CITY AND COUNTY OF SAN FRANCISCO

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Via Federal eRulemaking Portal (Regulations.gov),
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard,
Baltimore, MD 21244-1850

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Re Comments Submitted in Opposition to Proposed Rules Concerning Restrictions on Providing Gender-affirming Care to Minors

The undersigned jurisdictions submit these comments in response to two Proposed Rules restricting access to gender-affirming care for transgender youth issued by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), collectively referred to herein as the Agencies.

SUMMARY

The proposed rules target so-called "sex-rejecting procedures," which they define as "any pharmaceutical or surgical intervention that attempts to align an individual's physical appearance or body with a stated identity that differs from the individual's sex." Medicare and Medicaid Programs; Hospital Conditions of Participation: Prohibiting Sex-Rejecting Procedures for Children, 90 Fed. Reg. 59463 (proposed Dec. 19, 2025) (to be codified at 42 C.F.R. pt. 482); Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, 90 Fed. Reg. 59441, (proposed Dec. 19, 2025) (to be codified at 42 C.F.R. pt. 441 and 457).

The first proposed rule, "Medicare and Medicaid Programs; Hospital Conditions of Participation: Prohibiting Sex-Rejecting Procedures for Children" (Conditions of Participation Proposed Rule) prohibits hospitals receiving federal Medicare and Medicaid funding from offering these procedures to children, with very limited exceptions. In effect, this Rule conditions a hospital's ability to provide medical care to low-income patients, families, people with disabilities, and seniors on the hospital's willingness to deny evidence-based treatment to transgender minors. The second proposed rule, "Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children" (Medicaid Proposed Rule), prohibits state Medicaid agencies from funding these procedures for children under eighteen enrolled in Medicaid and for individuals

under nineteen enrolled in the Children's Health Insurance Program (CHIP). Collectively, the undersigned jurisdictions refer to both the Conditions of Participation Proposed Rule and the Medicaid Proposed Rule as the Proposed Rules.

Medicare, Medicaid, and CHIP coverage assist more than 150 million Americans. Approximately 36.6 million children—about half of the children in the United States—are enrolled in Medicaid or CHIP, and there are more than 380,000 Medicare institutional providers. Accordingly, these proposed regulations have the effect of nearly banning essential procedures for transgender youth nationwide, creating barriers to care for vulnerable patients, and further stigmatizing an already-marginalized group. The undersigned jurisdictions stand by our transgender communities and recognize that patients must have access to medically necessary care and should, together with their doctors and families, be permitted to determine their own best course of care.

Moreover, the Proposed Rules are as unlawful as they are misguided. The Proposed Rules are unconstitutional and violate the Administrative Procedure Act, the Rehabilitation Act, and the Americans with Disabilities Act. They interfere with the practice of medicine, which the Agencies have no authority to do. And, in the guise of establishing a generally applicable safety standard, they take the unprecedented step of depriving hospitals of all Medicaid and Medicare funding if the hospital provides one kind of medical care to a patient class. There is no other Condition of Participation that puts hospitals in the impossible position of having to choose between retaining their federal funding and fulfilling their duty to provide medically necessary care to their patients.

For these reasons—and for those more fully discussed below—the undersigned jurisdictions hereby express their strong opposition to each of the Proposed Rules and ask that the Agencies withdraw both in their entirety.

I. Introduction[1]

Will, now 16, came out to his family as transgender when he was 11. Coming out was "really scary," he says, because "there were no other queer people in my family." Though his family was supportive, Will did not feel ready to start puberty blockers. So, for almost four years, Will sat with intensifying alienation from the female body in which he was living. He developed anorexia: Food seemed to him like the only way he could control what was happening to his body.

[1] The stories and quotes relayed in the Introduction were gathered during a conversation with transgender teenagers and their families on February 2, 2026. We have used their preferred pseudonyms.

Then, at 14, Will felt ready to move forward. He had completed female puberty, so he began taking Testosterone shots once every two weeks. But, before he was able to begin his shots of "T," Will was evaluated by his pediatrician, an endocrinologist, his therapist, and multiple other health care professionals. The decision to begin hormone therapy was deliberative—unfolding over many years and multiple consultations. Will has been receiving T every two weeks for two years and has recently begun to contemplate "top" surgery. Beginning hormone therapy improved his mental health struggles dramatically and has been key to his sustained recovery from his eating disorder. According to Will and his mom, if and when he decides to move forward with surgery, Will will be put on a waiting list for referrals. After Will gets off the wait list, he has been told, the time from consultation to surgery is at least six months.

17-year-old Skye came out to her family two years ago on New Years Day, after what she describes as a "slow" and steady realization that a male identity didn't quite "fit." It was both "freeing and scary" to come out—but worth it so Skye could live as "a truer version" of herself. Skye's mom reached out to her pediatrician who connected the family with resources. Skye met with specialists and therapists before starting puberty blockers. After a running dialogue and multiple consultations with physicians, Skye began taking estrogen shots six months ago—a year-and-a-half after she came out. The hormone shots have been a gamechanger for her positive mentation.

Eric has been wrestling with his identity since he was in the 4th grade, and, for a time, he identified as nonbinary. When he was in the 8th grade, however, he came out as transgender. The upcoming transition to high school was appealing as an opportunity to align his outward appearance with his identity. Quite simply, "I wanted to have a chance to have people see me without first knowing me as a girl," he says.

When Eric came out as transgender, he was eager to begin hormone therapy, but his mother wanted to proceed methodically. This was frustrating at times for Eric—especially as the healthcare providers who consulted with Eric and his family slowed the pace. Eric first began his T shots 11 months after coming out as transgender.

"We figured it out in our family," he says of the process, which sometimes made him feel impatient. "We didn't need someone outside of our family telling us what was right."

Each of these teens described a sense of intense relief when they were able to finally begin hormone therapy or puberty blockers. The thought of being unable to access hormone treatments or being unable in the future to have gender-affirming surgery if they decide to do so fills them with dread.

If he can no longer access T shots, Will predicts his gender dysphoria, depression, and anxiety would rush back in. He worries about relapsing into his eating disorder, about what school would be like. A recurring fear is that, if he loses access to T, he might start menstruating

unexpectedly at school. How would the other students react? Would they laugh? Would they make fun of him? Would this "out" him as transgender to students who didn't know him before hormone therapy began?

Without hormone treatments, "I don't even know what I would do," says 16-year-old Bibi, a transgender girl. "I genuinely don't know what I would do either," echoes 14-year-old AAR. "HRT is the only thing that helps people know I'm a guy," he continues.

It's "overwhelming to think about [a] future not in my own body," says Eric. "Hard to be hopeful."

"When people say this is life-saving medicine, that is not hyperbole. You can't separate mental health from being trans," says Skye.

