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 what benefits your plan covers and the requirements to access them. This chapter explores the process to access gender-affirming care for those with Medi-Cal managed care plans and common barriers you might encounter along the way. Identifying barriers in your case determines the next steps to access the service. This Chapter explains how accessing gender-affirming care *should* happen and helpful strategies to overcome barriers that may surface during the process.

If you are faced with barriers when trying to access gender-affirming care services, see Chapter 5 to learn how to address the barriers.

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

Generally, the first step to access health care services is identifying a qualified provider to perform the service and talking with your **Primary Care Provider** (PCP). If you do not have a PCP, you will need one in order to obtain the necessary referrals to specialists. 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 from your PCP in order to see the provider, including if you want the appointment covered by your health plan.

a. In-Network vs. Out-of-Network

In-network providers, or "contracted providers," are health care providers who have 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," are

providers who do not have a formal agreement with your plan. Out-of-network providers typically do not accept payment from your health plan for services, and your plan usually will not pay for service they provide without prior authorization, even if the service they are providing is a covered benefit.

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 or a list of in-network providers who provide the care you're seeking. It is common that health plan directories are inaccurate or health plan representatives do not accurately identify in-network providers. Health plans are ultimately responsible for finding an in-network provider (or an out-of-network provider if there is no provider in-network). Although it is best practice to also contact a provider's office to confirm they accept your specific health plan. If you experience any issues with identifying in-network providers, you can file a grievance with your plan. See Chapter *5* to learn more about grievances and appeals.

Medi-Cal managed care plans are responsible for knowing the providers in their network and the services they provide.[1] Your plan should not force you to search for a provider on your own, investigate whether they are in- or out-of-network, or investigate whether the provider performs the service you're seeking. If your plan is unable to identify any qualified in-network providers to perform the service, then your plan is required to find an out-of-network provider.[2] If your plan does not identify in-network providers upon request, we recommend filing a grievance, which is covered in Chapter *5*.

[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].

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

Your plan is not only required to publish and maintain an accurate provider directory, but they must also include those who accept new patients.[3] The provider directory must include: name, group affiliation, street address, telephone number, website, specialty as appropriate, if the provider is accepting new patients, cultural and linguistic capabilities of the provider and their office, and whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.[4]

Medi-Cal managed care plans 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 contracted 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

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 in case your plan fails to provide it. Documentation of your request creates an important

[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).

you an inaccurate list of providers, you can file a grievance. See Chapter 5 to learn more about grievances and appeals.

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

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

b. Primary Care Provider

Any time you 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 generally the doctor who must submit referrals for specialty care. Your PCP will submit necessary prior authorization requests to your health plan 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 (TGI) community.[7] If

[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].

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 many 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 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]

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] Note the provider's attestation is voluntary. *See* DHCS APL 24-017 at 4.

[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*].

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 which services require a 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, 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 the service 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

[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.

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 reconstructive surgery criteria. 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 care.[18] When reviewing requests for gender-affirming services, 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.

You have the right to a second opinion. If you attend an appointment with a provider but you want a second opinion, your plan must authorize it with a .[20] The second opinion must be provided by any provider of your choice from any independent practice association or medical group within the

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[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).

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]

C. Network Adequacy

As explained earlier, your Medi-Cal managed care plan must 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 maintain adequate provider networks.[24] However, the rules differ depending on whether a Medi-Cal plan is regulated by California's Department of Health Care Services (DHCS) and DMHC, or only DHCS.[25] Plans must maintain and monitor a network of appropriate providers sufficient to provide adequate access to all services for enrollees, including those with physical and mental disabilities.[26] Health plan networks are adequate when the service is available both 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

Provider shortages for gender-affirming care are common. These shortages are exacerbated as more states ban gender-affirming care services, and providers limit services in anticipation of possible federal funding cuts. Shortages contribute to significant delays for services, which means it can take anywhere from weeks to years in advance to access services. Gender-affirming care is still an evolving area of medicine so

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[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).

access to gender-affirming care specialists can be difficult to find.[28] Therefore, provider shortages contribute to the lack of providers in-network. The majority of gender-affirming care providers tend to be located in concentrated and large metropolitan areas such as San Francisco and Los Angeles. Consequently, 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;

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[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.

- advising you of their available appointment times; and/or
- 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.

ADVOCACY TIP # 4.2: Although it is your Medi-Cal plan's responsibility to find either in-network providers or out-of-network providers if they do not have one 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. If you encounter this situation, have your PCP submit a prior authorization request for your preferred provider. If the request 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

In all cases where your plan approves out-of-network care, your plan must coordinate payment with out-of-network providers to ensure you avoid higher 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 must enter into a **Letter of Agreement**

[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.

