Exhibit 28

Mandatory & Optional Medicaid Benefits

This page outlines mandatory Medicaid benefits, which states are required to provide under federal law, and optional benefits that states may cover if they choose.

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Benefits

- Prescription Drugs
- Clinic services
- Physical therapy

- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary*
- Health Homes for Enrollees with Chronic Conditions – Section 1945

*This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

Mandatory & Optional Medicaid Benefits

Centers for Medicare & Medicaid Services

Exhibit 29

Robert Price
Agree

Todd R. White
Chief Executive Officer

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

304-348-2041 T
959-282-1026 F

Exhibit
04

May 6, 2021

Susan Hall, Chief, Center of Managed Care
WV Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
E-mail: susan.l.hall@wv.gov

RE: Mid-Year Contract Change Acknowledgement for the SFY2021 Purchase of Service Provider Agreement for Mountain Health Trust -- Contract No. CMA BMS20*09

Dear Ms. Hall:

This letter serves as the written acceptance by Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia of the SFY21 mid-year terms and rates changes set forth in the updated *State Fiscal Year 2021 Model Purchase of Service Provider Agreement for Mountain Health Trust Between State of West Virginia Department of Health and Human Resources Bureau for Medical Services and Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia*, effective 1/1/21.

Sincerely,

Todd R. White
Chief Executive Officer

TRW/ago

EXHIBIT
33

STATE FISCAL YEAR 2021

MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT

BETWEEN

STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

AND

Aetna Better Health of WV

The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point of sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services.

The MCO shall be subject to following provisions of Section 1004 of the SUPPORT for Patient and Communities Act:

- **Claim Reviews:**
  - Retrospective reviews on opioid prescriptions exceeding state defined limitations on an ongoing basis.
  - Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.
- **Programs to monitor antipsychotic medications to children**: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.
- **Fraud and abuse identification:** The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

1.3.3 Organ and Tissue Transplantations

MCO enrollees receiving services for transplantation of organs or tissues, other than corneal transplants, are covered under FFS Medicaid for the entire duration of their treatment.

The MCO must have the ability to notify the State of any past, present, or future transplant recipient and request transfer to FFS Medicaid. BMS will coordinate with Utilization Management vendor and Medicaid Management Information Systems (MMIS) vendor to transition enrollees to the FFS system and coordinate care at that time. The enrollee will be covered under FFS retroactively to the beginning of the month that the MCO notifies the State. Capitation will be recouped for this month. Any claims paid during the month by the MCO may be reversed and directed to the fiscal agent for payment.

1.4 Non-covered Services

MCOs are not permitted to provide Medicaid excluded services that include, but are not limited to, the following:

1. All non-medically necessary services;
2. Sterilization of a mentally incompetent or institutionalized individual;
3. Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition;
4. All organ transplants, except for those specified in Appendix A;

5. Treatments for infertility[5] and for the reversal of sterilization;
6. Sex transformation procedures and hormone therapy associated with sex transformation procedures
7. All cosmetic services, except for those provided as a result of accidents or birth defects; and
8. Christian Science nurses and sanitariums.

The MCO must not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by BMS' Outpatient Drug Pharmacy Program.

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The MCO must not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

MCOs cannot enhance the benefits provided to Medicaid enrollees, with the exception of clinical preventive services, without the prior approval of BMS.

1.5 Other Requirements Pertaining to Covered Services

MCOs must assume responsibility for all covered medical conditions, inclusive of pre-existing conditions of each enrollee as of the effective date of enrollment in the plan. MCOs may not prohibit or otherwise restrict a covered health professional from advising his/her patient about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for that care or treatment are provided under the Contract, if the professional is acting within the lawful scope of practice.[6]

MCOs and their participating providers may not bill or collect any payment from Medicaid enrollees for care that was determined not to be Medically Necessary. Anyone who knowingly and willfully charges for any service provided to a patient under a State Plan approved under Title XIX or under a MCO Contract under 1903(m) of the Social Security Act, money or other consideration at a rate in excess of the rates established by BMS or Contract will be guilty of a

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[5] Infertility services are excluded per West Virginia State law, section 33-25A-4(2)(b).

[6] The term "health care professional" means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the Managed Care Plan's Contract for the services. A health care professional includes the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse, registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Exhibit 30

UniCare Health Plan of West Virginia, Inc.
200 Association Drive, Suite 200
Charleston, WV 25311
Tel 888 611-9958
Fax 888 338-1320

Agree
Robert Price

UNICARE

An Anthem Company

May 6, 2021

Exhibit
05

Susan Hall, Chief of Managed Care
WV Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301

RE: SFY21 Mid-Year Rate Amendment Acceptance

Dear Ms. Hall:

UniCare has reviewed the SFY21 mid-year Manage Care Contract and Rates amendment under procurement BMS20*08. UniCare accepts the proposed contract and rates amendment. We look forward to our continued partnership with BMS.

Sincerely,

Tadd Haynes
President

EXHIBIT
37

STATE FISCAL YEAR 2021

MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT

BETWEEN

STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

AND

Unicare WV

The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point of sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services.

The MCO shall be subject to following provisions of Section 1004 of the SUPPORT for Patient and Communities Act:

- **Claim Reviews:**
  - Retrospective reviews on opioid prescriptions exceeding state defined limitations on an ongoing basis.
  - Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.
- **Programs to monitor antipsychotic medications to children**: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.
- **Fraud and abuse identification:** The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

1.3.3 Organ and Tissue Transplantations

MCO enrollees receiving services for transplantation of organs or tissues, other than corneal transplants, are covered under FFS Medicaid for the entire duration of their treatment.

The MCO must have the ability to notify the State of any past, present, or future transplant recipient and request transfer to FFS Medicaid. BMS will coordinate with Utilization Management vendor and Medicaid Management Information Systems (MMIS) vendor to transition enrollees to the FFS system and coordinate care at that time. The enrollee will be covered under FFS retroactively to the beginning of the month that the MCO notifies the State. Capitation will be recouped for this month. Any claims paid during the month by the MCO may be reversed and directed to the fiscal agent for payment.

1.4 Non-covered Services

MCOs are not permitted to provide Medicaid excluded services that include, but are not limited to, the following:

1. All non-medically necessary services;
2. Sterilization of a mentally incompetent or institutionalized individual;
3. Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition;
4. All organ transplants, except for those specified in Appendix A;

5. Treatments for infertility[5] and for the reversal of sterilization;
6. Sex transformation procedures and hormone therapy associated with sex transformation procedures
7. All cosmetic services, except for those provided as a result of accidents or birth defects; and
8. Christian Science nurses and sanitariums.

The MCO must not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by BMS' Outpatient Drug Pharmacy Program.

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The MCO must not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

MCOs cannot enhance the benefits provided to Medicaid enrollees, with the exception of clinical preventive services, without the prior approval of BMS.

1.5 Other Requirements Pertaining to Covered Services

MCOs must assume responsibility for all covered medical conditions, inclusive of pre-existing conditions of each enrollee as of the effective date of enrollment in the plan. MCOs may not prohibit or otherwise restrict a covered health professional from advising his/her patient about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for that care or treatment are provided under the Contract, if the professional is acting within the lawful scope of practice.[6]

MCOs and their participating providers may not bill or collect any payment from Medicaid enrollees for care that was determined not to be Medically Necessary. Anyone who knowingly and willfully charges for any service provided to a patient under a State Plan approved under Title XIX or under a MCO Contract under 1903(m) of the Social Security Act, money or other consideration at a rate in excess of the rates established by BMS or Contract will be guilty of a

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[5] Infertility services are excluded per West Virginia State law, section 33-25A-4(2)(b).

[6] The term "health care professional" means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the Managed Care Plan's Contract for the services. A health care professional includes the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse, registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Exhibit 31

Robert Price
Agree

TheHealthPlan

Exhibit
06

April 21, 2021

Susan Hall, Chief of Managed Care
WV Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301

RE: SFY21 Mid-Year Rate Amendment Acceptance

Dear Ms. Hall:

The Health Plan has reviewed the SFY21 mid-year Manage Care Contract and Rates amendment under procurement BMS20*10. The Health Plan accepts the proposed contract and rates amendment. We look forward to our continued partnership with BMS.

Sincerely,

DocuSigned by:
[signature]
471124B160224EC...

Jeff Knight

President & COO

EXHIBIT
41

STATE FISCAL YEAR 2021

MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT

BETWEEN

STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

AND

The Health Plan of West Virginia

The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point of sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services.

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3. Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition;
4. All organ transplants, except for those specified in Appendix A;

5. Treatments for infertility[5] and for the reversal of sterilization;
6. Sex transformation procedures and hormone therapy associated with sex transformation procedures
7. All cosmetic services, except for those provided as a result of accidents or birth defects; and
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Exhibit 32

To: Beane, Cynthia E (BMS)[Cynthia.E.Beane@wv.gov]
From: Becker, James
Sent: Tue 10/13/2020 5:24:39 PM
Subject: [External] gender dysphoria question
Received: Sat 5/1/2021 1:10:48 PM

Cindy,
We've held off on approving the Vantas implant for this child getting treated at UPMC.
Based on conversations with several experts, it is a standard of care. Dr. Yoost at Marshall said she would have someone with those issues treated in with a comprehensive program at a Center of Excellence.
If this child had a diagnosis of "precocious puberty" we would allow the use of this medicine for that condition.

These are tough issues.

Thanks for your input.
Jim

Exhibit
Ex 0008

Exhibit 33

National Center for TRANSGENDER EQUALITY

Ensuring Nondiscrimination for Transgender People in the West Virginia Medicaid Program
January 2019

West Virginia Medicaid provides essential benefits to the health and well-being of many of the state's most vulnerable residents, including transgender West Virginians. Like you, we believe that all West Virginians should have access to high quality and affordable health care. Therefore, we are confident you will agree that the Department of Health and Human Resources (DHHR) should adopt an affirmative clinical coverage policy to clarify the coverage of medically necessary care for transgender people. Doing so is particularly critical in light of the long history of health care discrimination that transgender people have faced and federal law that prohibits discrimination against transgender people in state Medicaid programs.

West Virginia Medicaid does not expressly exclude health care services needed for gender transition. However, the program has not yet adopted an affirmative clinical coverage policy that confirms that treatment for gender dysphoria—whether mental health services, hormone therapy, or surgery—is medically necessary for many transgender people and thus should be covered. In the absence of clear guidance, transgender Medicaid beneficiaries have struggled to access medically necessary care, leaving beneficiaries, providers and Managed Care Organizations (MCOs) confused about their rights and obligations under West Virginia's Medicaid program. For example, while several MCOs explicitly say that their plans do not discriminated against members based on gender identity, plan booklets still contain broad exclusions of coverage for transition-related care.[1]

Adopting an affirmative coverage policy will ensure that beneficiaries, providers and MCOs understand that these medically necessary health care services are covered and ensure that all transgender West Virginians enrolled in Medicaid can consistently access the care that they need without discrimination. Doing so is particularly critical in light of the long history of health care discrimination that transgender people have faced, and is recognized as a best practice among other state Medicaid programs.

Adopting an affirmative coverage protocol is consistent with the mission of DHHR to provide a system of high-quality and cost-effective health care services to West Virginians and their families and improve their quality of life. This memorandum explains the medical and legal need to ensure that West Virginia Medicaid covers medically necessary procedures, services, and treatments for transgender individuals. Thank you again for your consideration and efforts to promote health equity.

Health treatment for gender dysphoria is widely recognized as medically necessary, but until recently was commonly excluded from coverage.

Medical consensus has established that gender identity is an inherent aspect of human identity.[2] Transgender people are those whose innate gender identity is different from that typically associated with their assigned sex at birth. An estimated 0.6 percent of the U.S. adult population—at least 1.4 million adults—are transgender, including 6,100 West Virginians.[3] Sources such as the

[1] See, e.g.: Aetna Better Health, West Virginia Medicaid Managed Care Member Handbook, p. 30, https://www.aetnabetterhealth.com/westvirginia/assets/pdf/members/Final%20ABH%20WV%20Model%20Member%20Handbook_SFY%2019%20082918.docx.pdf; Unicare Health Plan of West Virginia, Inc, Member Handbook, p. IV and 43, http://mss.unicare.com/DocumentLibrary/UWV-MHB-0011-18-WV-Model-Handbook-Combined_ENG-508.pdf; The Health Plan, West Virginia Medicaid Managed Care Member Handbook, p. 27, https://www.healthplan.org/sites/default/files/documents/resources/medicaid/Revised_Member%20Handbook%20SFY19.pdf; West Virginia Family Health, Member Handbook, p. CP4 and p. 37, https://www.wvfh.com/Portals/4/members/WV-Member-Handbook.pdf

[2] *See, e.g.*, World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, Seventh Edition, 16 (2011).