The teenagers discussed above had distinct, diverse experiences seeking out and receiving gender-affirming care. No single approach would have worked for each child, and, by the accounts of these teens and their parents, no one-size-fits all approach was even entertained, much less imposed. The only universal components of their lived experience are that (i) each consulted multiple medical professionals before taking any single step, (ii) each reported alleviation of anxiety and gender dysphoria upon beginning their treatments, and (iii) each reported terror and dismay at the prospect that this healthcare might suddenly become prohibitively difficult or impossible to access.

Yet, this outcome is seemingly what the Proposed Rules intend. Eliminating access to gender-affirming care has emerged as one of the Trump administration's top priorities. Less than a month after he assumed office for his second term, President Trump signed an executive order titled "Protecting Children from Chemical and Surgical Mutilation." That executive order labels gender-affirming care as "child-abusive" and declares that "[c]ountless children soon regret that they have been mutilated and begin to grasp the horrifying tragedy that they will never be able to conceive children of their own or nurture their children through breastfeeding."[2] The specter of patient regret, disfiguration, infertility, and inability to breastfeed are also invoked by a companion declaration issued by HHS Secretary Robert F. Kennedy, Jr.[3] (the Kennedy Declaration), a supposed "umbrella review" purporting to evaluate the evidence of harms and benefits to minors of gender-affirming care (the 2025 HHS Review or Review), and the Proposed Rules. But, notably, none of these documents cite any trustworthy sources for these startling assertions, which prioritize the hypothetical babies that transgender teens *might one day have* over living, breathing children and teenagers seeking appropriate medical care and begging for our empathy, kindness, and medical assistance.

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[2] Exec. Order No. 14,187, 90 Fed. Reg. 8771 (Jan. 28, 2025).
[3] Robert F. Kennedy Jr., Declaration of the Secretary of Health & Human Services, U.S. Dep't of Health & Human Servs (HHS), (Dec. 18, 2025), https://perma.cc/GL47-GUGE.

Under the guise of "protecting" children, the Agencies have developed two Proposed Rules that will wreak havoc on American health care. Because of the number of children and teenagers on Medicaid or enrolled in CHIP[4] and the number of hospitals or medical facilities that receive Medicaid or Medicare funding, the Proposed Rules in effect ban most gender-affirming care for transgender youth. Despite a veritable ocean of research confirming the extraordinary, and often life-saving, benefits of providing gender-affirming care to minors, no such benefits are meaningfully referenced in the Kennedy Declaration, the HHS Review, or the Proposed Rules themselves. As discussed further below, to justify this sweeping and unprecedented intrusion, the Agencies have selectively plucked so-called "scientific" literature authored by individuals and organizations with a recognized bias against the transgender community. The Agencies have also mischaracterized data and conclusions of studies.

The undersigned do not, and could not, claim that gender-affirming care is entirely without risk. *No* medical intervention—not aspirin, not antibiotics, not hip replacement surgery, not an appendectomy—is without risk. The duty of a physician is to discuss with a patient those risks and to contextualize those risks relative to doing nothing (or relative to alternate treatments). Here, by focusing exclusively on the apparition of risk to the exclusion of the extensively documented medical benefits of providing gender-affirming care, the Agencies purport to wrest that responsibility from treating physicians and the facilities where they provide patient care and bestow such responsibility, without statutory authority to do so, on the federal government.

Whether and when to seek hormonal or surgical treatment is highly dependent upon the needs of the transgender youth in question. Those best equipped to opine are the patient, the patient's family, and the patient's treating physicians—not politicians and administrators in Washington D.C.

The undersigned jurisdictions therefore request that HHS rescind both of the Proposed Rules in their entirety.

II. Administering Gender-affirming Care Is in Practice a Methodical, Meticulous, and Lengthy Process.

To justify their draconian overreach, in each of the Proposed Rules the Agencies imply that there is an epidemic of transgender teenagers being rushed into extreme medical interventions without complete informed consent. This inaccurate characterization ignores the realities of providing gender-affirming care to minor patients.

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[4] Approximately 36.6 million children are enrolled in Medicaid or CHIP. U.S. Centers for Medicare & Medicaid Services, October 2025 Medicaid & CHIP Enrollment Data Highlights, Medicaid.gov (last updated Jan. 29, 2026), https://perma.cc/SUU2-3LP5. *See also* CMS Fast Facts, CMS (Apr. 2025), https://perma.cc/4D9M-XB97.

As an initial matter, the number of transgender teens receiving hormonal or surgical care is small. For instance, despite insinuations to the contrary, only very rarely are surgical procedures undertaken for transgender minors. In fact, *over the course of five years*, from 2016 to 2020, approximately 48,000 patients (of all ages) in the United States underwent one or more gender confirmation surgery (breast or chest reduction or augmentation, facial procedures, or genital reconstruction).[5] Of these patients, *only 3,678 were in the youngest cohort, aged 12 to 18*.[6]

For these few individuals and their families, following established medical guidelines, the decision to pursue gender-affirming care is methodical and deliberate—and, crucially, made after significant consultation between the minor patients, their families, and their healthcare teams. Contrary to the Agencies' insinuations, minors are not left alone to decide whether to pursue gender-affirming care. Indeed, the vast majority of adolescents are legally required to rely on their parents and guardians—the adults whose role it is to protect their health and safety, and who routinely make other important health care decisions with and for them—to decide whether gender-affirming care is safe and appropriate, to weigh the risks and benefits, and to approve any and all aspects of treatment. The Proposed Rules only indirectly acknowledge the crucial contribution of parents to this decision-making process.[7]

Here, to support their assertion that decisions about gender-affirming care are made haphazardly and aggressively, the Agencies misrepresent mainstream medical guidance for transgender children and teenagers. For instance, the Proposed Rules assert that the World Professional Association for Transgender Health's (WPATH) guidelines for gender-affirming care "effectively recognize[] transgender identification as a medical condition justifying medical interventions" under any circumstances.[8] This could hardly be further from the truth. WPATH's evidence-based clinical guidelines *do not* recommend puberty blockers, hormone therapy, or surgeries for children that have not yet reached puberty.[9] And, even for pubescent children and

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[5] Jason Wright et al., National Estimates of Gender-affirming Surgery in the United States, Jama Network Open (Aug. 23, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808707 (last visited Feb. 12, 2026).

[6] *Id.* at p. 5.

[7] Medicaid Proposed Rule, 90 Fed. Reg. at 59458 (estimating the amount of Medicaid spending that would simply be delayed until individuals reach age 18 to receive gender-affirming care).

[8] Medicaid Proposed Rule, 90 Fed. Reg. at 59447; Conditions of Participation Proposed Rule, 90 Fed. Reg. at 59469.

