CONNECTICUT HOSPITAL ASSOCIATION

February 17, 2026

Robert F. Kennedy, Jr.,
Secretary, Department of Health and Human Services
Office of the Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: [CMS-3481-P; RIN 0938-AV97] DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Medicare & Medicaid Services: Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children

Dear Secretary Kennedy:

The Connecticut Hospital Association (CHA) appreciates the opportunity to provide comments on File Code CMS-3481-P, ***Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children***, a proposed rule published officially in the December 19, 2025 federal register[1] seeking to substantially alter the requirements for Medicare and Medicaid participating hospitals with respect to gender-affirming care, described in the proposed rule as "sex-rejecting procedures" (SRPs).[2] **We strongly urge the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) to withdraw the proposed rule in its entirety to avoid unfairly and illegally interfering with patient rights, institutional provider rights, practitioner rights, and state law determinations regarding healthcare and the practice of medicine.**

Fundamentally, the proposed rule is unenforceable and void because it violates the Social Security Act, specifically 42 USC 1395, Section 1801. Absent new congressional authority modifying the Social Security Act itself or expressly legislating to create an exception to the application of Section 1801 relating to this type of medical treatment, the proposed rule cannot stand, is not within HHS's power, and should not move forward. The proposed rule directly violates the Social Security Act by attempting to control and supervise the practice of medicine and interfere with the manner in which medical services are delivered. Section 1801 of the Social Security Act expressly bans HHS (and similarly bans every federal officer and agency) from exercising supervision or control over any of the following:

- The practice of medicine
- The manner in which medical services are provided
- The administration or operation of an institution providing health services

There is no valid legal explanation provided by HHS as to why it would be permitted to create a rule in plain contradiction to an existing federal statutory mandate. As HHS is no doubt aware, all sources of relevant law

[1] 90 Federal Register Vol. 242, pages 59463-59478

[2] Please note that, as context requires, our comments will utilize both the nomenclature "gender-affirming care" (a term used in our state's laws) and the HHS term in the proposed rule, "sex-rejecting procedures" (abbreviated in the proposed rule as SRPs).

relating to agency rules, including CMS rules made through the Conditions of Participation (CoPs) for Medicare and Medicaid services, make plain that the proposed rule is not legally valid or available to CMS.

In the absence of a valid legal argument (because no such argument can be made under existing law), HHS provides a syllogistic refutation of why Section 1801 does not apply, found chiefly in the proposed rule at page 59471 (center column), stating:

> *"[w]e believe that providing the SRPs for children is not healthcare and hence are not subsumed under the term of "the practice of medicine."*

That position is an unsupportable, conclusory statement that directly contradicts all existing federal statutes and all relevant case law. It is not a legal argument but a value judgment. We do not question that the value judgment is deeply and vehemently held, but a value judgment expressing a preference for one type of care over another cannot be the underpinning of a federal rule pursuant to the Social Security Act. HHS is not able to redefine Section 1801 to give it new meaning; only Congress has the power to amend Section 1801 — and Congress has not done so.

It is well-established in federal law that HHS has significant power and responsibility to regulate Medicare and Medicaid coverage and administer the related CMS programs, and that its exercise of that power must not include rules that attempt to exercise control or supervision over the practice of medicine or the manner in which medical services are delivered. This congressionally mandated prohibition is long-standing, well-understood, and generally noncontroversial.[3]

Medical experts (practitioners and researchers) may disagree about what types of care are best, and they also may hold varied opinions about the manner in which care should be delivered. Indeed, there is often passionate disagreement and debate on various topics within the province of the practice of medicine. The Social Security Act plainly bars federal agencies from regulating the outcomes of those disagreements and debates, leaving each state, including Connecticut, to govern the practice of medicine within its state.

As HHS notes in the proposed rule, this is an evolving area of medicine with differences of opinion. The proposed rule is replete with examples and evidence, *supplied by HHS*, that medical professionals and many leading medical organizations have reached consensus that this type of care is part of the practice of medicine (see, e.g., page 59468, left-hand column). Whether HHS agrees with one set of medical professionals over others is immaterial because HHS lacks the legal authority to regulate by choosing sides in debates about the practice of medicine. The Social Security Act plainly and expressly instructs HHS (and every federal agency) that the administration of the Medicare (or Medicaid) program must not direct or prohibit a particular kind of treatment or diagnosis. This is a well-known limitation placed on HHS authority, routinely cited in federal court decisions. Medicare regulations may not "direct or prohibit any kind of treatment or diagnosis"; "favor one procedure over another"; or "influence the judgment of medical professionals" (see, e.g., Goodman v. Sullivan, 891 F.2d 449, 451 (2d Cir. 1989)).

Federal courts have clarified that HHS cannot use the Social Security Act to require specific medical treatment in contravention of state law (see, e.g., Texas v. Becerra, 89 F.4th 529 (2025)), holding that EMTALA, because it is subject to the limitations in Section 1801 of the Social Security Act, does not permit HHS to force providers to perform abortions where prohibited by state law. Similarly, perhaps identically, HHS may not use the Conditions of Participation to prohibit care in Connecticut, where state law expressly allows for access to gender-affirming care.[4]

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[3] Related proposed rules (including but not limited to CMS-2451-P; RIN 0938-AV73) seeking to revise or revoke otherwise standard reimbursement rules applicable to the Medicaid program relating to gender-affirming care also should be withdrawn because they violate Section 1801 as an illegal attempt by the agency to "exercise any supervision or control over the practice of medicine or the manner in which medical services are provided," which necessarily violates the Social Security Act.

[4] Section 52-571m(a)(2) of the Connecticut General Statutes includes the definition of "gender-affirming health care services."

