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Submitted electronically via www.regulations.gov

February 17, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3481-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children (CMS-3481-P)

Dear Administrator Oz,

The AAMC welcomes this opportunity to comment on the proposed rule entitled "Medicare and Medicaid Programs: Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children," 90 Fed. Reg. 59463 (December 19, 2025), issued by the Centers for Medicare & Medicaid Services (CMS or the agency) that would prohibit hospitals participating in Medicare and Medicaid from the provision of gender affirming medical care (referred to in the proposed rule as "sex rejecting" procedures) to patients under the age of 18.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

Participation in the Medicare and Medicaid programs is foundational to our members' ability to fulfill their missions and meet the health care needs of the communities they serve. We urge CMS to withdraw the proposed prohibition in the rule as it exceeds CMS's statutory authority, intrudes upon state regulation of medical practice, interferes with the physician-patient relationship, undermines health care system stability, and threatens access to care for all patients.

We are deeply concerned that the proposed rule sets a precedent that would presage CMS banning the provision of other health care services that are lawful under state law and undermine the physician-patient relationship and the principle that physicians are best equipped to work with patients and their families to arrive at shared decision-making about their health care.

CMS Lacks Statutory Authority to Prohibit Categories of Medicare Care Through Conditions of Participation

CMS proposes to add a new section (42 CFR section 482.46) to the CoP regulations to prohibit Medicare- and Medicaid-participating hospitals from performing "sex-rejecting" procedures on any individual under the age of 18, with three exceptions. For the purposes of this prohibition, CMS proposes to define the term "sex-rejecting procedure" to mean "any pharmaceutical or surgical intervention that attempts to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex." CMS cites its general rulemaking authority as well as section 1861e(9) of the Act that explicitly provides CMS authority to enact regulations for hospitals that it finds necessary in the interest of the health and safety of individuals who are furnished services in hospitals (i.e., the CoPs).

While the AAMC recognizes the agency's interest and role in protecting the health and safety of individuals, the AAMC opposes the use of CoPs in this context and urges CMS not to finalize these changes. Section 1861(e)(9) of the Social Security Act[1] authorizes CMS to establish Conditions of Participation to promote patient safety, quality of care, and program integrity. In this section, Congress specified certain procedural requirements participating hospitals must meet, such as maintaining clinical records, bylaws for medical staff, and 24-hour nursing coverage, and then authorized CMS to "define such other requirements as (CMS) finds necessary in the interest of health and safety."[2]

Using the hospital CoPs to prohibit the provision of certain health care services was not authorized by Congress and marks a significant departure from CMS's authority under the CoPs. Under the statutory interpretation canon of *ejusdem generis*, " a general or collective term at the end of a list of specific items is typically controlled and defined by reference to the specific classes that precede it.[3] Therefore, the reference to "such other requirements" should be interpreted consistent with the facility-wide procedural requirements that were enumerated in the preceding paragraphs.[4] Historically, hospital CoPs have regulated a variety of administrative functions and health care services, including a hospital's responsibilities to its patients, obligations of the hospital's governing body, requirements related to emergency preparedness and planning, staffing requirements, minimum medical record requirements, and processes to develop safety procedures and quality improvement plans. CMS has never utilized the CoPs as a vehicle to categorically prohibit the provision of specific services, and this change would create a dangerous precedent.

[1] 42 U.S.C. section 1395x(e).
[2] Id.
[3] Fischer v. United States, 603 U.S. 480, 487 (2024).

Furthermore, section 1801 of the Social Security Act prohibits Federal interference in the practice of medical care.[5] Specifically, no federal officer or employee may exercise "any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."[6] By barring hospitals from providing specific treatments as a condition of Medicare and Medicaid participation, CMS would effectively regulate the practice of medicine- a domain historically reserved to state licensure authorities. Absent clear congressional authorization, this proposal exceeds CMS's authority.

CMS alleges in the proposed rule that gender-affirming medical care does not constitute the practice of medicine. However, that characterization is inconsistent with longstanding legal and professional frameworks. Gender-affirming medical services involve clinical assessment, diagnosis, and longitudinal patient management-activities that fall squarely within state-regulated medical practice. State medical licensing boards, accreditation bodies, and national professional organizations treat these services as medical care subject to physician licensure, clinical standards and malpractice oversight. It is inappropriate for CMS to bypass statutory limits on its authority by "re-labeling" regulated medical services as something other than medical practice.

