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The Medicaid Program and LGBT Communities

Overview and Policy Recommendations

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In 1965, President Lyndon B. Johnson signed the Social Security Amendments Act, creating dual programs—Medicaid and Medicare—that have dramatically improved access to health care for some of the nation's most vulnerable communities. Nearly 50 years later, President Barack Obama signed the Affordable Care Act, or ACA, setting in motion one of the most significant set of changes to Medicaid since the program's inception.

Today, Medicaid is the nation's largest insurer, funding a significant portion of national spending on personal health care and providing low- or no-cost health coverage to nearly 70 million people—including many individuals who are lesbian, gay, bisexual, and transgender, or LGBT.[1] Importantly, LGBT people are more likely than non-LGBT people to be living in poverty and to be uninsured.[2] Overall, one in five Americans receives health insurance coverage through Medicaid in any given year, and nearly two-thirds of Americans report a close personal connection with the Medicaid program, either because they have received assistance from Medicaid or because they have close friends or family who have.[3]

This issue brief reviews the characteristics and benefits of Medicaid as they relate to LGBT individuals, including why the Medicaid program is essential to the health of LGBT communities. It also looks at how the program could be improved to ensure greater access to quality coverage for LGBT people and their families.

What is Medicaid, and whom does it cover?

Medicaid is a public program that provides health coverage for low-income individuals who fall into a range of eligibility categories, including people living with a disability, people who are pregnant, and people with dependent children.[4] Medicaid is a means-tested entitlement program, meaning that eligibility is linked to individual or

family income, and the program is required to cover all individuals who meet eligibility requirements. Medicaid is primarily administered by states within parameters set by federal law, and the program is jointly financed by states and the federal government—on average, the federal government pays 53 cents of every $1 spent by states on their Medicaid programs.[5]

When the ACA was signed into law in 2010, it substantially modified Medicaid's eligibility rules. Specifically, the ACA required state Medicaid programs to cover all individuals making up to 138 percent of the federal poverty level, or FPL.[6] In 2016, the FPL stands at $11,880 for an individual and $24,300 for a family of four.[7] When the U.S. Supreme Court considered the constitutionality of the ACA in June 2012, however, it ruled that the federal government cannot compel the states to expand Medicaid, leaving the decision of whether or not to expand the program to governors and state legislatures. As of July 2016, 31 states and the District of Columbia have expanded their Medicaid programs to cover all individuals with incomes up to 138 percent of the FPL.[8]

In the 19 states that have not adopted expansion, millions of people remain uninsured. For individuals making less than the federal poverty level, a lack of Medicaid expansion means that the ACA cannot offer them financial assistance to access health insurance coverage. Because the states that have not adopted expansion also have comparatively larger populations of communities of color and higher rates of poverty—including LGBT people of color and their families—the decisions made by these states disproportionately impact people of color and people who cannot otherwise afford insurance.[9]

There is no deadline for states to decide whether or not to move forward with Medicaid expansion, although states that delay expansion stand to lose substantial amounts of federal funding: The federal government paid 100 percent of the costs of expansion between 2014 and 2016, and this percentage drops slightly before settling at 90 percent in 2020 and beyond.[10] Overall, this financing arrangement meant that, if all states had expanded their Medicaid programs, the federal government would have picked up approximately 93 percent of the tab, meaning that all states together would have borne only 7 percent of the total cost of Medicaid expansion.[11]

What benefits does Medicaid cover?

In general, Medicaid provides more comprehensive benefits at a lower cost than private insurance coverage.[12] Benefits for adults enrolled in Medicaid vary, however, between states and by program. For those enrolled in traditional Medicaid—the coverage available to those who were eligible for Medicaid prior to the Affordable Care Act, including pregnant people and people with disabilities—there is a core set of benefits required by law, including but not limited to:

- Doctor visits
- Inpatient and outpatient hospital services
- Some mental health services
- Family planning services and supplies
- Long-term care facility services
- Home health care
- Emergency services
- Transportation to medical services
- Laboratory and X-ray services
- Early and Periodic Screening, Diagnostic, and Treatment services for children and adults younger than age 21

In addition to this list of mandatory services, states also have the flexibility within the parameters of federal guidance to offer a range of optional services, which typically include outpatient prescription drug coverage, dental services, and case management services, among others. More than 60 percent of state Medicaid spending is on optional services, which testifies to the degree to which states choose to offer coverage for optional services because of their importance to the health of Medicaid enrollees.[13] Because they are not required by federal law, however, optional benefits are vulnerable to being lost as a result of state budget cuts.

