


UTILIZATION MANAGENT	 ASPIRE HEALTH PLAN		<u>Effective Date</u> April 1, 2024	
	GENDER AFFIRMING CARE SERVICES BY NON-CONTRACTED PROVIDERS		<u>Policy #</u> AHP-HS083	
			<u>Review Date</u> 8/5/2025	<u>Applicable to:</u> <input checked="" type="checkbox"/> Blue Shield Trio
	<u>Approver's Name & Title</u>		Kellie Verdugo, Director of Utilization Management	

1.0 PURPOSE

1.1 The purpose of this policy is to ensure commercial HMO members have timely, adequate access to transgender surgeries, therapies, or other transgender services provided by non-Mental Health/Substance Use Disorder (MH/SUD) providers.

2.0 POLICY

2.1 The Plan's commercial license is restricted, and as such, it is not delegated for the provision, network management, utilization review or reimbursement of mental health and substance use disorder treatment.

2.2 The Plan is delegated by the following full-service Commercial HMO plan partners for the provision, network management, utilization review and reimbursement of services related to certain transgender surgeries, therapies, or other transgender services provided by non-MH/SUD providers pursuant to Rule 1300.74.72, Rule 1300.74.72.01, or Rule 1300.74.721.

2.2.1 Blue Shield of California

2.3 The Plan applies the Evidence of Coverage and Disclosure documents, policies and procedures, clinical guidelines/criteria and review hierarchy of its commercial HMO plan partners when authorizing and arranging for services related to certain transgender surgeries, therapies, or other transgender services provided by non-MH/SUD providers.

2.4 If the Plan is unable to offer an in-network appointment for services related to transgender surgeries, therapies, or other transgender services provided by non-MH/SUD providers within timely and geographic access standards outlined in [AHP-PS009 Time-Elapsed Standards and Compliance](#), the Plan shall provide and arrange coverage for medically necessary MH/SUD services from an out-of-network provider or providers.

2.5 The Plan shall reimburse the provider for the entire course of medically necessary services unless there is an in-network timely and geographically accessible provider available to deliver MH/SUD services in accordance with [AHP ASO CL005 Claims Turnaround Time](#).

2.6 The Plan may transfer the Member to an in-network provider if it would not harm the Member, and the transfer is within the standard of care for the enrollee's condition.

3.0 DEFINITIONS

3.1 Refer to AHP Definitions Manual

4.0 PROCEDURE

4.1 Written Notice of Out-Of-Network Coverage

4.1.1 If a provider is not available to an enrollee in accordance with geographic and timely access standards such as those required by [AHP-PS009 Time-Elapsed Standards and Compliance](#), the Plan will issue the following written notice to the Member, the Member's authorized representative (if any), and the requesting provider (if any), within **five (5) calendar** days following the initial request for in-network services:

4.1.1.1 (Insert health plan name) must arrange and pay for the services requested by (provider's name) from a health care provider outside our network because (plan name) does not have an in-network [insert provider type] provider available within the required timeframe or geographic area. Your provider requested coverage for the following services: (describe services). You will only be responsible for paying your usual in-network cost sharing amount for these services. You may obtain additional information about obtaining out-of-network MH/SUD services from (insert plan name) at (insert plan's toll-free customer service number). If you are having trouble with (insert health plan name) arranging the approved out-of-network services and have been unable to resolve the issue with (insert health plan name), please contact the Department of Managed Health Care's Help Center at 1-888-466-2219 or go to the Department's website at www.healthhelp.ca.gov to receive additional help.

4.2 Selection of and Outreach to an Out-of-Network Provider

4.2.1 The Plan will select and contact an out-of-network provider or providers who are qualified and available to provide the gender affirming care services the enrollee needs by:

4.2.1.1 Obtaining a request from the referring provider for out-of-network provider services;

4.2.1.2 Establishing a referral Plan's UM System of Record (CIM) by the up Health Services Coordinator;

4.2.1.3 Contacting the available out-of-network provider(s) to confirm services can be rendered within the regulatory timeframes;

4.2.1.4 Within three (3) business days of when the Plan contacts the selected provider, furnishing a written authorization to the out-of-network provider.