As the Supreme Court held in *Loper Bright Enterprises v. Raimondo*, courts should no longer defer to agency interpretations of statute, and should instead decide on a "single, best meaning."[7] In light of the statutory text, we do not believe that Congress intended the Medicare statute to permit CMS to prohibit healthcare services that are permissible under state laws or to assert authority when Congress deliberately stated that there is no authority to interfere in the practice of medicine.

The Proposed Changes Improperly Infringe on State Authority Over Medical Practice

Traditionally, regulation of the practice of medicine, including defining appropriate standards of care, has been the responsibility of states and state medical boards. States establish medical licensure standards, define scopes of practice, oversee professional discipline, and determine what constitutes lawful practice of medicine within their jurisdictions. This state-based framework reflects long-standing constitutional principles recognizing that clinical-decision-making and professional regulation are matters best addressed at the state level. The Supreme Court recently affirmed that the federal government does not have the general authority to regulate the practice of medicine.[8] As CMS acknowledges in the proposed rule, many states expressly permit and regulate gender affirming medical services, with some imposing targeted

[5] 42 U.S.C. section 1395
[6] Id.
[7] 603 U.S. 369, 400 (2024).
[8] Medina v. Planned Parenthood S. Atl., 606 U.S. 357, 364 (2025); Gonzales v. Oregon, 546 U.S. 243 (2006).

limitations,[9] and others seeking to facilitate access through anti-discrimination requirements[10] and protections for patient confidentiality.[11] As stated previously, the proposed CoP changes would override these state determinations without clear authorization from Congress. Under the so-called "federalism canon," when an agency asserts the authority to regulate an area of historic state responsibility, 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."[12]

The Proposal Conflicts with Existing State Non-Discrimination and Patient-Protection Obligations

A CoP prohibiting gender affirming medical care risks placing providers in conflicting compliance positions with state laws. Health care providers have legal obligations to comply with state laws, including those that prohibit discrimination against individuals based on their membership in a protected class, such as disability, religion, race, color, national origin, sex, sexual orientation, gender identity, or expression. Under these state laws, refusing to provide health care services to a class of individuals based on their protected status, such as withholding the availability of services from transgender individuals based on their gender identity or their diagnosis of gender dysphoria, while offering such services to cisgender individuals, may constitute discrimination.

Additionally, federal rules forcing abrupt cessation of care risk placing clinicians and hospitals in violation of state laws regarding patient abandonment. Under state laws, once a physician-patient relationship has been established, clinicians and other providers may not terminate care without reasonable notice and a meaningful opportunity for the patient to secure alternative treatment. Abrupt termination of care may expose clinicians and hospitals to licensure discipline and liability.

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[9] *See, e.g.*, Ala. S.B. 184 (2022); Ark. H.B. 1570 (2021); Ariz. S.B. 1138 (2022); Fla. S.B. 254 (2023); Ga. S.B. 140 (2023); Iowa S.F. 538 (2023); Idaho HB71 (2023); Ind. Act No. 480 (2023); Kan. S.B. 63 (2025); Ky. S.B. 150 (2023); La. H.B. 648 (2023); Miss. H.B. 1125 (2023); Mo. S.B. 49 (2023); Neb. L.B. 574 (2023); N.C. H.B. 808 (2023); N.D. H.B. 1254 (2023); Ohio H.B. 68 (2024); Okla. S.B. 613 (2023); S.C. B. 4624 (2024); S.D. H.B. 1080 (2023); Tenn. S.B. 001 (2023); Tex. S.B. 14 (2023); Utah S.B. 16 (2023); W. Va. H.B. 2007 (2023); Wyo. S.F. 0099 (2024).

[10] *See, e.g.*, N.Y. Comp. Civ. R. & Regs. tit. 10, § 405.7; Cal. Ins. Code § 10140; Conn. Gen. Stat. § 46a-64; D.C. Code §§ 2-1402.31(a)(1); Del. Code Ann. tit. 6, §§ 4501-4, 4601-5; Haw. Rev. Stat. § 432:1-607.3; N.M. Stat. Ann. § 24-34-3(A); 23 R.I. Gen. Laws § 23-17-19.1; 28 R.I. Gen. Laws § 28-5.1-12; 220 R.I. Code R. 80-05-1.

