



Benefits Collaborative FAQs: Transgender Services

This FAQ document summarizes:

- Frequently asked questions regarding Colorado Department of Healthcare Policy & Financing (Department) efforts to define the transgender services benefit through the Benefits Collaborative Process; and
- Suggestions made within the Benefits Collaborative Process, and supported by more than one stakeholder, for how to improve the draft Transgender Services Benefit Coverage Standard.

Below each item, the Department has provided an *interim* response.

Important Note: The development of the Transgender Services Benefit Coverage Standard is ongoing; there are many stages of the Benefits Collaborative Process that the draft has yet to complete. This FAQ document is a snap-shot of the Department position as of 12/10/2015 and should not be read as a final policy determination.

Item 1

Why is the Department addressing transgender services through the Benefits Collaborative now?

- Over the past five years, the Department has steadily been working to codify the appropriate amount, scope and duration of all Colorado Medicaid covered services. Transgender services has long been scheduled to go through the Benefits Collaborative Process this year.
- In addition, a recently proposed Department of Health and Human Services rule, titled Nondiscrimination in Health Programs and Activities, may take effect next year, which would mandate that our state cover all gender transition related services, when medically necessary, if we already cover these services for other medically necessary reasons. In anticipation of this proposed rule, the Department is examining all coverage of gender



transition related services to ensure Medicaid members are receiving medically appropriate care.

Item 2

Is this a new benefit?

- No, the Department is not creating a new benefit, we are codifying an existing benefit and working to ensure that transgender persons can access existing benefits, when medically necessary.
 - Coverage of transgender services is not new; the Department has covered hormone therapy and counseling related to transition for quite a while. Coverage of surgery is not new; the Department currently covers surgeries (such as mastectomy and phalloplasty), when medically necessary.
 - What is new is that it is now widely accepted that the services Colorado Medicaid already offers can be medically necessary to treat Gender Dysphoria; i.e., evidence-based best practice and federal guidance have changed. So, we must extend that coverage to individuals who require it, based on medical necessity, regardless of diagnosis.
 - Medical necessity criteria must be met, and we will have an opportunity over the course of this process to discuss what the appropriate medical necessity criteria should be for all transition related services.

Item 3

Will Gender Confirmation Surgery, also known as sex reassignment surgery, be a covered service under Colorado Medicaid?

- Yes. The Department recognizes that Gender Confirmation Surgery can be medically necessary to treat Gender Dysphoria and we agree that we have a responsibility to extend existing surgery coverage to transgender individuals, when medically necessary, for the purpose of transition.
- A second Benefits Collaborative meeting has been scheduled for Tuesday, February 16th, 2016 to discuss what the appropriate medical necessity criteria should be for all transition related surgeries.



Item 4

Where can I find the first draft of the Transgender Services Benefit Coverage Standard the Department shared with the public on Thursday, November 5th, 2015?

- The first draft of the Benefit Coverage Standard can be found on the Department website, at the link below.

<https://www.colorado.gov/pacific/sites/default/files/Benefits%20Collaborative%20Transgender%20Services%20Benefit%20Coverage%20Standard%20November%209%2C%202015.pdf>

- Note: the first draft does not include Gender Confirmation Surgery. The Department will be using the time between now and February 16th to do the additional research necessary prior to proposing specific surgical policy.

Item 5

Why does the draft policy discussed on 11/5/2015 (*see item 4 above*) refer to a diagnosis of Gender Identity Disorder? Terminology used in the DSM 5 is Gender Dysphoria.

- Response forthcoming



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Item 6

The requirement that Medicaid members have a diagnosis of Gender Identity Disorder (or Gender Dysphoria) to access services may exclude individuals with a medical need for services.

For example, people who have undergone surgery may no longer have - or identify as having - GID/Gender Dysphoria, but may require continual cross-sex hormone therapy. Others may not be - or may become - non-dysphoric, with or without surgery. Others may identify as gender-queer, may not be seeking to transition from the sex they were assigned at birth but may, nevertheless, benefit from hormone therapy.