(LOA) or **Single Case Agreement** (SCA) with the provider.[34] 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 if you get services out-of-network without prior authorization. For example, if a surgeon does not accept any health insurance as payment for services, then your health plan cannot force the surgeon to accept payment from them to cover services. This means you will have to pay the provider for the services out-of-pocket. 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

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[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.

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

[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.

	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 Medi-Cal managed care plans to provide timely access to services.[40] California complied with the federal requirement by incorporating the Knox-Keene Act's timely access standards wchich apply to all Medi-Cal managed care plans by statute.[41] The amount of time a 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

[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).

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 no qualified providers within the required time or distance from your home, then 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 meet the standard. These practical limitations do not excuse your

E. Medical Necessity & the Prior Authorization Process

Gender-affirming care may include services, such as: hormone therapy, surgery, speech and language procedures and therapies, behavioral health services, and more.[44] Not all TGI people seek gender-affirming services.[45] Services must be medically necessary to treat a diagnosis for gender dysphoria (or any other applicable diagnoses) and based on appropriate standards of care under Medi-Cal criteria in order for Medi-Cal to cover it..[46] Medi-Cal requires service requests from "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**

[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.

Diverse People (SOC), published by the **World Professional Association for Transgender Health (WPATH)**(WPATH Standards of Care).[48] Keep in mind that your treating provider's medical opinion about the best treatment plan for gender dysphoria may differ from your health plan's utilization management criteria to get coverage approved. It can be helpful to think of the utilization management criteria as a check-list for approval.

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 (TGI) 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] However, 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] Health plan's must evaluate those under 21 years of age by the EPSDT criteria and failure to do so is grounds for an appeal.

Medi-Cal managed care plans must also cover reconstructive surgery for all members, including TGI members, and there are separate review criteria for reconstructive procedures.[52] 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

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[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)). Also known as the, "Early Periodic Screening Diagnostic and Treatment" standard.

[52] DHCS APL 20-018 at 2.

[53] DHCS APL 20-018 at 2.

"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 evaluate whether the requested service meets the criteria for reconstructive surgery, taking into consideration your self-identified gender.[57]

Health plans must factor in and consider the knowledge and expertise of providers qualified to treat gender dysphoria and they must use nationally recognized medical/clinical guidelines when evaluating service requests, such as the WPATH Standards of Care.[58]

Nationally recognized medical experts in the field of gender-affirming care have identified the following core services commonly provided 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.[59] Surgical procedures and treatment that bring secondary gender characteristics into conforming with an

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[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.

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.[60]

1. When services are denied because the plan deems it cosmetic

While the law requires Medi-Cal managed care plans to cover medically necessary services to treat gender dysphoria, it is not uncommon for plans to deny coverage on the basis that the treatment is "cosmetic," because cosmetic services are generally not a covered benefit.[61] However, California Courts of Appeal held in 1978 that gender-affirming surgeries are not "cosmetic" when medically necessary to treat gender dysphoria.[62]

Medi-Cal plans may justify to deny or reduce coverage of a requested service as cosmetic giving the following reasons: it only changes physical appearance and does not improve functionality; it is not reconstructive surgery; or, the body part's appearance already aligns with the person's gender identity. As mentioned above, health plans must assess coverage for treatment on a case-by-case basis and determine whether it is either medically necessary and/or reconstructive. Health plans cannot use blanket exclusions to deny a service that might ordinarily be considered cosmetic, because those services may actually be medically necessary or reconstructive when used to treat gender dysphoria. Under state law, Medi-Cal managed care plans must evaluate authorization through an individualized case-by-case assessment to determine whether a requested service is necessary to treat gender dysphoria.[63] If the service is denied as cosmetic when the treating provider has determined it's medically necessary, and the written denial fails to give a clinical reason why it is not medically necessary, you may file an appeal for failure to conduct a medical necessity evaluation as required under DHCS All Plan Letter (APL) 20-018.

2. When services are denied as not medically necessary

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[60] DHCS APL 20-018 at 4.

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

[62] *GB v. Lackner,* 80 Cal. App. 3d 64 (1978); *JD v. Lackner*, 80 Cal. App. 3d 90 (1978); *see* NHeLP *Guide to Medi-Cal* at 5.8.

[63] DHCS APL 20-018 at 4.