4.3 Arrangement of Appointment of Admission for Out-of-Network Coverage

4.3.1 The Plan shall schedule the appointment for the Member or arrange for the admission of the member (if the service will be inpatient) according to the following timeframes:

4.3.1.1 No more than **ten (10) business days** after the initial request for non-urgent services;

4.3.1.2 Within **15 business days** of a request for specialist physician services;

4.3.1.3 Within **48 hours** of the initial request for urgent MH/SUD services (as defined by Health and Safety Code section 1367.01(h)(2)) when the health plan does not require prior authorization; or

4.3.1.4 Within **96 hours** of the initial request for urgent MH/SUD services (as defined by Health and Safety Code section 1367.01(h)(2)) if the health plan requires prior authorization.

4.3.2 If the Member is unable to attend the appointment offered by the Plan, the Plan shall continue to arrange and schedule a new appointment with the same out-of-network provider or a different out-of-network provider to ensure the delivery of medically necessary services.

4.4 Notification of Out-of-Network Appointment or Admission

4.4.1 Within **24 hours** of scheduling the appointment or admission, the Plan shall communicate the following information in the most expeditious manner possible to the Member, the Member's authorized representative, or the Member's provider and document the communication in CIM:

4.4.1.1 That the Plan has scheduled the appointment or admission

4.4.1.2 The name of the provider

4.4.1.3 The date and time of the appointment or admission

4.4.1.4 The location and contact information for the provider

4.5 Record Retention

4.5.1 The Plan shall document in CIM and retain a record of all communications with the enrollee, including a description of the requested services, the name and location of the provider(s) contacted, the date(s) the plan contacted the provider(s), the type of provider(s), the service(s) authorized, and the selected provider(s), location(s), and duration of the service(s) provided.

4.6 Failure to Arrange Appointment or Admission

4.6.1 If the Plan fails to arrange coverage for a Member as noted above, the Member (or representative) may arrange for the Member to obtain care from any

appropriately licensed provider(s), regardless of whether the provider contracts with the Plan, so long as:

4.6.1.1 The Member's first appointment with the provider or admission to the provider occurs no more than 90 calendar days after the date the Member, the Member's representative, or the Member's provider initially submitted a request for covered services to the Plan.

4.6.2 If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, the Member may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.

4.7 Transition of Member to Blue Shield Case Management

4.7.1 Once the Member requiring out-of-network non-behavioral health transgender services establishes care with the selected provider, management of the Member's care is transitioned to Blue Shield Specialty Case Management.

4.8 The Plan will email Transgenderinquiries@blueshieldca.com to notify Blue Shield Specialty Case Management of the referral.

4.9 Transition of the Member to an In-Network Provider

4.9.1 The Plan may transition the Member to an in-network, timely and geographically accessible provider if the following criteria are met:

4.9.1.1 The provider can deliver the services to the Member,

4.9.1.2 Requiring the enrollee to transition to the in-network provider would not harm the Member, and

4.9.1.3 Transitioning providers is within the standard of care for the enrollee's condition at the time of the transition.

4.9.2 Before the Plan transitions the Member to an in-network provider, the Plan shall provide the Member, the Member's representative (if any), and the provider(s) treating the Member with at least **90 calendar days'** notice.

4.9.3 The Plan shall be responsible for making the determination in accordance with good professional practice and with the clinical standards set forth in Health and Safety Code sections 1374.721.

4.9.4 The Plan shall treat any dissatisfaction with the transition to an in-network provider as a grievance and forward to its full-service commercial HMO plan partner in accordance with [AHP ASO OP005 Forwarding Grievances Complaints and Appeals to Health Plan](#).

4.10 Criteria Upon Request

4.10.1 The Plan shall make any utilization review determination criteria and any education program materials available upon request to other stakeholders in accordance with [AHP ASO OP003 Disclosure of UM Criteria and Policies](#).

5.0 TRAINING

5.1 All employees are trained within 90 days of hire, then annually thereafter.

6.0 REVIEW PERIOD

6.1 Regulatory and compliance policies are reviewed by the Policy Owner annually at a minimum (more frequently if a change, regulatory or otherwise, that causes a change to the policy).

7.0 REGULATORY REQUIREMENTS AND REFERENCES

7.1 Health and Safety Code section 1367.045, 1374.72, and 1374.721

7.2 California Code of Regulations, title 28, sections 1300.74.72, 1300.74.72.01 and 1300.74.721

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.