Note

States' Obligation to Provide for Trans Youth: How Medicaid Requires (Most) States to Provide Access to Puberty Blockers

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Over the last few years, many states have endeavored to strip minor access to gender-affirming healthcare, and these efforts have seen considerable success. By the end of 2023, twenty-two states had enacted legislation that limits youth access to gender-affirming healthcare. In line with these efforts, many states have created policies that exclude Medicaid coverage for gender-affirming puberty blockers—medications that delay the physical changes to one's body that occur with sexual maturity. These efforts contravene guidance from the medical community, which pronounces the importance of access to gender-affirming puberty blockers for transgender and gender-diverse youth, and often considers them medically necessary for those experiencing gender dysphoria.

With such strong support from the medical community, state actions that limit minor access to gender-affirming puberty blockers call into question state compliance with the obligations imposed by the Medicaid Act. More specifically, the required expansive youth benefit—the Early and Periodic Screening, Diagnostic, and Treatment program—requires the provision of comprehensive preventative, diagnostic, and treatment services to identify and treat health issues in children.

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This Note focuses on whether states can deny Medicaid coverage for gender-affirming puberty blockers under the Medicaid Act—an issue that has gone largely unexplored in the courts. In considering the research relating to gender dysphoria and puberty blockers, and after applying those findings to the requirements of the EPSDT program, this Note argues that, in most cases, states must provide Medicaid coverage for gender-affirming puberty blockers under the Medicaid Act.

INTRODUCTION

> "If we were to stop care, I would be afraid that our child wouldn't survive. . . . There's no question that she's not safe to herself."
>
> – Mother of a thirteen-year-old transgender girl[1]

Soon after the Texas governor issued a directive stating that providing gender-affirming care to minors can "legally constitute child abuse,"[2] the mother of a family of four from Galveston, Texas, discussed the fear she felt for her transgender child, who was currently receiving gender-affirming care.[3] This angst was so intense that she created a plan in the event that her daughter's treatment halted.[4] She developed relationships with gender-affirming care providers in not one, but two, other states, as she was concerned about such care later becoming unavailable even in those states.[5] She discussed where she and her family would move if they had to relocate, despite the fact that both she and her spouse worked in Texas, and had another child in high school there.[6] *That* is how fearful this mother was for her transgender child if gender-affirming care were no longer accessible to her. But this mother is not alone. Many families living in states where gender-affirming care is no longer legal for youth have had to flee their states to seek life-saving care, and this number may continue to rise.[7]

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1. The Political Scene Podcast, *The Attack on Gender-Affirming Medical Care*, NEW YORKER, at 07:19 (May 23, 2022), https://www.newyorker.com/podcast/politics-and-more/the-attack-on-gender-affirming-medicalcare [https://perma.cc/A3SZ-ELJY].

2. *See* Madeleine Carlisle, *'It's Creating a Witch Hunt.' How Texas Gov. Greg Abbott's Anti-Trans Directive Hurts LGBTQ Youth,* TIME (Feb. 24, 2022), https://time.com/6150964/greg-abbott-trans-kids-child-abuse [https://perma.cc/33TH-RXHW] (outlining Texas Governor Greg Abbott's letter to the Texas Department of Family and Protective Services, directing it to conduct "investigations into the families of trans and gender expansive youth who've received gender-affirming care, asserting that the care can 'legally constitute child abuse'" (quoting Letter from Greg Abbott, Governor, Texas, to Jaime Masters, Comm'r, Texas Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf [https://perma.cc/ZT3D-46CT])).

3. *See* The Political Scene Podcast, *supra* note 1.

4. *Id.* at 5:32.

5. *Id.* at 5:38.

6. *Id.* at 5:53.

7. *See* Sasha von Oldershausen, *"I Don't Want to Live in This State of Terror Anymore": Some Families with Trans Children Are Leaving Texas*, TEX. MONTHLY (July 24, 2023), https://www.texasmonthly.com/news-politics/trans

The past two years have shown a rapid increase in state hostility towards access to gender-affirming healthcare, with a particular eye for restrictions on such access for transgender or gender diverse (TGD) youth.[8] In the first six months of 2023, legislators had introduced 130 bills in that year alone to limit access to gender-affirming healthcare.[9] Many of these bills saw success,[10] indicating that such restrictions are gaining momentum. In 2022, only three states had passed laws limiting minor access to gender-affirming care.[11] By the end of 2023, an additional nineteen bills had been passed.[12]

-families-leaving-texas [https://perma.cc/DNZ6-3XZL] (describing several families with trans children in Texas who have had to leave or have considered leaving the state to continue medical care).

8. For definitions of "transgender" and "gender diverse," see text accompanying notes 25–26.

9. Annette Choi & Will Mullery, *19 States Have Laws Restricting Gender-Affirming Care, Some with the Possibility of a Felony Charge*, CNN (June 6, 2023), https://www.cnn.com/2023/06/06/politics/states-banned-medical-transitioning-for-transgender-youth-dg/index.html [https://perma.cc/VAQ5-X9CY].

10. *Id.* ("Of the 130 bills specifically targeting access to trans health care introduced this year, 18 have been enacted, according to the ACLU.").

11. In 2021, Arkansas became the first state to pass a ban on gender-affirming healthcare for minors. Elliott Davis Jr., *States That Have Restricted Gender-Affirming Care for Trans Youth*, U.S. NEWS & WORLD REP. (Jan. 5, 2024), https://www.usnews.com/news/best-states/articles/2023-03-30/what-is-gender-affirming-care-and-which-states-have-restricted-it-in-2023 [https://perma.cc/8MEC-QY74]. However, this law was permanently enjoined in June 2023. *Id.* Arkansas's lead was followed by Alabama and Arizona, each of which passed bans on gender-affirming healthcare for minors in 2022. *Alabama Ban on Gender-Affirming Care for Transgender Youth Takes Effect*, REUTERS (May 9, 2022), https://www.reuters.com/world/us/alabama-ban-gender-affirming-care-transgender-youth-takes-effect-2022-05-09 [https://perma.cc/LM73-BZ6K]; Devan Cole, *Arizona Governor Signs Bill Outlawing Gender-Affirming Care for Transgender Youth and Approves Anti-Trans Sports Ban*, CNN (Mar. 30, 2022), https://www.cnn.com/2022/03/30/politics/arizona-transgender-health-care-ban-sports-ban/index.html [https://perma.cc/ZE69-H29S].

12. *See* Christy Mallory & Elana Redfield, *The Impact of 2023 Legislation on Transgender Youth*, WILLIAMS INST. 4 (Oct. 2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Legislation-Summary-Oct-2023.pdf [https://perma.cc/B3EZ-LXU5]). Note, however, that not all of these bans are currently in effect, as many have been or are being challenged in the courts. *See* Davis, *supra* note 11 (noting that "a district court judge in Florida issued a preliminary injunction that temporarily blocked enforcement of some parts of the law on behalf of several young plaintiffs" and that a state judge in Montana issued a preliminary injunction that blocked enforcement of Montana's ban on gender-affirming care for minors).

Many of these newly enacted laws impose severe penalties for violations. For example, several threaten healthcare providers with a felony-level charge for providing gender-affirming care in contravention of the ban.[13] Some of these statutes even reach beyond healthcare providers. At least one law prohibits *anyone* from engaging in "conduct that aids or abets" minors in receiving access to this healthcare—even the child's parents.[14] Given these efforts, it is unsurprising that many states have created policies excluding Medicaid coverage for puberty blockers,[15] also known as pubertal suppressants, used to treat gender dysphoria. As of December 2022, seven states had policies expressly excluding Medicaid coverage of gender-affirming care.[16] Another eighteen states had unclear policies regarding coverage of gender-affirming care.[17] Additionally, multiple states have introduced legislation[18] seeking to prevent state Medicaid programs

13. Choi & Mullery, *supra* note 9.

14. *Id.*

15. See *infra* text accompanying note 40, for a definition of "puberty blockers."

16. Christy Mallory & Will Tentindo, *Medicaid Coverage for Gender-Affirming Care*, WILLIAMS INST. 4 (Dec. 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-Gender-Care-Dec-2022.pdf [https://perma.cc/LU88-Q7SR] (pointing to bans in Arizona, Florida, Missouri, Nebraska, South Carolina, Tennessee, and Texas).

17. *Id.* at 3–4 ("[I]t is unclear . . . either because the law is silent on coverage or because the state maintains a ban, but enforcement of the ban is unclear."). Note that this report refers to the coverage of gender-affirming care broadly and does not specifically refer to coverage for minors under EPSDT. Whether state coverage for minors under EPSDT varies from the general Medicaid policy of that state is often unclear. However, some states have openly stated they will not cover gender-affirming healthcare for minors. *See, e.g.*, Molly Minta et al., *Mississippi Medicaid: Gender-Affirming Care for Kids Is Not 'Safe and Effective,'* MISS. TODAY (Feb. 16, 2023), https://mississippitoday.org/2023/02/16/mississippi-medicaid-gender-affirming-care-for-kids-is-not-safe-and-effective [https://perma.cc/4W23-RPCW]; Jo Yurcaba, *Florida Becomes Eighth State to Restrict Transgender Care for Minors*, NBC NEWS (Mar. 16, 2023), https://www.nbcnews.com/nbc-out/out-politics-and-policy/florida-becomes-eighth-state-restrict-transgender-care-minors-rcna75337 [https://perma.cc/G27F-HYFT].

18. Typically, Medicaid spending is governed by policies promulgated by state agencies, not legislation. *See* Mallory & Tentindo, *supra* note 16, app. at 20–23 (comparing the policies, regulations, and statutes from all states who had issued policies on Medicaid coverage of gender-affirming care as of December 2022, with most states having done so through state agencies).

from covering gender-affirming care for minors.[19] Because more than forty-one million children nationwide[20] are eligible for Medicaid's children's benefit—the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT)—this has widespread implications for many of our nation's TGD youth.

This Note will analyze whether, under EPSDT, states are prohibited from refusing to provide Medicaid coverage for puberty blockers used to treat gender dysphoria in adolescents.[21] Parts I and II present background information pertaining to the analysis in Part III. Part I describes gender dysphoria and the use of puberty blockers to treat the condition in adolescents. Part II provides a brief background of the EPSDT program, diving into its legislative history and gradual development of the program. Part III draws on relevant case law and administrative guidance to determine how a federal court should apply the EPSDT coverage requirements to gender-affirming puberty blockers. Specifically, Part III provides a detailed analysis of the principal EPSDT requirements as applied to puberty blockers. These EPSDT requirements include whether gender dysphoria is a treatable condition under EPSDT, whether puberty blockers qualify as a Medicaid service, and whether puberty blockers are "medically necessary"[22] to "correct or ameliorate"[23] gender dysphoria.

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19. *E.g.*, Brooke Migdon, *Here Are the States Planning to Restrict Gender-Affirming Care Next Year*, HILL (Dec. 29, 2022), https://thehill.com/changing-america/respect/diversity-inclusion/3789757-here-are-the-states-planning-to-restrict-gender-affirming-care-next-year [https://perma.cc/S32J-6T8F] (noting that proposals in Oklahoma and Virginia seek to bar Medicaid programs from covering gender-affirming care for minors).

20. This statistic is from 2019. *Improving Childhood Health: The Unrealized Potential of Medicaid's EPSDT Program*, THE NETWORK FOR PUB. HEALTH L. (Sept. 8, 2021), https://www.networkforphl.org/news-insights/improving-childhood-health-the-unrealized-potential-of-medicaids-epsdt-program [https://perma.cc/3XET-M7HX].

21. Though section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination, this Note does not address anti-discrimination arguments. 42 U.S.C. § 18116. Nor does this Note address Equal Protection arguments under the Fourteenth Amendment. U.S. CONST. amend. XIV, § 1. Instead, this Note focuses on the types of medical care and services required under the terms of the EPSDT program itself.

22. 42 C.F.R. § 440.230(d) (2024).