There are many reasons a health plan may deny gender-affirming services based on lack of medical necessity. Review the specific language of the written denial, also called a Notice of Adverse Benefit Determination (NOABD), to determine the specific reason for the health plan's denial of services. The notice must "clearly state the reasons for the denial."[64] Specifically, written notice must provide:

- a detailed explanation for 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."[65]

If the NOABD does not include all of the required information above, you have the right to appeal based on the faulty notice. If the NOABD denies the gender-affirming service because it is not reconstructive in nature, 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.

i. Utilization Management Controls

Utilization management controls are procedures that are required for 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.[66] Your Medi-Cal managed care plan may adopt its own utilization management controls, subject to certain limitations.[67] These controls are intended to help ensure that you receive the most cost-effective, medically necessary services, and

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[64] DHCS APL 20-018 at 5.

[65] DHCS APL 20-018 at 5.

[66] *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).

[67] 42 C.F.R. § 438.210(a)(4); *see also* NHeLP *Guide to Medi-Cal* at 1.16.

to avoid unnecessary program costs. When misused, utilization management controls can create barriers to access gender-affirming care. Health plan utilization management controls can include:[68]

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 the 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.[69] The national clinical guideline for the treatment of gender dysphoria is the WPATH Standards of Care version 8 as discussed earlier.[70]

3. Prior authorization process

Medi-Cal managed care plans generally require approval for coverage of certain gender-affirming services before you actually receive the services.[71] 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 in the process.

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

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

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

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

[71] 42 C.F.R. § 438.210(a)(4); Cal. Health & Safety Code §§ 1363.5, 1367.01; 22 C.C.R. § 53246.

documentation to "explain the reasons for the needed service to protect life, to prevent significant illness or disability, or to alleviate severe pain."[72] 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. Prior authorization reviews must be performed by qualified "professionals."[73]

As explained earlier, before you can receive some gender-affirming services, especially surgeries, your PCP has to submit a referral for a consultation with a gender-affirming provider (also referred to as a "specialist") and then the health plan has to approve it. This means that after the consultation appointment, the specialist needs to submit a prior authorization request to the health plan for any additional services if you decide to move forward with their treatment plan. For example, to access facial gender-affirming surgery, the PCP sends the 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, they must make a decision to approve, modify, or deny the service generally within five (5) business days. However, if you face an imminent and serious threat to your health, then the health plan must make a decision within 72 hours.[74] 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 two (2) business days of the decision.[75] 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.[76]

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

[73] 42 U.S.C. § 1396a(a)(30)(B).

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

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

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

Members must receive a written response to prior authorization requests within seven (7) business days. If the health plan fails to issue a timely decision in writing by the eighth (8th) business day, you may file a grievance. If the written decision does not follow any of the 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.

ADVOCACY TIP # 4.9: Attend the consultation appointment before your provider requests 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

4. Categorical (or blanket) exclusions

A **categorical exclusion** or, a **blanket exclusion,** refers to services that are not covered benefits under 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.[77] Federal regulations prohibit your plan from categorically excluding or limiting coverage for gender-affirming services.[78] Your Medi-Cal plan may not categorically exclude gender-affirming services on the basis that it excludes these services for all members.[79] 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,

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[77] 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[.]").

[78] 45 C.F.R. § 92.207(b)(4); DHCS APL 20-018 at 2.

[79] DHCS APL 20-018 at 4.

or where a person's gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.[80] 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."[81] 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.[82]

ADVOCACY TIP # 4.10: When denying a requested gender-affirming service, your Medi-Cal managed care plan must send you a written notice of adverse benefit determination (NOABD) explaining "the reasons for the adverse benefit determination."[83] "The NOABD 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.'"[84]

ii. Service-Specific Issues to Watch for

1. Hair removal services

It is quite common to see hair removal services as an excluded health care benefit, but these services are covered when medically necessary. 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

[80] 45 C.F.R. §§ 92.206, 92.207(b)(3); DHCS APL 20-018 at 2.

[81] DHCS APL 20-018 at 4.

[82] DHCS APL 20-018 at 4.

[83] 42 C.F.R. § 438.404; DHCS APL 20-018 at 5.

[84] DHCS APL 20-018 at 5.

preoperative preparation process."[85] Hair removal services are often sought to remove secondary gender characteristics, such as body or facial hair. In the context of gender-affirming care, these services are often medically necessary to treat gender dysphoria, because the location and amount of hair on the body or face may exacerbate the dysphoria. Hair removal is often medically necessary as prerequisite for surgery. Also note that the WPATH SOC 8 does not recommend, nor require, any photographs to demonstrate "the extent of characteristics proposed for further treatment are outside the range of normal for the preferred gender.," Review the health 'plans' internal clinical policy to confirm they do not improperly require photographs to determine whether to cover such services.[86]

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

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

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. Health plans must consider each pathway in evaluating a prior authorization request for hair removal services. Failure to do so is grounds for an appeal.

