



Montana Healthcare Programs Provider Notice

October 7, 2026

Effective October 13, 2026

Informational

All Providers

Changes to Gender Dysphoria Coverage in Accordance with New Federal Final Rules

The Montana Department of Public Health and Human Services (DPHHS) is notifying providers of a change to Montana Medicaid HMK *Plus* and HMK/CHIP coverage and payment policy for certain services provided for gender transition. Beginning October 13, 2026, DPHHS will no longer cover or pay for certain pharmaceutical and surgical services when they are prescribed, furnished, or performed for gender transition for Medicaid HMK *Plus* members under the age of 18 and HMK/CHIP members under the age of 19. Surgical services were previously only available for HMK/CHIP members at age 18. Affected services include puberty-blocking medications, hormone therapy, and surgical services that alter primary or secondary sex characteristics, when prescribed, furnished, or performed for gender transition. This policy change comes as new federal rules limit Medicaid and CHIP payment for certain services.

This policy applies to the purpose for which a medication, service, or procedure is provided. The same medication, service, or procedure may remain covered when it is medically necessary and otherwise covered for another medical condition.

LIMITED TRANSITION PERIOD FOR HORMONE THERAPY

A limited transition-period authorization may be available for eligible members who were receiving hormone therapy for gender dysphoria as of October 13, 2026. This transition period ends on April 13, 2027.

For eligible members, federal Medicaid and CHIP matching funds may remain available for hormone therapy for up to six months after October 13, 2026, subject to the federal rule, prior authorization, and all other applicable program requirements.

The limited transition period is available only to eligible members who were receiving hormone therapy as of October 13, 2026. It does not apply to puberty-blocking medications.

This notice does not establish a clinical tapering protocol. Providers should use their clinical judgment and work with members regarding individualized treatment planning.

CLAIMS PROCESSING

Effective for dates of service on or after October 13, 2026, claims for puberty-blocking medications or surgical procedures are not covered when the medication or procedure is prescribed, furnished, or performed for gender transition for a Medicaid member under age 18 or an HMK/CHIP member under age 19.

Effective for dates of service on or after October 13, 2026, claims for hormone therapy are not covered when the medication is prescribed or furnished for gender transition for a Medicaid member under age 18 or an HMK/CHIP

member under age 19, except for eligible hormone-therapy claims approved under the limited transition-period process.

MEMBERS WHO REACH AGE 18 (OR AGE 19 FOR HMK/CHIP)

The federal prohibition applies only to Medicaid members under age 18 and HMK/CHIP members under age 19. A member who has reached that age on the date of service is outside the prohibition, and claims for that member are payable on ordinary terms, including claims for hormone therapy after April 13, 2027.

Member age will be evaluated as of the date of service. A member who reaches age 18 (or age 19 for HMK/CHIP) before the end of the transition period will not experience an interruption in coverage.

All claims remain subject to existing Medicaid and HMK/CHIP requirements, including medical necessity, provider enrollment, billing requirements, and any other applicable authorization requirements.

DETERMINING THE PURPOSE OF A SERVICE

Because this federal policy turns on the purpose for which a service is provided, DPHHS will identify affected claims using diagnosis, procedure, and drug codes. The same medication or procedure remains payable when it is provided for another purpose — for example, a GnRH agonist prescribed for central precocious puberty, endometriosis, or another covered indication, or hormone therapy prescribed at physiologic replacement doses to treat a diagnosed endocrine condition.

Providers should document the indication in the medical record and on the claim. Where a claim is denied and the service was provided for another covered purpose, the denial may be addressed through the Department's existing claims review and administrative review processes.

PRIOR AUTHORIZATION

Providers must obtain prior authorization before submitting claims for hormone therapy during the limited transition period.

For pharmacy-benefit prior-authorization requests, contact the Mountain Pacific Drug Prior Authorization Unit at (800) 395-7961 or fax (800) 294-1350.

Prior authorization for physician-administered drugs billed through the medical benefit can be requested by faxing a request to Health Resources Division at (406) 444-1861.

SERVICES NOT CHANGED BY THIS POLICY

This policy does not change coverage of medically necessary mental and behavioral health services, including services for gender dysphoria, when otherwise covered by Montana Medicaid HMK *Plus* or HMK/CHIP.

This policy also does not change coverage of medications, services, or procedures that are medically necessary and otherwise covered when used to treat another covered medical condition.

DETRANSITION TREATMENT AND TREATMENT OF COMPLICATIONS

This policy does not change the Department's obligation under § 53-6-101(14), MCA, and § 53-4-1005(6), MCA, to provide coverage for detransition treatment, under equivalent cost-sharing policies, to members who were enrolled when gender transition treatment was provided and who received benefits under that coverage. That obligation is not limited by the member's age.

Treatment of complications caused or exacerbated by a previously furnished procedure is likewise outside the scope of the federal prohibition and remains covered when otherwise medically necessary.

AUTHORITY

This policy implements the federal final rule titled Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, CMS-2451-F, Federal Register document no. 2026-16508, published August 13, 2026.

The applicable federal provisions are 42 CFR §§ 441.800-441.802 for Medicaid, including the State plan requirement at 42 CFR § 441.802(a) and the tapering provision at 42 CFR § 441.802(c), and 42 CFR § 457.476 for CHIP.

The federal rule restricts the use of federal Medicaid and CHIP funding for the affected services. DPHHS is implementing the coverage and payment policy described in this notice. Providers should follow future DPHHS policy guidance, claims-processing instructions, and prior-authorization criteria.

Contact and Website Information

For pharmacy prior authorization submissions, access the Medicaid Provider Portal - Mountain Pacific or call the Mountain Pacific drug prior authorization team at (800) 395-7961 or fax (800) 294-1350.

If you have questions, please contact Health Resources Division at (406) 444-4455, or HSHSRDBenefitQuestions@mt.gov

For claims questions or additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email [Montana Provider Relations Helpdesk](#).

Visit the [Montana Healthcare Programs Provider Information website](#) to access your provider type page. Choose Resources by Provider Type in the left-hand menu.

Visit the [Contact Us page](#) on the Provider Information website for additional DPHHS contact numbers.