[3] Andrew R. Flores et al., *How Many Adults Identify as Transgender in the United States?* (2016), available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

Institute of Medicine,[4] Healthy People 2020,[5] the Substance Abuse and Mental Health Services Administration,[6] and the *National Healthcare Disparities Report*[7] indicate that transgender individuals experience significant disparities in health indicators such as experiences of abuse and violence, mental and behavioral health concerns, and HIV infection. This in turn links to higher levels of poverty, uninsurance, stigma, and discrimination[8]—particularly when seeking health care.[9]

The estimated 6,100 transgender people in West Virginia, like everyone else, need acute care when they are sick and preventive care to keep from becoming sick. In addition, many transgender West Virginians need access to medically necessary care related to gender transition. For many transgender people, their identity—the essence of who they are—is closely connected with a medical condition known as gender dysphoria (formerly known as gender identity disorder).[10] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) defines gender dysphoria as: (1) a marked incongruence between one's experienced/expressed gender and assigned gender (manifested in at least two of six specific symptoms), which (2) is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.[11]

Necessary treatment for gender dysphoria may include mental health care, hormone therapy, and a variety of possible surgical treatments.[12] These medical services are not unique to transgender people. The same hormone therapy used for transgender patients, for example, is provided to patients with endocrine disorders and menopausal symptoms. The surgical procedures that may be used in gender transition, such as breast removal or augmentation, hysterectomy, oophorectomy, orchiectomy, salpingectomy, and various reconstructive procedures, are regularly covered by Medicaid programs for non-transgender individuals for purposes such as treating injuries or for cancer treatment or prevention. The use of this range of treatments to treat gender dysphoria is commonly referred to as "transition-related care."

It is the overwhelming consensus among medical experts that transition-related treatments, including surgical procedures, are medically necessary, effective, and safe when clinically indicated to alleviate gender dysphoria.[13] According to the American Medical Association (AMA), untreated gender dysphoria "can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and

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[4] Inst. of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.
[5] Dep't of Health & Human Servs., *Healthy People 2020: LGBT Health Topic Area* (2015), http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.
[6] Substance Abuse & Mental Health Servs. Admin, *Top Health Issues for LGBT Populations* (2012), http://store.samhsa.gov/product/Top-Health-Issues-for-LGBT-Populations/SMA12-4684.
[7] Agency for Healthcare Research & Quality, *National Healthcare Disparities Report* (2012), http://archive.ahrq.gov/research/findings/nhqrdr/nhdr12/index.html.
[8] Joint Comm'n, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide* (2011), http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf.
[9] Sandy E. James et al., The Report of the 2015 U.S. Transgender Survey 96–97 (2016), www.ustranssurvey.org/report (finding that one-third of transgender respondents who saw a health care provider in the year prior to the survey were denied treatment, turned away or suffered mistreatment or discrimination for being transgender) Center for American Progress, Discrimination Prevents LGBTQ People from Accessing Health Care (2018) https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ (finding that among transgender people who had visited a doctor in the past year, 29% said a doctor or other health care provider refused to see them because of their actual or perceived gender identity)
[10] *See, e.g.*, Schwenk v. Hartford, 204 F.3d 1187, 1193 (9th Cir. 2000) (referring to "gender dysphoria [as] the technical diagnosis for transsexuality"); Farmer v. Haas, 990 F.2d 319, 320 (7th Cir. 1993) (using "transsexualism" and "gender dysphoria" as interchangeable); Glenn v. Brumby, 724 F. Supp. 2d 1284, 1304, n.5 (N.D. Ga. 2010) *aff'd*, 663 F.3d 1312 (11th Cir. 2011) (stating that "GID and transsexualism are closely related and are sometimes used as synonyms").
[11] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 452 (5th ed., 2013).
[12] *See* World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People 16 (7th edition, 2011).
[13] *See, e.g.*, Am. Academy of Fam. Physicians, Resolution No. 1004 (2012); Am. Medical Assn., Resolution 122 (A-08), Removing Financial Barriers to Care for Transgender Patients (2008); Am. Psychiatric Assn., Position Statement: Access to Care for Transgender and Gender Variant Individuals (2012); Am. Psychological Assn., Policy on Transgender, Gender Identity & Gender Expression Non-Discrimination (2008); Am. College of Physicians, Lesbian, Gay, Bisexual, and Transgender Health Disparities: A Policy Position Paper, 163 ANN INTERN MED. 135-137 (2015); Am. Coll. of Obstetricians & Gynecologists, Committee Op. 512, 118 OBSTETRICS & GYNECOLOGY 1454 (2011); National Assn. of Social Workers, Transgender and Gender Identity Issues Policy Statement (2008).

treatment, suicidality and death."[14] Numerous studies and meta-analyses —including a recent comprehensive literature review on the issue—[15] have similarly demonstrated the significant benefits of transition-related care in the treatment of gender dysphoria.[16] As such, treatments for this condition cannot be considered "cosmetic" or "experimental." Recognizing this, the Medicare program rescinded its 30-year exclusion of transition-related surgical care in 2014 after concluding that gender confirmation surgery "is safe and effective and not experimental," "has gained broad acceptance in the medical community," and "is an effective treatment option."[17] Following the removal of the exclusion, the Medicare Appeals Council issued a decision in favor of covering transition-related surgery when medically necessary.[18]

Despite the medical necessity of transition-related care for transgender people, some Medicaid programs have historically limited access to care associated with gender transition. Currently, only 11 states continue to have exclusions for coverage of transition-related care,[19] and at least two of them are being challenged in court.[20] These limits—typically exclusions or coverage denials for transition-related care—target transgender people for discrimination by forcing them to forego necessary treatments or to pay out-of-pocket for the same medically necessary services provided to non-transgender people. As the U.S. Department of Health and Human Services noted:

> [M]any health-related insurance plans or other health-related coverage, including Medicaid programs, currently have explicit exclusions of coverage for all care related to gender dysphoria or associated with gender transition. Historically, covered entities have justified these blanket exclusions by categorizing all transition-related treatment as cosmetic or experimental. However, such across-the-board categorization is now recognized as outdated and not based on current standards of care.[21]

Even where Medicaid programs have not *explicitly* excluded transition-related care, transgender people are often denied medically necessary care. Such denials may occur if the plan records a "gender mismatch," such as when a transgender man needs a hysterectomy or other type of "sex-specific" service (such as a Pap smear or a mammogram), or because plans continue to justify denials of care by categorizing certain procedures as cosmetic or experimental when needed for transition-related purposes. As a result, the same procedures—such as a hysterectomy—are typically covered for non-transgender people but denied as cosmetic or experimental for transgender people. These types of coverage denials are particularly common in the absence of explicit affirmative coverage protocols and standards. For these reasons, the AMA, American Psychiatric Association, American Psychological Association, and other major medical association have adopted policy statements in support of coverage for medically necessary transition-related care; many of these statements are collected in Appendix A.

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[14] Am. Med. Ass'n House of Delegates, *Removing Financial Barriers to Care for Transgender Patients* (2008).
[15] Cornell University, Public Policy Research Portal, *What does the scholarly research say about the effect of gender transition on transgender well-being?,* https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/
[16] William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES OF SEXUAL BEHAVIOR 759 (2012); Marco Colizzi, Rosalia Costa & Orlando Todarello, *Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from a Longitudinal Study*, 39 PSYCHONEUROENDOCRINOLOGY 65 (2014); Audrey Gorin-Lazard et al., *Hormonal Therapy is Associated with Better Self-Esteem, Mood, and Quality of Life in Transsexuals*, 201 J. Nervous & Mental Disorders 996 (2013); M. Hussan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY, 214 (2010); Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 ARCHIVES OF SEXUAL BEHAVIOR 679 (2005); Giuloio Garaffa, Nim A. Christopher & David J. Ralph, *Total Phallic Reconstruction in Female-to-Male Transsexuals*, 57 EUROPEAN UROLOGY 715 (2010); Caroline Klein & Boris B. Gorzalka, *Sexual Functioning in Transsexuals Following Hormone Therapy and Genital Surgery: A Review*, 6 J. OF SEXUAL MEDICINE 2922 (2009).
[17] Departmental Appeals Board, *NCD 140.3, Transsexual Surgery*, Decision No. 2576 (2014), available at: http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf.
[18] Dep't of Health and Human Services, NCD 140.3, Transsexual Surgery, 12 (2014); HHS Department Appeals Board, Decision of Medicare Appeals Council, Docket Number M-15-1069, United Healthcare/AARP (January 21, 2016)
[19] These states are: Alaska, Georgia, Illinois, Iowa, Maine, Missouri, Nebraska, Ohio, Tennessee, Wisconsin and Wyoming.
[20] See: Flack v. Wisconsin Department of Health Services, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) and Good/Beal v. Iowa Department of Human Services, No. CVCV054956 (Iowa District Court for Polk County, 2018).
[21] Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31375, 31429 (May 13, 2016).

Federal law requires equal treatment of transgender beneficiaries in the design of Medicaid benefits

Denials of coverage that are based solely upon gender identity, transgender status, or related diagnoses constitute unlawful, arbitrary discrimination against transgender people under federal law, including the Medicaid Act and the Affordable Care Act. Claims that are submitted for transition-related care must be considered under the same standards of medical necessity and clinical appropriateness, utilizing current clinical standards, as when such claims are submitted by other enrollees for other indications. To ensure compliance with these protections, we strongly urge DHHR to clarify that medically necessary health care services for gender transition are covered under West Virginia Medicaid.

i. State coverage policies must comply with nondiscrimination in benefit design under the Medicaid Act and federal Medicaid regulations

State coverage policies must comply with the federal Medicaid Act. In *Cruz v. Zucker*, a federal district court ruled that a New York regulation that categorically excluded coverage of specific procedures for the treatment of gender dysphoria violated the Medicaid Act.[22] The court held that under the Medicaid Act's availability provision, "a state may not place an outright ban on medically necessary treatments for a particular diagnosis," including gender dysphoria.[23] The Court also found that the exclusions violated the Medicaid Act's comparability provision, which "prohibits discrimination among individuals with the same medical needs stemming from different medical condition," as New York Medicaid provided coverage for the same procedures for people diagnosed with other medical conditions, but not for people diagnosed with gender dysphoria.[24] In response to the ruling, New York adopted rules to eliminate its exclusions for transition-related procedures, replacing them instead with a policy of case-by-case coverage determinations for services outside of a defined list.[25]

Additionally, federal regulations for Medicaid Managed Care Organizations explicitly prohibit MCOs from discriminating against beneficiaries on the basis of gender identity and from adopting any policies or practices that have the effect of discriminating on the basis of gender identity.[26]

To comply with the federal Medicaid Act and federal regulations, we urge DHHR to ensure that transgender West Virginians have equal access to the coverage of procedures that have been identified by the World Professional Association of Transgender Health (WPATH) Standards of Care as medically necessary for the treatment of gender dysphoria. In particular, we urge DHHR to adopt a clinical coverage policy for the treatment of gender dysphoria. This policy can be used when such care is clinically indicated as determined by a qualified health care professional based on the WPATH Standards of Care.

ii. Nondiscrimination in benefit design under the Affordable Care Act

Section 1557 of the Affordable Care Act prohibits prohibits discrimination against transgender beneficiaries in state Medicaid programs.[27] Federal courts have specifically found that

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[22] 195 F.Supp.3d 554, 571 (S.D.N.Y. Jul. 5, 2016) (applying 42 U.S.C. § 1396a(a)(10)(A)).
[23] *Id.*, citing DeSario v. Thomas, 139 F.3d 80, 96 (2d Cir.1998).
[24] *Id.*, citing Davis v. Shah, 821 F.3d 231, 258 (2d Cir. 2016).
[25] New York State Reg., Dec. 7, 2016, I.D. No. HLT-40-16-00030-P, Transgender Related Care and Services.
[26] 81 FR 27497 ("The MCO, PIHP, PAHP, PCCM or PCCM entity will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.")
[27] 42 U.S.C. § 18116(a). *See, e.g., Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); *Cruz v. Zucker*, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health

discriminatory health insurance and coverage practices, such as exclusions of transition-related care, violate the Affordable Care Act.[28] For example, in *Flack v. Wisconsin Department of Health Services*, a federal court found that an exclusion of transition-related care the state's Medicaid program amounted to illegal discrimination by treating transgender individuals differently on the basis of sex when it comes to coverage, in violation of the Affordable Care Act and the Equal Protection Clause.[29] Even in the absence of a blanket exclusion of transition-related care, certain coverage exclusions of specific services may constitute illegal discrimination. For example, Courts have similarly found that even when a Medicaid program generally covers gender dysphoria treatment, maintaining medically unsupported exclusions of *specific* treatments for transgender beneficiaries could constitute discrimination,[30] including when programs deny coverage for services used in the treatment of gender dysphoria when similar services are covered for the purpose of treating other conditions.[31]

As noted above, all procedures potentially used in gender transition—including hormone therapy or reconstructive surgical procedures—are used to treat both transgender and non-transgender people. However, historically, such procedures had often been covered only for *non-transgender* people under state Medicaid programs. Under the Affordable Care Act, denying coverage for substantially similar procedures simply because those procedures are used for the treatment of gender dysphoria would constitute unlawful discrimination against transgender people. Further, services may only be limited based on "a neutral, nondiscriminatory reason."[32] Automatic coverage denials for certain treatments for gender dysphoria—in spite of a medical provider's determination of medical necessity—discriminate against transgender beneficiaries.

