February 17, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, D.C. 20201

Re: Medicare and Medicaid Programs; Hospital Conditions of Participation: Prohibiting Sex-Rejecting Procedures for Children, RIN 938-AN30

Dear Secretary Kennedy,

The National Health Law Program (NHeLP) writes in opposition to the notice of proposed rulemaking from the Department of Health and Human Services (HHS) regarding Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights (hereinafter "the Proposed Rule"). For over 55 years, NHeLP has advocated, educated, and litigated to preserve, protect, and expand access to health care for low-income and underserved populations.

If finalized, the Proposed Rule would prohibit hospitals from participating in Medicare and Medicaid if they offer a range of medical services, including medications that delay puberty, hormones, and surgery, to treat gender dysphoria in adolescents. Throughout these comments, we use the term "gender-affirming care" to refer to these services. For the following reasons, the Proposed Rule should be withdrawn:

1) HHS has no legal authority to impose the proposed conditions of participation.

2) HHS's contention that gender-affirming care is not health care is arbitrary and capricious.

3) HHS underestimates the costs and administrative burden of the proposed condition of participation.

4) The Proposed Rule is based on improper motives, flawed assumptions, and a misinterpretation of the available evidence and data, and therefore fails to reflect reasoned decisionmaking

5) The proposal will cause significant harm, especially to adolescents with gender dysphoria.

Regarding points #4 and #5 above, we incorporate by reference sections II and III of NHeLP's comments Re: Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, RIN 0938-AV73 [hereinafter Medicaid Funding Proposed Rule]. We have attached those comments (including the relevant attachments to those comments) for HHS's reference and consideration. The concerns we articulated in sections II and III of those comments apply equally to the Proposed Rule.

We offer the following comments in support of points #1, #2, #3 above:

I. HHS lacks the authority to impose the proposed conditions of participation.

In the Proposed Rule, HHS concedes that the Medicare Act prohibits it from "exercise[ing] any supervision or control over the practice of medicine or the manner in which medical services are provided."[1] In an effort to get around that clear Congressional direction, HHS makes the startling claim that gender-affirming care is "not healthcare and hence are not subsumed under the term of 'the practice of medicine.'"[2] But HHS's attempt to define the practice of medicine is contrary to law, and federal law does not permit it to impose the proposed conditions of participation.

Tellingly, the Proposed Rule does not identify any statutory authority that allows it to define particular medical services as not within "the practice of medicine." There is none. In fact, it is well-established that states have primary authority to regulate the practice of medicine.[3] This is consistent with the 10th Amendment of the United States Constitution, which authorizes the states to establish laws and regulations protecting the health, safety and

[1] Medicare and Medicaid Programs; Hospital Conditions of Participation: Prohibiting Sex-Rejecting Procedures for Children, 90 Fed. Reg. 59463, 59471 (Dec. 19, 2025) [hereinafter "Proposed Rule"] (quoting 42 U.S.C. § 1395).
[2] Proposed Rule at 59471.
[3] *See Linder v. United States*, 268 U.S. 5, 18 (1925) ("Obviously, direct control of medical practice in the states is beyond the power of the federal government."); *Mass. Med. Soc'y v. Dukakis*, 815 F.2d 790, 791 (1st Cir. 1987) (Section 1395 "explicitly states the…intent to minimize federal intrusion" into state healthcare regulation).

general welfare of their citizens.[4] Thus, it is "state lawmakers, not the federal government" that are "the primary regulators of professional [medical] conduct."[5] And, as HHS acknowledges, it is legal for clinicians to provide the services at issue in more than half of states.[6] Notably, courts "have generally declined to read federal law as intruding on that responsibility, unless Congress has clearly indicated that the law should have such reach."[7] In addition, courts particularly "expect Congress to speak clearly when authorizing an agency to exercise powers of vast economic and political significance." [8] Authorizing HHS to entirely exclude hospitals from Medicare and Medicaid because they provide certain medical services likely qualifies as a question of vast political significance, particularly in light of the states' historical primacy in regulating the practice of medicine.[9]

Nevertheless, HHS goes on to make the staggering claim that its determination that the services at issue do not constitute the practice of medicine would "preempt[] the applicability of any State or local law." [10] Again, it provides no authority for this statement. And again, there is none. As explained above, HHS simply does not have the authority to define what is or is not the practice of medicine and certainly may not supersede state laws doing so. Moreover, HHS's statement seems inconsistent with its assurance that "primary care providers and endocrinologists outside of hospitals…would not be affected by these requirements," and could continue to deliver the services at issue in non-hospital settings.[11] It is nonsensical to say that certain services do not constitute the practice of medicine when provided in a hospital, but do constitute the practice of medicine when provided outside of hospital settings (or in hospitals that do not participate in Medicare or Medicaid).

