

**BEFORE THE UNITED STATES OFFICE OF MANAGEMENT AND BUDGET**

**Request for Information: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government, 86 Fed. Reg. 24,029 (May 5, 2021)**

**Federal Register No. 2021-09109; Document ID 2021-0005-0001**

**Name of Respondent:** The National LGBTQIA+ Primary Care Alliance

**Areas of Response:**

1. Equity Assessment and Strategy
2. Barrier and Burden Reduction
3. Procurement and Contracting
4. Financial Assistance
5. Stakeholder and Community Engagement

**Description of Organization:**

The National LGBTQIA+ Primary Care Alliance includes Federally Qualified Health Centers, State Primary Care Associations, and other healthcare organizations and providers throughout the nation, who promote best practices for providing culturally responsive and compassionate healthcare and related services for persons identifying as lesbian, gay, bisexual, transgender, and gender diverse, queer, intersex, and/or asexual or on the ace spectrum (LGBTQIA+). The 15 Alliance members joining in these comments collectively serve several hundred thousand individuals and families every year, in the Northeast, Mid-Atlantic, South, Midwest and West. Our members also advocate for federal, state, and local laws and public policies that advance the health and well-being of sexual and gender diverse people, with particular emphasis on persons of color, immigrants, people with disabilities and chronic illnesses, low-income individuals and families, transgender and gender diverse persons, sex workers, drug users, and other particularly marginalized communities.

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## COMMENTS OF THE NATIONAL LGBTQIA+ PRIMARY CARE ALLIANCE

The National LGBTQIA+ Primary Care Alliance is pleased to offer these comments on ways in which federal agency regulations, policies and procedures can reduce inequities that burden sexual and gender diverse people. As health care providers with a special mission to address issues that affect the health and wellness of lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender diverse (LGBTQIA+) communities, our comments specifically address the unique needs of these communities. We specifically address the need for the federal government to:

- Collect data on sexual orientation, gender identity and intersex status (pp. 2-5)
- Preserve and extend telehealth services and address unreasonable jurisdictional licensing restrictions (pp. 5-7)
- Enforce nondiscrimination and encourage clinically and culturally competent healthcare (pp. 7-10)
- Address inequities exacerbated by COVID (p. 10)
- Expand health insurance coverage and address barriers to care in existing insurance plans (pp. 10-12)
- Address the distinct needs of transgender and gender diverse persons (pp. 12-16); intersex persons (p. 16); sexual and gender diverse elders (pp. 16-17); immigrants and persons with limited English proficiency (p. 17); and persons living with disabilities (p. 18)
- Expand nutrition and housing resources (pp. 18-19)
- Take stronger measures to address the continuing opioid epidemic (pp. 19-20)

### **I. The Federal Government Should Include Measures of Sexual Orientation and Gender Identity in All Surveys, and Prioritize the Development and Testing of Measures of Intersex Status**

As documented by the National Academies of Science, Engineering and Medicine<sup>1</sup> and many other authorities, sexual and gender diverse populations suffer numerous health disparities, economic injustices, stigma, and discrimination, and are systemically marginalized. One significant driver of these injustices and public health challenges is that in many respects sexual and gender diverse people are ignored by, or remain invisible to, policymakers and providers of healthcare and other services. The failure to include sexual orientation, gender identity and intersex status in many surveys and routine questionnaires perpetuates the invisibility of sexual and gender diverse people and further stigmatizes them as unworthy of notice. The federal government should include, on all surveys and studies of health, housing, education, economic transaction, and recipients of public services, measures of orientation, gender identity, and (when appropriate questions are developed and tested) intersex status – which we refer to as SOGII measures and data.

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<sup>1</sup> National Academies of Sciences, Engineering, and Medicine, Understanding the Wellbeing of LGBTQIA+ Populations (Washington, DC: 2020), available at <https://www.nap.edu/catalog/25877/understanding-the-well-being-of-lgbtqi-populations>.