The nondiscrimination requirements of the Affordable Care Act also apply to any limitation on coverage that "results in discrimination against a transgender individual."[33] In particular, Medicaid programs may not employ discriminatory benefit designs or policies that create onerous and unjustifiable barriers to coverage that make it impossible or highly impractical for transgender people to access essential care. For example, a program cannot impose standards that are not supported by sound medical evidence for determining eligibility or medical necessity of transition-related procedures. And, as noted above, state Medicaid programs cannot deny coverage for services used in the treatment of gender dysphoria when similar services are covered for the purpose of treating other conditions for non-transgender people. To ensure that these rules are clear and understood by providers, claims handlers, and others, we urge DHHR to clarify its policies on the coverage of medically necessary transition-related care.

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plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause). Other federal courts have found that similar federal sex discrimination laws also prohibit anti-transgender discrimination. *See*, *e.g.*, *Whitaker v. Kenosha Unified School District*, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011) (Equal Protection Clause); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (Title VII); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); Grimm v. Gloucester County School Board, No. 4:15-cv-54 (E.D. Va. May 22, 2018) (holding that denying a transgender boy access to school restrooms matching his gender violated Title IX and the Equal Protection Clause of the U.S. Constitution); M.A.B. v. Board of Education of Talbot County, 286 F. Supp. 3d 704 (D. Md. March 12, 2018) (holding that prohibiting a transgender boy from boys' locker room based on transgender status is a Title IX sex-discrimination claim as well as a gender-stereotyping claim).

[28] *See, e.g., Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc; *Cruz v. Zucker*, 195 F.Supp.3d 554; *Tovar v. Essentia Health*, No. 16-cv-00100-DWF-LIB; *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018.

[29] *Flack v. Wis. Dep't of Health Servs.*, No. 3:18-cv-00309-wmc

[30] *Cruz*, 195 F.Supp.3d at 571; Jesse McKinley, *For Transgender Youths in New York, It Would Be a Health Care Milestone*, N. Y. TIMES (Oct. 5, 2016), https://www.nytimes.com/2016/10/06/nyregion/new-york-moves-to-allow-medicaid-to-cover-hormone-therapy-for-transgender-youth.html.

[31] *Id.* State nondiscrimination laws applicable to insurance have also been interpreted similarly. *See, e.g.,* 10 Cal. Admin. Code § 2561.2(a)(4) (prohibiting exclusion of services for gender transition "if coverage is available for those services under the policy when the services are not related to gender transition"); Oregon Insurance Division Bulletin INS 2012-1 ("A health insurer may not deny or limit coverage or deny a claim for a procedure provided for [gender dysphoria] if the same procedure is allowed in the treatment of another [non-gender dysphoria] condition").

[32] Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31375, 31433 (May 13, 2016).

[33] *Cruz v. Zucker*, 195 F.Supp.3d; 45 C.F.R. § 92.207. *See also,* generally: *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); *Prescott v. Rady Children's Hospital-San Diego*, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017),

Affirmative coverage of transition-related care is increasingly routine in state Medicaid programs, federal health programs, and private health insurance coverage

Seventeen states and the District of Columbia have adopted affirmative coverage standards for transition-related care to help ensure that their Medicaid programs do not discriminate against transgender beneficiaries.[34] These states have updated their regulations or issued new guidance to 1) remove transgender-specific exclusions and 2) adopt affirmative coverage standards for the coverage of transition-related care. State coverage protocols typically address the scope of covered services (including hormone therapy, mental health services, and surgeries) and direct providers to provide treatment in accordance with the latest version of the nationally and internationally recognized WPATH Standards of Care. As noted above, even affirmative coverage standards—such as that in New York—have been successfully challenged under federal law as discriminatory against transgender people where they maintain categorical, medically unsupported exclusions of specific services for transgender beneficiaries.[35] A number of other states, such as Illinois and Virginia, are actively considering similar guidance.

The standards set by the Medicaid programs in Colorado, Connecticut, Montana, and Pennsylvania reflect best practices to ensure that transgender people receive the medical care they need. We urge you to consider a similar approach as these states in developing an appropriate affirmative clinical coverage policy for the treatment of gender dysphoria. We have included direct references to their policies in Appendix B of this memorandum. This policy would affect covered services under physician services, behavioral health, reconstructive surgery, and pharmacy services. Additionally, we urge you to direct MCOs to remove blanket exclusions for transition-related care currently outlined in Medicaid member handbooks. Finally, DHHR should amend existing current clinical coverage policies—such as those related to, at a minimum, hysterectomy, outpatient pharmacy, mental health drug management, breast surgeries, reconstructive and cosmetic surgery—to ensure that these policies do not limit access to medically necessary transition-related care.

There are also 19 states and DC that prohibit transgender exclusions in private health insurance. Insurance regulators and state officials in many of these states have interpreted or adopted state nondiscrimination statutes and statutory prohibitions on unfair trade practices in private health insurance to prohibit insurers from discriminating against transgender enrollees.[36] Federal health programs also cover transition-related care. As previously mentioned, the Medicare program eliminated a national exclusion for transition-related surgeries in 2014, based on the recognition that it was not supported by the overwhelming medical evidence demonstrating that transition-related surgeries are safe, effective and medically necessary when indicated.[37] The Office of Personnel Management directed Federal Employee Health Benefit plans to eliminate blanket exclusions for transition-related care in 2015.[38]

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[34] Cal. Code Regs. tit. 10, § 2561.2 (2011) (*see also* State of Cal., Dep't of Health Care Servs., Medi-Cal Update, Gen. Medicine, Bulletin 465, Policy Clarification: Gender Identity Disorder (September 25, 2013)); Comm. Health Network of Conn, Gender Reassignment Surgery (2016); Col. Health Program Benefits and Operations, Rule MSB 17-03-21-B, Revision to the Medical Assistance Benefits Rule Concerning Transgender Services, Section 8.735 (July 14 2017); D.C. Dep't of Health Care Fin., Non-Discrimination in the District's State Medicaid Program Based on Gender Identity or Expression (Feb. 27, 2014) (*see also* D.C. Dep't of Health Care Fin., Gender Reassignment Surgery Policy (Mar. 1, 2016); Hawaii. H.B. 2084 (2016); 130 Mass. Code Regs. 450.202; 42-2 Md. Reg. 181; Minnesota Department of Human Services, Gender-Confirming Surgery Protocol (February 2, 2017); Montana Department of Health and Human Services, Federal Final Rule, "Nondiscrimination in Health Program and Activities" and Implication for Coverage of Services Related to Gender Transition (May 26, 2017); Nevada, Division of Health Care Financing and Policy, Medicaid Services Manual Transmittal Letter, December 21, 2017; New Hampshire, Amend He-W 531.06, effective 3/29/14 (Document #10561), September 2017; New Jersey, Assembly Bill 4568, Approved P.L.2017, c.176.; 2015-10 N.Y. St. Reg. 19 ; New York State Reg., Oct. 5, 2016, I.D. No. HLT-40-16-00030-P, Transgender Related Care and Services; Proposed Rule Making; Or. Admin. R. 410-141-0520, *See also:* Prioritized List: Guideline for Gender Dysphoria; Penn. Department of Human Services. Medical Assistance Bulletin, July 18, 2016; State of R.I., Exec. Office of Health & Human Services, Gender Dysphoria/Gender Nonconformity Coverage Guidelines (October 28, 2015); Dep't of Vt. Health Access, The Department of Vermont Health Access Medical Policy (May 13, 2016); Washington State Health Care Authority, Physician-Related Services/ Health Care Professional Services Billing Guide, July 1, 2016

[35] Jesse McKinley, "For Transgender Youths in New York, It Would Be A Health Care Milestone," *New York Times* (Oct. 5, 2016).

[36] These states include California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington.

[37] Dep't of Health and Human Services, NCD 140.3, Transsexual Surgery, 12 (2014).

[38] FEHB Program Carrier Letter No. 2015-12, Covered Benefits for Gender Transition Services, (June 24, 2015).

Similar guidance from DHHR clarifying the availability of coverage for medically necessary transition-related care would ensure that all transgender West Virginians enrolled in Medicaid are protected from discrimination.

Transition-related care coverage does not impose significant costs while significantly enhancing the well-being of beneficiaries.

Where state Medicaid programs have assessed the cost of covering transition-related care, minimal costs have been observed. The Oregon Health Authority, for instance, spent an estimated $435,000 on transition-related care, a number that will likely reduce significantly in subsequent years after catching up with the initial demand.[39] Overall, a report issued before the announcement of benefits stated that the cost of adding hormone therapy "would likely be minimal to the [Medicaid] program" and the cost of adding gender confirmation surgery would be "higher than that of cross-sex hormone therapy alone, but still very low."[40] Policymakers also noted the potential for cost savings through reduced suicide attempts.[41]

Private and public employers that have covered transition-related care for their employees have similarly found it to be highly cost-effective. When San Francisco eliminated its exclusion in 2001, the city responded to cost concerns by limiting the scope of the benefit and implementing a $1.70 premium surcharge for all employees. Actual cost and utilization data were so much less than expected that the surcharge produced a multi-million-dollar surplus. The city eventually raised the dollar cap and ultimately eliminated the surcharge entirely.[42] This example has led other states and cities such as California, Massachusetts, Minnesota, Nevada, New York, Oregon, Pennsylvania, Washington, the District of Columbia, Atlanta, Austin, Bloomington, Chicago, Cincinnati, Columbus, Dayton, Detroit, Minneapolis, Missoula, Orlando, Phoenix, Rochester, and St. Louis to eliminate exclusions in their employee plans.[43]

In an Economic Impact Assessment of its 2012 rule that prohibited insurance discrimination against transgender people, the California Department of Insurance concluded that "any such costs are immaterial and insignificant."[44] Similarly, the removal of transgender exclusions from the Massachusetts Group Insurance Commission was found to be highly cost-effective, with a budget impact of $0.016 per member per month that was offset by a reduction in negative health outcomes, such as HIV infection, depression, and suicidality.[45] More recently, in August 2018, the Wisconsin Group Insurance Board voted to remove the exclusion of treatment of gender dysphoria from its state employee plan. Memos from the Wisconsin Department of Employee Trust Funds to the Board cited positive developments in employer coverage of transition-related care and low costs of implementation, which they estimated to be between 0.007% and 0.018% of the $1.3 billion in state health plan premiums.[46]

Private companies also report minimal economic impact from providing equal coverage for transgender employees. The Human Rights Campaign's Corporate Equality Index reports that for the 750 employers who did so, eliminating exclusions "comes at an overall negligible cost to the

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[39] Lost In Transition: Oregon's promise to aid low-income transgender people comes up short. Oregon Live, Updated Jan 23, 2017, https://www.oregonlive.com/transgender-health/2016/04/oregon_health_plan_transgender.html.
[40] *Id.*
[41] *Id.*
[42] San Francisco Human Rights Comm'n, *San Francisco City and County Transgender Health Benefit* (Aug. 2007), available at: http://www.hrc.org/files/assets/resources/San_Francisco_City_and_County_Transgender_Health_Benefit_-_2007-08-10.pdf.
[43] Human Rights Campaign & Equality Federation Institute, *2016 State Equality Index* 20 (2016), http://assets.hrc.org//files/assets/resources/SEI-2016-Report-FINAL.pdf; Human Rights Campaign, *Municipal Equality Index: A Nationwide Evaluation of Municipal Law* (2016), http://assets.hrc.org//files/assets/resources/MEI-2016-Final-Online.pdf.
[44] Cal. Dep't of Ins., *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (2012), available at: http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.
[45] William V. Padula et al., "Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis," 31 *Journal of General Internal Medicine* 394 (2015).
[46] State of Wisconsin, Department of Employee Trust Funds. *Correspondence Memorandum* (August 14, 2018), http://etf.wi.gov/boards/agenda-items-2018/gib0822/item6a1.pdf; State of Wisconsin, Department of Employee Trust Funds. *Correspondence Memorandum* (January 30, 2017), http://etf.wi.gov/boards/agenda-items-2017/gib0208/item4.pdf

employers' overall health insurance plans. This holds true across industries."[47] A survey of employers by the Williams Institute at the UCLA School of Law found that transition-related health care benefits have "zero or very low costs" and low utilization rates estimated at 1 per 10,000 to 20,000 employees.[48] Overall, the report finds that "transition-related health care benefits have very low costs, have low utilization rates by employees, and yet can provide benefits for employers and employees alike."[49] More than 86 leading universities and colleges, including state universities in at least 28 states, have similarly found that it is cost-effective to provide this coverage in their student health plans.[50]

Failing to adequately treat gender dysphoria can result in negative outcomes for individuals as well as society—but the opposite is equally true and attainable. Affirming transgender individuals by ensuring nondiscriminatory coverage significantly improves the lives of these individuals and society at large. While the costs to ensure trans-related care provisions are minimal, the benefits are significant.[51] The California Economic Impact Assessment has similarly found that eliminating transgender exclusions results in "lower costs associated with the high cost of suicide and attempts at suicide, overall improvements in mental health and lower rates of abuse," and "will not only save insurers from the costs associated with suicide, but prevent significant numbers of transgender insureds from losing their lives."[52] Finally, failing to provide coverage for transition-related care can lead to higher costs as a result of litigation. For example, the state of Wisconsin was recently ordered by a jury to pay almost $800,000 in damages for two transgender state employees for denying coverage of medically necessary care. Only a small fraction of the total paid was for the actual cost of the procedures (around $80,000), with $720,000 constituting reparations for the discrimination suffered.[53]

Conclusion

To ensure that transgender West Virginians can access the care they need without discrimination, we urge DHHR to adopt an appropriate affirmative clinical coverage policy for the treatment of gender dysphoria to be used when such care is clinically indicated as determined by a qualified health care professional based on the WPATH Standards of Care. For best practices for such policies, please refer to Appendix B of this memorandum.