- Response forthcoming

Item 7

On the bottom of page 2 of the draft policy proposed 11/5/2015 (*see item 4 above*), the sub-heading titled "Antiandrogen Therapy" needs to be modified. The services described underneath that heading can be anti-androgen or anti-estrogen. This also needs to be reflected in the Brief Coverage Statement.

- Response forthcoming



Item 8

The Department received varying points of feedback regarding the requirement proposed on 11/5/2015 that Medicaid members obtain a "referral letter from a licensed mental health professional" before accessing services. Specific feedback included:

In the Eligible Providers section of the standard there is mention of a "referral letter" but the need for a letter is not mentioned again in the standard; the result is that the requirement is unclear.

The informed consent model outlined in the version 7 guidelines of the World Professional Association for Transgender Health (WPATH), states that patients should be able to choose for themselves whether or not to begin hormone therapy, so long as their practitioner has explained to them the risks and benefits of the therapy and what to expect.

Part of the reason the aforementioned informed consent model became popular is because, traditionally, there weren't many mental health professionals trained to diagnose and refer. The requirement of a referral letter could create an access to care issue. Could this policy, for example, drive out of state costs?

In the experience of certain stakeholders, once providers receive a certificate or some kind of special training to provide transgender related care, they cease to accept Medicaid, which may also create an access to care issue.

There is no specific licensure that an otherwise licensed mental health practitioner can currently obtain related to the treatment and diagnosis of Gender Identity Disorder/Gender Dysphoria. Professionals at the Gender Identity Center of Colorado, for example, are not licensed mental health professionals but assert that they often have more experience in providing counseling and writing referral letters than a Medicaid member's mental health professional or general practitioner.

One stakeholder related that she believes that obtaining her hormones from overseas and beginning to treat herself was the wrong approach and highly recommends obtaining counseling and a referral letter prior to therapy, such as the kind of counseling and referral letter provided by the Gender Identity Center of Colorado, but that the language in the policy should read as a recommendation, not a requirement.



Several other stakeholders shared stories of obtaining hormones overseas and the fear that accompanies the potential for self-medicating incorrectly. These individuals noted that the policy needs to be drafted in a way that does not create an access to care issue that encourages people to treat themselves and potentially do themselves harm.

Providers can charge roughly \$100 to write a referral, which represents an additional cost to Medicaid that may not be appropriate, given that the WPATH v7 guidelines state practitioners should be able to make these determinations within the scope of their practice.

If a referral letter is required, does the Department, or could the Department, provide a training to providers on referral letter requirements?

- Response forthcoming

Item 9

Does the Department know if there are Medicaid providers willing to provide these services?

- Response forthcoming

Item 10

Some hormones can be self-administered at home, should this be explicitly stated in the standard, under the Eligible Places of Service section?

- Response forthcoming

Item 11

Luprolides are only one class of anti-androgen/estrogen therapy and there may be more cost effective options.

- Response forthcoming



Item 12

In both the 2009 Adult and Pediatric Endocrine Council guidelines and the WPATH guidelines there is no requirement that a child receive 6 months of counseling, nor a diagnosis of GID/Gender Dysphoria, to begin receiving anti-androgens/anti-estrogens.

In the opinion of one stakeholder, setting this counseling expectation could endanger the lives of youths.

- Response forthcoming

Item 13

Varying opinions were expressed regarding at what Tanner Stage anti-androgens should be administered.

One physician advocated for Tanner Stage 1.

Another physician noted that anti-androgens are not benign and can, for example, lead to loss of bone mineral density, and advocated for early Stage 2.

It was also noted that beginning treatment at Tanner Stages 2-3 is consistent with the WPATH and Pediatric Endocrine Council guidelines.

- Response forthcoming

Item 14

Who is, and is not, required to provide informed consent - and how - should be more clearly defined in the standard.

For example, Standards and regulations state children under the age of 18 must obtain a referral letter from a mental health provider in order to access hormone therapy. Also, state law requires that parents be notified and must give consent.

- Response forthcoming



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Item 15

Does administration of estrogen to children under the age of 18 require a manual review by pharmacists who work for the Department? If so, why?

- Response forthcoming

Item 16

Where does the following language come from "if significant medical or mental health conditions are present they must be well controlled"?

- Response forthcoming