In states that have expanded Medicaid under the ACA, newly eligible individuals receive a slightly different package of benefits known as an Alternative Benefit Plan, or ABP.[14] The benefits covered by ABPs are based on the essential health benefit standard created by the ACA, which includes and in some cases expands on the benefits available through traditional Medicaid.[15] The 10 required essential health benefit categories of covered services are:[16]

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

In addition to the essential health benefit standard, ABPs are subject to the Mental Health Parity and Addiction Equity Act of 2008, which requires parity in mental health coverage.[17] ABPs are also subject to Section 2713 of the Affordable Care Act, which prohibits cost-sharing for a range of approved preventive screenings and services, lessening costs significantly for Medicaid beneficiaries. These requirements do not apply to traditional Medicaid.

In order to establish their ABPs, states have the option of choosing between four benchmark plan options that provide the basis for the design and breadth of the available benefits:[18]

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program
- A state employee plan
- The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
- Coverage approved by the federal secretary of health and human services, which can include the benefits offered to traditional Medicaid enrollees

Most states that have expanded Medicaid have selected the secretary-approved option in order to closely align the benefits available to traditional and expansion Medicaid beneficiaries.[19]

Why is Medicaid an important program for LGBT communities?

LGBT communities report high rates of poverty and uninsurance

The high prevalence of poverty in LGBT communities, especially among transgender people and LGBT people of color, makes Medicaid a critical program for the health and well-being of LGBT communities. Nationwide, about one in five gay and bisexual men and one in four lesbian and bisexual women are living in poverty.[20] The 2011 National Transgender Discrimination Survey found that more than 25 percent of transgender people report an annual household income of less than $20,000 and that transgender people are four times more likely than the general population to be living below the poverty line.[21] In a 2014 nationwide survey of LGBT people with incomes less than 400 percent of the FPL, 61 percent of all respondents had incomes in the Medicaid expansion range—up to 138 percent of the FPL—including 73 percent of African-American respondents, 67 percent of Latino respondents, and 53 percent of white respondents.[22]

High rates of poverty in LGBT communities correlate with high rates of uninsurance. National Gallup poll data indicate that LGBT people are generally more likely to be uninsured than their peers.[23] In a separate study in 2013, the last year before the ACA's full coverage expansion went into effect, one in three—or 34 percent—of LGBT adults ages 18 to 64 with incomes less than 400 percent of the FPL were uninsured.[24] Of the uninsured in that study, almost half—48 percent—lived in southern states whose governments opposed Medicaid expansion.

Many LGBT individuals are unable to access coverage without Medicaid expansion because the traditional Medicaid eligibility categories exclude most childless adults, regardless of how low their incomes are. To cover childless adults who were not otherwise categorically eligible before the ACA's coverage expansion, states were required to either use solely their own funds or obtain a federal waiver. In 2009, only five states offered full Medicaid-comparable coverage to childless adults.[25]

For both LGBT childless adults and LGBT parents, Medicaid expansion is important because it standardizes the income eligibility thresholds that were previously widely variant depending on state guidelines—and that continue to vary in states without expansion. For example, in 2010, a working parent with two children became ineligible for Medicaid coverage in Texas by making more than 26 percent of the FPL for a family of three, or about $400 per month.[26] That same parent could have made more than $1,370 per month—90 percent of the FPL—and still been eligible for coverage under Ohio's Medicaid program, or close to $2,290 per month—150 percent of the FPL—and still have been eligible in New York.[27] In 2016, because Ohio adopted the Medicaid expansion while Texas did not, the monthly income limit for a working parent of two in Ohio is now $2,318—138 percent of the FPL—while in Texas the monthly limit has actually dropped to just above $300 per month—18 percent of the FPL.[28]

Medicaid expansion is also important for people living with HIV. Under traditional Medicaid's stringent categorical eligibility requirements, individuals with HIV frequently cannot qualify for Medicaid coverage until their health has deteriorated to the point where they qualify on the basis of disability because the disease has progressed to AIDS. The ACA's Medicaid expansion eliminates this barrier to timely HIV treatment by allowing all individuals with incomes up to 138 percent of the FPL to qualify for Medicaid coverage regardless of their disability status. In states that have not expanded Medicaid, however, this barrier to access remains.