Differing views and debates over which side of the medical community is "right" about how to treat and diagnose patients are irrelevant to whether HHS has the power to make the proposed rule. HHS does not have the power. Connecticut law protects the right to access this type of care. It is within the state's power to make decisions about the practice of medicine and the scope of care, including when there may be scientific uncertainty.[5] HHS lacks the power to interfere with state laws governing the practice of medicine, absent a specific federal law passed by Congress (which Congress has not chosen to pass).[6]

CHA appreciates that the agency is expressing deeply held beliefs about what medical procedures HHS thinks patients and families should choose. We neither question nor debate the depth of, nor dedication to, those views and beliefs. But those viewpoints are, legally and procedurally, value judgments that do not substitute for legal standards or set thresholds. Moreover, those value judgments improperly seek to supervise or control the practice of medicine.[7] Because Section 1801 of the Social Security Act has a built-in guardrail that stops federal agencies from imposing their opinions and value judgments regarding the practice of medicine or the manner in which medical services are provided, the proposed rule must be withdrawn.

Exemptions Are Too Narrow and Will Have Unintended Consequences

As discussed above, the proposed rule as written necessarily interferes with the practice of medicine and patient choice generally and would also significantly interfere with routine and necessary medical care for many patients. The exceptions in the proposed rule, designated as 42 CFR 486.46(b), are internally inconsistent, confusing, and arbitrary.

Even if portions of the federal government continue to recognize only two biological sex classifications (male and female), it is evident that many individuals are born with differences (or disorders) of sexual development (DSD). DSDs can be from a variety of causes, including but not limited to genetic mutations, fetal development events, trauma, hormonal insufficiencies, chemical and environmental exposures in utero, among others. The medical community, through the ongoing practice of medicine, continues to learn new things every day to identify and treat patients with DSDs. Individuals with DSDs may have experienced medical intervention at an early age in an effort to fit within one of two gender classifications. Or there may have been insufficient recognition at birth or no reasonable way to recognize a DSD until a later age, leading to inaction by medical providers. And these patients may suffer from gender dysphoria or encounter increased psychosocial risks relating to their medical situation.[8]

Some individuals will later learn that prior action *or inaction* by their providers and families failed to accurately align their gender with their biological sex classification. Some of these patients will need the exact type of care the rule seeks to ban. But access to that care will be hard to find because the proposed rule risks the practical

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[5] As recently as June 2025, the United States Supreme Court reiterated that setting the scope of medical practice is a typical state power: "States have 'wide discretion to pass legislation in areas where there is medical and scientific uncertainty'" (United States v. Skrmetti, 605 U.S. 495 (2025) quoting Gonzales v. Carhart, 550 U.S. 124, 163, 127 S.Ct. 1610, 167 L.Ed.2d 480).

[6] If there were a federal law that attempted to set boundaries on the practice of medicine, potentially in conflict with Section 1801 or contrary to state law, there would be a different analysis than offered in these comments, albeit an analysis that likely would have the same outcome. The need for that analysis does not exist at this time because there is no such federal law. State law controls the parameters of the practice of medicine in this situation.

[7] It is sufficient as a matter of administrative law that myriad sources and medical authorities support gender-affirming care as acceptable within the practice of medicine. (HHS cites to several of these in the proposed rule.) Additionally, it cannot be overlooked that Connecticut and several other states have chosen to protect access to gender-affirming care. Connecticut expressly defines gender-affirming care as a healthcare service. HHS and CMS plainly understand that several states have made these determinations about gender-affirming care. See, e.g., proposed rule language at pages 59469-59470.

[8] See, e.g., Hansen-Moore JA, Kapa HM, Litteral JL, Nahata L, Indyk JA, Jayanthi VR, Chan YM, Tishelman AC, Crerand CE. *Psychosocial Functioning Among Children With and Without Differences of Sex Development.* Journal of Pediatric Psychology. 2020 Dec 14:jsaa089. doi: 10.1093/jpepsy/jsaa089. Epub ahead of print. PMID: 33313877

effect of denying *all* individuals access to healthcare by creating an environment where hospitals (and other providers) are forced to refuse care for fear of violating CMS rules.

Minors and Consent for Care

The proposed rule mischaracterizes the legal thresholds for parental consent. We appreciate that this may be an unintended semantic mistake, but the proposed rule language misstates the nature of patients' medical consent specific to minors.

At page 59471 (top of the center column), the proposed rule states the following:

> *"While we are proposing certain exceptions, any procedures or treatments under these exceptions must still be performed with the consent of the child's parent or legal guardian, as currently required under the patient rights CoP at § 482.13(b)(2), the medical records CoP at § 482.24 (c)(4)(v), the surgical services CoP at § 482.51(b)(2), and in compliance with applicable State law(s)."*

This language is misleading and attempts to frame the *procedural requirements* for documenting consents, set forth in the Conditions of Participation, as substitutes for substantive rights relating to consent for care — rights that are necessarily dictated by state law (not the Conditions of Participation).

Each state, including Connecticut, holds the power to determine what substantive consent is required for medical care and treatment. In the absence of express congressional action, which does not exist in this context, HHS may not casually override or supplant the state law. Any reference to parental consent, a minor's personal consent, or the intersection of those types of consent must be interpreted as, and should expressly incorporate, the thresholds and parameters for consent regarding medical procedures that are necessarily found in state law (while the documentation details outlined in the Conditions of Participation are administrative in nature).

Conclusion

The decisions about this type of care, often heart-wrenching decisions, require significant medical assessment, access to sophisticated facilities and care teams, and will benefit from ongoing research and advancements in treatment. These types of care are inextricably in the realm of the practice of medicine, outside the purview of HHS. In states that allow these types of care, decisions should be left to patients and their families in consultation with their medical providers without interference from the federal government.

Sincerely,

Paul Kidwell
Senior Vice President, Policy

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By Email