KNOW YOUR RIGHTS

New York Medicaid Coverage for Gender Dysphoria

1. If I live in New York and I am a Medicaid recipient, what transition-related care will be covered?

In New York, coverage is available for hormone therapy (including cross-sex hormones and pubertal suppressants), surgeries, and other procedures. In order to receive coverage, you have to have a diagnosis of gender dysphoria and your doctor has say that the treatment you seek is medically necessary. NY has two types of Medicaid, fee for service and managed care plans, your request for gender affirming care may be different depending on which type of Medicaid you have. **NOTE: If you are under the age of 18, you need parental consent for any and all medical treatment.**

The process can feel complicated and overwhelming, but you are entitled to this coverage and if you need help compiling the paperwork, you can call Legal Aid's **Access to Benefits Helpline** on Tuesdays from 9:30-12:30 at **888-663-6880**.

2. What is medical necessity?

It means that your doctor (and/or other medical professionals) says that the treatment is necessary to treat your gender dysphoria.

3. What if I need hormone therapy?

<u>For pubertal suppressants:</u>

- You must reach puberty level of Tanner Stage II which is determined by your doctor. You need a medical professional to provide documentation that you are eligible and ready for the treatment and other requirements, such as proof that you understand the outcomes, risks, and benefits of beginning hormone therapy and that you have the necessary psychological and social support.

<u>For cross-sex hormones:</u>

- If you are over 18 years of age, you need a medical professional to provide documentation that it is medically necessary.
- If you are 16 to 17 years of age, you need a medical professional to provide documentation that you are eligible and ready for the treatment and other requirements, such as proof that you understand the outcomes, risks, and benefits of beginning hormone therapy and that you have the necessary psychological and social support.
- If you are under 16, you need a medical professional to provide documentation that you are eligible and ready for the treatment and other requirements, such as proof that you understand the outcomes, risks, and benefits of beginning hormone therapy and that you have the necessary psychological and social support and your health insurance company's prior approval.

4. What do I need to show to receive coverage for surgery?

The default rule is that you must be 18 or older, but patients under 18 may receive coverage for surgery in specific cases if it is medically necessary and you receive prior approval from your health insurance company.

In order to receive coverage for gender affirming surgery (also known as sex reassignment surgery) and breast removal surgery, you must provide proof of the following:

- You have letters from two New York State licensed health professionals who recommend you for surgery:
  - 1 letter must be from either a psychiatrist, psychologist, physician, psychiatric nurse practitioner or licensed clinical social worker with whom you have an established on-going relationship.
  - The other letter may be from either a psychiatrist, psychologist, physician, psychiatric nurse practitioner or licensed clinical social worker who has evaluated you.

- Together the letters must say:
  - That you have a persistent case of gender dysphoria;
  - That you have received hormone therapy for at least a year for all genital surgeries;
  - That you have lived for at least a year in the gender role congruent with your gender identity, and have received mental health counseling, as deemed medically necessary, during that time;
  - If you have other health conditions - either medical or mental health - that would conflict with surgery, those conditions are well-managed; and
  - Lastly, that you have the ability to give informed consent for surgery.
  - NOTE: For breast removal surgery, no hormone therapy is necessary.

5. What do I need to show in order to receive coverage for other transition-related surgeries?

Medicaid covers other surgeries, such as breast augmentation surgery, facial feminization surgery, etc. if medical necessity is shown and prior approval is received from your health insurance company.

- This means that Medicaid requires the two letters described above showing a determination of medical necessity by a qualified medical professional.
- NOTE: If you are seeking breast augmentation, you must have received hormone therapy for at least two years, during which time breast growth has been negligible.

The most important thing to keep in mind is that if you need transition-related treatment, **you have the right to request it**, and if you are denied, **you have the right to appeal the denial**. You should act quickly because there are time limits on when you can file an appeal.

Questions? Need help filing an appeal? Contact Legal Aid at the **Access to Benefits Helpline** on Tuesdays from 9:30-12:30 at **888-663-6880**. Be sure to keep all letters and paperwork associated with your claim.

THE LEGAL AID SOCIETY

MAKING THE CASE FOR HUMANITY

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