We also urge DHHR to direct MCOs to remove any blanket exclusions for transition-related care included member handbooks and replace them with affirmative coverage language.

DHHR should also amend its own clinical coverage policies —such as those related to, at a minimum, hysterectomy, outpatient pharmacy, mental health drug management, breast surgeries, reconstructive and cosmetic surgery—to ensure that these policies do not limit access to medically necessary transition-related care.

We thank you for the opportunity to discuss this important issue and stand ready to support you in your efforts. If you have questions regarding this memorandum or other opportunities for ensuring

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[47] Human Rights Campaign, *Corporate Equality Index 2018: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality* 28 (2018).

[48] Jody L. Herman, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefit Plans: Findings from a Survey of Employers*, (2013), available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf.

[49] *Id.* at 17.

[50] Campus Pride, Trans Policy Clearinghouse: Colleges and Universities that Cover Transition-Related Medical Expenses under Student Health Insurance, available at: http://www.campuspride.org/tpc-student-health-insurance.

[51] A systematic literature review study by Cornell University analyzed all peer review articles published in English between 1991 and 2017, and concluded that 93% of the studies on this topic found that gender transition—including transition-related care—improves the well-being of transgender people. The remaining 7% reported mixed or null findings and no studies concluded that gender transition causes overall harm. Cornell University, Public Policy Research Portal, *What does the scholarly research say about the effect of gender transition on transgender well-being?,* https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/

[52] Cal. Dep't of Ins., *supra* note 40 at 9, 11.

[53] *Boyden v. Conlin,* No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause), Think Progress, Transgender women celebrate monumental court win (2018), https://thinkprogress.org/wisconsin-transgender-women-health-care-court-victory-e5ca758264b4/

health equity for transgender people in West Virginians, please do not hesitate to contact [CONTACT INFO].

Thank you for your work to help all transgender people in West Virginia access the health care they need.

Where state Medicaid programs have assessed the cost of covering transition-related care, minimal costs have been observed. The Oregon Health Authority, for instance, spent an estimated $435,000 on transition-related care, a number that will likely reduce significantly in subsequent years after catching up with the initial demand.[i] Overall, a report issued before the announcement of benefits stated that the cost of adding hormone therapy "would likely be minimal to the [Medicaid] program" and the cost of adding gender confirmation surgery would be "higher than that of cross-sex hormone therapy alone, but still very low."[ii] Policymakers also noted the potential for cost savings through reduced suicide attempts.[iii]

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[i] Lost In Transition: Oregon's promise to aid low-income transgender people comes up short. Oregon Live, Updated Jan 23, 2017, https://www.oregonlive.com/transgender-health/2016/04/oregon_health_plan_transgender.html.

[ii] *Id.*
[iii] *Id.*
[iv] San Francisco Human Rights Comm'n, *San Francisco City and County Transgender Health Benefit* (Aug. 2007), available at: http://www.hrc.org/files/assets/resources/San_Francisco_City_and_County_Transgender_Health_Benefit_-_2007-08-10.pdf.
[v] Human Rights Campaign & Equality Federation Institute, *2016 State Equality Index* 20 (2016), http://assets.hrc.org//files/assets/resources/SEI-2016-Report-FINAL.pdf; Human Rights Campaign, *Municipal Equality Index: A Nationwide Evaluation of Municipal Law* (2016), http://assets.hrc.org//files/assets/resources/MEI-2016-Final-Online.pdf.
[vi] Cal. Dep't of Ins., *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (2012), available at: http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.
[vii] William V. Padula et al., "Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis," 31 *Journal of General Internal Medicine* 394 (2015).
[viii] State of Wisconsin, Department of Employee Trust Funds. *Correspondence Memorandum* (August 14, 2018), http://etf.wi.gov/boards/agenda-items-2018/gib0822/item6a1.pdf; State of Wisconsin, Department of Employee Trust Funds. *Correspondence Memorandum* (January 30, 2017), http://etf.wi.gov/boards/agenda-items-2017/gib0208/item4.pdf
[ix] Human Rights Campaign, *Corporate Equality Index 2018: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality* 28 (2018).
[x] Jody L. Herman, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefit Plans: Findings from a Survey of Employers*, (2013), available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf.
[xi] *Id.* at 17.
[xii] Campus Pride, Trans Policy Clearinghouse: Colleges and Universities that Cover Transition-Related Medical Expenses under Student Health Insurance, available at: http://www.campuspride.org/tpc-student-health-insurance.

THE JOURNAL OF
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ORIGINAL RESEARCH & REVIEWS

TRANSGENDER HEALTH

Which U.S. States' Medicaid Programs Provide Coverage for Gender-Affirming Hormone Therapy and Gender-Affirming Genital Surgery for Transgender Patients?: A State-by-State Review, and a Study Detailing the Patient Experience to Confirm Coverage of Services

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ABSTRACT

Background: To date, a comprehensive state-by-state assessment of transgender transition-related health care coverage for gender-affirming hormone therapy (GAHT) and genital gender-affirming surgery (GAS) has not been reported.

Aims: The aims of this study were 1) to verify which U.S. states' Medicaid systems do/do not cover GAHT and GAS; 2) to assess the ease/difficulty for patients to determine whether GAHT and GAS are Medicaid-covered benefits; and 3) to understand possible state-related predictors of Medicaid coverage for gender-affirming care.

Methods: We reviewed the official Medicaid Handbook and website for all 51 states (+D.C.) and 5 territories to confirm whether GAHT and GAS are covered benefits. When indeterminate, we called the Medicaid office in each state, and for many, Medicaid managed care organizations (MCOs), and individual in-state providers, to confirm coverage. We recorded our experiences, number of, and duration of phone calls to confirm coverage.

Outcomes: The main outcome was a definitive answer from the state/territory's Medicaid program or MCOs regarding whether GAHT and GAS are/are not covered benefits. Secondary outcome measures included responses we received and the total number/duration of phone calls necessary to confirm coverage.

Results: Only 12 of 51 states and 0 of 5 territories featured their policy regarding coverage for GAHT in their Medicaid Handbook/webpages. We confirmed that 34 of 51 state Medicaid programs do cover GAHT, whereas 9 of 51 states' and 2 of 5 territories' do not. We could not confirm coverage of GAHT in 8 of 51 states and 3 of 5 territories. Only 26 of 51 states and 0 of 5 territories featured their policy regarding coverage for GAS in their Medicaid Handbook/webpages. We confirmed that 25 of 51 state Medicaid programs do cover GAS, whereas 22 of 51 states' and 3 of 5 territories' do not. We could not confirm coverage of GAS in 4 of 51 states and 2 of 5 territories. Up to 12 calls, lasting up to 125 minutes, were required to confirm coverage for GAHT/GAS.

Clinical Implications: Our findings indicate that important health care access barriers/disparities exist today and warrant improvement.

Strengths & Limitations: To our knowledge, this is the most comprehensive assessment of transgender transition-related health care coverage. Limitations include possible bias, as it could be that we were more persistent than actual patients would be to determine service coverage, and a lack of specificity regarding which specific hormone formulations or procedures are/are not covered.

Conclusion: Our findings show that only 34 of 51 (67%) states' Medicaid programs include GAHT and 25 of 51 (49%) include GAS as covered benefits. Our experience suggests that the process to confirm coverage can be especially time-consuming and frustrating for patients. **Zaliznyak M, Jung EE, Bresee C, et al. Which U.S. States' Medicaid Programs Provide Coverage for Gender-Affirming Hormone Therapy and Genital Gender-Affirming Surgery for Transgender Patients?: A State-by-State Review, and a Study Detailing the Patient Experience to Confirm Coverage of Service. J Sex Med 2021;18:410–422.**

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Key Words: Transgender; Gender Dysphoria; Medicaid Assistance Program; Gender-Affirming Hormone Therapy (GAHT); Gender-Affirming Surgery (GAS); Sex Reassignment Surgery (SRS)

INTRODUCTION

Transgender is a term for people whose gender identity does not align with or reflect the social-cultural roles associated with the biological sex that they were assigned at birth in the individual's social environment.[1] Flores et al estimated that between 0.6% and 0.7% of the U.S. population (1.4-1.65 million) is identified as transgender, representing a 100% growth from the same study that was published in 2011.[2] A 2015 national survey of transgender individuals found that transgender individuals suffer from health-related disparities at a considerably higher rate than the United States average.[3] The survey found that 29% of respondents were living in poverty,[3] compared with the U.S. poverty rate of 11.8%.[4] This same survey found 40% of surveyed transgender respondents reported attempting suicide at least once in their life, and 7% attempted suicide in the past year[3]—nearly 14 times greater than the U.S. national average of 0.5%,[5] and 39% reported suffering from serious psychological distress [3][3]—compared with the U.S. national average of 3.4%.[6] In addition, 55% of respondents reported being denied coverage for transition-related surgery, and 25% reported being denied coverage for transition-related hormone therapy treatment.[3]

Studies have shown that transgender people with untreated gender dysphoria experience relatively higher rates of depression, anxiety, suicidality, and HIV as compared with cisgender people.[3,7–11] The 3 now well-established treatment domains for gender dysphoria, which include counseling and therapy to help the individual with social transition (full-time life in the gender role they identify with), gender-affirming hormone therapy (GAHT), and gender-affirming surgery (GAS), have been shown to significantly improve quality of life[10,12–15] for transgender people with gender dysphoria. Research has shown that health-insurance coverage for the subset of transgender patients who choose these transition-related treatments is both affordable and cost-effective.[10,16]

Today, with changing social mores and greater visibility of transgender people in popular culture media, there are a growing number of community-based transgender support and resource centers throughout the United States which support transgender youth and adults.[17] We see also an increase in transgender people seeking transition-related health services,[18,19] as transition-related health care has been shown to improve patient quality of life and the efficiency of our health care service system.[10,12–16] A significant proportion of transgender people utilize public health care services (such as Medicaid).[19,20] It was estimated that 152,000 transgender adults (11% of the estimated transgender population in America) are enrolled in Medicaid.[20] This estimate, however, is likely an underestimate as it is 4 years old (2016), and because most epidemiologic studies tend to underestimate the prevalence of individuals that identify as gender non-conforming.[21]

Medicaid is a joint federal and state health insurance program for people of low income or disabilities, and pays the health care provider directly for the entire cost of most health care procedures, doctor's visits, and prescription drugs. In October 2018, approximately 66,000,000 Americans, or one in every 5 U.S. citizens, were enrolled in a state Medicaid program.[22] Given recent unprecedented national unemployment rates related to the COVID-19 global pandemic, the proportion of U.S. citizens that depend on Medicaid for their health care may increase, at least in the short term.

Although Medicaid provides health care insurance, this does not necessarily translate to access to needed health care services. In an effort to address discrimination in access to health care services, section 1557 of the ACA (2010), states are prohibited from denying federal benefits to individuals based on a patient's gender.[23] How Federal Medicaid funding is utilized is controlled by the State legislature and Medicaid Programs. In 2013 California became the first state to issue policies that explicitly include coverage for gender transition—related care under its state Medicaid program.[24] By 2014 California also passed legislation that specifically bans health insurance policy riders that allow for health care to be denied based on gender identity, and explicitly including medically necessary transgender health care. Since then, additional State Medicaid programs have followed suit to include gender transition—related care (including gender affirming surgery) as covered benefits under their Medicaid programs. Despite such precedent, many states continue to deny coverage for gender transition—related health care to transgender citizens within their state Medicaid programs.[20,25,26] Several states, for example, have explicitly written policies that exclude coverage for transition-related care. Many more states have Medicaid policies that simply do not make clear whether they exclude or include gender transition—related services.[20,25,26] This opacity makes it difficult for transgender citizens of those states to, first, know clearly whether such benefits are or are not available to them under Medicaid, and second, lack of clarity makes it difficult for people to make educated decisions regarding which specific Medicaid managed care plan to enroll into (plans can vary regarding what transition-related services they cover). Finally, uncertainty about whether or not highly important services are available is highly anxiety-provoking to most people, which fuels despair and can lead to high-risk behaviors. Altogether, explicit policies that deny access and/or

opaque and indiscernible policies concerning whether transition-related services are or are not covered serve to deny transgender youth and adults' access to vitally important and medically necessary transition-related health care.

