An Advocate's Guide to Access Gender-Affirming Care in California

March 2025

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PREFACE

On behalf of the Health Consumer Alliance's LGBTQIA+ Working Group, it is a great honor to present *An Advocate's Guide to Access Gender-Affirming Care in California*.

LGBTQIA+ communities disproportionately face health inequities as a result of historic and systemic discrimination. The rates of these inequities are often higher among youth and older adults, communities of color, and transgender, gender-diverse, and intersex (TGI) communities. Because of the lack of local health data on the LGBTQIA+ community, state and local governments have failed to adequately address the systemic barriers to accessing competent health care for the LGBTQIA+ community. As a consequence, the TGI community continues to experience the greatest health disparities and too frequently resort to suicide rather than suffer disenfranchisement.

This Guide is intended to be a resource for health care advocates, non-legal community advocates, legal aid attorneys, and other healthcare stakeholders in California. The objective of this Guide is to share our successful advocacy strategies so that they may be replicated by other advocates. It is designed as a step-by-step template that is easy to adopt into your casework, regardless of your experience with serving the TGI community. The purpose of this Guide is to empower advocates with the knowledge and tools necessary to overcome the systemic and historic barriers to accessing competent health care for the TGI community. By sharing our knowledge and experiences, we hope to inspire community advocates to act as agents of change for their local community.

The current version of this Guide is intended to assist individuals enrolled in Medi-Cal experiencing barriers to accessing gender-affirming care. We designed this Guide with the intent to add chapters in the future to assist individuals with other types of health insurance coverage. Although the current scope of this Guide focuses on Medi-Cal, it may be beneficial for other individuals, such as non-legal advocates learning more about health insurance coverage or legal professionals learning how to better serve the TGI community.

Sincerely,

Antonio Page-Kahn (he/him)
Project Lead
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CHAPTER 1: Introduction

CHAPTER 1 – OUTLINE

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A. WE ARE THE HEALTH CONSUMER ALLIANCE 1.3

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CHAPTER 1: INTRODUCTION

A. We are the Health Consumer Alliance

The Health Consumer Alliance (HCA) is a statewide network operated by ten community-based legal aid organizations and three support centers. The HCA offers free legal assistance online, by telephone, and in-person. Each organization serves specific regions of the state. There are no income requirements to qualify for the HCA's services. The HCA helps people with issues accessing their health care, including, but not limited to: barriers to getting or maintaining health coverage, barriers to accessing health care services and benefits, billing and medical debt issues, and more. We also provide statewide policy advocacy to resolve systemic health care issues impacting Californians.

The HCA's community-based legal aid organizations are supported by the National Health Law Program[1] (NHeLP), Western Center on Law and Poverty[2] (WCLP), and Justice in Aging[3] (JIA).

The HCA's community-based legal aid organizations are:

- Bay Area Legal Aid[4]
- California Rural Legal Assistance[5]
- Central California Legal Services[6]
- Community Legal Aid of SoCal[7]
- Greater Bakersfield Legal Assistance[8]
- Inland Counties Legal Services[9]
- Legal Aid Society of San Diego[10]
- Legal Aid Society of San Mateo County[11]
- Legal Services of Northern California[12]
- Neighborhood Legal Services of Los Angeles County[13]

B. Purpose of & Goal for this Guide

Despite legal protections and recognitions, LGBTQIA+ California residents face disproportionately high rates of poverty, suicide, homelessness, isolation, substance use, violence, and barriers to health care. The rates of these inequities are often higher among youth and older adults, communities of color, and transgender, gender-diverse, and intersex (TGI) communities.

LGBTQIA+ communities disproportionately face health inequities as a result of historic and systemic discrimination. Because of the lack of local health data on the LGBTQIA+ community, state and local governments have failed to adequately address the systemic barriers to accessing competent health care for the LGBTQIA+ community. As a consequence, the TGI community continues to experience the greatest health disparities and too frequently resort to suicide rather than suffer disenfranchisement. In March 2020, a global pandemic hit society highlighting the disparities and the need for us to redesign our services to better address the disparities.
This Guide is intended to be a resource for health care advocates, non-legal community advocates, legal aid attorneys, and other healthcare stakeholders in California. The purpose of this Guide is to share our successful advocacy strategies so that they may be replicated by other advocates. It is designed as a step-by-step template that is easy to adopt into your casework, regardless of your experience with serving the TGI community. We hope this guide encourages more advocates to work on these cases. The purpose of this Guide is to empower advocates with the knowledge and tools necessary to overcome the systemic and historic barriers to accessing competent health care for the TGI community. By sharing our knowledge and experiences, we hope to inspire community advocates to act as agents of change for their local community.

The information provided in this Guide is not to be construed as legal advice and can never replace individualized counsel from a licensed attorney with experience in this area. Further, note that receipt of and/or viewing of this document in no way establishes an attorney-client relationship with the authors of the Guide, or their organizations.

C. Overview of this Guide

The current version of this Guide is intended to assist individuals enrolled in Medi-Cal experiencing barriers to accessing gender-affirming care. We designed this Guide with the intent to add chapters in the future to assist individuals with other types of health insurance coverage. Although the current scope of this Guide focuses on Medi-Cal, it may be beneficial for other individuals, such as non-legal advocates learning more about health insurance coverage or legal professionals learning how to better serve the TGI community.

Given the evolving landscape of the law and guidance relating to access to gender-affirming care and civil rights protections for the LGBTQIA+ population, the authors of this Guide will strive to update relevant sections of this Guide as possible. However, please seek individualized legal advice from a licensed attorney with expertise in this area of law.

Chapter 2 provides a list of terminology and documents that are important or hold significant meaning, and are used throughout this Guide.

Chapter 3 reviews common types of health insurance coverage and the laws that apply to each of them. You may use Chapter 3 to help you identify the type of health insurance coverage you have.

Chapter 4 discusses common barriers to gender-affirming care for individuals enrolled in a Medi-Cal managed care plan and strategies we use in our daily practice to overcome the barriers for our clients. Use Chapter 4 to help you identify the specific barriers in your case. Once you identify the specific barriers, use Chapter 5 to identify the appropriate procedural process for you to address the barriers. Although Chapter 4 uses the laws and regulations specific to Medi-Cal managed care plans, Chapter 4 may also be helpful to get a general understanding of the ways barriers to gender-affirming care manifest during the health insurance coverage process. Astute legal professionals or advocates may find Chapter 4 useful when developing legal strategies for analogous statutes or regulations.

Chapters 6 and 7 are designed to help individuals or organizations that are new to serving the TGI community or that want to strengthen their relationship with the TGI community. Chapter 6 provides some steps to consider when initiating engagement of the TGI community in your area. Chapter 7 provides an in-depth discussion of cultural competency, which goes hand-in-hand with Chapter 6 on outreach and engagement. Specifically intended for legal professionals, Chapter 7 also provides a discussion of inherent risks of trauma to TGI clients during an intake process, conflict of interest checks, and with case management systems.

ENDNOTES

[1] https://healthlaw.org/

[2] https://wclp.org/

[3] https://justiceinaging.org/

[4] https://baylegal.org/

[5] https://crla.org/

[6] https://centralcallegal.org/

[7] https://www.communitylegalsocal.org/

[8] https://gbla.org/

[9] https://www.inlandlegal.org/

[10] https://www.lassd.org/

[11] https://www.legalaidsmc.org/

[12] https://lsnc.net/

[13] https://nlsla.org/

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CHAPTER 2: Important Terminology & Documents

CHAPTER 2: IMPORTANT TERMINOLOGY & DOCUMENTS

1. **Beneficiary**: An individual who receives benefits. Someone who is a member of a health plan and receives health plan benefits from that plan is a health plan beneficiary. For purposes of this toolkit, beneficiary and patient may be used interchangeably at times.[1]
2. **Benefits**: The health services, treatment, or other types of care that your health insurance plan covers and pays for.
3. **Blanket coverage exclusion**: Blanket coverage exclusion refers to an insurance policy that excludes coverage for a specific benefit or service regardless of medical necessity. This may also be referred to as blanket denial, targeted exclusion, or categorical exclusion.[2]
4. **California Department of Health Care Services (DHCS)**: DHCS is California's Single State Medicaid Agency, and is the state entity who administers the Medi-Cal program.
5. **California Department of Insurance (CDI)**: CDI oversees insurance regulations and insurance markets, including most PPOs in the state. CDI regulates many different types of insurance, not just health insurance.
6. **California Department of Managed Health Care (DMHC)**: DMHC is a licensing and regulatory body that oversees most of California's HMOs and EPOs, and some PPOs, including most Medi-Cal managed care plans.
7. **California Department of Social Services (CDSS)**: CDSS oversees and administers public benefits and social safety net programs in the state. While CDSS does not administer nor oversee the Medi-Cal program, they are tasked with oversight of the State Hearings Division which handles Medi-Cal related State Fair Hearings.
8. **Cisgender**: Describes a person whose gender identity aligns with the sex they were assigned at birth, based on societal expectations. The term cisgender is derived from the Latin preposition *cis*, which means "on this side of," and is the antonym of *trans*, which means "across" or "beyond."[3]
9. **Deadname**: Typically the name used before a person's current name and may also be known as their "birth name" or "given name."
10. **Deadnaming**: Deadnaming is using the incorrect name to refer to a transgender, gender-diverse, or intersex person.[4] Deadnaming may occur intentionally or unintentionally.[5] The incorrect name, referred to as their deadname, is typically the name used before their current name and may also be known as their "birth name," "given name," or "name assigned at birth."[6]
11. **Employee Retirement Income Security Act (ERISA)**: The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established health plans for private employers to provide protection for individuals in these plans.[7]

12. **Essential health benefits (EHB):** Ten service categories that the Patient Protection and Affordable Care Act requires to be included in most individual and small-group health coverage policies.[8]

13. **Evidence of Coverage (EOC)**: An Evidence of Coverage is a comprehensive legal document that outlines all aspects of your health plan, including benefits, costs, and limitations, essentially serving as the full contract between you and the insurance provider or health plan.[9]

14. **Exclusive Provider Organization (EPO)**: An EPO is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals who are part of the EPO's network (except in an emergency). In other words, you cannot go "outside" the network for medical care. Most EPOs in California are regulated by DMHC.[10]

15. **Explanation of Benefits (EOB)**: An explanation of benefits is sent to a health insurance or plan member each time the insurer or plan is billed for a service(s) provided. It is the health insurer or plan's written explanation for a claim, listing the provider, the service, and the date of the service(s). Essentially, it is a statement of how the health insurer or plan calculated the individual's benefits. If the claim is denied, it will also provide a reason for the denial.[11]

16. **Fee-for-service**: A method of receiving and paying for care where someone can get services from any provider that accepts an individual's health coverage program. The health coverage program pays the provider a set rate for the services rendered.[12]

17. **Fully-Insured plan**: An employer can purchase coverage from an insurer to cover their employees for a set premium. In this "fully-insured" arrangement, the insurer bears the financial risk if that group of employees ends up costing more than expected; these plans are regulated by the state in which they are sold.[13]

18. **Gatekeeping**: Gatekeeping refers to the practice of a medical provider or health insurance plan placing unnecessary barriers on GAC. Examples of gatekeeping include: requiring a letter from a mental health professional or using "medical readiness" as an eligibility requirement to accessing GAC and/or GAS. Although plans can legally require these prerequisites in certain situations, they are not required to. This became the standard practice under WPATH's Standards of Care with the intent to avoid "transition regret." However, the concern of transition regret is much higher than the rate of transition regret and there is no evidence that gatekeeping prevents regret. Advocacy to shift into an informed consent model of care for adults continues.[14]

19. **Gender-Affirming Care (GAC)**: Gender-affirming care is patient-centered health care that may include a range of interventions that help people align their gender identity with their physical traits. This can look different for every person. Essentially, GAC is determined on a case-by-case basis.[15]

20. **Gender-Affirming Surgery (GAS)**: "These are surgeries to modify a person's body to be more aligned with that person's gender identity. Types of GAS include chest and genital surgeries, facial feminization, body sculpting, and hair removal."[16]

21. **Gender dysphoria:** A condition where a person experiences significant distress and discomfort due to a mismatch between their body's physical presentation and their gender identity.[17]

22. **Gender Identity**: A person's gender identity is their inner sense of their gender. A person's gender identity may or may not align with the gender or sex they were assigned at birth. Examples of identities may be woman, man, non-binary, and/or having no gender. This is how a person sees themselves and how they identify their gender.[18]

23. **Gender incongruence:** A persistent and significant difference between a person's experienced gender (the gender with which they identify) and the sex assigned to them at birth.[19]

24. **Health insurer**: An entity that provides and/or sells health insurance.

25. **Health Maintenance Organization (HMO)**: An HMO is a collection of hospitals, doctors, and other health services all organized under one network. You usually pay only small co-pays when using services, no matter how many or what kind of services you use. In return, you must usually use the hospital(s), doctors, and other health providers in the HMO's network. In an HMO, you select a primary care physician. If you need a specialist, the primary care physician must first refer you to that specialist before you can see them. HMOs in California are regulated by DMHC. Most Medi-Cal managed care plans are HMOs.[20]

26. **Informed Consent Model of Care**: An approach that gives people comprehensive information about GAC options and their risks and benefits, allowing them to make an informed decision about their care without requiring all patients to undergo extensive mental health evaluations before receiving care. The approach prioritizes patient autonomy and agency in the transition process.[21]

27. **In-Network**: An in-network provider or facility has a contract with a person's health insurer or plan.[22]

28. **Knox-Keene Act (KKA)**: A set of laws passed by the California state legislature providing DMHC with the authority to regulate health care service plans. Among these regulations are consumer protection laws, such as grievance and appeal processes.

29. **Letter of Agreement (LOA)**: A letter of agreement, sometimes referred to as a "Single Case Agreement," is a limited contract between a health insurer or plan and an out-of-network provider to provide a health care service to the health insurer or plan's member.[23]

30. **Misgendering**: Refers to the act of incorrectly assigning a gender identity to another person. This can happen explicitly or indirectly, and intentionally or unintentionally, through gendered language and deadnaming. Referring to a person as a "boy" or "man" or using "he/him" pronouns when that person self-identifies as a woman or girl is an example of explicit misgendering. Another example includes a refusal to use the pronouns a person uses for themselves, such as refusing to use gender neutral pronouns. It is possible to directly or indirectly misgender people through gendered language such as mother/father, brother/sister, or Mr./Mrs./Ms. or in settings where colloquial language – such as referring to a group of people as "guys" or "ladies" – is used.

31. **Network**: A network is a group of health care providers and facilities that contract with a health insurer or plan to provide covered services for their members.[24]

32. **Notice of Action (NOA)**: A Notice of Action is "the official [written] notice the county must send to a beneficiary anytime the County is taking any action to start, stop, or change the beneficiary's Medi-Cal eligibility."[25]

33. **Notices**: A written letter that notifies health consumers or enrollees of any actions or determinations made on their case or their coverage. Notices must include information about the action taken, the reason, and due process rights, such as grievance/appeal acknowledgment, grievance/appeal resolution letter, adverse benefit determination.

34. **Out-of-Network (OON)**: An out-of-network provider or facility is a provider or facility that is not contracted with a person's health insurer or plan network.[26]

35. **Preferred Provider Organization (PPO)**: In a PPO, insurance companies or plans contract with doctors, hospitals, and other providers to form a "preferred network." Depending upon your PPO, you can usually get health care services outside the PPO's preferred network but you will have to pay more. Unlike an HMO, you will usually have to pay a deductible and coinsurance for your care. However, you can usually see a specialist without first being referred by your PCP, and you have much more freedom in choosing a doctor or hospital. PPOs in California are regulated by CDI, except Blue Shield and Anthem Blue Cross PPOs, which are regulated by DMHC.[27]

36. **Primary care provider (PCP)**: A primary care provider is a healthcare professional who practices general medicine (this can include Internal Medicine doctors, Pediatricians, General Practitioners, Nurse Practitioners, and other providers). This is the provider a person goes to for routine checkups and care. They may refer their patients to other providers to receive specialty and ancillary care.[28]

37. **Prior Authorization (PA)**: Prior authorization is an advanced approval required by a health insurer or plan before it will pay for a requested health care service, treatment, or prescription drug. Prior authorization is also referred to as "pre-approval," "prior approval," "preauthorization," or "precertification."[29]

38. **Pronouns**: the words that take the place of a person's name to refer to that person. Examples include: they/them, she/her, he/him, ze/zirs, and more.

39. **Provider directory:** A list of health care providers that are in-network with an HMO or PPO, or a list of "preferred" providers for a PPO.

40. **Self-Funded / Self-Insured plan**: A self-insured employer uses a large pool of their money to pay for the health care of its employees. The employer most often contracts with insurance companies or third party administrators to manage the health benefits. Most self-insured plans are under the jurisdiction of the Department of Labor and some self-insured plans may be state-based.[30]

41. **Summary of Benefits**: A summary of benefits is a document that provides an overview of a health plan's benefits and coverage at a high level. It provides coverage examples and outlines covered benefits and fees associated with them.[31]

42. **TGI**: TGI stands for transgender, gender-diverse, and intersex. The term is an abbreviation intended to serve as an umbrella term for people who feel that the gender assigned to them at birth does not match their chosen gender or gender identity.[32]

43. **Utilization Management Controls**: Refers to the use of various techniques and strategies, such as prior authorization requirements, which allow health insurance plans to ensure that all benefits or services are medically appropriate for the beneficiary based upon evidence-based criteria or guidelines before those benefits or services are provided.

44. **World Professional Association for Transgender Health (WPATH)**: A 501(c)(3) non-profit, interdisciplinary professional and educational organization devoted to transgender health.[33]

45. **WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC):** Guidelines published by WPATH for practitioners who provide GAC that represent a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria and help professionals understand the parameters within which they may offer assistance to those with these conditions.[34]

Endnotes

[1] Medicare Rights Ctr., *Medicare Interactive, Beneficiary,* *https://www.medicareinteractive.org/glossary/beneficiary#:~:text=A%20beneficiary%20is%20a%20person,are%20a%20health%20plan%20beneficiary.* (last visited Feb. 8, 2025); 17 C.C.R. § 6814

[2] Advocates for Trans Equality, *Trans Health Project: Health Insurance – Understanding a Denial* (July 14, 2021), https://transhealthproject.org/trans-health-insurance-tutorial/understanding-denials/#targeted-exclusion-in-plan-document (last visited Feb. 8, 2025).

[3] Nat'l LGBTQIA+ Health Education Ctr., *Glossary of Terms*, https://www.lgbtqiahealtheducation.org/glossary/en/ (last visited Feb. 8, 2025)[hereinafter Nat'l LGBTQIA+ HEC *Glossary of Terms*].

[4] Nat'l LGBTQIA+ HEC *Glossary of Terms*; Healthline, *What is Deadnaming?*, https://www.healthline.com/health/transgender/deadnaming (last visited Feb. 8, 2025)[hereinafter *What is Deadnaming?*].

[5] Nat'l LGBTQIA+ HEC *Glossary of Terms*; *What is Deadnaming?*.

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[7] U.S. Dep't of Labor, *Employee Retirement Security Act (ERISA)*, https://www.dol.gov/general/topic/retirement/erisa (last visited Feb. 8 2025).

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[9] Cal. Dep't of Ins., *Understanding Your Policy*, https://www.insurance.ca.gov/01-consumers/110-health/30-have/understand-policy.cfm#:~:text=Every%20policy%20has%20a%20written,information%20about%20using%20your%20coverage. (last visited Feb. 8, 2025).

[10] Cal. Dep't of Ins., *Common Health Insurance Terms*, https://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm (last visited Feb. 8, 2025)[hereinafter CDI *Common Health Insurance Terms*].

[11] CDI *Common Health Insurance Terms.*

[12] Jen Flory, Elizabeth Landsberg, Shirley Sanematsu, & Mona Tawatao, Western Ctr. on Law & Poverty, *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Medi-Cal Advocates* at 338 (March 2016), https://wclp.org/wp-content/uploads/2019/07/Western_Center_2016_Health_Care_Eligibility_Guide_Full_rev.1.pdf [hereinafter WCLP *A Guide for Medi-Cal Advocates*].

[13] Kaye Pestaina, Rayna Wallace, & Michelle Long, *The Regulation of Private Health Insurance*, KFF (updated July 29, 2024), https://www.kff.org/health-policy-101-the-regulation-of-private-health-insurance/ [hereinafter *The Regulation of Private Health Insurance*].

[14] Verbeek, Wesley et al. “"Mental Readiness" and Gatekeeping in Trans Healthcare.” *Canadian journal of psychiatry. Revue canadienne de psychiatrie* vol. 67,11 (2022) at 828-830, https://pmc.ncbi.nlm.nih.gov/articles/PMC9561692/ (last visited Feb. 8, 2025).

[15] Nat’l LGBTQIA+ HEC *Glossary of Terms*.

[16] Nat’l LGBTQIA+ HEC *Glossary of Terms*.

[17] Am. Psychiatry Ass’n, *What is Gender Dysphoria?*, https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria (last visited Feb. 8, 2025); Nat’l LGBTQIA+ HEC *Glossary of Terms*.

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March 2025

CHAPTER 3: Types of Coverage

Chapter 3 – Outline

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CHAPTER 3: TYPES OF COVERAGE

Accessing health care can be a disorienting maze leaving people exhausted and no closer to receiving the care they need. For most people, realized access to health care is only achievable with health insurance. The type of health insurance coverage a person has dictates the manner in which they can access health care services, with different rules for each type of coverage. The seemingly endless options for coverage types create a dizzying variation in rules that often leaves doctors and patients confused on which course of treatment is both medically appropriate and financially feasible.

The legal framework that regulates health insurance plans is extremely complicated. Generally, your health plan may be regulated by both federal law and state laws. The specific laws that apply to your health insurance coverage are determined by the way you obtain the coverage and what type of coverage you have.

This Chapter provides an overview of different types of health insurance coverage, the applicable laws, and the government agencies responsible for regulating them. This Chapter will help you identify the type of health insurance coverage you have.

A. Federally Regulated

a. Medicare

Medicare is a federal health insurance program for people ages 65 and older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.[1] Medicare consists of four programs: Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (Part C), and Medicare Prescription Drug Benefit (Part D).[2] Original Medicare includes both Parts A and B.[3] Original Medicare is also known as Medicare Fee-for-Service.[4] Your Medicare card will indicate if you have Part A, Part B, or both.[5]

Some people may access Medicare benefits through a health plan. In some cases, people may also buy supplemental coverage to help pay out-of-pocket costs in Original Medicare. These are commonly referred to as Medicare Supplemental Plans or Medigap Plans. In other cases, people enroll in an "all in one" health plan alternative to Original Medicare, known as a Medicare Advantage plan. Medicare Advantage plans include coverage of Part A, Part B, and usually Part D covered services. Medicare Advantage plans may offer extra benefits that Original Medicare does not cover — like vision, hearing, dental. If you join a Medicare Advantage plan or other Medicare plan, you will receive a member card from the plan.[6]

Medicare is a defined benefit program, and only covers certain devices, supplies, drugs, and biologicals that have been determined to fall within a specific benefit category, are not excluded from Medicare coverage by law, and, in most cases, are reasonable and necessary as described in section 1862(a)(1)(A)[7] of the Social Security Act.[8] Both Original Medicare and Medicare Advantage meet the Patient Protection and Affordable Care Act's (ACA) requirements for minimum essential coverage.[9]

For more detailed information about coverage and options for people with Medicare, see these resources:

- JusticeinAging.org
- Medicare.gov

b. VA Healthcare

Veterans Affairs (VA) health care covers veterans who have met basic service and discharge requirements. VA health care is implemented by the Veterans Health Administration (VHA). Individuals who have served in active military, naval, or air service and separated under any condition other than dishonorable may qualify for VA health care benefits.[10]

VA medical benefits packages are unique and depend on the veteran's priority group, advice of the VA primary care provider, and the medical standards for treating any conditions that the veteran may have.[11] Priority groups are assigned on the basis of the veteran's military service history, disability rating, income level, whether the veteran qualifies for Medi-Cal, and other benefits the veteran may be receiving, such as VA pension benefits.[12] All VA health care programs meet the ACA's requirements for minimum essential coverage.[13] Veterans and service members may apply for VA health care at: https://www.va.gov/health-care/apply-for-health-care-form-10-10ez/introduction.

