastroenterologist at CHC. He is also a professor of pediatrics at the University of Colorado School of Medicine. He has practiced medicine for sixteen years.

102. Dr. Brumbaugh is the chief medical officer at CHC. He oversees 2,000 medical providers and works with the chief nurse regarding quality of care.

103. In his administrative role, Dr. Brumbaugh makes strategic decisions for four different licensed hospitals. He gives guidance on the scope of services and advice to CHC's board. Dr. Brumbaugh is familiar with the legal framework for operating CHC.

104. Dr. Brumbaugh was accepted by the Court as an expert in the field of hospital administration.

105. Dr Brumbaugh is not an expert in gender affirming care. He has become familiar with the area given his administrative role. He disagrees with the Kennedy Declaration and its characterization of gender affirming treatment as "sex-rejecting treatment."

106. Dr. Brumbaugh and CHC are proud of the TRUE Center.

107. The UPL program was created by Medicaid to provide additional support to underserved patients. The TRUE Center is part of the program which designated tens of millions of dollars to serve underserved patients.

108. CHC applied for UPL funds to support clinical services at the TRUE Center. The TRUE Center cannot survive without UPL funding.

109. Dr. Brumbaugh agrees that any patient decisions are best made by the patient and family, not the federal government. The federal government is taking actions in violation of the TRUE Center's core values.

110. The TRUE Center provides a wide variety of gender affirming care, including for behavioral health, medical and occupational health, and speech. Prior to January 2026, it included prescriptions for hormone therapy and puberty blockers. Since January 2026, CHC no longer provides these drugs for those under eighteen for the purpose of gender affirming care.

111. Dr. Brumbaugh believes the treatment the TRUE Center provided before January 2026 was safe and complied with the standard of care. He agrees that denying gender affirming care can have adverse physical and mental health effects. He understands that CHC's changes in care have caused distress to patients, families, doctors, and other medical providers. He feels the changes are in the best interest of the hospital and whole patient population.

112. The federal government is interfering with care in a way that is unprecedented during Dr. Brumbaugh's time in health care.

113. In 2024, CHC received $182.6 million in funding, mostly from the federal government. Some portion is related to research.

114. CHC provides thousands of patients care at a scope that exceeds any other hospital in the region for pediatric care. For example, CHC provides level one pediatric trauma care, the only such facility in the region. It provides organ and bone marrow transplants and cancer treatment.

115. Forty-seven percent of CHC's patients are Medicaid enrollees.

116. CHC does not employ doctors. The doctors have privileges so they can practice in their field at CHC.

117. CHC does not make decisions on prescriptions, doctors do. Doctors base their decisions on experience, expertise, the patient's history, the clinical exam, and the doctor's understanding of what is the best treatment available.

118. CHC does not tell doctors that they have to prescribe a drug or offer a refill on a drug.

119. The events of 2025 regarding gender affirming care, including the language of the President's first executive order, were distressing. The order targeted research funding. A federal court enjoined the federal government from blocking federal research funding. CHC decided to stop gender affirming care but then resumed.

120. A memorandum issued by the U.S. Attorney General suggested that the federal government would use every means possible to stop gender affirming care. The Department of Justice issued a broad subpoena to CHC, asking for massive amounts of protected information. CHC challenged the subpoena in federal court. CHC has not produced any records in response.

121. On December 18, 2025, HHS issued two proposed rules regarding the conditions of participation and Medicaid funding for gender affirming care. These are rules that hospitals have to follow to participate in the Center for Medicare and Medicaid Services' programs. All commercial insurance companies require that the hospital meet conditions of participation in order to be qualified for contracts and to bill for services.

122. CHC has joined with a coalition of children's hospitals to provide comments in opposition to the proposed rules to show the rules are contrary to the interests of children.

123. Dr. Brumbaugh and CHC were surprised by the Kennedy Declaration. Dr. Brumbaugh has never seen anything like it before. He disagrees with it. However, the Declaration informed CHC's decision-making on gender affirming care.

124. The Kennedy Declaration sets up the possibility of exclusion of CHC and providers' ability to participate in Medicaid funding, including the University of Colorado School of Medicine. Such an exclusion would be devastating to pediatrics in the region.

