



February 17, 2026

Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244-1850

**Consortium of Constituents with Disabilities Comments Re: HHS Docket
CMS-2481-P, 90 Fed. Reg. 59463 (Dec. 19, 2025)**

The undersigned members of the Health Care, Rights, and Long Term Services and Supports Task Forces of the Consortium for Constituents with Disabilities (CCD) write to express our strong opposition to the proposed rule revising Medicare and Medicaid Hospital conditions of participation to prohibit participation by hospitals that perform transition-related health care. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

The unprecedented actions proposed by the Department of Health and Human Services to essentially ban gender-affirming care betray the intent, plain meaning, and established interpretation of the Medicaid and Medicare statutes to expand access to health care for underserved communities. Instead, the Department seeks to restrict health care access for a marginalized, minority community with the intent of ending a range of care this community relies on for their health and well-being.

The animus underlying this regulation is rooted in bias. As the Department acknowledges, both the rulemaking and the HHS “umbrella review” it predominantly relies on for evidentiary basis were conducted pursuant to Executive Order (E.O.) 14187, titled “Protecting Children from Chemical and Surgical Mutilation.” This EO both directed HHS “to “take all appropriate actions to end the chemical and surgical mutilation of children, including regulatory and subregulatory actions, which may involve

[. . .]: Medicare or Medicaid conditions of participation or conditions for coverage”¹ and further ordered:

- (i) agencies shall rescind or amend all policies that rely on WPATH guidance, including WPATH’s “Standards of Care Version 8”; and
- (ii) within 90 days of the date of this order, the Secretary of Health and Human Services (HHS) shall publish a review of the existing literature on best practices for promoting the health of children who assert gender dysphoria, rapid-onset gender dysphoria, or other identity-based confusion.²

In other words, long before HHS had collected or analyzed a shred of evidence to justify this rule, the E.O. unambiguously directed HHS to pursue a pre-ordained outcome in prohibiting this medical care, rejecting the wide body of research and clinical guidelines supporting it.

Animus is further illustrated by the adoption of the term “sex-rejecting procedures” to refer to a broad range of transition-related health care services. This term has no basis in either established clinical terminology or in the popular lexicon for transition-related health care, nor does it reflect a neutral, non-derogatory description of the services encompassed, nor even the language of the preceding E.O. Rather, HHS appears to have adopted this term to minimize and erase the medical needs of a marginalized group. The animus behind this rulemaking is further demonstrated through the language employed by the Secretary and other HHS officials during the press conference announcing this rulemaking, where terms and phrases such as “warped”, “predatory”, “barbaric”, “mutilation”, “perverted”, “war on nature”, and “evil” were used to describe the care decisions made by families and their providers³.

The proposed rule further discriminates based on disability. While patients with other diagnoses such as precocious puberty, 5-alpha reductase deficiency, Klinefelter syndrome, Turner Syndrome, or growth hormone deficiency may access hormone therapy and related care at funded providers, patients who need such care based on gender dysphoria may not. Restricting medically necessary and physician-prescribed healthcare because the patient has a disfavored diagnosis is disability discrimination.

¹90 FR 8771,
<https://www.federalregister.gov/documents/2025/02/03/2025-02194/protecting-children-from-chemical-and-surgical-mutilation>

² *Ibid.*

³ U.S. Department of Health and Human Services (Dec 18, 2025) Protecting Children. [Video] Youtube. <https://www.youtube.com/watch?v=aY1XfN6Tt0Q> transcript available at: <https://dredf.org/wp-content/uploads/2026/01/December-18-2025-Protecting-Children-HHS-Event-Transcript.txt>

The use of Hospital Conditions of Participation (CoP) to exercise this discriminatory restriction of health care is particularly objectionable given the long-established administrative history of the provision. CoP has, in contrast to this proposed rule, expanded access by protecting patients from discriminatory practices in medical settings. A particularly well-known and illustrative example is the role that CoP enforcement played immediately after the passage of the Medicare and Medicaid Act in enforcing Hospital compliance with the Civil Rights Act of 1964.⁴ Here, the Medicare and Medicaid Act required hospitals, through CoP, to conduct operations in compliance with existing civil rights law. HHS enforcement actions targeted noncompliance with the statutory mandate of Medicare and Medicaid: to expand health care access for the most vulnerable and discriminated-against members of society. This proposed rule pursues directly contrary ends, without any clear justification.

The rule also exceeds HHS's statutory authority by attempting to use the Hospital Conditions of Participation improperly to regulate the practice of medicine. The proposed rule, if adopted, would effectively make a set of treatments wholly unavailable to a disfavored group, regardless of whether any federal funding is used to furnish those treatments. Such a rule would reach into the practice of medicine in a unique and dramatic way, violating the statutory provision barring CMS from "exercis[ing] any supervision or control over the practice of medicine or the manner in which medical services are provided"⁵. The proposed rule sidesteps this statutory constraint by rejecting the premise that the targeted services are medical health care services. This argument defies common sense. By rejecting existing clinical practice guidelines employed by regulatory bodies and substituting its own bare bones analyses, HHS *is* engaging in regulation of the practice of medicine through the proposed rule. The Department may not write its own exemption from statutory constraints.