[9] E. Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, Taylor & Francis (Sep. 15, 2022), https://www.tandfonline.com/doi/full/10.1080/26895269.2022.2100644#abstract (last visited Feb. 17, 2026); Wylie C. Hembree et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102 The Journal of

teenagers, the WPATH guidelines are conservative, emphasizing "there is no 'one-size-fits-all' approach and [transgender] people may need to undergo all, some, *or none* of these interventions to support their gender affirmation."[10]

The WPATH guidelines set forth detailed criteria for adolescents to obtain gender-affirming medical and surgical treatment, including guidelines for determining whether a licensed healthcare professional is qualified in the first instance to provide it.[11] And, further, before even developing a treatment plan for an adolescent seeking medicinal or surgical-related care, the WPATH guidelines direct the qualified health care professional to conduct a "comprehensive biopsychosocial assessment" of the patient in order to understand the patient's "strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care."[12]

Furthermore, the WPATH guidelines urge health care professionals to involve professionals from relevant disciplines—including, but not limited to, adolescent medicine and primary care, endocrinology, psychology, psychiatry, speech and language pathology, social work, and surgery—to determine whether puberty suppression, hormone initiation, or gender-related surgery are appropriate and remain indicated throughout the course of treatment.[13] If hormone treatment is indicated, clinicians are advised to undertake regular and comprehensive monitoring, including but not limited to evaluating physical changes and potential adverse effects every three months during the first year of hormone therapy.[14]

Despite the Proposed Rules' claims to the contrary, informed consent is foundational to established best practices for providing gender-affirming care to minors. In addition to the criteria above, for instance, the WPATH guidelines only deem gender-affirming medical or surgical treatments appropriate when, among other things (i) the adolescent meets diagnostic criteria of gender incongruence; (ii) gender incongruence is sustained over time; (iii) the

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Clinical Endocrinology & Metabolism, no. 11, at p. 3871 (Nov. 2017), https://depts.washington.edu/tgnbhealthprogram/wp-content/uploads/2021/09/Endocrine-Treatment-of-Gender-Dysphoric-Gender-Incongruent-Persons-An-Endocrine-Society-Clinical-Practice-Guideline-2017.pdf (last visited Feb. 12, 2026).

[10] Coleman, *supra,* n. 9, at p. S7 (emphasis added).

[11] The guidelines state that licensed health care professionals providing gender-affirming care should, among other things, (i) have expertise and training in child, adolescent, and family mental health across the developmental spectrum; (ii) have expertise and training in gender identity development and gender diversity in children and adolescents; (iii) be able to assess capacity to consent; (iv) possess knowledge about gender diversity across the life span; and (v) have expertise and training in autism spectrum disorders and other neurodevelopmental presentations or be able to collaborate with a developmental disability expert when working with neurodivergent patients. Coleman*, supra,* n. 9, at p. S49.

[12] *Id*. at pp. S50-51, S57-S58.

[13] *Id*. at p. S56.

[14] Hembree, *supra,* n 9, at p. 3871.

adolescent demonstrates the emotional and cognitive maturity required to provide informed consent or assent for the treatment; (iv) any mental health concerns that might interfere with diagnostic clarity or capacity to consent have been addressed;[15] and (v) the adolescent has been informed of the potential effects of treatment on fertility.[16]

WPATH also strongly recommends that an adolescent undergo at least a year of hormone therapy before embarking on any surgical procedures—unless for some reason hormone therapy is contraindicated.[17] Far from rushing patients into hormone therapy and surgical interventions, health care professionals are encouraged to engage in careful, thorough, systematic approaches to treatment. These protocols mandate a gradual exploration of therapeutic, medicinal, and, only as a last potential step, surgical treatment options for patients.

Additional factors prevent minors from being rushed into medical interventions—namely, the same barriers that make it difficult for patients to access any kind of essential care. Anyone who has sought treatment within the American healthcare system knows that access is often curbed by provider shortages, requirements for referrals, cost barriers, long wait times, disputes concerning insurance coverage, and other logistical and administrative challenges. For families seeking gender-affirming care, these difficulties are compounded by the numerous state laws restricting minors' access to gender-affirming care. The end result of meticulous treatment protocols and systemic barriers is that very few, if any, patients or their families would describe the accessibility of gender-affirming care as easy or fast—and certainly not rushed.

III. Depriving Transgender Youth of Medically Necessary Care Will Have Tragic Consequences.

The Agencies paint a portrait of gender dysphoria and transgender youth that bears little to no relation to reality.

Transgender identity is a normal variation of human expression. And gender dysphoria, the feeling of distress that can occur when a person's gender identity differs from the sex assigned at birth, is a medical condition universally recognized by credible medical institutions.[18] Accordingly, organizations representing tens of thousands of medical professionals—including,

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[15] Notably, the WPATH guidelines caution that when an adolescent patient "is experiencing acute suicidality, self-harm, eating disorders, or other mental health crises that threaten physical health, … *appropriate care should seek to mitigate the threat or crisis so there is sufficient time and stabilization for thoughtful gender-related assessment and decision-making*." Coleman, *supra,* n. 9 at p. S63 (emphasis added).

[16] *Id.* at p. S48.

[17] *Id.*

[18] *See, e.g.*, Gender Dysphoria, Mayo Clinic (Jan. 01, 2025), https://perma.cc/G597-577T.

by way of example, the American Medical Association (AMA),[19] the Endocrine Society, and the American Academy of Child and Adolescent Psychiatry—endorse evidence-based, individualized gender-affirming care for transgender youth and oppose broad restrictions on physicians' clinical judgment.[20] Interventions including social gender transition, psychotherapy, hormone blocking agents, and hormone treatment are widely accepted treatment methods that are recommended carefully and deliberately by physicians.

A. Denying Access to Care Will Harm Teenagers and Children.

Quite simply, being a transgender child or teenager is dangerous—particularly if the child or teenager is not receiving gender-affirming care. Transgender and nonbinary youth are *twice as likely to attempt suicide* compared to their cisgender LGBTQ+ peers.[21] Relative to cisgender youth, transgender youth endure stigma, discrimination, and bullying that puts them at higher risk for truancy from school (which correlates with an increased risk of exposure to the juvenile justice system), substance use, eating disorders, personality disorders, and anxiety.[22] Transgender youth receiving gender-affirming care are significantly less likely to experience depression or suicidality than transgender youth not receiving gender-affirming care.[23]

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[19] The AMA is the largest association of physicians in the United States. In February of 2026, the AMA clarified its position on gender-affirming surgery for minors and recommended that such surgeries "generally" should be deferred to adulthood. The AMA, however, cautioned against application of a blanket prohibition: "Treatment decisions should be made between the physician, patient, and family based on the best medical evidence and clinical judgment." Paige Twenter, AMA Clarifies Position on Gender-Affirming Surgeries for Minors, Becker's Clinical Leadership (Feb. 5, 2026), https://perma.cc/G4WG-S7SK.

[20] AMA to States: Stop Interfering in Health Care of Transgender Children, American Medical Association (Apr. 26, 2021) https://perma.cc/B7AQ-DBFS; Transgender and Gender Diverse Children and Adolescents, Endocrine Society (Jan. 24, 2022), https://perma.cc/7634-NDZ3;

[21] Myeshia Price-Feeney et al., Understanding the Mental Health of Transgender and Nonbinary Youth. Journal of Adolescent Health, (Oct. 3, 2019) https://www.jahonline.org/action/showPdf?pii=S1054-139X%2819%2930922-X (last visited Feb. 12, 2026).