23. 42 U.S.C. § 1396d(r)(5).

I. PUBERTY BLOCKERS AS RECOMMENDED TREATMENT FOR GENDER DYSPHORIA IN ADOLESCENTS

As a preliminary matter, it is important to define the terms used throughout this Note. The term "cisgender" refers to "a person whose gender identity aligns in a traditional sense with the sex assigned to them at birth."[24] "Transgender" is "[a]n umbrella term encompassing those whose gender identities or gender roles differ from those typically associated with the sex they were assigned at birth."[25] "Gender [d]iversity" is "the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex."[26] "Gender dysphoria" is "psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity."[27] While some TGD individuals experience gender dysphoria, not all do.[28]

In 2021, an estimated 42,000 children and teens were newly diagnosed with gender dysphoria in the United States.[29] Gender dysphoria is a recognized mental disorder in DSM-5-TR,[30] which

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24. *What Is Gender Dysphoria?*, AM. PSYCHIATRIC ASS'N (Aug. 2022), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria [https://perma.cc/9RQQ-7RQK].

25. *A Glossary: Defining Transgender Terms*, AM. PSYCH. ASS'N (Sept. 2018), https://www.apa.org/monitor/2018/09/ce-corner-glossary [https://perma.cc/THT2-64CG].

26. *Key Terms and Concepts in Understanding Gender Diversity and Sexual Orientation Among Students*, AM. PSYCH. ASS'N 20 (2015), https://www.apa.org/pi/lgbt/programs/safe-supportive/lgbt/key-terms.pdf [https://perma.cc/3UYX-QB9F].

27. *What Is Gender Dysphoria?*, *supra* note 24.

28. *See* Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS e201822162 (2018), https://doi.org/10.1542/peds.2018-2162; *What Is Gender Dysphoria?*, *supra* note 24.

29. Robin Respaut & Chad Terhune, *Putting Numbers on the Rise in Children Seeking Gender Care*, REUTERS (Oct. 6, 2022), https://www.reuters.com/investigates/special-report/usa-transyouth-data [https://perma.cc/265D-H3KR].

30. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) is the authoritative guide for the classification of mental disorders used by mental health professionals throughout the United States. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/dsm [https://perma.cc/ZFN6-3Z9C]. It "features the most current text updates based on scientific literature with contributions from more than 200 subject matter experts." *Id.*

defines the condition as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender."[31] Gender dysphoria is "associated with clinically significant distress or impairment in social, school, or other important areas of functioning," and "often interferes with daily activities."[32]

TGD youth are at a significantly greater risk of experiencing negative mental health outcomes than their cisgender peers.[33] This includes increased incidence of anxiety, depression, suicidal ideation, and suicide attempts.[34] One study showed that "transgender[35] youth had a twofold to threefold increased risk of depression, anxiety disorder, suicidal ideation, suicide attempt, self-harm without lethal intent, and both inpatient and outpatient mental health treatment" as compared with cisgender matched controls.[36] The study found that 31.1% of transgender youth reported previous suicidal ideation and 17.2% a previous suicidal attempt, whereas only 11.1% of matched cisgender youth reported suicidal ideation and 6.1% reported a previous suicidal attempt.[37] TGD youth also struggle more with eating disorders as compared with their cisgender peers. One study found that transgender youth were almost three times as likely to restrict their eating, and almost nine times as likely to use

31. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 511 (5th ed., text rev. 2022) [hereinafter DSM-5-TR].

32. *Id.* at 512, 519.

33. Diana M. Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA NETWORK OPEN e220978 (2022), https://doi.org/10.1001/jamanetworkopen.2022.0978.

34. *Id.*

35. While this Note acknowledges that TGD individuals experience gender dysphoria, most studies only refer to "transgender" adolescents. The failure to differentiate between transgender and gender diverse individuals likely reflects different terminology use rather than the purposeful exclusion of gender diverse individuals. It is possible that the individuals this Note refers to as "gender diverse" were actually included in these studies despite not being acknowledged as TGD. Regardless, the documented experiences of transgender individuals can shed light on the experiences of TGD individuals generally.

36. Sari L. Reisner et al., *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, 56 J. ADOLESCENT HEALTH 274, 274 (2015).

37. *Id.* at 277.

diet pills to control their weight.[38] Ultimately, gender dysphoria is a significant contributor to these negative mental health outcomes as it leads to "negative self-concept, increased rates of depression, suicidality, and other mental disorder co-occurrence."[39]

Puberty blockers have been shown to improve mental health outcomes in TGD minors. Puberty blockers are medications that delay the physical changes to one's body that occur with sexual maturity.[40] The effects of puberty blockers are reversible, meaning that if one chooses to take the medication, once they stop, their body will resume the pubertal process of their sex assigned at birth.[41] In contrast, once one goes through puberty, such development is irreversible.[42] The onset of pubertal development has been associated with greater feelings of anxiety and suicidal

38. Rachel Harvey, *Eating Disorders Do Not Discriminate: Trans Teens Face Greater Risk*, PENN MED. NEWS: NEWS BLOG (Mar. 28, 2019) (citing Carly E. Guss et al., *Disordered Weight Management Behaviors, Nonprescription Steroid Use, and Weight Perception in Transgender Youth*, 60 J. ADOLESCENT HEALTH 17 (2017)), https://www.pennmedicine.org/news/news-blog/2019/march/eating-disorders-do-not-discriminate-trans-teens-face-greater-risk [https://perma.cc/G6AB-BKB7].

39. DSM-5-TR, *supra* note 31, at 519; *see also* Rafferty et al., *supra* note 28 (collecting studies showing the impact of gender dysphoria on mental health); Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 643 (2022) ("Feelings of gender dysphoria associated with incongruence between one's physical traits and gender identity are also associated with mental health challenges for transgender and nonbinary youth.").

40. *Health Care for Transgender and Nonbinary Teens: Frequently Asked Questions*, THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (June 2022), https://www.acog.org/womens-health/faqs/health-care-for-transgender-and-nonbinary-teens [https://perma.cc/Y6WJ-8RHS] (explaining how puberty blockers work to delay the physical changes that typically come with puberty).

41. Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3880 (2017) (describing the suppression of puberty as "fully reversible" if the individual decides to cease treatment); *see also* Hedi Claahsen-van der Grinten et al., *Gender Incongruence and Gender Dysphoria in Childhood and Adolescence—Current Insights in Diagnostics, Management, and Follow-Up*, 180 EUR. J. PEDIATRICS 1349, 1352 (2021) (noting that there is "longstanding experience" with use of puberty blockers in young children diagnosed with beginning puberty too early).

42. Hembree et al., *supra* note 41, at 3881.

thoughts among TGD individuals.[43] Puberty blockers are often used to alleviate the increased pressure of gender dysphoria associated with sexual maturation in order to allow the minor time to explore their gender identity.[44] One recent study found "a significant inverse association between treatment with pubertal suppression during adolescence and lifetime suicidal ideation among transgender adults who ever wanted this treatment," which suggests that puberty blocker treatment for transgender adolescents is associated with positive mental health outcomes.[45] Another report found that the use of puberty blockers in adolescents was associated with better psychological functioning, higher quality of life, better social life, and decreased suicidality in adulthood.[46]

In light of the prevalence of negative mental health outcomes for transgender individuals, such positive showings demand considerable weight. These studies, and others,[47] provide support for national and international guidelines that recommend treating eligible transgender adolescents with puberty blockers.[48] Among such organizations, both the Endocrine

43. *See* Claahsen-van der Grinten et al., *supra* note 41, at 1352 ("The development of their biological secondary sex characteristics is generally a highly distressful experience for adolescents with [gender incongruence/gender dysphoria] that may lead to serious complaints of psychological functioning and behavior.").

44. Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 PEDIATRICS e20191725 (2020), https://doi.org/10.1542/peds.2019-1725 ("Pubertal suppression allows these adolescents more time to decide if they wish to either induce exogenous gender-congruent puberty or allow endogenous puberty to progress.").

45. *Id.*

46. E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH (SUPP. 1) S1, S126 (2022) (citing Lynn Rew et al., *Review: Puberty Blockers for Transgender and Gender Diverse Youth—A Critical Review of the Literature*, 26 CHILD & ADOLESCENT MENTAL HEALTH 3 (2021)).

47. *See, e.g.*, Meredithe McNamara et al., *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* 18 (July 8, 2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20final%20july%208%202022%20accessible_443048_284_55174_v3.pdf [https://perma.cc/GB3U-3BRC] ("[A]t least 16 studies show that puberty blockers and hormones benefit patients with gender dysphoria . . . .").

48. *See, e.g.*, Jeannie Oliphant et al., *Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa, New Zealand*, 131 N.Z. MED. J. 86, 94–95 (2018) (providing

Society and the World Professional Association for Transgender Health (WPATH) recommend treating eligible transgender adolescents who have begun puberty, specifically no earlier than Tanner stage 2,[49] with puberty blockers.[50] In particular, WPATH has deemed puberty blockers a "medically necessary" treatment in some cases.[51] Such recommendations are supported by many other professional medical associations, including the American Psychiatric Association[52] and the American Academy of Child

general recommendations to support TGD people in Aotearoa, New Zealand, based on previously proposed international standards of care); Michelle M. Telfer et al., *Australian Standards of Care and Treatment Guidelines for Transgender and Gender Diverse Children and Adolescents*, 209 MED. J. AUSTL. 132, 133–35 (2018) (recommending general principles for supporting TGD children and adolescents as well as separate principles for each age group).

49. Tanner staging is a sexual maturity rating. Caroline Salas-Humara et al., *Gender Affirming Medical Care of Transgender Youth*, CURRENT PROBS. PEDIATRIC & ADOLESCENT HEALTH CARE, Sept. 2019, at 1, 8. Tanner stage 2 is the stage at which puberty commences. *Id.* at 2. The first sign of puberty in individuals assigned female at birth is breast development, typically occurring between eight and thirteen years of age. *Id*. For those assigned male at birth, the first sign of puberty is testicular enlargement, usually occurring between nine and fourteen years of age. *Id*.

50. Hembree et al., *supra* note 41, at 3870 (articulating the Endocrine Society's recommendation to treat gender dysphoria with pubertal suppressants); Coleman et al., *supra* note 46, at S110 (reaffirming WPATH's recommendation to use pubertal suppressants). Note, however, that both WPATH and the Endocrine Society have a series of criteria the adolescent must fulfill before pubertal suppressants are recommended. *See* Lieke Josephina Jeanne Johanna Vrouenraets et al., *Medical Decision-Making Competence Regarding Puberty Suppression: Perceptions of Transgender Adolescents, Their Parents and Clinicians*, 32 EUR. CHILD & ADOLESCENT PSYCHIATRY 2343, 2358 (2023) (listing the four criteria as "understanding, appreciating, reasoning, and communicating a choice"). They are not recommended for all TGD adolescents and are not recommended prior to puberty. *Id.* at 2357–58 (assessing the relevance of a particular individual's medical decision-making competence on the choice to start pubertal suppression).

51. Coleman et al., *supra* note 46, at S110 ("In eligible youth . . . who have reached the early stages of puberty, the focus is usually to delay further pubertal progression with [puberty blockers] until an appropriate time when [gender-affirming hormone therapy] can be introduced. In these cases, pubertal suppression is considered medically necessary.").

52. *Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth*, AM. PSYCHIATRIC ASS'N 2 (July 2020), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf [https://perma.cc/X57S-TGX4] (expressing support for "access to affirming and supportive treatment for trans and gender diverse youth and their families, including . . . puberty suppression").

and Adolescent Psychiatry.[53] In short, "[e]very major medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people."[54]

II. EPSDT BACKGROUND AND LEGISLATIVE HISTORY

With such widespread support within the medical community, gender-affirming puberty blockers seem to promote the Early and Periodic Screening, Diagnostic, and Treatment program's sweeping preventative purpose. This Part offers an overview of the EPSDT framework and legislative history, providing an informative lens through which to view application of the program's requirements. This is particularly useful given that courts frequently draw upon the broad purpose of EPSDT to provide preventative treatment in deciding cases regarding state coverage of certain treatments.[55]

EPSDT is a required Medicaid benefit,[56] which means that every state that has opted to participate in the Medicaid

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53. *AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY (Nov. 8, 2019), https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx [https://perma.cc/N52C-8FFQ] (expressing support for "the use of current evidence-based clinical care with minors" including "hormone blocking agents").