The lack of consistent, reliable, population-based data on sexual and gender minorities presents substantial challenges to researchers at community-based health centers, academic institutions, and government agencies. Without population-based data as a benchmark, researchers into the health, economic status, and wellbeing of sexual and gender diverse populations cannot know how representative their study samples are of those populations generally. This limits the potential applicability and effectiveness of study results. Including sexual orientation, gender identity and intersex traits along with other key demographic data in every city, county, state and territorial, and national public health and demographic survey would be a major step forward in research on health equity issues affecting sexual and gender diverse populations.<sup>2</sup> While many national and state public health surveys ask sexual orientation questions, and some ask transgender status or gender identity questions, many do not.<sup>3</sup> The Behavioral Risk Factor Surveillance System (BRFSS) survey asks for information on the respondent's sexual orientation and gender identity in an optional module (the SOGI module), which many but not all states use, and not every year. This leads to inconsistent data collection. We request that the Centers for Disease Control move the BRFSS SOGI module to be part of the core BRFSS questionnaire, so that each state conducting the BRFSS collects data on sexual orientation and gender identity consistently each year. This will allow for the pooling of multiple years of data so that researchers can look at health risk indicators for intersectional populations, such as Black lesbian or bisexual women or older LGBTQIA+ people. Should the CDC not take this action, we request that HHS direct the CDC to take this step.

Similarly, the lack of consistent, reliable, population-wide data poses considerable challenges for policymakers and educators. Without fully understanding the extent and exact nature of health disparities in minority populations, including sexual and gender diverse communities, we cannot fully understand what measures are needed to rectify the disparities.

Consistent collection of SOGI data throughout the nation would also be of great assistance to LGBTQIA+ health centers, including those submitting these comments. Our physicians, other medical providers and behavioral health specialists strive to deliver the best possible care to our patients. Many of our health centers also operate robust community health programs that address key public health challenges, including HIV and sexually transmitted infection prevention and treatment, cancer screenings, smoking cessation counseling, drug use counseling, and mental health services. While we collect information on our own patients and clients, we need consistent, reliable data on our entire communities for benchmarking and to plan optimal community health interventions. For QA/QI purposes, it is important to compare measures of our health centers' patient health to the health of the larger population – and to health indicators for the specific communities we serve, including persons identifying as LGBTQIA+. The lack of uniform, reliable, nationwide data on these populations to serve as a

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<sup>2</sup> A major limitation of much of the data on sexuality that is currently collected by private and public researchers for public health purposes is that it focuses exclusively on sexual behavior. While this is appropriate in some contexts (for instance, epidemiological studies of HIV and other sexually transmitted infections), sexual orientation is a much broader concept that can encompass identity and attraction as well as sexual behavior. Identifying sexual orientation with sexual activities involving the same or a different gender may distort the population under study and can lead to misunderstandings of LGBTQIA+ people.

<sup>3</sup> Centers for Medicare and Medicaid Services, *Sexual and Gender Minority Clearinghouse*, last modified 8/10/20, <https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/data-tools/sgm-clearinghouse>.

benchmark makes our QA/QI efforts more challenging. Similarly, it is difficult to plan the best use of our limited resources for community health interventions without such data.

False narratives that promote the idea that SOGII data collection is intrusive are not supported by experiences of community health centers that provide LGBTQIA+ healthcare services. Rather, the opportunity for patient identities to be seen and respected in the healthcare setting builds trust and increases the opportunity for meaningful, authentic healthcare interactions. When patients have the ability to identify as LGBTQIA+, healthcare providers are able to provide holistic and comprehensive care that improves health outcomes. There is also no basis for concern about including questions about sexuality and gender identity in Census and other non-medical surveys. The questions are always optional; many experience such questions as affirming, and there is no evidence that including them results in lower response rates.<sup>4</sup>

As noted in a recent open letter to health leaders endorsed by 180 LGBTQIA+ organizations,<sup>5</sup> measures of sexual orientation, gender identity and intersex traits should be collected in:

- Every electronic health record
- Every insurance record
- All research studies and clinical trials
- All health laboratory tests
- All public health surveillance: including surveys, disease (e.g., cancer, cardiovascular health) and mortality reporting
- In the mandatory demographic core of the CDC's Behavioral Risk Factor Surveillance System, which is administered by every state and territory but currently makes SODI data collection optional
- Across COVID-NET, a network of 100 large hospitals reporting on COVID-19 care
- In the National COVID Cohort Collaborative's COVID-19 Clinical Data Warehouse Data Dictionary

LGBTQIA+ health centers have many years of experience in collecting information from our LGBTQIA+ patients and colleagues, as do many health systems, local and state agencies, and their counterparts in many nations around the world. [This set of measures](#) has been widely tested and are currently being recommended by community experts.<sup>6</sup> Funding is needed to test

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<sup>4</sup> See, e.g., Cahill S, Singal R, Grasso C, et al. 2014. Do ask, do tell: High levels of acceptability by patients of routine collection of sexual orientation and gender identity data in four diverse American community health centers. *PLoS One*, 9(9), available at <https://dash.harvard.edu/bitstream/handle/1/12987242/4157837.pdf;sequence=1>; Haider A, Schneider E, Kodadek L, et al. 2017. Emergency department query for patient centered approaches to sexual orientation and gender identity: The EQUALITY Study. *JAMA Intern. Med.*, 177(6): 819-828, available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2621833>.