125. Dr. Brumbaugh is not aware of any court order invalidating the Kennedy Declaration. Dr. Brumbaugh believes that CHC is bound by the Kennedy Declaration.

126. The Kennedy Declaration defines "sex-rejecting procedures" to include puberty blockers, hormone therapy, and surgical intervention. It states, "the Secretary may exclude individuals or entities from participation in any Federal health care program if the Secretary determines the individual or entity has furnished or caused to be furnished items or services to patients of a quality which fails to meet professionally recognized standards of health care."

127. If excluded from federal health care programs such as Medicaid, CHC could not treat any patients enrolled in Medicaid—not just patients receiving gender affirming care.

128. Currently, one half of CHC's patients are on Medicaid. Exclusion from federal funding would greatly impact pediatric health care in Colorado. There is no other facility for pediatric Medicaid patients to receive certain care like heart and bone marrow transplants or neurosurgery.

129. CHC is required to attest to private commercial insurance companies that it is not excluded from federal payment programs in order for the insurance companies to pay for services at CHC. If CHC were excluded from federal payment programs, CHC could not serve patients who have commercial insurance.

130. Exclusion from federal payment programs would cause CHC to drastically reduce its overall scope of service because there would be no revenue to support the provision of services.

131. If CHC were excluded from federal payment programs, it would lose accreditation by the Colorado Department of Public Health and Environment ("CDPHE").

132. If CHC were excluded from federal payment programs, the University of Colorado School of Medicine faculty could not provide services at CHC.

133. The Kennedy Declaration states that individual doctors also face exclusion. If a doctor is excluded, the doctor cannot be credentialed and CHC cannot offer the doctor privileges. The School of Medicine could not employ the doctor. Exclusion for a doctor would be "career ending."

134. In response to the Kennedy Declaration, CHC assessed risk and took the immediate step to stop providing medical gender affirming care such as puberty blockers and hormone therapy. CHC advised the doctors by a meeting in late December. CHC advised patients on January 5, 2026.

135. A CHC doctor wrote a prescription for medical gender affirming care on December 19, 2025. Dr. Brumbaugh is concerned that additional prescriptions would cause a pattern of conduct that would be worse for CHC.

136. HHS General Counsel Mike Stuart posted on X on December 30, 2025 that it referred CHC to the OIG for investigation. CHC took this post to mean that there was a significant escalation in risk to CHC and made decisions in response.

137. While the Oregon lawsuit is pending, the OIG has agreed to suspend any notices of exclusion but the agreement does not state that any current writing of prescriptions would not be considered in future decisions. As Chief Medical Officer, Dr. Brumbaugh believes that CHC and providers are still at risk for exclusion despite this agreement.

138. On January 15, 2026, HHS General Counsel Mike Stuart posted on X that HHS reported six more hospitals to the OIG for investigation for providing gender affirming care. This post indicated to Dr. Brumbaugh that the federal government was not backing down.

139. Given recent actions of the federal government, Dr. Brumbaugh does not believe it is beyond the realm of possibility that the federal government would exclude CHC and/or individual providers from Medicaid participation.

140. CHC does not want to limit its scope of care to any patients, including those receiving gender affirming care.

141. CHC made the decision to stop medical gender affirming care to protect its ability to serve all pediatric patients.

142. To date, HHS has not excluded any hospital or providers for providing gender affirming care. Dr. Brumbaugh does not have knowledge of HHS shutting down a hospital by exclusion from federal payment programs.

143. If HHS only excluded doctors providing gender affirming care, it would shut down the TRUE Center but probably not the hospital as a whole. CHC could continue providing medical care to other patients.

144. Dr. Brumbaugh is not aware of any individual doctors who have been referred to the OIG for investigation.

145. Dr. Brumbaugh understands that if CHC is excluded from federal payment programs, the hospital has limited appeal rights.

III. APPLICABLE LAW

A. The Colorado Anti-Discrimination Act

Section 24-34-601(2)(a), C.R.S. provides that

> It is a discriminatory practice and unlawful for a person, directly or indirectly, to refuse, withhold from, or deny to an individual or a group, because of disability . . . sex . . . [or] gender identity . . . the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of a place of public accommodation . . . .