To apply, a person must provide social security numbers for themself, their spouse, and any dependents. The person must also provide insurance card information for all health insurance coverage they have, including coverage through a spouse or significant other, Medicare, private insurance, or employer insurance.[14]

This Guide does not provide detailed information about coverage and options for people with VA Health Care. To find more information about VA Health Care, see: https://www.va.gov/health-care/

c. TRICARE

TRICARE is the health care program for uniformed service members (called "sponsors" for the purposes of TRICARE) and their eligible family members.[15] TRICARE is managed by the Defense Health Agency (DHA).[16] TRICARE delivers health care to beneficiaries through an integrated network of military hospitals, clinics, and civilian providers.[17]

TRICARE covers two types of beneficiaries: (1) sponsors who are active duty, retired, or Guard/Reserve members, and (2) family members such as spouses and children who are registered in the Defense Enrollment Eligibility Reporting System (DEERS).[18] Eligibility is determined by the sponsor's Uniformed Service.[19] Eligibility and location determine which plans are available to service members. TRICARE provides a Plan Finder tool that determines whether someone is eligible for TRICARE plans.[20] Active-duty service members must enroll in TRICARE Prime.[21] All others may enroll in TRICARE Prime or TRICARE Select.[22]

This Guide does not provide detailed information about coverage and options for people enrolled in TRICARE. To find more information about TRICARE, see: https://www.tricare.mil/

d. Employer-Sponsored Health Coverage: Self-Insured Plans

Many people have health insurance coverage as a benefit through their employer. Employers may offer health insurance plans that are either self-insured plans or fully-insured plans.[23] **Self-insured plans**, also known as **self-funded plans**, are health insurance plans in which employers act as their own insurers by paying for the medical fees of their employees out of the company's revenue.[24] **Fully-insured plans** are where employers' pay a fixed premium to a third-party health insurance carrier to pay for their employees' medical expenses.[25] For more information on fully-insured plans, see section B.d. Employer-Sponsored Health Coverage: Fully-Insured Plans below.

ADVOCACY TIP # 3.1: Practically speaking, most employers are not knowledgeable or experienced in the administrative oversight of health insurance plans. Rather than hire staff with the knowledge and expertise in the administrative process of health insurance plans, employers who offer self-insured plans as a benefit for their employees tend to pay a third-party administrator to perform the administrative oversight (usually a health insurance company). An employer paying an insurance company to complete the administrative oversight of a self-insured plan is different from an employer purchasing a pre-packaged product (fully-funded plan) from a health insurance company.

Self-insured plans are federally regulated by U.S. Department of Labor's (DOL) Employee Benefits Security Administration (EBSA)[26] under the **Employee Retirement Income Security Act (ERISA)**.[27] Under ERISA, self-insured plans must have an appeal procedure that meets specific requirements.[28] To determine the appeal process of a self-insured plan refer to your benefit contract.[29] ERISA does not govern health plans offered by religious institutions, a government entity, Medicaid/Medi-Cal, Medicare, or private health insurance bought in the non-group market.[30] Due to preemption, most state insurance laws, including state benefit mandates, do not apply to self-insured ERISA plans, resulting in fewer regulatory requirements on ERISA health plans.[31] **California's Department of Insurance (CDI)** also warns that "[s]elf-insured plans do not have to follow [state] laws on essential health benefits, complaints, and coverage."[32] However, states still retain the authority to regulate insurance carriers and **health maintenance organizations (HMOs)**.[33]

To find out which health plan you have through your employer, you should ask your employer. Specifically, it is recommended that you contact the Employee Benefits Administrator within your employer's human resources department.[34] Otherwise, employers should send employees plenty of information about the type of insurance coverage they offer, including where, when, and how to enroll. Typically, this information includes information on which type of insurance plans are available.[35]

ERISA plans must provide beneficiaries with a summary of the plan, called the summary plan description.[36] The summary plan description is an important document that describes the rights, benefits, and responsibilities of beneficiaries.[37] It must include important information regarding the plan, such as information on how the plan works, eligibility requirements, what benefits the plan provides, and how those benefits may be obtained.[38] Employers are required to automatically provide copies of these documents to plan participants upon enrollment and upon written request of a beneficiary.[39] ERISA also gives the U.S. DOL the authority to request copies of the document from plans administrators/employers on behalf of beneficiaries.[40]

ADVOCACY TIP # 3.2: Sometimes, your plan's summary plan description (sometimes referred to as Evidence of Coverage) or member ID card will specify whether the plan is self-funded or fully-insured. Example # 3.1 (below) highlights someone enrolled in an employer-sponsored self-insured plan: a sample member ID card with language indicating health plan is the third-party administrator of claims payment services only. While not conclusive, employer size can often indicate whether someone's plan is covered under ERISA: very large national companies are almost always self-funded and subject to ERISA, while small local businesses are almost always fully-insured and licensed by the state.

EXAMPLE # 3.1: A member ID card for an employer-sponsored self-insured plan.

This employee benefit plan provides benefits to you and your eligible dependents.

provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

LV1 CareFirst BlueChoice and PPO
LV2 Out of Network

590100DCLV (10/21)

Customer Service: 833-502-9927
Provider Service: 877-228-7268

24-Hour Nurse Advice Line: **800-535-9700**
Mental Health/Substance Abuse: **800-245-7013**
Pre-Auth/Case Management: **866-773-2884**
Locate out of area providers: **800-810-2583**

Providers must submit all Medical claims to

Mail Administrator
PO Box 14115 (for claims)
PO Box 14114 (for correspondence)
Lexington, KY 40512

B. State Regulated

a. Medi-Cal

Medicaid is the nation's largest public health coverage program covering nearly 73 million people across the country.[41] The Medicaid Act is part of the larger Social Security Act (SSA).[42] States are not required to participate in the Medicaid Program but when they choose to do so, they must agree to follow a set of federal laws and rules and develop a state Medicaid plan.[43]

California is one of the states that participates in the Medicaid Program and calls it **Medi-Cal**. Over 13 million people in California are enrolled in Medi-Cal.[44] Medi-Cal is available to California residents with limited incomes. There are two different ways a person on Medi-Cal may receive their benefits: (a) fee-for-service Medi-Cal, and (b) Medi-Cal managed care.[45] In addition, people who access prescription drugs as part of their treatment will likely interact with Medi-Cal's prescription drug program, called Medi-Cal Rx.

1. Fee-for-service Medi-Cal

Fee-for-service Medi-Cal is also known as "regular" or "straight" Medi-Cal.[46] In fee-for-service Medi-Cal, after the provider furnishes the covered service to the beneficiary, the provider submits a claim to the state, and the state pays a fee for that particular claim.[47] In fee-for-service Medi-Cal, a beneficiary may obtain services from any health care provider who participates in the Medi-Cal program.[48] Over the past few decades, many states including California have been transitioning away from this fee-for-service model.[49] However, there is a limited Medi-Cal fee-for-service system that continues today for populations who are not subject to managed care enrollment or select services that are not part of the managed care delivery system.[50]

People enrolled in fee-for-service Medi-Cal will have a Benefits Identification Card (BIC), that identifies them as a Medi-Cal beneficiary.

2. Medi-Cal managed care plans

In **Medi-Cal managed care**, providers contract with managed care plans which, in turn, contract with the state.[51] Providers are paid by the managed care plan and the managed care plan is paid by the state.[52] Unlike fee-for-service, however, managed care plans are not paid for individual services the plans offer.[53] Rather, they are paid on a capitated basis, meaning the state pays a set monthly amount for each Medi-Cal beneficiary enrolled in the managed care plan regardless of the actual cost of the services the managed care plan provides in a month.[54] The managed care plan bears the financial risk if the cost of providing services exceeds the capitated payment.[55] On the other hand, if enrollees use fewer services, the plan keeps the excess payment.[56] Most, but not all, Medi-Cal managed care plans are licensed and regulated by **California's Department of Managed Health Care (DMHC)** and are subject to a set of consumer protection laws called the **California Knox-Keene Act (KKA)**.[57] Most County Organized Health System (COHS) plans, Mental Health Plans, and Medi-Cal Rx are exempt

from DMHC licensure and may not be subject to the KKA.[58] The Medi-Cal managed plan available to you is dependent on the county in which you reside. People enrolled in a Medi-Cal managed care plan will have a BIC as well as a card from their managed care plan (e.g., Partnership Health Plan, Kaiser, or Santa Clara Family Health Plan).

For a list of available Medi-Cal managed care plans, see: https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx.

3. Medi-Cal Rx

Coverage for prescription drugs and pharmacy services under Medi-Cal is administered by **California's Department of Health Care Services (DHCS)** through a separate fee-for-service system called **Medi-Cal Rx**. Medi-Cal beneficiaries obtain their prescription from their fee-for-service or managed care provider, and then the prescriptions are reviewed by Medi-Cal Rx and, if approved, the prescription will be filled at a Medi-Cal participating pharmacy.[59]

b. Medicare-Medicaid Plans (Medi-Medi Plans)

Medicare-Medicaid Plans (Medi-Medi Plans) are a type of Medicare-approved health plan that may lower costs for some people by coordinating Medicare and Medicaid benefits to make it easier for individuals to get services.[60] In California, Medi-Medi Plans are available to people who have both Medicare and Medi-Cal.[61] The Medi-Medi Plan combines Medicare and Medi-Cal benefits into one plan that coordinates the services for both programs. Medi-Medi Plans are available only to dual eligible beneficiaries.[62] In 2025, Medi-Medi Plans are offered only in Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, and Tulare Counties.[63] Medi-Medi Plans will be available to eligible members in all other California Counties by 2026.[64]

You can join a Medi-Medi Plan if you have both Medicare Part A and B and Medi-Cal, are 21 years or older, and live in one of the above counties where Medi-Medi Plans are offered.[65] If you are already enrolled in a Medi-Cal plan, you may call the plan directly to ask about the Medi-Medi Plan option.[66] You may also call Medicare at (800) MEDICARE or call Health Care Options at (844) 580-7272 (TTY (800) 430-7077).[67]

This Guide does not provide detailed information about coverage and options for people enrolled in Medi-Medi plans. To find more information about Medi-Medi plans, see: https://www.dhcs.ca.gov/services/Pages/Medi-Medi-Outreach.aspx

c. Covered California

Covered California is California's state-based marketplace established under the Patient Protection and Affordable Care Act (ACA) that provides private health insurance for individuals and families.[68] Any California resident can get health insurance through Covered California.[69] Many residents can receive financial assistance to help with the cost of purchasing coverage

through Covered California.[70] Covered California also provides some private employer-based insurance through the Small Business Health Options Program (SHOP).[71] Covered California plans are regulated by CDI and DMHC.[72] Health marketplaces created under the ACA, and plans sold through these marketplaces ("qualified health plans" or QHPs), must follow specific requirements under federal and state laws to ensure plans provide covered services and consumer protections.[73] For instance, plans sold through Covered California must include in their plan offerings the full list of certain covered services, also known as **essential health benefits** (EHB), that are established in the state's benchmark plan.[74]

California standardized health benefits provided in QHPs so that each QHP sold in the Covered California marketplace provides the same covered services (also known as the "standard plan design"). Specific benefits are detailed under the insurance policy, which can be found in the health plan's Evidence of Coverage and policy manual(s). You should receive this information when you enroll, but you can request it any time from the plan.

ADVOCACY TIP # 3.3: When you need to buy vegetables, you may go to the local farmers market or grocery store to buy vegetables. It is helpful to think of Covered California as the farmers market or store where you go to shop for health insurance plans.

Applicants with low or moderate incomes who are not eligible for Medi-Cal may qualify for monthly subsidies that lower premium costs for insurance plans through Covered California.[75] The subsidies may be a premium tax credit from the federal government, or cost-sharing reductions that reduce out-of-pocket expenses, or both.[76] The amount of financial help someone may receive is determined by the person's total household income, zip code, household size and number of people who need coverage, and the age of people who need coverage.[77] Covered California provides a calculator to estimate the cost of coverage.[78]

Covered California offers a wide variety of health plans organized in four levels of coverage:

Platinum plans	Cover 90% of health care costs	You pay 10%
Gold plans	Cover 80% of health care costs	You pay 20%
Silver plans	Cover 70% of health care costs	You pay 30%
Bronze plans	Cover 60% of health care costs	You pay 40%

Plans in higher value categories have higher monthly premiums but lower out-of-pocket costs. Some people also have the option of buying a minimum coverage plan, or catastrophic plan, with a low monthly premium to protect them from a worst-case scenario.[79]

Covered California plans are obligated to comply with the consumer protections under California's KKA or Insurance Code, depending on the type of plan. Both of these laws include important protections such as network adequacy, timely access to services, and language/accessibility requirements.[80] Covered California coverage of gender-affirming care is standard across all its plans: bronze, silver, gold, and platinum plans.

Covered California plans are also subject to federal and state non-discrimination laws. This includes Section 1557 of the ACA, which prohibits discrimination, including discrimination based on sex and disability.[81] California's Insurance Gender Non-Discrimination Act also expressly prohibits insurance plans from discriminating based on sex, which includes gender, gender identity, and gender expression.[82] Individuals with a plan through Covered California are entitled to dispute issues with accessing services, including gender-affirming care, through a grievance and appeal process.[83]

California residents may apply for Covered California online, with a certified enroller, or by phone. To apply online, visit https://www.coveredca.com/apply. You may find certified enrollers using https://storefronts.coveredca.com. To apply by phone, call (800) 300-1506 (TTY: (888) 889-4500).

d. Employer-Sponsored Health Coverage: Fully-Insured Plans

Fully-insured plans are where employers pay a fixed premium to a third-party health insurance carrier to pay for their employees' medical expenses.[84] Fully-insured plans are traditionally used by employers and have predictable fixed prices, which tends to increase employee retention.[85] Fully-insured plans tend to have higher costs than self-insured plans.[86] Fully-insured plans and the appeal process for fully-insured plans are regulated by the state in which they are sold.[87] Beneficiaries of fully-insured plans, which are state regulated, enjoy the additional mandated benefits that are required in each state; California requires more protections and coverage than the federal government does.

To find out which health plan you have through your employer, you should ask your employer. Specifically, it is recommended that employees contact the Employee Benefits Administrator within the employer's human resources department.[88] Otherwise, employers should send employees plenty of information about the type of insurance coverage they offer, including where, when, and how to enroll. Typically, this information includes information on which type of insurance plans are available.[89]

Fully-insured employer-sponsored plans are obligated to comply with the consumer protections under California's KKA or Insurance Code, depending on the type of plan. Both of these laws include important protections such as network adequacy, timely access to services, and language/accessibility requirements.[90]

To find more information about fully-insured employer-sponsored health plans, see: https://www.insurance.ca.gov/01-consumers/110-health/10-basics/index.cfm

e. Student Health Insurance Plans (SHIPs)

Many universities require students to carry health insurance that meets minimum levels of coverage. For example, students at the University of California are required to have medical insurance that meets minimum levels of coverage.[91] To provide students with health care coverage, the University of California operates UC SHIP, a self-funded, comprehensive health insurance program for registered undergraduate and graduate students that is underwritten and administered by the Regents of the University of California.[92] The University of California will automatically enroll all registered students into the UC SHIP plan.[93] Students may opt out if they meet certain criteria.[94] Not all universities require or offer SHIPs. For example, the California State University (CSU) strongly recommends its students have health insurance coverage but does not offer a SHIP. Rather, CSU advises its students may be eligible for either no-cost Medi-Cal coverage or a discount on health insurance purchased through Covered California.[95]

This Guide does not provide detailed information about coverage and options for people enrolled in SHIPs. To find more information about SHIPs, see:
https://www.coveredca.com/support/before-you-buy/students/

ENDNOTES

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[2] *CMS Guide for Med. Tech. Comps.*

[3] *CMS Guide for Med. Tech. Comps.*

[4] *CMS Guide for Med. Tech. Comps.*

[5] U.S. Ctr. for Medicare and Medicaid Servs., *Your Medicare Card*, https://www.medicare.gov/basics/get-started-with-medicare/using-medicare/your-medicare-card (last visited Feb. 2, 2025)[hereinafter *Your Medicare Card*].

[6] *Your Medicare Card*.

[7] Codified in 42 U.S.C. § 1395y(a)(1)(A).

[8] *CMS Guide for Med. Tech. Comps.*

[9] U.S. Ctr. for Medicare and Medicaid Servs., *Minimum Essential Coverage*, https://www.cms.gov/marketplace/health-plans-issuers/minimum-essential-coverage#:~:text=Minimum%20Essential%20Coverage%20Categories,26%2C%202014%20in%20any%20State (last visited Feb. 2, 2025)[hereinafter *Minimum Essential Coverage*].

[10] U.S. Dep't of Veteran Aff., *Eligibility for VA Health Care*, https://www.va.gov/health-care/eligibility/ (last visited Feb. 2, 2025) [hereinafter *Eligibility for VA Health Care*].

[11] U.S. Dep't of Veteran Aff., *About VA Health Benefits*, https://www.va.gov/health-care/about-va-health-benefits/ (last visited Feb. 2, 2025)[hereinafter *About VA Health Benefits*].

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https://www.va.gov/health-care/apply-for-health-care-form-10-10ez/introduction (last visited Feb. 2, 2025).

[15] U.S. Dep't of Def., TRICARE, *Eligibility*, https://tricare.mil/Plans/Eligibility (last visited Feb. 2, 2025)[hereinafter TRICARE *Eligibility*].

[16] U.S. Def. Health Agency, *My Military Health*, https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency (last visited Feb. 2, 2025).

[17] Military Health System, *TRICARE Health Plan*, https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/TRICARE-Health-Plan (last visited Feb. 2, 2025).

[18] TRICARE *Eligibility*.

[19] TRICARE *Eligibility*.

[20] U.S. Dep't of Def., TRICARE, *Find a Tricare Plan*, https://www.tricare.mil/Plans/PlanFinder (last visited Feb. 2, 2025).

[21] U.S. Dep't of Def., TRICARE, *TRICARE Prime*, https://www.tricare.mil/Plans/HealthPlans/Prime (last visited Feb. 2, 2025)[hereinafter *TRICARE Prime*].

[22] *TRICARE Prime*.

[23] Often, the terms "self-insured" and "self-funded" are used interchangeably.

[24] Society for Human Resource Management, *Self-Insured vs. Fully Insured* (Sept. 1, 2009), https://www.shrm.org/topics-tools/news/hr-magazine/self-insured-vs-fully-insured [hereinafter *Self-Insured vs. Fully Insured*].

[25] *Self-Insured vs. Fully Insured*.

[26] Cal. Dep't of Ins., *Overview: Healthcare Coverage in California*, https://www.insurance.ca.gov/01-consumers/110-health/10-basics/overview.cfm (last visited Feb. 2, 2025)[hereinafter *Overview: Healthcare Coverage in California*].

[27] Kaye Pestaina, Rayna Wallace, & Michelle Long, KFF, *The Regulation of Private Health Insurance* (updated July 29, 2024), https://www.kff.org/health-policy-101-the-regulation-of-private-health-insurance/ [hereinafter *The Regulation of Private Health Insurance*].

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[29] *Is Your Health Plan Self-Insured?*

[30] *See generally The Regulation of Private Health Insurance*; U.S. Dep't of Labor, *ERISA*, https://www.dol.gov/general/topic/health-plans/erisa (last visited Feb. 2, 2025)[hereinafter *ERISA*]; The Nat'l Academy for State Health Policy, *ERISA Preemption Primer* (March 31, 2009), https://www.nashp.org/wp-content/uploads/2009/03/ERISA_Primer.pdf (last visited Feb. 2, 2025)[hereinafter *ERISA Preemption Primer*].

[31] *The Regulation of Private Health Insurance*.

[32] *Overview: Healthcare Coverage in California*.

[33] *ERISA Preemption Primer*.

[34] *Is Your Health Plan Self-Insured?*

[35] *Is Your Health Plan Self-Insured?*,

[36] 29 C.F.R. §§ 2520.102-2, 2520.102-3, 2520.104b-2. *See also* U.S. Dep't of Labor, *Plan Information*, http://dol.gov/general/topic/health-plans/planinformation (last visited Feb. 2, 2025)[hereinafter *Plan Information*].

[37] U.S. Dep't of Labor, Emp. Benefits Security Admin., *How to Obtain Employee Benefit Documents from the Department of Labor*, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/how-to-obtain-employee-benefit-documents.pdf (last visited Feb. 2, 2025)[hereinafter *How to Obtain Employee Benefit Documents from the Dep't of Labor*].

[38] *How to Obtain Employee Benefit Documents from the Dep't of Labor*.

[39] *How to Obtain Employee Benefit Documents from the Dep't of Labor*.

[40] *How to Obtain Employee Benefit Documents from the Dep't of Labor*.

[41] Nat'l Health Law Prog., *An Advocate's Guide to Medi-Cal Services* 1.2 (2d ed. 2022), https://healthlaw.org/resource/an-advocates-guide-to-medi-cal-services/ [hereinafter NHeLP *Guide to Medi-Cal*].

[42] Medicaid provision can be found in section 1902 of the Social Security Act, codified in 42 U.S.C. § 1396 *et seq.*; *see also* NHeLP *Guide to Medi-Cal* at 1.2.

[43] NHeLP *Guide to Medi-Cal* at 1.2.

[44] NHeLP *Guide to Medi-Cal* at 1.2.

[45] NHeLP *Guide to Medi-Cal* at 1.5-1.8.

[46] NHeLP *Guide to Medi-Cal* at 1.5, 1.6.

[47] NHeLP *Guide to Medi-Cal* at 1.5, 1.6.

[48] 42 U.S.C. § 1396a(a)(25)(C); 42 C.F.R. §§ 447.15, 447.20; *see also* NHeLP *Guide to Medi-Cal* at 1.6.

[49] NHeLP *Guide to Medi-Cal* at 1.6.

[50] NHeLP *Guide to Medi-Cal* at 1.6.

[51] NHeLP *Guide to Medi-Cal* at 1.6, 1.7; *see generally* 42 C.F.R. § 438 *et seq.*.

[52] NHeLP *Guide to Medi-Cal* at 1.6, 1.7.

[53] NHeLP *Guide to Medi-Cal* at 1.6, 1.7.

[54] NHeLP *Guide to Medi-Cal* at 1.6, 1.7.

[55] NHeLP *Guide to Medi-Cal* at 1.6.

[56] NHeLP *Guide to Medi-Cal* at 1.6.

[57] NHeLP *Guide to Medi-Cal* at 1.7; *see generally* Cal. Health & Safety Code §§ 1340-1399.818.

[58] NHeLP *Guide to Medi-Cal* at 1.7; *see generally* Cal. Health & Safety Code §§ 1340-1399.818.

[59] NHeLP *Guide to Medi-Cal* at 1.6; *see also* Cal. Dep't Health Care Servs., *Medi-Cal Rx Provider Manual* § 2.1 (2022), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf [hereinafter *Medi-Cal Rx Provider Manual*]; Cal. Dep't Health Care Servs., *Medi-Cal Rx: Transitioning Medi-Cal Pharmacy Services from Managed Care to Fee-for-Service Frequently Asked Questions* 14 (V. 13.0, 2022), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/faq/Medi-Cal_Rx_Transitioning_Medi-Cal_Pharmacy_Services_from_Managed_Care_to_FFS_FAQs.pdf [hereinafter *Medi-Cal Rx FAQs*].

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[63] *Medicare Medi-Cal Plan List*.

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[67] *Joining a Medi-Medi Plan*.

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[70] *Who can get a health plan through Covered California?*

[71] 42 U.S.C. § 18031; Cal. Gov't Code §§ 100500-100521; 10 C.C.R. § 6410.

[72] Cal. Health & Safety Code §§ 1340-1345.5.

[73] 42 U.S.C. §§ 18021, 18022; Cal. Health & Safety Code §1367.005; Cal. Ins. Code §10112.27.

[74] 42 U.S.C. §§ 18021, 18022; Cal. Health & Safety Code §1367.005; Cal. Ins. Code §10112.27.

[75] Covered California, *How much does it cost to buy insurance through Covered California?*, https://www.coveredca.com/support/before-you-buy/cost-of-health-insurance/ (last visited Feb. 2, 2025).

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[79] Covered California, *Minimum Coverage Plans*, https://www.coveredca.com/support/getting-started/minimum-coverage-plans/ (last visited Feb. 2, 2025).

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[82] Cal. Health & Safety Code § 1365.5; Cal. Ins. Code § 10140; Cal. Dep't of Managed Health Care, Director's Letter No. 12-K (April 9, 2013), https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/DirectorsLettersAndOpinions/dl12k.pdf.

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[87] *Is Your Health Plan Self-Insured?*

[88] *Is Your Health Plan Self-Insured?*

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An Advocate's Guide to Access Gender-Affirming Care in California

March 2025

CHAPTER 4: How to Identify Specific Barriers & Access to Services for Medi-Cal Managed Care Beneficiaries

Chapter 4 – Outline

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CHAPTER 4: HOW TO IDENTIFY SPECIFIC BARRIERS & ACCESS SERVICES FOR MEDI-CAL MANAGED CARE BENEFICIARIES

Once you have identified the type of health insurance coverage and regulating authority, you are ready to identify the specific barriers to accessing your gender-affirming service. Identifying the specific barriers in your case is important to determine the next steps to access the service. This Chapter will review common barriers to gender-affirming care for people with Medi-Cal managed care plans and strategies we have used to overcome them.

Once you have used this Chapter to identify the specific barriers in your case, please see Chapter 5 for an in-depth discussion of the procedural process to address the barriers. In other words, this Chapter will help explain how accessing gender-affirming care *should* happen and, if it does not happen, Chapter 5 will explain what to do to make it happen.

A. Finding a Primary Care Provider & In-Network Gender-Affirming Care Providers

Generally, the first step to accessing any health care service is identifying a qualified provider to perform the service and talking with your **Primary Care Provider** (PCP). For some gender-affirming services, your Medi-Cal managed care plan may also require a letter from a mental health provider. For example, Medi-Cal managed care plans generally require a letter from a mental health provider before they will cover gender-affirming surgeries. Once you have identified a provider, and obtain a mental health letter when required, you have to get a referral to see the provider from your PCP.

a. In-Network v. Out-of-Network

In-network providers, also known as "contracted providers," refers to the health care providers who have entered into formal agreements with your health plan to provide covered services and comply with your health plan's rules. In-network providers should already be aware of your plan's policies and procedures such as the process to submit prior authorization requests and claims for services. **Out-of-network providers**, also known as "non-contracted providers," refers to health care providers who do not have a standing formal arrangement to provide services to anyone with your health plan.

ADVOCACY TIP # 4.1: If you want to avoid potentially inaccurate information in your plan's online provider directory, call your plan to request a printed copy of in-network providers who are qualified to perform your desired service. Document the fact that you requested this printed copy. If your plan fails to provide it, then your request is part of the evidence for your argument that your plan has failed to comply with state law.

There are a few ways to determine which providers are in your health plan's network. You can refer to your plan's **provider directory** available on their website or contact your health plan directly to ask for a provider. It is common that health plan directories are inaccurate or health plan representatives do not accurately identify in-network providers. Although it is wise to contact a provider's office to confirm they accept your specific health plan, the plan is ultimately responsible for finding an in-network provider (or an out-of-network provider if there is no provider in-network). If you experience any issues with identifying in-network providers, you should file a grievance with your plan. See Chapter 5 to learn more about grievances and appeals.

Your Medi-Cal managed care plan has a responsibility to be familiar with the providers in their network and the services they provide.[1] Your plan should not force you to search for your own providers, investigate whether they are in- or out-of-network, or investigate whether the provider performs the requested service. If your plan is unable to identify any qualified providers in-network to perform the service, then your plan is required to help you find an out-of-network provider.[2] If your plan does not identify in-network providers upon request, we recommend filing a grievance. See Chapter 5 to learn more about grievances and appeals.

Your plan is required to publish and maintain a provider directory with information on contracting providers who deliver health care services, including those who accept new patients.[3] The provider directory must include: name, group affiliation, street address, telephone number, website, specialty as appropriate, whether the provider is accepting new enrollees, cultural and linguistic capabilities of the provider and provider's office, and whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.[4]

Your Medi-Cal managed care plan must produce a printed copy of the provider directory within 5 days of your request for a copy.[5] Your health plan's online directory or a health plan representative listing providers aloud over the phone are not sufficient substitutes for a printed copy. A provider directory must not list or include information on a provider who is not currently under contract with the plan. When informed of an inaccuracy, your health plan must promptly investigate and, if necessary, undertake corrective action within 30 business days to ensure accuracy.[6] If your plan refuses to send you a printed copy of in-network providers or they send you an inaccurate list of providers, you can file a grievance. See Chapter 5 to learn more about grievances and appeals.

EXAMPLE # 4.1: Banx (they/them) lives in San Diego and is enrolled in a Medi-Cal managed care plan. Banx is pursuing bottom surgery. There is only one bottom surgeon in San Diego, Dr. Reyes, and they are not in-network. Banx's PCP sends a prior authorization request for a consultation for bottom surgery with Dr. Reyes. The plan denies the request because Dr. Reyes is out-of-network and the plan alleges to have qualified surgeons in-network. But, the health plan did not include any information in the denial letter about the alleged qualified in-network providers such as names and contact information. Banx should immediately file an appeal with their plan. See Chapter 5 for more information on grievances and appeals.

ADVOCACY TIP # 4.2: Although it is your Medi-Cal plan's responsibility to find in-network providers for you or find a provider out-of-network if they do not have providers in-network, it may be helpful to search for a provider that you prefer. If your plan does not have a sufficient network of providers for the care you need, it can often mean your plan is not aware of any providers. Use the opportunity to find a provider you really want to see. It saves you and your health plan time while allowing you to see the provider who would otherwise not be in the plan's network. For example, if your plan fails to send you a printed list of providers or your plan indicates that they do not have an in-network provider who can provide the service you need, have your PCP submit a prior authorization request for your preferred provider. If the prior authorization for the preferred provider is denied and your plan fails to identify a qualified in-network provider, file an appeal with your plan. If your plan upholds the denial on appeal, file a Complaint or Independent Medical Review (IMR) with the California Department of Managed Health Care (DMHC) to request approval for your preferred provider. If your health plan is unable to find a different provider during the DMHC Complaint/IMR process, then DMHC is more likely to approve your preferred provider. See Chapter 5 for more information on grievances and appeals. Even though your plan must arrange for medically necessary services out-of-network if they are unable to provide the services in-network, it does not mean you are entitled to any choice of provider out-of-network. Your plan's network inadequacy does not create a legal entitlement to approval for any out-of-network provider of your choice. You may certainly try to get an out-of-network provider of your choice authorized by your plan, especially if they do not have anyone who they refer to out-of-network already. This strategy to leverage your plan's inadequate network in order to get your desired provider may work to your advantage, but it is not a legal right.

EXAMPLE # 4.2: Chris (he/him) is enrolled in a Medi-Cal managed care plan and seeking metoidioplasty surgery. Chris calls his Medi-Cal plan to ask for a written list of in-network surgeons who perform metoidioplasty for gender-affirming purposes. The plan's representative states she cannot send Chris a written list of surgeons as requested. Rather, the representative instructs Chris to search for surgeons on his own, then call back to confirm if they are in-network. Chris does not want to search for providers on his own. Chris should file a grievance for the representative's failure to send a written list of surgeons and forcing Chris to search for providers on his own. See Chapter 5 for more information on grievances and appeals.

ADVOCACY TIP # 4.3: Finding LGBTQIA+ affirming providers who you feel comfortable with can be challenging. If your PCP is not supportive or affirming, you can change your PCP at any time by contacting your health plan. Asking others in the local community is another way to find a culturally competent and experienced PCP, but make sure they take your health plan. However, many providers are willing to learn. You are never under any obligation to educate your providers and it may be helpful to reach out to your provider to connect them with relevant resources to educate themselves. See Chapter 6 to learn about helpful resources for providers.

b. Primary Care Provider

Any time you have a health condition or need care, your PCP is the provider to go to first so they can assess whether or not they can treat you or if they need to refer you to a specialist. Your PCP is the doctor who generally must submit referrals to specialty care, including gender-affirming care. Your PCP will submit most prior authorization requests to your health plan for gender-affirming care services such as consultations for surgeries, gender-affirming hormone therapy, or hair removal services. If you do not have a PCP, call your health plan and ask for a written list of in-network PCPs who are competent in gender-affirming care and experienced with serving the transgender, gender-nonconforming, and intersex community.[7] If your plan refuses to provide the list in writing or does not have any in-network providers, file a grievance.[8]

c. Mental Health Providers

TGI people may seek mental health services for a wide variety of reasons like anyone else. For many TGI individuals, mental health services may be a component of their gender-affirming care.[9] However, a letter from a licensed mental health provider is required before Medi-Cal will cover many gender-affirming procedures that are sought under a gender dysphoria diagnosis.[10] Gender dysphoria is a mental health condition defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision* (DSM-5-TR).[11] As defined in the DSM-5-TR, **gender dysphoria** is the distress a person experiences as a result of the sex and gender they were assigned at birth, such as when a person's assigned sex and gender do not match that person's gender identity.[12]

ADVOCACY TIP # 4.4: It is important to note that while **cisgender** people also receive gender-affirming services, unlike TGI individuals, they are not required to obtain a letter from a mental health provider. The practice of requiring TGI individuals to obtain such a letter, while not requiring the same of cisgender people seeking those services, is commonly referred to as **gatekeeping**. Medi-Cal plans generally follow the WPATH Standards of Care, which establishes the services that require a letter from a mental health provider for gender-affirming services. Review a copy of your health plan's policy to check when you will need this letter. If your plan refuses to provide you a copy of the policy, file a grievance. Your Medi-Cal plan may require a support letter from a mental health provider before approving some gender-affirming services, but they cannot force you to obtain the letter or an assessment from a non-affirming provider. In fact, the mental health provider must be experienced in providing culturally competent care to transgender and gender-diverse individuals.[13] There are organizations and clinicians that offer free appointments for individuals to get a mental health support letter.

Medi-Cal considers mental health services a "core service" of treatment for gender dysphoria.[14] If you are seeking gender-affirming surgery, the determination of whether a service requested is medically necessary and/or constitutes reconstructive surgery must be made, as appropriate, by your PCP, licensed mental health professional, and/or the treating surgeon.[15] In pursuing gender-affirming services, you may seek mental health services such as gender dysphoria assessments, counseling regarding gender expression and transition options, diagnosis and treatment of co-occurring mental health conditions, and referrals to other treatments.[16]

B. QUALIFIED PROVIDER

Medi-Cal requires that prior authorization requests for gender-affirming care are made by "specialists experienced in providing culturally competent care to transgender individuals."[17] Requests should be supported by evidence demonstrating either medical necessity or the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by your PCP, a licensed mental health professional (when required), and/or surgeon. The providers should be qualified and have experience providing gender-affirming health care.[18] When analyzing requests for a gender-affirming service, your plan must consider the knowledge and expertise of providers qualified to treat gender dysphoria.[19]

As mentioned earlier in this Chapter, it is common for plans to lack familiarity of providers with expertise in gender-affirming care, both in- and out-of-network. Consequently, plans frequently refer beneficiaries to unqualified providers who are either not experienced with gender-affirming care, do not perform the requested service, or do not perform a specific technique. For example, your health plan may refer you to a surgeon who performs phalloplasty rather than metoidioplasty. If you are inappropriately referred to an unqualified provider, file a grievance with your health plan and explain the reason the provider is unqualified.

If you attend an appointment with a provider but you want a second opinion, your plan must provide or authorize an appointment with an appropriately qualified provider for a second opinion.[20] If you are requesting a second opinion about care from a specialist, the second opinion must be provided by any provider of your choice from any independent practice association or medical group within the network of the same or equivalent specialty.[21] Your plan must provide or arrange for you to have access to either an in-network or out-of-network provider for second opinions.[22]

ADVOCACY TIP # 4.5: In our experience, Medi-Cal managed care plans are not always willing to admit they do not have in-network providers who specialize in the gender-affirming care that you need. Rather than confirm they do not have an in-network provider, plans have been known to refer individuals to in-network providers who are not qualified or do not perform the gender-affirming service. If this happens to you, we recommend filing a grievance with your health plan.

C. NETWORK ADEQUACY

Your Medi-Cal managed care plan is required to contract with enough providers to ensure you have access to all your covered benefits, including gender-affirming services.[23] Federal and state laws require Medi-Cal managed care plans to have adequate provider networks.[24] But the rules differ somewhat depending on whether a Medi-Cal plan is regulated by California's Department of Health Care Services (DHCS) and DMHC, or only DHCS.[25] Each plan must ensure it maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services for enrollees, including those with physical and mental disabilities.[26] Your health plan's network is adequate when the service is available within a certain distance and time from your home, as well as within a certain time frame from the date of your request.[27]

a. Provider Shortages

Even in California there is a shortage of gender-affirming care providers. This issue will likely be exacerbated by persecution of gender-affirming care providers and other states' bans on gender-affirming care. The shortage contributes to significant delays for services, such as surgeries, and some providers are scheduling appointments anywhere from weeks to years in advance. Gender-affirming care is also still a growing area of medicine.[28] Therefore, provider shortages contribute to the lack of providers in-network. The majority of gender-affirming care providers are concentrated in large metropolitan areas such as San Francisco and Los Angeles. Residents in rural areas are more likely to experience barriers due to inadequate networks. If your Medi-Cal managed care plan is unable to provide access to the services in-network, then the plan must arrange for the services out-of-network for you. If your plan's provider network is inadequate and you must obtain services out-of-network, Medi-Cal is still required to cover travel-related expenses. For a more detailed overview of travel-related expenses that are Medi-Cal covered benefits, see below for section E.c.2. Travel-Related Expenses of this Chapter.

b. Your Plan Must Arrange for Gender-Affirming Care Out-of-Network If There Are No Providers In-Network

Your plan cannot deny coverage for gender-affirming services by failing to have a provider in their network who is qualified to perform the service. If your Medi-Cal managed care plan's provider network is unable to provide access to gender-affirming services in a timely manner, your plan must adequately and timely cover the services out-of-network for as long as the network is unable to provide them.[29]

Your Medi-Cal managed care plan is required to take steps to ensure you have access to the services.[30] Such steps may include:[31]

- contacting out-of-network providers with the appropriate expertise on your behalf to ensure they have appointments available within the timely access standards;
- advising you of their available appointment times; and/or
- actually scheduling an appointment for you.

It is important to understand your plan may not delay your care beyond the applicable timely access standards due to a lack of a single case agreement or other arrangement with an out-of-network provider.[32] If your health plan is forcing you to coordinate any of the administrative process for the prior authorization request for out-of-network services, file a grievance.

In all cases where your plan approves out-of-network care, your plan must coordinate payment with out-of-network providers to ensure you do not incur greater costs for seeing an out-of-network provider than you would have incurred if you saw an in-network provider.[33] Before you receive the services out-of-network, your plan will need to enter into a formal arrangement with the provider.[34] The formal agreement is commonly known as a **Letter of Agreement** (LOA) or **Single Case Agreement** (SCA). It is important to note that while your plan is required to cover out-of-network services, your plan cannot force an out-of-network provider to accept payment from the plan. For example, if a surgeon refuses to accept any health insurance plan, then your health plan cannot force the surgeon to accept payment. Additionally, when your plan is required to cover out-of-network services, your plan may choose any qualified out-of-network provider and may not necessarily approve your desired provider. Make sure that your preferred provider is willing to take your insurance.

D. Medi-Cal Timely Access Requirements

Medi-Cal managed care plans must ensure you receive services within certain geographic distances and in a timely manner. **Geographic distance standards** focus on the distance and time to travel to the appointment from your home. Plans must comply with geographic distance standards, which vary depending on provider type and county in which you live.[35] **Timely access to care standards** focus on the time frame, starting from the date of your request, within which your plan must provide you the covered services. If the services are not available from in-network providers within the geographic and timely access standards, your health plan is required to arrange for the services to be delivered by an in-network provider within the geographic and timely access standards.[36]

a. Geographic Distance Standards

In calculating the appropriate geographic distance and travel time requirements, your plan must account for the means of transportation that you use.[37] California law requires Medi-Cal plans make care available within the following distances and times from your place of residence[38]:

Adult & pediatric primary care	10 miles or 30 minutes
Hospitals	15 miles or 30 minutes
Dental services	10 miles or 30 minutes
Obstetrics & gynecology primary care	10 miles or 30 minutes

<table>
<tr><td rowspan="4">Adult & pediatric specialists[39]</td><td>Dense Counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, & Santa Clara</td><td>15 miles
or
30 minutes</td></tr>
<tr><td>Medium Counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, & Ventura</td><td>30 miles
or
60 minutes</td></tr>
<tr><td>Small Counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, & Yuba</td><td>45 miles
or
75 minutes</td></tr>
<tr><td>Rural Counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, & Tuolumne</td><td>60 miles
or
90 minutes</td></tr>
<tr><td rowspan="4">Outpatient mental health services</td><td>Dense Counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, & Santa Clara</td><td>15 miles
or
30 minutes</td></tr>
<tr><td>Medium Counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, & Ventura</td><td>30 miles
or
60 minutes</td></tr>
<tr><td>Small Counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, & Yuba</td><td>45 miles
or
75 minutes</td></tr>
<tr><td>Rural Counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, & Tuolumne</td><td>60 minutes
or
90 miles</td></tr>
</table>

b. Timely Access to Appointments Standards

Federal law requires your Medi-Cal managed care plan provide you timely access to services.[40] California has complied with the federal requirement by incorporating the Knox-Keene Act's timely access standards to apply to all Medi-Cal managed care plans by statute.[41] The amount of time your plan is required to provide access to a service will depend on the type of service and provider and whether the service is urgent or non-urgent. Your plan is required to ensure you have access to services within the following time frames:[42]

<table>
<tr><td rowspan="2">Urgent Care</td><td>where no prior authorization is required</td><td>within 48 hours of request</td></tr>
<tr><td>where prior authorization is required</td><td>within 96 hours of request</td></tr>
<tr><td colspan="2">Non-Urgent Care and Primary Care</td><td>within 10 business days of request</td></tr>
<tr><td colspan="2">Non-Urgent Specialty Care</td><td>within 15 business days of request</td></tr>
<tr><td colspan="2">Non-Urgent Non-Physician Mental Health Care</td><td>within 10 business days of request</td></tr>
<tr><td colspan="2">Non-Urgent Ancillary Services</td><td>within 15 business days of request</td></tr>
</table>

These times may be extended if the referring or treating provider determines that a longer wait time will not negatively impact your health.[43]

ADVOCACY TIP # 4.6: It is important to note there are practical limitations to the geographic distance and timely access standards. If there are simply no qualified providers within the required time or distance from your home, your plan cannot feasibly meet the standard. Similarly, if the soonest appointment for a service is beyond the required time frame, then your plan cannot possibly meet the standard. These practical limitations do not excuse your plan from covering the service, they excuse your plan only from satisfying the geographic distance and timely access standards.

E. Medical Necessity & the Prior Authorization Process

Gender-affirming healthcare services may include hormone therapy, surgery, speech and language procedures and therapies, behavioral health services, and more.[44] Not all TGI people seek gender-affirming services.[45] When you seek a gender-affirming service to treat your gender dysphoria, the service must be considered medically necessary under Medi-Cal criteria and under the appropriate standards of care in order for Medi-Cal to cover it.[46] Medi-Cal requires

requests for such care to be made by "specialists experienced in providing culturally competent care to transgender and gender-diverse individuals."[47] Care must be provided according to nationally recognized clinical guidelines; the most commonly used source for the standards of care is the **Standards of Care for The Health of Transgender and Gender Diverse People (SOC)**, published by the **World Professional Association for Transgender Health (WPATH)**, or the WPATH Standards of Care.[48] It is crucial to understand the difference between your treating provider's medical opinion about the treatment plan for your gender dysphoria and your health plan's utilization management criteria to approve coverage. Recognizing the utilization management criteria as a check-list for approval, rather than an expert's medical diagnosis, can help reduce the risk of trauma.

ADVOCACY TIP # 4.7: It is helpful to build a relationship with a health care provider experienced in serving the TGI community. The relationship should be symbiotic where the advocate can rely on the provider for medical expertise, and the provider can rely on the advocate's legal expertise regarding coverage and access. This allows the advocate to investigate whether a health plan's reason for denial is a medical decision or coverage decision. Refer to Chapter 6 for more information on building relationships with community organizations.

a. Medi-Cal Plans Must Cover "Medically Necessary" Gender-Affirming Services & Reconstructive Surgery

Medi-Cal plans are contractually obligated to provide medically necessary covered services to all members, including transgender, gender-nonconforming, and intersex members.[49] For individuals 21 years of age or older, state law defines "medically necessary" as a service that is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."[50] For individuals under 21 years of age, state law defines "medically necessary" as a service that "corrects or ameliorates defects and physical and mental illness and conditions."[51]

Medi-Cal managed care plans are also required to cover reconstructive surgery for all members, including TGI members.[52] It is important to understand the "analysis of whether or not a surgery is considered reconstructive surgery is separate and distinct from a medical necessity determination."[53] State law defines **reconstructive surgery** as "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease . . . to create a normal appearance to the extent possible."[54]

Your Medi-Cal managed care plan must consider each requested service on a case-by-case basis to determine:

(1.) whether the requested service is medically necessary to treat your gender dysphoria; and,
(2.) whether the request service meets the statutory definition of "reconstructive surgery."[55]

If your plan determines the service is medically necessary to treat your gender dysphoria, they must approve the requested service.[56] If your plan determines the service is not medically necessary to treat your gender dysphoria, they must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration your self-identified gender and if it does meet the criteria, they must approve.[57]

When analyzing your request for a gender-affirming service, your plan must consider the knowledge and expertise of providers qualified to treat gender dysphoria (including your providers) and must use nationally recognized medical/clinical guidelines.[58] One source of clinical guidance for the treatment of gender dysphoria is found in the most current WPATH SOC.[59]

Nationally recognized medical experts in the field of transgender care have identified the following core services in treating gender dysphoria: mental health services; psychotherapy; hormone therapy; and a variety of surgical procedures and treatment that bring primary and secondary gender characteristics into conformity with the individual's self-identified gender.[60] Surgical procedures and treatment that bring secondary gender characteristics into conforming with an individual's self-identified gender may include, but are not limited to, sex reassignment surgery, facial gender confirmation surgery, body contouring, hair removal, and voice therapy and vocal surgery, if these services are determined to be medically necessary to treat your gender dysphoria, or if the services meet the statutory definition of reconstructive surgery.[61]

ADVOCACY TIP # 4.8: The "medical necessity" evaluation, the "reconstructive surgery" evaluation, and any "cosmetic" evaluation a plan may incorrectly try to introduce are three distinctly different evaluation. If your health plan uses one evaluation to justify the outcome of another evaluation, then you know it is not a proper denial. For example, if your health plan claims it is not medically necessary because it is cosmetic, then you know the denial is improper and should be appealed. Each evaluation is independent and has no bearing on the other two evaluations.

1. Gender-affirming service denied because the plan deems it cosmetic

While the law and guidance clearly indicates all procedures that are medically necessary to treat gender dysphoria are covered, Medi-Cal managed care plans frequently deny coverage of certain treatments, deeming them "cosmetic."[62] California Courts of Appeal held in 1978 that gender-affirming surgeries are not "cosmetic" when medically necessary to treat gender dysphoria.[63]

In practice, health plans have a history of successfully implementing a strategy to deny gender-affirming care on the basis of it being cosmetic. Health plans use many justifications including: it only changes physical appearance and does not improve functionality; it is not reconstructive surgery; and, the body part's appearance already aligns with your gender identity. Infamously, health plans then exaggerate their cosmetic determination to argue the service automatically lacks any medical necessity since they determined it is cosmetic. In doing so, the health plans

side step an individualized assessment to determine if the service is necessary to treat your gender dysphoria. Under state law, your Medi-Cal managed care plan must conduct an individualized case-by-case assessment for medical necessity even if your health plan determines the service is cosmetic.[64] If the service is denied as cosmetic, but the written denial fails to give a clinical reason it is not medically necessary, then file an appeal for failure to conduct a medical necessity evaluation as required under DHCS All Plan Letter (APL) 20-018.

2. Gender-affirming services denied because it is not medically necessary

There are many reasons a health plan will deny a gender-affirming service because it is not medically necessary. In order to determine the specific reason your Medi-Cal managed care plan denied your service, it is best to start with reviewing the specific language of the written denial. The notice of adverse benefit determination should "clearly state the reasons for the denial."[65] It should provide:

- a detailed explanation of the specific reasons for the denial;
- a description of the criteria or guidelines used;
- the clinical reason for the decision regarding medical necessity to support the denial on the basis of "not medically necessary to treat gender dysphoria"; and,
- the clinical reason for the decision to support the denial on the basis of "does not satisfy the criteria of the reconstructive surgery statute."[66]

If the denial only states the gender-affirming service is not medically necessary to treat your gender dysphoria but does not provide a clinical reason, appeal the denial. If the denial states the gender-affirming service is not medically necessary because it does not constitute reconstructive surgery, then file an appeal for failure to conduct a proper medical necessity evaluation in accordance with DHCS APL 20-018. See Chapter 5 for more information on grievance and appeals.

ADVOCACY TIP # 4.9: Attend the consultation appointment before you request prior authorization for additional services. Otherwise, your health plan will likely deny the request for the service due to a lack of medical necessity. For example, your plan will not approve coverage for facial gender-affirming surgery until you have attended a consultation with a qualified surgeon to confirm you are a good candidate for the surgery.

b. Utilization Management Controls

Utilization management controls are procedures required before your Medi-Cal managed care plan will approve coverage for the prescribed procedure or treatment. The Medicaid Act allows states to impose a number of utilization management controls on the use of services.[67] Your Medi-Cal managed care plan may adopt its own utilization management controls, subject to certain limitations.[68] These controls are intended to help ensure that you receive the most

cost-effective, medically necessary services, and to avoid unnecessary program costs. Historically, health plans have weaponized the utilization management controls to create barriers to gender-affirming care. Your plan's utilization management controls can include[69]:

(1.) prior authorization for health services to ensure only medically necessary services are reimbursed;

(2.) post service prepayment and post payment audits, which are reviews for medical necessity and program coverage after service is rendered but before payment is made or after the claim is paid, respectively; and,

(3.) limits on the number of services, and review of services pursuant to Professional Standards Review Organizations.

The authorization criteria must be consistent with sound clinical principles.[70] The nationally clinical guideline for the treatment of gender dysphoria is SOC 8 published by WPATH in 2022.[71]

1. Prior authorization process

Medi-Cal managed care plans generally require prior approval for coverage of certain gender-affirming services before you actually receive the services.[72] This pre-approval process is also referred to as **prior authorization**. If your plan requires prior authorization and you receive the service without their pre-approval, you may be responsible to pay for the service out of pocket. The prior authorization process is often where many barriers to gender-affirming care occur.

Your provider will submit a prior authorization request with documentation of your need for the requested service, medicine, or device. In a few situations, you will initiate the prior authorization process such as prior authorization requests for travel-related expenses. Today, most prior authorization requests are submitted electronically but providers may also have the option to submit by fax or mail. State law requires the documentation to "explain the reasons for the needed service to protect life, to prevent significant illness or disability, or to alleviate severe pain."[73] Your provider should submit complete medical justification with the prior authorization request because that may be the only document your plan reviews when deciding whether to approve the coverage or not. Generally, prior authorization reviews should be performed by qualified "professionals."[74]

Most of the time, your PCP will send your health plan a prior authorization request for a consultation with a gender-affirming provider. After the consultation appointment, the gender-affirming care provider will then submit a prior authorization request for any additional services beyond the consultation appointment. For example, if you are seeking facial gender-affirming surgery, your PCP will send your health plan a prior authorization request for a consultation with a surgeon. After your consultation, the surgeon will then send a prior authorization request to your plan for any pre-surgery services (such as hair removal from the face and neck, CT scan, etc.) and for approval of the facial surgery procedures. Health plans sometimes deny prior

authorization requests in whole or in part when there are multiple facial procedures involved. The grievance and appeal process would apply in either scenario.

When your plan receives a prior authorization request, your plan must make a decision to approve, modify, or deny the service within 5 business days and within 72 hours when your condition is such that you face an imminent and serious threat to your health.[75] Decisions to approve, modify, or deny prior authorization requests shall be communicated to the requesting provider within 24 hours of the decision and must be sent to you in writing within 2 business days of the decision.[76] The decision must include a clear and concise explanation of the reasons for your plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.[77]

These timing requirements mean that you should receive a written response to your prior authorization request within 7 business days. If you do not receive a decision in writing by the 8 business day, file a grievance. If the decision does not follow any of these legal requirements, file a grievance or appeal. You do not have to wait until you receive a final decision to appeal as long as the applicable timeline has passed. Please see Chapter 5 for more information on grievances and appeals.

2. Categorical or blanket exclusions

A **categorical** or **blanket exclusion** refers to services that are never benefits covered by the health plan even when it is your treating provider's expert opinion that the service is medically necessary. Your Medi-Cal managed care plan is contractually obligated to provide medically necessary covered services to all members and prohibited from including categorical or blanket exclusions in their policies under federal and state laws.[78] Federal regulations prohibit your plan from categorically excluding or limiting coverage for gender-affirming services.[79] Your Medi-Cal plan may not categorically exclude gender-affirming services on the basis that it excludes these services for all members.[80] Your plan cannot deny or limit coverage of any services that are ordinarily or exclusively available to members of one gender based on gender assigned at birth, gender identity, or where a person's gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.[81] Your plan also must not categorically limit a service or the frequency of services available to a TGI person. "For example, classifying certain services, such as facial feminization surgery, as always 'cosmetic' or 'not medically necessary for any Medi-Cal member' is an impermissible 'categorical exclusion' of the service."[82] Your plan may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determinations, and apply appropriate utilization management criteria that are non-discriminatory.[83]

ADVOCACY TIP # 4.10: When denying a requested gender-affirming service, your Medi-Cal managed care plan must send you a notice of action (NOA) explaining "the reasons for the adverse benefit determination."[84] "The NOA must provide a detailed explanation of the specific reasons for the denial, a description of the criteria or guidelines used, and the clinical reasons for decisions to support the denial both on the basis of 'not medically necessary to treat gender dysphoria' and 'does not satisfy the criteria of the reconstructive surgery statute.'"[85]

c. Service-Specific Barriers

1. Hair removal services are medically necessary as a stand-alone service & as part of a pre-operative preparation process

WPATH's SOC 8 Statement 15.14 recommends "health care professionals offer transgender and gender-diverse people referrals for hair removal from the face, body, and genital areas for gender-affirmation or as part of a preoperative preparation process."[86] WPATH does not limit medical necessity to services in preparation for surgery or a skin graft. Importantly, WPATH SOC 8 is devoid of any requirement for submission of photographs to demonstrate "the extent of characteristics proposed for further treatment are outside the range of normal for the preferred gender," which many health plans' internal clinical policy improperly requires of its members seeking gender-affirming care.[87]

EXAMPLE # 4.3: Let us look at an example to demonstrate the difference between the two pathways to obtain approval for hair removal services. Karen (she/her) is a trans woman seeking gender-affirming services to remove hair from her face. At this time, Karen is not interested in pursuing facial feminization surgery. Therefore, Karen would pursue a prior authorization request for hair removal services as a stand-alone service. Since Karen is not currently seeking facial feminization surgery, Karen is not seeking the service as part of a preparation process for facial feminization surgery. Karen's PCP will send the prior authorization request to Karen's health plan for hair removal.

EXAMPLE # 4.4: Compare that to Karen's friend, Tabitha. Tabitha (she/her) is a trans woman seeking services to remove hair from her face. Tabitha is also pursuing facial feminization surgery. Tabitha has already attended a consultation appointment with the surgeon and her health plan has approved the surgery. Since her plan has approved the surgery and hair removal is required before surgery, Tabitha's request for hair removal services should be automatically approved as well.

EXAMPLE # 4.5: Tabitha and Karen met a new friend, Brenda (they/them), that is experiencing a barrier to accessing hair removal services from their face. Brenda is still talking with their PCP about whether facial feminization surgery is the next step to treat Brenda's gender dysphoria, and does not want to make that decision right now. Brenda's PCP sent Brenda's health plan a prior authorization request for hair removal services to treat Brenda's gender-dysphoria. Their health plan denied the request until Brenda submits medical grade photos of their facial hair grown out. The health plan's request for photos is inappropriate because growing out facial hair triggers Brenda's gender dysphoria. Additionally, WPATH does not require photos. Brenda should file an appeal with the health plan.

The prior authorization process for hair removal services is slightly more complicated than other gender-affirming services because there are two pathways to obtain approval: (1) as a stand-alone service; or, (2) as part of a pre-operative preparation process. When health plans deny a prior authorization request for hair removal services, it is frequently because they fail to recognize both pathways and only consider hair removal to be medically necessary in preparation for some surgeries.

2. Travel-related expenses

Medi-Cal managed care plans are required to cover "expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary."[88] Travel-related expenses are covered for medically necessary services that are not available within a reasonable distance and time from your home.[89] Travel-related expenses may include transportation services, meals, and lodging.

Plans are required to cover transportation-related expenses determined to be necessary for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), including the cost of:[90]

- transportation;
- meals and lodging to and from medical care, and while receiving medical care;
- an attendant to accompany you, if necessary; and,
- the attendant's transportation, meals, and lodging.

Medi-Cal managed care plans are required to cover the salary of the accompanying attendant as a covered travel expense if the attendant is medically necessary and not a family member.[91] Your plan may refer to the Internal Revenue Service per diem rates for lodging and meals as a guide.[92] Medi-Cal managed care plans may utilize prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary.[93] If your Medi-Cal managed care plan requires prior authorization and utilization management controls for related travel expenses, your plan must notify you of the process to request authorization.[94] You must comply with your plan's prior authorization process to get your travel-related expenses covered.[95]

ADVOCACY TIP # 4.11: If your plan has approved gender-affirming services out-of-network and you anticipate travel expenses, we recommend that you send a written prior authorization request to your plan explaining the anticipated travel expenses (unlike prior authorization requests sent by providers). Request a written copy of any policies or procedures regarding approval for travel-related expenses. See Example # 4.6 below for a template of a letter to request any policies or procedures regarding travel-related expenses. You may refer to your plan's Evidence of Coverage or Member Handbook for an address, fax number, or email address for your plan's member services department. If your plan has assigned you a case manager, we recommend sending your prior authorization request to your case manager.

Your Medi-Cal managed care plan is required to provide 2 methods of payment for travel-related expenses either by: (1.) reimbursing you or (2.) pre-payment to the vendor.[96] Reimbursement must cover the actual expenses incurred by you and your accompanying attendant as long as they are reasonable and supported by receipts.[97] Your plan must approve and reimburse payments no later than 60 calendar days following your plan's confirmation that all required receipts and documentation have been received.[98]

Your plan must prepay vendors for related travel expenses, including expenses for meals and lodging, if you cannot pay in advance. You must attest to your plan that you are unable to pay in advance for travel-related expenses, which you can do in person, electronically, or by telephone.[99] As part of the prior authorization process, your plan may arrange lodging for you and your accompanying attendant located within a reasonable distance from the location where you will obtain medically necessary services.[100] If your plan does not prepay for meals, your plan is required to reimburse approved meal expenses.[101] If your plan does not prepay for other necessary travel expenses (e.g., parking, tolls), your plan is required to reimburse you for those expenses.[102]

EXAMPLE # 4.6: Template letter to request policies and procedures regarding travel-related expenses.

[Date MM/DD/YYYY],

Dear [*Health Plan Name*],

My name is [*your first, last name*] and my member ID is [*your member ID number*]. [*Health plan name*] approved the prior authorization request for [*gender-affirming service*] with [*out-of-network provider*], at [*provider's address*].

I anticipate the following travel-related expenses:
[*Add travel-related expenses here*]

Please accept this letter as my written request for prior authorization of the travel-related expenses as Medi-Cal covered benefits. Please identify any policies or procedures regarding approval for travel-related expenses, and send me a copy if they exist.

Thank you,

[*Print Your first and last name*]
[*Your Signature*]
[*Your phone number*]

Because of the concentration of gender-affirming care providers in metropolitan areas and lack of providers in rural areas, individuals living in rural areas often have to travel longer distances and sometimes more frequently to access care. Therefore, individuals living in rural areas are often more likely to experience issues getting travel-related expenses covered. If you need services out-of-network because your plan is unable to provide the services in-network, determine which travel-related expenses you will need in order to access your gender-affirming service. Make sure you account for the time and distance you will travel to and from the service and any post-recovery restrictions or requirements. You can file a grievance with your plan if they deny coverage or reimbursement for travel-related expenses. See Chapter 5 for more information on grievances and appeals.

F. Continuity of Care

Continuity of Care (COC) is critical to Medi-Cal beneficiaries in a variety of circumstances including when a provider leaves a member's Medi-Cal managed care plan, when a beneficiary moves from fee-for-service (FFS) into a Medi-Cal managed care plan, or moves into Medi-Cal managed care from Covered California, or when a plan member's enrollment changes from one Medi-Cal health plan to another.[103] COC protections allow Medi-Cal beneficiaries to continue receiving existing treatments (including medications) without having to go through additional prior authorization process for a period of time after transition, and in some cases also permit Medi-Cal beneficiaries to continue seeing providers who are out-of-network with their Medi-Cal managed care plan for a period of time.[104]

In certain circumstances, California law gives new Medi-Cal managed care enrollees the right to continue seeing, for up to 12 months, an out-of-network provider from whom they had previously received care.[105] For example, when a person who was previously enrolled in Covered California moves into Medi-Cal managed care coverage, the Medi-Cal managed care plan must make a good faith effort to obtain information from the beneficiary about any active and ongoing treatments or medications.[106] The process for requesting COC is the same as for beneficiaries newly transitioning to Medi-Cal managed care from FFS Medi-Cal.[107]

The Knox-Keene Act (KKA) also includes its own provisions that require licensed plans to provide COC to allow an enrollee to continue certain types of care with an out-of-network provider when the provider leaves their plan, or when the person has newly enrolled into a plan.[108] California has incorporated the KKA COC protections to apply to all beneficiaries enrolled in a Medi-Cal managed care plan, and thus, all Medi-Cal managed care enrollees are entitled to these additional protections.[109] To get continuity of care, the enrollee must not have had any option to choose a plan that included the provider.[110] COC protections often overlap with other protections such as the ones described above, including for an enrollee to continue receiving care from out-of-network providers beyond the period otherwise authorized.[111] Under the additional COC protections, a health plan must provide COC to allow an enrollee to undergo a procedure, such as surgery performed by an out-of-network provider when that provider has been scheduled or recommended within 180 days of the date that the previously in-network provider's contract was terminated or within 180 days of the effective date of coverage for a newly covered enrollee.[112]

G. YOUR RIGHT TO ADEQUATE NOTICE

One of the most important protections of the Medi-Cal program is your right to receive written notification when your benefits are denied, terminated, or reduced.[113] The written notification is commonly referred to as a **notice of action (NOA)** or **notice of adverse benefit determination (NOABD)**. Federal regulations provide specifics as to the requirements for notice of an adverse benefit determination.[114] California has specific state laws, regulations, and guidance that govern managed care plans' obligations concerning notice and appeal rights involving benefit determinations.[115]

The right to notice is one of the least understood legal rights when trying to access health care services. Specifically, individuals do not realize it is their right to receive written notice that is both timely and adequate. Failing to appreciate the right to adequate and timely notice often leads to feeling stuck in a cycle of endless calls with health plan representatives that give different and confusing reasons your gender-affirming care is not approved.

Important situations where your health plan is required to send you written notice include:

(1.) adverse benefit determinations, such as when your plan denies your prior authorization request for a gender-affirming service;[116] and,

(2.) in response to your grievance or appeal.[117]

a. The denial or grievance/appeal resolution must be communicated in writing

When your Medi-Cal managed care plan denies your request for a gender-affirming service, your plan is required to notify you in writing of their decision to deny the service.[118] Your plan is also required to communicate in writing their decisions regarding grievances and appeals you file.[119] Communicating this information over the phone is not sufficient. You should not rely solely on communications over the phone with a plan representative. Rather, you should rely on your plan's written communications regarding decisions for appeals, grievances, and denials. If your plan will communicate a denial only over the phone and refuses to send you a written denial, we recommend you file a grievance. If your plan will communicate the resolutions of a grievance or appeal only over the phone and refuses to send you a written resolution, we recommend that you file a Complaint with the DMHC. See Chapter 5 for more information on grievances and appeals.

> **ADVOCACY TIP # 4.12**: In our experience, we frequently see written denials or grievance/appeal resolution letters that provide a justification for the plan's decision that is completely different from the justification a plan representative gives you over the phone. Sometimes, the written justification contradicts the justification received over the phone. We recommend that you rely on the written communication.

b. The notice must be timely

The time frame for your plan to send you a written notice of their decision depends on the circumstances. When your health plan receives a prior authorization request for services, your health plan must notify you of their decision in writing within 7 business days.[120] If your condition is such that you face imminent and serious threat to your health, your plan must notify you of their decision within 96 hours.[121]

If you file a grievance or appeal, your plan must adequately consider and resolve the grievance or appeal within 30 calendar days.[122] If the case involves an imminent and serious threat to your health (including but not limited to, severe pain, potential loss of life, limb, or major bodily function), your plan is required to provide you with a written statement on the disposition or pending status of the grievance within 3 days of receiving the grievance.[123]

c. The notice must be clear and concise

The written communication regarding decisions to deny, delay, or modify gender-affirming services shall include a clear and concise explanation of the reasons for your plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity and reconstructive surgery.[124] Your plan must provide a written response to your grievance or appeal with a clear and concise explanation of the reason for your plan's response.[125]

We frequently see written notices from health plans that are confusing and fail to articulate a clear reason for the plan's decision. For example, we frequently see denials for surgeons who are out-of-network because the plan alleges to have qualified surgeons in-network but the denial letter refers you to a surgeon who does not perform the service or is not in-network.

Endnotes

[1] 42 C.F.R. § 438.10(h); Cal. Health & Safety Code § 1367.27.

[2] Cal. Health & Safety Code § 1374.72; Cal. Dep't of Managed Health Care, All Plan Letter No. 22-030 (Dec. 22, 2022), https://dmhc.ca.gov/Portals/0/Docs/OPL/APL%2022-030%20-%20Requirement%20for%20Plans%20to%20Arrange%20for%20Covered%20Services%20(12_22_2022).pdf [hereinafter DMHC APL 22-030].

[3] Cal. Health & Safety Code § 1367.27.

[4] 42 C.F.R. § 438.10(h).

[5] Cal. Health & Safety Code § 1367.27(d)(1).

[6] Cal. Health & Safety Code § 1367.27(j)(3).

[7] Cal. Dep't of Health Care Servs., All Plan Letter No. 24-017 at 3-4 (Dec. 5, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-017.pdf [hereinafter DHCS APL 24-017]. Senate Bill (SB) 923 (Chapter 822, Statutes of 2022), known as the "TGI Inclusive Care Act," included new requirements for plans to ensure their provider directories are accurate. No later than March 1, 2025, plans must maintain an up-to-date directory of in-network providers who have attested they offer and have provided gender-affirming services.

[8] It is important to note the provider's attestation is voluntary. *See* DHCS APL 24-017 at 4. In light of the attacks on the TGI community and gender-affirming care providers on a national level, it is plausible that some in-network providers do not want to be identified as GAC providers in the plan's directory online.

[9] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transgender and Gender Diverse People* at S171 (V. 8, 2022), https://wpath.org/publications/soc8/ [hereinafter WPATH *Standards of Care 8*]("Many TGD people will not require therapy or other forms of mental health care as part of their transition, while others may benefit from the support of mental health providers and systems (Dhejne et al., 2016).").

[10] *See* Cal. Dep't of Health Care Servs., All Plan Letter No. 20-018 (Oct. 26, 2020), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-018.pdf [hereinafter DHCS APL 20-018].

[11] *See* "Gender Dysphoria" in Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2022)[hereinafter *DSM-5-TR*].

[12] *See* "Gender Dysphoria" in *DSM-5-TR*; *see also* Nat'l Health Law Prog., *An Advocate's Guide to Medi-Cal Services* at 5.3 (2d ed. 2022), https://healthlaw.org/resource/an-advocates-guide-to-medi-cal-services/ [hereinafter NHeLP *Guide to Medi-Cal*].

[13] DHCS APL 20-018 at 3; *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 1.

[14] Cal. Dep't of Health Care Servs., *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 2 (2022), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/F81D2354-BA35-4415-9B82-8B2DF9A505FA/transgender.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*].

[15] *See* DHCS APL 20-018 at 4 (clarifying that "core services in treating gender dysphoria [include] mental health services [and] psychotherapy."); *see also* NHeLP *Guide to Medi-Cal* at 5.3.

[16] WPATH *Standards of Care 8* at S23-26. *See also* NHeLP *Guide to Medi-Cal* at 5.3, 5.4.

[17] DHCS APL 20-018 at 3; *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 1; *see also* NHeLP *Guide to Medi-Cal* at 5.3.

[18] DHCS APL 20-018 at 3.

[19] DHCS APL 20-018 at 3-4.

[20] Cal. Health & Safety Code § 1383.15(a).

[21] Cal. Health & Safety Code § 1383.15(f).

[22] 42 C.F.R. § 438.206(b)(3).

[23] 42 C.F.R. § 438.206(b)(1); Cal. Health & Safety Code §§ 1367(g), 1367.03(a)(7); 28 C.C.R. § 1300.67.2.2(c)(7).

[24] 42 C.F.R. § 438.206(b)(1); Cal. Health & Safety Code § 1367(g); 28 C.C.R. § 1300.67.2.2(c)(7).

[25] 42 C.F.R. §§ 438.206(c)(1); 438.68; 22 C.C.R. § 53885; 28 C.C.R. §§ 1300.51(c)(H), 1300.67.2.2(c)(5).

[26] 42 C.F.R. § 438.206(b)(1); Cal. Health & Safety Code §§ 1367(g), 1367.03(a)(7); 28 C.C.R. § 1300.67.2.2(c)(7).

[27] Cal. Health & Safety Code § 1367.03(a)(7).

[28] *See* WPATH *Standards of Care 8*, at S29 ("Lack of knowledgeable providers is a major barrier to gender affirming care. . .").

[29] 42 C.F.R. § 438.206(b)(4); Cal. Health & Safety Code § 1367.03(a)(7)(C); 28 C.C.R. § 1300.67.2.2(c)(7)(C); *see also* Abbi Coursolle, Nat'l Health Law Prog., *Network Adequacy Rules for Medi-Cal Managed Care Plans* at 6 (Issue No. 1, Rev. May 7, 2018), https://healthlaw.org/wp-content/uploads/2014/08/Managed-Care-CA-Series-UPDATED-5.7.18.pdf [hereinafter NHeLP *Network Adequacy Rules for MC MCP*].

[30] DMHC APL 22-030 at 2.

[31] DMHC APL 22-030 at 2.

[32] DMHC APL 22-030 at 2.

[33] 42 C.F.R. § 438.206(b)(5); 22 C.C.R. §§ 51002, 53855(c); *see also* NHeLP *Network Adequacy Rules for MC MCP* at 6.

[34] *See* Cal. Dep't of Health Care Servs., All Plan Letter 22-032 at 5 (Dec. 27, 2022)[hereinafter DHCS APL 22-032](discussing the formal arrangement with an out-of-network provider in the context of Continuity of Care).

[35] 42 C.F.R. § 438.68; Cal. Welf. & Inst. Code § 14197; *see also* NHeLP *Guide to Medi-Cal* at 1.7.

[36] Cal. Health & Safety Code § 1374.72; DMHC APL 22-030.

[37] 42 C.F.R. § 438.68(c)(1)(vi); *see also* NHeLP *Network Adequacy Rules for MC MCP* at 4.

[38] Cal. Welf. & Inst. Code §§ 14197(b), (c); *see also* Cal. Dep't of Health Care Servs., All Plan Letter 23-001 at Attach. A (Jan. 6, 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-001.pdf [hereinafter DHCS APL 23-001]. *See generally* NHeLP *Network Adequacy Rules for MC MCP* at 4, 5.

[39] Specialists for this purpose include practitioners in the following specialty areas: Cardiology/Interventional Cardiology; Nephrology; Dermatology; Neurology; Endocrinology; Ophthalmology; Ear, nose, and throat/Otolaryngology; Orthopedic surgery; Gastroenterology; Physical medicine and rehabilitation; General surgery; Psychiatry; Hematology; Oncology; Pulmonology; HIV/AIDS specialists/infectious diseases; Obstetrics and gynecological specialty care.

[40] 42 C.F.R. § 438.206(c)(1); *see also* NHeLP *Network Adequacy Rules for MC MCP* at 5.

[41] Cal. Welf. & Inst. Code § 14197(d)(1)(A); *see also* NHeLP *Network Adequacy Rules for MC MCP* at 5.

[42] 28 C.C.R. § 1300.67.2.2(c)(5).

[43] 28 C.C.R. § 1300.67.2.2(c)(5)(G); *see also* NHeLP *Network Adequacy Rules for MC MCP* at 5.

[44] NHeLP *Guide to Medi-Cal* at 5.2; *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 2; DHCS APL 20-018 at 4.

[45] NHeLP *Guide to Medi-Cal* at 5.2.

[46] NHeLP *Guide to Medi-Cal* at 5.2, 5.3; *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 2 (citing 22 C.C.R. § 51303); DHCS APL 20-018 at 2-3.

[47] *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 2.

[48] *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 1; DHCS APL 20-018 at 3-4. *See also* WPATH *Standards of Care 8*; NHeLP *Guide to Medi-Cal* at 5.3.

[49] DHCS APL 20-018 at 2.

[50] Cal. Welf. & Inst. Code § 14059.5; DHCS APL 20-018 at 2; *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 2 (citing 22 C.C.R. § 51303).

[51] DHCS APL 20-018 at 2 (citing 42 U.S.C. § 1396d(r)(5)).

[52] DHCS APL 20-018 at 2.

[53] DHCS APL 20-018 at 2.

[54] DHCS APL 20-018 at 3 (citing Cal. Health & Safety Code § 1367.63).

[55] DHCS APL 20-018 at 4.

[56] DHCS APL 20-018 at 3.

[57] DHCS APL 20-018 at 3.

[58] DHCS APL 20-018 at 4.

[59] DHCS APL 20-018 at 4.

[60] DHCS APL 20-018 at 4.

[61] DHCS APL 20-018 at 4.

[62] NHeLP *Guide to Medi-Cal* at 5.8.

[63] *GB v. Lackner,* 80 Cal. App. 3d (1978); *JD v. Lackner*, 80 Cal. App. 3d 90 (1978); *see* NHeLP *Guide to Medi-Cal* at 5.8.

[64] DHCS APL 20-018 at 4.

[65] DHCS APL 20-018 at 5.

[66] DHCS APL 20-018 at 5.

[67] *See* 42 U.S.C. § 1396a(a)(30); 42 C.F.R. §§ 440.230(d), 456.1 *et seq*; *Wickline v. Department of Health Services*, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986)(Medicaid agency can be held accountable when medically inappropriate decision results from defects in the design or implementation of utilization review mechanism).

[68] 42 C.F.R. § 438.210(a)(4); *see also* NHeLP *Guide to Medi-Cal* at 1.16.

[69] Cal. Welf. & Inst. Code § 14133; 22 C.C.R. § 51159.

[70] Cal. Health & Safety Code §§ 1363.5, 1367.01(f).

[71] DHCS APL 20-018 at 4; *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* at 1.

[72] 42 C.F.R. § 438.210(a)(4); Cal. Health & Safety Code §§ 1363.5, 1367.01; 22 C.C.R. § 53246.

[73] Cal. Welf. & Inst. Code §§ 14059.5, 14133.3(a)(If the Medi-Cal beneficiary is under age 21, the EPSDT medical necessity definition applies.).

[74] 42 U.S.C. § 1396a(a)(30)(B).

[75] Cal. Health & Safety Code § 1367.01(h)(1)-(2).

[76] Cal. Health & Safety Code § 1367.01(h)(3).

[77] Cal. Health & Safety Code § 1367.01(h)(3).

[78] DHCS APL 20-018; *see also* Cal. Health & Safety Code § 1365.5 (IGNA prohibits discrimination against individuals based on gender, including gender identity or gender expression. "[T]he benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions . . . or other modifications because of the . . . sex . . . of any contract party . . . or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise[.]").

[79] 45 C.F.R. § 92.207(b)(4); DHCS APL 20-018 at 2.

[80] DHCS APL 20-018 at 4.

[81] 45 C.F.R. §§ 92.206, 92.207(b)(3); DHCS APL 20-018 at 2.

[82] DHCS APL 20-018 at 4.

[83] DHCS APL 20-018 at 4.

[84] 42 C.F.R. § 438.404; DHCS APL 20-018 at 5.

[85] DHCS APL 20-018 at 5.

[86] WPATH *Standard of Care 8* at S156.

[87] We frequently see health plans that inappropriately require medical grade photos of the individual's body part with hair and will use this type of language in the denial.

[88] 42 C.F.R. § 440.170(a); DHCS APL 22-008.

[89] DHCS APL 22-008 at 12.

[90] 42 C.F.R. § 440.170(a)(3); DHCS APL 22-008 at 11.

[91] 42 C.F.R. § 440.170(a)(3)(iii); DHCS APL 22-008 at 11.

[92] DHCS APL 22-008 at 11.

[93] DHCS APL 22-008 at 11.

[94] DHCS APL 22-008 at 12.

[95] DHCS APL 22-008 at 12.

[96] DHCS APL 22-008 at 12.

[97] DHCS APL 22-008 at 12.

[98] DHCS APL 22-008 at 12.

[99] DHCS APL 22-008 at 12.

[100] DHCS APL 22-008 at 12.

[101] DHCS APL 22-008 at 13.

[102] DHCS APL 22-008 at 13.

[103] Abbi Coursolle, Nat'l Health Law Prog., *Continuity of Care in Medi-Cal Managed Care* at 1 (2d ed. 2023), https://healthlaw.org/resource/continuity-of-care-in-medi-cal-managed-care-updated-2023/ [hereinafter NHeLP *Continuity of Care*].

[104] NHeLP *Continuity of Care* at 1.

[105] Cal. Welf. & Inst. Code § 14182(b)(13); *see also* NHeLP *Network Adequacy Rules for MC MCP* at 6; Cal. Dep't of Health Care Servs., All Plan Letter No. 23-022 at 14 (Aug. 15, 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-022.pdf [hereinafter DHCS APL 23-022]; NHeLP *Continuity of Care* at 13.

[106] DHCS APL 23-022 at 14; *see also* NHeLP *Continuity of Care* at 12.

[107] DHCS APL 23-022 at 15; *see also* NHeLP *Continuity of Care* at 13.

[108] Cal. Health & Safety Code § 1373.96; *see also* NHeLP *Continuity of Care* at 14.

[109] Cal. Welf. & Inst. Code § 14184.200(a)(2); *see also* DHCS APL 23-022, at 8-9, 14-15; NHeLP *Continuity of Care* at 14.

[110] Cal. Health & Safety Code § 1373.96(j); *see also* NHeLP *Continuity of Care* at 14.

[111] NHeLP *Continuity of Care* at 14.

[112] Cal. Health & Safety Code § 1373.96(c)(6); *see also* DHCS APL 23-022 at 9; *see also* NHeLP *Continuity of Care* at 14-15.

[113] *See* NHeLP *Guide to Medi-Cal* at 1.15 ("Medicaid is an entitlement program, meaning any individual who meets the program's eligibility requirements has a right to enroll. Medicaid applicants and beneficiaries therefore have a property interest in Medicaid benefits. This property interest is protected by the Due Process Clause of the U.S. Constitution. *See* U.S. Const., Amend. XIV, § 1.").

[114] 42 C.F.R. §§ 438.402(c), 431.220, 431.244; *see also* NHeLP *Guide to Medi-Cal* at 1.16.

[115] Cal. Welf. & Inst. Code § 14197.3; Cal. Dep't of Health Care Servs., All Plan Letter 17-006 at 2 (Aug. 31, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf [hereinafter DHCS APL 17-006]; Cal. Dep't of Health Care Servs., Mental Health & Substance Use Disorder Services Information Notice No. 18-010E at 5 (March 27, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf [hereinafter DHCS MHSUDS No. 18-010E]. *See also* NHeLP *Guide to Medi-Cal* at 1.16.

[116] 42 C.F.R. § 438.404; Cal. Welf. & Inst. Code § 14197.3(a).

[117] 42 C.F.R. § 438.408(a)(2)(i); Cal. Health & Safety Code § 1368(a)(5); 28 C.C.R. § 1300.68(d)(3).

[118] 42 C.F.R. § 438.404; Cal. Welf. & Inst. Code § 14197.3(a).

[119] 42 C.F.R. § 438.408(a)(2)(i); Cal. Health & Safety Code § 1368(a)(5); 28 C.C.R. § 1300.68(d)(3).

[120] Cal. Health & Safety Code §§ 1367.01(h)(1), (3).

[121] Cal. Health & Safety Code §§ 1367.01(h)(2)-(3).

[122] 42 C.F.R. § 438.408(b); Cal. Health & Safety Code § 1368.01(a); 22 C.C.R. § 1300.68(a).

[123] Cal. Health & Safety Code § 1368.01(b).

[124] Cal. Health & Safety Code § 1367.01(h)(3).

[125] 42 C.F.R. §§ 438.408(d)(1), (d)(2)(i); Cal. Health & Safety Code § 1368(a)(5); 22 C.C.R. § 1300.68(d)(3).

An Advocate's Guide to Access Gender-Affirming Care in California

March 2025

CHAPTER 5: File a Grievance or Appeal

Chapter 5 - Outline

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CHAPTER 5: FILE A GRIEVANCE OR APPEAL

In Chapter 4, we reviewed specific barriers that Medi-Cal managed care plan beneficiaries may face when accessing gender-affirming care and we identified specific rules Medi-Cal plans must follow. In this Chapter, we will explain the protections you have as a Medi-Cal beneficiary and the procedural steps you can take to address any barriers you face when accessing gender-affirming care.

Although there are strong laws in place to ensure you have access to medically necessary services, the business model of health insurance fosters a powerful incentive to limit coverage of services in order to maximize profits. Too often, the laws and protections in place are only as strong as your willingness to learn and fight to enforce your rights. Critical protections for Medi-Cal beneficiaries includes your rights to receive a notice and request a hearing when your gender-affirming care is denied, terminated, or reduced. These rights are generally known as due process rights.

This Chapter will explain the due process rights you have as a beneficiary enrolled in Medi-Cal or a Medicare-Medicaid Plan (Medi-Medi Plan). This Chapter will also serve as a reference guide as you exercise your rights and navigate through the grievance or appeal process when your benefits are denied, terminated, or reduced.

ADVOCACY TIP # 5.1: There are 2 common misconceptions we hear from clients about the grievance and appeal process. First, people may feel that filing a grievance or appeal with your health plan is similar to asking for a manager at a restaurant to complain about the quality of food or service. However, this comparison is not accurate. Rather, the grievance and appeal process is the formal process to address any barriers or issues; any other efforts to address a barrier or issue can be considered an informal attempt to resolve. The second misconception is that the grievance and appeal process is a waste of time because the plan already decided to deny coverage for gender-affirming care and will not change their mind. However, this is a dangerous misconception and exactly what the health insurance companies want you to think because it makes them more money.

A. MEDI-CAL MANAGED CARE PLANS

Individuals who are enrolled in a Medi-Cal Managed Care Plan (MCP) must receive notice, grievance and appeal rights when a service is denied, delayed, terminated, reduced, suspended, or modified. To determine whether you are enrolled in Medi-Cal MCP and the type of plan you are enrolled in, please refer to Chapter 3: Types of Coverage of this Guide. This section will explain how you can exercise these rights if your gender-affirming services are denied, delayed, terminated, reduced, suspended, or modified by your Medi-Cal managed care plan.

Most Medi-Cal MCPs are licensed by California's Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the Knox-Keene Act (KKA).[1] The KKA is a set of laws passed by the California state legislature providing DMHC with the authority to regulate health care service plans. Among these regulations are consumer

protection laws, such as grievance and appeal processes. Other Medi-Cal MCPs–most County Organized Health System (COHS) plans, Mental Health Plans, and Medi-Cal Rx–are exempt from DMHC licensure and may not be subject to the KKA. However, there are certain provisions in the KKA that apply to all Medi-Cal managed care plans, regardless of whether they are licensed by DMHC.

a. Notice

Your Medi-Cal managed care plan's decision to deny, delay, reduce, modify, suspend, or terminate an existing service is known as an **adverse benefit determination**.[2] Your Medi-Cal managed care plan must provide you with a written **notice of adverse benefit determination** (NOABD) that is clear and concise before making an adverse benefit determination.[3] Your plan must provide the NOABD concerning the adverse benefit determination at least 10 days in advance.[4] MCPs must explain in the written notice to you what adverse benefit determination the plan is making and why, and inform you about your rights including: the right to a grievance or appeal and how to file one, the right to a fair hearing and how to request one, the right to continue benefits pending the appeal and how to exercise that right, and the circumstances in which you have a right to expedited review and how to request it.[5] The NOABD must be translated in prevalent non-English languages, and oral interpretation must be available in all languages upon request.[6] The NOABD must also be available in alternative formats.[7]

The NOABD must be timely. MCPs must provide the NOABD according to particular timeframes:[8]

Type of Decision	Timeframe
Approve, deny, or modify requested care for cases involving an imminent & serious threat to health.	**72 Hours** (or shorter if required by your health)
Deny, delay, or modify a request for prior or concurrent authorization of a service.	**2 Business Days**
Regarding prior authorization & concurrent claims (claims involving services you are currently receiving).	**5 Business Days**
Post-service (reimbursement claims).	**30 Days**

Once you receive a NOABD from your MCP, you have the right to file an internal grievance or appeal with your MCP. If you are not satisfied with the outcome of the internal grievance or appeal, you may proceed with requesting an external review.

b. Continuing Benefits: Aid Paid Pending

If you receive a NOABD from your MCP that is reducing, suspending, or terminating your current gender-affirming services ordered by an authorized provider, you are entitled to continue receiving those gender-affirming services while you appeal the decision. This is known as **Aid Paid Pending**. If you want to receive Aid Paid Pending when filing an internal grievance or appeal, you must file a request for Aid Paid Pending within 10 days from the date of the NOABD or before the date of the proposed adverse benefit determination.[9] When this request for Aid Paid Pending is timely filed, the managed care plan must continue the gender-affirming service until the internal grievance or appeal is resolved.

If you request continuing benefits pending an internal review (but do not request a fair hearing), and the internal review is not resolved in your favor, you must request a fair hearing (with Aid Paid Pending) within 10 days of the notice of grievance/appeal resolution or before the effective date of the proposed adverse benefit determination, in order to continue those benefits pending the fair hearing resolution.[10] If, after receiving the internal review resolution, you decide to proceed with external review of the decision, you are not entitled to continue benefits pending a DMHC Independent Medical Review (IMR) or Complaint.[11] The next subsections will explain the internal review process (also known as a grievance or appeal) and your options for external review if you are not satisfied with the outcome of the internal review.

c. Internal Review: Grievance or Appeal

In most cases, you must file a grievance or an appeal about a specific issue before you may proceed to external review regarding that issue – this is known as **internal review**. Once your plan has an official opportunity to resolve the issue through the internal grievance or appeal process, you may seek intervention from the government through either a DMHC Complaint, Independent Medical Review (IMR), or state fair hearing—this is known as **external review**.[12] Only in expedited cases—those involving an "imminent and serious threat" to your health—may you proceed directly to external review without waiting for your plan's internal grievance/appeal process.[13]

ADVOCACY TIP # 5.2: We recommend you file a grievance or appeal in writing via mail, fax, or email. We recommend you keep a copy of the grievance or appeal for your records. If you file it orally over the phone, we recommend asking the health plan representative for a tracking number and/or confirmation number.

MCPs are required to offer two separate tracks for the internal review process: grievances or appeals. First, it is helpful to understand the difference between an "appeal" and a "grievance."[14] An **appeal** is the process to challenge an adverse benefit determination and have it reconsidered. An adverse benefit determination by a health plan may be a denial, delay, reduction, modification, suspension, or termination of services or payment. An appeal must be requested within 60 days of the notice of adverse benefit determination.[15]

EXAMPLE # 5.1: Example of an appeal.

Ash (they/he) is enrolled in a Medi-Cal managed care plan. Ash is seeking top surgery (bilateral mastectomy). Ash called their MCP and asked for a written list of in-network providers who perform bilateral mastectomy for gender-affirming purposes. The MCP sent Ash a written list of providers that included 2 in-network surgeons: Dr. A and Dr. B. Ash's PCP sent the MCP a prior authorization request for a consultation with Dr. A. The MCP denied the request for Dr. A. Ash should file an appeal with their MCP to challenge the denial.

A **grievance** is any complaint with the plan that does not involve a notice of adverse benefit determination. A grievance may include a complaint of the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and your right to dispute an extension of time by the MCP to make an authorization decision.[16] A grievance may be filed at any time.[17]

EXAMPLE # 5.2: Example of a grievance.

Prianka (she/her) just moved to San Diego. Prianka was approved for Medi-Cal and enrolled in a Medi-Cal managed care plan. Prianka has not been able to find a new Primary Care Provider (PCP) that is experienced with serving the TGI community and gender-affirming care. Prianka called her managed care plan a few times for help with finding a new PCP, but the plan has not been helpful and instructed Prianka to find a PCP on her own. Prianka should file a grievance with her Medi-Cal managed care plan to address her inability to find a PCP.

The plan has 30 days to provide a written decision to the grievance or appeal, unless the grievance or appeal is urgent.[18] The written decision is sometimes referred to as a "notice of grievance resolution" or "notice of appeal resolution." A grievance or appeal is deemed urgent if the case involves an imminent and serious threat to your health, which includes, but is not limited to, severe pain, potential loss of life, limb, or major bodily function.[19] If the grievance or appeal is urgent, the health plan has 72 hours to provide a written decision.[20] For non-expedited cases, the time you may seek a state fair hearing starts from either the time of resolution of the appeal, or if the appeal was not resolved, after 30 days has expired.[21]

d. External Review: DMHC Complaint or IMR (KKA-Licensed Plans Only)

If you are not satisfied with your Medi-Cal managed care plan's resolution of the internal review and your plan is Knox-Keene licensed, then you may proceed to file a DMHC Complaint or IMR. You may also proceed to a DMHC Complaint or IMR if you have not received a decision on your internal review within 30 days of filing it.[22] In certain urgent cases, you may proceed to a DMHC Complaint or IMR without filing an internal grievance or appeal at all.[23] The law does not prohibit you from seeking both a DMHC Complaint and an IMR, and sometimes DMHC processes your submission as a hybrid Complaint/IMR.[24] However, in practice, a Complaint and an IMR are offered as alternatives to each other.[25] DMHC uses a single form for

both the IMR and Complaint processes and DMHC will determine whether it should be processed as an IMR or Complaint. As mentioned above, this process typically applies to KKA-licensed plans only.

1. Independent Medical Review (IMR)

An IMR is a clinical review process used for cases involving disputes over medical necessity of a service or treatment, payment for an emergency or urgent care service provided out-of-network, or whether a particular service or treatment is experimental or investigational. For example, a health plan's denial of facial feminization surgery as "cosmetic" would proceed through the IMR process. All other cases, such as complaints about network adequacy or timely access to care, are resolved through DMHC's Complaint process.

You can request an IMR within 6 months after an unfavorable grievance or appeal resolution letter, or if your grievance or appeal has been pending for 30 days without a resolution.[26] You may use an authorized representative to make the request.[27] An urgent IMR or complaint should be resolved within 3 days.[28] A case is deemed urgent and will be expedited if it involves an "imminent and serious threat" to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health.[29] You should have your provider put in writing that you will face serious harm if you do not receive the service requested.[30] Otherwise, if not deemed urgent, DMHC must resolve the IMR/Complaint within 30 days.[31]

ADVOCACY TIP # 5.3: In practice, timeframes typically start once DMHC determines that it has received all the necessary information from the plan. As a result, it is becoming more common that the standard IMR/Complaint processing timeframes may go beyond the 30-day period. There are still little to no remedies for you to utilize when DMHC goes beyond this timeframe.

An IMR is performed by independent medical professionals who are not connected to your health plan.[32] DMHC must contract with outside organizations to perform the review, so you must consent to participating in the process and sharing their medical records with the outside review entity.[33] The MCP bears the cost of the IMR, and cannot charge you any fee for participating in the process.[34] The IMR reviewers must review all documents related to the denial, your medical records, relevant peer-reviewed scientific and medical evidence, national professional standards, expert opinions, and accepted standards for medical practice.[35] You may provide any information you deem relevant along with your request for IMR.[36] IMR reviewers do not have access to your out-of-network records, so you must provide any out-of-network records you want considered in the IMR process. Once a decision is rendered, it must be provided to you, the DMHC, and your plan.[37] If the decision is in your favor, the plan must implement the decision within 5 days.[38]

2. DMHC Complaint

DMHC's Complaint process provides external review of matters that are not eligible for IMR, such as network adequacy and timely access to care complaints.[39] Similar to the process for an IMR, you must generally pursue an internal grievance first, and may then file a DMHC Complaint after an unfavorable grievance decision, or after waiting 30 days for the plan to resolve an internal grievance.[40] In expedited cases, you only need to participate in the internal grievance process for 3 days before filing a DMHC Complaint, and, at DMHC's discretion, may forgo the grievance process altogether.[41] You may use an authorized representative to file the Complaint.

DMHC must analyze all documents received from you and your plan and determine the appropriate resolution.[42] Once DMHC makes a determination, it must be sent to you in writing.[43] DMHC must resolve a DMHC Complaint within 30 days (although in practice, DMHC tends to resolve complaints beyond 30 days), and the written resolution must include an explanation of its findings and reasons for its decision.[44] For any Complaint that involves delayed, denied, terminated, reduced or modified medically necessary health care services that should have initially been covered, your plan must promptly provide or reimburse you for the service(s).[45]

ADVOCACY TIP # 5.4: Although it is required that your MCP send DMHC all of your relevant medical documents and information so that DMHC can make a fully-informed decision. In practice, this is not always a reality; MCPs may fail to supply all of the relevant documentation that DMHC needs. To ensure DMHC considers all of the relevant documents and information, we recommend including medical documents and information you want DMHC to review when you file a DMHC Complaint or IMR.

e. External Review: State Fair Hearing

You have the right to request a state fair hearing when you are dissatisfied with your Medi-Cal benefits.[46] You may request a hearing for a broad scope of service problems, including denials or delays in receiving a service or your plan not offering a provider of a needed service within your geographic area, which can frequently occur when you are seeking a specific GAC provider.[47] Partaking in the health plan's internal grievance or appeal process, or in the DMHC Complaint or IMR process, does not waive your right to request a state fair hearing when the result of those processes were unfavorable to you.

You may request a state fair hearing within 120 days after completion of the health plan's internal grievance or appeal process, or after the DMHC Complaint or IMR process.[48] You must exhaust the plan's internal review process before proceeding with a state fair hearing.[49] However, if your plan fails to adhere to the notice and timing requirements for adverse benefit determinations (*e.g.*, failing to provide notice of a benefit modification, or providing a late denial notice), you can immediately request a state fair hearing and you will be deemed to have exhausted the internal appeal and grievance processes.[50] Your request for a state fair hearing

can be made by an authorized representative.[51] Once you proceed to a state fair hearing, you cannot later file a DMHC Complaint/IMR.[52]

If you file a state fair hearing request more than 120 days after receiving the notice of grievance/appeal resolution, the state fair hearing request may be accepted only if there is good cause.[53] **Good cause** in this context means a "substantial and a compelling reason beyond the party's control," like being hospitalized or seriously ill.[54] However, a request for a hearing for good cause will not be granted if the request is filed more than 180 days after receiving the notice of grievance or appeal resolution from your Medi-Cal managed care plan.[55]
Hearings must ordinarily be resolved within 90 days.[56] You can request **an expedited hearing** if the 90-day timeframe for a standard hearing would "seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function."[57] If the request for an expedited hearing is granted, the case must be calendared on an expedited basis and you must be given at least 10 days advance notice detailing the time, date, and type of hearing to be conducted.[58] The Administrative Law Judge's decision must be issued as expeditiously as possible, but no more than 5 days after the hearing, unless you agree to a delay to submit additional documents for the appeals record.[59] If the request is denied, you must be notified of the denial and the case must be set for a regular state hearing.[60]

There are various ways to request a state fair hearing. You may request a state fair hearing with California's Department of Social Services:

- By calling (800) 743-8525
- Online at https://acms.dss.ca.gov/acms/login.request.do
- By faxing your completed form on the NOABD back to (916) 229-4110.
- By mailing your completed form on the NOABD back to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243
  Mail Station 9-17-442
  Sacramento, California 94244-2430

1. Informal Resolutions: Conditional & Unconditional Withdrawals

After a hearing request is filed, your Medi-Cal MCP may offer to resolve the matter informally, without need for the hearing. In that case, the appeal is withdrawn in writing, either conditionally or unconditionally.[61] A **conditional withdrawal** is a retraction of your hearing request based on the agency's agreement to take further actions to resolve the issue.[62] Conditional withdrawals are documented with a written agreement between you and the county, requiring that a party (or both parties) complete the actions agreed upon during the informal resolution process within 30 days.[63] If the conditions are met, the appeal is dismissed.[64] **Unconditional withdrawals** immediately dismiss the appeal without prejudice, meaning you may file a new hearing request on that same issue as long as it is timely.[65]

2. Formal Resolution: Administrative Law Judge's Decision

If your case proceeds to a formal hearing, the State Hearings Division must set the hearing within 30 working days after the request is filed.[66] The date of the hearing request is the date the CDSS receives the request. CDSS must send you a written notice of the date, time, and location of the hearing at least 10 days before the hearing.[67] The notice must explain how the hearing will take place, either by telephone, video conference, or in person.

You have the right to review your entire file with your county Medi-Cal office before the hearing.[68] The MCP's hearing representative must send you a copy of their position statement, at least 2 working days before the hearing, setting forth the issues in question at the Fair Hearing.[69] You may receive the position statement by mail or upon request by electronic communications.[70] If the MCP's hearing representative does not make the position statement available in the required time period or if the MCP's hearing representative modifies it within the 2 days before the hearing, you have the right to ask for postponement, or to move forward with the hearing anyway.[71]

As mentioned earlier, all state fair hearings must be decided or dismissed within 90 days from when the hearing was requested.[72] Once the Administrative Law Judge has issued a proposed decision, it must be sent to you (or your authorized representative) and the Director of DHCS.[73] The Director of DHCS has 30 days from receipt of the Judge's proposed decision, or within 3 business days for an expedited resolution, to accept or change the decision, or to set another hearing date.[74] If the Director does not do anything with the proposed decision, then the proposal is accepted.[75] If the decision is in your favor, then your MCP must implement the Judge's orders within 30 days from when the hearing decision is received by your MCP.[76]

If the decision is not in your favor, or if you are otherwise dissatisfied with the decision, you have a right to seek a rehearing.[77] You can request a rehearing by sending a written request to the State Hearings Division Rehearing unit within 30 days after receiving the decision.[78] The rehearing request must be in writing and state the date of the adverse decision. It must also list any reasons for why a rehearing should be granted, e.g. the adopted decision not being supported by the parties. The Director of DHCS must take action to grant or deny the request for rehearing within 15 days of receiving it; otherwise, the request will be deemed denied.[79] The hearing decision remains final until a rehearing is granted.[80]

You may also, with or without requesting a rehearing, file a writ of mandamus in state court.[81] The deadline to file a petition for writ of mandamus is one year from receiving notice of the Director's final decision.[82] There is no filing fee and, if you prevail, you are entitled to attorney fees and costs.[83]

ADVOCACY TIP # 5.5: The criteria to get an approved rehearing request are narrow rather than broad. The grounds to approve a rehearing request includes the adopted decision is inconsistent with the law, is not supported by the evidence in the record, is not supported by the findings, does not address all of the claims or issues raised by the parties, supported by the record or evidence, or lacks sufficient information to determine the basis for its legal conclusion. Additional reasons include: newly discovered evidence, that was not in custody or available to the party requesting rehearing at the time of the hearing, is now available and the new evidence, had it been introduced, could have changed the hearing decision; or for any other reason necessary to prevent the abuse of discretion or an error of law, or for any other reason consistent with Section 1094.5 of the Code of Civil Procedure. Based on these grounds, it is important that evidence provided to receive an approval of your rehearing request is concrete enough to satisfy one or more of the grounds outlined in the law.

B. Medi-Cal Fee-For-Service

Individuals who are enrolled in Medi-Cal Fee-For-Service (FFS) have the constitutional protections to receive an adequate notice from DHCS and an opportunity to seek a state fair hearing to appeal DHCS' actions or decisions.[84] To determine whether you are enrolled in Medi-Cal FFS, please refer to Chapter 3: Types of Coverage of this Guide. If you receive services through Medi-Cal FFS, you do not need to go through an internal review and you can proceed directly to request a state fair hearing after receiving an adverse benefit determination. This section will explain how you can exercise these rights.

a. Notice

DHCS must provide you with an adequate and timely written notice of adverse benefit determination (NOABD) when DHCS decides to deny, terminate, or reduce your gender-affirming services.[85] The NOABD must inform you of the action being taken by DHCS, the reasons for the action, the specific legal support for the action, your right to a hearing, your right to representation, and your right to continued benefits.[86] The NOABD must be written in plain language and be accessible to individuals with disabilities and persons with limited English proficiency.[87] The NOABD must provide you a choice to receive notices in an electronic format or by regular mail.[88] When the intended action involves termination of eligibility or suspension, termination or reduction of services, a NOABD generally must be sent at least 10 days before the date of the action.[89] The NOABD may be mailed no later than the day of the action in exceptional circumstances, including instances when your physician prescribes a change in the level of medical care.[90]

b. Continuing Benefits: Aid Paid Pending

As mentioned earlier, if you receive a NOABD that a service you are currently receiving is being terminated, reduced, suspended, or modified, you may be able to keep receiving the service while the hearing is pending through Aid Paid Pending. To receive Aid Paid Pending, you must file the request for a state fair hearing within 10 days of receiving the NOABD or before the effective

date of action.[91] Once this request is filed, your benefits will continue until a hearing decision is issued or until the authorization period expires, whichever occurs first.[92]

c. External Review: State Fair Hearing

Once you receive a NOABD from DHCS, you have the right to appeal the adverse benefit determination at a state fair hearing.[93] You must file a request for a state fair hearing within 90 days of the date of the NOABD, which can be extended to 180 days upon a showing of good cause—a "substantial and a compelling reason beyond the [your] control," like being hospitalized or seriously ill.[94]

You can request an expedited hearing if the 90-day timeframe for a standard hearing would "seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function."[95] If the request for an expedited hearing is granted, the case must be calendared on an expedited basis and you must be given at least 10 days advance notice detailing the time, date, and type of hearing to be conducted.[96] The Administrative Law Judge's decision must be issued as expeditiously as possible, but no more than 5 working days after the hearing, unless you agree to a delay to submit additional documents for the appeals record.[97] If the request is denied, you must be notified of the denial and the case must be set for a regular state hearing.[98]

There are various ways to request a state fair hearing. You may request a state fair hearing with California's Department of Social Services:

- By calling (800) 743-8525
- Online at https://acms.dss.ca.gov/acms/login.request.do
- By faxing your completed form on the NOABD back to (916) 229-4110
- By mailing your completed form on the NOABD back to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243
  Mail Station 9-17-442
  Sacramento, California 94244-2430

ADVOCACY TIP # 5.6: If you paid out of pocket for a service because of a barrier or denial, then you need to submit a Conlan reimbursement packet first, before you may request a state fair hearing. For additional information on how to submit a Conlan reimbursement, see: https://www.dhcs.ca.gov/services/medi-cal/Pages/Online-Conlan-Claim-Forms.aspx.

1. Informal Resolutions: Conditional & Unconditional Withdrawals

After your hearing request is filed, DHCS may offer to resolve the matter informally, without need for the hearing.[99] In that case, the appeal is withdrawn in writing, either conditionally or unconditionally.[100] A conditional withdrawal is a retraction of your hearing request based on the DHCS's agreement to take further actions to resolve the issue.[101] Conditional withdrawals are documented with a written agreement between you and DHCS, requiring that a party (or both parties) complete the actions agreed upon during the informal resolution process within 30 days.[102] If the conditions are met, the appeal is dismissed.[103] Unconditional withdrawals immediately dismiss the appeal without prejudice, meaning you may file a new hearing request on that same issue as long as it is timely.[104]

2. Formal Resolution: Administrative Law Judge's Decision

If your case proceeds to a formal hearing, the State Hearings Division must set the hearing within 30 working days after the request is filed.[105] The date of the hearing request is the date the CDSS receives the request. CDSS must send you a written notice of the date, time, and location of the hearing at least 10 days before the hearing.[106] The notice must explain how the hearing will take place, either by telephone, video conference, or in person.

You have the right to review your entire file with your county Medi-Cal office before the hearing.[107] DHCS' hearing representative must send you a copy of their position statement, at least 2 working days before the hearing, setting forth the issues in question at the Fair Hearing.[108] You may receive the position statement by mail or upon request by electronic communications.[109] If DHCS does not make the position statement available in the required time period or if DHCS modifies it within the 2 days before the hearing, you have the right to ask for postponement, or to move forward with the hearing anyway.[110]

All state fair hearings must be decided or dismissed within 90 days from when the hearing was requested.[111] Once the Administrative Law Judge has issued a proposed decision, it must be sent to you (or your authorized representative) and the Director of DHCS.[112] The Director of DHCS has 30 days from receipt of the Judge's proposed decision, or within 3 business days for an expedited resolution, to accept or change the decision, or to set another hearing date.[113] If the Director does not do anything with the proposed decision, then the proposal is accepted.[114] If the decision is in your favor, then DHCS must implement the Judge's orders within 30 days from when the hearing decision is received by DHCS.[115]

If the decision is not in your favor, or if you are otherwise dissatisfied with the decision, you have a right to seek a rehearing.[116] You can request a rehearing by sending a written request to the State Hearings Division Rehearing unit within 30 days after receiving the decision.[117] The rehearing request must be in writing and state the date of the adverse decision. It must also list any reasons for why a rehearing should be granted, e.g. the adopted decision not being supported by the parties. The Director of DHCS must take action to grant or deny the request for

rehearing within 15 days of receiving it; otherwise, the request will be deemed denied.[118] The hearing decision remains final until a rehearing is granted.[119]

You may also, with or without requesting a rehearing, file a writ of mandamus in state court.[120] The deadline to file a petition for writ of mandamus is one year from receiving notice of the Director's final decision.[121] There is no filing fee and, if you prevail, you are entitled to attorney fees and costs.[122]

C. Medi-Cal Rx Complaint Process

In 2022, Governor Gavin Newsom created a new program within Medi-Cal, called Medi-Cal Rx,[123] in an effort to lower the cost of prescription drugs for Medi-Cal beneficiaries. To learn more about Medi-Cal Rx, please also review Chapter 3: Types of Coverage of this Guide.

Medi-Cal Rx has adopted an informal complaint process when you have concerns with a decision about a prescription, in addition to the existing state fair hearing process.[124] This informal complaint process does not replace the State Fair Hearing process. To appeal the adverse benefit determination, you must go through the state fair hearing process, as discussed in this Chapter's section B. Medi-Cal Fee-For-Service, above.

The Medi-Cal Rx Consumer Service Center (CSC) administers the complaint (sometimes also called grievance) processes for Medi-Cal pharmacy benefits. Complaints can be filed at any time and there are no time restrictions based on the date the incident occurred. The complaint may be filed by yourself or an authorized representative and may be submitted in person, in writing, or by phone. The Customer Service Representatives (CSR) process the complaints/grievances in all threshold languages and a TTY option using the 711 National Service.[125]

A complaint would include situations such as:

- Dissatisfaction due to Medi-Cal Rx coverage policy, quality of care, and/or timeliness of care;
- Dissatisfaction due to inaccuracies and/or omissions relative to services/information being provided; and/or
- Dissatisfaction due to aspects of interpersonal relationships such as rudeness of a provider or employee (inclusive of discriminatory practices pursuant to applicable state/federal law).[126]

Once a complaint is received, the CSR will determine whether the complaint can be resolved immediately (no further research is required). If the complaint can be resolved immediately, the complaint is "exempt" and will be resolved via the communication it was submitted and then closed. Medi-Cal Rx usually will not send an acknowledgement letter for exempt complaints, but the CSR will generate a closeout communication and maintain a log of the complaint with important information (e.g., date of the call, your name, identification number, nature of the complaint, nature of the resolution, name of the CSR).

If the complaint cannot be resolved immediately and further research is required, an acknowledgement letter of receipt of the complaint will be sent to you within 1 day. The CSR will conduct an initial investigation and will determine within 3 days if the complaint needs to go to DHCS to be resolved. Typically, DHCS resolves complaints involving discriminatory practices, policy disagreements, and legal threats. If the complaint does not need to be sent to DHCS, the CSR will conduct an investigation to determine whether the complaint can be resolved within 10 days. The investigation may include listening to calls, reviewing your history related to the complaint, contacting the prescriber or pharmacy, and interviewing CSRs who may have been involved with a previous interaction. Once an investigation is conducted, the CSR will create an action plan to resolve the complaint.

If within this period the CSR determines that your complaint cannot be resolved within 10 days, the CSR will send you a notice, documenting the status of your complaint. Your complaint should be resolved within 30 days and the CSC will send you a final notice, summarizing the resolution, either through mail or electronically. The resolution must include the outcome of the complaint, your name, date of the initial complaint submission, the Case ID, date of complaint resolution, and summary of complaint resolution. If you submitted a complaint anonymously, communication letters will not be generated. If the case requires more than 30 days to resolve, the CSR will document the reason for the extension and communicate the reason to DHCS. CSR and DHCS will develop a resolution plan and execute.

If the complaint involves an urgent matter, it can be escalated by the agent for immediate attention and action, which you can request by yourself or the CSR can flag the complaint as urgent on their own.

D. Medi-Medi Plans

In California, people who have both Medicare and Medi-Cal have the choice to remain in Original Medicare, enroll in a regular Medicare Advantage Plan (referred to as "MA" or "MAP"), enroll in PACE,[127] or enroll in one of the Medi-Medi plans (referred to as "integrated dual special needs plans" or "D-SNP"). To determine whether you are enrolled in Medi-Medi plan, please refer to Chapter 3: Types of Coverage of this Guide.

The majority of people in California who choose a Medi-Medi plan enroll in either an D-SNP or a FIDE-SNP (e.g. SCAN Connections). Both of these plans are considered an "applicable integrated plan" under federal law and regulation, requiring the Medi-Medi plan evaluate claims and pre-authorization requests for needed services under both the Medicare and Medi-Cal coverage criteria. Moreover, as a result of federal law, these Medi-Medi plans must provide you with integrated notices and integrated grievance and appeals processes.

For a general overview of the differences between these different D-SNP plans, please see Justice in Aging's advocate resource.[128]

a. Integrated Grievances & Appeals

Those D-SNPs designated as applicable integrated plans must establish and oversee an integrated grievance and appeal system to ensure you have the opportunity to submit grievances and appeals, and receive timely adjudication. D-SNPs conduct both grievances and plan coverage determination appeals, called Integrated Organizational Determinations. We will discuss each below and their respective rights and timelines, as well as things to consider when pursuing them.

1. Grievances

As in the Medi-Cal managed care plan context, a grievance (or complaint) is any expression of dissatisfaction about a matter other than an adverse benefit determination.

You may file a grievance at any time. Within 5 calendar days of receiving your grievance, your D-SNP must send you a written acknowledgement of the grievance that is dated and postmarked. Your D-SNP must resolve standard grievances and send you a written resolution as expeditiously as you health condition requires, but no later than 30 calendar days from receipt of the grievance. Expedited grievances are those that involve imminent and serious health risks and must be resolved in 24 hours.[129]

ADVOCACY TIP # 5.7: Always request a written notice of grievance resolution because there are scenarios in which only an oral notification is required.[130]

2. Pre-authorization coverage determinations & appeals

Your D-SNP may require a prior authorization process for certain services, equipment, and supplies. In D-SNPs these coverage determinations are referred to as Integrated Organizational Determinations under federal law.[131] Given that D-SNPs have integrated both the Medicare and Medi-Cal benefits, they must make coverage determinations using the coverage determination or medical necessity standards under both Medicare and Medi-Cal. Denials for these Integrated Organizational Determinations are issued either as full or partial denials.

D-SNPs must make coverage determinations within 5 business days from the D-SNP receipt of information reasonably necessary to make the determination, but no later than 14 calendar days from when the D-SNP receives the request.[132] If there is an expedited request for coverage determination, your D-SNP must provide you notice as expeditiously as your condition requires but no later than 72 hours from receipt of the request.[133]

3. Integrated reconsiderations / Internal plan appeals

If your D-SNP's initial coverage determination is not favorable, you have similar appeal rights to those articulated above for Medi-Cal managed care members. D-SNPs must use the same federal definition of "appeal" and "adverse beneficiary determination." Note that federal regulations extended the time to request an appeal with a Medicare managed care plan to 65 days (originally it was 60 days).[134]

Prior to terminating, suspending, or reducing a previously authorized gender-affirming service, D-SNPs must provide an integrated coverage determination notice at least 10 calendar days in advance of the effective date of the action.[135] To continue services pending appeal or review, you must request "continuation of benefits" within 10 calendar days of the postmark date on the notice or prior to the intended effective date of the action, whichever is later.[136]

When you request a reconsideration, your D-SNP must provide you the reasonable opportunity to present evidence and testimony and make legal and factual arguments for integrated grievances and integrated reconsiderations.[137] You must be notified of the limited time available for presenting evidence sufficiently in advance of the resolution timeframe.

Your D-SNP must complete the reconsideration process as expeditiously as the your health condition requires, but no later than 30 calendar days from the date of request and, in response to an expedited appeal, no more than 72 hours.[138] Your D-SNP must send you a reconsideration decision in writing when they send you a full or partial denial of an integrated organizational determination (i.e. pre-authorization determination). The notice will explain the secondary external review process.

4. Second level or external agency appeal

After the internal integrated appeal options are completed, secondary and external appeal options branch out depending on the source of coverage for the service or item.[139] Services or items in dispute that are primarily covered by Medicare may be pursued through typical Medicare managed care appeal processes. Services or items in dispute that are primarily covered by Medi-Cal may be pursued through the Medi-Cal managed care external review processes.

For decisions relating to Medi-Cal covered services (e.g. long-term care, certain equipment, etc.), external review occurs in accordance with DMHC's Independent Medical Review process and/or the associated state fair hearing process as described above in the section relating to Medi-Cal managed care appeal options. For determining Medi-Cal scope of coverage please refer to the medical necessity and prior authorization process discussion in Chapter 4.

For decisions relating to Medicare covered services, external review of D-SNP reconsideration determinations is handled as they are by Medicare Advantage plans. Specifically, D-SNPs must automatically forward any full or partial denial of an integrated organizational decision for a review by an external Independent Review Entity (IRE; Maximus is the IRE in California.) You

may also request a second level review within 65 days of the post mark of the Integrated Organizational Determination. The IRE will then issue a decision within 30 days for pre-service coverage determinations, 60 days for coverage determinations relating to payment for services already provided, and 7 days for Medicare Part B drug related decisions.

Beyond the second level appeal, you have further rights to appeal unfavorable determinations through the Administrative Law Judge hearing level (request within 65 days),[140] then appeal through the Medicare Appeals Council (request within 65 days),[141] and then by filing a lawsuit in Federal District Court (file your petition within 60-days).[142] Detailed discussion of these appeals procedures may be found on the National Center on Law and Elder Rights (NCLER's) website.[143]

E. Civil Rights Complaints

If you believe your civil rights have been violated, there are several state and federal complaint processes available to enforce those rights.

a. DHCS Office of Civil Rights: Discrimination Complaint

If you believe you have been subjected to unlawful discrimination in the Medi-Cal program, you can file a complaint with the Department of Health Care Services' Office of Civil Rights if the discrimination was on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws.[144]

1. Procedure & Policy

You must complete the DHCS 1044 Discrimination Complaint Form[145] and can include additional sheets of paper if needed to fully describe your discrimination complaint. You must include on the form:

- Name & address of medical administrator/provider;
- Date of occurrence;
- The basis of discrimination: sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws;
- A description of the incident that occurred; and
- The resolution or outcome you are seeking.

Once you complete the discrimination complaint form, you may be file it:

- By mailing it to: Office of Civil Rights,
Department of Health Care Services
PO Box 997413, MS 0009
Sacramento, CA 95899-7413
- By emailing it to CivilRights@dhcs.ca.gov
- By calling DHCS's Office of Civil Rights at (916) 440-7370.

DHCS provides free aids and services to people with disabilities to communicate effectively with DHCS.

You have 365 days from the day of the discriminatory action to submit a complaint to the DHCS Office of Civil Rights. DHCS will send you a written notification within 10 days that your complaint has been received and will let you know if more information is needed. DHCS will begin an investigation within 30 days of receiving the discrimination complaint to determine if the complaint is within its jurisdiction. During the investigation, DHCS may share information about your complaint with your Medi-Cal MCP, the health care provider, or entity that committed the discriminatory action. In accordance with applicable law, DHCS will take appropriate steps to preserve the confidentiality of your records relating to complaints and will share them only with those who have a need to know.

If the discrimination complaint is within DHCS' jurisdiction, DHCS will issue a written determination explaining its findings (or if the investigation is ongoing), provide an update on the status of the investigation, and the expected date of completion within 90 days of receipt. Once the investigation is completed, DHCS will issue a written determination. The written determination will be based on a preponderance of the evidence and will include a notice of your right to pursue further administrative or legal remedies. If the discrimination complaint is not within DHCS' jurisdiction, DHCS will notify you of their determination in writing within 90 days of receipt of the discrimination complaint.

2. Appeal

You may appeal DHCS' written determination within 15 days of receiving it. The written determination will be deemed received 5 days after mailing or immediately received if faxed or emailed. Appeals must identify the written determination being appealed or include a copy of the written determination and an explanation of the reason you are appealing the determination. Appeals may be filed:

- By mailing it to: Office of Civil Rights
Department of Health Care Services
PO Box 997413, MS 0009
Sacramento, CA 95899-7413
- By emailing it to CivilRights@dhcs.ca.gov

The DHCS Director, or their representative, will issue a written determination of an appeal no later than 60 days after DHCS receives the appeal. The determination on appeal will not be decided upon by any person who participated in the determination of the discrimination complaint that is being appealed.

ADVOCACY TIP # 5.8: The availability and use of the DHCS discrimination grievance procedure does not prevent you from pursuing other legal or administrative remedies, including filing a discrimination grievance with a Medi-Cal managed care plan, or filing a complaint of discrimination in California state court.

b. California Civil Rights Department (CRD) Complaint

If you are in California and believe you have been subjected to discrimination, harassment, or retaliation, you can file a complaint with the California Civil Rights Department. [146]

1. Procedure & Policy

The first step is to submit an intake form. This form may be submitted:[147]

- Online through the California Civil Rights System (CCRS) portal,
- By mailing it to 651 Bannon Street, Suite 200 Sacramento, CA 95811,
- By emailing it to contact.center@calcivilrights.ca.gov ,
- By calling (800) 884-1684 (voice), (800) 700-2320 (TTY), or California's Relay Service at 711, or
- In person by visiting one of their office locations.[148]

It is important to have the following information to provide to CRD:

- The specific facts and any records about the incident(s), including the name and contact information of the person or entity you believe harmed you (if known);
- Copies of any documents or other evidence related to your complaint; and
- The names and contact information of any witnesses (if known).