<sup>5</sup> Spencer Watson, *180 Organizations Call for Routine LGBTQI+ Health Data Collection*, Center for LGBTQ Economic Advancement and Research, <https://lgbtq-economics.org/2021/06/25/180-organizations-call-for-routine-lgbtqi-health-data-collection/?fbclid=IwAR2iMTeyipujVjHwr2C78wYpGjxUnwWUCGa3sWi8rGyYaKrw-KhWrjPgZrA> (visited July 2, 2021).

<sup>6</sup> NORC at the University of Chicago and the Fenway Institute, 2019, *The Nuts and Bolts of SOGI Data Implementation: A Troubleshooting Toolkit*, [https://fenwayhealth.org/wp-content/uploads/TFI-54\\_SOGI-Data-Collection-Series-of-3-Tip-Sheets-for-pride-month\\_NutsAndBolts.pdf](https://fenwayhealth.org/wp-content/uploads/TFI-54_SOGI-Data-Collection-Series-of-3-Tip-Sheets-for-pride-month_NutsAndBolts.pdf) (visited June 25, 2021).

enhanced measures – including measures of intersex traits, which are sadly neglected, and the wide diversity of non-binary identities and terminology across cultures and age groups – but the value of adding tested measures now has been amply demonstrated.

## **II. HHS Should Continue, and Expand, Actions Undertaken During the COVID-19 Pandemic to Encourage Telehealth Services, and Address Barriers to Equitable Healthcare Resulting from Outdated State and Local Licensing Requirements**

During the COVID-19 pandemic, primary care providers were forced to swiftly expand telehealth services to maintain chronic disease management and keep as many patients as possible out of overwhelmed hospital systems. More than 90% of community health centers, many of which have targeted services for LGBTQIA+ communities, are currently providing telehealth service for their patients.<sup>7</sup> These services have maintained access for existing patients, and have expanded access to those who are seeking LGBTQIA+ competent and compassionate care. Although telehealth services initially were expanded in response to the limitations on in-person care necessitated by pandemic-related shutdowns, they have proved to be very effective for many types of care and have reduced barriers to care faced by many of our LGBTQIA+ and lower-income patients who often travel great distances to be able to access culturally responsive care. We are concerned that the regulatory changes which allowed us to expand these services will be curtailed when the COVID-related public health emergency ends and that inequities will be exacerbated as a result. We urge the Administration to continue the innovations that have fostered telehealth, and to expand them to further address our patients' challenges.

In the experience of community health centers, telehealth services – both video and audio – have proved effective for many types of healthcare, including:

- Gender-affirming care – assessing goals of gender transition, especially prescribing, monitoring, and adjusting hormone therapy, and providing referrals for gender affirming surgery.
- Behavioral healthcare – individual and group therapy and psychiatry sessions, working with individual patients to address trauma, manage anxiety and depression, and reduce isolation and increase resiliency by strengthening support systems.
- Chronic disease management – including substance use disorders (treated with Suboxone), diabetes (blood sugar and blood pressure monitoring), and HIV prevention and treatment (monitoring of drug therapy and patient symptoms).
- A large number of other patient concerns/symptoms where diagnosis can reliably be made without a physical examination of the patient.

Although the initial motivation for telehealth expansion was to prevent a *reduction* in vital health services, our experience has been that telehealth has actually *increased* services to

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See also National LGBTQIA+ Health Education Center, *Learning Resources: Collecting Sexual Orientation and Gender Identity Data*, <https://www.lgbtqiahealtheducation.org/resources/in/collecting-sexual-orientation-and-gender-identity-data/> (visited June 25, 2021).

<sup>7</sup> See National Association of Community Health Centers, *Health Centers Responding to COVID-19: One Year Review, April 2020 – April 2021*, <https://www.nachc.org/research-and-data/health-centers-responding-to-covid-19-1-year-review/> (visited June 24, 2021).

many of our patients and has helped us make further inroads into curbing healthcare access inequities. Specifically:

- The ability to talk with a provider in one's own home, or another convenient location, has made it easier to access care for persons facing transportation problems, patients with childcare responsibilities, and patients who cannot or are reluctant to take time off from work to travel to a doctor's office or clinic.
- Elderly patients and patients with significant disabilities, or illnesses that make it difficult to travel, can talk with their providers in their own homes or other locations easier to reach.
- Some LGBTQIA+ patients, especially transgender and gender non-conforming patients, are reluctant to travel to public places because of their experience with, and subsequent fear of, harassment or violence motivated by homophobia or transphobia.
- Concerns about the cost and burdens of extensive travel are heightened for many LGBTQIA+ persons – especially transgender and gender non-conforming persons, who live in geographic areas that lack competent, welcoming providers, and who consequently rely on LGBTQIA+ specialty providers located many miles from their homes – often in other states. For instance, Whitman-Walker Health's transgender and gender-expansive patients live not only in every part of Virginia and Maryland, but also in Pennsylvania, West Virginia, Delaware, North Carolina, and points beyond; many Callen-Lorde Community Health patients live in New Jersey or Connecticut; Transhealth Northampton and Fenway Health are located in Massachusetts but have many patients in other parts of New England; and Lyon-Martin serves clients all over California.
- Many patients with multiple health challenges receive care from several different providers, often located at different sites. Access to their providers through telehealth significantly eases the challenges of accessing care, increases their engagement in care, and benefits their health.

For these reasons, telehealth has significantly expanded our patients' access to and engagement with care. For instance, at Whitman-Walker Health, patient no-show rates for appointments have declined by more than 50%. At Callen-Lorde Community Health, reductions in no-show rates have enabled providers to see more than 300 additional patients each month. HHS should take all available actions to permanently extend telehealth regulations and policies. In addition, reimbursement rates for telehealth services should be the same as in-person visits, in order to be sustainable for health centers.

We are particularly concerned that access to **audio-only telehealth services** be maintained and that reimbursement rates for such services be increased. Audio-only telephonic access has been especially important for many patients due to the lack of broadband internet or devices that enable the utilization of videoconferencing. Telephonic care also enables privacy for patients that are seeking virtual care, but do not have a safe or private space to videoconference, such as youth seeking access to LGBTQIA+ healthcare who fear being outed to their families. We have also found audio-only telehealth to be important for older adults to access care who may not be able to video conference and yet require chronic disease management and experience challenges with transportation for onsite care or live in rural areas without easy access to LGBTQIA+ healthcare services. In addition, some transgender patients experiencing gender dysphoria prefer audio-only encounters to avoid seeing their image on the

screen. Currently, reimbursement rates for audio-only services generally are significantly lower than for video services. This unfavorable treatment fails to recognize the importance of audio-only services for many patients. It also fails to recognize that in behavioral health, audio-only therapeutic encounters are more demanding for providers and require greater skill when a patient's appearance and body language cannot be assessed. Continued support through equitable reimbursement and grant funding for both telephonic and video health services would allow health centers to continue these needed telehealth services to ensure that the communities currently accessing these services will not experience a disruption in care.<sup>8</sup>

**Licensure & liability issues.** Interstate licensure and liability issues create a barrier for patients to continue telehealth services when they are physically located in another state. There is a danger that clinicians who were previously treating patients in their state of licensure will be unable to continue telehealth care to patients who are out-of-state once the public health emergency has ended. Many FQHCs with a mission to serve LGBTQIA+ individuals have many patients located in neighboring states, because of lack of competent, welcoming care in those other jurisdictions. As noted above, Whitman-Walker, Callen-Lorde, Transhealth Northampton, Fenway Health and other LGBTQIA+ community health centers serve many transgender and gender non-conforming persons living in other states. Complex licensing requirements, which differ for each jurisdiction and each type of professional license, impose substantial barriers to the efficient and effective delivery of vitally needed care for these individuals. HHS's Fourth Amendment to the Declaration for Medical Countermeasures Against COVID-19, under the Public Readiness and Emergency Preparedness Act (PREP Act), provides some temporary, limited protection for cross-jurisdictional telehealth services. Support for long-term solutions that specifically address interstate licensure and liability considerations for the provision of telehealth primary care and behavioral health services would avoid a disruption in care and ensure the LGBTQIA+ community has access to competent and compassionate health care.

