



Colorado Consumer Health Initiative

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Department of Health Care Policy & Financing
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Re: Comments on the Draft Transgender Services Benefit Coverage Standard

Dear Transgender Benefits Collaborative Team,

Thank you for the opportunity to engage in the Department of Health Care Policy and Financing's (HCPF) work to develop a transgender services benefit coverage standard. We appreciate HCPF's work towards accessible health care for all Coloradans. The Colorado Consumer Health Initiative (CCHI), a nonprofit membership organization dedicated to ensuring all Coloradans have access to quality, affordable, and equitable health care, has the following comments on the Transgender Services Benefit Coverage Standard draft dated February 9, 2016.

Services for Medicaid Clients 20 Years and Younger

- We appreciate and support the change in the standard to allow initiation of Gonadotropin-Releasing Hormone (GnRH) concurrent with 6 months of mental health evaluation and monitoring as opposed to delaying the treatment.
- With respect to whether puberty delay treatment should be set at Tanner Stage 2 or Stage 2-3, we would like to draw your attention to the attached Endocrine Society Clinical Practice Guideline which suggests treatment be set at Tanner Stage 2.
- We believe that there should be a protocol in place relating to surgeries for individuals under age 20. We recognize that this is a more difficult issue and that the growing availability of puberty delay treatment hormone can significantly suppress the need for many surgeries, however many individuals will still be in need of surgeries to effectively treat gender dysphoria. Therefore, we urge HCPF to adopt such a protocol.

Services for Medicaid Clients 21 Years and Older

- We do not believe that 12 months of continuous cross-sex hormone therapy should be a prerequisite for surgery. For some individuals, hormone therapy

has contraindications (e.g. cardiovascular risks or cancer-related risk factors) preventing them from undergoing the treatment.

- The requirement that the letters of referral include “any other medical or behavioral health conditions for which the provider is treating the client” can potentially be a breach of a patient’s privacy. While it is important that any conditions that are relevant to the patient’s course of treatment for gender dysphoria be outlined, other medical or behavioral health records of treatment should not be required as part of the process of gender transition.
- The restriction of augmentation mammoplasty to “clients who do not develop breasts after cross-sex hormone therapy” does not take into account many other factors in an individual’s life. As previously mentioned, some individuals have contraindications with cross-sex hormone treatment and cannot participate in this treatment. This requirement suggests that augmentation would not be allowed until the patient attempted this treatment. Further, the judgment of the treating physician should be considered regarding the effective treatment of gender dysphoria rather than attempting to set a subjective standard.
- The list of covered services for transgender men should include nipple grafts.

Non Covered Services

We are concerned that the draft benefit contains a list of excluded services that may in fact be medically necessary for individuals with gender dysphoria. At the February 16th meeting, the HCPF team requested examples of plans that covered these procedures. Pages 6 – 8 of the New York State Department of Health Medicaid Update, attached, describe the covered transgender services; page 7 indicates that some procedures will not be covered unless medically necessary and prior authorized. We urge HCPF to adopt the same approach as New York and provide such services if found to be medically necessary. The New York standards read as follows and refers to the list of procedures on page 7 of the attached document:

“Payment will not be made for any procedures that are performed solely for the purpose of improving an individual’s appearance. The following procedures will be presumed to be performed solely for the purpose of improving appearance and will not be covered, unless justification of medical necessity is provided and prior authorization is received (emphasis added).”

We urge HCPF to modify the draft benefit coverage standard to include this

language in the introduction to the section entitled “Non-Covered Services.”

In conclusion, we appreciate the opportunity to provide input into this collaborative process. Please feel free to reach out to us with any questions or comments.

Sincerely,



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