HHS appears to posit that its authority to impose requirements on hospitals "as necessary in the interest of the health and safety of individuals who are furnished services in the institution" allows it determine what is and is not the practice of medicine.[12] That authority in no way extends to defining what interventions constitute the practice of medicine.[13] Rather,

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[4] U.S. CONST. amend. X.
[5] *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2004), *aff'd sub nom., Gonzales v. Oregon*, 546 U.S. 243 (2006); *see also United States v. Skrmetti*, 605 U.S. 495, 524 (2025) ("We afford States wide discretion to pass legislation in areas where there is medical and scientific uncertainty," and questions regarding gender-affirming care should be left to "the people, their elected representatives, and the democratic process") (internal quotations and citation omitted).
[6] Proposed Rule at 59469–70.
[7] *Bond v. United States*, 572 U.S. 844, 848 (2014).
[8] *Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs*., 594 US 758, 764 (2021) (internal quotation marks omitted).
[9] *See West Virginia v. EPA,* 597 U.S. 697, 744 (2022) (Gorsuch, J., concurring) ("Unsurprisingly, the major questions doctrine and the federalism canon often travel together" because overbroad assertions of executive authority "risk[] intruding on powers reserved to the States.")
[10] Proposed Rule at 59477.
[11] Proposed Rule at 59472.
[12] 42 U. S. C. § 1395x(e)(9).
[13] *See, e.g., Florida. v. Dep't of Health & Hum. Servs*., 19 F.4th 1271, 1287 (11th Cir. 2021) (suggesting that the Secretary's discretion to regulate hospital health and safety does not permit regulation of "the manner in which medical services are provided, or the operation an institution"); *see also, e.g., Am. Health Care Ass'n v. Kennedy*, 777 F. Supp. 3d 691, 702 (N.D. Tex. 2025),

Congress enumerated a specific list of procedural requirements for participating hospitals—such as maintaining clinical records, 24-hour nursing coverage, and a sufficient discharge planning process—and then authorized CMS to define "such other requirements as [CMS] finds necessary in the interest of the health and safety of individuals who are furnished services in the institution."[14] Under the statutory interpretation canon of *ejusdem generis*, the reference to "such other requirements" should be interpreted consistent with the facility-wide procedural requirements enumerated in the preceding paragraphs.[15] HHS simply cannot dictate what services may be provided by a participating hospital; the statute only allows HHS to oversee the provision of those services to ensure that they are provided in a manner that promotes health and safety.[16]

In addition, the proposed condition of participation constitutes unlawful sex discrimination under the Equal Protection clause of the U.S. Constitution and section 1557 of the Affordable Care Act.

The Proposed Rule discriminates based on sex, so it is subject to heightened scrutiny under the Equal Protection clause. Moreover, as the Supreme Court recently held, even if "a law's classifications are neither covertly nor overtly based on sex," it is still subject to "heightened review" if "it was motivated by an invidious discriminatory purpose."[17] Here, *all* of the evidence indicates that the Proposed Rule was motivated by animus against transgender people and intentional sex discrimination. None of HHS's justifications for the Proposed Rule are sufficient to withstand heightened scrutiny, as described in detail in our comments to the Medicaid Funding Proposed Rule.

As for section 1557, where a regulation distinguishes on sex to determine a "but for" cause of harm, it impermissibly discriminates based on sex.[18] Because the Proposed Rule here would prohibit hospitals from participating in Medicare and Medicaid if they provide the

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appeal dismissed, No. 25-10700, 2025 WL 3528313 (5th Cir. Sept. 19, 2025) (in exercising discretion to regulate hospital health and safety, Secretary cannot exceed statutory authority).

[14] 42 U.S.C. § 1395x(e) (emphasis added).

[15] *See Fischer v. U.S.*, 603 U.S. 480, 487 (2024). While some conditions of participation are targeted to specific hospital departments, they nonetheless consist of broadly applicable procedural requirements.

