COLORADO
Department of Health Care Policy & Financing

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Questions & Answers: Gender-Affirming Care Stakeholder Engagement

This document summarizes questions and answers related to the Gender-Affirming Care stakeholder meeting on March 1, 2023. This policy is still being developed. The Department's responses below reflect the Department's position as of 04/17/2023.

Item 1

Who can provide a diagnosis of gender dysphoria? (behavioral health provider, primary care provider, etc.)

Gender dysphoria may be diagnosed by a licensed provider acting within their scope of practice.

Item 2

Are there plans to adopt the use of ICD-11 criteria for Gender Incongruence?

The Department acknowledges the terminology used in the ICD-10 description of gender dysphoria is outdated. However, the Department currently relies on the ICD-10 criteria because providers must use the ICD-10 code series when entering a diagnosis on a claim form. The Department does not have plans to move to ICD-11 at this time. The Centers for Medicare and Medicaid Services (CMS) will provide direction when and if the Department is to move to ICD-11.

The Department would like to work with providers to determine if there are ways in which it would be beneficial to incorporate the ICD-11 criteria into policy. Providers are encouraged to reach out to the Department with any specific recommendations.

Item 3

What does the Department mean by the term "addressed" in the following requirement for gender-affirming care?

> **Any co-existing physical and behavioral health conditions that interfere with diagnostic clarity, capacity to consent, or may otherwise interfere with gender-affirming care have been addressed.**

The Department agrees this requirement is ambiguous. The draft policy will be rephrased to state:

> Any co-existing physical and behavioral health conditions do not interfere with diagnostic clarity or capacity to consent, and associated risks and benefits have been discussed.

Item 4

Will behavioral health providers be expected to discuss fertility-related concepts with members?

Under the proposed policy, members must be informed of potential effects of treatment on fertility prior to initiating gender-affirming hormone therapy or gender-affirming surgery. The provider requesting prior authorization for the service would be responsible for ensuring that members have been informed.

Item 5

Why must the assessment prior to initiating gender-affirming hormone therapy be performed by a licensed behavioral health provider?

This assessment serves the same purpose as the assessment required prior to surgery. Therefore, this language will be changed to align with the surgery section of the proposed policy, which requires a signed statement from a “licensed health care professional who has competencies in the assessment of transgender and gender diverse people.”

Item 6

Will pre-surgical procedures such as electrolysis be covered?

Permanent hair removal, including electrolysis, will continue to be covered for eligible members only when used to treat a surgical site.

Item 7

How will the department evaluate requests for gender-affirming surgery for members under 18 years of age?

Department clinical staff will review requests on a case-by-case basis taking into account all relevant clinical information. Reviews will rely on the availability of and quality of clinical

evidence and applicable Department rules regarding medical necessity determinations. Proposed policy language was structured to allow flexibility in this area as best practices continue to evolve.

Item 8

Why is the Department requiring 24 months of gender-affirming hormone therapy prior to breast augmentation?

The Department agrees with stakeholder feedback that 12 months of gender-affirming hormone therapy is a sufficient duration prior to breast augmentation. This will be changed in the proposed policy.

Item 9

How would requests for procedures such as breast augmentation or facial surgery be evaluated to determine whether services are medically necessary or cosmetic?

This determination depends on the individualized and contextual assessment of a member's gender dysphoria. In determining whether a procedure is medically necessary, the Department will consider:

- Does the procedure meet the definition of medical necessity at 8.076.1.8?
- Is the procedure excluded from coverage under 8.011.11?
- Does the procedure comply with all other applicable Medicaid requirements that pertain to the specific service, including those in the gender-affirming care rule at 8.735?

Item 10

Are there any guidelines for providers who self-identify as having competencies in the assessment of transgender and gender-diverse people for the purpose of performing an evaluation for gender-affirming care?

The Department does not have specific criteria for determining competency. There is not currently a universal certification or credential indicating expertise in gender-affirming care. Providers are expected to work within their competencies and refer members to another more appropriate provider when necessary.

Item 11

If the lists of procedures are removed from rule, how will stakeholders know what is covered?

Removing the lists of procedures is intended to create more flexibility for providers and for the Department in determining what care is medically necessary for a particular member. Lists of potentially covered procedures will be included in the gender-affirming care billing manual as examples. Additional procedures may be requested and will be reviewed for medical necessity.

Item 12

Are gender-affirming facial surgeries and tracheal shaves now covered?

Requests for these procedures are currently reviewed on a case by case and are approved when medically necessary. When the proposed policy becomes effective, gender-affirming facial and neck surgeries will be covered according to the criteria listed in the proposed policy.

Item 13

When will the proposed policy language take effect?

Once the proposed policy language is internally finalized, the documents will be submitted to the Medical Services Board. There will be opportunities for comment with the public rule review and reading at the Medical Services Board meetings. This process will take approximately four months.

For more information contact

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