54. Brandt v. Rutledge, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021) (footnote omitted), *aff'd sub nom.* Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022).

55. *See, e.g.*, Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980) (finding a state policy that categorically excluded gender-affirming surgery from Medicaid coverage to be "not consistent with the objectives of the Medicaid statute"); Ekloff v. Rodgers, 443 F. Supp. 2d 1173, 1180–81 (D. Ariz. 2006) (looking to "the legislative history of Medicaid in general and the EPSDT program in particular" to hold that minors were entitle to preventative incontinent briefs under Arizona's Medicaid program); S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 589–90 (5th Cir. 2004) ("Thus, the text of the statute and its legislative history demonstrate that states participating in the Medicaid program must provide all of the health care and services permitted under § 1396d(a) when necessary to correct or ameliorate a defect or condition discovered by screening."); Q.H. v. Sunshine State Health Plan, Inc., 307 So. 3d 1, 11 (Fla. Dist. Ct. App. 2020) (explaining the broad meaning of "medical necessity" as evidenced by the EPSDT's legislative history).

56. 42 C.F.R. § 441.55 (2024). *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., EPSDT - A GUIDE FOR STATES: COVERAGE IN THE MEDICAID

program—as currently all states have done[57]—must provide EPSDT coverage to eligible minors under age twenty-one.[58] EPSDT is intended to be much broader than adult Medicaid benefits. It was enacted to provide comprehensive preventative, diagnostic, and treatment services in order to identify and treat health issues in children early on.[59] Unlike other Medicaid benefits, EPSDT is comprehensive and, rather than a mere payment plan, it requires states to actively ensure minors actually receive healthcare.[60] As stated by the United States Department of Health and Human Services: "States have an affirmative obligation to make sure that Medicaid-eligible children and their families are aware of EPSDT and have access to required screenings and necessary treatment services."[61]

The intended breadth of EPSDT is made clear by its legislative history. EPSDT is intended to be "the nation's largest preventive health program for children"[62] and to offer "unparalleled" benefits.[63] The United States Department of Health, Education, and Welfare noted that, by enacting the 1967 amendment,

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BENEFIT FOR CHILDREN AND ADOLESCENTS (June 1, 2014) [hereinafter EPSDT - A GUIDE FOR STATES], https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_210.pdf [https://perma.cc/K46H-KPR7] (describing the shared responsibility of states and the Centers for Medicare & Medicaid Services to implement EPSDT).

57. James F. Blumstein, NFIB v. Sebelius *and Enforceable Limits on Federal Leveraging: The Contract Paradigm, the Clear Notice Rule, and the Coercion Principle*, 6 J. HEALTH & LIFE SCIS. L. 123, 127 (2013).

58. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 1.

59. *Id.*

60. *See* Jane Perkins & Sarah Somers, *Medicaid's Gold Standard Coverage for Children and Youth: Past, Present, and Future*, 30 ANNALS HEALTH L. & LIFE SCIS. 153, 160, 164 (2021) (quoting Brief of Amici-Curiae National Health Law Program et al. in Support of Plaintiffs-Appellees at 10, Rosie D. *ex rel.* John D. v. Baker, 958 F.3d 51 (1st Cir. 2020) (No. 19-1262)) ("[EPSDT] marked a clear departure from Medicaid's role as a mere 'vendor payment' program that paid providers upon submission of a claim."); EPSDT - A GUIDE FOR STATES, *supra* note 56, at 5 (citing CTRS. FOR MEDICARE & MEDICAID SERVS., 45 THE STATE MEDICAID MANUAL § 5124.B [hereinafter STATE MEDICAID MANUAL]) ("The affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults.").

61. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 1.

62. H.R. REP. NO. 101-247, at 398 (1989).

63. Health Care Coverage for Children: Hearing Before the S. Comm. On Fin., 101st Cong. 24 (1989) (statement of Kay Johnson, Director, Health Division of the Children's Defense Fund) [hereinafter Johnson Statement].

> Congress intended to require States to take aggressive steps to screen, diagnose and treat children with health problems. . . . Senate and House Committee reports emphasized the need . . . to make services available so that young people can receive medical care before health problems become chronic and irreversible damage occurs.[64]

Since its 1967 inception, the EPSDT program has been repeatedly strengthened and expanded. In 1972 and 1981, Congress added provisions requiring that states take a more active role in ensuring the accessibility of EPSDT services.[65] These requirements include providing outreach to families of those eligible for EPSDT, such as information regarding the availability of EPSDT services and the benefits of preventative care.[66] Additionally, Congress required that states assist with transportation and appointment scheduling when needed.[67] In 1989, Congress felt that EPSDT outcomes were still lacking because many states withheld coverage for some of the benefits allowable under federal law.[68] Congress thus withdrew the states' authorities to determine the scope of EPSDT services, instead defining them by statute.[69] In passing the Omnibus Reconciliation Act of 1989, Congress created the mandate that states cover all mandatory and optional Medicaid services under EPSDT.[70]

The legislative history demonstrates that EPSDT is intended to be a largely preventative program, identifying and diagnosing childhood illnesses at the earliest opportunity, before

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64. U.S. DEP'T OF HEALTH, EDUC., & WELFARE, MEDICAL ASSISTANCE MANUAL § 5-70-20(A) (1972).

65. *See* Christie Provost Peters, *Issue Brief No. 819: EPSDT: Medicaid's Critical But Controversial Benefits Program for Children*, NAT'L HEALTH POL'Y F., Nov. 20, 2006, at 4–7 (discussing the history of EPSDT).

66. *Id.* at 8.

67. *Id.*

68. *See* 135 CONG. REC. 24444 (1989) ("The EPSDT benefit package has never been described in detail in the statute. There have arisen questions regarding the content of the program, as well as which providers are qualified to furnish the EPSDT screening and treatment. Additionally, while states have always had the option to do so, many still do not provide to children participating in EPSDT all care and services allowable under federal law, even if not otherwise included in the state's plan.").

69. Perkins & Somers, *supra* note 60, at 162 ("The 1989 amendments clarified that states must provide services necessary to 'correct or ameliorate' health conditions." (citing 42 U.S.C. § 1396d(r)(5))); *see also* Johnson Statement, *supra* note 63, at 199 ("[EPSDT] and the protections it provides are too important to be left to the rulemaking process alone.").

70. Perkins & Somers, *supra* note 60, at 162 (citing Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262).

they have a chance to progress. With this background, this Note proceeds to analyze whether a federal court should find that excluding coverage of puberty blockers to treat gender dysphoria is a violation of the statutory mandate of EPSDT.

III. MOST STATES CANNOT EXCLUDE PUBERTY BLOCKER COVERAGE UNDER EPSDT

Many states have policies that either do not address EPSDT coverage of gender-affirming puberty blockers or explicitly exclude the treatment from coverage.[71] Whether this is found to be a violation of federally mandated EPSDT requirements will depend on the interpretation of the most salient Medicaid requirements: namely, whether gender dysphoria is a treatable condition under EPSDT, whether puberty blockers qualify as a medical service, and whether puberty blockers are "medically necessary"[72] to "correct or ameliorate"[73] gender dysphoria. The first of these questions will be analyzed in Section A. The second issue—whether puberty blockers qualify as a Medicaid service—is important because EPSDT requires states to cover only those services that fall within the ambit of the Medicaid Act. This will be discussed in Section B. Whether pubertal suppressants "correct or ameliorate" gender dysphoria is addressed in Section C. And finally, the most complex issue—whether puberty blockers are "medically necessary"—is discussed in Section D.

At the outset, it is important to note the background of case law that can be drawn upon in analyzing the relevant EPSDT provisions. In 2023, in *Dekker v. Weida*,[74] a federal district court, for the first time ever, addressed whether the terms of the EPSDT statute would require a state to provide minors experiencing gender dysphoria access to puberty blockers. Specifically, the court had the opportunity to discuss whether Florida's administrative rule and statute that prohibited Medicaid payment for gender-affirming puberty blockers complied with the terms of the Medicaid Act.[75] As of this writing, this is the only instance in which a federal court has squarely addressed the issue, and

71. *See supra* notes 16–17 and accompanying text.

72. 42 C.F.R. § 440.230(d) (2024).

73. 42 U.S.C. § 1396d(r)(5).

74. Dekker v. Weida, 4:22cv325-RH-MAF, 2023 WL 4102243, at *4 (N.D. Fla. June 21, 2023).

75. *Id.* at *20.

the court found that EPSDT required the state to cover gender-affirming pubertal suppressants.[76] However, the court's analysis, though enlightening, was limited. This Note provides a significantly more detailed analysis of the EPSDT provisions than the *Dekker* opinion does. Thus, *Dekker* is considered where relevant, but is not discussed in every Section of this discussion, as *Dekker* does not reach many parts of the analysis.

Aside from *Dekker*, the novelty of these state coverage exclusions for gender-affirming puberty blockers has resulted in a dearth of available case law upon which to analogize the present issue. No analogous instance has been identified in which states have, under EPSDT, issued a blanket coverage exclusion of a treatment with widespread support from the medical community.[77] Further, because many EPSDT beneficiaries are, by definition, economically disadvantaged,[78] many EPSDT recipients and their families may not have the resources to bring a lawsuit for denial of benefits. Thus, there are a limited number of cases upon which to draw to analyze how courts have applied EPSDT requirements. It is against this background that this Note applies the available case law to EPSDT statutory and regulatory requirements to best understand how they apply to gender-affirming puberty blockers.

A. GENDER DYSPHORIA IS A TREATABLE CONDITION UNDER EPSDT

EPSDT mandates that states provide coverage for a wide variety of healthcare services to diagnose and treat both physical

76. *Id.*

77. *See supra* notes 47–54 and accompanying text (discussing medical community support of gender-affirming care treatments, including puberty blockers).

78. Medicaid is a health insurance program designed to provide access to healthcare for those with limited financial resources. 42 U.S.C. § 1396-1 ("For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . ."). States are required to provide all children with Medicaid coverage who are eighteen years old or younger, and whose families earn at or less than 133% of the federal poverty line. 42 C.F.R. § 435.118(b)–(c) (2024); *see also* Yael Cannon, *The Kids Are Not Alright: Leveraging Existing Health Law to Attack the Opioid Crisis Upstream*, 71 FLA. L. REV. 765, 794 (2019) (discussing Medicaid coverage for children).

and mental health conditions.[79] This includes periodic screening services which must include a comprehensive health and developmental history that assesses physical health, mental health, and development.[80] These screening services must be provided at intervals "which meet reasonable standards of medical . . . practice" or, when needed, at more frequent intervals.[81] If a physical or mental illness is discovered by the screening services, the state is *required* to provide "[s]uch other necessary health care, diagnostic services, treatment, and other measures [listed under the Medicaid Act] to correct or ameliorate defects and physical and mental illnesses and conditions."[82]

Gender dysphoria is a listed mental disorder in DSM-5-TR, the authoritative guide for the diagnosis of mental disorders used by healthcare providers in the United States and throughout much of the rest of the world.[83] Therefore, under the plain language of the statute, screening, diagnosis, and treatment for gender dysphoria falls within the scope of EPSDT coverage because gender dysphoria is a well-recognized mental disorder that would be discovered by regular mental health screening services.[84]

B. WITH ONE EXCEPTION, PUBERTY BLOCKERS FALL UNDER MEDICAID SERVICES

Having concluded that gender dysphoria treatment falls within the scope of EPSDT, it must then be determined whether states are required to cover gender-affirming puberty blockers

79. *See infra* notes 85–89 and accompanying text (describing categories of services covered under the Medicaid Act and EPSDT).