[10] *See, e.g.*, Cal. Civ. Code § 56.109(a); Colo. S.B. 23-188 (2023); Conn. H.B. 5506, §§ 503-07 (2022); D.C. Act. No. 24-738 (2023); Ill. H.B. 4664, art. 28 (2023); Me. Laws. Ch. 648 (2024); Md. S.B. 119 (2024); Mass. Acts Ch. 127 (2022); Minn. Laws Ch. 29 (2023); N.M. S.B. 13 (2023); N.Y. Laws Ch. 143 (2022); N.Y. Laws Ch. 101 (2024); Ore. H.B. 2002 (2023); R.I. H.B. 7577 (2024); Vt. Act No. 14 (2023); Vt. Act No. 15 (2023).

[11] *See, e.g.*, Cal. Civ. Code § 56.109(a); Colo. S.B. 23-188 (2023); Conn. H.B. 5506, §§ 503-07 (2022); D.C. Act. No. 24-738 (2023); Ill. H.B. 4664, art. 28 (2023); Me. Laws. Ch. 648 (2024); Md. S.B. 119 (2024); Mass. Acts Ch. 127 (2022); Minn. Laws Ch. 29 (2023); N.M. S.B. 13 (2023); N.Y. Laws Ch. 143 (2022); N.Y. Laws Ch. 101 (2024); Ore. H.B. 2002 (2023); R.I. H.B. 7577 (2024); Vt. Act No. 14 (2023); Vt. Act No. 15 (2023).

[12] Bond v. United States, 572 U.S. 844, 848 (2014).

The Proposed Changes Improperly Interfere with the Physician-Patient Relationship

Additionally, the proposal represents a harmful intrusion into the patient-physician relationship and threatens access to medical care for transgender young people. Medical decisions are best made by patients and their families, in consultation with their physicians, based on clinical evidence, professional judgment, and the individual needs and values of the patient. Federal agencies, such as CMS are not positioned to determine what constitutes appropriate medical care for individual patients. Determinations about appropriate diagnosis and treatment should fall squarely within the professional judgment of licensed physicians, guided by evidence-based standards of care and ethical obligations to their patients. It is inappropriate for government policies to intrude into the physician-patient relationship – undermining both quality of care and patient trust**.** Further, clinical standards are developed through rigorous scientific processes led by medical professionals and specialty societies and should not be done through administrative rulemaking.

The Proposal Jeopardizes Access to Care for All Patients

Hospitals participating in Medicare and Medicaid serve as the backbone of health care delivery in their communities. They provide emergency services, inpatient and outpatient care, specialty services, and serve as essential access points to health care for vulnerable populations. Participation in Medicare and Medicaid is necessary for hospitals to sustain operations and meet the health care needs of their communities. The proposed change to the CoPs would force hospitals to choose between continued participation in Medicare and Medicaid and the provision of lawful, professionally recognized services under state law.

If hospitals are forced to close, access to care will be jeopardized for all patients, not only those impacted by the proposed prohibition on gender affirming medical care. There would be reduced availability of emergency and inpatient services, longer travel distances for care, increased wait times, loss of important services, such as behavioral health, trauma care, and surgical services. Academic medical centers provide complex, specialized care while training the next generation of physicians. Bans on lawful patient care threaten not only patient care today but also the education of future clinicians.

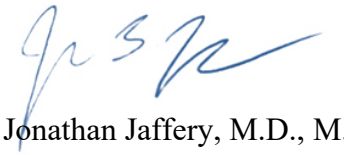
CMS Should Provide Time to Transition Care if Rule is Finalized

While we believe CMS does not have authority to amend the CoPs to prohibit medical care, if CMS finalizes this prohibition, we urge CMS to provide a reasonable period of time for patients in an active course of treatment to secure alternative forms of care. Abrupt termination of care would jeopardize the health and safety of patients. Providers have ethical and legal obligations to provide adequate notice to patients that their care is being terminated, to amend treatment plans, to provide the patient with a meaningful opportunity and sufficient time to transition to alternative care, and to facilitate the patients transition to that care. At a minimum, we urge CMS to allow a period of at least 6 months from the date the rule is effective to enable this transition.

CONCLUSION

The AAMC is committed to ensuring access to high-quality care that treats all people, equally and with respect, and providing training to physicians and other health care professionals that is consistent with those values. We urge CMS to withdraw this proposed rule as it exceeds CMS's statutory authority, undermines the physician-patient relationship, and threatens access to care for all patients. If you have any questions regarding our comments, please feel free to contact Gayle Lee (galee@aamc.org).

Sincerely,



Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer