



PROPOSED RULE MAKING

CR-102 (July 2022) (Implements RCW 34.05.320) Do NOT use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 24, 2024

TIME: 10:44 AM

WSR 24-15-152

Agency: Health Care Authority

Original Notice

Supplemental Notice to WSR _____

Continuance of WSR _____

Preproposal Statement of Inquiry was filed as WSR 24-08-052 ; or

Expedited Rule Making--Proposed notice was filed as WSR _____; or

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or

Proposal is exempt under RCW _____.

Title of rule and other identifying information: (describe subject) WAC 182-531-1675 Washington apple health – Gender affirming interventions for gender dysphoria.

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
August 27, 2024	10:00 AM	The Health Care Authority holds public hearings virtually without a physical meeting place.	To attend the virtual public hearing, you must register in advance: https://us02web.zoom.us/webinar/register/WN_Jx4tOCLyTByfJfl1Pj88Cg If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of intended adoption: August 28, 2024 (Note: This is **NOT** the effective date)

Submit written comments to:

Name: HCA Rules Coordinator

Address: PO Box 42716, Olympia WA 98504-2716

Email: arc@hca.wa.gov

Fax: 360-586-9727

Other:

By (date) August 27, 2024, by 11:59 PM

Assistance for persons with disabilities:

Contact Johanna Larson

Phone: 360-725-1349

Fax: 360-586-9727

TTY: Telecommunication Relay Services (TRS): 711

Email: Johanna.larson@hca.wa.gov

Other:

By (date) August 16, 2024

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is revising these rules to align with current standards of care. The rule amendments:

- Add gender affirming hair removal as a covered service to align with current practice.
- Clarify that modifications or corrections to a previous surgery must be related to infection or impairment of function.
- Require one behavioral health assessment instead of two for surgeries. For those age 17 and younger, the assessment must be a biopsychosocial behavioral health assessment.
- Remove the requirement that a client live 12 months in a congruent gender role. Gender incongruence must be marked and sustained.
- Require the client to be able to give informed consent. If a behavioral health condition interferes with the ability to give informed consent, the provider must facilitate treatment of the underlying behavioral health condition to support the ability to give informed consent.
- Clarify that 12 months of hormone therapy is required for breast augmentation (with exceptions where noted).
- Clarify that six months of hormone therapy is required for bottom surgery (with exceptions where noted).
- Require the surgeon to provide documentation of the client's informed consent.

- Require documentation for facial or body hair removal to align with current practice.

Reasons supporting proposal: See purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

- | | | |
|-------------------------|------------------------------|--|
| Federal Law? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Federal Court Decision? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| State Court Decision? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Type of proponent: Private Public Governmental

Name of proponent: (person or organization) Health Care Authority

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Melinda Froud	PO Box 42716, Olympia, WA 98504-2716	360-725-1408
Implementation:	Lisa Little	PO Box 45502, Olympia, WA 98504-5502	360-725-2033
Enforcement:	Lisa Little	PO Box 45502, Olympia, WA 98504-5502	360-725-2033

Is a school district fiscal impact statement required under [RCW 28A.305.135](#)?

Yes No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name:

Address:

Phone:

Fax:

TTY:

Email:

Other:

Is a cost-benefit analysis required under [RCW 34.05.328](#)?

Yes: A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

Phone:

Fax:

TTY:

Email:

Other:

No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act and Small Business Economic Impact Statement

Note: The [Governor's Office for Regulatory Innovation and Assistance \(ORIA\)](#) provides support in completing this part.

(1) Identification of exemptions:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see [chapter 19.85 RCW](#)). For additional information on exemptions, consult the [exemption guide published by ORIA](#). Please check the box for any applicable exemption(s):

This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.061](#) because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

- This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by [RCW 34.05.313](#) before filing the notice of this proposed rule.
- This rule proposal, or portions of the proposal, is exempt under the provisions of [RCW 15.65.570](#)(2) because it was adopted by a referendum.
- This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.025](#)(3). Check all that apply:
 - [RCW 34.05.310](#) (4)(b) (Internal government operations)
 - [RCW 34.05.310](#) (4)(c) (Incorporation by reference)
 - [RCW 34.05.310](#) (4)(d) (Correct or clarify language)
 - [RCW 34.05.310](#) (4)(e) (Dictated by statute)
 - [RCW 34.05.310](#) (4)(f) (Set or adjust fees)
 - [RCW 34.05.310](#) (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)
- This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.025](#)(4) (does not affect small businesses).
- This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of how the above exemption(s) applies to the proposed rule:

(2) Scope of exemptions: *Check one.*

- The rule proposal is fully exempt (*skip section 3*). Exemptions identified above apply to all portions of the rule proposal.
- The rule proposal is partially exempt (*complete section 3*). The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using [this template from ORIA](#)):
- The rule proposal is not exempt (*complete section 3*). No exemptions were identified above.