To date, a comprehensive state-by-state assessment of transgender transition-related health care coverage under state Medicaid for genital GAS and GAHT has not been reported. In this work, we queried all U.S. Medicaid programs to assess the availability of 2 primary transition-related health care services (GAS and GAHT). We also sought to gain a patient-centered perspective for how easy or difficult it is to confirm Medicaid coverage for transition-related services: we tracked the burden of effort (as number of separate phone calls and total time spent on the telephone) necessary to arrive at a definitive answer regarding whether or not GAHT and GAS are covered benefits under their state's Medicaid program. And finally, we attempted to understand possible state-related predictors as to why states do or do not provide Medicaid coverage for GAS.

METHODS

We queried all 50 U.S. state Medicaid programs, plus the District of Columbia (N = 51), and the 5 U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S Virgin Islands) to determine whether or not each includes GAHT and GAS as covered benefits to patients who meet the treatment criteria. We used the methodology outlined in Figure 1 to confirm coverage for GAHT, and the methodology outlined in Figure 2, to confirm coverage for GAS. We also queried whether the criteria listed for GAS, as listed on the Medicaid Program Handbook and webpages, aligned with World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) guidelines for GAS.[13]

We included the 5 U.S. territories in our search after consulting the national Medicaid program webpages (www.medicaid.gov) to confirm that federal Medicaid programs operates in all 5 territories.[27]

Methodologic Approach

[Step 1] We Searched Each State Medicaid Program Website/Webpages to Confirm Coverage

We began by first reviewing each state's online Medicaid Handbook and program webpages to determine whether these featured any explicit written policy regarding coverage of gender transition–related GAHT and GAS. We reviewed any content related to eligibility criteria for GAS to determine whether this reflected 4 principal WPATH SOC guideline requirements for GAS: 1. diagnosis of gender dysphoria; 2. use and tolerance of GAHT for ≥1 year before GAS; 3. social transition for ≥1 year before GAS; and 4. two referral letters from mental health providers that support readiness for GAS.[13]

If states had explicitly written policies that indicated that GAHT and/or GAS are covered benefits, we recorded their policy and a URL link to the policy statement both for documentation and to serve as a reference for the public (Supplementary Table 1).

[Step 2] We Called State Medicaid Program Offices Directly

When state and U.S. territory Medicaid program webpages did not have explicit written policies regarding Medicaid coverage for GAHT and GAS, we called the state Medicaid office for each state and spoke with health care services representatives to confirm whether GAHT and GAS were classified as a covered benefit.

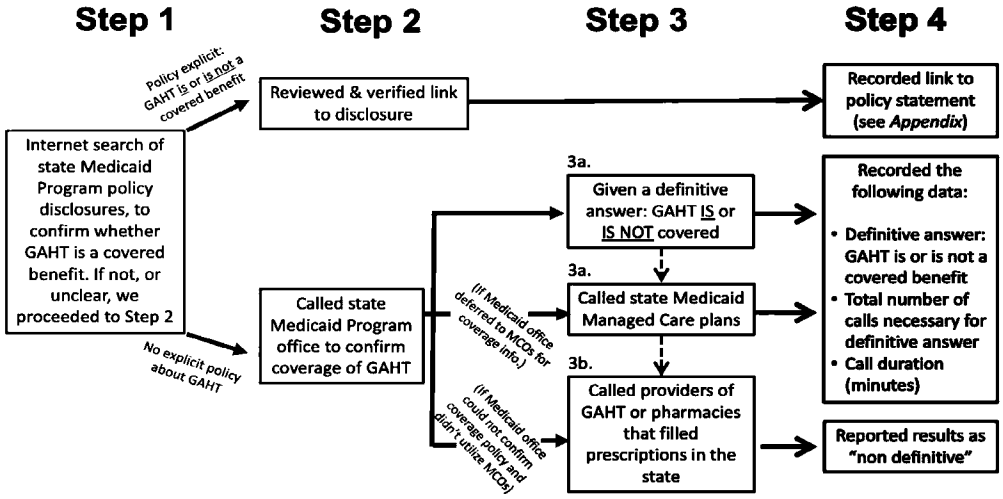

Figure 1. Flowchart outline of our study approach and methods to confirm Medicaid coverage for GAHT on for each U.S. state and territory. GAHT = gender-affirming hormone therapy. Figure 1 is available in color online at www.jsm.jsexmed.org.

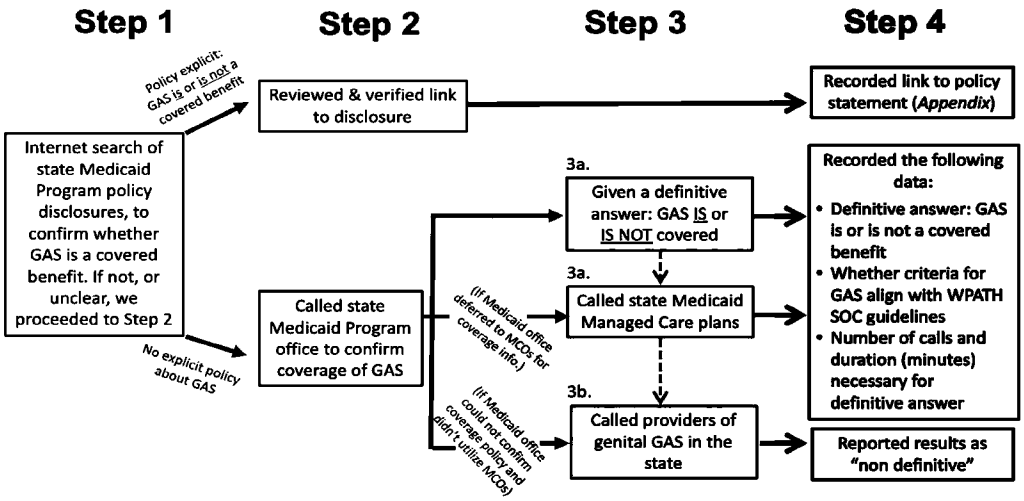

Figure 2. Flowchart outline of our study approach and methods to confirm Medicaid coverage for GAS on for each U.S. state and territory. GAS = gender-affirming surgery. Figure 2 is available in color online at www.jsm.jsexmed.org.

If the Medicaid Program Office was unable to confirm a coverage policy, the state or territory was classified by us as "indeterminate". If the Medicaid program representative requested information that no patient could reasonably provide (eg, surgery current procedural terminology [CPT] or treatment CPT codes), or do (eg, if the representative recommended that we consult a physicians-only hotline to inquire about coverage, or that the patient's surgeon submit a preauthorization request form for GAHT or GAS), we proceeded to classify the state or territory as "indeterminate".

If the Medicaid office representative could not confirm whether CHT or GAS is covered benefits, we proceeded to step 3 (below).

[Step 3] When the State Medicaid Program Office Could Not Confirm Coverage of GAHT or GAS, We Contacted [3a.] Medicaid Managed Care Organizations and/or [3b.] Local Providers to Confirm Coverage

[3a.] Each state Medicaid Program office that could not confirm whether GAHT or GAS is or is not a Medicaid-covered benefit was asked whether their state or U.S. territory Medicaid program defers to managed care organizations (MCOs) for policy regarding coverage of GAHT and GAS. If the answer to this question was either a definitive "no" (eg, because state policy specifically prohibits coverage by Medicaid funds) or "not applicable" (eg, when a given state or territory has no Medicaid MCOs), the state or territory's Medicaid program was classified as "indeterminate" for whether or not GAHT and GAS are covered benefits under Medicaid.

However, if the Medicaid program office was at all uncertain about coverage, before classifying it as "indeterminate", we requested the contact information for any MCO that the state or territory contracts with and we contacted these directly to confirm coverage. We contacted each organization (or up to a maximum of 7) by telephone until at least one responded that they do cover GAHT or GAS, or, until all MCOs confirmed that they do not cover GAHT or GAS.

If any of the MCOs that we contacted deferred confirmation about coverage to completion of a requirement that we believe a patient could not reasonably complete (eg, 1. the patient's physician consult a "physician-only" consultation hotline for further inquiry, or 2. the patient provide specific CPT codes for GAHT and/or GAS), we classified the MCO's coverage of GAHT and GAS as "indeterminate".

Only application of the research methodology described in 1-3a. above resulted in a definitive and final classification of all states/territories' Medicaid programs into one of 3 groups regarding Medicaid program coverage of GAHT and GAS: "does cover", "does not cover", or "indeterminate".

[3b.] For all states/territories whose coverage of GAHT or GAS was still classified as "indeterminate" after completing research method steps 1-3a., we attempted to collect circumstantial evidence of coverage of GAHT/GAS by their state/territory Medicaid programs by contacting individual GAHT/GAS providers to query their own experiences providing these services under Medicaid coverage. We performed an internet-based search for a minimum of 2 GAHT and 2 GAS providers and contacted them by telephone to ask whether they (or colleagues they know personally) have ever successfully provided GAHT and/or GAS under coverage by their state/territory's Medicaid program. When more than 2 providers of GAHT or GAS operated within a state, we would choose to contact the first 2 which appeared through our internet-based search. (For GAHT, we extended the definition of "providers" to pharmacies affiliated with transgender community centers and clinics).

Results from research method step 3b. were recorded, but all states/territories for whom research method step 3b. was performed to query Medicaid coverage for GAHT/GAS were still given a final classification of "indeterminate", given the circumstantial and subjective nature of this research method.

[Step 4] Data Analysis

We recorded and analyzed the following data points for all states/territories:

1. Whether or not a given state/territory's Medicaid program did or did not include GAHT and/or GAS as a covered benefit;
2. For states/territories whose Medicaid programs state explicitly on their webpages that they do cover GAS, we recorded whether the eligibility criteria for these services align with current WPATH SOC guidelines eligibility criteria for GAS;
3. We created a record of any conflicting information or unusual experiences from contacting states/territories' Medicaid program and MCO service representatives.
4. For all state Medicaid programs/MCOs that we contacted by telephone (steps 2-3a.), we recorded the total number of individual phone calls and total call duration (minutes) that was necessary to definitively confirm coverage. We excluded from these calculations any calls/time spent contacting individual providers (ie, step 3b.).

When states/territories' Medicaid Handbook or webpages featured their benefits coverage policy for GAHT/GAS, we recorded the URL to this written policy as a reference tool for patients and providers.

Associations between outcomes were calculated as the nonparametric Spearman rank correlation (r_S), and were considered significant where $P < .05$.

RESULTS

We completed methods steps 1-3b. for 51 U.S. states (includes the District of Columbia) (N = 51 states) and all 5 U.S. territories (American Samoa, Guam, Northern Mariana Islands; Puerto Rico; U.S. Virgin Islands) for GAHT (Figure 3 and Figure 4) and GAS (Figure 5 and Figure 6).

Gender-Affirming Hormone Therapy

Methods, step 1: Our review of each state/territory's Medicaid Program webpages found that only 12 of 51 states listed any explicit policy on their web content regarding whether GAHT is or is not a covered benefit. All 12 states with an explicit policy stated that they do cover GAHT. No state or U.S. territory's web content announced a policy that they do not cover GAHT. Owing to an absence of explicit policy the remaining 39 of 51 states and all 5 territories were classified as "indeterminate" (Figure 3).

Methods, step 2: We began step 2 with 39 states and all 5 U.S. territories still classified as "indeterminate". After telephoning these 39 states' Medicaid program offices, we confirmed that 10 of 39 do cover GAHT, whereas 4 of 39 do not cover GAHT. The remaining 25 of 39 states remained classified as "indeterminate" (Figure 3).

U.S. territories: We called the Medicaid program contact telephone number listed on the Federal Medicaid website for each of the territories.[28] 2 of the 5 territories confirmed that they do not cover GAHT. The Medicaid program office of 1 territory (Puerto Rico) could not confirm whether GAHT is or is not a covered benefit, and for the remaining 2 territories (Guam and U.S. Virgin Islands) there was no answer to our telephone calls. All 3 territories (Guam, Puerto Rico, and U.S. Virgin Islands) were classified as "indeterminate" (Figure 3).