### **III. The Federal Government Should Promulgate and Vigorously Enforce Clear, Detailed Nondiscrimination Requirements and Require Federally Funded Healthcare Providers to be Culturally Responsive and Clinically Competent**

**The need for strong, vigorously enforced nondiscrimination mandates.** The members of the LGBTQIA+ Primary Care Alliance, and other health centers with a commitment to nondiscriminatory and culturally competent care, see – on a daily basis – many patients who have encountered discrimination, and/or incompetent, unwelcoming care, at hospitals, clinics, doctors' offices, and other healthcare settings. While our centers strive to provide the best care to these individuals, many patients suffer from health problems exacerbated by care denied or inadequate care received elsewhere. Moreover, our primary care providers frequently have difficulty locating appropriate referrals for their patients needing specialist care. Our efforts must be supplemented by decisive federal action to discourage and remedy discriminatory acts and policies throughout the healthcare industry, and to foster cultural responsiveness and clinical

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<sup>8</sup> For more information on the importance of telehealth services and their contribution to healthcare equity, see National Association of Community Health Centers, *Telehealth Mythbusters*, <https://www.nachc.org/wp-content/uploads/2021/04/Telehealth-Myths-and-Facts-April-2021.pdf> (visited June 24, 2021).

competence among providers and in medical, nursing, behavioral health, and other healthcare professional schools.

In addition, as discussed in more detail in Section VI, below, our transgender and gender non-conforming patients encounter many barriers to the procedures and treatment they need from discriminatory insurance plans – including Medicare, state Medicaid programs, insurance plans available to federal government employees, and private insurance.

We appreciate the May 2021 Notification of Interpretation and Enforcement, stating that HHS will enforce the sex discrimination provision of Section 1557 of the Affordable Care Act to prohibit discrimination on the basis of sexual orientation and gender identity. We urge HHS to issue, as soon as practicable, a new proposed regulation under Section 1557 of the ACA, including clear prohibitions of discrimination based on sexual orientation, gender identity and intersex characteristics, in federally provided and federally financed health care and federally regulated health insurance. The new proposed rule, supplemented by sub-regulatory guidance documents and enforcement actions by HHS’ Office for Civil Rights, should specify practices that constitute unlawful discrimination by health providers and health insurance plans. With regard to insurance discrimination, The World Professional Association for Transgender Health (WPATH) has issued many public statements outlining procedures that should be considered medically necessary for the treatment of gender dysphoria and the criteria that should guide coverage decisions. Yet, many insurance plans continue to deny many of these procedures, and many plans have outdated policies that do not align with WPATH criteria. Insurance coverage should mirror the recommendations for coverage that have been established by WPATH.

HHS should also clarify and strengthen regulations prohibiting discrimination by recipients of HHS grants and contracts, including but not limited to health professional educational institutions, and providers in federal prison and detention center settings.<sup>9</sup>

In addition, HHS should revoke the rule issued during the Trump Administration sanctioning religious and conscience-based denials of care, which violate fundamental standards of professional ethics, and which has been vacated as exceeding HHS’ statutory authority and inconsistent with the Administrative Procedure Act by three Federal District Courts.<sup>10</sup>

*Reform of FDA guidelines on blood donations.* One longstanding policy that systematically disadvantages many LGBTQIA+ people - in particular, gay and bisexual men and transgender persons – is the FDA policy against blood donation by any man who has had any type of sexual activity with another man during a specified deferral period – most recently,

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<sup>9</sup> In the final weeks of the Trump Administration, HHS issued a notice that it would not enforce regulatory language prohibiting grantees from discriminating based on sexual orientation and gender identity, *Notice of Nonenforcement of Health and Human Services Grants Regulation*, 84 Fed. Reg. 63,809 (Nov. 19, 2020); and subsequently issued a Final Rule deleting that language, *Health and Human Services Grants Regulation*, 86 Fed. Reg. 2257 (Jan. 12, 2021). In response to a court order, HHS has postponed the effective date of the January 12 Final Rule until August 11, 2021, but has not revoked the November 19, 2020, Notice of Nonenforcement

<sup>10</sup> *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23170 (May 21, 2019); *vacated*, *New York v. United States HHS*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019), *appeal filed*, No. 19-4254 (L.) (2nd Cir.); *vacated*, *Chity and Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001 (N.D.C.A. 2019), and *Washington v. Azar*, 426 F. Supp. 3d 704 (E.D. Wash. 2019), *appeals filed and consolidated*, Nos. 20-15398 et al. (9th Cir.).



within the past three months.<sup>11</sup> While the current three-month period is a significant change from earlier policies that called for deferral of blood donations in the case of any male-male sexual activity in the past one year – and until 2015, in the case of any male-male sexual activity at any time since the 1970s – the current policy still excludes many men whose sexual activities pose no risk of HIV or any other blood-borne infection. Treating all gay and bisexual men as a “high-risk group,” regardless of their actual behavior, perpetuates stigma and misconceptions about actual risks of HIV transmission. In addition, transgender men who take testosterone often experience secondary polycythemia as a side effect. One of the treatments for secondary polycythemia is therapeutic phlebotomy, or blood donation; however, transgender men are often grouped into this “high-risk group,” again regardless of actual behavior, and are denied access to medically necessary care. We appreciate that the FDA acknowledges the goal of transitioning to individual risk assessment of prospective blood donors based on their recent sexual history, and is currently funding a study to develop the evidence base for this approach. We urge the Administration to support this study, and to take reasonable steps to expedite policy change based on the developing evidence.