[16] *Cf. Biden v. Missouri*, 595 U.S. 87, 94 (2022) (finding that "there can be no doubt that addressing infection problems in Medicare and Medicaid facilities is what [the HHS Secretary] does"). When Congress wants to delegate to HHS the authority to weigh clinical evidence it has done so explicitly. *See, e.g.,* 42 U.S.C. §§ 1395y(a)(1) (empowering HHS to issue National Coverage Determinations (NCDs) excluding coverage for services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member"), 1395m(a)(E)(i) (directing HHS to "establish standards for clinical conditions for payment" for durable medical equipment), 1395m(c)(2)(B) (instructing HHS, "in consultation with the Director of the National Cancer Institute, [to] review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent").

[17] *United States v. Skrmetti*, 605 U.S. 495, 516 (2025).

[18] *See L.B. v. Premera Blue Cross*, 795 F. Supp. 3d 1311, 1315 (W.D. Wash. 2025); *see also Am. Ass'n of Physicians for Hum. Rts., Inc. v. Nat'l Institutes of Health*, 795 F. Supp. 3d 678, 695 (D. Md. 2025); *see also Bostock v. Clayton Cnty.*, 590 U.S. 644, 656 (2020).

services at issue based on the sex of the person seeking the service, and the person's sex is the "but for" cause of the exclusion, the proposal violates section 1557.[19]

Because HHS lacks the authority to regulate the practice of medicine, and the proposed condition unlawfully discriminates based on sex, it cannot impose this condition of participation on hospitals. This proposal exceeds HHS's authority.

II. HHS's contention that gender-affirming care is not health care is arbitrary and capricious.

HHS justifies the Proposed Rule on its contention that the services are not the practice of medicine. Again, states are the primary definers of what constitutes the practice of medicine. Most states define the practice of medicine as something like: "the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition."[20] HHS does not explain how it defines the practice of medicine, but instead gives several reasons that it posits exclude the provision of gender-affirming care from the practice of medicine. None of these reasons holds water.

First, HHS states that, based on its review of gender-affirming care, the services "pose unnecessary, disproportionate risks of harm."[21] As discussed in detail in our comments to the Medicaid Funding Proposed Rule, the scientific evidence does not support that conclusion. What is more, nothing in defining the practice of medicine involves a weighing of the risks and benefits associated with a particular intervention.

Notably, never before has HHS excluded hospital participation from Medicare or Medicaid based on the hospital's provision of care that HHS deems "too risky." Indeed, the proposal marks a sharp departure from the "longstanding practice of Health and Human Services in

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[19] *See L.B.*, 795 F. Supp. 3d at 1315

[20] Fla. Stat. 458.305(3); *see also, e.g.*, Ark. Code Ann. § 17-95-202(5)(A) (practice of medicine includes "[h]olding out oneself to the public within this state as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever"); Ga. Code Ann. § 43-34-21(4) (practice of medicine includes holding "oneself out to the public as being engaged in the diagnosis or treatment of disease, defects, or injuries of human beings; or the suggestion, recommendation, or prescribing of any form of treatment for the intended palliation, relief, or cure of any physical, mental, or functional ailment or defect of any person"); Md. Code Ann., Health Occ. § 14-101(n) (practice of medicine "means to engage, with or without compensation, in medical: (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery"); Neb. Rev. Stat. Ann. § 38-2024(4) (practice of medicine includes those who "suggest, recommend, or prescribe any form of treatment for the intended palliation, relief, or cure of any physical or mental ailment of any person"); S.C. Code Ann. § 40-47-20(36)(c) (practice of medicine includes "offering or undertaking to prevent or to diagnose, correct or treat in any manner, or by any means, methods, or devices, disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of a person, including the management of pregnancy and parturition"); W. Va. Code Ann. § 30-3-4(3) (practice of medicine "means the diagnosis or treatment of, or operation or prescription for, any human disease, pain, injury, deformity or other physical or mental condition").

[21] Proposed Rule at 59471.

implementing the relevant statutory authorities" that allow it to regulate hospital health and safety.[22] Hospitals, including those that participate in Medicare and Medicaid, routinely provide interventions that carry a very high level of risk, including many surgeries.[23] For example, coronary artery bypass surgery carries a high risk of complications and even death, especially among certain populations, but it remains the most common heart surgery in the world, and is certainly performed at Medicare and Medicaid participating hospitals.[24] Ascending aortic replacement is another common surgery that is performed thousands of times each year, including at Medicare and Medicaid participating hospitals, that can be very risky, with mortality over 5%.[25] Further, Medicare and Medicaid participating hospitals perform incredibly risky experimental procedures.