If you are unable to gather all the required information at the time you file, you can still begin the filing process through the CCRS portal and add additional information as you acquire it. Your unfiled complaint will remain available in the system for 30 days.

You must submit a complaint within 1 year of the date you were last harmed. When you file a discrimination complaint, it will initiate an intake interview with a CRD representative. The representative will evaluate the allegations and decide whether to accept your case for investigation. CRD can only investigate violations of civil rights laws that the CRD enforces.[149]

ADVOCACY TIP # 5.9: There are several ways to file a complaint with the CRD. The fastest and easiest way is online via the California Civil Rights System (CCRS) portal. It offers many benefits, such as self-service appointment scheduling; a list of upcoming appointments; the ability to upload files to your case as needed; and the ability to pause filing and resume at a later time if more information is needed (within 30 days of complaint creation). However, if the CCRS portal is not the best way for you, you can file by email, mail, phone, or in-person.

Some of those laws include:

- Laws that prohibit discrimination in state-funded programs[150]
- Disabled Persons Act[151]
- Ralph Civil Rights Act[152]

If your complaint is accepted for investigation, CRD will prepare a complaint form for your signature. When you submit the complaint, it will be sent to the person or entity that you believe discriminated against you. If CRD files your complaint, it means that it has preliminarily determined that the allegations are covered by a law that the department enforces—it does not determine whether there is reasonable cause to believe any laws have been violated. If your complaint is not accepted for investigation, it is likely because your complaint, if proven, would not have violated the civil rights laws that CRD enforces.

If it accepts your case, CRD will independently investigate the facts and the legal issues. This involves reviewing your responses in the complaint and other information and evidence that you and the opposing entity submit. CRD uses the facts obtained through its investigation to determine if there is reasonable cause to believe a law the department enforces has been violated. If not, the case is closed. If there is reasonable cause, CRD notifies the parties of this determination and may notify them that the department intends to file a lawsuit in court. Prior to filing a lawsuit, CRD typically requires the parties to go to mediation to attempt to reach an agreement to resolve the dispute through conciliation or by referring your case to CRD's Dispute Resolution Division when appropriate or required by law.

Here are some possible outcomes from the complaint: (1) Recovery of out-of-pocket losses; (2) An injunction prohibiting the unlawful practice; (3) Access to housing or a job opportunity; (4) Policy changes; (5) Training; (6) Reasonable accommodation(s); Damages for emotional distress; and (7) Civil penalties and punitive damages.

2. Appeal

If you are dissatisfied with the outcome of CRD's investigation, and the case has not been settled or accepted by CRD to file a lawsuit in court, you may appeal CRD's closure of the case. You have 10 days from receipt of the closure letter to submit an appeal. The closure letter will provide instructions on what the appeal should contain. It is important that your appeal clearly states what specifically you would like reviewed during the appeal. For example, if CRD was

unable to interview all of your witnesses or gather certain evidence, your appeal should identify the name of the witness and provide their contact information or specify the evidence that you believe was overlooked. Another example: if you believe that CRD misapplied the law, your appeal should describe what you understand the law to be. Since an appeal is narrower than the investigation, it is important that you provide all relevant information during the investigation.

The closure letter will direct you to submit your appeal to either (1) the investigator's supervisor (the closure letter will contain the supervisor's contact information); or (2) the Appeals Unit. It is very important that you follow the instructions in the closure letter to ensure that you file your appeal in a timely manner to the correct person or unit.

You may submit the appeal to the Appeals Unit:

- By mailing it to Civil Rights Department
  Attention: Appeals Unit
  651 Bannon Street, Suite 200
  Sacramento, CA 95811
- By emailing it to Appeals@calcivilrights.ca.gov
- By calling the Contact Center at (800) 884-1684, (800) 700-2320 (TTY), or California's Relay Service at 711.

If you submitted your **appeal to the investigator's supervisor**, the supervisor will respond to your appeal by sending you a letter informing you of the reasons for upholding the closure letter or contacting you to inform you that your case will be reopened.

If you submitted your **appeal to the Appeals Unit**, the Appeals Unit will send you a letter informing you the appeal has been either accepted for review or rejected. If you receive a letter informing you the appeal was accepted for review, no further action is needed. Once an appeal reviewer has had an opportunity to review your case file and appeal, they will contact you if more information is needed to decide your appeal. Appeals are processed by the Appeals Unit in the order they are received. The Appeals Unit does not have a deadline by which to decide an appeal. However, the Appeals Unit processes appeals as quickly as possible without sacrificing the quality of its work.[153] You can check on the status of your appeal by contacting the person or unit you submitted your appeal to and include your assigned CRD case number on all correspondence.

ADVOCACY TIP # 5.10: If you filed an appeal, we strongly encourage you to seek additional legal advice and not wait until the appeal process is over to decide if you will file a civil lawsuit. There are statutory time limits for filing civil lawsuits in court and this appeal process does not pause the statutory time limit.

c. U.S. Department of Health & Human Services, Office for Civil Rights (OCR) Complaint

The U.S. Department of Health and Human Services, Office for Civil Rights can receive complaints regarding violations of your rights of nondiscrimination, conscience, religious freedom, and health information privacy. [154] You can file a complaint of discrimination form:[155]

- Electronically through the Office for Civil Rights Complaint Portal,[156]
- By mailing the Complaint form to:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building,
  Washington, DC 20201
- By faxing the Complaint form to (202) 619-3818
- By emailing the Complaint form to ocrmail@hhs.gov

Complaints must be filed within 180 days of when you knew the alleged discriminatory act occurred. OCR may extend the 180-day period if you can show good cause. The complaint must also include the name of the health care or social service provider involved, and describe the acts or omissions you believe violated civil rights laws or regulations. OCR typically aims to resolve complaints within 180 days, but may take more time if determined necessary.

ADVOCACY TIP # 5.11: Under this current Presidential Administration, the OCR has changed its discrimination language to only include violations of rights of nondiscrimination, conscience, religious freedom, and health information privacy. The removal of language concerning discrimination violations of race, color, national origin, sex, age, or disability indicates OCR is not interested in enforcing complaints of discrimination based on sex, gender identity, gender expression, or sexual orientation. Due to the ongoing attacks on access to GAC federally, we highly encourage that TGI individuals accessing GAC in California utilize DHCS and California state civil rights complaints to address any discriminatory actions they may be experiencing from plans, health care providers, and other entities.

Endnotes

[1] *See generally* Cal. Health & Safety Code §§ 1340-1399.818. *See also* Cal. Dep't of Managed Health Care, *DMHC Laws & Regulations*, https://www.dmhc.ca.gov/LawsRegulations.aspx (last visited Feb. 22, 2025).

[2] 42 C.F.R. § 438.404; Cal. Welf. & Inst. Code § 14197.3(a); Cal. Dep't of Health Care Servs., All Plan Letter No. 21-011 (Aug. 31, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf [hereinafter DHCS APL 21-011].

[3] 42 C.F.R. § 438.404; Cal. Welf. & Inst. Code § 14197.3(a); Cal. Dep't of Health Care Servs., All Plan Letter No. 21-011 (Aug. 31, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf [hereinafter DHCS APL 21-011].

[4] 42 C.F.R. § 438.404(c)(1) (referencing 42 C.F.R. § 431.211); DHCS APL 21-011[MCPs]; Cal. Dep't of Health Care Servs., Mental Health & Substance Use Disorder Services Information Notice 18-010E at 6 (March 27, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf [hereinafter DHCS MHSUDS No. 18-010E] [MHPs and DMC-ODS] (referencing 42 C.F.R. §§ 431.211, 438.404(c)).

[5] 42 C.F.R. § 438.404(b); DHCS APL 21-011 (MCPs); DHCS MHSUDS 18-010E [MHPs and DMC-ODS]; 22 C.C.R. § 51014.1; 22 C.C.R. § 53894(a) [Two-plan county plans]; 22 C.C.R. § 53261(a) [all other MCPs]; 9 C.C.R. § 1850.212(b) (MHPs).

[6] 42 C.F.R. § 438.10(d); DHCS APL 21-011 (MCPs); DHCS MHSUDS 18-010E at 15 [MHPs and DMC-ODS]; *see also* 22 C.C.R. § 53876(a)(3) [Two-plan county plans].

[7] 42 C.F.R. § 438.10(d); DHCS MHSUDS 18-010E at 15 [MHPs and DMC-ODS].

[8] Cal. Health & Safety Code § 1367.01(h).

[9] 42 C.F.R. § 438.420(b); DHCS APL 21-011 [MCPs].

[10] 42 C.F.R. § 438.420(c); DHCS APL 21-011 [MCPs].

[11] 22 C.C.R. § 51014.2.

[12] 42 C.F.R. § 431.220; 22 C.C.R. § 50951; Cal. Health & Safety Code §§ 1368(b)(1)(A), 1374.30 (only if the MCP is a Knox-Keene licensed plan).

[13] Cal. Health & Safety Code § 1368(b)(1)(A).

[14] 42 C.F.R. § 438.400-424; Cal. Health & Safety Code § 1368.03(a); 22 C.C.R. § 1300.68(a)(1).

[15] 42 C.F.R. § 438.402(c)(2)(ii).

[16] 42 C.F.R. § 438.400(b); DHCS APL 21-011 [MCPs].

[17] DHCS APL 21-011.

[18] 42 C.F.R. § 438.408(b)(2); 28 C.C.R. § 1300.68(a), 22 C.C.R. § 53858(g)(1)[2-Plan], § 53914(g)(1)[Geographic Managed Care]; Cal. Welf. & Inst. Code § 14197.3(b); DHCS APL 21-011 (MCPs); Cal. Health & Safety Code § 1368.01(a)-(b).

[19] Cal. Health & Safety Code § 1368.01(b); DHCS APL 21-011.

[20] 42 C.F.R. §§ 438.408(b)(3), 438.410(a); Cal. Health & Safety Code §§ 1368.01(b), 1368.03(a), 1374.30(j)(3); 22 C.C.R. § 53858(e)(7)[2-Plan; no Geographic Managed Care equivalent]; DHCS APL 21-011 [MCPs].

[21] Cal. Health & Safety Code § 1368(b)(1)(A).

[22] 42 C.F.R. § 438.408(b)(2); 28 C.C.R. § 1300.68(a), 22 C.C.R. § 53858(g)(1)[2-Plan], § 53914(g)(1)[Geographic Managed Care]; Cal. Welf. & Inst. Code § 14197.3(b); DHCS APL 21-011.

[23] 28 C.C.R. § 1300.74.30(b).

[24] Abbi Coursolle, Nat'l Health Law Prog., *Internal and External Review: Medi-Cal Managed Care Plans* at 8 (2d ed. 2019), https://healthlaw.org/resource/internal-and-external-review-medi-cal-managed-care-plans-managed-care-in-california-series-issue-no-4-revised-october-2019/ [hereinafter NHeLP *Internal and External Review: Medi-Cal Managed Care Plans*].

[25] NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 8.

[26] Cal. Health & Safety Code §§ 1370.4, 1374.30(j)(1).

[27] Cal. Health & Safety Code § 1368(b).

[28] Cal. Health & Safety Code § 1374.33(c).

[29] Cal. Health & Safety Code § 1374.33(c).

[30] Cal. Health & Safety Code § 1374.33(c).

[31] Cal. Health & Safety Code § 1374.33(c).

[32] Cal. Health & Safety Code § 1374.32.

[33] Cal. Health & Safety Code § 1374.30(m)(2).

[34] Cal. Health & Safety Code § 1374.30(l).

[35] Cal. Health & Safety Code § 1374.33.

[36] Cal. Health & Safety Code § 1374.30(m)(3).

[37] Cal. Health & Safety Code § 1374.33(c).

[38] Cal. Health & Safety Code § 1374.34(a).

[39] *See* Cal. Health & Safety Code § 1368.02.

[40] *See* Cal. Health & Safety Code § 1368.03.

[41] Cal. Health & Safety Code § 1368(b)(1)(A).

[42] *See* Cal. Health & Safety Code § 1368.02.

[43] *See* Cal. Health & Safety Code § 1368.02.

[44] Cal. Health & Safety Code § 1368(b)(5).

[45] Cal. Health & Safety Code § 1368(b)(6).

[46] Cal. Welf. & Inst. Code § 10950; *see also* 22 C.C.R. § 51014.1; NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 5.

[47] *See* Cal. Welf. & Inst. Code § 10950; *see also* NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 5.

[48] Cal. Welf. & Inst. Code § 10951(b)(1)(A)-(B).

[49] Cal. Welf. & Inst. Code § 10951(b)(1)(A)-(B).

[50] 42 C.F.R. §§ 438.402(c)(1)(i)(A), 438.408(f)(1)(i)(called deemed exhaustion in the final rule and this issue brief); DHCS MHSUDS 18-010E, at 11, 14; *see also* NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 6.

[51] 42 C.F.R. §§ 431.201, 438.402(c)(3)(ii); Cal. Welf. & Inst. Code §§ 10950(a), 10951(a); DHCS APL 21-011 at 14; DHCS MHSUDS 18-010E at 9, 10.

[52] 28 C.C.R. § 1300.74.30(f)(3).

[53] Cal. Welf. & Inst. Code § 10951(b)(2).

[54] Cal. Welf. & Inst. Code § 10951(c). Other factors considered when determining whether there is "good cause" include the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. An instance that would not be considered "good cause" is a person's inability to understand an adequate and language-compliant notice.

[55] Cal. Welf. & Inst. Code § 10951(b)(2).

[56] 42 C.F.R. § 431.244(f); Cal. Dep't of Social Servs., Manual of Policies & Procedures § 22-060, https://www.cdss.ca.gov/Portals/9/Regs/4CFCMAN.pdf [hereinafter CDSS MPP § 22-060].

[57] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; Cal. Dep't of Social Servs., All County Letter No. 13-40 at 1-3 (May 20, 2013), https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-40.pdf [hereinafter CDSS ACL 13-40].

[58] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[59] Cal. Gov. Code § 100506.4(a)(2).

[60] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[61] Cal. Dep't of Social Servs., All County Letter No. 23-82 at 2 (Sept. 19, 2023), https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2023/23-82.pdf?ver=2023-10-06-083956-020 [hereinafter CDSS ACL 23-82].

[62] CDSS ACL 23-82 at 4.

[63] CDSS ACL 23-82 at 7.

[64] CDSS ACL 23-82 at 4.

[65] CDSS ACL 23-82 at 3.

[66] Cal. Welf. & Inst. Code § 10952(a).

[67] Cal. Welf. & Inst. Code § 10952(a).

[68] 42 C.F.R. § 431.242.

[69] Cal. Welf. & Inst. Code § 10952.5 (This applies to State Fair Hearings for both Medi-Cal eligibility and Medi-Cal scope of benefits).

[70] Cal. Welf. & Inst. Code § 10952.5(a).

[71] Cal. Welf. & Inst. Code § 10952.5(c).

[72] 42 C.F.R. § 431.244(f); CDSS MPP § 22-060.

[73] Cal. Welf. & Inst. Code § 10959(a).

[74] Cal. Welf. & Inst. Code § 10959(a).

[75] Cal. Welf. & Inst. Code § 10959(b).

[76] Cal. Welf. & Inst. Code § 10961.

[77] Cal. Welf. & Inst. Code § 10960.

[78] Cal. Welf. & Inst. Code § 10960.

[79] 42 C.F.R. § 431.232(b); Cal. Welf. & Inst. Code § 10960.

[80] Cal. Welf. & Inst. Code § 10960(d).

[81] Cal. Welf. & Inst. Code § 10960(e).

[82] Cal. Welf. & Inst. Code § 10962.

[83] Cal. Welf. & Inst. Code § 10962.

[84] Cal. Welf. & Inst. Code § 10950(a); Cal. Gov't Code § 100506.4(a)(1); 22 C.C.R. § 50951.

[85] 42 C.F.R. §§ 431.206(b), 431.210, 435.912, 435.917(a); 22 C.C.R. § 51014.1.

[86] 42 C.F.R. §§ 431.206(b), 431.210; 22 C.C.R. § 51014.1.

[87] 42 C.F.R. §§ 435.916(g), 435.917(a), 431.206(e), 435.905(b).

[88] 42 C.F.R. § 435.918(a).

[89] 42 C.F.R. § 431.206; 22 C.C.R. § 51014.1.

[90] 42 C.F.R. § 431.213; 22 C.C.R. § 51014.1.

[91] 42 C.F.R. § 431.230; 22 C.C.R. §§ 51334(c), 51014.2(a), (c).

[92] 42 C.F.R. § 431.230; 22 C.C.R. §§ 51334(c), 51014.2(a), (c).

[93] Cal. Welf. & Inst. Code § 10950(a); Cal. Gov. Code § 100506.4(a)(1); 22 C.C.R. § 50951.

[94] Cal. Welf. & Inst. Code § 10951(a)(1)(2); Cal. Gov. Code § 100506.4(a)(1). Cal. Welf. & Inst. Code § 10951(c). Other factors considered when determining whether there is "good cause" include the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. An instance that would not be considered "good cause" is a person's inability to understand an adequate and language-compliant notice.

[95] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 1-3.

[96] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[97] Cal. Gov. Code § 100506.4(a)(2)

[98] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[99] CDSS ACL 23-82 at 2.

[100] CDSS ACL 23-82 at 2.

[101] CDSS ACL 23-82 at 4.

[102] CDSS ACL 23-82 at 7.

[103] CDSS ACL 23-82 at 4.

[104] CDSS ACL 23-82 at 3.

[105] Cal. Welf. & Inst. Code § 10952(a).

[106] Cal. Welf. & Inst. Code § 10952(a).

[107] 42 C.F.R. § 431.242.

[108] Cal. Welf. & Inst. Code § 10952.5 (this applies to State Fair Hearings for both Medi-Cal eligibility and Medi-Cal scope of benefits).

[109] Cal. Welf. & Inst. Code § 10952.5(a).

[110] Cal. Welf. & Inst. Code § 10952.5(c).

[111] 42 C.F.R. 431.244(f); CDSS MPP § 22-060.

[112] Cal. Welf. & Inst. Code § 10959(a).

[113] Cal. Welf. & Inst. Code § 10959(a).

[114] Cal. Welf. & Inst. Code § 10959(b).

[115] Cal. Welf. & Inst. Code § 10961.

[116] Cal. Welf. & Inst. Code § 10960.

[117] Cal. Welf. & Inst. Code § 10960.

[118] 42 C.F.R. § 431.232(b); Cal. Welf. & Inst. Code § 10960.

[119] Cal. Welf. & Inst. Code § 10960(d).

[120] Cal. Welf. & Inst. Code § 10960(e).

[121] Cal. Welf. & Inst. Code § 10962.

[122] Cal. Welf. & Inst. Code § 10962.

[123] Cal. Dep't of Health Care Servs., *Welcome to Medi-Cal Rx*, https://medi-calrx.dhcs.ca.gov/home/ (last visited Feb. 22, 2025).

[124] Complaint and grievance are used interchangeably in this section, which is also in accordance with Medi-Cal Rx policy. *See* Cal. Dep't of Health Care Servs., *Medi-Cal Rx Complaints/Grievances Policy Version 6* (April 7, 2021), https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Complaints-and-GrievanceV6.0-04072021.pdf (last visited Feb. 22, 2025)[hereinafter DHCS *Medi-Cal Rx Complaints/Grievances Policy*].

[125] DHCS' existing threshold languages (17 total) are Arabic, Armenian, Cambodian, Chinese, English, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Punjabi, Russian, Spanish, Tagalog - Filipino, Thai, and Vietnamese.

[126] *See also* DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 2-4 (reasons that would not be considered a complaint).

[127] For an overview of PACE (Program of All-Inclusive Care for the Elderly) *see* U.S. Ctr. for Medicare and Medicaid Servs., Medicare, *PACE*, https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE (last visited Feb. 12, 2025).

[128] Rachel Gershon & Tiffany Huyenh-Cho, Justice In Aging, *Dual Eligible Special Needs Plans (D-SNPs): What Advocates Need to Know* (Feb. 28, 2024), https://justiceinaging.org/dual-eligible-special-needs-plans-d-snps-what-advocates-need-to-know/ (last visited Feb. 12, 2025)[hereinafter *D-SNPs: What Advocates Needs to Know*].

[129] Cal. Health & Safety Code § 1368.01(b); 28 C.C.R. § 1300.68.01.

[130] 42 C.F.R. § 422.630.

[131] The terms "coverage determination" and "Integrated Organizational Determinations" are used interchangeably in this section.

[132] 42 C.F.R. § 422.631(d)(2)(i)(B); Cal. Health & Safety Code § 1367.01(h)(1).

[133] 42 C.F.R. § 422.631(d)(2)(iv); Cal. Health & Safety Code § 1367.01(h)(2).

[134] 42 C.F.R. § 422.633(d)(1); U.S. Ctr. for Medicare and Medicaid Servs., *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 50.9.1 (Nov. 18, 2024), https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf (last visited Feb. 12, 2025) [hereinafter *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*].

[135] 42 C.F.R. § 422.631(d)(2)(i)(A).

[136] 42 C.F.R. § 422.632(a).

[137] 42 C.F.R. § 422.629 (d).

[138] 42 C.F.R. §§ 422.633(f)(1), (2).

[139] To identify Medicare coverage determination guidance for particular services or items using National level, *see* U.S. Ctr. for Medicare and Medicaid Servs., *Medicare Coverage Database*, https://www.cms.gov/medicare-coverage-database/search.aspx (last visited Feb. 12, 2025). To identify Medicare coverage determination guidance for particular services or items using Local levels, *see* Noridian Healthcare Solutions, *Medicare*, https://med.noridianmedicare.com/ (last visited Feb. 22, 2025) (for California local coverage determinations information); U.S. Ctr. for Medicare and Medicaid Servs., *National Government Services*, https://www.ngsmedicare.com/web/ngs/home?lob=93618&state=97162&rgion=93624 (last visited Feb. 22, 2025) (for Home Health and Hospice).

[140] *See Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 70.1; *see* § 70.2 (regarding the amount in controversy requirements).

[141] *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 70.1 (except there are no amount in controversy requirements).

[142] *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 70.1 (note the 2025 amount in controversy requirement for Federal District Court review is $1,900).

[143] *See* U.S. Dep't of Health & Human Servs., Administration for Community Living, *National Center on Law and Elder Rights*, https://ncler.acl.gov/medicare#gsc.tab=0 (last visited Feb. 22, 2025).

[144] Cal. Dep't of Health Care Servs., *Discrimination Grievance Policies and Procedures*, https://www.dhcs.ca.gov/discrimination-grievance-procedures (last visited Feb. 22, 2025).

[145] Cal. Dep't of Health Care Servs., *DHCS Discrimination Complaint Form (Title VI and ADA)*, https://www.dhcs.ca.gov/Documents/1044-DHCS-DISCRIMINATION-COMPLAINT-FORM.pdf (last visited Feb. 22, 2025).

[146] *See generally* State of California, Civil Rights Department, *Complaint Process*, https://calcivilrights.ca.gov/complaintprocess/#appealBody (last visited Feb. 24, 2025).

[147] Instructions on how to create an account and upload documents can be found at State of California, Civil Rights Department, *How to File a Complaint*, https://calcivilrights.ca.gov/complaintprocess/how-to-file-a-complaint/# (last visited Feb. 24, 2025).

[148] State of California, Civil Rights Department, *Office Locations*, https://calcivilrights.ca.gov/locations/ (last visited Feb. 24, 2025).

[149] *See* Cal. Gov. Code § 11135 [laws that prohibit discrimination in state-funded programs]; Cal. Civil Code § 54 [Disabled Persons Act]; Cal. Civil Code § 51.7 [Ralph Civil Rights Act (prohibits hate violence or threat of hate violence)]; Cal. Gov. Code §§ 12900-12999 [Fair Employment and Housing Act]; Cal. Gov. Code § 12945.2 [Cal. Family Rights Act (CFRA)]; Cal. Civil Code § 51 [Unruh Civil Rights Act (requires business establishments to provide equal accommodations)]; Cal. Civil Code § 51.9 [prohibits sexual harassment in business, service or professional contexts outside of traditional employment relationships]; Cal. Civil Code § 52.5 [Cal. Trafficking Victims Protection Act].

[150] *See* Cal. Gov. Code § 11135.

[151] *See* Cal. Civil Code § 54.

[152] *See* Cal. Civil Code § 51.7.

[153] For additional information please refer to 2 C.C.R. §§ 10033, 10065.

[154] *See* U.S. Dep't of Health and Human Servs., *How to File a Civil Rights Complaint,* https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html (last visited Feb. 22, 2025).

[155] U.S. Dep't of Health and Human Servs., Office for Civil Rights, *Civil Rights and Conscience Complaint*, https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf (last visited Feb. 24, 2025).

[156] U.S. Dep't of Health and Human Servs., Office for Civil Rights, *Complaint Portal Assistant*, https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf (last visited Feb. 24, 2025).

An Advocate's Guide to Access Gender-Affirming Care in California

March 2025

CHAPTER 6: Outreach & Building Relationships with the TGI Community

CHAPTER 6 – OUTLINE

CHAPTER 6: OUTREACH & BUILDING RELATIONSHIPS WITH THE TGI COMMUNITY 6.3

A. CONNECT WITH COMMUNITY-BASED ORGANIZATIONS & HEALTH CARE PROVIDERS THAT SERVE THE LGBTQIA+ COMMUNITY 6.3

B. ROLE & MODE OF OUTREACH IN YOUR LOCAL TGI COMMUNITY 6.4

C. ORGANIZATIONS SERVING LGBTQIA+ PEOPLE 6.5

CHAPTER 6: OUTREACH & BUILDING RELATIONSHIPS WITH THE TGI COMMUNITY

Outreach and engagement within your local TGI community is more than going to resource fairs and creating awareness of your respective services. Given the tenor and tone of public discourse relating to the TGI population in which bigoted and discriminatory speech, practices, and laws are freely published, promoted, and signed into law on a national, state, and local level, the TGI population is under attack. The TGI community in your area may be, rightfully, protective and distrustful of efforts to engage. Therefore, outreach and engagement must be carried out in a manner that respects the experiences of TGI people, by those who demonstrate TGI-specific cultural competency. The key to success is consistent engagement, demonstrated competency and skill, and commitment to service that is beneficial to TGI individuals or the broader TGI community.

This Chapter outlines some basic steps to consider when initiating engagement of the TGI community in your area and by no means is an exhaustive guide. Further, not all elements of these suggested approaches may be relevant in your area. Rather, these are offered as elements to consider implementing into your ongoing outreach and engagement efforts.

Please see Chapter 7 of this Guide for an in-depth discussion of cultural competency, which goes hand-in-hand with this Chapter on outreach and engagement. In order for your outreach and engagement to be respectful and productive, you should have some level of cultural competency before initiating these activities. And, on the other hand, your continued participation in outreach and engagement will likely strengthen your cultural competency over time.

A. Connect with Community-Based Organizations & Health Care Providers that Serve the LGBTQIA+ Community

Despite generations of oppression and attempts of eradication, LGBTQIA+ people have a unique talent to find each other and build a sense of community, even in the deepest and darkest of proverbial closets. The HIV/AIDS epidemic was a catalyst that pushed many informal networks of support into more structured organizations to specifically address the needs of LGBTQIA+ people contracting HIV/AIDS, mainly gay men. The San Diego Blood Sisters is one notable example, a group of lesbians who organized blood drives to collect donations. When the government, doctors, and scientists refused to care for HIV positive patients, lesbians stepped in. This is only one example of the types of grass root efforts within the LGBTQIA+ community that have extensive histories in each of your communities. Having some context and appreciation for an organization's history and contributions to the advancement of LGBTQIA+ rights and services in your area will enhance your engagement efforts.

Unfortunately, many institutions and governments are still not designed with TGI people in mind, and many explicitly exclude or criminalize TGI people. Many individuals rely on local community-based LGBTQIA+ organizations to access health care services and other resources. Consequently, community-based organizations and providers serving LGBTQIA+ people are in the best position to identify and track emerging systemic issues and barriers to accessing health care services in your community. Connecting with community-based organizations and health care providers serving LGBTQIA+ people is a vital part of outreach and building trust with the LGBTQIA+ community.

A common example of these community-based organizations is a community center that focuses on serving LGBTQIA+ people such as The San Diego LGBT Community Center and the North County LGBTQ Resource Center. However, these more structured community organizations tend to be physically located in bigger cities, which leaves LGBTQIA+ people in rural areas with fewer options for resources and services.

As the result of two simultaneous pandemics, COVID-19 and MPOX, community-based organizations were forced to adapt to providing services remotely and many organizations continue to maintain hybrid models to access their services either in person or remotely. The evolution to a hybrid model eliminated many physical barriers to accessing services and resources, while allowing organizations to focus on the disparities unique to their local community. For example, LGBTQIA+ community centers frequently organize and host support groups that are hybrid which allows individuals to join in person or online. Consequently, building trust with your local LGBTQIA+ community may require you to engage in outreach with community-based organizations that are not physically located in or near your neighborhood.

Finally, in the initial stages of forming new relationships, it is also important to ensure you give a direct point of contact for your organization to promptly address any questions or concerns. That direct point of contact must promptly respond to any questions or concerns in order to help build trust, establish credibility, and identify clear lines of communication for overcoming any barriers to accessing your organization's services.

B. Role & Mode of Outreach in Your Local TGI Community

The type of outreach most beneficial for you or your organization will likely depend on your available resources and experience with the TGI community. There may be a temptation to think that outreach is best achieved by attending big community events with the largest number of attendees. The logic follows: a large number of attendees allows for the greatest exposure of your services in the least amount of time. For example, pride parades are usually an annual event in cities and towns across the country attended by many LGBTQIA+ people. While pride parades and related events certainly present a great opportunity for exposure and to distribute informational flyers, they may not be ideal to build trust with the community.

If you are in the beginning stages of building trust with the TGI community, your time may be better spent attending smaller, regularly scheduled events, such as community support groups or monthly gatherings. The smaller events foster more opportunities for one-on-one face time to start or continue learning about the personal experiences of LGBTQIA+ people. Consistent attendance at community events is vital to building trust. Outreach and engagement should not be limited to times when TGI people are in the room or have a seat at the table. Due to historic discrimination and disenfranchisement, TGI people do not have representation in decision making processes. You can cultivate opportunities to engage the TGI community by identifying situations in your work routine and scope of services that lack TGI representation or input.

It is helpful to think about outreach to another organization as a two-way street. You are not just announcing the services your organization provides; you should be listening carefully to the other organization to understand what services they already provide, and where there might be gaps that your organization can fill. Understanding the work that is already being done by the other organization shows you respect its history and helps avoid duplication of effort and client confusion about which organization does what.

C. Organizations Serving LGBTQIA+ People

Below are some common types of organizations that serve LGBTQIA+ people that are helpful for engaging consumers, learning about local needs and concerns, and collaborating on local solutions. This is a non-exhaustive list intended to help you identify local partners to jump start your local outreach and engagement efforts:

- LGBTQIA+ community centers
- Legal associations or groups such as National LGBTQ+ Bar Association,[1] LGBTQ+ Lawyers Association of Los Angeles,[2] Tom Homann LGBTQ+ Law Association,[3] etc.
- Medical associations or boards
- LGBTQIA+ and Gender-related health clinics
- LGBTQIA+ Advocacy groups such as TransFamily Support Services,[4] Lambda Legal,[5] TransLatin@ Coalition,[6] Equality California,[7] etc.

ENDNOTES

[1] The Nat'l LGBTQ+ Bar Ass'n and Foundation, https://lgbtqbar.org/ (last visited Feb. 22, 2025).

[2] LGBTQ+ Lawyers Association of Los Angeles, https://lgbtqlawyersla.org/ (last visited Feb. 22, 2025).

[3] Tom Homann LGBTQ+ Law Ass'n, https://www.thla.org/ (last visited Feb. 22, 2025).

[4] TransFamily Support Servs., https://transfamilysos.org/ (last visited Feb. 22, 2025).

[5] Lambda Legal, https://lambdalegal.org/ (last visited Feb. 22, 2025).

[6] The TransLatin@ Coalition, https://www.translatinacoalition.org/ (last visited Feb. 22, 2025).

[7] Equality California, https://www.eqca.org/ (last visited (Feb. 22, 2025).

An Advocate's Guide to Access Gender-Affirming Care in California

March 2025

CHAPTER 7: Cultural Competency

Chapter 7 – Outline

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CHAPTER 7: CULTURAL COMPETENCY

This Chapter is intended for individuals that are new to serving the TGI community. If you are new to serving the TGI community, please do not let your lack of experience discourage you from taking cases involving barriers to gender-affirming care. But it will take some steps to ensure you are providing culturally competent services.

While various definitions of cultural competency exist, the term generally refers to the ability to understand the values, beliefs, and practices of a given culture, thereby allowing one to interact respectfully and effectively with someone of that culture.[1] For example, in order to be culturally competent with respect to the TGI community, you must, at minimum, respect each individual's name and gender identity, as well as have an understanding of why these aspects of identity are significant for this particular community.

Examples of not being culturally competent include "deadnaming" and "misgendering." The nature of the legal profession and case management systems carries inherent risks for deadnaming and misgendering that can be minimized, if not eliminated. Adjustments to the intake process, such as intake forms and questions, can reduce the risk of causing trauma or triggering a person's gender dysphoria.

Keep in mind that cultural competency includes awareness and understanding of multiple intersecting aspects of an individual's lived experiences, including race, ethnicity, sexual orientation, disability, and more.[2] This Chapter will largely focus on gender identity.

A. Deadnaming: Current Name, Legal Name, & Birth Name

Some transgender, gender-diverse, and intersex individuals may change their name (and sometimes multiple times) as a part of their social transition. **Deadnaming** occurs when the incorrect name is used to refer to a transgender, gender-diverse, or intersex person.[3] Deadnaming may occur intentionally or unintentionally.[4] The incorrect name, referred to as their **deadname**, is typically the name used before their current name and may also be known as their "birth name" or "given name."[5]

Deadnaming can be harmful and invalidating for TGI individuals and is considered disrespectful.[6] Deadnaming (and using incorrect pronouns) should be avoided even when the person is not present, as doing so may create an unsafe environment by outing their transgender status to others and revealing private information of the individual.[7]

Not all TGI people legally change their name, even if they go by a different name. There are many reasons for this, including cost, time, energy, and safety. This means the name they currently use may not appear on their legal or other identity documents. Since many TGI people disproportionately experience health and income disparities, not all TGI people can physically or financially access a legal name or gender marker change.

You should use a person's self-identified name and avoid using their birth name, regardless of whether the person has legally changed it. As discussed below, it is important to avoid deadnaming a TGI client during the intake process. A person's deadname is largely not relevant, with few exceptions, to providing TGI individuals with assistance, even if it is still their legal name. In the legal profession, there are two exceptions when a person's deadname is relevant to providing TGI individuals with assistance:

(1.) Conducting a conflict of interest check.

In this Chapter's section F. Intake Forms & Questions; Screening Script, we provide some sample intake questions to help gather the information necessary to conduct a conflict of interest check in a culturally competent manner. In section G. Conflict of Interest Check, we provide some tips on conducting a culturally competent conflict of interest check and methods to reduce trauma for TGI clients.

(2.) If their legal issue is somehow related to the difference in their identity documents.

Barriers to accessing health care may arise if a person's name does not match their identity documents. This is important to keep in mind if your organization provides representation to clients and to spot legal issues. For example, if a health plan denies coverage of a service to a TGI person because the name they currently use is different from their birth name, then the person's birth name (or deadname) is related to their legal issue.

B. Pronouns

When you first meet a new person, it is respectful to ask their name or introduce yourself, rather than guessing someone's name. The same principle is applicable to a person's **pronouns** (the words, other than the person's name, that should be used to refer to that person). Rather than assume someone uses "he/him" or "she/her", it is a best practice to ask people what pronouns they would like you to use and to share your pronouns, too. There is no "right" way to be transgender and transgender people are not monolithic. It is important not to make assumptions about a person's gender identity, pronouns, or preferences based on their appearance. In fact, some people go by multiple pronouns, such as "he/they" or "she/he/they". Asking people what pronouns they use and sharing your pronouns normalize asking and answering, and help to create a culture of visibility and inclusivity.

C. Misgendering

Misgendering refers to the act of incorrectly assigning a gender identity to another person. This can happen explicitly or indirectly, and intentionally or unintentionally, through gendered language. Referring to a person as a boy or man or using "he/him" pronouns when that person self-identifies as a woman or girl is an example of explicit misgendering. Refusing to use a nonbinary person's pronouns because you may disagree with them is another form of misgendering. It is also possible to indirectly misgender people through gendered language such

as mother/father, brother/sister, or Mr./Mrs./Ms. Or in settings where colloquial language – such as referring to a group of people as "guys" or "ladies" – is used.

If you misgender someone, it is important to not make the situation about you and to not draw out the situation. Mistakes happen and it is human to accidentally use the wrong pronoun or pronouns. If you misgender another person, apologize, correct yourself by using the correct pronoun, and then move on. It is also important to make every effort to not repeat the mistake. The National LGBTQIA+ Health Education Center advises frontline health care staff that:

> Occasionally, a patient will have a very negative reaction to being misgendered, even after an apology. Remember that many TGD[8] people have experienced extreme discrimination and trauma, making it challenging for them to trust others. Try to stay calm and not take their reaction personally. A second thoughtful apology can go a long way in changing the patient's experience."[9]

If asking about and using different pronouns are new skills for you, be patient with yourself and keep practicing. Having a colleague or friend to practice with can be a helpful way to get comfortable and keep yourself accountable.

ADVOCACY TIP # 7.1: Some people use multiple types of pronouns and/or do not have a preference over pronouns. If you want to try to practice your cultural competency skills, try using a different pronoun that a person goes by instead of using the same one. For example, a person who goes by "he/they", try using "they" for a change if you typically have referred to that person with "he" pronouns.

D. Recognizing the Mental Impact on TGI People

Navigating issues related to medical necessity or otherwise getting gender-affirming services authorized by insurance can take a mental toll on TGI individuals and many barriers can stem from this particular criterion for coverage. Improper denials for gender-affirming care on the basis of being cosmetic or lacking medical necessity can trigger the individual's gender dysphoria. The denials are often loaded with unaffirming, transphobic, or outdated language. It can also be helpful to prepare your client to expect at least one inappropriate denial on their journey to accessing gender-affirming care. In doing so, it is important to also equip them with the knowledge and advocacy strategies to overcome the denial. This can help prevent the shock of receiving a denial.

E. Case Management Systems

A case management system is a tool that advocates use to create, document details of, and organize cases. When creating a new case in the system, the advocate needs to have some basic information about the client in order to label the case correctly (by client name, by legal issue type, etc). This basic information might be collected from the client during the intake process, discussed in section F. of this Chapter.

If your case management system is formatted to automatically label/identify cases using the client's legal name, it creates a risk of deadnaming or misgendering clients. A culturally competent case management system will allow the advocate to use a different input, such as a case number, as a case identifier. Or, if the case identifier must be a name, then it should be the client's currently used name and not legal name.

Once this basic information is entered into the case management system, the advocate (often assisted by functionality built into the case management software) can perform a conflict of interest check by comparing this new client's information to information that is already in the system about cases the organization is handling now or has handled in the past. The conflict of interest check is discussed in section G of this Chapter.

Case management systems can also be used to keep statistics and identify trends. For example, you can use sorting and searching functions to identify how many cases in a given year involved a certain issue type, or clients living in a certain zip code. Being able to quantify your organization's work is important for various reasons, such as identifying systemic issues, complying with grant reporting rules, and seeking additional funding.

F. Intake Forms & questions / Screening Script

If you and/or your organization uses an intake process, it is important to ensure that the questions asked during intake are inclusive and responsive to individuals who are TGI. Below are some general intake questions that may be applicable to many intake forms:

(1.) May I have your name?

What is your (currently used) name?

What name do you go by?

CAUTION: It is important to note that questions (2.) and (3.) may be relevant questions only if you are a law firm or providing legal representation, and need to conduct a conflict of interest check.

(2.) Is it the same as your current legal name?

If their currently used name and their legal name are different, you may ask if they want to legally change their name and/or gender marker. If so, then you may try to refer them to a local name and gender marker change clinic to assist with that legal process.

(3.) Do you have any prior names, including nicknames, maiden names, aliases?

If they have a prior legal name(s) and/or gender marker(s), ask if they are experiencing any barriers to change it with the county, health plan, or providers' offices.

(4.) What is your gender identity?

(5.) What pronouns do you use?

While not every TGI person contacting your organization will have a legal issue that is related to accessing gender-affirming care, there are questions that can be helpful to screen for potential barriers. Below are some sample prompts to issue spot:

(1.) Are you seeking a gender-affirming service that you are not already receiving?

(2.) Are you having any problems getting gender-affirming care? Is there anything preventing you from obtaining gender-affirming care?

(3.) Do you have any questions about gender-affirming care?

(4.) Have you been denied any gender-affirming services?

If your organization requires you to ask all individuals about their sex, gender identity, sexual orientation, etc., it is normal to encounter some resistance, confusion, questions or concerns, or sometimes bigotry when asking such questions. It is a best practice to explain why the questions are necessary to ask and why they are important.

Here are some examples of helpful responses:

- We understand your concern about these questions. Answering is voluntary, and any answer will be kept confidential.
- We do not want to assume any information, the same way we do not assume names.
- These questions allow us to better serve all of our community in the most respectful way possible.
- This information allows us to identify systemic issues or barriers impacting our community.

G. Conflict of Interest Check

There are aspects of serving the TGI community that may present new challenges for law firms to navigate at first. Legal professionals who provide legal representation or certain levels of legal assistance are required to screen for any conflict of interest under legal ethics rules. In order to conduct conflict of interest checks, they must ask prospective clients for all the names they have used including their current and prior legal names, nicknames, maiden names, and aliases. Regardless of whether they have legally changed their name, a TGI person's birth name or deadname can be a great source of trauma and trigger their gender dysphoria even though the information is necessary before providing certain levels of legal representation. It is a best practice to explain the reason you are asking for this information and to reassure the individual that you are using the information in a limited scope and you will be addressing the person by the name they currently use.

ADVOCACY TIP # 7.2: When explaining the reason for conflict of interest checks, it can be helpful to use an example of a married couple seeking a divorce. It is also helpful to reassure that the information is confidential, you are asking for the information only to complete a conflict check, and you will be addressing the person by the name and pronouns they currently use.

For some TGI people, saying their deadname out loud is simply not an option. Simply explaining why you are asking about their deadname and explaining the limited scope in which you need to say or use their deadname is often helpful to manage expectations and let the client decide how they would like to proceed in providing that information to you. It is helpful to offer alternative methods for providing the information such as writing the name down, sending it in an email, or providing a copy of the court order if they legally changed their name.

H. Creating a Safe & Inclusive Space for TGI People

a. Documents & Materials

Gendered language can appear in many places such as letters, emails, forms, and brochures. Making documents and materials culturally competent depends on different factors, such as the purpose of the document and its intended audience. Be sure to review any template correspondence for gendered language and remove it or switch to gender-neutral language. If it is an intake form or other type of form containing client information, it is also helpful to include a space for the person's pronouns, if necessary.

Examples of gendered language, along with the gender-neutral term to use instead:

Instead of:	***Use:***
He or She	They
Pregnant women	Pregnant people
Maternal health	Parental health Birthing person
Husband or Wife	Spouse Partner

Remember that TGI individuals have complex, full lives like everyone else. They are parents, children, siblings, etc.

b. Bathrooms & Signage

It is important to create an affirming physical environment for TGI clients, too. This can include common areas, office spaces, bathrooms, and more. Below are a few best practices to help make your organization a more inclusive and safe space for TGI clients.

One primary way to create an inclusive environment is by avoiding gendered spaces, which most commonly comes up around bathrooms. Not everyone identifies as a "man" or a "woman" and even binary TGI individuals still may feel apprehensive about entering a bathroom even if it corresponds with their gender identity. Unfortunately, even in more TGI-friendly cities and towns, many TGI people encounter a lot of discrimination, harassment, and violence existing in public spaces, including public restrooms. Ensuring that your organization has gender-neutral or all-gender restrooms or simply converting restroom signage to gender-neutral or all-gender bathroom signage is an important way to make a more open space for TGI clients (and colleagues). The National LGBTQIA+ Health Education Center recommends that you "[m]ark single-occupancy bathrooms as 'All Gender.' If this option is not possible, have a policy and signage that allow TGD patients to use the bathroom that most closely matches their gender identity."[10]

It is also helpful to use inclusive language and images on other forms of communication that are visible to all, such as organization websites, educational materials, and posters.[11] For example, the National LGBT Cancer Network published some recommendations, including, "[p]ost a nondiscrimination policy that includes sexual orientation and gender identity[; e]nsure that public areas include wall art with LGBTQ images and contain LGBTQ publications[; p]lace rainbow stickers or pins on staff and posters[; and i]nclude LGBTQ images and language in all printed materials/brochures."[12]

REMEMBER: Cultural competency is a multifaceted process and requires commitment. All of the above factors are important in order to make your place of work more affirming for TGI clients and your representation of TGI clients more effective. However, building trust with TGI communities, like anything else, takes time and continued action. While using brochures and having physical materials and signage that appear inclusive for TGI clients are important, they are only initial steps and largely superficial if all other efforts are not incorporated into your organization's plans to build cultural competency. The ways of speaking with and issue spotting common experiences and barriers for TGI clients to ensure effective representation and to protect their interests within an attorney-client relationship are what is most important; this can only be accomplished through continued practices.

Endnotes

[1] A related term is cultural humility, which involves not only understanding and respect for another culture but also self-reflection of your own culture, including an awareness of how your own biases or assumptions shape your views. *See, e.g.*, Katherine A. Yeager and Susan Bauer-Wu, "Cultural Humility: Essential Foundation for Clinical Researchers." *Appl Nurs Res.* (Aug 12, 2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3834043/ (last visited Feb. 21, 2025).

[2] *See* Columbia Law School, *Kimberlé Crenshaw on Intersectionality, More than Two Decades Later* (June 8, 2017), https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later (last visited Feb. 21, 2025).

[3] Healthline, *What is Deadnaming?*, https://www.healthline.com/health/transgender/deadnaming (last visited Feb. 21, 2025) [hereinafter *What is Deadnaming?*].

[4] *What is Deadnaming?*

[5] *What is Deadnaming?*

[6] Nat'l Inst. Health Office of Intramural Training & Education Blog, *Understanding the Impact of Misgendering and Deadnaming* (Jul. 31, 2023), https://web.archive.org/web/20231007003321/https://oitecareersblog.od.nih.gov/2023/07/31/understanding-the-impact-of-misgendering-and-deadnaming/ (last visited Feb. 21, 2025) [hereinafter *Understanding the Impact*].

[7] *Understanding the Impact*.

[8] In this source, "TGD" means "transgender and gender-diverse."

[9] National LGBTQIA+ Health Education Center, *Affirmative Services for Transgender and Gender-Diverse People: Best Practices for Frontline Health Care Staff* (updated Winter 2020) at 8, https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/03/TFIE-40_Best-Practices-for-Frontline-Health-Care-Staff-Publication_web_final.pdf (last visited Feb. 21, 2025) [hereinafter *Affirmative Services*].

[10] *Affirmative Services* at 12.

[11] National LGBT Cancer Network, *Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies*, https://cancer-network.org/wp-content/uploads/2017/02/best_practices.pdf (last visited Feb. 21, 2025) [hereinafter *Cultural Competency Trainings*].

[12] *Cultural Competency Trainings* at 19.