**The need for expanded federal support for cultural and clinical competency training.** Even in setting where there is not outright discrimination, the lack of clinical competency and cultural humility by providers and staff continues to be a major problem for our communities. This lack should be addressed through the implementation of LGBTQIA+ training requirements into federally funded and administered healthcare programs. Our centers and others offer training and technical assistance programs that can support expansion of training requirements.

Since 2010, The Fenway Institute’s National LGBTQIA+ Health Education Center (Education Center) has served as the National Training and Technical Assistance Partner of the Health Resources and Services Administration’s Bureau of Primary Health Care (HRSA BPHC) to conduct education, training, and technical assistance with over 1,300 U.S. health centers and enhance capacity for serving sexual and gender minority people in 50 U.S. states, Washington D.C., and Puerto Rico. These activities include onsite and virtual training and technical assistance, national webinars and learning collaboratives, federal best practice guidelines, interactive eLearning modules, and national conferences. For five years, the Education Center has operated HRSA BPHC’s TransECHO Program, which has led peer-based training and technical assistance in gender-affirming clinical care and culturally responsive service delivery at over 200 U.S. health centers. Increased funding would support expansion of the Education Center’s programs and build support for implementing a training requirement.

Lyon-Martin’s TransLine is an e-consultation service for medical and mental health providers in need of clinical support providing care to transgender individuals. It is supported by transgender health experts at over 20 different health centers across the country. Callen-Lorde has partnered with RubiconMD to provide LGBTQIA+ medical e-consultations. With federal

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<sup>11</sup> *Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products: Guidance for Industry*, April 2020, Updated August 2020, <https://www.fda.gov/media/92490/download>.

funding, these types of e-consultation services and collaborations would help to build LGBTQIA+ clinical competency and cultural humility through clinical collaboration.

Whitman-Walker Health and the National LGBT Cancer Network, together with leading educators, researchers, providers, and patient advocates across the country that include other members of the LGBTQIA+ Primary Care Alliance, have been developing detailed recommendations for LGBTQIA+ cultural responsiveness training of healthcare providers and staff. These recommendations, which will be released in the fall of 2021, will assist federal agencies and recipients of federal health care funding to improve existing training programs and to develop new ones.

#### **IV. The Administration Should Address the Inequities Exacerbated by the COVID-19 Pandemic**

LGBTQIA+ populations experience greater vulnerability to COVID-19 infection and worsened health outcomes due to many compounding risk factors. LGBTQIA+ people are almost twice as likely to work in frontline professions, experience higher rates of health conditions that are risk factors for complications from COVID-19, have higher rates of substance use, and have lower rates of health insurance coverage and access. Due to the limited access to culturally responsive and clinically competent care, LGBTQIA+ people also experience barriers to accessing COVID-19 testing, treatment, and vaccination. As a result of stigma and experiences of discrimination and mistreatment in health care settings, LGBTQIA+ communities – especially people of color, transgender and gender non-conforming people, intersex people older adults, and people with disabilities – also experience medical mistrust, which impacts willingness to meaningfully engage with, or seek care at all from, healthcare providers.

As noted above (Section I), there is a critical need to include measures of sexual orientation, gender identity and intersex (SOGII) traits in federally conducted and federally funded surveys; and a critical need for the federal government to encourage such measures in all health records. In order to address the compounding risk factors that impact LGBTQIA+ health and wellness during the COVID pandemic, federally funded and supported programs must require SOGII data collection and reporting in COVID-19 testing, care, and vaccination uptake. Non-affirming options for SOGII erase LGBTQIA+ people and the impact that this global pandemic continues to have on this population.

There is also a need for the federal government to publicize, and vigorously enforce, clear nondiscrimination rules in COVID vaccination, treatment, and testing, and to work with community groups and healthcare providers – including members of the LGBTQIA+ Primary Care Alliance – to eliminate barriers to vaccination and to address vaccine hesitancy.