Even more outrageous are the unsourced, unjustified claims the proposed rule makes as to the definition of "health care" and "health" itself, in order to justify its attempt to redefine medical practice to exclude transition-related health care. This conception of "health" attempts to set a deeply dangerous precedent for federal regulation of healthcare providers, established state regulatory jurisdictions, and the autonomy and well-being of state residents. Once again, the rule does not rely on any source for its definition of health, which stands in stark opposition to well-established medical consensus such as those holistic definitions employed by the World Health

⁴ Gordon, E. (2018, February 15) Medicare and the desegregation of health care. WHY. <https://why.org/segments/medicare-desegregation-health-care/>

⁵ 42 U.S.C. 1395.

Organization⁶ and even the working definitions of health that HHS employs throughout its programs⁷. The rule asserts that *all* persons “are either healthy or unhealthy based on whether they are operating according to their biological functions.” Disability communities have condemned approaches to health that employ this false binary for decades⁸ because they assert that health care narrowly involves affirming/restoring “healthy” and “normal” biological functions. This can lead to denial of care for people with disabilities and chronic conditions, and anyone of any age whose bodily parts do not function typically. It also makes them subject to all kinds of restrictions and regulations because their healthcare needs supposedly lie outside of the “practice of medicine.” Worse still, this rationale has historically been employed to impose medical interventions on individuals with disabilities without their consent and, conversely, to withhold desired interventions with the potential to improve the well-being of people with disabilities. Applying this reasoning, the federal government could presumably impose countless other restrictions, prohibitions or mandates on the delivery of care or clinical decision-making via CoP, simply by declaring that the service or practice does not “count” as practice of medicine. At the very least, this seems to assert a standard whereby the CMS could justify the direct regulation of the practice of medicine with regard to the considerable preponderance of preventive medical care, which quite frequently involves acting on “healthy” bodies and systems by its very definition.

This conception of health and health care also undermines decades of evidence-based progress in recognizing and treating mental health disabilities and substance use disorders, because it holds a person’s experience of living in their body is irrelevant to medically necessary services. By rejecting the position that psychological distress is a meaningful component of mental health, not only does this rule invite further future intrusion into practice of medicine related to mental health, but it rejects the Department’s own positions on the most pressing health care needs of America’s youth as including measures of psychosocial distress⁹

⁶ “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” See WHO Const., para.2

⁷ Compare Healthy People 2030 Foundational Principles: “The health and well-being of all people and communities is essential to a thriving society[...].Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions.[...]Achieving health and well-being requires eliminating health disparities, improving health for all people, and attaining health literacy. See Office of Disease Prevention and Health Promotion, US Department of Health and Human Services. <https://odphp.health.gov/healthypeople/about/healthy-people-2030-framework>

⁸ A binary conception of health directly contributes to overlooking the health and healthcare disparities experienced by disabled people, discounts the understanding that disability is a natural part of the human condition, and strengthens ableist stereotypes of the educational, social, physical, and professional capacities of people with disabilities. See [Advancing Health Equity And Reducing Health Disparities For People With Disabilities In The United States](#) Monika Mitra, Linda Long-Bellil, Ian Moura, Angel Miles, and H. Stephen Kaye, *Health Affairs* 2022 41:10, 1379-1386.

⁹ “Parallel to the decline in physical activity, American youth face a deepening psychosocial crisis. This is marked by rising mental health disorders, significant sleep deficits, chronic stress, and pervasive loneliness, all exacerbated by the widespread influence of technology. “ See: The White House.

Because the proposed rule is a discriminatory product of animus towards transgender individuals, including people with gender dysphoria, it does not meaningfully engage with the full body of evidence around transition-related health care, it attempts to exceed the clear statutory bar on regulating the practice of medicine, and it promotes an unsupported and unjustified definition of health and health care that directly endanger the lives, health and self-determination of the disabled community, we strongly oppose the proposed rule and urge the Department to rescind this rulemaking.

Signed,

Access Ready

American Music Therapy Association

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Bazelon Center for Mental Health Law

Caring Across Generations

Center for Law and Social Policy (CLASP)

Deaf Equality

Disability Rights Education and Defense Fund (DREDF)

Family Voices NJ

Institute for Exceptional Care

Justice in Aging

National Disability Institute

National Partnership for Women and Families

SPAN Parent Advocacy Network

TDIforAccess

Establishing the President's Make America Healthy Again Commission. The White House (2025).

Available at:

<https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/> (Accessed February 12, 2026).