[22]Jack K. Day et al., Safe Schools? Transgender Youth's School Experiences and Perceptions of School Climate, National Library of Medicine (Jun. 1, 2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC7153781/; Sanjana Pampati et al, School Climate Among Transgender High School Students: An Exploration of School Connectedness, Perceived Safety, Bullying, and Absenteeism, National Library of Medicine (Dec. 13, 2018) https://pmc.ncbi.nlm.nih.gov/articles/PMC8106508/.

[23] Diana M. Tordoff et al., Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care, JAMA Network Ppen (Jul. 1, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423 (last visited Feb. 12, 2026) ; Anna I.R. van der Miesen et al., Psychological Functioning in Transgender Adolescents

Study after study shows that receiving gender-affirming care reduces depression and suicidality and leads to better long-term mental health outcomes, particularly when such care begins in adolescence.[24] Access to gender-affirming care can improve symptoms of depression and suicidality within one year.[25]

When care previously available is restricted or access denied altogether, dangers to transgender kids' health and safety reemerge—adverse mental health outcomes,[26] increased risk of depression and suicidality,[27] and even avoidance of health care systems.[28] There is unfortunately extensive evidence of this particular phenomenon. Twenty-seven states have in recent years put into place varying degrees of bans on gender-affirming care.[29] Within the first year after the enactment of these laws, the number of suicide attempts by transgender youth skyrocketed upward *by 72%*.[30] The Proposed Rules all but ensure that all fifty states will experience these tragic, sometimes fatal, entirely avoidable consequences.

Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers, Journal of Adolescent Health (Jun. 2020), https://www.jahonline.org/article/s1054-139X(20)30027-6/abstract (last visited Feb. 17, 2026).

[24] *E.g.*, Jamie Swan et al., Mental Health and Quality of Life Outcomes of Gender-Affirming Surgery: A Systematic Literature Review, Journal of Gay & Lesbian Mental Health (Feb. 25, 2022), https://www.tandfonline.com/doi/full/10.1080/19359705.2021.2016537; Anthony N. Almazan & Alex S. Keuroghlian, Association Between Gender-Affirming Surgeries and Mental Health Outcomes, JAMA Surgery (April 28, 2021), https://jamanetwork.com/journals/jamasurgery/fullarticle/2779429 (last visited Feb. 12, 2026); Taylah R.van Leerdam et al., The Effect of Gender-Affirming Hormones on Gender Dysphoria, Quality of Life, and Psychological Functioning in Transgender Individuals: a Systematic Review, National Library of Medicine (Feb. 8, 2023) https://pmc.ncbi.nlm.nih.gov/articles/PMC9991433/; Jack L. Turban et al., Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults, National Library of Medicine (Jan. 12, 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC8754307/.

[25] Tordoff, *supra*, n. 23.

[26] Turban, *supra*, n. 24.

[27] Tordoff, *supra*, n. 23.

[28] Lauren S.H. Chong et al., Experiences and Perspectives of Transgender Youths in Accessing Health Care: a Systematic Review, JAMA Pediatrics (Jul. 19, 2021) https://jamanetwork.com/journals/jamapediatrics/article-abstract/2782148 (last visited Feb 12, 2026).

[29] Policy Tracker: Youth Access to Gender-Affirming Care and State Policy Restrictions, KFF.org (last updated Nov. 24, 2025), https://perma.cc/D4G8-EDBG.

[30]Wilson Y. Lee et al., State-Level Anti-Transgender Laws Increase Past-Year Suicide Attempts Among Transgender and Non-Binary Young People in the USA, Nature Human Behavior (September 26, 2024), https://www.nature.com/articles/s41562-024-01979-

Just last year, a University of Utah study evaluated 230 clinical studies of over 28,000 pediatric patients with gender dysphoria and concluded that "policies to prevent access to and use of [gender-affirming hormone therapy] for treatment of [gender dysphoria] in pediatric patients cannot be justified based on the quantity or quality of medical science findings or concerns about potential regret in the future," and that "high-quality guidelines are available to guide qualified providers in treating pediatric patients who meet diagnostic criteria."[31] "[T]he consensus of the evidence" supports that gender-affirming hormone therapy treatments "are effective in terms of mental health, psychosocial outcomes, and the induction of body changes consistent with the affirmed gender" and "are safe in terms of changes to bone density, cardiovascular risk factors, metabolic changes, and cancer."[32]

Children and teens will suffer unnecessarily if gender-affirming care is withheld from them or if access to it is compromised.

B. Communities and Health Care Providers Will Also Suffer Harm.

Public health systems and the health care providers who operate within them will also suffer if access to gender-affirming care is curtailed. In states with bans on such care, health care providers describe fear of prosecution and the stress of having to explain cessation of treatment to patients.[33] Further, research shows that transgender youth significantly avoid or delay routine or preventative primary care when they anticipate or have experienced negative interactions with medical providers, such as being told they cannot receive needed care.[34] Preventative care, of course, not only improves an individual's health but also reduces the costs and burdens on the support systems that local jurisdictions provide for their residents. Accordingly, reducing access to gender-affirming care threatens to increase long-term public health costs.

5.epdf?sharing_token=EbX7LsH7-AF5n99850vpnNRgN0jAjWel9jnR3ZoTv0PNveFlXHsicuqelg3jvg1Wcsju1CXHxspC9onbX6frEcU1-J5M25Ml5piLTNjBr959LGK7ejPr20VtTVSb18ArMlJnGNGgZYyU9CJQoJuUjN01H4VVGluDqO_epnWIg_A%3D (last visited Feb. 12, 2026).

[31] Joanne LaFleur, *Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria,* College of Pharmacy University of Utah (Aug. 6, 2024) at pp. 90-91, https://le.utah.gov/AgencyRP/downloadFile.jsp?submissionId=287 (last visited Feb. 12, 2026).

[32] *Id.*

[33] Stacy Weiner, States are Banning Gender-Affirming Care for Minors. What Does That Mean for Patients and Providers?, AAMC News (Feb. 20, 2024), https://perma.cc/GB3R-ZT3J.

[34] Taylor L. Boyer et al., Binary and Nonbinary Transgender Adolescents' Healthcare Experiences, Avoidance, and Well Visits, Journal of Adolescent Health, (Oct. 2022), https://www.jahonline.org/article/S1054-139X(22)00447-5/pdf (last visited Feb. 12, 2026).

Moreover, as written, the Proposed Rules also compromise health care providers' ability to provide health care to patients whose primary reason for seeking health care has nothing at all to do with seeking gender-affirming care.