#### **V. The Federal Government Should Continue to Expand Health Insurance Coverage and Address Barriers in Existing Public and Private Insurance Systems**

Although the Affordable Care Act has substantially reduced the number of uninsured Americans – through state and federal marketplaces and expansion of Medicaid – there are still too many individuals and families who lack health insurance, which dramatically limits their access to adequate care. Twelve states in the South and Midwest have refused to adopt Medicaid

expansion.<sup>12</sup> Undocumented persons are not eligible for Medicaid, and there are lengthy waiting periods for many immigrants with legal status. Premium subsidies under the ACA are not available to undocumented individuals, and they are not substantial enough to actually make insurance affordable. Many individuals and families remain uninsured because they are over-income for Medicaid but find health insurance premiums too expensive for their limited means. During the COVID pandemic, many individuals and families lost their health insurance as a result of losing their jobs.

In addition, too many people are under-insured even if they have insurance. Even ACA marketplace plans with relatively reasonable premiums with the help of subsidies, impose very substantial annual deductibles and copay requirements, which make it very challenging for even middle-class persons to afford needed healthcare and force many to postpone seeking a doctor for anything other than emergencies. Most insurance plans impose drug formularies, and restrictive networks for primary care and specialty care, that do not meet many plan members' healthcare needs, especially for transgender, gender non-conforming, and intersex people who need to access specialized gender affirming care. Even when people seek hospital care in emergencies, and even if they have insurance, they often face draconian bills from out-of-network hospitals and providers who provided the care they needed.

Access to mental health care and substance use treatment are particularly challenging, even for people with insurance. Most state Medicaid plans impose pre-authorization requirements and other significant restrictions on behavioral health coverage. Many insurance plans and most Medicaid plans do not cover intensive outpatient treatment and residential treatment programs, despite the fact that Medicaid enrollees are often much more in need of higher levels of care. Insurance strongly favors short-term therapy, even for individuals with clear need for long-term treatment. Undiagnosed and un- or under-treated mental health conditions and substance use are major causes of poor physical as well as mental health outcomes and violence and social malaise.

Although community health centers, including those joining in these comments, are committed to providing high-quality healthcare regardless of ability to pay, our providers encounter great difficulties in accessing specialist referrals for our un- and under-insured patients. Moreover, undiagnosed and untreated mental health issues and substance misuse make it very challenging to provide adequate care to many patients.

In order to adequately address the continuing health disparities that afflict communities of color and LGBTQIA+ persons, it is essential the federal government:

- Vigorously pursue fundamental, systemic reform of the healthcare system, including improvements to ACA health insurance marketplaces; additional initiatives to encourage resisting states to adopt Medicaid expansion; providing health insurance for undocumented persons; expanding coverage of behavioral healthcare; and efforts to simplify and rationalize our fractured system through Medicare expansion or other single-payer initiatives.

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<sup>12</sup> Kaiser Family Foundation, *Status of State Medicaid Expansion Decisions*, June 7, 2021, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map> (visited June 20, 2021).

- Explore regulatory and statutory initiatives to address current health insurance, hospital, and provider abuses, including “surprise” billing;<sup>13</sup> unreasonable restrictions on behavioral health care; and unreasonable drug formularies, provider networks and pre-authorization requirements.
- Undertake initiatives to meaningfully reduce the costs of healthcare, which makes it more difficult to achieve comprehensive, equitable coverage.

In addition, as discussed Section III and in the following Section VI, the federal government should take decisive action to address continuing barriers to gender-affirming care, including prohibiting discriminatory restrictions in health insurance plans – including Medicare and the Federal Employee Health Benefit Program – and prohibiting discrimination on the basis of gender identity by healthcare providers and staff.

**Failure of Federal Employee Health Benefit plans to cover fertility treatments.**

Many prospective LGBTQIA+ parents rely upon fertility assistance conceive children and create families. An increasing number of states require insurance plans to cover these services. Unfortunately, existing Federal Employee Health Benefit plans do not cover fertility assistance. In light of the President’s recent Executive Order directing OPM to ensure equitable benefits for federal workers, including LGBTQIA+ employees,<sup>14</sup> we encourage the agency to address this health inequity to support LGBTQIA+ individuals and couples who wish to have children. Furthermore, given the fact that hormone therapy has unknown effects on fertility, transgender and gender non-conforming clients starting hormone therapy are often counseled to consider gamete preservation prior to initiating hormone therapy to preserve fertility options in the future; however, given the lack of insurance coverage of gamete preservation, many transgender people are forced to choose between accessing gender-affirming care and preserving their fertility. Most end up risking their fertility options by pursuing hormone therapy and forgo gamete preservation due to the insurmountable expense of it. Thus, this is an issue of utmost importance in the movement toward LGBTQIA+ inclusive reproductive justice.

