Administration for Children's Services

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MEMORANDUM

To: ACS and Provider Agency Staff

From: Benita Miller

Date: January 29, 2013

Re: NMR Guidance for Trans-Related Healthcare

Pursuant to ACS Policy 2010/04, Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care, dated June 7, 2010, attached please find guidance summarizing the method by which provider agencies can request that ACS review, approve, and reimburse transgender-related healthcare that is categorically excluded from New York State's Medicaid coverage. This guidance specifically includes "gender affirming healthcare associated with Gender Dysphoria," hereafter referred to as trans-related healthcare, as one of the conditions for which the NMR Policy may be utilized. Please note that this guidance is meant to clarify the existing NMR Policy and is not meant to replace it.

All decisions regarding ACS approval and reimbursement for trans-related NMR treatment and services will be made by the Deputy Commissioner for the ACS Division under which case planning responsibility falls. The Deputy Commissioner will review all written recommendations provided by the Health Review Committee, examine requests for payment, and make the final decision to approve or deny the provider agency's request. All efforts will be made by ACS's Deputy Commissioner to complete the decision-making process expeditiously once all relevant documentation has been collected from the provider agency and reviewed.

As always, we invite any questions or concerns you may have regarding the ongoing implementation of this policy by contacting us at LGBTQ@dfa.state.ny.us . Thank you.

[1] Trans-related healthcare broadly describes the medical care transgender, transsexual, and gender non-conforming people seek in relation to their gender identity. The term may be used in specific instances to describe specific types of care. However, unless specified, we use it to encompass the supportive psychotherapy, hormonal therapies, surgical procedures, voice therapy, and electrolysis or laser hair removal that trans people seek in relation to their gender.

ACS Non-Medicaid Reimbursable Policy Guidance for Trans-Related Health Care

Pursuant to ACS Policy 2010/04, *Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care*, dated June 7, 2010, this guidance summarizes the method by which foster care agencies can request that ACS review, approve, and reimburse trans-related healthcare that is categorically excluded from New York State's Medicaid coverage. This guidance specifically includes "gender affirming healthcare associated with Gender Dysphoria," hereafter referred to as trans-related healthcare, as one of the conditions for which the Policy may be utilized[1]. The following requirements must be met before ACS will review, approve, and reimburse foster agencies:

Foster Care Agency Responsibilities

1. A foster youth requests trans-related treatment/services from the foster care agency.
2. The foster care agency, together with the youth's health provider(s), assesses whether a foster youth may need treatment/services not covered by Medicaid.
3. If the case planning agency has concerns about a recommended or requested course of treatment/services, or receives conflicting medical recommendations, the case planner should first consult with their foster care agency's designated LGBTQ Point Person, hereafter referred to as "Point Person." If further clarification is necessary, the case planner should then consult with the ACS LGBTQ Office for Policy and Practice by emailing: LGBTQ@dfa.state.ny.us.
4. If such treatment is professionally recommended by appropriately credentialed professionals, whenever feasible, the foster care agency should explore other private or public funding opportunities to pay for the treatment/services (i.e. financial support from family and friends).
5. Prior to submitting a request to ACS, the foster care agency must comply with all existing medical consent requirements as described in the ACS Procedure 102/Bulletin 99-1 (amended), *Guidelines for Providing Medical Consent for Children in Foster Care.*[2]
6. Once other funding opportunities have been exhausted, the case planning agency should submit a request for reimbursement with all appropriate documentation as outlined in item number 8 below to the ACS LGBTQ Office at LGBTQ@dfa.state.ny.us. The case planning agency should also copy their point person to this email. All documents sent regarding reimbursement must be password protected in accordance with the ACS Policy 2010/07, *Security of Confidential, Case Specific and/or Personally Identifiable Information*, dated December 6, 2010.
7. In situations where a child or youth is placed with an agency other than their case planning agency, the case planning agency remains responsible for facilitating the submission of a request and for collaborating with the child planning agency as

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[2] Please note that this policy is currently being revised.

needed. The request shall be prepared by the child planner but must be signed by the case planner, case planner supervisor, and the Executive Director for the case planning agency.

8. In addition to documenting and updating all case activities in CONNECTIONS[3], the case planning agency must submit the following documentation to support the NMR reimbursement request:
   - ACS Non-Medicaid Reimbursable Treatment Referral Form CS 9040;
   - Memorandum signed by Foster Care Provider Executive Director/designee or the Child Protective Manager (Division of Child Protection) that documents the request for treatment/services. This memorandum must include:
     - An explanation of possible risk to the child if treatment/services are not provided based on documentation provided by qualified medical and mental health professionals.
     - How and from whom consent for treatment will be provided.
     - Whether there are any related barriers, including discussions the case planner has with the parent(s)/guardian(s) about the treatment/services and any concerns the parent(s)/guardian(s) may have raised;
   - Price quote/invoice for treatment/services;
   - Relevant medical and mental health assessment and documentation including:
     - Proposed "Gender Dysphoria" treatment/services supported by qualified medical and mental health professionals, including documentation of how treatment/services is expected to relieve substantial psychological and/or physical distress;
     - Proposed "Gender Dysphoria" treatment/services is demonstrated to be effective based on current medical and mental health standards[4];
     - Significant benefit is expected for the child/youth as documented by qualified medical and mental health professionals as a result of the treatment/services;
     - Documentation is needed from the qualified medical and mental health professionals about the risks associated with the treatment and a statement must be included demonstrating that the benefits outweigh these risks;
     - As indicated by a qualified treating mental health care provider, ongoing mental health care services must be provided in accordance with the Foster Care Quality Assurance Standards.
   - Documentation confirming legal status of the child as being placed in the care and custody or custody and guardianship of the Commissioner. If legal status changes, the case planner shall update documentation of the current legal status;

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[3] See, 05-OCFS-ADM-02, *Case Management Changes Associated with CONNECTIONS Build 18 (February, 2005)*, dated April 19, 2005, and 08-OCFS-ADM-01, *Changes associated with CONNECTIONS Build 18.9: Health, Education and Permanency Hearing Report Modules*, dated February 18, 2008.

[4] In accordance with *The Standards of Care (SOC), Version 7*, which represents significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender non-conforming people beyond hormone therapy and surgery (Coleman, 2009a, 2009b, 2009c, 2009d), found at: http://www.wpath.org/publications_standards.cfm.

- If there is a court order for treatment/services (the order must be attached and deadlines for compliance must be noted).

9. After ACS Administrative review, approval of treatment/services, and compliance with the medical consent requirements noted above, the foster care agency can then proceed with scheduling appropriate treatment/services. Note reimbursement will not occur retroactively without preapproval. ACS may consider reimbursement of reasonable fees related to initial consultation services not otherwise reimbursed on a case-by-case basis supplemented with appropriate documentation.

ACS Responsibilities

1. Upon receiving a foster care agency's request for reimbursement with all appropriate documentation submitted and password protected as outlined above, the ACS LGBTQ Office for Policy and Practice will alert ACS's Division of Family Permanency Services' Office of Shared Response (OSR).
2. OSR will then contact the case planner within 14 days of receipt of request to confirm receipt and provide a status update including if additional documentation is necessary.
3. OSR will also forward the information to the appropriate FCLS Supervising Attorney, who will forward the information to the child/youth's attorney to make them aware of the request made on behalf of their client.
4. Once OSR obtains all necessary documentation, the ACS Health Review Committee will be consulted and will review the case along with all supporting and non-supporting documentation, and provide written recommendations to the ACS Deputy Commissioner.
5. The following are the basic standards by which ACS's Deputy Commissioner will conduct a review to evaluate and, in his or her discretion, determine whether to approve the requests for treatment/services and for reimbursement. Each of these standards must be met in order for a request to be considered for approval and reimbursement:
   - ACS Non-Medicaid Reimbursable Treatment Referral Form CS 9040;
   - Memorandum signed by Foster Care Provider Executive Director/designee or the Child Protective Manager (Division of Child Protection) that documents the request for treatment/services. This memorandum must include:
     - An explanation of possible risk to the child if treatment/services are not provided based on documentation provided by qualified medical and mental health professionals.
     - How and from whom consent for treatment will be provided.
     - Whether there are any related barriers, including discussions the case planner has with the parent(s)/guardian(s) about the treatment/services and any concerns the parent(s)/guardian(s) may have raised;
   - Price quote/invoice for treatment/services;
   - Relevant medical and mental health assessment and documentation including:
     - Proposed "Gender Dysphoria" treatment/services supported by qualified medical and mental health professionals, including documentation of how treatment/services is expected to relieve substantial psychological and/or physical distress;

- Proposed "Gender Dysphoria" treatment/services is demonstrated to be effective based on current medical and mental health standards[5];
- Significant benefit is expected for the child/youth as documented by qualified medical and mental health professionals as a result of the treatment/services;
- Documentation is needed from the qualified medical and mental health professionals about the risks associated with the treatment and a statement must be included demonstrating that the benefits outweigh these risks;
- As indicated by a qualified treating mental health care provider, ongoing mental health care services must be provided in accordance with the Foster Care Quality Assurance Standards.

- Documentation confirming legal status of the child as being placed in the care and custody or custody and guardianship of the Commissioner. If legal status changes, the case planner shall update documentation of the current legal status;
- If there is a court order for treatment/services (the order must be attached and deadlines for compliance must be noted).

* **Special Note.** Since New York State's Medicaid program categorically excludes trans-related healthcare, documentation is not required to demonstrate that there is no appropriate, alternative treatment option covered by Medicaid

Decisions regarding Children's Services' support for trans-related, non-Medicaid reimbursable treatment/services will be made by the Deputy Commissioner for the Children's Services division under which case planning responsibility falls, either the Division of Family Permanency or the Division of Child Protection. The Deputy Commissioner will review written recommendations provided by the Health Review Committee, examine requests for payment, and make the final decision to approve or deny the request. All efforts will be made by ACS's Deputy Commissioner to complete the decision-making process expeditiously once all relevant documentation has been collected and reviewed.

Once ACS's Deputy Commissioner makes a decision about a request for treatment/services and reimbursement the Deputy Commissioner or her/his designee will provide written notification of the decision, including any instructions with respect to obtaining necessary medical consent or court order, to the foster care agency, OSR and the LGBTQ Office for Policy and Practice. OSR will notify the FCLS Supervising Attorney of the relevant Borough who will forward this information to the assigned FCLS attorney. The assigned FCLS attorney will provide an update to the child/youth's attorney.

[5] In accordance with *The Standards of Care (SOC), Version 7*, which represents significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender non-conforming people beyond hormone therapy and surgery (Coleman, 2009a, 2009b, 2009c, 2009d), found at: http://www.wpath.org/publications_standards.cfm.