Access for immigrants, even in states that have expanded Medicaid, is unfortunately restricted to only a handful of categories, including people with green cards, refugees, people granted asylum, Cubans and Haitians, and certain victims of trafficking.[29] There are an estimated 637,000 LGBT adult immigrants with legal status in the United States, many of whom become eligible for Medicaid benefits only after a five-year waiting period.[30] In 2012, the Obama administration barred beneficiaries of the Deferred Action for Childhood Arrivals, or DACA, program—which initially permitted undocumented young people who were brought to the United States as children to access Medicaid under the same conditions as lawfully present immigrants—not only from Medicaid but also all new health insurance options created under the ACA.[31] States can, however, elect to extend eligibility for the Children's Health Insurance Program, or CHIP, to pregnant people and children without the five-year waiting period, and in California, undocumented children younger than age 19 are eligible for Medi-Cal, the state's Medicaid program.[32]

Despite these significant lingering concerns, the ACA's coverage reforms, including Medicaid expansion, have had a substantial impact on uninsurance rates among LGBT people. Between 2013 and 2014, the number of uninsured LGBT adults with incomes less than 400 percent of the FPL dropped by almost a quarter, from 34 percent to 26 percent.[33] In 2013, 22 percent of them had coverage through Medicaid, including 40 percent of those with incomes up to 138 percent of the FPL, and in 2014, 28 percent of them had Medicaid coverage.[34]

In 2014, Medicaid covered 29 percent of insured low- and middle-income LGBT Latinx individuals and 37 percent of insured low- and middle-income African Americans; 37 percent of insured LGBT adults with incomes of 139 percent of the FPL or less; and 36 percent of those with a high school education or less.[35] States that expanded Medicaid between 2013 and 2014 saw a 10 percentage point drop in the overall rate of uninsurance among their low- and middle-income LGBT communities, compared to a 6-point drop in states that did not expand Medicaid—leading to an average uninsurance rate in this population of 18 percent in Medicaid expansion states versus 34 percent in non-expansion states in 2014.[36]

Discrimination against LGBT individuals affects access to health insurance coverage

The high rates of uninsurance in the LGBT population are linked not only to poverty but also to experiences of discrimination. Despite advances in legal protections and social acceptance for LGBT people over the past several decades, there is still no federal law that explicitly protects LGBT individuals from discrimination in employment and other areas of everyday life.[37] Only 20 states and the District of Columbia have passed legislation protecting transgender people from discrimination, and only 22 states and the District of Columbia protect lesbian, gay, and bisexual people.[38] In the absence of these protections, LGBT people in the majority of states are at risk of being legally evicted from their apartments, denied credit, refused hotel rooms, and fired from their jobs on the basis of their sexual orientation or gender identity.[39]

Studies show that up to 43 percent of gay workers and 90 percent of transgender workers have experienced discrimination and harassment in the workplace.[40] Employment discrimination pushes many LGBT people into low-wage jobs that do not offer benefits such as health insurance coverage, or into unemployment.[41] A 2009 state-level survey in California, for instance, found that 14 percent of lesbian, gay, and bisexual adults are unemployed, compared to 10 percent of heterosexual adults.[42] For transgender adults, unemployment rates are twice the rate of the population as a whole, rising to as high as four times the national unemployment rate for transgender people of color.[43] As a result of discrimination and unemployment, a 2014 study showed that only 38 percent of insured LGBT adults with incomes less than 400 percent of the FPL had insurance through their own employer or a spouse or partner's employer, in contrast to 58 percent of the insured non-LGBT population in the same income range.[44]