80. 42 U.S.C. § 1396d(r)(1)(B)(i).

81. *Id.* § 1396d(r)(1)(A)(i).

82. *Id.* § 1396d(r)(5).

83. *Frequently Asked Questions*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/dsm/frequently-asked-questions [https://perma.cc/Z2XE-BYCL]; *see supra* notes 30–32 and accompanying text (stating the definition and criteria for gender dysphoria as written in the DSM-5-TR).

84. *See supra* text accompanying note 82 (stating the plain language of the Medicaid Act). For treatment to be covered by EPSDT, "the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services." STATE MEDICAID MANUAL, *supra* note 60, § 5122(F). Because providers are required to screen for mental illnesses, treatment would be required for gender dysphoria. *See id.* § 5122A ("Screening services include . . . assessment of both physical and mental health development . . . .").

specifically. The first step in this analysis is determining whether gender-affirming puberty blockers for adolescents are included in the Medicaid Act's list of medical services.

The Medicaid Act lists thirty-one broad categories of medical services under § 1396d(a) for which states may provide Medicaid coverage.[85] The Act does not list specific services, but rather, general classes of services.[86] With the exception of a few compulsory services, states are not required to cover all services listed in the Medicaid Act for adult beneficiaries twenty-one-years-old or above, but instead may generally exercise discretion in deciding which services to include within their state's coverage.[87] However, EPSDT removes the state's discretionary power to withhold coverage for children's services. EPSDT requires states to provide services to treat children's physical or mental illnesses and conditions "whether or not such services are covered under the State plan."[88] This means that states are required to provide minors with mental health services that may be unavailable to adults under the state's Medicaid plan. Therefore, if pubertal suppressants are included in any of the Medicaid services under § 1396d(a) and are found to meet the remaining EPSDT requirements—that they are "medically necessary" to "correct or ameliorate" gender dysphoria—states cannot deny coverage.[89]

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85. 42 U.S.C. § 1396d(a)(1)–(31).

86. *See id.* For example, among the classes of services are "physicians' services furnished by a physician," "medical care, or any other type of remedial care recognized under State law," and "clinic services furnished by or under the direction of a physician." *Id.* § 1396d(a)(5)(A), (6), (9). Note that these classes of services contain additional limitations. *E.g.*, *id.* § 1396d(a)(5)(A) (stating that "physicians' services furnished by a physician" are covered, but the physician providing the services must meet the definition of the term "physician" in section § 1395x(r)(1)).

87. Medicaid mandates that states provide coverage for certain benefits, but provides states discretion to offer several optional benefits as well. *Mandatory & Optional Medicaid Benefits,* MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html [https://perma.cc/L8AW-QAE4] (listing optional benefits such as prosthetics and eyeglasses).

88. 42 U.S.C. § 1396d(r)(5).

89. *See* Moore *ex rel.* Moore v. Reese, 637 F.3d 1220, 1233 (11th Cir. 2011) ("[A] state's mandatory EPSDT obligations to Medicaid-eligible children under § 1396d(r)(5) include 'health care, diagnostic services, treatment, and other measures' that are (1) outlined in § 1396d(a) and (2) 'necessary . . . to correct or ameliorate . . . conditions discovered by the screening services,' (3) regardless of whether a state plan provides such services to adults." (alteration in original) (citing 42 U.S.C. § 1396d(r)(5), (a))).

For puberty blockers to fall under the Medicaid Act's list of medical services, they must meet two statutory requirements. First, because puberty blockers are a drug, the medicine itself must be either approved by the Food and Drug Administration (FDA) or listed in one of three statutorily defined compendia for its proposed off-label use.[90] This first requirement is met. While no puberty blocker has received FDA approval for pediatric treatment of gender dysphoria,[91] at least one type of puberty blocker is listed in Drugdex, one of the three specified compendia.[92] Second, since most pubertal suppressants must be prescribed and administered by a physician, usually as an implantation under the skin or as a periodic injection, the outpatient

90. Abbi Coursolle, *More Transparency Needed to Ensure Medicaid Beneficiaries Have Access to Necessary Off-Label Prescription Drugs*, NAT'L HEALTH L. PROGRAM 3 (Apr. 7, 2022) (first citing 42 U.S.C § 1396r–8(k)(2); and then citing *id.* § 1396r–8(k)(6)), https://healthlaw.org/wp-content/uploads/2022/04/2022-04-07-Off-Label-Paper-Final.pdf [https://perma.cc/WR8G-KAKH]. "Off-label" use means that a drug has not received FDA approval for use to treat a certain condition within a particular population. *E.g.*, McNamara et al., *supra* note 47, at 19.

91. Many medications are commonly used for pediatric off-label purposes. McNamara et al., *supra* note 47, at 20 ("Off-label use is so common in pediatrics that off-label drugs are prescribed in 20% of patient visits."). This is in part because of the expense of obtaining FDA approval, something that many drug companies are unwilling to fund. *Id.* at 19. It should also be noted that, in *Cruz v. Zucker*, the court found the compendia requirement to be inapplicable in EPSDT cases. 195 F. Supp. 3d 554, 581 (S.D.N.Y. 2016), *reh'g granted*, 218 F. Supp. 3d 246 (S.D.N.Y. 2016). That is, the court held that states must still provide coverage for drugs that meet the remaining EPSDT requirements, even if they have not received FDA approval for such use and are not included in any of the compendia. *Id.* ("[T]he Compendia Requirement does not extend to the EPSDT Provision."). However, this is in contradiction with *Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty*, which concluded that EPSDT does require compliance with the FDA approval or compendia requirements. 366 F. Supp. 2d 1050, 1114–17 (N.D. Okla. 2005), *rev'd on other grounds*, Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208 (10th Cir. 2007). Given this uncertainty, this Note analyzes compliance with the compendia requirement.

92. As one example, Triptorelin is listed in one of the three compendia, Drugdex, for pediatric puberty-blocking use. *Triptorelin*, MERATIVE MICROMEDEX (Jan. 12, 2024) (on file with *Minnesota Law Review*). Drugdex is part of Micromedex. Micromedex Help Guide, UNIV. MINN. LIBRS., https://libguides.umn.edu/Micromedex [https://perma.cc/N2AD-GKFX].

services required to administer the drug must be one of the listed services under § 1396d(a).[93]

In most states, puberty blockers meet the latter criterion as well. Physician administration of pubertal suppressants could fall under a variety of the broad categories of medical services listed in the Medicaid Act. For example, the statute lists outpatient services,[94] physician services,[95] medical care,[96] and "other diagnostic, screening, preventive, and rehabilitative services, including . . . any medical or remedial services . . . recommended by a physician . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[97] However, each of these categories is limited to those services authorized under state law.[98] This interpretation is reinforced by the *State Medicaid Manual*, which states that "[a]ll services must be provided in accordance with . . . any State laws of general applicability that govern the provision of health services."[99] Statewide bans of minor access to puberty blockers target this major vulnerability in the Act. As of this writing, there are currently twenty-two states that have passed laws banning or restricting youth access to gender-affirming puberty blockers.[100] Because these statutes render

93. 42 U.S.C. § 1396d(a)(1)–(31) (providing a full list of the types of covered medical services).

94. *Id.* § 1396d(a)(2).

95. *Id.* § 1396d(a)(5).

96. *Id.* § 1396d(a)(6).

97. *Id.* § 1396d(a)(13).

98. *See id.* § 1396d(a)(2) (noting that services must be "consistent with State law permitting such services"); *Id.* § 1396d(a)(6) (listing medical or remedial care "recognized under State law"); *Id.* § 1396d(a)(13)(C) (listing medical or remedial services that are recommended by a physician "within the scope of their practice under State law"); 42 C.F.R. § 440.50(a)(1) (2024) (limiting physicians' services to those that are performed "[w]ithin the scope of practice of medicine or osteopathy as defined by State law").

99. STATE MEDICAID MANUAL, *supra* note 60, § 5122F.

100. *See* Davis, *supra* note 11 (Idaho, Indiana, Kentucky, Louisiana, Missouri, Montana, Nebraska, North Carolina, North Dakota, Tennessee, West Virginia, and Wyoming); Brendan Farrington, *US Judge Blocks Florida Ban on Trans Minor Care in Narrow Ruling, Says 'Gender Identity Is Real*,*'* ASSOCIATED PRESS (June 6, 2023), https://apnews.com/article/transgender-health-desantis-florida-033556c6a4c301d9ad342c74a6410800 [https://perma.cc/JA9H-ZM9X] (Florida); Katarina Sostaric, *Iowa Transgender Kids Are Now Barred from Getting Gender-Affirming Care and Using Certain School Bathrooms*, IOWA PUB. RADIO (Mar. 22, 2023), https://www.iowapublicradio.org/state

pubertal suppressants used to treat gender dysphoria in adolescents unauthorized by state law, the treatment is not included in the medical services listed in the Medicaid Act in the states with bans or restrictions that remain in force Thus, it may be plausibly argued that once the treatment falls outside the

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-government-news/2023-03-22/iowa-transgender-kids-are-now-barred-from-getting-gender-affirming-care-and-using-certain-school-bathrooms [https://perma.cc/W53F-YMKW] (Iowa); Jo Yurcaba, *Mississippi Governor Signs Bill Banning Transgender Health Care for Minors*, NBC NEWS (Feb. 28, 2023), https://www.nbcnews.com/nbc-out/out-politics-and-policy/mississippi-governor-signs-bill-banning-transgender-health-care-minors-rcna72765 [https://perma.cc/KJG6-WZ6J] (Mississippi); Jack Forrest & Joe Sutton, *Oklahoma Governor Signs Legislation Banning Gender-Affirming Care for Minors*, CNN (May 2, 2023), https://www.cnn.com/2023/05/02/politics/oklahoma-gender-affirming-care-ban-minors/index.html [https://perma.cc/B7TP-DJUT] (Oklahoma); Alex Nguyen & William Melhado, *Gov. Greg Abbott Signs Legislation Barring Trans Youth from Accessing Transition-Related Care*, TEX. TRIB. (June 3, 2023), https://www.texastribune.org/2023/06/02/texas-gender-affirming-care-ban [https://perma.cc/9EKL-MAG6] (Texas); Jo Yurcaba, *Utah Is the First State to Pass a Gender-Affirming Care Ban in 2023*, NBC NEWS (Jan. 28, 2023), https://www.nbcnews.com/nbc-out/out-politics-and-policy/utah-poised-first-state-pass-gender-affirming-care-ban-2023-rcna67941 [https://perma.cc/NK8Z-FP27] (Utah); *South Dakota Governor Signs Trans Youth Health Care Ban*, ASSOCIATED PRESS (Feb. 13, 2023), https://apnews.com/article/sd-state-wire-kristi-noem-health-south-dakota-gender-2b6ba634acc1f17f6ab9ade36fc1ae96 [https://perma.cc/L299-Z8UF] (South Dakota); Kim Chandler, *Alabama Can Enforce Ban on Puberty Blockers and Hormones for Transgender Children, Court Says*, ASSOCIATED PRESS (Aug. 21, 2023), https://apnews.com/article/transgender-care-ban-alabama-minors-cccb5ec40b65c3c179600d291e707afd [https://perma.cc/8LUL-NZT5] (Alabama); Chloe Kim, *Ohio Upholds Ban on Child Transgender Procedures, Overriding Governor's Veto*, BBC NEWS (Jan. 24, 2024), https://www.bbc.com/news/world-us-canada-68089932 [https://perma.cc/2A6A-Y53M] (Ohio); Andrew DeMillo, *Judge Rules Arkansas Ban on Gender-Affirming Care for Transgender Minors Violates US Constitution*, ASSOCIATED PRESS (June 20, 2023), https://apnews.com/us-news/arkansas-gender-general-news-2a0d032f4e4f3195c180d879239e6521 [https://perma.cc/2M8L-GPGK] (Arkansas). Arkansas's law was subsequently struck down and is no longer in effect. *Id.* Note that Arizona and Georgia have also passed bills that restrict minor access to gender-affirming healthcare; however, they do not prohibit access to puberty blockers specifically. *See* Francesca Paris, *Bans on Transition Care for Young People Spread Across U.S.*, N.Y. TIMES (Apr. 17, 2023), https://www.nytimes.com/2023/04/15/upshot/bans-transgender-teenagers.html [https://perma.cc/KKE6-Q33E] (stating that Arizona bans access to gender-affirming surgery for minors but does not ban puberty blockers or cross-sex hormones, whereas Georgia bans access to surgery and cross-sex hormones but not puberty blockers).

bounds of the services listed in § 1396d(a), EPSDT no longer requires its coverage.[101]

However, several of these newly passed laws restricting youth access to gender-affirming puberty blockers are currently being challenged in the courts, and, thus far, some of these challenges have been successful on constitutional grounds.[102] Additionally, the U.S. Department of Health and Human Services has issued a notice of proposed rulemaking that would revise the regulations pertaining to section 1557 of the Affordable Care Act to state that discrimination on the basis of gender identity is sex discrimination, thereby bolstering the argument that even a statewide ban cannot shield a state from its duty to provide coverage for gender-affirming puberty blockers to minors.[103]

Ultimately, outside of the states with statewide prohibitions on puberty blockers, puberty blockers used to treat gender dysphoria fall within the ambit of EPSDT. This will also be the case in the states with existing bans if those bans do not survive current legal challenges. Thus, if puberty blockers are "medically necessary" to "correct or ameliorate" gender dysphoria, states must provide the treatment.