For example, it is common for health care providers to assume responsibility for administering pre-existing prescriptions for an admitted patient. One could envision a circumstance where a minor patient is admitted to a hospital with a prior prescription for puberty blockers or some other hormone therapy related to gender-affirming care. Under the Conditions of Participation Proposed Rule, continuing medications under these circumstances could put the hospital's ability to participate in Medicaid and Medicare at risk, creating enormous uncertainty and untenable risk for hospitals. Interruption of an individual's gender-affirming medication regimen, however, would cause more than a mere inconvenience. Momentary disruption of the administration of hormone therapy could, among other things, cause symptoms to manifest (*e.g.*, febrile presentation, nausea) that may, in addition to causing the patient unnecessary discomfort, compromise the ability of the health care provider to monitor symptoms related to the reason the patient sought care (*e.g.*, an accident or admission for overnight observation or testing).

As another example, the Conditions of Participation Proposed Rule has an exception for "procedures for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex." Many teenage girls have elective breast reduction surgery—for cosmetic reasons or because overlarge breasts cause chronic back or joint pain. If a teenager who is assigned female at birth identifies as transgender, would a breast reduction surgery sought due to back pain be categorized as an exempted or forbidden procedure? This Proposed Rule leaves this question unanswered and unnecessarily complicates the provision of needed care to patients. This Proposed Rule could also lead to inconsistent interpretations by medical professionals.

Similarly, a situation could very well arise where a patient identifies as transgender but requires hormone therapy for a health condition unrelated to gender-affirming care—testosterone to treat an autoimmune disorder, for example. Under the Proposed Rules, a physician designing a course of treatment must weigh how the provision of hormone therapy to this transgender patient will be perceived by Medicaid and Medicare administrators. The prospect of losing all Medicare and Medicaid funding to the healthcare facility where this physician practices is a powerful disincentive to prescribe the hormone therapy this patient needs. Losing millions of dollars would impact the quality of care that other patients (most of whom are not transgender) receive at the physician's hospital or clinic. With such stark consequences on the table, providing appropriate care to the patient before that physician may be deemed not worth the financial risk—inappropriately pushing health care providers to make decisions based on economic factors rather than patient care considerations (as discussed further in Section IV.A.2).

IV. The Proposed Rules Violate the Administrative Procedure Act, the Rehabilitation Act, and the Americans With Disabilities Act.

The Proposed Rules are unconstitutional and unlawful. They violate the Administrative Procedure Act (APA) because the Proposed Rules are arbitrary and capricious and because the Rules exceed the statutory authority afforded the Agencies for regulating Medicare and Medicaid. The Proposed Rules also violate the Rehabilitation Act and the Americans with Disabilities Act.

A. The Proposed Rules Violate the APA.

1. The Proposed Rules Are Arbitrary and Capricious.

The Proposed Rules are arbitrary and capricious, thus violating § 706(2)(A), for at least these reasons: (i) the explanations in each of the Proposed Rules relies on untrustworthy resources and mischaracterizations of data and conclusions and overlook completely the benefits of providing gender-affirming care to minors; and (ii) the Agencies failed to consider reliance interests of multiple affected parties.

a. The Agencies' Reasoning Is Conclusory, Biased, and Unsupported.

Administrative law requires that an agency "set forth its reasons for decision,"[35] so that its decision is "reasonable and reasonably explained."[36] When an agency's proposed reasoning is based on false or incomplete information, such reasoning is inherently insufficient. The explanations the Proposed Rules supply are either based on unreliable or methodologically flawed evidence or on misrepresentations of the cited literature's conclusions or data.

The Proposed Rules rely almost exclusively on the 2025 HHS Review on gender dysphoria that concludes, after a purported "umbrella review" of scientific literature concerning gender-affirming care and gender dysphoria in transgender youth, that providing gender-affirming care through medical intervention does more harm than good. The Review, however, has been widely criticized by scientific organizations and medical professional associations for misrepresenting the current medical consensus and promoting misinformation.[37]

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[35] *Amerijet Int'l, Inc. v. Pistole*, 753 F.3d 1343, 1350 (D.C. Cir. 2014).
[36] *Fed. Commc'ns Comm'n v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).
[37] G. Nic Rider et al., Scientific Integrity and Pediatric Gender Healthcare: Disputing the HHS Review, Sexuality Research & Social Policy (Oct. 13, 2025), https://perma.cc/SWV8-RC82; David Aizuss & Susan J. Kressly, AMA & AAP Joint Statement on Evidence-Based Health Care, Am. Acad. of Pediatrics (AAP) (Nov. 19, 2025), https://perma.cc/4JQ5-9RQ6; AAP

The Review was co-authored by Evgenia Abbruzzese, a founder of the Society for Evidence-Based Gender Medicine (SEGM). Despite its innocuous-sounding name, SEGM is an organization with an aggressive anti-transgender agenda. Designated by the Southern Poverty Law Center as an anti-LGBTQ+ hate group, SEGM has undertaken a global media and public policy blitz to lend scientific credibility to legal claims against LGBTQ+ civil rights, including transgender access to gender-affirming care.[38]

The Proposed Rules also cite heavily to the Cass Review, a 2024 study commissioned by England's National Health Service and overseen by Dr. Hilary Cass, a pediatrician with no prior experience in transgender medicine. Yet, the Proposed Rules fail to mention that the Cass Review has been widely criticized in published peer reviews for its "methodological flaws and misrepresentation of evidence."[39] Indeed, these peer reviews have noted that the Cass Review "subverts widely accepted processes for development of clinical recommendations and repeats spurious, debunked claims about transgender identity and gender dysphoria" which "raise[s] serious concern about the scientific integrity" of the report.[40] Reliance on such biased and unreliable sources is alone arbitrary and capricious.

The Proposed Rules and Review are also littered with misrepresentations. For instance, to bolster their own credibility, the Proposed Rules and the Review claim to rely on a methodology informed by "evidence-based medicine," a term coined by Dr. Gordon Guyatt. The Proposed Rules claim this methodology mandates rejection of "low-certainty evidence." But this misrepresents Dr. Guyatt's work. Dr. Guyatt and his colleagues have since responded to the Review's mischaracterizations:

> It is profoundly misguided to cast health care based on low-certainty evidence as bad care or as care driven by ideology, and low-certainty evidence as bad science. Many of the interventions we offer are based on low-certainty evidence, and enlightened individuals often legitimately and wisely choose such interventions. Thus, forbidding delivery of gender-affirming care and limiting medical management options on the basis of low

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Statement on HHS Report Treatment for Pediatric Gender Dysphoria, Am. Acad. of Pediatrics (May 1, 2025), Am. Acad. of Pediatrics (May 1, 2025), https://perma.cc/9R6F-7CHQ.

[38] Anti-LGBTQ, Southern Poverty Law Center, (last visited Feb. 11, 2026), https://perma.cc/4W3F-3VKZ.

[39] Chris Noone et al., Critically Appraising the Cass Report: Methodological Flaws and Unsupported Claims, Springer Nature Link (May 10, 2025), https://perma.cc/642J-9YNB; Daniel G. Aaron et al., The future of gender-affirming care — a law and policy perspective on the Cass Review, 392 N. Engl. J. Med. 526 (2025), https://www.nejm.org/doi/10.1056/NEJMp2413747.

[40] Meredithe McNamara et al., An Evidence-Based Critique of the Cass Review on Gender-affirming Care for Adolescent Gender Dysphoria, Yale 2 (2024), https://perma.cc/RJ6N-Q2H8.

> certainty evidence is a clear violation of the principles of evidence-based shared decision-making *and is unconscionable*.[41]

In other words, the Review's conclusion relies on a fallacy that gender-affirming care is harmful simply because its efficacy is "low-certainty." As Dr. Guyatt himself confirmed, this logic is counter to best practices of patient care.

In addition to glossing over the analytical deficiencies of the Cass Review, the Proposed Rules misstate Dr. Cass's conclusions. The Cass Review does not support an outright ban on gender-affirming care. Rather, this Review consistently advocates for an individualized approach to care and acknowledges, "for some [children], the best outcome will be transition whereas others may resolve their distress in other ways."[42]

Finally, the supposed reasoning underlying the Proposed Rules is also irredeemably flawed because it omits any meaningful reference to the scores of studies, many of which are cited in this comment, that illustrate the demonstrable benefits of gender-affirming care for transgender youth—and the well-documented risks if gender-affirming care is withheld.

For all of these reasons, the Agencies have failed to reasonably explain the Proposed Rules, and the Rules are arbitrary and capricious.

b. The Agencies Failed to Consider the Reliance Interests of Transgender Youth and Their Families or of Hospitals and Communities.

When federal agencies change course, they "must be cognizant that longstanding policies may have engendered serious reliance interests that must be taken into account."[43] In doing so, the agency must determine whether reliance interests were "significant," "weigh any such interests against competing policy concerns," and provide its reasoning at the time of its decision.[44] An agency's failure to assess and consider those reliance interests independently makes its decision arbitrary and capricious.[45]

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[41] Gordon Guyatt et al., Systematic Reviews Related to Gender-Affirming Care, McMaster University Department of Health Research Methods, Evidence, and Impact (Aug. 14, 2025), https://hei.healthsci.mcmaster.ca/systematic-reviews-related-to-gender-affirming-care/ (last visited Feb. 13, 2026) (emphasis added).
[42] Hilary Cass, Independent review of gender identity services for children and young people: Final report 21 (2024), https://cass.independent-review.uk/home/publications/final-report/.
[43] *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 591 U.S. 1, 30 (2020).
[44] *Id.* at 23–24, 33.
[45] *Id.* at 30.

There are many examples of the ways in which the Agencies have failed to consider reliance interests. For instance, the Agencies did not consider the extent to which hospitals and local governments rely on Medicare and Medicaid reimbursements to remain open and operational.[46] And there is no evidence the Agencies accounted for states' heavy, long-standing reliance on their own traditional authority to regulate "the practice of medicine within their borders."[47] This reliance led to the creation and maintenance of systems that, for many years, have provided payment coverage for gender-affirming care to transgender minors. Families of transgender minors, in turn, have come to rely upon this coverage and these resources, embarking, in consultation with their health care providers, upon treatment plans that may have to be jettisoned entirely, should the Proposed Rules go into effect. The Proposed Rules certainly do not account for the harms that will result, discussed above, Section III.A, if such care is withheld, and, given the stakes, this failure is remarkably callous. Finally, given the longstanding reliance of health care providers and families on Medicare and Medicaid funding, the Agencies likewise did not consider the degree to which prohibiting Medicaid and CHIP coverage for gender-affirming care or withholding Medicare or Medicaid funding to any institutions that provide gender-affirming care to minors would impact all families' abilities to access all types of healthcare—not just gender-affirming care. *See supra*, Section III.B.

2. The Conditions of Participation Proposed Rule Goes Far Beyond any Statutory Authority Granted to the Secretary to Govern Medicare.

The Conditions of Participation Proposed Rule also violates the APA for the additional reason that it is "in excess of statutory jurisdiction, authority, or limitations." *See* 5 U.S.C. §706(2)(C).

This Proposed Rule represents an unprecedented stretching of Medicare conditions of participation in order to control the medical services hospitals can offer. Generally speaking, Medicare conditions of participation (CoPs) set standards for health and safety that hospitals are required to meet to participate in Medicare. For example, some current CoPs require hospitals: (i) to have an organized medical staff, independent from administration, that oversees the delivery of clinical care;[48] (ii) to have active programs for infection control and antibiotic

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[46] *See, e.g., Nat'l Fed'n of Indep. Bus. (NFIB) v. Sebelius*, 567 U.S. 519, 542 (2012) (noting that by 1982 every state had chosen to participate in Medicaid).

[47] W*ashington State Health Care Auth. v. Centers for Medicare & Medicaid Servs.*, 57 F.4th 703, 708 (9th Cir. 2023) (quoting *Planned Parenthood Ariz. Inc. v. Betlach*, 727 F.3d 960, 975 (9th Cir. 2013); *see also Medina v. Planned Parenthood of South Atlantic*, 606 U.S. 357, 364 (2025) ("...States have traditionally exercised primary responsibility over 'matters of health and safety,' including the regulation of the practice of medicine.").

[48] 42 C.F.R. § 482.22.

stewardship;[49] and (iii) to offer food and dietetic services for patients.[50] To the extent that any CoPs cover specific types of clinical services, CoPs impose only basic requirements for hospital operations, such as offering diagnostic radiologic or laboratory services by qualified staff.[51] Notably, the CoPs that impose requirements as to any particular category of services leave the determination for when, and under what circumstances, such services are delivered *to medical professionals*.[52]

Existing CoPs establish a baseline for the kind of services a Medicare-participating hospital must be able to offer, as well as ensure a minimum level of quality in the delivery of those services. CoPs have never before been wielded to dictate the course of treatment a health care provider must or must not take for a particular patient. The Conditions of Participation Proposed Rule hijacks this framework by wresting discretion from medical professionals. This Proposed Rule is not supported by any statutory grant of authority to either of the Agencies or their officials to administer the Medicare program—and, indeed, the Conditions of Participation Proposed Rule directly conflicts with the Medicare Act's prohibition on any Federal officer or employee's *controlling the practice of medicine*, discussed immediately below.

a. Federal Law Prohibits Medicare Program Administration from Interfering with the Practice of Medicine.