Insurance carriers also discriminate against LGBT individuals. In the same 2014 study, for instance, close to nine percent of respondents in same-sex relationships reported that an insurance carrier had discriminated against them on the basis of their sexual orientation. For example, some respondents reported encountering refusal to allow them to enroll in coverage with a same-sex spouse or partner as a family.[45] In the Medicaid context, many Medicaid programs did not consider same-sex spouses legally married for purposes of eligibility and enrollment even after the 2013 Supreme Court ruling that struck down the majority of the federal Defense of Marriage Act, or DOMA. Following *Obergefell v. Hodges*, the 2015 Supreme Court ruling that expanded marriage equality nationwide, however, the federal government began requiring all state Medicaid programs to recognize legally married same-sex couples on the same basis as different-sex couples.

Transgender individuals experience particularly high rates of discrimination in health insurance coverage

Insurance discrimination against transgender individuals, including in state Medicaid programs, is particularly pervasive. According to 2016 estimates, there are at least 1.4 million transgender people living in the United States, many of whom need medical treatment to help them physically transition from their assigned sex at birth to the sex with which they identify.[46] According to the standards of care maintained by the World Professional Association for Transgender Health, the health care services that may be medically necessary as part of gender transition include gender reassignment surgeries, hormone therapy, and mental health counseling.[47] Unfortunately, many health plans explicitly exclude coverage for all services related to gender transition, and carriers frequently expand these exclusions in practice to also deny coverage for sex-specific preventive screenings such as cervical Pap tests and mammograms, and sometimes for any care at all.[48]

Many of these exclusions date to the early 1980s, when the federal Medicare program adopted a policy excluding transition-related care from coverage on the assumption that it was "cosmetic" and "experimental," despite a widespread medical consensus deeming health care services related to gender transition medically necessary.[49] Numerous state Medicaid programs, as well as most private insurance plans, quickly followed suit. As a result, Medicaid coverage for transition-related health care has long been available only in a small handful of states on the basis of court rulings requiring these states' Medicaid programs to consider the medical necessity of transition-related care for transgender individuals on a case-by-case basis.[50]

Transgender exclusions, however, are slowly being eradicated. In 2001, a California superior court ruled against Medi-Cal's general exclusion of transition-related care and required the program to implement a coverage policy. This ruling cited a pair of court cases from the 1970s regarding Medicaid coverage for sex reassignment surgery for transgender women, in which the judges had found that "the proposed surgery is medically reasonable and necessary."[51] The judges in these rulings further noted, "we do not believe, by the wildest stretch of the imagination, that such surgery can reasonably and logically be characterized as cosmetic."[52]

Several years later, in 2006, California passed the Insurance Gender Nondiscrimination Act, which prohibits discrimination in insurance on the basis of gender identity. Regulations promulgated by the California Department of Insurance in 2012 clarify that the act requires insurance carriers to cover any medically necessary service for a transgender person, as long as the service is covered for non-transgender subscribers on the same plan.[53] This concept of parity has far-reaching implications, as the medical treatments that transgender people may need for gender transition are typically covered for non-transgender people for a variety of conditions, including endocrine disorders, cancer prevention or treatment, and reconstructive surgeries following an injury.[54]

On the heels of these regulations, insurance regulators in numerous states have begun to issue guidance clarifying that their own state laws—including human rights laws prohibiting gender identity discrimination, unfair trade practices statutes prohibiting sex-based discrimination in insurance coverage, and mental health parity requirements—prohibit transgender-specific insurance exclusions.[55] Medicare lifted its exclusion in 2014, and Medicaid agencies in several states have also recently amended their rules to remove transgender exclusions and expressly affirm the availability of coverage for transition-related care; as of August 2016, these states are California, Connecticut, Illinois, Maryland, Massachusetts, New York, Oregon, Rhode Island, Vermont, and Washington, plus the District of Columbia.[56] Unfortunately, Medicaid programs in 18 states continue to explicitly exclude care for transgender individuals, and the remainder do not address the issue of transgender coverage at all—which in practice has often meant that coverage is denied.[57]