C. PUBERTY BLOCKERS "CORRECT OR AMELIORATE" GENDER DYSPHORIA

One source of breadth of the EPSDT benefit is that it requires states to provide access to services for minors that may

101. *See* 42 U.S.C. § 1396d(r)(5) (requiring states to provide treatments and medical services listed in § 1396d(a) of the Medicaid Act).

102. *See, e.g.*, Doe v. Ladapo, 676 F. Supp. 3d 1205 (N.D. Fla. 2023) (granting a preliminary injunction against a state law banning gender-affirming care for minors, finding that the law likely violated the Equal Protection Clause and the Due Process Clause); Brandt v. Rutledge, 4:21CV00450 JM, 2023 WL 4073727, at *1 (E.D. Ark. June 20, 2023) (granting permanent injunctive relief against a state law banning gender-affirming care for minors, finding the law violated the Equal Protection Clause, the Due Process Clause, and the First Amendment). *But see* L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 491 (6th Cir. 2023), *cert. dismissed in part sub nom.* Doe v. Kentucky, 144 S. Ct. 389 (2023) (mem.) (reversing and remanding district courts' grants of preliminary injunctive relief against state laws banning gender-affirming care for minors, finding that an Equal Protection challenge and a Due Process challenge were not likely to succeed).

103. *See* Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47916 (proposed Aug. 4, 2022).

not be available for adults under the state plan.[104] EPSDT's sweeping scope also stems from the statutory language requiring states to provide any services listed under Medicaid "to correct or *ameliorate* defects and physical and mental illnesses and conditions."[105]

The services provided need not cure the illness they are intended to treat. Services that merely prevent the condition from worsening or from leading to additional complications meet the requirement.[106] The Centers for Medicare and Medicaid Services (CMS) states that "ameliorative" care includes services that "maintain or improve [a] child's current health condition."[107] CMS goes on to define maintenance services as those that "sustain or support rather than those that cure or improve health problems."[108] Further, "[s]ervices are covered when they prevent a condition from worsening or prevent development of additional health problems."[109] CMS provides the example that physical and occupational therapy for maintenance purposes are covered under EPSDT.[110] Although CMS merely provides guidance on the issue, the federal courts have demonstrated a willingness to accept the CMS interpretation.[111]

For example, in *S.D. v. Hood*, the district court held that disposable incontinence underwear were necessary to ameliorate the minor plaintiff's incontinence caused by spina bifida.[112]

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104. *See supra* notes 85–89 and accompanying text.

105. 42 U.S.C. § 1396d(r)(5) (emphasis added).

106. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 10; *see also* A.M.T. v. Gargano, 781 F. Supp. 2d 798, 805–06 (S.D. Ind. 2011) (first citing Collins *ex rel.* Collins v. Hamilton, 231 F. Supp. 2d 840, 849 (S.D. Ind. 2002), *opinion corrected on other grounds sub nom.* Collins v. Humphreys, 231 F. Supp. 2d 851 (S.D. Ind. 2002), *aff'd sub nom.* Collins v. Hamilton, 349 F.3d 371 (7th Cir. 2003); and then citing Ekloff v. Rodgers, 443 F. Supp. 2d 1173, 1180 (D. Ariz. 2006)) (following the interpretations of other courts finding that the definition of "ameliorate" means "to make better or more tolerable").

107. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 10.

108. *Id.*

109. *Id.*

110. *Id.*

111. *See, e.g.*, *infra* notes 112–20 and accompanying text; C.R. *ex rel.* Reed v. Noggle, 559 F. Supp. 3d 1323, 1336 (N.D. Ga. 2021) (accepting the CMS definition of "ameliorate" as persuasive authority).

112. S.D. *ex rel.* Dixon v. Hood, No. Civ.A 02-2164, 2002 WL 31741240, at *8 (E.D. La. Dec. 5, 2002), *aff'd sub nom.* S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004). Spina bifida is caused by an imperfect formation of the spine,

Louisiana argued that the incontinence underwear were merely a "convenience."[113] However, the court found that without them, the minor would face an enhanced risk of skin infections and would suffer mental health repercussions, as he would not have been able to engage in normal day-to-day activities for someone his age.[114]

In *A.M.T. v. Gargano*, the district court addressed a situation in which the state of Indiana withheld Medicaid coverage for physical and occupational therapy for a class of minors diagnosed with cerebral palsy[115] or mitochondrial metabolic myopathy,[116] conditions that caused them to experience functional limitations.[117] The state argued that:

> [T]herapies to maintain a level of functionality where further progress can no longer be expected or progress is minimal in relation to the time needed to achieve that minimal progress is not covered [under EPSDT] because it is "solely for the purposes of sustaining an individual at a particular level, rather than increasing or improving their abilities."[118]

However, the court disagreed, instead finding that to "ameliorate" a condition includes merely preventing its regression.[119] In

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resulting in lack of sensation below the waist, leading to bladder and bowel incontinence. *Id.* at *1.

113. *Id.* at *6.

114. *Id.* at *8 (stating that regarding mental health, "incontinence underwear is medically necessary, otherwise [the child] would be unable to live a normal life and engage in age appropriate activities").

115. Cerebral palsy is a disorder that affects body movement and muscle coordination. *Cerebral Palsy*, NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE (Nov. 28, 2023), https://www.ninds.nih.gov/health-information/disorders/cerebral-palsy [perma.cc/X8FL-SVQY].

116. Mitochondrial metabolic myopathy is a disorder that can cause breakdown of muscle tissue. *Metabolic Myopathy*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/conditions-and-diseases/metabolic-myopathy [https://perma.cc/2LF3-EJWN].

117. A.M.T. v. Gargano, 781 F. Supp. 2d 798, 800 (S.D. Ind. 2011).

118. *Id.* at 806 (quoting Defendant's Response in Opposition to Plaintiffs' Motion for Summary Judgment at 15, *Gargano*, 781 F. Supp. 2d 798 (No. 1:10-cv-358)).

119. *Id.* at 807 ("Although a child with a chronic condition may reach a level where further progress can no longer be expected or where progress is minimal in relation to the time needed to achieve that minimal progress, therapies that prevent regression still ameliorate the condition by making it more tolerable. Specifically, therapies that prevent regression facilitate and maximize daily opportunities and prevent a child from suffering the needless degeneration of functionality. This was Congress' intent with EPSDT.").

other words, the court found that maintenance services and treatments are covered under EPSDT.[120]

Pubertal suppressants meet this requirement of "ameliorating" gender dysphoria because studies show that by pausing puberty, puberty blockers help to allay the intense distress, negative self-concept, anxiety, depression, and suicidality experienced by TGD individuals with gender dysphoria.[121] Like the incontinence underwear in *Hood*, puberty blockers improve participation in day-to-day activities by alleviating anxiety, depression, and suicidality that may impair one's ability to function in many areas of life.[122] Additionally, studies have shown that puberty blockers help to reduce suicidal ideation into adulthood in individuals diagnosed with gender dysphoria.[123] Not only does this align with *Hood*, which shows that courts are willing to accept that to "ameliorate" includes preventing a worsening of the condition, but it is also consistent with the primary purpose of EPSDT, which is to identify health issues early on in order to reduce their detrimental impact as the child grows older.[124] Finally, *Gargano* shows that there is no need for individuals to show continual improvement by taking puberty blockers. Rather, because puberty blockers help an individual avoid regression—intensified mental health distress—they "ameliorate" gender dysphoria within the meaning of the Medicaid Act.

D. PUBERTY BLOCKERS ARE "MEDICALLY NECESSARY"

While EPSDT creates a broad scope of mandatory coverage, it is not without limits. One of the most significant constraints is the medical necessity standard. The medical necessity standard is not explicitly stated in the Medicaid Act but is a judicially created and accepted standard as a part of the Medicaid framework.[125] The standard was first recognized in *Beal v. Doe* when the Supreme Court addressed whether states were required to

120. *Id.*

121. *See supra* notes 43–54 and accompanying text (describing the mental health benefits of puberty blockers).

122. *See supra* notes 31–32, 43–54 and accompanying text.

123. *See supra* notes 44–46 and accompanying text.

124. *See supra* notes 62–64 and accompanying text (describing congressional intent for EPSDT to be preventative).

125. Victor M. Jones*, To Bryce Gowdy, with Love: Prioritizing Medicaid's "EPSDT" Mandate for America's Most Vulnerable Youth*, 48 S.U. L. REV. 127, 195–96 (2020).

fund abortions under Medicaid.[126] Without deciding whether states were in fact required to fund abortions, the Court determined that such would be the case only if the abortion were deemed medically necessary.[127] Further, the Court stated that the Medicaid Act "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the [Medicaid] Act."[128]

Consistent with *Beal*, current federal regulation authorizes states to "place appropriate limits on a service based on such criteria as medical necessity."[129] Thus, states do not need to cover gender-affirming puberty blockers unless they are deemed medically necessary to treat gender dysphoria. There is no federal statutory, regulatory, or administrative definition for "medical necessity."[130] Due to this lack of federal guidance, states have created their own definitions of "medical necessity,"[131] which often act as tools by which to limit coverage.

But the analysis does not end there. There is also contention about who makes the determination as to whether an individual meets the state definition of medical necessity set forth. Namely, is it the patient's treating physician, the state, or a combination of the two?

This Section will explore the limiting principles to which states are subjected in their power to draw the boundaries of medical necessity, as well as how courts have determined what roles the state and treating physician are meant to play in ascertaining whether the beneficiary meets the state definition.

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126. Beal v. Doe, 432 U.S. 438, 443–44 (1977).

127. *See id.* at 444–45 ("Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund *unnecessary*—though perhaps desirable—medical services.").

128. *Id.* at 444 (quoting 42 U.S.C. § 1396a(a)(17)).

129. 42 C.F.R. § 440.230(d) (2024).

130. Jones, *supra* note 125, at 195 ("Medical necessity is not a term defined by [the Medicaid Act] or CMS guidance . . . .").

131. *Id.* at 196; *see also State Definitions of Medical Necessity Under the Medicaid EPSDT Benefit*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Apr. 23, 2021), https://nashp.org/state-definitions-of-medical-necessity-under-the-medicaid-epsdt-benefit [https://perma.cc/26JF-N2A6] (listing various states' definitions of "medical necessity").