A bedrock principle of the Medicare program, made explicit by statute, is that Medicare program administration should not interfere with substantive medical decision making. Specifically, Congress determined that nothing in the Medicare Act "shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. . ."[53] This prohibition applies when a regulation may "directly influenc[e] a doctor's decision on what type of medical treatment will be provided, thus *directly interfering with the practice of medicine*."[54] Yet this is

[49] 42 C.F.R. § 482.42.
[50] 42 C.F.R. § 482.28.
[51] *See* 42 C.F.R. §§ 482.26, 482.27.
[52] *See, e.g.* 42 C.F.R. § 482.26(b)(4) (providing in pertinent part that, "[r]adiologic services must be provided only on the order of practitioners with clinical privileges, or consistent with State law, of other practitioners authorized by the medial staff and the governing body to order the services."); 42 C.F.R. § 482.52 (stating with respect to anesthesia services that "they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy.").
[53] 42 U.S.C. § 1395.
[54] *American Med. Ass'n v. Weinberger*, 522 F.2d 921, 925 (7th Cir. 1975); *see also United Staes v. University Hosp., State University of New York at Stony Brook*, 729 F.2d 144, 160 (2nd Cir. 1984) (emphasis added) (citing 42 U.S.C. § 1395 as an example of "consistent congressional policy against the involvement of federal personnel in medical treatment decisions...).

precisely what the Conditions of Participation Proposed Rule would do.[55] The Proposed Rule places hospitals at risk of termination from Medicare participation purely by virtue of offering certain procedures and treatment plans. The prohibition on Medicare funding, tied even loosely to the provision of gender-affirming care, interferes with a physician's treatment determination for individual patients. The Conditions of Participation Proposed Rule directly conflicts with 42 U.S.C. Section 1395.

The Agencies contend that section 1395 is not an impediment to this Proposed Rule, asserting, "[W]e believe that providing [gender-affirming care] for children is not healthcare and hence not subsumed under the term 'the practice of medicine.' Therefore, the proposed rule would not regulate the practice of medicine."[56] But the only support the Agencies offer for this conclusory contention is the 2025 HHS Review, which, as discussed above, has been widely criticized by scientific and medical organizations.[57]

This contention is rife with both legal and logical flaws. As an initial matter, the Agencies have no authority—statutory or otherwise—to unilaterally determine what is and what is not "health care" for purposes of the restrictions imposed by section 1395. That Congress has not delegated this authority to the Agencies makes perfect sense—the power to simply declare a treatment or activity is not "health care" would render section 1395 a nullity. There is no indication Congress intended its edict against Federal officer interference in the practice of medicine to be disregarded by agency fiat.

The Agencies' position is also illogical. How could complicated procedures that only licensed medical professionals can perform constitute neither "health care" nor the "practice of medicine?"[58] There is no gray area: Prescribing and administering pharmaceuticals and performing surgeries are quintessential activities of the practice of medicine.[59]

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[55] This interference in the practice of medicine also violates principles of federalism. *See Gregory v. Ashcroft*, 501 U.S. 452, 457-60 (1991) (discussing a proper balance between States and the federal government). Indeed, the Supreme Court has recognized that States have "traditionally exercised primary responsibility over the . . . regulation of the practice of medicine." *Medina*, 606 U.S. at p. 364.

[56] Conditions of Participation Proposed Rule, 90 Fed. Reg. at 59471.

[57] *See id.*, fns. 73 – 78.

[58] Conditions of Participation Proposed Rule, 90 Fed. Reg. at 59477.

[59] *See, e.g.* Cal. Bus. & Prof. Code § 2051 ("The physician's and surgeon's certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of disease, injuries, deformities and other physician and mental conditions."); Revised Code of Washington 18.71.011 ("A person is practicing medicine if he or she does any one or more of the following: . . . (2) Administers or prescribes drugs or medicinal preparations to be used by any other person; (3) Severs or penetrates the tissues of human beings.. .").

Moreover, by including exceptions to the broad prohibition on gender-affirming care in the Conditions of Participation Proposed Rule, the Agencies permit hospitals to offer some of the very same "pharmaceutical or surgical intervention[s]" when performed for certain purposes the Agencies deem acceptable.[60] How can the *exact same procedure* be the "practice of medicine" when performed in response to one diagnosis, but somehow not the "practice of medicine" when performed in conjunction with a different diagnosis? There is no authority, justification, or support for the Agencies' attempts to make line-item determinations as to what is and is not "health care."

b. The Conditions of Participation Proposed Rule Exceeds the Secretary's Authority to Impose Additional Conditions.

Even if the Conditions of Participation Proposed Rule did not run afoul of section 1395, the terms of the Proposed Rule would exceed any authority Congress vested in the Agencies. As the Agencies have themselves recognized, the enabling statute establishes only that hospitals must meet certain requirements to participate in Medicare and that "[t]he Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in the hospital."[61] The delegated power to establish requirements for hospitals to enroll in, and then remain in good standing with, the Medicare program cannot naturally be read to include the power to impose a blanket ban on the provision of particular services to a subset of patients, including those who may not be Medicare beneficiaries.

The Agencies contend several times that the Conditions of Participation Proposed Rule is necessary to protect the "health and safety of children" and therefore an appropriate exercise of the agency's Medicare oversight authority under the Social Security Act.[62] As mentioned above, however, the Agencies have traditionally used this power solely to impose general standards. Seeking to police physician and health care provider discretion, as the Conditions of Participation Proposed Rule does, is an unprecedented use of the Agencies' general power to protect the "health and safety" of hospital patients.[63]

In any event, this Proposed Rule does not serve "the interest of the health and safety of the individuals who are furnished services in the hospital."[64] On an individual level, as detailed

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[60] Conditions of Participation Proposed Rule, 90 Fed. Reg. at 59477.
[61] 42 C.F.R. § 482.1 (citing Section 1861(e) of the Social Security Act, as codified at 42 U.S.C. § 1395x(e)); *see also* 42 U.S.C. § 1395x(e)(1)-(9).
[62] *See* 42 U.S.C. § 1395x(e)(9) (hospital must "meet[] such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution").
[63] *See, e.g.* Conditions of Participation Proposed Rule, 90 Fed. Reg. at 59464.
[64] 42 C.F.R. § 482.1(a)(1)(ii).

extensively in this comment, there is ample data illustrating the health benefits of providing gender-affirming care to minors with gender dysphoria. Prohibiting hospitals that receive Medicare funding from offering services to minor patients that improve their health is not in the interest of individual patients—and it certainly does not protect their "health and safety."

Finally, many hospitals—particularly those serving underserved populations—cannot survive without Medicare reimbursement as a revenue stream. By proclaiming that Medicare funding will no longer be routed to facilities that provide gender-affirming care, the Agencies put health care providers in an impossible position: treat their transgender patients and perhaps be forced to close or cease treating patients who need help in order to stay open. Each choice forces health care providers to compromise patient care; neither option protects the "health and safety" of patients.[65]

To put it plainly, the Agencies are attempting to use the threat of the loss of critical federal funding as a cudgel to force hospitals and hospital-affiliated facilities to stop providing health care to serve a subset of patients the Agencies disfavor.[66] That is not what Congress intended.

For each of these reasons, the Proposed Rules run afoul of the APA and are therefore unlawful.

B. The Proposed Rules Violate the Prohibitions on Disability Discrimination in the Rehabilitation Act and the Americans with Disabilities Act.

