



TRANSGENDER SERVICES BENEFIT COVERAGE STANDARD

Note: Capitalized terms within this Benefit Coverage Standard, which do not refer to the title of a benefit, program, or organization, have the meaning specified within the *Definitions* section, found on pages 5-8.

BRIEF COVERAGE STATEMENT

Transgender services are a covered benefit for Colorado Medicaid clients who have a diagnosis of Gender Dysphoria or a history of a diagnosis of Gender Dysphoria. Services include: behavioral health care, Gonadotropin-Releasing Hormone analogs/agonists, cross-sex hormone therapy, gender confirmation surgery, and pre- and post-operative care.

RELATED BENEFITS ADDRESSED IN OTHER BENEFIT COVERAGE STANDARDS AND GUIDING DOCUMENTS

- Preferred Drug List¹
- Disorders of Sex Development Benefit Coverage Standard
- Women's Health Services Benefit Coverage Standard
- Outpatient Behavioral Health Fee-For-Service Billing Manual

ELIGIBLE CLIENTS

- All Colorado Medicaid eligible clients, who meet the criteria listed within the *Covered Services* section of this Benefit Coverage Standard, may receive transgender services, when Medically Necessary.
- The federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires that children aged 20 years and younger receive coverage of all Medically Necessary services that are recognized under section 1905 of the Social Security Act, whether or not such services are covered under this state plan benefit.

¹ Providers may also reference Appendix P for further guidance regarding antiandrogen and cross-sex hormone therapy.



COVERED SERVICES

The following services are a benefit of the Colorado Medicaid program when:

- Client has a diagnosis of Gender Dysphoria; and
- The service is Medically Necessary; and
- Client possesses the capacity to make a fully informed decision and to consent to treatment.

BEHAVIORAL HEALTH CARE

Covered Behavioral Health Services are detailed in the Department's Outpatient Behavioral Health Fee-For-Service Billing Manual at colorado.gov/hcpf.

MEDICAID CLIENTS 20 YEARS AND YOUNGER

GONADOTROPIN-RELEASING HORMONE (GnRH) ANALOGS/AGONISTS

GnRH Analogs/Agonists are covered for clients 16 years and younger who meet the following criteria:

- Client receives at least 6 months of counseling and psychometric testing for Gender Dysphoria concurrent with the initiation of GnRH analogs/agonists leuprolides; and
- Client has exhibited changes of puberty (confirmed by estradiol for natal females and testosterone for natal males) and no earlier than Tanner stages 2-3 (bilateral breast budding or doubling to tripling testicular size to 4-8 cc).
- All other criteria as defined in pharmaceutical section of Colorado Medical Assistance Program rule at 8.800.

CROSS-SEX HORMONE THERAPY

Cross-sex Hormone Therapy is covered for clients 20 years and younger who meet the following criteria:

- Client meets criteria outlined in the Preferred Drug List.

MEDICAID CLIENTS 21 YEARS AND OLDER

CROSS-SEX HORMONE THERAPY

Antiandrogen and Cross-sex Hormone Therapy is covered for clients 21 years and older who meet the following criteria:

- Client meets criteria outlined in the Preferred Drug List.



GENDER CONFIRMATION SURGERY

Gender Confirmation Surgery is a covered benefit for Colorado Medicaid clients when:

- Client has completed twelve months of continuous Cross-sex Hormone Therapy;
- For each surgical Episode, client has obtained two signed letters of referral from licensed providers who have independently assessed the client and are referring the client for the surgery.
 - One letter must be from a licensed behavioral health provider, such as a psychiatrist or clinical psychologist, with whom the individual has an established and ongoing relationship.
 - The other letter must be from a licensed medical provider who has, at minimum, evaluated the individual once within the last sixty days.

Each letter of referral must:

- Document that client has a diagnosis of Gender Dysphoria; and
- Document that client has completed twelve months of continuous Cross-sex Hormone Therapy; and
- Attest that Gender Confirmation Surgery is Medically Necessary; and
- Outline any other medical or behavioral health conditions for which the provider is treating the client; and
- Establish that any medical or mental health conditions are well-controlled; and
- Attest that client possesses the capacity to make a fully informed decision and to consent to treatment.