In addition, the Proposed Rule would set the precedent that HHS could, at any time and for any reason, decide a particular intervention is too risky, and then exclude hospitals that offer it from participating in Medicare and Medicaid. The resulting uncertainty would particularly impact individuals who need surgical interventions, which often must be scheduled months in advance. If, between the time a surgery is requested and the date it is set to be performed, HHS deems that procedure too risky to be offered by Medicare and Medicaid participating hospitals, people will likely be forced to delay or go without necessary care. In sum, it would be arbitrary for HHS to exclude hospitals that provide gender-affirming care from Medicare and Medicaid because of the potential risk associated with the care.

Second, HHS suggests that gender-affirming care involves changes to "organs, organ systems, and processes natural to human development like puberty" that are "healthy," which does not constitute the practice of medicine; HHS asserts that "the intentional destruction of healthy biological functions…is not health care."[26]

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[22] *Biden v. Missouri*, 595 U.S. 87, 94 (2022).
[23] *See, e.g.*, Jonathan F. Finks et al., *Trends in Hospital Volume and Operative Mortality for High-Risk Surgery,* 364 N.E.J.M. 2128 (2011), https://pmc.ncbi.nlm.nih.gov/articles/PMC3150488/.
[24] *See, e.g.,* Cleveland Clinic, Coronary Artery Bypass Graft (2025), https://my.clevelandclinic.org/health/treatments/16897-coronary-artery-bypass-surgery; Mario Gaudino et al., *Operative Outcomes of Women Undergoing Coronary Artery Bypass Surgery in the US, 2011 to 2020*, 158 JAMA SURGERY 494 (2023), https://jamanetwork.com/journals/jamasurgery/fullarticle/2802105 (worse outcomes for women); Soslan Enginoev et al., *Risk Factors for Deep Sternal Wound Infection after Off-Pump Coronary Artery Bypass Grafting: a Case-Control Study*, 37 BRAZ. J. CARDIOVASCULAR SURGERY 13 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8973134/ (identifying risk factors including high BMI, lower extremity artery disease, and use of bilateral internal thoracic artery (BITA) graft).
[25] *See, e.g.,* Judson B Williams et al., *Contemporary Results for Proximal Aortic Replacement in North America*, 60 J. AM. COLL. CARDIOLOGY 1156, 1157 (2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3699187/ (among 45,894 surgeries performed from 2004 to 2009, "[o]perative mortality was 3.4% for elective and 15.4% for non-elective cases"); Daniel Hernandez-Vaquero et al., *Life Expectancy after Surgery for Ascending Aortic Aneurysm*, 9 J. CLINICAL MED. 615 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7141111/ (of 738 patients who had the procedure at one institution between 2000 and 2019, 5.96% died during the post-operative period).
[26] Proposed Rule at 59471.

For one, HHS does not explain how it defines the terms "healthy" or "natural" in this context, making its conclusions about gender-affirming care arbitrary. For another, HHS is simply incorrect in its characterization of the practice of medicine. Contrary to HHS's assertion, there are many widely accepted clinical interventions that are considered health care that involve changes to "organs, organ systems, and processes natural to human development like puberty" that are "healthy."[27] HHS notes that "removing a patient's breasts as a treatment for breast cancer…aims to restore bodily health and to remove cancerous tissue."[28] But HHS fails to acknowledge that some individuals have prophylactic mastectomies to reduce their risk of developing breast cancer in the future.[29] Prophylactic mastectomies, like the gender-affirming chest surgeries HHS aims to prohibit Medicare and Medicaid hospitals from offering, involve "removing healthy breast[]" tissue.[30]

Other surgeries—such as chest surgery to treat gynecomastia, or breast reduction surgery to treat a variety or physical and emotional conditions—similarly involve the removal of healthy tissue.[31] Moreover, HHS has never attempted to prevent Medicare and Medicaid participating hospitals from providing cosmetic surgeries on minors, such as breast augmentations or rhinoplasties; these procedures unquestionably involve changes to "healthy" organs, systems, and processes, and are routinely performed in Medicare and Medicaid participating hospitals around the country.[32] It is simply not true that the practice of medicine is limited to interventions that treat "unhealthy" or "abnormal" organs, systems, or processes.[33] Excluding hospitals from participating in Medicare and Medicaid for providing gender-affirming care based on HHS's narrow interpretation that excludes any interventions that involve changes to organs, systems, or processes that are "healthy" or "normal" is arbitrary and capricious.