(3) Small business economic impact statement: *Complete this section if any portion is not exempt.*

If any portion of the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

- No Briefly summarize the agency's minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs. The proposed rules do not impose more-than-minor costs on small businesses.
- Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses and a small business economic impact statement is required. Insert the required small business economic impact statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: July 24, 2024

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



WAC 182-531-1675 Washington apple health—Gender affirming interventions for gender dysphoria. (1) Overview of treatment program.

(a) **Medicaid agency coverage.** The medicaid agency covers the services listed in (b) of this subsection to treat gender dysphoria (also referred to as gender incongruence) under WAC 182-501-0050 and 182-531-0100. These services include life-changing procedures that may not be reversible.

(b) **Medical services covered.** Medical services covered by the agency include, but are not limited to:

- (i) Presurgical and postsurgical hormone therapy;
- (ii) Puberty suppression therapy;
- (iii) Behavioral health services; ~~((and))~~
- (iv) Gender affirming hair removal services; and

(v) Surgical and ancillary services including, but not limited
to:

- (A) Anesthesia;
- (B) Labs;
- (C) Pathology;
- (D) Radiology;
- (E) Hospitalization;
- (F) Physician services; and

(G) Hospitalizations and physician services required to treat postoperative complications of procedures performed under this section.

(c) ~~((Surgical services covered. Surgical services to treat gender dysphoria are a covered service for clients who have))~~ **Diagnosis of gender dysphoria/gender incongruence.** A diagnosis of gender dysphoria/gender incongruence is required to obtain services under this program and must be made by a provider who meets the qualifications outlined in chapter 182-502 WAC.

(d) **Medical necessity.** ~~((Under this program,))~~ The agency authorizes and pays for only medically necessary services. Medical necessity is defined in WAC 182-500-0070 and is determined under WAC 182-501-0165 and limitation extensions in accordance with WAC 182-501-0169.

(e) **Provider requirements.** Providers should be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria/gender incongruence, including experience utilizing standards of care that include the World Professional Association for Transgender Health (WPATH) Standards of Care.

(f) **Clients age ~~((twenty))~~ 20 and younger.** The agency evaluates requests for clients age ~~((twenty))~~ 20 and younger according to the early and periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC. Under the EPSDT program, the agency pays for a service if it is medically necessary, safe, effective, and not experimental.

(g) **Transportation services.** The agency covers transportation services under the provisions of chapter 182-546 WAC.

(h) **Out-of-state care.** Any out-of-state care, including a presurgical consultation, must be prior authorized as an out-of-state service under WAC 182-501-0182.

(i) **Reversal procedures.** The agency does not cover procedures and surgeries related to reversal of any gender affirming surgery.

(j) **Corrective surgeries for intersex traits.** The agency covers corrective or reparative surgeries for people with intersex traits who received surgeries that were performed without the person's consent.

(2) **Prior authorization.**

(a) **Prior authorization requirements for surgical services.** As a condition of payment, the agency requires prior authorization for all surgical services to treat gender (~~(dysphoria, including modifications to, or complications from, a previous surgery)~~) dysphoria/gender incongruence, except as provided in subsection (3) of this section. This includes modifications or revisions to, or correcting complications from, a previous surgery related to infections or impairment of a function.

