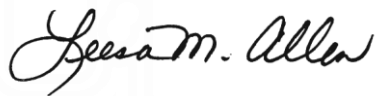


ISSUE DATE July 18, 2016	EFFECTIVE DATE July 18, 2016	NUMBER 99-16-11
SUBJECT Federal Final Rule, "Nondiscrimination in Health Programs and Activities" and Implication for Coverage of Services Related to Gender Transition		BY  Leesa M. Allen, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate their MA enrollment every five years. Providers should log into PROMISe to check their revalidation date and submit a revalidation application at least 60 days prior. Enrollment (revalidation) applications may be found at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994. Providers who enrolled on or before SEPTEMBER 25, 2011 must complete the revalidation process as soon as possible. DHS must complete the revalidation for all providers enrolled on or before September 25, 2011 by September 25, 2016.

PURPOSE:

The purpose of this bulletin is to notify providers of how the Federal Final Rule, "Nondiscrimination in Health Programs and Activities," affects the coverage of services related to gender transition.

SCOPE:

This bulletin applies to all providers rendering services in either the Medical Assistance (MA) fee-for-service or managed care delivery systems.

BACKGROUND:

On May 18, 2016, the U.S Department of Health and Human Services' Office of Civil Rights issued the final rule, entitled "Nondiscrimination in Health Programs and Activities," which implements Section 1557 of the Patient Protection and Affordable Care Act of 2010 (ACA) (Pub. L. 111-148). Section 1557 prohibits discrimination in certain health programs and activities on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (Title IV), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504) and the Age Discrimination Act of 1975 (Age Act), which together prohibit discrimination on the basis of race, color, national origin, sex, age or disability.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
<http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm>

The Federal Final Rule prohibits a State Medicaid Program, as an entity covered under the scope of the Rule, from having or implementing any categorical coverage exclusion or limitation for health services related to gender transition. The State Medicaid Program is not, however, restricted from determining whether any particular service meets medical necessity requirements or otherwise meets applicable coverage requirements in a particular case. (See 45 CFR § 92.207)

DISCUSSION:

Pennsylvania's current MA regulations include several explicit categorical coverage exclusions that prohibit MA payment for surgical procedures and medical care related to sex reassignment. (See 55 Pa.Code § 1121.54(10), § 1126.54(a)(7), § 1141.59(11), 1163.59(a)(1), § 1221.59(7) (relating to noncompensable services)). These categorical payment prohibitions in Pennsylvania's current MA regulations are inconsistent with the Federal Final Rule and will no longer be applied.

Services related to gender transition that otherwise fall within a beneficiary's scope of covered MA benefits (e.g., physician's services, inpatient and outpatient hospital services, prescribed drugs) will be compensable under the MA Program when medically necessary. In determining medical necessity for gender transition services, the Department and Managed Care Organizations (MCO's) will use the World Professional Association for Transgender Health (WPATH) Standard of Care as guidelines and any successor WPATH guidelines to determine whether the services are medically necessary.

PROCEDURE:

Effective July 18, 2016, the categorical MA regulatory prohibitions on payment for services related to sex reassignment (see 55 Pa.Code § 1121.54(10), § 1126.54(a)(7), § 1141.59(11), 1163.59(a)(1), § 1221.59(7) (relating to noncompensable services)) are no longer in effect.

Providers should follow any prior authorization requirements and billing guidelines related to covered services associated with gender transition. Providers should refer to their MA Provider Handbook instructions regarding the program exception process related to authorization for any procedure codes not listed on the MA Program Fee Schedule. For beneficiaries in the managed care delivery system, providers should contact the applicable MCO regarding the prior authorization or program exception process.