A "[p]lace of public accommodation" means "any place of business engaged in any sales to the public and any place offering services, facilities, privileges, advantages, or accommodations to the public, including but not limited to: . . . (VII) A dispensary, clinic, [or] ***hospital*** . . . ." § 24-34-600.3(1)(a), C.R.S. (emphasis added).

"Gender identity" means "an individual's innate sense of the individual's own gender, which may or may not correspond with the individual's sex assigned at birth." § 24-34-301(10), C.R.S. Further, "'[d]isability' has the same meaning as set forth in the federal 'Americans with Disabilities Act of 1990', 42 U.S.C. sec. 12101 et seq., and its related amendments and implementing regulations." *Id*. at -(7).

A person is disabled under CADA and the ADA if the person has a "physical or mental impairment that substantially limits one or more major life activities." *Id.*; 28 C.F.R. § 36.105(a)(1)(i).

Section 24-34-801(1)(c), C.R.S. provides that the policy of the State of Colorado is to assure that all individuals, regardless of impairment or disability, are entitled to full and equal access to places of public accommodation. Further, section 24-34-300.7(2), C.R.S. declares that Colorado has a long history of supporting freedom of choice for Coloradans, which includes the "choice to make decisions related to safely seeking health-care services, including legally protected health-care activities . . . that support mental, physical, and emotional well-being for Coloradans, their children, and their family members." Section 24-34-300.7(2) also makes clear that it is the public policy of the State of Colorado to ensure that these decisions can be made without unnecessary governmental interference. "Legally protected health-care activity" is defined to include seeking, providing, receiving, or referring for gender-affirming health-care services that are not unlawful in Colorado. §12-30-121(d), C.R.S.

To prevail on a discrimination claim under CADA, "plaintiffs must prove that, 'but for' their membership in an enumerated class, they would not have been denied the full privileges of a place of public accommodation." *Craig v. Masterpiece Cakeshop, Inc.*, 370 P.3d 272, 280 (Colo. App. 2015) (citing *Tesmer v. Colo. High Sch. Activities Ass'n*, 140 P.3d 249, 254 (Colo. App. 2006)), *rev'd on other grounds*, 584 U.S. 617 (2018). A plaintiff need not establish that membership in the enumerated class was the sole cause of the denial of services. *Id*. Rather, it is sufficient to show that the alleged discriminatory act "was based in whole or in part on their membership in the protected class." *Id*. A "but for" test "directs [courts] to change one thing at a time and see if the outcome changes." *Bostock v. Clayton Cnty., Georgia*, 590 U.S. 644, 645 (2020). If it does, the court has identified a "but for" cause. *Id*. CADA does not require a showing of animus. *Craig*, 370 P.3d at 282.

B. Exclusion from Participation in Federal Health Care Programs

Under the federal Social Security Act, the Secretary of HHS may exclude from participation in federal health care programs "[a]ny individual or entity that the Secretary determines . . . has furnished or caused to be furnished items or services to patients . . . of a quality which fails to meet professionally recognized standards of health care . . . ." 42 U.S.C. § 1320a-7(b)(6)(B). Further, the OIG may exclude an individual or entity that has rendered services to patients "of a quality that fails to meet professionally recognized standards of health care." 42 C.F.R. § 1001.701(a)(2).

HHS regulations define "[p]rofessionally recognized standards of health care" as "[s]tatewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a State." 42 C.F.R. § 1001.2. The regulatory definition further provides that, when HHS "has declared a treatment modality not to be safe and effective,

practitioners who employ such a treatment modality will be deemed not to meet professionally recognized standards of health care." *Id*.

An agency such as HHS is not permitted to ignore or violate the plain language of its own regulations while the regulations are in effect. *Nat'l Env't Dev. Ass'n's Clean Air Project v. E.P.A.*, 752 F.3d 999, 1011 (D.C. Cir. 2014).

