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

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

HCA
Health Consumer Alliance

CHAPTER 4 – OUTLINE

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

Adult & pediatric specialists[39]	Dense Counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, & Santa Clara	15 miles or 30 minutes
	Medium Counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, & Ventura	30 miles or 60 minutes
	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	45 miles or 75 minutes
	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	60 miles or 90 minutes
Outpatient mental health services	Dense Counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, & Santa Clara	15 miles or 30 minutes
	Medium Counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, & Ventura	30 miles or 60 minutes
	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	45 miles or 75 minutes
	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	60 minutes or 90 miles

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]

Urgent Care	where no prior authorization is required	within 48 hours of request
	where prior authorization is required	within 96 hours of request
Non-Urgent Care and Primary Care		within 10 business days of request
Non-Urgent Specialty Care		within 15 business days of request
Non-Urgent Non-Physician Mental Health Care		within 10 business days of request
Non-Urgent Ancillary Services		within 15 business days of request

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).