Methods, step 3a: We began with 25 states and 3 U.S. territories still classified as "indeterminate". The Medicaid programs for 20 of these 25 states and for 1 U.S. territory deferred questions about coverage of GAHT to their Medicaid MCOs and directed us to contact their state's MCOs to confirm coverage. Upon calling, we identified 12 of 20 states with at least one MCO that confirmed that they do cover GAHT and 5 of 20 states whose MCOs *all* confirmed that they do not cover GAHT. (There was one exception: for Texas, only 4 of 7 MCOs stated that GAHT was not a covered benefit for their MCO or any other Texas MCOs, whereas the remaining 3 MCOs were "not certain" about coverage ("indeterminate"). We ultimately classified this state as one that does not cover GAHT.) MCOs from the remaining 3 of 20 states (Arkansas; Nebraska; Tennessee): none stated that they do cover GAHT; a small number stated that they do not cover GAS, and the majority from each state could not confirm whether GAHT is or is not a covered benefit. These 3 states were classified as "indeterminate."

U.S. territories: One of Puerto Rico's MCOs confirmed that GAHT is not a covered benefit, but the majority could not confirm whether it is or is not a covered benefit. For this reason, Puerto Rico was ultimately classified as "indeterminate".

Summary of results to confirm coverage for GAHT under Medicaid by methods steps 1-3a: States with an explicit written policy regarding coverage of GAHT as a covered benefit: 12 of 51; States that do cover GAHT: 34 of 51; States that do not cover GAHT: 9/51; States classified as "indeterminate": 8 of 51.

U.S. territories: U.S. territories with an explicit written policy regarding coverage of GAHT: 0 of 5. Territories we confirmed that do cover GAHT: 0 of 5. U.S. territories we confirmed that do not cover GAHT: 2 of 5. U.S. territories classified as "indeterminate": 3 of 5 (Figures 3 and 4).

Methods, step 3b: We began with 8 states and 3 U.S. territories still classified as "indeterminate". We identified at least 2 providers of GAHT per state by internet search and contacted them to confirm whether they have had success providing GAHT under coverage by Medicaid. Providers from 4 of 8 states reported that they have provided GAHT to patients under

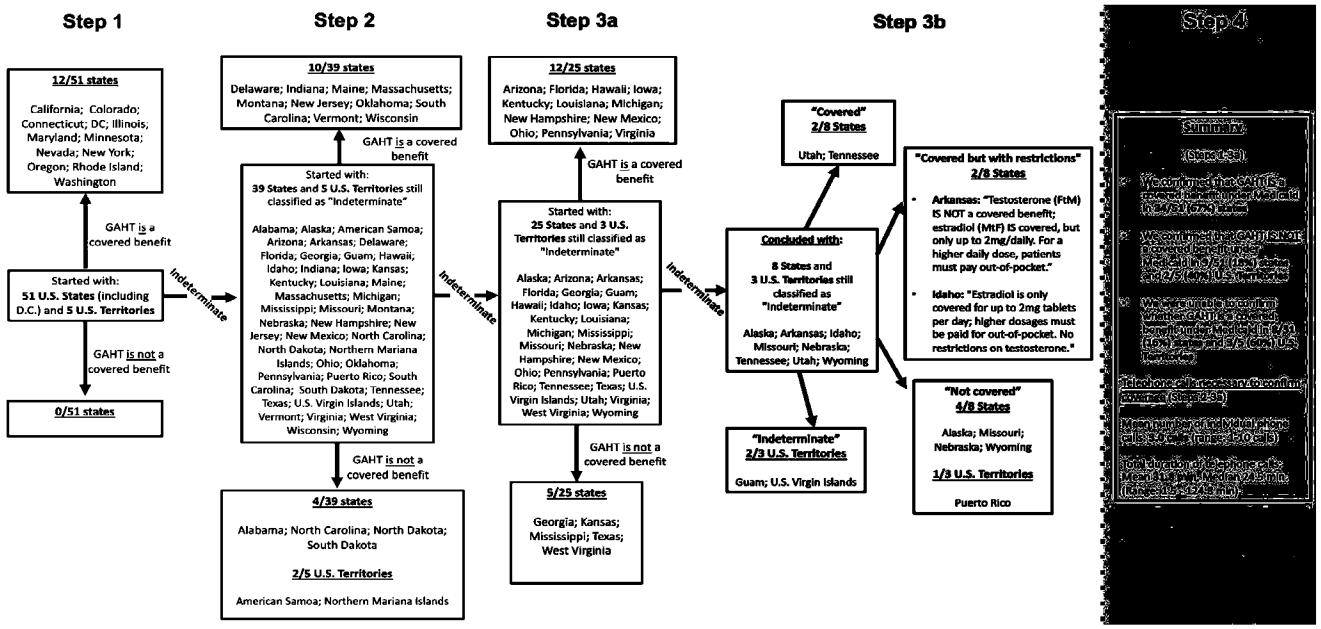

Figure 3. Flowchart outline of our results obtained through our step-by-step methodology to confirm Medicaid coverage for GAHT. GAHT = gender-affirming hormone therapy. Figure 3 is available in color online at www.jsm.jsexmed.org.

Medicaid coverage (although 2 of 4 reported specific restrictions to coverage; see Figure 3), whereas providers from the remaining 4 of 8 states reported they have not had success providing GAHT under Medicaid.

U.S. territories: We were able to identify a single provider of GAHT by internet search in only 1 territory (Puerto Rico); the provider reported that Medicaid in Puerto Rico "does not cover" GAHT (Figure 3).

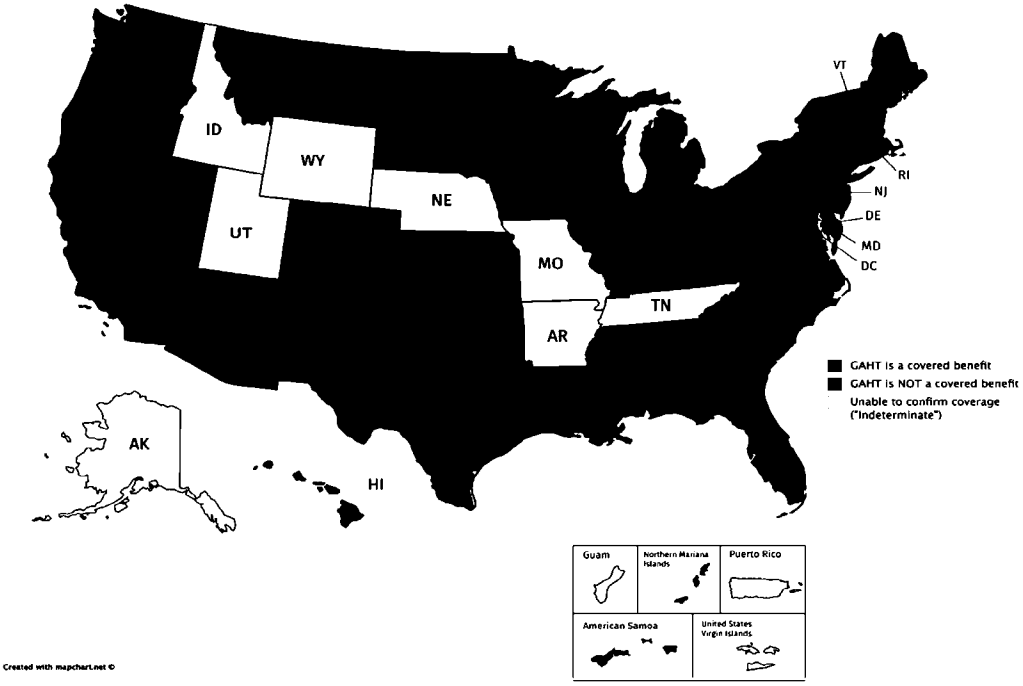

Figure 4. Maps of all 51 U.S. states (includes District of Columbia) and 5 U.S. territories, colored based on whether our work confirmed whether GAHT is a covered benefit (green), is not a covered benefit (red), or whether coverage remains "indeterminate". GAHT = gender-affirming hormone therapy. Figure 4 is available in color online at www.jsm.jsexmed.org.

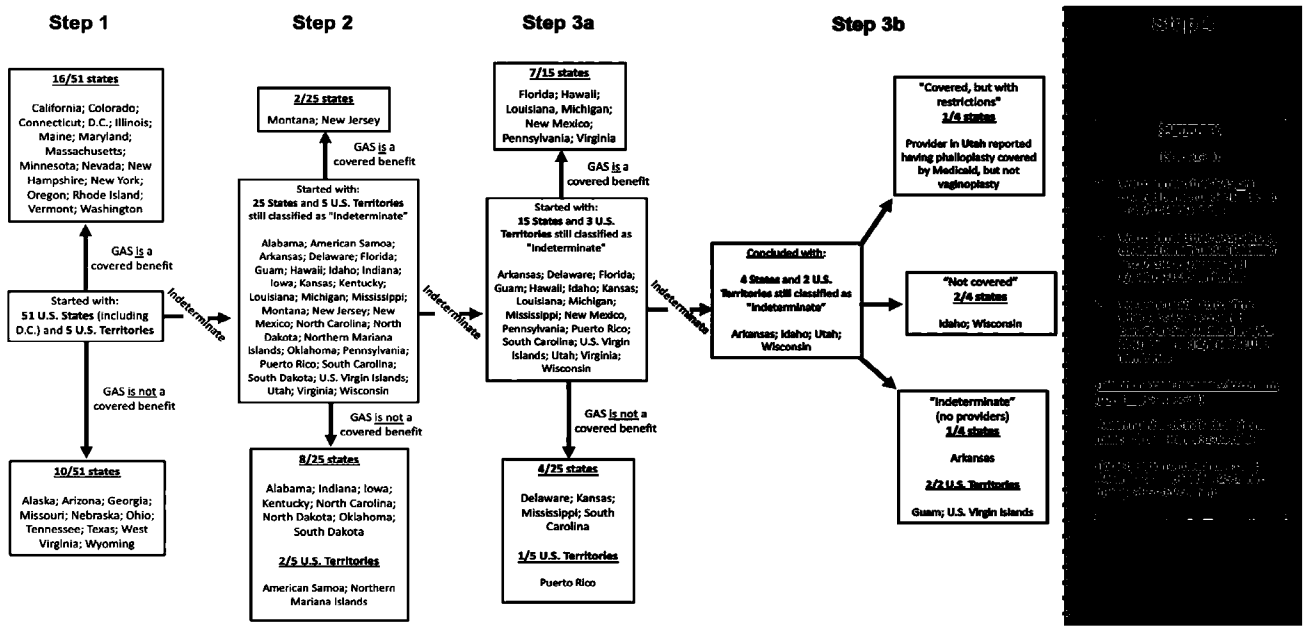

Figure 5. Flowchart outline of our results obtained through our step-by-step methodology to confirm Medicaid coverage for GAS. GAS = gender-affirming surgery. Figure 5 is available in color online at www.jsm.jsexmed.org.

Methods, step 4: The mean number of individual phone calls necessary to complete steps 2-3a. was 3.0 calls (range 1-10). Mean and median call duration were 31.8 min and 24.5 min, respectively; range was 1.5-124.8 min (Figure 3).

Genital Gender-Affirming Surgery

Methods, step 1: Our review of each state/territory's Medicaid program webpages found that only 26 of 51 states featured any explicit policy regarding whether or not GAS is a covered benefit:

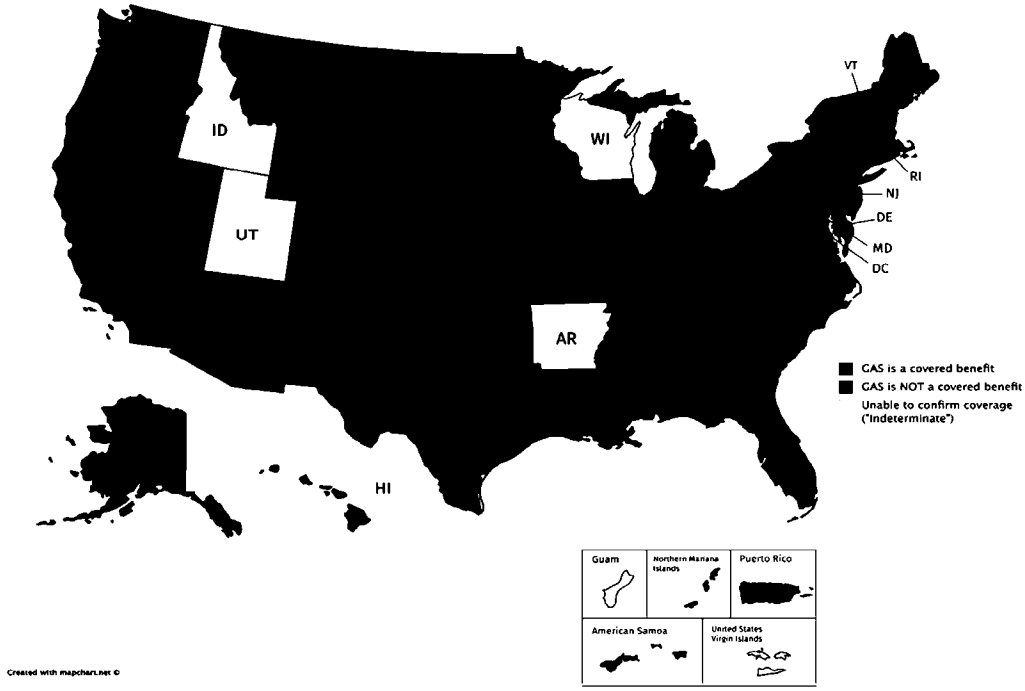

Figure 6. Maps of all 51 U.S. states (includes District of Columbia) and 5 U.S. territories, colored based on whether our work confirmed whether GAS is a covered benefit (green), is not a covered benefit (red), or whether coverage remains "indeterminate". GAS = gender-affirming surgery. Figure 6 is available in color online at www.jsm.jsexmed.org.