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

[86] 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.

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

5. Travel-related expenses

Medi-Cal managed care plans must cover "expenses for transportation and other related travel expenses necessary to secure medical examinations and treatment for a beneficiary."[87] Travel-related expenses are covered for medically necessary services that are not available within a reasonable distance and time from your home.[88] These expenses may include transportation services, meals, and lodging.

Health Plans must cover necessary Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), including the cost of:[89]

- 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.[90] Your health plan may refer to the Internal Revenue Service per diem rates for lodging and meals

[87] 42 C.F.R. § 440.170(a); DHCS APL 22-008.

[88] DHCS APL 22-008 at 12.

[89] 42 C.F.R. § 440.170(a)(3); DHCS APL 22-008 at 11.

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

as a guide.[91] 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.[92] 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.[93] You can also find your health plan's policy in your coverage handbook or explanation of benefits. The prior authorization process is required to get travel-related expenses covered.[94]

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

Your Medi-Cal managed care plan is required to provide at leasttwo2 methods of payment for travel-related expenses: (1.) directly reimbursing the member or (2.) pre-paying the vendor.[95] Reimbursement must cover the **actual expenses** incurred by the member and an accompanying attendant, if applicable. Out-of-pocket costs must be reasonable and supported by receipts.[96] Health plan must approve and reimburse payments no later than 60 calendar days following their confirmation that all required receipts and documentation have been received.[97]

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[91] DHCS APL 22-008 at 11.

[92] DHCS APL 22-008 at 11.

[93] DHCS APL 22-008 at 12.

[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.

Health plans must prepay vendors for related travel expenses, including for meals and lodging, if members cannot pay in advance. Members who need services prepaid must attest to the health plan that they are unable to pay in advance. Attesting or verifying this information can be done in person, by email, by fax, or by telephone.[98] Health plans may arrange lodging located within a reasonable distance from the location where the services will be provided during the prior authorization process.[99] If your health plan does not prepay for meals, or other necessary travel expenses (e.g., parking, tolls), the plan must reimburse you for those expenses.[100]

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*]

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

[98] DHCS APL 22-008 at 12.

[99] DHCS APL 22-008 at 12.

[100] DHCS APL 22-008 at 13.

often more likely to rely on and, consequently, 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. Calculating travel-related expenses should be based on the time and distance you will travel to and from the service, including any post-recovery restrictions or requirements. Members have the right to file a grievance if the health plan denies 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, most commonly when a provider leaves a member's Medi-Cal managed care plan network, when a beneficiary moves from fee-for-service (FFS) coverage into Medi-Cal managed care coverage, moves into Medi-Cal managed care from Covered California coverage, or when Medi-Cal plan member's enrollment changes from one Medi-Cal managed care plan to another.[101] COC protections allow Medi-Cal beneficiaries to continue receiving existing treatment (including medications) without having to obtain a new prior authorization for a period of time after their coverage changes, and in other cases COC permits Medi-Cal beneficiaries to temporarily continue seeing their providers from their former plan when their provider is not in their new plan's provider network.[102]

In certain circumstances, California law gives new Medi-Cal managed care members the right to continue seeing their provider from their previous health coverage if that provider is now out-of-network with the member's new health plan. If granted, the member will have COC for that specific provider for up to 12 months.[103] When a member requests COC after

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[101] 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*].

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

[103] 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/MMCDAPLsandPolicy

transitioning into Medi-Cal managed care coverage, the health plan must make a good faith effort to obtain information from the member about any active and ongoing treatments or medications.[104] To get COC, the enrollee must demonstrate there was no health plan option with their treating provider in-network to choose from.[105]

The Knox-Keene Act (KKA) also requires licensed plans to provide COC for certain types of care when the provider leaves their plan, or when the person has newly enrolled into a plan.[106] KKA COC protections apply to all beneficiaries enrolled in a Medi-Cal managed care plan.[107] For example, health plans must provide COC for members to get services, such as surgery, from an out-of-network provider if the service was already scheduled or recommended within 180 days of the date their contract with the health plan terminated or within 180 days of the effective date of coverage for a newly covered enrollee.[108]

Letters/APL2023/APL23-022.pdf [hereinafter DHCS APL 23-022]; NHeLP *Continuity of Care* at 13.

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

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

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

[107] 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.

[108] 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.