Third, HHS asserts that there is a "lack of clarity about what [these services'] fundamental aims are, unlike the broad consensus about the purpose of medical treatments for conditions like appendicitis, diabetes, or severe depression," which, according to HHS, justifies treating gender-affirming care as something other than the practice of medicine.[34] Once again, the consensus about the purpose of an intervention is simply not relevant to the question of whether a service constitutes the practice of medicine. But HHS is also wrong that there is no clarity and consensus about the fundamental aims of gender-

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[27] *Id.* at 59471.
[28] *Id.*
[29] Breastcancer.org, *Prophylactic Mastectomy* (2024), https://www.breastcancer.org/treatment/surgery/mastectomy/types/prophylactic.
[30] Proposed Rule at 59471.
[31] *See, e.g.,* Massimo Pinelli et al., *Gynecomastia: An Uncommon, Destabilizing Condition of the Male Adolescent*, 94 ACTA BIO-MEDICA e2023055 (2023), https://www.mattioli1885journals.com/index.php/actabiomedica/article/view/14028.
[32] *See, e.g.,* Am. Soc. Plast. Surg., Briefing Paper: Plastic Surgery for Teenagers, https://www.plasticsurgery.org/news/briefing-papers/briefing-paper-plastic-surgery-for-teenagers (last visited Feb. 3, 2026) ("According to [American Society of Plastic Surgeons] statistics, 23,527 cosmetic surgery procedures were performed on people aged 19 and under in 2022.").
[33] Proposed Rule at 59471.
[34] *Id.*

affirming care services. Specifically, puberty blockers are used to delay the changes of puberty in youth with gender dysphoria who have started puberty; hormone treatments and surgeries for gender dysphoria align physical characteristics with gender identity, which reduces the symptoms of dysphoria.[35] That some jurisdictions have prohibited or curtailed the provision of the services at issue within their boundaries does not demonstrate any lack of clarity or consensus about their purpose. Nor does the fact that HHS disagrees with the clear purpose of these clinical interventions show any lack of clarity or consensus about their purpose. HHS's reasons for excluding hospitals that provide these services from participating in Medicare and Medicaid are arbitrary and capricious.

III. HHS underestimates the costs and administrative burden of the proposed condition of participation.

HHS posits that the primary implementation costs for the approximately 4,800 hospitals subject to this rule will be in providing notices to patients that gender-affirming care will no longer be available.[36] However, HHS does not estimate the number of actual providers and non-clinical staff working within those hospital systems who will be impacted. HHS also fails to adequately address significant costs and administrative burdens associated with implementation of the proposed condition of participation. While the condition of participation will prohibit hospitals from offering medications to delay puberty, hormones, or surgery when necessary to treat gender dysphoria, it will not prohibit them from offering the same services when necessary to treat other health conditions. Hospitals and providers will need to develop, test, implement, and evaluate billing coding systems, operational procedures, manuals, policies, and trainings to distinguish between permissible and

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[35] *See, e.g.,* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse* People, *Version 8*, 23 INT. J. TRANS. HEALTH SUP. 1, S48-51, S61-62 (2022), https://www.tandfonline.com/doi/full/10.1080/26895269.2022.2100644; Wylie C.Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOL. METAB. 3869, 3876 (2017), https://academic.oup.com/jcem/article/102/11/3869/4157558?login=false; *see also, e.g.,* Am. Med. Ass'n, *Clarification of Evidence-Based Gender-Affirming Care H-185.927* (2024), https://policysearch.ama-assn.org/policyfinder/detail/%22Clarification%20of%20Evidence-Based%20Gender-Affirming%20Care%22?uri=%2FAMADoc%2FHOD-185.927.xml; Letter from James L. Madara, Am. Med. Ass'n, to Bill McBride, Nat'l Gov. Ass'n (Apr. 26, 2021), https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf; Am. Acad. Ped., *AAP Continues to Support Care of Transgender Youths as More States Push Restrictions* (2022), https://publications.aap.org/aapnews/news/19021/AAP-continues-to-support-care-of-transgender; Am. Coll. Phys., Attacks on Gender-Affirming and Transgender Health Care (2025), https://www.acponline.org/advocacy/state-health-policy/attacks-on-gender-affirming-and-transgender-health-care; Am. Psychiatric Ass'n, *Frontline Physicians Oppose Legislation That Interferes in or Criminalizes Patient Care* (2022), https://www.psychiatry.org/newsroom/news-releases/frontline-physicians-oppose-legislation-that-interferes-in-or-criminalizes-patient-care; Am. Psychological Ass'n, *APA Adopts Groundbreaking Policy Supporting Transgender, Gender Diverse, Nonbinary Individuals* (2024), https://www.apa.org/news/press/releases/2024/02/policy-supporting-transgender-nonbinary.