Medicaid nondiscrimination protections

All state Medicaid programs are bound by federal nondiscrimination laws. The three laws that are particularly relevant to access for LGBT individuals are regulations promulgated under the federal Medicaid statute prohibiting arbitrary restrictions on Medicaid coverage on the basis of diagnosis or health condition, Section 1557 of the Affordable Care Act, and regulations governing the activities of Medicaid managed care organizations. The enforcement of these nondiscrimination protections is in addition to provisions within the federal Medicaid statute that require state Medicaid programs to grant a fair hearing to any individual whose claim for medical services is denied or not acted upon in a timely manner.[58]

Federal Medicaid statute requirements

A core aspect of federal law that affects access to Medicaid coverage for a variety of conditions is a longstanding Medicaid regulation prohibiting arbitrary coverage restrictions on the basis of diagnosis. Specifically, state Medicaid programs may not "arbitrarily deny or reduce the amount, duration, or scope of a required service under [the Medicaid statute] to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition" with which the individual is diagnosed.[59] Thus, if a service is a required service under Medicaid, this regulation forbids limits on that service that single out individuals with a particular condition or diagnosis—including conditions that disproportionately affect the LGBT population, such as HIV. While this provision has been invoked at the state level to support coverage of services related to gender transition, federal courts have not issued rulings specifically addressing the application of this provision to gender reassignment services.

Affordable Care Act Section 1557

Section 1557 of the Affordable Care Act, which is the health reform law's primary civil rights provision, prohibits discrimination on the basis of race, color, national origin, disability, age, or sex by any program or entity that receives federal financial assistance. Because every state Medicaid program receives financial support from the federal government, Section 1557 covers all Medicaid beneficiaries.

Section 1557 has been in effect since the ACA was passed in 2010. In May 2016, the U.S. Department of Health and Human Services Office for Civil Rights released final regulations clarifying the scope and intent of Section 1557.[60] Among other provisions, the final rule clarifies that Section 1557's sex-based nondiscrimination protections extend to gender identity and sex stereotyping. Section 1557 thus explicitly protects transgender and gender-nonconforming individuals and, while the regulations do not expressly define sexual orientation discrimination as a form of sex discrimination, they do protect gay, lesbian, and bisexual individuals and their families from discrimination on the basis of sex stereotypes. These stereotypes include, for example, the assumption that men should only seek romantic relationships with women, and vice versa.

The final rule prohibits discriminatory plan benefit design and marketing, including examples such as placing all HIV medications in the highest cost-sharing tier and failure to provide single-tablet therapy, which is the standard of care in HIV treatment. It also prohibits health insurance coverage programs and plans from categorically excluding all services related to gender transition or making coverage decisions in a manner that results in discrimination against a transgender individual—such as denying coverage for mental health services related to gender transition while covering them for depression, among many other examples. The final rule also requires health care providers to provide medically necessary health care services to transgender individuals, as long as those services are within the provider's scope of practice and are provided to non-transgender individuals. The provisions of the Section 1557 final rule took effect on July 18, 2016, for state Medicaid programs, meaning that the 18 states whose Medicaid programs still exclude transition-related care may face administrative remedies or private lawsuits if they do not remove these exclusions.

Medicaid managed care regulations

In April 2016, the Centers for Medicare and Medicaid Services, or CMS, issued regulations requiring Medicaid managed care organizations, or MCOs, to abide by LGBT-inclusive cultural competency and nondiscrimination requirements in addition to ACA Section 1557.[61] Medicaid MCOs are private insurance companies that contract with state governments to cover some or all of their Medicaid beneficiaries, in a practice known as Medicaid managed care. As of 2016, 39 states and the District of Columbia use Medicaid MCOs, and Medicaid MCOs cover approximately 80 percent of Medicaid beneficiaries nationwide.[62]

The 2016 Medicaid MCO regulations expressly prohibit enrollment discrimination on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. They also require state Medicaid programs and MCOs to develop methods of ensuring that all beneficiaries are able to receive health care services in a culturally competent manner, regardless of factors such as gender, sexual orientation, or gender identity.