If the OIG proposes to exclude an individual or entity, the OIG "will send written notice of its intent, the basis for the proposed exclusion and the potential effect of an exclusion." 42 C.F.R. § 1001.2001(a). Within 30 days, the individual or entity may submit evidence and written argument regarding whether exclusion is warranted, and request a hearing to present oral argument to an OIG official. *Id*. at -(b). If the OIG determines that exclusion is warranted, it will send written notice of its decision, which "will be effective 20 days from the date of the notice." 42 C.F.R. § 1001.2002(a)-(b).

An excluded individual or entity may request a hearing before an ALJ, who may affirm, alter, or reverse the imposition of the exclusion. *See* 42 C.F.R. § 1005.2(a); 42 C.F.R. § 1005.20(b). However, the ALJ lacks authority to enjoin any act of the HHS Secretary; review the OIG's exercise of discretion to exclude an individual or entity, or determine the scope or effect of exclusion; or reduce a period of exclusion to zero, if the ALJ finds that the excluded individual or entity committed an act described in section 1320a-7(b). *See* 42 C.F.R. § 1005.4(c)(4)-(6). A party may administratively appeal the ALJ's decision and then seek judicial review in a U.S. Court of Appeals. *See* 42 C.F.R. § 1005.21(a),(k).

An excluded individual or entity is excluded from Medicare, Medicaid, and any other federal health care programs. *See* 42 C.F.R. § 1001.1901(a). The excluded individual or entity will not receive payment from Medicare, Medicaid, or any other federal health care program for any services rendered. *Id*. at -(b)(1). If excluded, the exclusion "will be for a period of 3 years, unless aggravating or mitigating factors . . . form a basis for lengthening or shortening the period. In no case may the period be shorter than 1 year . . . ." *See* § 1001.701(d)(1); § 1320a-7(c)(3)(F) ("[T]he period of exclusion shall not be less than 1 year.").

C. Standards on Preliminary Injunction

Colo. R. Civ. P. 65 governs the issuance of preliminary injunctions. "A preliminary injunction is designed to preserve the status quo or protect rights pending the final determination of a cause." *City of Golden v. Simpson*, 83 P.3d 87, 96 (Colo. 2004); *see also Anderson v. Applewood Water Ass'n, Inc.*, 409 P.3d 611, 616 (Colo. App. 2016). A preliminary injunction is "an extraordinary remedy designed to protect a plaintiff from sustaining irreparable injury and to preserve the power of the district court to render a meaningful decision following a trial on the merits." *Rathke v. MacFarlane*, 648 P.2d 648, 651 (Colo. 1982); *see also Anderson*, 409 P.3d at 616 (holding the purpose of a preliminary injunction is "to prevent irreparable harm prior to a decision on the merits of a case."). Whether to grant or deny a preliminary injunction "lies within the sound discretion of the trial court." *Rathke*, 648 P.2d at 653. Injunctive relief should not be indiscriminately granted. *Id*. Rather, injunctive relief should be granted "sparingly and cautiously and with a full conviction on the part of the trial court of its urgent necessity." *Id.*

Rathke sets forth a six-part test for preliminary injunctions. The moving party must demonstrate each of the following:

1. Reasonable probability of success on the merits;
2. Danger of real, immediate, and irreparable injury which may be prevented by injunctive relief;
3. No plain, speedy, and adequate remedy at law;
4. The injunction will not disserve the public interest;
5. Balance of equities favors the injunction; and
6. Injunction will preserve the status quo pending trial on merits.

Id. at 653-54. If each criterion is not met, injunctive relief is not available. *Id*. at 654.

Pursuant to C.R.C.P. 65(d), every order granting an injunction shall be specific in its terms and describe in reasonable detail the acts sought to be restrained. Rule 65 is designed to provide fair notice to enjoined parties of precisely what conduct is prohibited, and to avoid finding parties in contempt based on orders that are too vague to be understood. *Schmidt v. Lessard*, 414 U.S. 473, 476 (1974). Accordingly, an injunction "must be sufficiently precise to enable the party subject to the injunction to conform his or her conduct to the injunction." *People v. Wunder*, 371 P.3d 785, 790 (Colo. App. 2016). An injunction that leaves important terms undefined may be impermissibly vague in violation of C.R.C.P. 65. *Id*.

An order granting an injunction "is binding only upon the parties to the action, their officers, agents, servants, employees, and attorneys, and upon those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise." C.R.C.P. 65(d).

1. Reasonable probability of success on the merits.

To determine whether a plaintiff has a reasonable probability of success on the merits, a trial court is "obliged to assess the proper legal standard and applicable burden of proof which would be required at a subsequent trial on the merits." *Rathke*, 648 P.2d at 655. The court must substantively evaluate the issues as it would during trial. *Dallman v. Ritter*, 225 P.3d 610, 621 (Colo. 2010). When assessing the likelihood of success on the merits, "the court should not treat this factor as one that is merely considered and balanced with the comparative injuries of the parties." *Home Shopping Club, Inc. v. Roberts Broad. Co. of Denver*, 961 P.2d 558, 561 (Colo. App. 1998). Rather, the moving party must demonstrate a reasonable probability of success on the merits as a prerequisite for injunctive relief. *Rathke*, 648 P.2d at 654.

2. Danger of real, immediate, and irreparable injury which may be prevented by injunctive relief.

Irreparable harm is generally defined as "certain and imminent harm for which a monetary award does not adequately compensate." *Gitlitz v. Bellock*, 171 P.3d 1274, 1279 (Colo. App. 2007) (citation omitted). An injury may be irreparable where "monetary damages are difficult to ascertain or where there exists no certain pecuniary standard for the measurement of the damages." *Id*. The

plaintiff must show that she is "likely to suffer irreparable harm" without injunctive relief. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

The irreparable harm inquiry focuses on future injury. *See Bd. of Cnty. Comm'rs of Pitkin Cnty. v. Pfeifer*, 546 P.2d 946, 949 (Colo. 1976). A court may grant injunctive relief as "a preventive and protective remedy, affording relief against *future*, rather than past, acts." *Anderson,* 409 P.3d at 616 (quoting *id*.) (emphasis original). However, an injunction cannot issue based on speculative harm to the plaintiff. *See Am. Invs. Life Ins. Co. v. Green Shield Plan, Inc.*, 358 P.2d 473, 475-76 (Colo. 1960).

Various U.S. District Courts have held that the denial of gender-affirming care for transgender individuals constitutes irreparable harm. *See e.g.*, *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021) (concluding that terminating access to puberty blocking hormones constitutes irreparable physical and psychological harm for transgender patients).

3. No plain, speedy, and adequate remedy at law.

A preliminary injunction is a form of equitable relief. *Rathke*, 648 P.2d at 651. A trial court will not grant an injunction if a plaintiff has a plain, speedy, and adequate remedy at law. *Home Shopping Club*, 961 P.2d at 562. Injunctive relief is only available if there is no legal remedy that provides "full, complete, and adequate relief." *Gitlitz*, 171 P.3d at 1279. An action for damages is a remedy at law. *See Boglino v. Giorgetta*, 78 P. 612, 614 (Colo. App. 1904).

Relevant to the question whether an adequate remedy at law exists "include whether damages can be proven with reasonable certainty . . . whether the harm alleged is continuing or will require plaintiff to resort to multiple litigation to effect the legal remedy, and the difficulty of obtaining, by the use of money, a suitable substitute for the promised performance." *Benson v. Nelson*, 725 P.2d 71, 72 (Colo. App. 1986).

4. The injunction will not disserve the public interest.

A court will only grant injunctive relief if the injunction will not disserve the public interest. *Rathke*, 648 P.2d at 654. When analyzing whether to enjoin a party from violating a state statute, a court may consider the "design of the statute" and its impact on the public interest. *See Kourlis v. Dist. Ct., El Paso Cnty.*, 930 P.2d 1329, 1336 (Colo. 1997). Violation of state law "imbued with great public importance" constitutes an "injury" to the public interest. *See Lloyd A. Fry Roofing Co. v. State Dep't of Health Air Pollution Variance Bd.*, 553 P.2d 800, 808 (Colo. 1976).