1. No Categorical Exclusions or Violations of the Comparability Requirement

States must provide beneficiaries with gender dysphoria the same access to treatment as individuals experiencing any other health condition. Federal regulation asserts that states may not "arbitrarily deny or reduce the amount, duration, or scope of a required service under [EPSDT] to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition."[132] This Note refers to this regulation as the "ban on categorical exclusions." In a similar vein, the Medicaid Act states that "the medical assistance made available to any individual . . . shall not be less in amount, duration, or scope than the medical assistance made available" to others receiving Medicaid assistance.[133] This is known as the comparability requirement. Between the ban on categorical exclusions and the comparability requirement, states are not given carte blanche to determine which illnesses are important and must be treated, and which are undeserving of state and federal funds.

Courts have rigorously applied these rules. In *White v. Beal*, the Third Circuit struck down a Pennsylvania regulation that granted eyeglasses benefits for treatment of eye disease or pathology, but withheld coverage for those who required eyeglasses to correct refractive error.[134] The State maintained that its decision to cover only those who suffered from eye disease or pathology was because they were most in need of eyeglasses.[135] However, the court closely inspected the State's rationale and found that, based on the record, the State's assumption that those suffering from refractive error were less in need of eyeglasses was in error.[136] Because of this, the court went on to find that the State's decision to deny benefits to those with refractive error was arbitrary and therefore in violation of the Medicaid Act.[137] This demonstrates that courts are unwilling to merely accept at face-value the state's proffered reason for denying coverage.

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132. 42 C.F.R. § 440.230(c) (2024).

133. 42 U.S.C. § 1396a(a)(10)(B)(i).

134. White v. Beal, 555 F.2d 1146, 1148 (3d Cir. 1977).

135. *Id.* at 1150.

136. *Id.* ("Assuming that medical need is a valid measurement of eligibility, the state's factual premise, however, is not supported by the record.").

137. *Id.* at 1152.

Further, violations of the ban on categorical exclusions and comparability requirement need not be explicit. In 1980, in *Pinneke v. Preisser*, the Eighth Circuit found that Iowa's state plan, which completely excluded gender-affirming surgery, necessarily arbitrarily denied benefits based solely on the condition because gender-affirming surgery was the only known treatment for transgender individuals.[138]

Finally, in *Dekker v. Weida*, the Florida district court engaged in an unforgiving analysis and found that denying gender-affirming puberty blockers to Medicaid beneficiaries violated the comparability requirement because a cisgender patient could receive puberty blockers for a diagnosis other than gender dysphoria, such as precocious puberty.[139] The court found that there was "no rational basis for a state to categorically ban [puberty blocker] treatments or to exclude them from the state's Medicaid coverage."[140]

These cases demonstrate that courts are suspicious of any type of exclusionary policy and will scrutinize available evidence to look beyond a state's purported reason for denying treatment coverage for a particular condition. As noted above, the evidence for gender-affirming puberty blockers weighs heavily in favor of the EPSDT recipient.[141] Thus, as was the case in *Dekker*, a state would have a difficult time convincingly asserting that a proscription on the treatment was the result of anything other than denial of a service "solely because of the . . . condition."[142] Further, under *Preisser*, a court may find that a total ban on gender-affirming puberty blocker coverage amounts to a categorical exclusion itself as the medication is the only available treatment

138. Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980).

139. Dekker v. Weida, 4:22cv325-RH-MAF, 2023 WL 4102243, at *20 (N.D. Fla. June 21, 2023). Precocious puberty is a condition when a child begins puberty too early. Archana S. Kota & Sehar Ejaz, *Precocious Puberty*, *in* STATPEARLS (Salah Aboubakr et al. eds., 2023) (ebook), https://www.ncbi.nlm.nih.gov/books/NBK544313 [https://perma.cc/YAE9-DH8G]. Puberty blockers have been used to treat precocious puberty for more than three decades. Eun Young Kim, *Long-Term Effects of Gonadotropin-Releasing Hormone Analogs in Girls with Central Precocious Puberty*, 58 KOREAN J. PEDIATRICS 1 (2015).

140. *Dekker*, 2023 WL 4102243, at *8.

141. *See supra* notes 43–54 and accompanying text.

142. 42 C.F.R. § 440.230(c) (2024).

for young adolescents experiencing gender dysphoria.[143] However, even if a court does not subscribe to the Eighth Circuit's reasoning that such a prohibition amounts to a per se categorical exclusion or comparability requirement violation, the court would no doubt be skeptical of such a prohibition.

In sum, the regulatory ban on categorical exclusions and the Medicaid Act's comparability requirement prevent states from crafting a definition of medical necessity that would directly or indirectly exclude individuals with gender dysphoria from reaping the benefits of EPSDT coverage.

2. State Definitions of Medical Necessity Must Incorporate the Expansive EPSDT Standards

While states may have definitions of medical necessity for both regular Medicaid benefits as well as EPSDT benefits,[144] by requiring that states cover treatment that "correct[s] or ameliorate[s]" a health condition, EPSDT creates a lower standard for establishing medical necessity than adult Medicaid benefits.[145] Therefore, although states may have a definition of medical necessity that complies with the federal requirements for regular Medicaid benefits, such a definition may impose too high a barrier for EPSDT purposes. In that case, courts will invalidate the state EPSDT definition of medical necessity.[146]

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143. Subsequent, more permanent treatment, such as hormone therapy or gender-affirming surgeries, is not recommended until adolescents become older. *See* Lindsey Tanner, *Trans Kids' Treatment Can Start Younger, New Guidelines Say*, ASSOCIATED PRESS (June 15, 2022), https://apnews.com/article/gender-transition-treatment-guidelines-9dbe54f670a3a0f5f2831c2bf14f9bbb [https://perma.cc/DF4C-2QPP]. WPATH states that hormone therapy may begin as young as fourteen, and some surgeries may be conducted at age fifteen or seventeen. *Id.* However, whether such treatment is recommended in a particular case for youth at that age varies by individual. *See* Coleman et al., *supra* note 46, at S257 (delineating eligibility criteria for adolescent gender-affirming hormonal treatment and surgery). Thus, for some, undergoing such additional treatment may not be recommended until they grow older.

144. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 23 ("States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases . . . .").

145. 42 U.S.C. § 1396d(r)(5); *see also* Perkins & Somers, *supra* note 60, at 165 ("EPSDT has its own medical necessity definition that is more expansive than the definition generally applied to services for adults.").

146. *See* EPSDT - A GUIDE FOR STATES, *supra* note 56, at 23 (noting that state parameters on medical necessity "may not contradict or be more restrictive than the federal statutory requirement").

For example, in *Q.H. v. Sunshine State Health Plan, Inc.*, the court held that Florida's definition of medical necessity was too restrictive to comply with EPSDT requirements.[147] The court noted Florida's mistake in applying the same definition of medically necessity for both adult Medicaid benefits and EPSDT, despite EPSDT's broader mandate.[148] The court then went on to nullify the definition, as it imposed a list of criteria which the child needed to meet to receive treatment for her condition.[149] Not only did the court find that this was overly restrictive, but it also held that EPSDT beneficiaries are "entitled to individualized review of their specific conditions" and that applying specific criteria did not qualify as individualized review.[150] This aligns with CMS guidance, which directs that the medical necessity determination "must be made on a case-by-case basis."[151] CMS states that in determining medical necessity, the particular needs of the child must be considered in a holistic manner.[152] This holistic determination is meant to consider both short- and long-term needs, including nutritional needs, social development, and mental health.[153]

As discussed previously, puberty blockers ameliorate gender dysphoria in adolescents.[154] Therefore, because the state EPSDT definition of medical necessity cannot be more restrictive than the statutory directive and EPSDT statutorily requires access to services "to correct or *ameliorate*"[155] a condition, gender-affirming puberty blockers will necessarily fall within the state

147. Q.H. v. Sunshine State Health Plan, Inc., 307 So. 3d 1, 14 (Fla. Dist. Ct. App. 2020).

148. *Id.*

149. *Id.* at 10–11 (finding that a predefined list of criteria to determine medical necessity was not "consistent with the preventative thrust of the EPSDT benefit" (quoting H.R. REP. NO. 101-247, at 399 (1989)).

150. *Id.* at 11 (quoting Jacobus v. Dep't of PATH, 857 A.2d 785, 792 (Vt. 2004)).

151. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 23.

152. *Id.*

153. *Id.* CMS guidance goes on to say that due to the required individualized assessments, hard limits on treatment or services are inconsistent with the EPSDT framework. *Id.* While a state may impose a "soft" limit on the number of physical therapy visits for a child, if the child demonstrates a need for visits beyond the predetermined amount, the state must provide them. *Id.* at 23–24.

154. *See supra* notes 43–54 and accompanying text (describing the mental health benefits of puberty blockers).

155. 42 U.S.C. § 1396d(r)(5).

definition of medical necessity. Additionally, the requirement of individualized assessment weighs heavily against an absolute exclusion of EPSDT coverage for gender-affirming puberty blocker treatment. Such a blanket prohibition does not account for the individual circumstances of each adolescent experiencing gender dysphoria, nor would it allow for deference to the treating physician to determine medical necessity, as courts are likely to do in EPSDT cases.[156] In sum, because state definitions of medical necessity for EPSDT purposes must not be more restrictive than the EPSDT requirements and should incorporate a case-by-case analysis in determining the presence of medical necessity, courts are likely to be hostile to an outright ban on gender-affirming puberty blocker coverage, even on the basis of lack of medical necessity.

3. State Determinations of Medical Necessity Are Cabined by Reasonableness

Though states are afforded limited power in determining the bounds of medical necessity, the state's determination is cabined by principles of reasonableness, which is generally defined as the level of acceptance within the medical community.[157]

As discussed previously, a prohibition on coverage for treatment that enjoys widespread support in the medical community is highly unusual.[158] Unsurprisingly, then, the issue of reasonableness regarding a state's EPSDT ban on treatment coverage has not been heavily litigated. Therefore, to illustrate this final point, this Note draws upon case law addressing allegedly experimental treatment. EPSDT does not require coverage of experimental treatments or services as those services are not considered "medically necessary."[159] There is no statutory or regulatory definition of what qualifies as experimental treatment under Medicaid.[160] However, CMS guidance mandates that the state's

156. *See infra* Part III.D.4 (discussing how the EPSDT requires deference to treating physicians).

157. Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980) (stating that medical necessity determinations must take into account "the accumulated knowledge of the medical community").

158. *See supra* Part II.

159. STATE MEDICAID MANUAL, *supra* note 60, § 5122F ("You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.").

160. EPSDT - A GUIDE FOR STATES, *supra* note 56, at 24–25.

determination of what constitutes an experimental treatment "must be reasonable and should be based on the latest scientific information available."[161] This aligns with the statutory requirement that "a state plan for medical assistance must . . . include reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [the Medicaid Act]."[162]

Courts have held that a state cannot exclude coverage for an EPSDT treatment or service on the basis of its alleged experimental nature if it is widely accepted within the medical community. For example, in *Rush v. Parham*, when considering the experimental nature, or lack thereof, of gender-affirming surgery, the Fifth Circuit followed a Medicare letter that stated that a foundational consideration is whether the treatment is "generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is being used."[163]

Similarly, in *Miller v. Whitburn*, the Seventh Circuit noted that "the best indicator" of a treatment's experimental nature is its "rejection by the professional medical community as an unproven treatment."[164] The court went on to recognize that some treatments may be so new that the medical community has yet to shape an opinion as to their effectiveness.[165] The court further stated that in such cases, if there is "authoritative evidence" which supports the treatment's "safety and effectiveness," then the treatment is not experimental.[166] In determining a treatment's safety, the court directs a weighing of the benefits of the treatment against its risks.[167] In conducting the balancing test, a court may consider factors including:

161. *Id.* at 25.

162. 42 U.S.C. § 1396a(a)(17).