(b) **Required documentation.** The provider must include the following documentation with the prior authorization request:

(i) (~~(Two psychosocial evaluations required.)~~) **Behavioral health assessment.** Documentation of (~~(two separate psychosocial evaluations)~~) a behavioral health assessment performed within 18 months preceding surgery by (~~(two separate)~~) a qualified (~~(mental)~~) behavioral health professional(~~(s)~~) as defined in WAC 182-531-1400. (~~(These providers)~~) This provider must be a licensed health care professional(~~(s)~~) who (~~(are)~~) is eligible under chapter 182-502 WAC, as follows:

- (A) Psychiatrist;
- (B) Psychologist;
- (C) Psychiatric advanced practice registered nurse (~~(practitioner~~ ~~-ARNP)~~) (APRN);
- (D) Psychiatric mental health nurse practitioner-board certified (PMHNP-BC);
- (E) Mental health counselor (LMHC);
- (F) Independent clinical social worker (LICSW);
- (G) Advanced social worker (LASW); or
- (H) Marriage and family therapist (LMFT).

(ii) (~~(One psychosocial evaluation for top surgery.~~ For top surgery with or without chest reconstruction, the agency requires only one comprehensive psychosocial evaluation.

~~(iii))~~ **Evaluation requirements.** (~~(Each)~~) The comprehensive (~~(psychosocial evaluation)~~) behavioral health assessment must:

(A) Confirm the diagnosis of gender dysphoria, or gender incongruence, or both, as defined by the *Diagnostic Statistical Manual of Mental Disorders*;

(B) Document that:

(I) (~~(The client has:~~

- ~~• Lived for 12 continuous months in a gender role that is congruent with their gender identity, except for top surgery, hysterectomy, or orchiectomy; or~~

- ~~• Been unable to live in their gender identity due to personal safety concerns.~~

~~(II) The client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed.~~

~~(iv))~~ The client's experience of gender incongruence is marked and sustained;

(II) The client has the desire to make their body as congruent as possible with a desired gender through surgery, hormone treatment, or other medical therapies;

(III) Gender incongruence causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

(IV) The client has no contraindicating behavioral health conditions that would impair the ability to give informed consent, as described in (c) of this subsection. If a client has a behavioral health condition that interferes with their ability to give informed consent and the client understands the risks, benefits, and alternatives to gender affirming treatment, the provider must facilitate treatment of the underlying behavioral health condition to support the client's ability to provide informed consent.

(iii) **Hormone therapy.** Documentation from the primary care provider or the provider prescribing hormone therapy that the client has:

(A) As appropriate to the client's gender goal for the following procedures:

(I) Had ~~((12))~~ six continuous months of hormone therapy immediately preceding ~~((the))~~ a request for genital surgery~~((, as appropriate to the client's gender goals,))~~; or

(II) Twelve continuous months of continuous hormone therapy immediately preceding a request for breast augmentation surgery, unless:

• Hormones are not clinically indicated for the ~~((individual, with the exception of))~~ client or hormones are not aligned with the client's gender health care plan, or both; or

• The client has requested a mastectomy or reduction mammoplasty~~((, which do not require hormone therapy))~~; or

~~((B))~~ • The client has a medical contraindication to hormone therapy; and

~~((C))~~ • The client has a medical necessity for surgery and ~~((that))~~ the client is adherent with current gender dysphoria treatment.

~~((v))~~ (B) Gender dysphoria/gender incongruence that is not a symptom of another medical condition; and

(C) Had no medical conditions that would impair the client's ability to give informed consent.

(iv) **Surgical.** Documentation from the surgeon of the client's:

(A) Medical history and physical examination(s) performed within the 12 months preceding surgery;

(B) Medical necessity for surgery and surgical plan; and

(C) For hysterectomies, a completed agency hysterectomy consent form must be submitted.

(c) **Informed consent.** The surgeon must provide documentation showing that they informed the client of:

(i) The nature of the proposed care, treatment, services, medications, and procedures;

(ii) Potential benefits, risks, or side effects, including potential problems that might occur during recuperation;

(iii) The likelihood of achieving the client's treatment goals;

(iv) Reasonable alternatives;

(v) Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services;

(vi) Any limitations on the confidentiality of information learned from or about the patient;

(vii) The effect of gender-affirming treatment on reproduction; and

(viii) Reproductive options before having gender-affirming surgeries that have the potential to create iatrogenic infertility.