However, an injunction that "could create a greater risk to a greater number of individuals" may "adversely affect the public interest." *See Trinidad Area Health Ass'n v. Trinidad Ambulance Dist.*, 562 P.3d 928, 936 (Colo. App. 2024). In *Trinidad*, the Colorado Court of Appeals upheld the denial of a preliminary injunction where compelling an ambulance district to perform around-the-clock interfacility transfers would have inhibited the ambulance district's ability to promptly respond to 911 calls. *Id*. The court found that compelling the ambulance district to provide these services could create a greater risk to a greater number of individuals, which would adversely affect the public interest. *Id.*

5. Balance of equities favors the injunction.

The balance of equities favors injunctive relief if "the threatened injury to the plaintiff outweighs the threatened harm the preliminary injunction may inflict on the defendant." *Rathke*, 648 P.2d at 654. When weighing the balance of the equities, a court may consider "equitable considerations having to do with [the public] interest." *Kourlis*, 930 P.2d at 1337.

6. Injunction will preserve the status quo pending trial on merits.

The purpose of an injunction is to preserve the status quo. *Home Shopping Club*, 961 P.2d at 563. In cases involving newly enacted rules or regulations, the appropriate "status quo is the status quo ante, that is the status quo before the rule was enacted." *Sanger v. Dennis*, 148 P.3d 404, 419 (Colo. App. 2006) "The status quo is the last uncontested status between the parties which preceded the controversy." *Dominion Video Satellite, Inc. v. EchoStar Satellite Corp.,* 269 F.3d 1149, 1155 (10th Cir. 2001).

IV. ANALYSIS

A. Reasonable Probability of Success on the Merits.

Having considered the written record and the testimony and argument during the preliminary injunction hearing, the Court concludes that Plaintiffs have demonstrated a reasonable probability of success on the merits on both of their CADA claims. Relevant to both claims, pursuant to CADA's plain text, hospitals are places of public accommodation. CADA precludes CHC, a hospital, from discriminating against an individual or group because of sex, gender identity, or disability.

The central issues at trial will include (1) whether CHC denied Plaintiffs full and equal enjoyment of goods, services, facilities, privileges, advantages, or accommodations on the basis of sex, gender identity or disability; and (2) whether gender dysphoria is a disability under CADA.

The Court found compelling Ms. Boe's testimony that CHC refused to prescribe Bella Boe, a transgender girl who has been diagnosed with gender dysphoria, hormones or offer referrals to other providers. The TRUE Center told Danielle Doe at an appointment that it would not provide care (i.e., bloodwork and measurements) for to a fertility preservation procedure related to gender affirming care. According to Ms. Doe, CHC will not write Danielle another prescription for puberty blockers related to her gender identity. Non-party Jacob Joe was similarly denied care when the TRUE Center canceled his appointment to replace his puberty blocker implant.

There is no dispute that CHC ceased offering prescriptions for hormone therapy and puberty blockers to minor patients for the purpose of gender affirming care. CHC continues to offer hormone therapy and puberty blockers to cisgender youth for purposes not related to gender affirming care. Refusing to offer these treatments to transgender patients for the purpose of gender affirming care facially differentiates between transgender and cisgender patients.

Further, the Court found compelling the testimony of Dr. Karasic that gender dysphoria can cause a disability in that it can substantially limit life activities. Whether CHC has

discriminated against Plaintiffs on the basis of sex was not explored at the preliminary injunction hearing.

CHC argues that its decision to suspend medical gender affirming care was not discriminatory because it has a legitimate, non-discriminatory reason for doing so: it is complying with the Kennedy Declaration to avoid potential exclusion from federal health care programs. Regardless of CHC's stated reasons for ceasing care, the Court finds that if this case were to proceed to trial, Plaintiffs have demonstrated a probability that they will succeed on the merits of their claims under CADA because the testimony and evidence at the preliminary injunction hearing tended to demonstrate that CHC has ceased offering medical gender affirming care at least *in part* due to Plaintiffs' gender identity and/or disability.

B. Danger of Real, Immediate, and Irreparable Injury Which May Be Prevented by Injunctive Relief.

Plaintiffs have established that they face a danger of real, immediate, and irreparable injury.