16 states had content that clearly states that their Medicaid program benefits do cover GAS, whereas 10 states clearly state that their Medicaid program benefits do not. We found that for the 16 states which do cover GAS, 15 of 16 explicitly specify eligibility criteria that align with the Transgender Health (WPATH) SOC guidelines.

U.S. territories: No territory's Medicaid program web content featured any policy statement regarding transgender health care. The remaining 25 of 51 states and all 5 U.S. territories were classified as "indeterminate" (Figure 5).

Methods, step 2: We began step 2 with 25 states and all 5 U.S. territories still classified as "indeterminate". After telephoning these 25 states' Medicaid program offices, we confirmed that 2 of 25 do cover GAS, and 8 of 25 do not cover GAS. The remaining 15 of 25 states remained classified as "indeterminate".

U.S. territories: We called the Medicaid program contact telephone number listed on the Federal Medicaid website for each of the territories.[28] 2 of the 5 territories confirmed that they do not cover GAS. The Medicaid program office of 1 territory (Puerto Rico) could not confirm whether GAS is or is not a covered benefit, and for the remaining 2 territories (Guam and U.S. Virgin Islands), there was no answer to our telephone calls. All 3 territories (Guam, Puerto Rico, and U.S. Virgin Islands) were classified as "indeterminate" (Figure 5).

Methods, step 3a: We began with 15 states and all 5 U.S. territories still classified as "indeterminate". The Medicaid programs for 13 of the 15 states and 1 U.S. territory classified by step 2 as "indeterminate" deferred questions about coverage of specific services to their Medicaid MCOs and directed us to contact their state's MCOs to confirm coverage. On calling these, we identified 7 of 13 states with at least one MCO that confirmed that they do cover GAS, whereas all* of the MCOs from 4 of 13 states confirmed that they do not cover GAS. (South Carolina was an exception: 4 of the 5 state MCOs stated that GAS is not a covered benefit whereas 1 was "not certain" about coverage ["indeterminate"]. We classified this state as one that does not cover GAS). MCOs from the remaining 2 of 13 states (Arkansas and Wisconsin): none stated that they do cover GAS; a small number stated that they do not cover GAS, and the majority from each state could not confirm whether GAS is or is not a covered benefit. These 2 states were classified as "indeterminate."

U.S. territories: We contacted Puerto Rico's MCOs and confirmed that these do not cover GAS.

Summary of results to confirm coverage for GAS under Medicaid by methods steps 1-3a: States with any explicit written policy regarding coverage of GAS as a covered benefit: 26 of 51; States that we found do cover GAS: 25 of 51; States that do not cover GAS: 22 of 51; States classified as "indeterminate": 4 of 51.

U.S. territories: U.S. territories that do cover GAS: 0 of 5; U.S. territories that do not cover GAS: 3 of 5; U.S. territories classified as "indeterminate": 2 of 5 (Figures 5 and 6).

Methods, step 3b: We began with 4 states and 2 U.S. territories still classified as "indeterminate". We identified only 1 provider of GAS in 3 of the 4 states (Idaho, Utah, Wisconsin) and 0 providers in the fourth state (Arkansas). We found 0 providers in the 2 U.S. territories. The single provider from one of these 3 states (Utah) reported successfully providing GAS to patients under Medicaid coverage, although with restrictions: (masculinizing GAS [phalloplasty] is covered, but feminizing GAS [vaginoplasty] is not covered (see Figure 5). All providers from the remaining 2 of 3 states reported no success providing GAS under Medicaid reimbursement.

U.S. territories: We could not identify any providers of GAS by internet search in the remaining 2 territories (Figure 5).

Methods, step 4: The mean number of individual phone calls necessary to complete steps 2-3a. was 3.3 calls (range 1-12). Mean and median call duration were 33.2 min and 25.1 min, respectively; range was 1.5 - 119.8 min.

We compiled a list of the U.S. states for whom we found explicit policy disclosure in their web content regarding whether or not GAHT and/or GAS is a covered benefit under their state Medicaid program, with an accompanying link to that disclosure (Supplementary Table 1). We also compiled a list of the Medicaid MCOs which confirmed covering GAHT and/or GAS (Supplementary Table 2).

Associations

Currently 25 states have passed non-discrimination laws that specifically outlaw health care plan provisions that allow insurers to refuse outright coverage for gender transition—related health care. There is a significant correlation between Medicaid programs that cover GAHT ($r_S = 0.61$, $P < .01$) and GAS ($r_S = 0.87$, $P < .01$) and states that have passed these non-discrimination laws. In addition, 14 states have not adopted Medicaid expansion per the ACA. We found that there is a significant correlation between states whose Medicaid programs do not provide coverage for GAHT ($r_S = 0.56$, $P < .01$) and GAS ($r_S = 0.62$, $P < .01$) and states that have not adopted the expansion of Medicaid under the ACA.

DISCUSSION

Our work shows that access to GAHT and GAS for people who depend on Medicaid for their health care remains limited and not uniformly distributed throughout the United States. Our research study had 3 aims: first, to provide an assessment that is as definitive as possible regarding coverage for gender transition—related health care in the literature to date; second, to provide a better understanding of the "patient experience" for those who depend on Medicaid and seek to confirm access to transition-related care (ie, how easy or difficult is it to confirm access to care); and third, to try to understand possible state-related predictors as to why states do or do not provide Medicaid coverage for gender-affirming care.

Regarding our first study aim, our approach allowed us to confirm that GAHT is a covered benefit under Medicaid in only ~ two-thirds of the U.S. states (34/51, 67%) (Figure 3), and that GAS is a covered benefit in only close to half (25/51, 49%) of all the U.S. states (including the District of Columbia) (Figure 5), all despite an abundance of evidence based data that shows that gender transition—related care in these domains improves quality of life and decreases health care—related costs.[10,12–15] Such data are cited in the Federal Government's nationwide Medicare policy Handbook as the basis for why care is a covered benefit under Medicare. In addition to how gender transition—related care helps individual patients, access to it serves our health care system and society in immeasurable ways as well, especially when we consider the fact that 1 in 5 Americans depends on Medicaid for health care, as transgender people are significantly more likely to be uninsured[16,29,30] and depend on Medicaid and/or health care from "urgent care" settings. High incidence of depression, anxiety, and status as "medically disabled" (related to depression and anxiety) pre-transition[13,14,31,32] contribute to high rates of unemployment (and as a consequence, dependence on the public health care system), and suggests that access to gender transition health care would help transgender people enter the workforce.[33–35] These findings closely correlate with the results of the 2015 National Transgender Survey which found that 55% of respondents reported being denied coverage for transition-related surgery, and 25% reported being denied coverage for transition—related hormone therapy treatment.[3] Several states indicated to us that coverage for GAS is denied because of the states position that gender reassignment surgery falls into the "cosmetic surgery" or "elective surgery" designation. This argument is contradictory to the position of several professional organizations (including the American Medical Association[36] and American Public Health Association[37]) which have endorsed classifying gender affirming health care such as GAHT and GAS as "medically necessary" treatments for transgender individuals suffering from gender dysphoria.

There were several notable findings from our study that warrant consideration.

Why does Medicaid cover gender transition—related health care in only a limited number of states, whereas Medicare (a federal program) covers it in all states? This is most likely explained by the fact that Medicaid is a combined federal and state program, managed by each state's government policies. Any opposition to coverage must either originate, or at a minimum pass through, each state's policy-making bodies. Although such opposition could be from medical-scientific disagreement with empiric data showing that gender transition—related health care improves quality of life and decreases costs to our health care system, our work found no evidence of writings or debate arguing that these data were incorrect, or, suggesting that transgender people were better served without gender transition—related health care among the states that explicitly deny or are silent about coverage. However, we did find that, by contrast, virtually all states that do cover transition-related care have webpage content which announced to the public that they do so and explained the rationale for their policy. All of these states' Medicaid program web-based content either states explicitly that any policy that denies access to transition-related care is discriminatory, and/or that transition-related care is recognized as "medically necessary".

We have also considered how to explain why, as our work showed, some state Medicaid programs cover gender transition—related services, whereas others do not. Given the abundance of empiric data that supports the benefit to patient quality of life, and cost-savings to state health care systems, it is hard to understand why some states would make such services inaccessible under Medicaid. We cannot answer this question definitively, but, results from our work leads us to conjecture that why some states' Medicaid programs do and others do not cover GAHT and GAS depends on whether or not the state (Medicaid program and state legislators that oversee it) view denial of access to these services as discrimination. For example, our work found that of the 25 states whose Medicaid programs cover GAS, 23 of these states have passed non-discrimination laws that specifically outlaw health care plan provisions that allow insurers to refuse outright coverage for gender transition—related health care.[38,39] This association was found to be significant ($r_S = 0.87$, $P < .01$). This will be an important observation to monitor in light of the June 12th, 2020, U.S. Federal Government policy announcement that it would direct the Department of Health and Human Services to more narrowly define sex discrimination in health care as being based on an individual's biological birth sex, while excluding both gender identity and sexual orientation as bases of discrimination. This policy would make it legal for health insurers to deny coverage for medically necessary gender transition—related health care and services.

Medicaid expansion became effective January 1st, 2014, and allowed for the expansion of Medicaid eligibility to individuals and families with annual incomes at or below 138% of the federal poverty line. The expansion of Medicaid inclusion is of particular importance to the U.S. transgender population as a 2015 national survey of transgender individuals found that 38% of respondents had household incomes that would fall within the Medicaid expansion range.[3] We observed a significant correlation between states whose Medicaid programs do not provide coverage for GAHT and GAS and states who have not adopted the expansion of Medicaid under the ACA.[40] Currently 14 states have not adopted Medicaid expansion per the ACA. Our study found that GAHT and GAS are not covered benefits in 7 of 14 (50%, $r_S = 0.56$, $P < .01$) and 12 of 14 (86%, $r_S = 0.62$, $P < .01$) of these states, respectively.

Another finding from our work which warrants consideration is that among the state Medicaid Programs that do cover GAHT (34/51) and GAS (25/51) (methods, steps 1-3A), only a relatively small fraction of these states advertised their coverage

Table 1. Inconsistent responses regarding coverage for GAS we encountered when it was necessary to call some state Medicaid program offices twice (methods, step 2)

	Responses from state Medicaid office	
State	State Medicaid Office response: FIRST telephone call (*Methods Step 2*)	State Medicaid office response: SECOND telephone call (*Methods Step 2*)
Michigan	Told "GAS *is* a covered benefit if 'medically necessary'"	Told "we cannot confirm if GAS is a covered benefit"
Mississippi	Told "GAS is *probably* not a covered benefit"	Told "procedure codes are required in order to confirm if GAS is a covered benefit"
Utah	Told "GAS is *generally* not a covered benefit, but has been covered in the past"	Told "GAS *is not* a covered benefit"
Virginia	Told "GAS is not a covered a covered benefit"	Told "procedure codes are required in order to confirm if GAS is a covered benefit"

GAS = gender-affirming surgery.

policy on their Medicaid program web content (for GAHT only 12 of 34 states did so, and for GAS, only 16 of 25 states did so). At face value, it makes sense for a program to clearly state their coverage policies, as doing so not only serves the public interest (ie, yields good patient/customer experience), but also reduces un-necessary phone calls with questions to the Medicaid program patient help hotlines. It is possible that the reason that the states whose Medicaid programs do cover these services but do not state doing so on their Medicaid program web content do so under the influence of Medicaid services administrators and/or state legislators, and/or providers opposed to providing these services to transgender people. However, we did consider other explanations too: some state Medicaid programs may not disclose coverage of transition-related health care services because they have "too few" or "no" transgender care—specialized providers. This explanation seems less likely; however, given that most all states today have at least some transgender-dedicated clinics and providers.

A question that no state's Medicaid Program Handbook or webpages addressed is what options patients have when their state Medicaid does cover less commonly offered services such as GAS, but there are either no providers within the state who do GAS, or, there are no providers within the state who accept Medicaid reimbursement for GAS. In such cases, despite benefits "coverage", Medicaid patients will go without care. It would be helpful for patients if Medicaid programs addressed this difficult situation, and offered options such as allowing patients to receive treatment from out of state Medicaid providers.