(d) Requirements for hair removal. For facial or body hair removal, a client must submit:

(i) A letter written within the past 18 months from the provider managing the client's gender-affirming hormone therapy:

(A) Describing the client's attempted hair removal techniques that failed, for each affected part of the body; and

(B) Identifying the medical condition that prevents the client from shaving or using other hair removal techniques, such as documented folliculitis, documented sensitivity to hair removal techniques, or thick, male-pattern hair growth that prohibits adequate hair removal.

(ii) A letter of medical necessity from the client's dermatologist or primary care provider written within the past 18 months that includes:

(A) The size and location of the area to be treated; and

(B) For each area of the body, the number of expected units needed to complete treatment.

(iii) Photographs of the areas to be treated, if requested by the agency.

(e) Other requirements. If the client fails to complete all of the requirements in ~~((subsection—(2)))~~(b) of this ~~((section))~~ subsection, the agency will not authorize gender affirming surgery unless:

(i) The clinical decision-making process is provided in the referral letter and attachments described in ~~((subsection—(2)))~~(b) of this ~~((section))~~ subsection; and

(ii) The agency has determined that the request is medically necessary in accordance with WAC 182-501-0165 based on review of all submitted information.

~~((d))~~ (f) Behavioral health provider requirements. The behavioral health provider~~((s))~~ who performs the ~~((psychosocial—evaluation))~~ behavioral health assessment described in ~~((subsection—(2)))~~(b)(i) of this ~~((section))~~ subsection must:

(i) Meet the provisions of WAC 182-531-1400;

(ii) Be competent in using the *Diagnostic Statistical Manual of Mental Disorders*, and the *International Classification of Diseases* for diagnostic purposes;

(iii) Be able to recognize and diagnose coexisting ~~((mental))~~ behavioral health conditions and to distinguish these from gender dysphoria/gender incongruence;

(iv) Be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and

(v) Have completed continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a ~~((mental))~~ behavioral health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

~~((e))~~ (g) Clients age 17 and younger. Clients age 17 and younger must meet the requirements for prior authorization identified in ~~((subsection—(2)))~~(a) through (d) of this ~~((section))~~ subsection, except that~~((:~~

~~((i—of))~~ (i) the comprehensive ~~((psychosocial—evaluations))~~ behavioral health assessment required in ~~((subsection—(2)))~~(b)(i) of this ~~((section))~~ subsection must be a biopsychosocial behavioral health assessment performed by a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.

~~((ii) For top surgery with or without chest reconstruction, the agency requires only one comprehensive psychosocial evaluation from a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.))~~

(3) **Expedited prior authorization (EPA).**

(a) **Approved EPA procedures.** The agency allows a provider to use the EPA process for clients age 17 and older for the following medically necessary procedures:

(i) Bilateral mastectomy or reduction mammoplasty with or without chest reconstruction; and

(ii) Genital or donor skin graft site hair removal when medically necessary to prepare for genital reassignment.

(b) **Clinical criteria and documentation.** To use the EPA process for procedures identified in (a) of this subsection, the following clinical criteria and documentation must be kept in the client's record and made available to the agency upon request:

(i) One comprehensive (~~psychosocial evaluation~~) biopsychosocial behavioral health assessment performed by a licensed behavioral health provider within the 18 months preceding surgery that meets the requirements identified in subsection (2) of this section;

(ii) Documentation from the primary care provider or the provider prescribing hormone therapy of the medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment; and

(iii) Documentation from the surgeon of the client's:

(A) Medical history and physical examinations performed within the 12 months preceding surgery; and

(B) Medical necessity for surgery and surgical plan.

(c) **Documentation exception.** When the requested procedure is for genital or donor skin graft site hair removal to prepare for bottom surgery, there is an exception to the requirements in (b) of this subsection. The only documentation required is either a:

(i) Letter of medical necessity from the treating surgeon that includes the size and location of the area to be treated, and expected date of planned genital surgery; or

(ii) Letter of medical necessity from the provider who will perform the hair removal that includes the surgical consult for bottom surgery and addresses the need for hair removal prior to gender affirming surgery.

(d) **Prior authorization required for other surgeries.** All other surgeries to treat gender dysphoria, including modifications to, or complications from a previous surgery require prior authorization to determine medical necessity.

(e) **Recoupment.** The agency may recoup any payment made to a provider for procedures listed in this subsection if the provider does not follow the EPA process outlined in WAC 182-501-0163 or if the provider does not maintain the documentation required by this subsection.