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February 2, 2015

Katherine Ceroalo
Department of Health Bureau of House Counsel
Regulatory Affairs Unit
Tower Building, Room 2438
Albany, NY 12237

Re: ID No. HLT-50-14-00001-P, Proposed Rule Making on Transgender Related Care and Services

Dear Ms. Ceroalo:

I write to offer comments on the proposed changes to Medicaid regulations regarding coverage of transgender care and related services. I applaud Governor Cuomo's action to have New York State end its discriminatory exclusion of transgender care for Medicaid recipients. The exclusion was rooted in bias and bad science, and it never had any place in New York. However, the proposed regulation falls short in a number of important areas and should be expanded to extend coverage for all medically necessary treatments.

This regulatory change will bring about a significant improvement in the health and wellbeing of transgender New Yorkers. Beyond the general authorization of coverage for transgender care and services, there are several points that I am pleased to see included. The language noting that hormone therapy may be covered regardless of surgical intentions is important. It recognizes that individuals do not, and should not be expected to, follow the same treatment plan. The inclusion of licensed clinical social workers as acceptable referees will reduce the bureaucratic burden for individuals seeking referrals, particularly given the scarcity of practicing psychiatrists and psychologists who both accept Medicaid and have a specialization in gender dysphoria.

However, some provisions of the proposed regulations depart from the principle of respecting medically-appropriate individual health care decision-making. They should be changed.

Section 505.2(1)(2) limits coverage of hormone therapy to individuals 18 or older. This is contrary to the recommended standard of care put forth by the World Professional Association for Transgender Health (WPATH), which states that hormone therapy may be safe for some patients beginning at 16 years old. This is a medical decision that should be determined by the minor's health care professional and the patient (including whoever has authority to consent for such treatment). This exclusion will harm mature young people. What medical procedures

minors may or may not consent for themselves, or whether parental consent is required, has nothing to do with whether or not the care is paid for by Medicaid. The varying legal rules relating to consent to care for minors apply to the full range of health care decisions such as brain surgery, carrying a pregnancy to term or having an abortion, and drug treatment. I urge the Department of Health to eliminate the 18-year-old threshold and to respect the standards agreed upon by experts in this field and the decisions of health care professionals and their patients.

In addition, section 505.2(1)(2) refers only to "hormone therapy," and there is no mention in the regulation of puberty blockers. This medically necessary treatment for some youth, which is endorsed as a safe and effective practice by the Endocrine Society, does not consist of hormones, but rather proteins which suppress the progression of puberty. The regulation should explicitly state that such care will be covered under the new regulation.

Section 505.2(1)(3) limits coverage of surgery resulting in sterilization to individuals 21 or older. While this superficially resembles federal Medicaid regulations limiting sterilization to the same age group, the restriction inappropriately elides elective birth control procedures with treatments necessary for the health and wellbeing of the patient. Federal Medicaid regulations grant exceptions to the 21-year-old threshold in the case of medical necessity, such as in instances of cancer care. The same medically necessary exemption should apply to transgender care in all cases where a treating physician deems it so.

Section 505.2(1)(3)(ii) mandates that hormone therapy precede surgery. Depending on the particular surgery and goals of an individual, good medical practice often calls for a different sequence. That decision should be between doctors and patients, which is where all treatment decisions belong. It should have no relation to whether a patient is covered by Medicaid or not. This language should be removed from the regulation.

Section 505.2(1)(4)(v) excludes all procedures deemed cosmetic and goes on to exclude a number of treatments that may be medically necessary in some instances. The regulation defines cosmetic as "anything solely directed at improving an individual's appearance," but this fails to recognize the necessarily appearance-based aspects of some transgender care. There is general agreement among medical and policy experts that transgender care is external to cosmetic care. The revised regulation should include the phrase "unless medically necessary" at the beginning of Section 505.2(1)(4).

Thank you for taking my comments into consideration. I look forward to a fully just coverage policy that is rooted exclusively in best medical practices.

Very truly yours,

Richard N. Gottfried
Chair
Assembly Committee on Health