The Proposed Rules also implicate prohibitions on discrimination in other statutory regimes. The limitations the Proposed Rules place on the provision of gender-affirming care may, as HHS itself previously concluded, amount to disability discrimination under the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.* (ADA), and the

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[65] Hospitals under certain state laws are required to provide gender-affirming care and healthcare free from discrimination based on sex, gender, and gender identity. The Proposed Rules thus require these hospitals to choose between disobeying state law or forgoing critical Medicare and Medicaid funding.

[66] The Agencies' actions in this regard also raise constitutional concerns. *See NFIB*, 567 U.S. at p. 578 (noting that Congress cannot use its spending power by "directly command[ing] a State to regulate or indirectly coerc[ing] a State to adopt a federal regulatory system as its own."); *City of Los Angeles v. Barr*, 929 F.3d 1163, 1176 n. 6 (9th Cir. 2019) (applying spending power principles to a federal agency).

Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq*. (the Rehabilitation Act and, together with the ADA, the Acts).[67]

Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 (Section 504), prohibits disability discrimination in programs or activities receiving federal financial assistance. Section 504(a) provides that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[68] The ADA prohibits discrimination against individuals with disabilities in public services and accommodations, including hospitals.[69]

As discussed above, gender dysphoria is a medically recognized condition that can substantially limit a person's ability to perform major life activities.[70] Thus, gender dysphoria may qualify as a disability under the Acts.[71]

The Agencies are well aware that the Acts pose an impediment to the legality of the Proposed Rules. HHS appears to have attempted to circumvent this impediment by a separate proposed rule issued by the HHS Office of Civil Rights (OCR Proposed Rule).[72] The OCR

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[67] HHS Notice and Guidance on Gender-affirming Care, Civil Rights, and Patient Privacy, HHS (Mar. 2, 2022) ("2022 HHS Guidance") (removed from HHS website but archived at, https://media.glaad.org/wp-content/uploads/2022/03/10053605/hhs-ocr-notice-and-guidance-gender-affirming-care-996.pdf).

[68] 29 U.S.C. § 794(a).

[69] *See* 42 U.S.C. § 12132 (prohibiting disability discrimination in "services, programs, or activities of a public entity"); 42 U.S.C. § 12182(a) (prohibiting disability discrimination in "any place of public accommodation"); *see also* 42 U.S.C. § 12181(7)(F) (defining public accommodations to include, *inter alia*, "professional office of a health care provider [or] hospital").

[70] *See supra* Section III.

[71] 29 U.S.C. § 705(9); 42 U.S.C. § 12102(1)(A). *See also* 2022 HHS Guidance (accord); *Williams v. Kincaid*, 45 F.4th 759, 766 (4th Cir. 2022), *cert.* denied, 143 S. Ct. 2414 (2023) (no dispute that gender dysphoria may qualify as a disability under § 12102(1)(A)); *Kozak v. CSX Transportation, Inc.*, No. 20-CV-184S, 2023 WL 4906148, at *3-4 (W.D.N.Y. Aug. 1, 2023) (same).

[72] *See* Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 90 Fed. Reg. 59478 (Dec. 19, 2025) (the OCR Proposed Rule). Indeed, HHS announced the Proposed Rules and the OCR Proposed Rule at the same time and stated that the OCR Proposed Rule serves to "reassure" providers that limiting gender-affirming care does not amount to disability discrimination under the Rehabilitation Act. HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children, HHS (Dec. 18, 2025), https://perma.cc/BZ23-ZM86.

Proposed Rule extends the statutory exclusion for "gender identity disorders not resulting from physical impairments"[73] (the GID Exclusion) to include "gender dysphoria not resulting from physical impairments."[74] HHS OCR's interpretation of the GID Exclusion, however, is incompatible with the purpose and historical meaning of that statute and, concomitantly, has been expressly rejected by numerous federal courts—including the only Circuit Court to consider it.[75]

Finally, even if the GID Exclusion encompasses gender dysphoria *not* resulting from a physical impairment, which, as explained above, it does not, the Proposed Rules still run afoul of the Acts because the Proposed Rules fail to make adequate exceptions for gender dysphoria that *does* result from a physical impairment. While the Proposed Rules permit the provision of gender-affirming care for "rare conditions where a child's reproductive or sexual anatomy does not develop in typical ways due to genetic, hormonal, or other medical factors that can be medically verified,"[76] this slim carveout fails to account for the population of children whose gender dysphoria may result from other physical differences.[77]

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[73] 42 U.S.C. § 12211(b)(1).
[74] OCR Proposed Rule, 90 Fed. Reg at 59481.
[75] *See* Comment of the Attorneys General of California *et al.* on Proposed Rule, *Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance*, 90 Fed. Reg. 59478 (RIN 0945–AA27) (Jan. 16, 2026); Comment of the New York City Department of Health and Mental Hygiene & the New York City Commission on Human Rights on Proposed Rule, *Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance*, 90 Fed. Reg. 59478 (RIN 0945–AA27) (Jan. 20, 2026).
[76] Conditions of Participation Proposed Rule 90 Fed. Reg. at 59448; Medicaid Proposed Rule 90 Fed. Reg. at 59469.
[77] This is a meaningful omission. Growing evidence suggests that gender dysphoria may have physiological origins apart from disorders of sexual development (DSDs). *See Doe v. Mass. Dep't of Corr.*, CV 17-12255-RGS, 2018 WL 2994403, at *6 (D. Mass. June 14, 2018) (noting recent studies "demonstrating that GD diagnoses have a physical etiology, namely hormonal and genetic drivers contributing to the in utero development of dysphoria"); DSM-V-TR at 517 (noting evidence of genetic contribution to gender dysphoria "[f]or individuals with gender dysphoria *without* a DSD" (emphasis added)). Indeed, until recently, the Department of Justice took the position that the evolving understanding of gender dysphoria suggested that it may have a physical basis in certain cases. *See* Statement of Interest of the United States of America at 1-2, *Blatt v. Cabela's Retail, Inc.*, No. 5:14-CV-04822 (E.D. Pa. Nov. 16, 2015) ("In light of the evolving scientific evidence suggesting that gender dysphoria may have a physical basis, along with the remedial nature of the ADA and the relevant statutory and regulatory provisions directing that the term 'disability' and 'physical impairment' be read broadly, the [Gender Identity Disorder] Exclusion should be construed narrowly such that gender dysphoria falls outside its scope.").

Finally, the Agencies cannot rely on their circular attempts to redefine gender-affirming care as outside the "practice of medicine" to avoid implicating the Acts. Gender-affirming care for children is healthcare, *see supra* Section III.A, and its denial implicates the Acts regardless of how the Agencies decide to artfully define governing terms of art. *See Alexander v. Choate*, 469 U.S. 287, 301 (1985) ("The benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled.").

CONCLUSION

For each of the reasons discussed above, the Proposed Rules are unlawful and must be rescinded.

Very truly yours,

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