



Washington State  
Health Care Authority  
RE: WSR 18-20-123

November 6, 2018

To Whom It May Concern:

Thank you for holding the public hearing which I attended. I wanted to offer a written summary of my professional opinion of the proposed changes for gender affirming healthcare. I approve of the change away from four components, excellence centers, and over-defining providers. I disagree with the non-covered services list, the changes related to the people under the age of 18, and the mental health letter requirements.

I believe the simplification of the language by moving away from the components and defined providers increases access to care and minimizes unnecessary barriers and language clarifications. Furthermore, not enough centers for excellence exist to provide care for Washington state's estimated ~740,000 gender diverse citizens, so eliminating this is more congruent with our current care model.

For the non-covered services list, I disagree with moving the decision of medical necessity from the domain of the doctor and patient to the realm of bureaucracy. The [American Medical Association](#) and the [American Academy of Family Practice](#), among other professional medical organizations, support a patient-centered care model which emphasizes a therapeutic alliance between healthcare providers and their patients in order to achieve shared decision making for medical care. Gender affirming care has three major standards of care published within the United States that are used as general guidelines for providers- [WPATH \(World Professional Association for Transgender Health\)](#), [UCSF The Center for Excellence in Transgender Health Primary Care Protocols](#), and the [Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society\\* Clinical Practice Guideline](#). The WPATH protocols list surgeries on the non-covered services list as medically necessary. The HCA list would be in direct opposition to internationally accepted professional medical standards of care. The UCSF guidelines really emphasize that the treatment of gender diverse individuals is driven by the goals of each individual patient and what is medically necessary for some will not be for others. The Endocrine society states, "surgery is medically necessary and would benefit the patient's overall health and/or well-being," as the referral criteria for surgery. This non-covered procedure list is not congruent with the current model of care in America or with the current standards of care for gender diverse patients. As noted at the hearing, the exceptional care rule does not actually provide any care for gender diverse patients despite medical-legal teams sending copious and accurate documentation of medical necessity.

For care changes regarding people under the age of 18, childhood and adolescence are some of the most impactful times to be involved in gender affirming care. Patient-centered, gender affirming care for pediatric and adolescent patients can minimize and prevent so much of the



other chronic physical and mental health conditions suffered by gender diverse people. By treating gender dysphoria early, patients are less likely to develop depression, anxiety, and suicidality ([https://www.jahonline.org/article/S1054-139X\(18\)30085-5/fulltext](https://www.jahonline.org/article/S1054-139X(18)30085-5/fulltext)). Additionally, we know many chronic diseases like cardiovascular disease, diabetes, migraines, IBS, and addiction develop in higher rates in patients with more cumulative trauma. All medical models for chronic disease management emphasize prevention or early detection to minimize cost to the system and improve healthcare outcomes. Why would we thus make early intervention which could save young lives harder to access, especially when it will ultimately cost the system more healthcare dollars? Also, why would we do this in a state where minors can consent to sexual health related care at any age for contraception and pregnancy, at 14 for STI testing, and at 13 for mental health care

(<https://depts.washington.edu/hcsats/PDF/guidelines/Minors%20Health%20Care%20Rights%20Washington%20State.pdf>)?

As for the mental health letter requirements, WPATH, UCSF, and the Endocrine Society continue to support comprehensive biopsychosocial models of care through multi-disciplinary teams as the gold standard of care for gender diverse people and to become less restrictive and more supportive of patient-centered care with each iteration. Every update sees them moving more and more toward informed consent models and away from blanket statements of cookie cutter care including age-restrictions and letter requirements. As a physician, I understand the gold standard of care as an ideal for which to aim, and I recognize the realities of practice in a world where resources are limited. The informed consent model allows any provider who feels competent and comfortable to assess for gender dysphoria and a patient's capacity to provide informed consent. For so many of my patients, I do not need a mental health specialist to provide further assessment to feel confident in referring them for surgery. Ideally, I want a mental health specialist as part of my patient's team to provide additional support as they move through surgery and presenting differently in society. This is very different than an evaluation letter for surgery- I want an ongoing therapeutic relationship for my patients with a mental health provider to support them through their transition and afterwards, not give them permission to have before. This would be the dream treatment plan for so many people going through so many medical experiences, and it is rarely a reality. Cost, availability, and accessibility all work against enactment of this model. UCSF goes so far as to say that while multidisciplinary team care is best; care by an individual, competent provider is better than no care which is what this rule might mean for some patients. Having a referral from a medical provider who is competent in gender affirming care should be enough to access gender affirming care procedures. Medical providers and patients can decide together when further evaluation and support is needed for clarifying treatment goals. This is a common role for physicians in primary care fields, we treat what we can comfortably and call for consult when we need help.

I appreciate you taking the time to review my insights regarding the proposed changes of WSR 18-20-123. I appreciate the simplification brought by removing the four component structure, center for excellence, and qualified providers language. I disagree with the non-covered



services list, restrictions in care to people under the age of 18, and the requirement of mental health evaluation letters for every patient.

Sincerely,

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Physician