Plaintiffs face a danger of irreparable injury from undergoing an unwanted puberty based on their sex at birth. The harm is not speculative; indeed, it is certain that when Plaintiffs cease taking puberty blockers, they will undergo puberty in accordance with biology. Plaintiffs are likely to experience irreversible physical changes to their bodies inconsistent with their gender identity that may require surgery to reverse. In addition, stopping hormone therapy may cause irreversible changes to the body. The Court credits the testimony of Dr. Reirden and Dr. Karasic that Plaintiffs are likely to experience immediate, irreversible physical and psychological harm from stopping gender affirming care.

The danger to Plaintiffs is also imminent. Plaintiffs are at imminent risk of psychological stress from stopping care, including an elevated risk of suicidal ideation. CHC's announcement that it will cease offering gender affirming care is already causing Plaintiffs ongoing distress. The evidence shows that Plaintiffs are likely to suffer further imminent psychological harm from the discontinuation of care. The Court finds that monetary damages are unlikely to adequately compensate Plaintiffs for such harm. It would be difficult to ascertain monetary damages for the injuries Plaintiffs face.

The evidence shows that Plaintiffs have limited options for alternate providers offering gender affirming care. Most pediatricians do not offer such care, and it is not easily provided via telehealth. Medicaid may also impose limitations on Plaintiffs' access to gender affirming care from other providers. However, gender affirming care may be available outside the reimbursement system and/or in other countries. The Court also heard testimony that other providers in the area may be able to provide care.

The Court recognizes the serious nature of the harm that Plaintiffs are likely to face if they are forced to stop gender affirming care. However, the Court notes that the requested injunction may not stop this harm from occurring. It is possible that an injunction could cause CHC or the TRUE Center to close, certain doctors to lose privileges, or CHC's and/or the providers' exclusion from Medicaid, which would result in the unavailability of medical gender affirming care from Defendant. Thus, Plaintiffs would suffer the very harm they seek to prevent. Regardless, the Court

finds that Plaintiffs have demonstrated that they face a danger of real, immediate, and irreparable injury from CHC's cessation of gender affirming care.

C. No Plain, Speedy, and Adequate Remedy at Law.

The Court finds there is no plain, speedy, and adequate remedy at law in this Court that would address Plaintiffs' ongoing and future harm. Litigation is likely to be protracted.

The Court notes, however, that the pending litigation in *Oregon v. Kennedy* may provide the Plaintiffs the remedy they seek: an invalidation of the Kennedy Declaration. That litigation is set for a hearing on summary judgment on March 19, 2026.

D. The Injunction Will Not Disserve the Public Interest.

Granting the requested injunctive relief would serve the public interest by protecting Plaintiffs and other vulnerable transgender and gender-diverse youth in the region. Protecting the Plaintiffs' access to medical care that is lawful in Colorado serves the public interest. However, if injunctive relief is granted and CHC or individual providers at the TRUE Center are excluded from participating in Medicaid, CHC could no longer offer gender affirming care, despite this Court's order. Therefore, granting injunctive relief may not protect the public's access to gender affirming care—and has a serious and substantial risk of ceasing the availability of all pediatric care from CHC.

The Court finds based on the evidence, written record, and argument at the preliminary injunction hearing that granting the requested injunctive relief would pose a grave danger to the public interest that is greater than the danger to Plaintiffs.

Outside of the TRUE Center, CHC provides specialized pediatric care to thousands of pediatric patients in the Rocky Mountain Region, regardless of gender identity. CHC offers a myriad of pediatric care including organ transplants, neurosurgery, and cancer treatment. A substantial percentage of CHC's patient population is on Medicaid and continuing to provide gender affirming care puts CHC at significant risk of exclusion. Exclusion of CHC would mean that in addition to not receiving Medicaid funds, it could not participate in commercial insurance. Further, exclusion could cause loss of accreditation by CDPHE. A hospital cannot operate without revenue or accreditation.

Further, even if CHC does not close but instead drastically reduces its services, the public across the Rocky Mountain Region would lose access to a wide range of pediatric care. This undoubtedly poses a grave danger to large populations of children and families. CHC provides critical services to underserved patients, including nearly half of its patient population enrolled in Medicaid (including some of Plaintiffs). CHC's exclusion could pose a particular risk to underserved and/or low-income patients in the state of Colorado.