The second aim of our research was to provide an estimate of how easy or difficult it is for patients to simply confirm whether their state Medicaid program benefits cover transition-related care. How much effort should patients be expected to have to expend to confirm whether or not their insurance covers a medically necessary service? If we assume that a "reasonable effort" constitutes 1. An internet search of their state's Medicaid Program web-based Services Handbook (which is specifically designed for public use to answer such questions), and/or 2. A telephone call to the Medicaid program patient services hotline to confirm coverage (our methods steps 1-2), then our findings suggest that more than half of U.S. states do not meet this standard. For example, by our research methods steps 1-2, we were able to confirm a clear policy regarding coverage of GAHT in only 26 of 51 (51%), and for GAS in only 36 of 51 (71%) of the states. It is our opinion that it is not reasonable to expect patients to have to do more than steps 1 and 2 simply to confirm whether or not they have access to medically necessary transition-related care. It should be noted that the aforementioned statistics do not address the negative impact on patients when the "explicit policy" is to deny coverage for transition-related GAHT and GAS.

The process to confirm access to care is time-consuming. Patients who would have to make telephone calls, as we did, to complete methods steps 2-3A (calling state Medicaid offices and Medicaid MCOs) to confirm services for GAHT (76% of states) and GAS (49% of states) must spend a significant amount of time on the telephone to confirm coverage: for GAHT, an average of 31.8 minutes (range 1.5-124.8) over an average of 3.0 calls (range 1-10) (Figure 4), and for GAS, an average of 33.2 minutes (range 1.5-119.8) over 3.3 calls (range 1-12) (Figure 5). These results do not include the time that was required to review state's Medicaid Program web-based Services Handbooks (methods, step 1) which can also be significantly time-consuming. A recent study found that it can take on average > 50 min to review a private insurance company's online insurance information to determine gender transition—related coverage.[41]

Besides being time-consuming, the process to confirm access to gender transition—related care under Medicaid can be frustrating for patients in other ways. For example, information from the Medicaid office was most often not straight-forward; representatives at state Medicaid offices would often ask us to call other departments (pharmacy/billing), individual state insurance plans, or direct supervisors to obtain coverage information. Such time delays and need for multiple telephone "hand-offs" during a single call disfavors patients who work during normal business hours and cannot afford extended time for telephone calls, and people with language barriers and/or modest communication skills.

The process to confirm access to gender transition—related care under Medicaid can also be opaque and contradictory (Table 1). For example, nearly all states and territories initially classified as "indeterminate" required at least one additional follow-up phone call to confirm coverage (methods, steps 2 and 3A). During these follow-up phone calls, we often received answers/responses regarding whether or not GAHT/GAS are covered benefits that contradicted previous statements from the same Medicaid program office or MCO (Table 1). We estimate that telephone calls to approximately 50% of all states classified as "indeterminate" yielded contradictory information of the types shown in Table 1.

Some telephone call exchanges with Medicaid representatives were notable for responses that were "negatively uncertain". For example, Medicaid program representatives from some states responded that while their Medicaid program has covered GAS in the past, coverage is "typically an exception", and is as such, "not common." Some Medicaid program representatives said that they "have been instructed to say" that GAS and/or GAHT are "generally not covered."

Finally, representatives from some states' Medicaid program offices (Alaska, Georgia, Idaho, Mississippi, Missouri, Tennessee, Texas, Utah, Virginia, and Wyoming) told us by telephone that they could only confirm whether GAHT and/or GAS are covered benefits if we provided CPT (medical procedure) codes, or, unless the patient's physician called a specific telephone hotline to inquire. Opaque, contradictory and/or "negatively uncertain" responses from Medicaid program office representatives are likely frustrating and discouraging for transgender patients, and for some, could possibly encourage distrust of their Medicaid health care system.

Strengths and Limitations

A strength of our study is that our research group has expertise in the very services we were inquiring about, as we are a high-volume tertiary-care center for gender-affirming care that includes genital GAS and GAHT, which regularly provides these services to patients covered by both Medicaid- and Medicaid-managed care plans. As such, we are likely more adept at navigating Medicaid services than the average patient. Another strength of the study design is that to better understand barriers actual patients face, we acted as proxies for real Medicaid patients and approached confirming access to care as a real patient seeking services might: by using the internet and contacting their state's Medicaid program office. However, despite our expertise with transgender health care, we were careful to not leverage this expertise in the course of our inquiries, as this would make the findings we report less representative of what actual patients experience. For example, some Medicaid programs requested surgical procedure CPT codes before they could confirm the availability of surgical services. We did not provide these as doing so would be out of line with what information that an actual patient could be expected to provide.

A limitation of our study design is that in an effort to more definitively determine whether GAS and GAHT are or are not available in a given state, it could be that we were more adept at navigating Medicaid Program office helplines and/or we were persistent than some actual patients would be. If so, this would bias our results to underestimate how long it takes for a real patient to correctly conclude whether GAS and GAHT are or are not covered benefits in their state. Another limitation of our study is that we did not confirm which specific hormone formulations or specific genital gender affirming procedures would or would not be covered by each state's Medicaid programs. Drug formulation and surgical procedure—specific details are not information that a Medicaid office can readily access or share. In addition, these details would presumably vary by provider, as well. It is certainly possible that some Medicaid programs or their MCOs may have distinctions regarding coverage of certain services over others, and potential Medicaid enrollees should continue to work with their insurance carriers and health care providers to ensure that their healthcare needs will be covered.

CONCLUSIONS

By our research approach, we were able to confirm that GAHT and genital GAS are covered benefits under the Medicaid programs in only 34 of 51 (67%) and 25 of 51 (49%) states, respectively, and in none of the 5 U.S. territories. Our work found that the process to confirm coverage of these services by individual state Medicaid programs is opaque, time-consuming, and represents a barrier to care that warrants improvement. We speculate that based on our findings the strongest predictor for whether or not a state's Medicaid program includes gender transition—related care as a covered benefit is whether or not it has legal statutes in place that recognize denial of care based on gender identity as discriminatory. To date, this is the most thorough work to confirm coverage of these services nationwide.

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REFERENCES

1. American Psychological Association. What does transgender mean?. Available from: https://www.apa.org/topics/lgbt/transgender. Accessed May 18, 2020.
2. Flores AR, Herman J, Gates GJ, et al. How many adults identify as transgender in the United States?; online resource Los Angeles, CA: The Williams Institute, UCLA School of Law; 2016. p. 1.
3. James SE, Herman JL, Rankin S, et al. The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. 2016.
4. Semega J, Kollar Melissa, Creamer John, et al; U.S. Census Bureau. Income and poverty in the United States: 2018. Current Population Reports, P60-266. Washington, D.C.: U.S. Census Bureau; 2019.
5. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2019.
6. Weissman JF, Pratt LA, Miller EA, et al. Serious Psychological Distress Among Adults: United States, 2009-2013. **NCHS Data Brief 2015;203:1-8.**
7. Clements-Nolle K, Marx R, Katz M. Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. **J Homosex 2006;51:53-69.**
8. Colizzi M, Costa R, Todarello O. Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. **Psychoneuroendocrinology 2014;39:65-73.**
9. Brennan J, Kuhns LM, Johnson AK, et al. Syndemic theory and HIV-related risk among young transgender women: the role of multiple, co-occurring health problems and social marginalization. **Am J Public Health 2012;102:1751-1757.**
10. Padula WV, Heru S, Campbell JD. Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. **J Gen Intern Med 2016;31:394-401.**
11. Zaliznyak M, Bresee C, Garcia MM. Age at First Experience of Gender Dysphoria Among Transgender Adults Seeking Gender-Affirming Surgery. **JAMA Netw Open 2020;3:e201236.**
12. Heylens G, Elaut E, Kreukels BP, et al. Psychiatric characteristics in transsexual individuals: multicentre study in four European countries. **Br J Psychiatry 2014;204:151-156.**
13. Coleman E, Bockting W, Botzer M, et al. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. **Int J Transgenderism 2012;13:165-232.**
14. Costa R, Colizzi M. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. **Neuropsychiatr Dis Treat 2016;12:1953-1966.**
15. Wierckx K, Van Caenegem E, Elaut E, et al. Quality of life and sexual health after sex reassignment surgery in transsexual men. **J Sex Med 2011;8:3379-3388.**
16. Padula WV, Baker K. Coverage for Gender-Affirming Care: Making Health Insurance Work for Transgender Americans. **LGBT Health 2017;4:244-247.**
17. Hsieh S, Leininger J. Resource list: Clinical care programs for gender-nonconforming children and adolescents. **Pediatr Ann 2014;43:238-244.**
18. Canner JK, Harfouch O, Kodadek LM, et al. Temporal Trends in Gender-Affirming Surgery Among Transgender Patients in the United States. **JAMA Surg 2018;153:609-616.**
19. Lane M, Ives GC, Sluiter EC, et al. Trends in Gender-affirming Surgery in Insured Patients in the United States. **Plast Reconstr Surg Glob Open 2018;6:e1738.**
20. Mallory C, Tentindo W; Williams Institute (University of California Los Angeles. School of Law). Medicaid coverage for gender-affirming care. Los Angeles, CA: The Williams Institute, UCLA School of Law; 2019. p. 1; online resource.
21. Meerwijk EL, Sevelius JM. Transgender Population Size in the United States: a Meta-Regression of Population-Based Probability Samples. **Am J Public Health 2017;107:e1-e8.**
22. Medicaid.gov. December 2018 Medicaid & CHIP Enrollment Data Highlights. Available from: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
23. U.S. Department of Health & Human Services. Discrimination on the Basis of Sex. Available from: https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
24. Department of Health Care Services. All Plan Letter 13-011: Ensuring Access to Transgender Services from Toby Douglas, Dir., Cal. Dep't. of Health Care Servs., to All Medi-Cal Managed Care Health Plans. Available from, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-011.pdf.
25. Movement Advancement Project. *Equality Maps: Healthcare Laws and Policies*. Available from, http://lgbtmap.org/equality-maps/healthcare_laws_and_policies.
26. Bakko M, Kattari SK. Differential Access to Transgender Inclusive Insurance and Healthcare in the United States: Challenges to Health across the Life Course. **J Aging Soc Policy 2019.**
27. Medicaid.gov. State Overviews. Available from: https://www.medicaid.gov/state-overviews/index.html; Accessed May 18, 2020.
28. Centers for Medicare & Medicaid Services. The Center for Consumer Information & Insurance Oversight. Available from: https://www.cms.gov/cciio/Resources/consumer-assistance-grants. Accessed May 18, 2020.
29. Macapagal K, Bhatia R, Greene GJ. Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults. **LGBT Health 2016;3:434-442.**

30. Daniel H, Butkus R. Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians. **Ann Intern Med 2015;163:135-137.**

31. Olson KR, Durwood L, DeMeules M, et al. Mental Health of Transgender Children Who Are Supported in Their Identities. **Pediatrics 2016;137:e20153223.**

32. Owen-Smith AA, Gerth J, Sineath RC, et al. Association Between Gender Confirmation Treatments and Perceived Gender Congruence, Body Image Satisfaction, and Mental Health in a Cohort of Transgender Individuals. **J Sex Med 2018;15:591-600.**

33. Drydakis N. Trans people, well-being, and labor market outcomes. **IZA World of Labor 2017;2017:386.**

34. Drydakis N. Trans employees, transitioning, and job satisfaction. **J Vocational Behav 2016;98:1-16.**

35. Martinez LR, Sawyer KB, Thoroughgood CN, et al. The importance of being "me": The relation between authentic identity expression and transgender employees' work-related attitudes and experiences. **J Appl Psychol 2017;102:215-226.**

36. American Medical Association. Removing Financial Barriers to Care for Transgender Patients. Available from, https://policysearch.ama-assn.org/policyfinder/detail/Removing%20Financial%20Barriers%20to%20Care%20for%20Transgender%20Patients%20H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml. Accessed May 18, 2020

37. American Public Health Association. Promoting Transgender and Gender Minority Health through Inclusive Policies and Practices. Available from, https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2017/01/26/promoting-transgender-and-gender-minority-health-through-inclusive-policies-and-practices. Accessed May 18, 2020.

38. Movement Advancement Project. *Healthcare Laws and Policies: Nondiscrimination in Private Insurance (and Bans on Transgender Exclusions)*. Available from: https://www.lgbtmap.org/img/maps/citations-nondisc-insurance.pdf. Accessed May 18, 2020.

39. "Stateline - an initiative of The Pew Charitable Trusts. States Diverge on Transgender Health Care. Available from, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/07/17/states-diverge-on-transgender-health-care. Accessed May 18, 2020.

40. Kaiser Family Foundation. Status of State Medicaid Expansion Decisions: Interactive Map. Available from, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. Accessed May 18, 2020.

41. Dowshen NL, Christensen J, Gruschow SM. Health Insurance Coverage of Recommended Gender-Affirming Health Care Services for Transgender Youth: Shopping Online for Coverage Information. **Transgend Health 2019;4:131-135.**

SUPPLEMENTARY DATA

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