

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance



NON-DISCRIMINATION IN THE DISTRICT'S STATE MEDICAID PROGRAM BASED ON GENDER IDENTITY OR EXPRESSION

Consistent with **BULLETIN 13-IB-01-30/13 REVISED** issued by the Department of Insurance, Securities and Banking (DISB), the Department of Health Care Finance (DHCF) issues a clarifying statement of policy pertaining to the District of Columbia's Medicaid program, gender identity or expression, and access to care.

Medicaid covers approximately one-third of District residents, making it a major contributor to the high insurance coverage rates enjoyed by the District of Columbia. Additionally, the comprehensive benefits provided by Medicaid are essential to the health and well-being of some of the District's most vulnerable residents. DHCF endorses the District's prohibition of discrimination in health insurance based on gender identity or expression, and further states that, while there is no evidence that there are policy barriers to access to care for District Medicaid beneficiaries seeking medically necessary sexual reassignment treatment, surgery, or other therapeutic services, the perception of providers and beneficiaries may be that Medicaid does not cover such services. Through this statement, DHCF confirms and clarifies that treatments and services related to the treatment of gender dysphoria are covered by Medicaid when they are determined to be medically necessary.

The benefits afforded to individuals seeking treatment for gender dysphoria, including gender reassignment surgeries, should not be construed as newly-mandated Medicaid benefits. As with all covered services provided through Medicaid, the District of Columbia will continue to cover medically necessary transgender health services to the extent permissible through Federal and local law. Rather, DHCF is committed to ensuring that individuals diagnosed with gender dysphoria are afforded the same right to obtain benefits under health insurance policies as individuals seeing medically necessary treatment for non-gender identity or expression related conditions; or as they themselves would experience for any other health care concerns.

Medically Necessary Services and Medicaid

If a District resident is eligible for Medicaid coverage in the District, and enrolls in the Medicaid program as a participant, that individual is eligible for all medically necessary covered services, as defined by the Medicaid State Plan. Key points pertaining to medical necessity in Medicaid include:

- There are express terms and limits on State discretion with regards to medical necessity in Medicaid programs. The first such limit is a requirement that a State’s medical necessity standard be reasonable (42 U.S.C. § 1396a(a)(17)(A). The second limit requires that a State’s medical necessity standard be consistent with the purpose of a particular Medicaid benefit. The third limit prohibits States from arbitrarily denying coverage on the basis of a condition in the case of a required service.
- The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of federal law create a unique medical necessity standard for children under age 21(42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r)). The standard requires States to provide any “necessary health care, diagnostic services, treatment, and other measures” that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions.”
- In determining the medical necessity of services and benefits provided to individuals enrolled in Medicaid, providers should refer to recognized professional standards of medical care. For transgender individuals requiring treatment for gender dysphoria, such standards are detailed in the most recent edition of the World Professional Association for Transgender Health Standards of Care (“WPATH Standards”)¹. Inasmuch as the WPATH Standards indicate that the appropriate course of treatment for individuals diagnosed with gender dysphoria may vary between patients, determinations of medical necessity for coverage purposes must also be guided by providers in communication with individual patients.
- For surgical procedures that are determined to be medically necessary, but may be cosmetic in nature :
 - Section 9 (Clinic Services) Part A in Supplement 1 to Attachment 3.1-B in the DC Medicaid State Plan states “Surgical procedures for medically necessary cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by the State Agency.”²

¹ The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.

² In its review of claims data from the Medicaid Management Information Systems (MMIS), DHCF has found no indication or pattern of denying claims on the basis of gender identity. Many procedures in the MMIS system that a provider may bill for throughout the course of offering treatment to a patient in transition do not require prior authorization.