Medicaid application and enrollment procedures

In addition to reforms such as Medicaid expansion and the nondiscrimination protections of Section 1557, the ACA also made a number of changes to the application and enrollment process for Medicaid. In particular, the ACA required states to eliminate application barriers that are unduly burdensome, such as asset tests. Under the "no wrong door" principle, Medicaid application and enrollment in all states is also now tied to health insurance marketplace application and enrollment. All states must either use the single, streamlined federal application or develop an alternate version of the application, which requires approval from CMS.

The single, streamlined application does not include demographic questions about sexual orientation or gender identity, which hinders efforts to understand how many LGBT individuals are enrolling in and receiving Medicaid coverage. The gender question currently on the application—which asks "what is your gender" and offers only the answer choices "male" and "female"—is also problematic for many transgender applicants, who report being unsure of how to answer when their gender identity does not match their official identity documents.[63]

While some transgender people have been able to change their sex on record with the Social Security Administration and in other state and federal records, there are many transgender people whose Social Security files and other records are still listed under the sex they were assigned at birth and therefore do not match their current gender identity.[64] When filling out the Medicaid application, these individuals must either misrepresent themselves or risk having their application delayed because they fail identity verification.

This question also poses difficulties for transgender individuals with regard to Medicaid eligibility. Specifically, some transgender men—men who were assigned female at birth—retain the ability to become pregnant and give birth to a child. Because pregnancy affects household size and eligibility for Medicaid benefits, it is important that transgender men are not screened out of questions on the electronic application regarding pregnancy. On the electronic version of the current application, however, transgender men cannot correctly identify themselves as men without being directed into a skip pattern that causes them to bypass the pregnancy questions.

Finally, the application's current gender question frequently results in denials of coverage due to a perceived mismatch between the individual's gender and the gender traditionally associated with certain preventive screenings, hormone prescriptions, and other health care services. For instance, a transgender woman who is enrolled in Medicaid as female may encounter denials of coverage for medically necessary services such as a prostate exam. On the other hand, if she is enrolled in Medicaid as male due to old records or identity documents that have not been updated, she may encounter denials of coverage for her estrogen therapy.

Recommendations

Below are some of the steps that the U.S. Department of Health and Human Services, state governments, and state Medicaid agencies can take to ensure that Medicaid provides equitable coverage and access to care for all beneficiaries, including LGBT people.

Close the coverage gap by expanding Medicaid

All states should expand eligibility for their Medicaid programs to all individuals with incomes up to 138 percent of the federal poverty level, in order to insure that vital health care services are accessible to low-income LGBT individuals and others who cannot afford private health insurance coverage.

States should also extend Medicaid access to qualified immigrants. California, for example, has extended Medicaid coverage to undocumented young people younger than age 19 and extended CHIP to children and pregnant people without requiring the five-year waiting period. The federal government should remove the bar to Medicaid access for DACA recipients and ensure that there is no Medicaid exclusion in any implemented version of the Deferred Action for Parents of Americans program.

Clarify the application of ACA Section 1557's nondiscrimination protections to state Medicaid programs

In order to ensure that all state Medicaid programs are aware of how Section 1557 of the ACA applies to them, the U.S. Department of Health and Human Services—specifically the Centers for Medicare and Medicaid Services and the Office for Civil Rights—should release a letter to state Medicaid directors or other guidance that outlines key aspects of Section 1557's requirements. This guidance should include a clear statement of the impermissibility of transgender-specific insurance exclusions and examples of policy language and utilization management practices that violate Section 1557 by resulting in discrimination against transgender individuals. An example of discriminatory plan language, for instance, would be a blanket exclusion for gender reassignment surgery.

Remove transgender-specific exclusions from Medicaid and institute affirmative coverage protocols

The provision of the ACA Section 1557 final rule that expressly prohibits transgender-specific exclusions in Medicaid went into effect on July 18, 2016. To ensure compliance with these requirements, state Medicaid programs should immediately remove these exclusions.