Plaintiffs contend that CHC does not face an actual threat of enforcement and is unlikely to face exclusion. The Court does not this argument compelling for several reasons.

First, Plaintiffs contend that HHS' agreement to forgo issuing notices of intent to exclude or notices of exclusion mitigates the actual risk of exclusion. However, HHS has only agreed not to exclude CHC until the pending motions are resolved in *Oregon v. Kennedy*. Regardless of Plaintiffs' view of the merits of that case, it is not appropriate for the Court to speculate about how the U.S. District Court for the District of Oregon will resolve the pending motions. It is possible that HHS will prevail and the Kennedy Declaration will remain binding on CHC, in which case CHC will face a very real threat of exclusion.

Next, Plaintiffs argue that CHC has already violated the Kennedy Declaration by providing gender affirming care in the days after the issuance of the Declaration. Dr. Brumbaugh testified that he is concerned that additional prescriptions would cause a pattern of conduct that could increase the likelihood of exclusion. The Court agrees that continuing to provide gender affirming care could place CHC at a greater risk of exclusion.

Plaintiffs further contend that CHC could appeal its exclusion or obtain an injunction to prevent its exclusion. However, federal regulations provide limited post-exclusion remedies and it would be inappropriate for this Court to base its analysis on whether another court would grant CHC an injunction in a hypothetical future case.

Plaintiffs essentially ask the Court to call the bluff of the federal government and order CHC to take action in violation of federal law.[2] The Court cannot discount the very real possibility that the federal government will take enforcement action against CHC. The current administration has indicated that it will use every means possible to stop gender affirming care and has interfered with care in a way that is unprecedented. HHS has already suggested that CHC has been referred to the OIG for investigation, along with other hospitals.

Accordingly, the Court treats the threatened harm to CHC as a very real possibility. Given the potentially devastating public impact on pediatric care in the region, the Court finds that the requested injunction could create a greater risk to a greater number of individuals, which would adversely affect the public interest.

E. Balance of Equities Favors the Injunction.

For the same reasons the public interest is not served by granting the requested injunctive relief, the balance of equities disfavors an injunction.

F. Injunction will preserve the status quo pending trial on merits.

Plaintiffs have requested an order "prohibit[ing] [CHC] from refusing to provide medically necessary care to transgender patients." CHC argues that the requested injunctive relief is overly broad, impermissibly vague, and requests relief for which no manageable standards exist. Plaintiffs contend that courts routinely issue such injunctions.

[2] The Court recognizes the competing interests of state vs. federal law. While the Court does not condone a violation of any law, the Court is particularly concerned with affirmatively ordering a party to violate a law in the face of significant consequences. Indeed, the Court questions its authority to make such an order.

The Court agrees with CHC that the terms of the proposed injunction are not sufficiently specific. Because the proposed injunction does not define the term "medically necessary care," it does not specify what, if any, specific medical care must be provided or when CHC must provide such treatment. Consequently, because the proposed injunction does not describe in reasonable detail the acts sought to be restrained, it will not enable CHC to conform its conduct to the injunction. Further, the requested injunctive relief would bind CHC but the Court questions whether it would bind the medical providers at the TRUE Center, who are not employees of CHC. If individual doctors at the TRUE Center refuse to write prescriptions for gender affirming care, it is unclear whether the proposed injunction form a valid basis for holding those providers in contempt. Because the requested relief is not sufficiently specific, the Court finds that it is not clear whether an injunction would preserve the status quo pending trial on the merits.

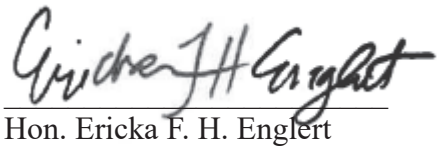
Because the Court has concluded that Plaintiffs have not demonstrated all the *Rathke* factors, the Court finds that it need not address arguments at this time regarding bonds, availability of a class-wide injunction prior to class certification, or the political question doctrine.

V. ORDER

For the foregoing reasons and authorities, Class Plaintiffs' Motion for Preliminary Injunction filed January 20, 2026 is DENIED.

SO ORDERED: February 13, 2026.

BY THE COURT:



Hon. Ericka F. H. Englert
District Court Judge