COVERED SURGERIES FOR MALE TO FEMALE TRANSITION:

- Clitoroplasty
- Labiaplasty
- Mammoplasty*
- Orchiectomy
- Penectomy
- Prostatectomy
- Urethroplasty
- Vaginoplasty
- Vulvoplasty

* Mammoplasty is a covered benefit for clients who do not develop breasts after Cross-sex Hormone Therapy

COVERED SURGERIES FOR FEMALE TO MALE TRANSITION:

- Erectile prosthesis



- Hysterectomy
- Mastectomy
- Medtoidioplasty
- Ovariectomy/oophorectomy
- Phalloplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular prostheses
- Urethroplasty
- Vaginectomy
- Vulvectomy

PRE- AND POST-OPERATIVE CARE

Medically Necessary pre- and post-operative care related to Gender Confirmation Surgery are a covered service.

NON-COVERED SERVICES

Non-covered surgeries, services and procedures include, but are not limited to:

- Abdominoplasty;
- Blepharoplasty;
- Calf, cheek, chin, or nose implants;
- Hair transplantation;
- Hair removal;
- Laryngoplasty;
- Liposuction;
- Thyroid chondroplasty; or
- Other procedures conducted for the purpose of Facial or Body Feminization or Masculinization.
- Reversal of any surgery, procedure, or service listed in the *Covered Gender Confirmation Surgeries* section of this Benefit Coverage Standard.

ELIGIBLE PROVIDERS

All providers who order, prescribe, refer or render services must be:

- Licensed by the Colorado Department of Regulatory Agencies or the regulatory agency of the state in which they do business.
- Enrolled with Colorado Medicaid in accordance with federal regulation 42 CFR 455.410



PROVIDER REQUIREMENTS

PRIOR AUTHORIZATION

Services related to GnRH Analogs/Agonists, Cross-sex Hormone Therapy, and Gender Confirmation Surgery, as listed in the *Covered Services* section of this Benefit Coverage Standard, must be prior authorized in accordance with existing Colorado Medicaid medical and pharmacy policies.

DEFINITIONS

The definitions below are only applicable within the scope of this Benefit Coverage Standard.

TERM	DEFINITION
Gonadotropin-Releasing Hormone Analogs/Agonists	A course of medication given to counteract the effects of androgens (male sex hormones) and estrogen (female sex hormones) on various organs and tissues.
Colorado Medicaid	Colorado Medicaid is a free or low cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.
Cross-sex Hormone Therapy	Induction of secondary sex characteristics of the desired gender through the administration of cross-sex hormones (estrogen or testosterone).



TERM	DEFINITION
Facial or Body Feminization or Masculinization	Surgical or non-surgical procedures performed on bony and soft tissues which are intended to make the face appear more feminine or masculine.
Gender Dysphoria	Formal diagnosis set forth by the Diagnostic Statistical Manual of Mental Disorders, 5th Edition, Text Rev (DSM V-TR) (American Psychiatric Association, 2013). Gender Dysphoria is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one’s sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning. Colorado Medicaid also includes the International Classification of Disease – Volume 10 (ICD-10) class F64 – Gender Identity Disorder diagnoses as part of the Gender Dysphoria definition.
Medical Necessity, Medically Necessary	Medical Necessity is defined in Colorado Medical Assistance Program rule at 10 C.C.R. 2505-10, § 8.076.1.8. See also 10 C.C.R. 2505-10, § 8.280 for children age 20 and younger.



TERM	DEFINITION
Preferred Drug List	Colorado Medicaid's Preferred Drug List includes clinically effective medications that do not require prior authorization or approval. This list is updated regularly and can be located on the Colorado Department of Health Care Policy & Financing website colorado.gov/hcpf
Prescribing Provider	A Prescribing Provider is a licensed or certified individual that can write a prescription for medical care, such as therapy, medications or equipment.
Rendering Provider	A Rendering Provider is the licensed or certified individual that provides medical care to a Colorado Medicaid client.
Gender Confirmation Surgery	Also known as gender affirmation surgery or sex reassignment surgery. Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Gender confirmation surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.