KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Transgender Services				POLICY #: 3.67-P	
DEPARTMENT: Utilization Management					
Effective Date: 11/11/2014	Review/Revised Date: 06/06/2021	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Member Services

_____ Date _____
Director of Utilization Management

POLICY:

Kern Health Systems (KHS) covers benefits in accordance with the legislative, regulatory, and contractual requirements including the following regulations:

- DHCS Contract No.03-76165 §6.7.1.1
- The Knox-Keene Act
- DHCS All Plan Letter 20-018

- ❖ Medi-Cal Provider Update March 2013[i]
- ❖ Health and Safety Code (HSC) section 1365.5

The Insurance Gender Nondiscrimination Act (IGNA) prohibits KHS from discriminating against individuals based on gender, including gender identity or gender expression. The IGNA requires that KHS provide transgender members with the same level of health care benefits available to non-transgender members.

The Affordable Care Act (ACA) and the implementing regulations prohibit discrimination against transgender individuals eligible for services and requires KHS to treat members in a manner consistent with the member's gender identity. The ACA requires that KHS provide all members with a common core set of benefits, known as Essential Health Benefits (EHB). Health insurers covering EHBs are prohibited from discriminating based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Specifically, federal regulations prohibit KHS from denying or limiting coverage of any health care services that are ordinarily or exclusively available to members of one gender to a transgender member based on the fact that a member's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.

Federal regulations further prohibit KHS from categorically excluding or limiting coverage for health care services related to gender transition. Federal regulations similarly prohibit categorically restricting the scope of services to a member "solely because of the diagnosis, type of illness, or condition."

DEFINITIONS:

KHS is contractually obligated to provide medically necessary covered services to all members, including transgender members.

State law defines "medically necessary" as follows:

a. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
b. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions.

KHS must also provide reconstructive surgery to all members, including transgender members. The analysis of whether a surgery is considered reconstructive surgery is separate and distinct from a medical necessity determination. 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." In the case of transgender members, Department of Health Care Services (DHCS) APL 20-018 indicates that gender dysphoria is treated as a "developmental abnormality" for purposes of the reconstructive statute and "normal" appearance is to be determined by referencing the gender with which the member identifies.

KHS is not contractually obligated to provide cosmetic surgery. State law defines cosmetic surgery as

"surgery that is performed to alter or reshape normal structures of the body in order to improve appearance."

The Diagnostic and Statistical Manual of Mental Disorder (DSM-5) characterizes gender dysphoria as "a marked incongruence between their [the member's] experienced or expressed gender and the one they were assigned at birth."

The term "transgender services" refers to services determined to be medically necessary for the treatment of "gender dysphoria" or determined to be necessary under the reconstructive surgery statute to create a "normal" appearance based on the gender with which the member identifies.

PROCEDURES:

1.0 TRANSGENDER SERVICE REQUESTS PROCESS

KHS will analyze transgender service requests under both the applicable medical necessity standard for services to treat gender dysphoria and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a basis for approving the request.

The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider, licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.

When analyzing transgender service requests, KHS must consider the knowledge and expertise of providers qualified to treat gender dysphoria (including the member's providers) and must use nationally recognized medical/clinical guidelines. One source of clinical guidance for the treatment of gender dysphoria is found in the most current "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health. Clinical guidance and literature regarding appropriate health care for transgender individuals is rapidly developing in light of new research and clinical experience. KHS and providers must continuously monitor current guidance on transgender health care to ensure consistency with current medical practice.

Nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria: mental health services; psychotherapy; hormone therapy; and a variety of surgical procedures and treatments that bring primary and secondary gender characteristics into conformity with the individual's identified gender. Surgical procedures and treatments that bring secondary gender characteristics into conformity with an individual's 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 a member's gender dysphoria, or if the services meet the statutory definition of reconstructive surgery.

1.1 Utilization Controls

KHS may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determinations, and/or apply appropriate utilization management criteria that are non-discriminatory. KHS may not categorically exclude health care services related to gender transition on the basis that it excludes these services for all members.

KHS must not categorically limit a service or the frequency of services available to a transgender member. 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. KHS must consider each requested service on a case-by-case basis and determine whether the requested service is either "medically necessary to treat the member's gender dysphoria" or meets the statutory definition of "reconstructive surgery."

1.2 Notice of Action (NOA) requirements for adverse benefit determinations

If KHS denies a request for transgender services on the basis that the services are not medically necessary, not considered reconstructive surgery, or does not meet the utilization management criteria, KHS's decision is subject to review through the appeal process, the State Fair Hearing process, and/or the Department of Managed Health Care's Independent Medical Review process, consistent with state and federal law. When denying a requested service, KHS must issue a notice of action (NOA) explaining "the reasons for the adverse benefit determination." The NOA must clearly state the reasons for the denial. 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 regarding medical necessity 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."

See *KHS Policy 3.22 Referral and Authorization Process* for additional information on the utilization review and authorization process. See *KHS Policy 3.23 Provider Appeals Regarding Authorization and KHS Policy 5.01 Member Grievance Process* for additional information on the appeal and grievance process.

2.0 DELEGATED OVERSIGHT

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

REFERENCE:

Revision 2021-05: Policy approved by DHCS 5/4/2021. **Revision 2020-12:** Revision by Director of Utilization Management to comply with DHCS All Plan Letter 20-018 **Revision 2014-11:** Policy developed by Director of Health Services to comply with DHCS All Plan Letter 13-011 Ensuring Access to Transgender Services.

[i] http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/gm201303.asp#a21