[36] Proposed Rule at 59476–77.

impermissible uses of these services. HHS accounts for none of these costs or administrative burdens.

These costs and burdens will be compounded by the financial strains hospitals are facing due to cuts associated with several federal changes. For example, changes to Medicaid and Marketplace eligibility and enrollment introduced by the One Big Beautiful Bill Act (OBBBA), together with cuts to subsidies and other proposed Marketplace rules, will result in 16 million individuals losing insurance.[37] In addition, states are likely to begin cutting back on Medicaid covered services and reimbursement rates in response to changes to the Medicaid provider tax formula.[38] As a result, hospitals will see a significant uptick in uncompensated care. Moreover, if OBBBA leads to an increase in the federal deficit, as the Congressional Budget Office projects, it would trigger further mandatory cuts to Medicare hospital payments.[39] The cuts will have a heightened effect on hospitals that serve rural and low-income communities, which were already facing tight operating margins before the changes.[40] Taken together, these federal changes will likely lead to further hospital closures, making it more difficult for low-income and underserved individuals to access necessary health care.

If HHS finalizes the Proposed Rule, it will also significantly curtail access to medically necessary gender-affirming care for minors because hospitals are one of the primary settings in which this care is provided. Already, a significant number of hospitals have stopped providing gender-affirming care for young people in response to other actions taken by the administration that threaten the federal funding hospitals receive.[41] Moreover, it is highly disingenuous for HHS to claim that "primary care providers and endocrinologists outside of hospitals…would not be affected by these requirements," and will be able to continue to deliver the services at issue in non-hospital settings.[42] The administration has been clear about its goal to "end" the provision of gender-affirming care to youth.[43] HHS has already taken several companion actions to try to limit the availability of gender-affirming care for youth in any setting, including most recently its announcement that it has referred several federally qualified health centers (FQHCs) to the HHS Office of Inspector

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[37] Zachary Levinson et al., Kaiser Fam. Found., *What are the Implications of the 2025 Budget Reconciliation Bill for Hospitals?* (2025), https://www.kff.org/medicaid/what-are-the-implications-of-the-2025-budget-reconciliation-bill-for-hospitals/.
[38] Alice Burns et al., Kaiser Fam. Found., *5 Key Facts About Medicaid and Provider Taxes* (2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/.
[39] Levinson et al.
[40] *Id.*
[41] Theresa Geffney, STAT, *Amid Federal Pressure, More Hospitals Stop Gender-Affirming Care for Minors* (Feb. 5, 2026), https://www.statnews.com/2026/02/05/hospitals-stop-gender-care-minors-trump-administration-pressure.
[42] Proposed Rule at 59472.
[43] Exec. Order No. 14187, Protecting Children from Chemical and Surgical Mutilation, 90 Fed. Reg. 8771 (Feb. 3, 2025); *see also* Robert F. Kennedy Jr., U.S. Dep't Health & Hum. Servs., *Declaration Re: Safety, Effectiveness, and Professional Standards of Care for Sex-Rejecting Procedures on Children and Adolescents* (2025), https://www.hhs.gov/sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf.

General for "performing sex-mutilating and sex-rejecting procedures for minors."[44] The Proposed Rule, together with the Medicaid Funding Proposed Rule (prohibiting Medicaid and CHIP coverage of gender-affirming care for adolescents), would further limit access to gender-affirming care. This will cause profound harm to transgender and gender diverse adolescents across the country, as we described in detail in our comments on the Medicaid Funding Proposed Rule.

IV. Conclusion

For the reasons stated above, we urge HHS to withdraw the Proposed Rule. We have included numerous citations to supporting research, including direct links to research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to comment on this proposed rule. If you have any questions or concerns, please feel free to contact Héctor Hernández-Delgado at hernandez-delgado@healthlaw.org, Abbi Coursolle at coursolle@healthlaw.org, or Catherine McKee at mckee@healthlaw.org.

Sincerely,

Elizabeth G. Taylor
Executive Director

[44] HHS General Counsel Mike Stuart (@HHSGCMikeStuart), X (Feb. 3, 2026), https://x.com/HHSGCMikeStuart/status/2018828343144010025 (stating that hospitals "are continuing to perform heinous and horrific acts of intentional permanent harm to minors…We will not stop until every single child is protected from the destruction of the integrity of God's chosen human body); HHS General Counsel Mike Stuart (@HHSGCMikeStuart), X (Feb. 11, 2026), https://x.com/HHSGCMikeStuart/status/2021649628639240524.