163. Rush v. Parham, 625 F.2d 1150, 1156 n.11 (5th Cir. 1980) (citing Enclosure # 2 to Intermediary Letters Nos. 77-4 & 77-5, [1976 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 28,152 (1976)) (finding that a basic consideration in determining whether a medical service is experimental is whether such treatment has gained general acceptance within the medical community).

164. Miller *ex rel.* Miller v. Whitburn, 10 F.3d 1315, 1320 (7th Cir. 1993).

165. *Id.*

166. *Id.*

167. *Id.* at 1320 n.11 (citing McLaughlin *ex rel.* McLaughlin v. Williams, 801 F. Supp. 633, 639 (S.D. Fla. 1992)).

> (1) [T]he mortality of the patients over the period in which the procedure has been performed; (2) how often it has been performed, and how successful it has been; (3) the reputation of the doctors and medical centers performing the procedure, and their record in related areas; (4) the long-term prognosis of patients who have had the procedure performed on them and (5) the extent to which medical science in related areas has developed rapidly.[168]

Ultimately, however, the main consideration is the presence of medical consensus supporting a particular course of treatment.[169]

Perhaps the strongest argument that gender-affirming puberty blockers are beyond the scope of EPSDT is that the treatment is experimental. This is the primary contention asserted by states hoping to limit youth access to gender-affirming care, both relating to EPSDT coverage and in other contexts.[170] As has been noted, use of puberty blockers to treat gender dysphoria is relatively new.[171] No studies have been conducted to determine the long-term effects of puberty blockers.[172] However, the short-

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168. *Id.* (citing *McLaughlin*, 801 F. Supp. at 639).

169. *Id.* at 1320 (stating that the court's "explanation of ['experimental'] . . . is . . . consistent with current medical opinion"); *see also* Dekker v. Weida, 4:22cv325-RH-MAF, 2023 WL 4102243, at *6 (N.D. Fla. June 21, 2023) ("The court said . . . whether the state's determination 'is' reasonable, would be controlled . . . by 'current medical opinion . . . .'" (citing Rush v. Parham, 625 F.2d 1150, 1157 n.13 (5th Cir. 1980)).

170. *See, e.g.*, Cruz v. Zucker, 195 F. Supp. 3d 554, 579 (S.D.N.Y. 2016), *reh'g granted*, 218 F. Supp. 3d 246 (S.D.N.Y. 2016) ("[The State] claims that hormone therapies for minors with gender dysphoria are experimental and that there is no medical consensus that they are safe and effective."); Brandt v. Rutledge, 551 F. Supp. 3d 882, 888 (E.D. Ark. 2021) ("Defendants contend that [the prohibition] is substantially related to the State's important governmental objectives of protecting vulnerable children from experimental treatment and regulating the ethics of the medical profession."), *aff'd sub nom.* Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022); *see also* Minta et al., *supra* note 17 (noting the Mississippi legislature considers gender-affirming care experimental).

171. Megan Twohey & Christina Jewett, *They Paused Puberty, but Is There a Cost?*, N.Y. TIMES (Nov. 14, 2022), https://www.nytimes.com/2022/11/14/health/puberty-blockers-transgender.html [https://perma.cc/HPW2-THEU] ("As the number of adolescents who identify as transgender grows, drugs known as puberty blockers have become the first line of intervention for the youngest ones seeking medical treatment.").

172. *Id.* (citing Chad Terhune et al., *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, REUTERS (Oct. 6, 2022), https://www.reuters.com/investigates/special-report/usa-transyouth-care [https://perma.cc/3N8B-M34M])) ("[L]imited studies and politicization of trans medicine can make it difficult to fully evaluate the decision. A Reuters

term studies that have been conducted show that pubertal suppressants can negatively affect bone mass, leaving youths at greater risk of skeletal fractures.[173] This is because bone mass usually sees significant growth during puberty as a result of the rising estrogen and testosterone levels.[174] Another concern, though less studied, is that puberty blockers may negatively impact brain development.[175] Adolescence is a time of considerable brain growth, and studies have shown that sex hormones influence social and problem-solving skills.[176] While the effects of puberty blockers are reversible in that they do not prevent individuals from fully maturing into their natal gender, the effect on bone mass and brain development may be irreversible.[177]

Though these health concerns are important and surely must be considered when deciding whether a TGD adolescent is best served by choosing to take or forego puberty blockers, that is a consideration for the treating physician, the parents, and the youth.[178] These risks do not render the treatment experimental,

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examination of a range of transgender treatments also found scant research into the long-term effects.").

173. *Id*. *But see* Statement from World Pro. Ass'n for Transgender Health & U.S. Pro. Ass'n for Transgender Health, USPATH and WPATH Respond to NY Times Article "They Paused Puberty, But Is There a Cost?," Published on November 14, 2022, at 2 (Nov. 22, 2022) [hereinafter Statement from WPATH & USPATH], https://www.wpath.org/media/cms/Documents/Public%20Policies/2022/USPATHWPATH%20Statement%20re%20Nov%2014%202022%20NYT%20Article%20Nov%2022%202022.pdf [https://perma.cc/6FQ4-R7HJ] ("Many types of blockers are routinely used in combination with estrogen well through adulthood without deleterious effects on bone density. . . . Bone density loss is generally not a concern once hormone therapy has begun.").

174. *See* Twohey & Jewett, *supra* note 171 ("During puberty, bone mass typically surges, determining a lifetime of bone health.").

175. *See id.* (citing Diane Chen et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, 5 TRANSGENDER HEALTH 246 (2020)) ("In a 2020 paper, 31 psychologists, neuroscientists and hormone experts from around the world urged more study of the effects of blockers on the brain.").

176. *Id.* ("Sex hormones have been shown to affect social and problem-solving skills.").

177. *See generally id.* (discussing the lack of literature studying the risks of hormone therapy on bone mass and brain development).

178. It is difficult to improve upon the court's statement in *Dekker v. Weida*:

> Risks attend many kinds of medical treatment, perhaps most. Ordinarily it is the patient, in consultation with the doctor, who weighs the risks and benefits and chooses a course of treatment. Florida's Medicaid program routinely covers treatments with greater risks than

nor do they detract from its efficacy in treating gender dysphoria.[179] The legal standard in determining a treatment's experimentality is not whether there are *any* risks of treatment. Courts are directed to first follow the medical community's guidance, accepting that treatment may include some risks.[180] Where guidance from the medical community is not fully formed, the standard takes into account the risks, but places greater emphasis on the treatment's efficacy in treating the condition.[181] Here, use of gender-affirming puberty blockers has widespread support among the medical community. It is encouraged by many leading, well-renowned medical associations, including WPATH, the Endocrine Society, the American Psychiatric Association, and others.[182]

However, even if a court were to find that it required additional evidence of the treatment's efficacy, studies have shown that puberty blockers help relieve symptoms of gender dysphoria.[183] In other words, puberty blockers are *effective* in treating the condition. Importantly, the foundation of knowledge regarding this course of treatment should not be disregarded as too "new" to be trusted. Transgender health practices are not novel; cases regarding gender-affirming healthcare first reached the courts more than half a century ago.[184] More specifically, pubertal suppressants have been used to treat gender dysphoria in

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> those involved here. What is remarkable about the challenged rule and statute is not that they address medical treatments with both risks and benefits but that they arrogate to the State the right to make the decision.

4:22cv325-RH-MAF, 2023 WL 4102243, at *16 (N.D. Fla. June 21, 2023).

179. *See* Statement from WPATH & USPATH, *supra* note 173, at 1 ("[L]acking in the [*New York Times*] article is an explicit statement that any harms which may exist outweigh the substantial benefits these treatments confer to transgender youth.").

180. *See supra* note 163.

181. *See supra* notes 163–69 and accompanying text (noting that both the Seventh and Fifth Circuits emphasize effectiveness of treatment in determining its experimentality). The Seventh Circuit implicitly acknowledged that medical treatment often carries inherent risks. *See supra* note 167 and accompanying text.

182. *See supra* notes 48–54 and accompanying text.

183. *See supra* notes 44–47 and accompanying text.

184. *See* Anonymous v. Weiner, 270 N.Y.S.2d 319, 320 (N.Y. Sup. Ct. 1966) (deciding whether a New York State agency must change the sex on a birth certificate for an individual who has undergone sex reassignment).

adolescents since the 1990s.[185] Puberty blockers have been used for much longer to treat precocious puberty and are considered the standard of care to treat the condition.[186] Thus, there has been adequate time to conduct sufficient research to develop a well-supported understanding of the benefits of the treatment. This is not to say that more research should not be conducted. The point here is that the vital benefits of pubertal suppressants are adequately supported by existing research to dismiss allegations of their experimental nature. Ultimately, though there may be some risks involved, the same could be said of many courses of treatment, and the known risks associated with puberty blockers do not outweigh their beneficial effects—at least not in all cases.

Where courts have directly addressed the experimentality of gender-affirming healthcare for minors, they have generally followed these basic rules and have found that such treatment is not experimental. For example, in *Brandt v. Rutledge*, the case challenging the statewide Arkansas ban on gender-affirming healthcare for minors, the district court found that gender-affirming treatment, including puberty blockers, were not experimental.[187] The Eighth Circuit later affirmed this ruling, finding no clear error in the district court's weighing of the competing evidence and holding that the Arkansas ban "prohibit[ed] medical treatment that conforms with 'the recognized standard of care for adolescent gender dysphoria.'"[188] In *Eknes-Tucker v. Marshall*, a case challenging the Alabama ban on gender-affirming care for minors, the district court similarly found that

185. Simona Giordano & Søren Holm, *Is Puberty Delaying Treatment 'Experimental Treatment'?*, 21 INT'L J. TRANSGENDER HEALTH 113, 113 (2020).

186. *See* Kim, *supra* note 139 (noting that, by 2015, puberty blockers had been used to treat precocious puberty for over thirty years); *see also* Kota & Ejaz, *supra* note 139 (stating that puberty blockers are the standard of care for treating precocious puberty).

187. *See* Brandt v. Rutledge, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021) ("If the [Arkansas ban] is not enjoined, healthcare providers in this State will not be able to consider the recognized standard of care for adolescent gender dysphoria. Instead of ensuring that healthcare providers in the State of Arkansas abide by ethical standards, the State has ensured that its healthcare providers do not have the ability to abide by their ethical standards which may include medically necessary transition-related care for improving the physical and mental health of their transgender patients."), *aff'd sub nom.* Brandt *ex rel.* Brandt v. Rutledge, 47 F.4th 661 (8th Cir. 2022).

188. *Rutledge*, 47 F.4th at 670 (quoting *Rutledge*, 551 F. Supp. 3d at 891).

Alabama had failed to produce credible evidence that gender-affirming medications, including puberty blockers, were experimental.[189] While the court acknowledged that there were risks associated with such treatments, the court stated that "[r]isk alone does not make a medication experimental."[190]

Most recently, in *Dekker v. Weida*, the district court followed the Alabama court's reasoning.[191] Florida's Agency for Health Care Administration (AHCA) developed a report on puberty blockers, which concluded that puberty blockers were not supported by generally accepted standards within the medical community and were considered experimental.[192] The court engaged in a thorough analysis of the medical evidence presented to it and determined that the AHCA's "conclusion was not supported by the evidence and was contrary to generally accepted medical standards."[193] The court found that the AHCA's conclusion was unreasonable, and that, based on the current body of medical knowledge, puberty blockers are not experimental.[194] The court went on to note that Congress could, but chose not to, give the state ultimate authority over what qualifies as "medically necessary" treatment.[195]

Ultimately, just as states cannot determine that a treatment is experimental if it is in contradiction with the current consensus of the medical field, states cannot craft a definition of

189. Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1145 (M.D. Ala. 2022), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (11th Cir. 2023). While the Eleventh Circuit did not directly address the district court's findings related to the allegedly experimental nature of puberty blockers, it did imply that it may have been somewhat skeptical of the lower court's findings. *See Eknes-Tucker*, 80 F.4th at 1224 (noting that "all of the cases dealing with the fundamental parental right reflect the common thread that states properly may limit the authority of parents where 'it appears that parental decisions will jeopardize the health or safety of the child'" and that "[n]o Supreme Court case extends . . . a general right to receive new medical or experimental drug treatments" (first alteration in original) (first quoting Wisconsin v. Yoder, 406 U.S. 205, 234 (1972); and then quoting L.W. *ex rel.* Williams v. Skrmetti, 73 F.4th 408, 417 (6th Cir. 2023))).