Furthermore, the experience of many state Medicaid programs indicates that simply removing exclusions is insufficient, as disputes still arise regarding the scope of covered services and transgender individuals continue to face denials of medically necessary care under the improper application of "cosmetic" or "experimental" coverage exclusions. To address this issue, all state Medicaid programs should promulgate clear protocols outlining coverage for gender transition on the basis of the most up-to-date expert standards of care in the field of transgender medicine. A number of expert medical bodies, including the World Professional Association for Transgender Health, the Endocrine Society, and the American Psychological Association, maintain evidence-based standards of care that outline the range of medically necessary services that may be part of gender transition.[65]

Importantly, affirmative protocols should not incorporate any list of procedures or services that are never covered, as the science is rapidly evolving concerning the full range of health care services that may be medically necessary as part of gender transition. Moreover, there are instances in which a procedure or service that is medically necessary for gender transition may typically be considered "cosmetic" for most other indications. Medicaid transgender coverage protocols should follow the example of states such as Connecticut, which clarifies that procedures such as facial feminization surgeries, electrolysis, and chest contouring may be medically necessary and will be reviewed for coverage on a case-by-case basis.[66] These protocols should also specifically clarify the availability of services such as puberty-delay medications, hormone therapy, mental health counseling, and surgeries for transgender youth through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit.

Include sexual orientation and gender identity nondiscrimination protections in the Medicare and Medicaid conditions of participation

In June 2016, CMS released a draft regulation proposing to amend the Medicare and Medicaid conditions of participation for hospitals and critical access hospitals to explicitly require nondiscrimination on the basis of sexual orientation and gender identity. These protections will provide an important corollary to those of ACA Section 1557 and should be codified as proposed in the final regulation.

Amend the single, streamlined application to collect better data related to sexual orientation and gender identity

In order to provide accurate data on the proportion of Medicaid beneficiaries who identify as lesbian, gay, bisexual, and/or transgender, the U.S. Department of Health and Human Services should update the single, streamlined federal application to include gender identity and sexual orientation questions that reflect established best practices in the field.

Specifically, the application should use a two-part question that asks about both current gender and sex assigned at birth. The California Health Interview Survey recently tested and adopted a version of a two-step question developed by the Center of Excellence for Transgender Health at the University of California at San Francisco, which reads as follows:

What is your gender?

- *Female*
- *Male*
- *Transgender*

What is your sex assigned at birth, on your original birth certificate?

- *Female*
- *Male*

This two-step question design allows transgender individuals to be identified in two ways: either because they select the "transgender" answer option for the first part of the question, or because they select different answers for the first and second parts of the question. For instance, a transgender woman might select "female" for the first part and "male" for the second. This would correctly identify her as a woman who is transgender and who thus may need health care services that are not typically associated with women, such as a prostate exam. An individual who identifies outside the male/female gender binary might select "transgender" for the first part, thus allowing that person to be correctly identified as a non-binary individual with the preventive screening needs associated with the sex they were assigned at birth.

In addition to making it possible for transgender applicants to be correctly identified, this question design will also reduce the risk of identity verification failure, ensure that the application appropriately assesses eligibility for Medicaid benefits for all individuals who can become pregnant, and help Medicaid programs and MCOs process claims

for services even if the gender of the service conflicts with the individual's gender as listed in the claim. Specifically, these data will allow a flag to be added to the individual's Medicaid file that overrides gender edits for any services and thereby allows these claims to go through without erroneous denials.

The application should also include a voluntary demographic question about sexual orientation, such as:

Do you consider yourself to be:

- *Straight or heterosexual*
- *Gay or lesbian*
- *Bisexual*
- *Other* _____

Conclusion

Medicaid provides access to vital health care services for millions of Americans, including LGBT people and their families. Expanding Medicaid in all states to cover all low-income adults and strengthening the traditional Medicaid program are critical advocacy priorities for LGBT communities and their allies. In particular, there are a number of steps that the federal and state governments can take—such as removing transgender coverage exclusions and amending the Medicaid application to accurately count and enroll LGBT individuals—to eliminate barriers to Medicaid coverage. LGBT individuals and advocates must also be aware that Medicaid provides enforceable rights and protections under federal law, meaning that active engagement with the government and the filing of complaints about issues such as discriminatory benefit design and denials of coverage are critical components of ensuring that state Medicaid programs serve everyone who needs them.

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