190. *Eknes-Tucker*, 603 F. Supp. 3d at 1145.

191. Dekker v. Weida, 4:22cv325-RH-MAF, 2023 WL 4102243 (N.D. Fla. June 21, 2023).

192. *Id.* at *4.

193. *Id.*

194. *Id.*

195. *Id.* at *6 (citing Moore *ex rel.* Moore v. Reese, 637 F.3d 1220, 1259 (11th Cir. 2011)).

"medical necessity" that runs counter to, or uses evidence that is unsubstantiated by, the medical profession's findings and general consensus. To the extent that the state has power over the medical necessity determination, this discretion is limited by the medical profession's acceptance of the treatment.

4. Courts Defer to Treating Physicians to Determine Medical Necessity

As previously discussed, EPSDT requires a case-by-case determination of medical necessity.[196] While the first three Subsections relate to the state definition of medical necessity, this Subsection addresses who must make the individualized assessment of medical necessity. Specifically, this Subsection argues that courts are most likely to defer to the treating physician, rather than the state, in determining whether puberty blockers are "medically necessary" to treat gender dysphoria in a particular adolescent. Because the term "medical necessity" was used first regarding adult Medicaid benefits, there is significantly more jurisprudence related to the standard under adult Medicaid coverage than EPSDT.[197] Therefore, it is helpful to first address medical necessity in this context before assessing how courts have analyzed the standard in relation to EPSDT.

In *Beal v. Doe*, the Supreme Court first held that the state *may* defer to a treating physician's opinion regarding whether a treatment is medically necessary, so long as there is evidence that the procedure is medically necessary.[198] The Eighth Circuit, in *Pinneke v. Preisser*,[199] took this a step further. The court determined that treating physicians must be given *complete* deference in determining medical necessity.[200] That is, the determination of medical necessity lies solely with the physician. In

196. *See supra* notes 150–53 and accompanying text.

197. Jones, *supra* note 125, at 197–98.

198. Beal v. Doe, 432 U.S. 438, 444 (1977) (requiring only that state standards be "reasonable" and "consistent with the objectives" of the Medicaid Act); *see also* Meghan C. Casey, Note, *In Whose Hands Are We Placing Children's Health?: An Examination of "Medical Necessity" for Medicaid's EPSDT Provision*, 29 J. CONTEMP. HEALTH L. & POL'Y 89, 97 (2012) (discussing how a state can give deference to a physician's opinion, as long as the procedure is not only desirable to the patient but also deemed medically necessary).

199. 623 F.2d 546 (8th Cir. 1980).

200. *Id.* at 550 ("The decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials.").

support of this view, the Eighth Circuit cited legislative history demonstrating that, in enacting the Medicaid Act, Congress intended the physician to be the "key figure" in determining medical necessity.[201]

In contrast, in *Rush v. Parham*, the Fifth Circuit determined more power belonged to the state.[202] The court found that (1) "a state may adopt a definition of medical necessity that places reasonable limits on a physician's discretion," and (2) the state Medicaid agency had the ability to review the physician's determination of medical necessity of a treatment on a case-by-case basis.[203] In another Fifth Circuit case, *Curtis v. Taylor*, the court held that the state had the authority to limit the number of physician's visits per month, even when additional visits were medically necessary for some individuals.[204] Finally, in *Cowan v. Myers*, California's Third Circuit ruled that states may limit the services covered under Medicaid, but physicians must be given complete deference to make the determination as to whether treatment is medically necessary or not for a particular individual.[205]

The above cases address medical necessity under adult Medicaid benefits and highlight the unpredictability of how a court might allocate the power of determining the presence of medical necessity in a particular case. Fortunately, unlike under regular Medicaid benefits, courts have been more consistent in determining that the treating physician should make the determination of what treatment is medically necessary in EPSDT cases.

In *Collins v. Hamilton*, the Seventh Circuit deferred entirely to the physician in determining medical necessity.[206] In doing so, the court cited cases from the Fourth, Eighth, and Eleventh

201. *Id.* at 549 n.3 (quoting S. REP. NO. 89-404, at 46 (1965)).

202. 625 F.2d 1150, 1154 (5th Cir. 1980).

203. *Id.*

204. Curtis v. Taylor, 625 F.2d 645, 651 (5th Cir. 1980) (discussing "[w]hether Florida may limit the number of paid physicians' visits to three per calendar month depends on whether three visits are sufficient 'to reasonably achieve' the purpose of going to the doctor's office" even if those treatments are medically necessary), *reh'g denied and opinion modified on other grounds*, 648 F.2d 946 (5th Cir. 1980).

205. Cowan v. Myers, 232 Cal. Rptr. 299, 305 (Cal. Ct. App. 1986) ("First, the state must decide which *services* are necessary; then, out of the covered services, the physician may determine which *treatment* is necessary for a particular condition.").

206. 349 F.3d 371, 376 (7th Cir. 2003).

Circuits to support the conclusion that the terms of EPSDT prohibited states from refusing to pay for services deemed medically necessary by an EPSDT provider.[207] Similarly, in *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services*, the Eighth Circuit held that EPSDT "mandates that . . . treatment be provided when it is prescribed by a physician,"[208] thereby leaving the determination of medical necessity entirely to the treating physician.[209] Further, in *Rosie D. v. Romney*, a federal district court held that "so long as a competent medical provider finds specific care to be 'medically necessary' to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it."[210] Yet again, in *N.B. v. Hamos*, a federal district court reiterated the same sentiment, noting that "[b]y virtue of the statutory framework, 'medically necessary' services under the EPSDT program are those recommended by the appropriate healthcare provider."[211] The court then went on to acknowledge the breadth of such a construction but stated that it is "entirely consistent with the sweeping scope of the EPSDT program."[212]

Though this approach is certainly plausible and appears to be (nearly) uniformly followed, it seems to contradict the CMS guidance, which suggests that state agencies should play a substantial role in determining medical necessity.[213] CMS tells states that they "make the determination as to whether the

207. *Id.* at 376 n.8 (first citing Pediatric Specialty Care, Inc. v. Ark. Dep't of Hum. Servs., 293 F.3d 472, 480 (8th Cir. 2002); then citing Pereira *ex rel.* Pereira v. Kozlowski, 996 F.2d 723, 725–26 (4th Cir. 1993); and then citing Pittman *ex rel.* Pope v. Sec'y, Fla. Dep't of Health & Rehab. Servs., 998 F.2d 887, 891 (11th Cir. 1993)).

208. 293 F.3d at 480.

209. *See id.* at 481 ("Therefore, after . . . clinic staff perform a diagnostic evaluation of an eligible child, if the . . . physician prescribes early intervention day treatment as a service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the Arkansas State Plan must reimburse the treatment." (footnote omitted)).

210. *See* Jones, *supra* note 125, at 201 (citing Rosie D. v. Romney, 410 F. Supp. 2d 18, 26 (D. Mass. 2006)).

211. *See* Jones, *supra* note 125, at 201–02 (citing N.B. v. Hamos, 26 F. Supp. 3d 756, 765 (N.D. Ill. 2014)).

212. *Hamos*, 26 F. Supp. 3d at 765.

213. *See* EPSDT - A GUIDE FOR STATES, *supra* note 56, at 24 ("[B]oth the state and a child's treating provider play a role in determining whether a service is medically necessary.").

service is necessary."[214] Further, the Eleventh Circuit, in *Moore ex rel. Moore v. Reese*, seems to have imported the approach used in *Rush* into its EPSDT jurisprudence.[215] In *Reese*, the court found that a state can create a definition of medical necessity that limits a physician's discretion.[216] The court went on to reiterate CMS guidance by stating that "[b]oth the treating physician and the state have roles to play, . . . and '[a] private physician's word on medical necessity is not dispositive.'"[217] However, *Reese* may be distinguishable from other EPSDT case law on the basis that it did not address whether particular care was medically necessary *at all*, but rather whether a certain *amount* of care was medically necessary.[218] Further, *Reese* may be explained by the court's reliance on a federal regulation that provides states authority to place limits on a service based on "utilization control procedures."[219]

Ultimately, there are two lessons to be learned from this body of case law. First, the trend of physician deference militates against a broad policy denying EPSDT coverage for puberty blockers used to treat gender dysphoria. To do so would take the determination *completely* out of the hands of the physician, something that the courts are loath to do in EPSDT cases.

Second, there is a clear tendency among courts to afford complete deference to the treating physician, often entirely removing the individualized assessment from the control of the state. However, it cannot be stated with absolute certainty that all courts will completely disallow the state to have any influence in determining whether medical necessity is met in a given case. To the extent that states are afforded any deference in ascertaining whether gender-affirming pubertal suppressants are

214. STATE MEDICAID MANUAL, *supra* note 60, § 5122F.

215. 637 F.3d 1220, 1253 (11th Cir. 2011).

216. *Id.* at 1255.

217. *Id.* (alteration in original) (quoting Moore *ex rel.* Moore v. Medows, 324 F. App'x 773, 774 (11th Cir. 2009)).

218. *Id.* at 1254; *see also* Casey, *supra* note 198, at 104 (distinguishing *Reese* from other cases).

219. *Reese*, 637 F.3d at 1255; 42 C.F.R. § 440.230(d) (2024). Utilization control procedures are designed for cost management in the healthcare service and delivery context, such as establishing prior authorization requirements. Angelo P. Giardino & Roopma Wadhwa, *Utilization Management*, *in* STATPEARLS, *supra* note 139, https://www.ncbi.nlm.nih.gov/books/NBK560806 [https://perma.cc/G6EC-Y7YW]. However, a service may not be limited so much that it is insufficient to "reasonably achieve its purpose." 42 C.F.R. § 440.230(b) (2024).

medically necessary for a particular individual, just as the state definition of medical necessity is tied to the medical field, so, too, the state's individualized determination must be based on scientific evidence promulgated by the medical community. Thus, if a court were to defer to the state in determining the presence of medical necessity, the state is still bound by a "reasonable" analysis of the individual's condition and efficacy of the proposed treatment.

CONCLUSION

When a treating physician finds that puberty blockers are medically necessary to treat adolescent gender dysphoria, a court is likely to hold that most states—those without statewide bans or restrictions on gender-affirming puberty blockers for minors—may not withhold coverage of the treatment under EPSDT. Therefore, most states may not exclude coverage of puberty blockers to treat gender dysphoria under EPSDT.

Both the statutory text and the legislative history of EPSDT signal that the program was created to provide comprehensive access to preventative and maintenance treatment for all mental health conditions, including gender dysphoria. EPSDT requires a case-by-case determination of medical necessity, which is wholly incompatible with a blanket exclusion on gender-affirming puberty blockers. Despite the potential risks involved, puberty blocker treatment has been shown to help ameliorate symptoms of gender dysphoria in adolescents, and it enjoys the support of the medical community. While EPSDT does provide states with finite power to limit treatment coverage under EPSDT by establishing their own definition of medical necessity, the state's definition is inevitably tied to the medical field's opinion on the safety and efficacy of treatment. When the treating physician believes puberty blockers to be medically necessary to treat an adolescent with gender dysphoria, the court is likely to defer completely to the physician's recommendation. However, even in instances where the state is provided a level of deference in so making the individualized determination, the state's opinion must be supported by scientific evidence. Thus, federal courts should find that states that exclude EPSDT coverage of puberty blocker treatment used to treat gender dysphoria are in violation of the Medicaid Act.