**VI. The Distinct Needs of Transgender and Other Gender Diverse People Should be Addressed**

The federal government must invest in caring for transgender and gender diverse populations. This means increasing access to quality gender affirming care, research, and education; protecting civil rights and ensuring access to gender-affirming care; and including measures of gender identity in federal surveys, reports and records.

Transgender and gender diverse people are in crisis. A record-breaking number of state-level legislation has been proposed and passed seeking to limit the rights of transgender Americans, particularly transgender youth. One hundred and twenty-five bills, all either aiming

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<sup>13</sup> We are encouraged by the recent interim final rule announced on July 1 by HHS, the Departments of Labor and Treasury, and OPM, <https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf>, and urge the agencies to finalize and expand on this important step.

<sup>14</sup> *Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce*, June 25, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/06/25/executive-order-on-diversity-equity-inclusion-and-accessibility-in-the-federal-workforce/>.

to ban transgender girls from sports, criminalize life-saving gender-affirming healthcare, ban transgender individuals from public restrooms, and/or prevent transgender people from accessing accurate identifying legal documentation, have been proposed in more than half of the statehouses in the country.<sup>15</sup>

Transgender people are disproportionately discriminated against in healthcare settings and have extremely high preexisting health conditions and unemployment,<sup>16</sup> exacerbated by the pandemic<sup>17</sup> and the current political climate. The lack of SOGII data collection does not allow accurate collection of demographic statistics about transgender Americans and therefore leads to less resources dedicated to this marginalized population. Moreover, with recent increases in unemployment, especially in rural areas,<sup>18</sup> transgender individuals have been at greater risk of losing employer-sponsored health insurance.<sup>19</sup>

Transgender people make up a small fraction of individuals reflected in the LGBTQIA+ acronym, and they are too often simply lumped into an “LGBT” category in the existing clinical literature. Published research that does accurately demarcate between gender and sexuality<sup>20</sup> reveals stark differences in a variety of healthcare experiences between sexual and gender minorities. Specific sexual and gender minority populations – including transgender men, transgender women and persons who identify as nonbinary – need to be considered separately as well as in combination, in order to identify their specific health disparities and healthcare needs.

As discussed in Section III, above, more federal funding is needed to provide comprehensive cultural responsiveness and clinical competence education for healthcare providers regarding transgender and gender diverse patients. Specific clinical guidelines<sup>21</sup> have been developed for transgender and gender-diverse patients do not readily apply to cisgender patients of sexual minorities. A lack of awareness here can lead to life-threatening mistakes such

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<sup>15</sup> Freedom for All Americans *Legislative Tracker: Anti-Transgender Legislation Filed for the 2021 Legislative Session*, <https://freedomforallamericans.org/legislative-tracker/anti-transgender-legislation> (visited June 25, 2021).

<sup>16</sup> White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. 2015. Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, 147, 222–231. <https://doi.org/10.1016/j.socscimed.2015.11.010>.

<sup>17</sup> Wang, Y., Pan, B., Liu, Y., Wilson, A., Ou, J., & Chen, R. 2020. Health care and mental health challenges for transgender individuals during the COVID-19 pandemic. *The Lancet Diabetes & Endocrinology*, 8(7), 564–565. [https://doi.org/10.1016/s2213-8587\(20\)30182-0](https://doi.org/10.1016/s2213-8587(20)30182-0), available at [https://www.thelancet.com/pdfs/journals/landia/PIIS2213-8587\(20\)30182-0.pdf](https://www.thelancet.com/pdfs/journals/landia/PIIS2213-8587(20)30182-0.pdf).

<sup>18</sup> James, S., *Coronavirus Economy Especially Harsh for Transgender People*, The New York Times, June 16, 2020, <https://www.nytimes.com/2020/06/16/us/coronavirus-covid-transgender-lgbtq-jobs.html?searchResultPosition=1> (visited July 3, 2021).

<sup>19</sup> Falk, G., Carter, J. A., Nicchitta, I. A., Nyhof, E. C., & Romero, P. D. (2021). *Unemployment Rates During the COVID-19 Pandemic: In Brief*, Congressional Research Service, Sept. 30, 2020, <https://crsreports.congress.gov/product/pdf/R/R46554/1>.

<sup>20</sup> Fritz, M. & Mulkey, N. 2021. The rise and fall of gender identity clinics in the 1960s and 1970s. *The Bulletin of the American College of Surgeons*, <https://bulletin.facs.org/2021/04/the-rise-and-fall-of-gender-identity-clinics-in-the-1960s-and-1970s/>.

<sup>21</sup> Deutsch, M. B., Radix, A., & Reisner, S. 2016. What’s in a guideline? Developing collaborative and sound research designs that substantiate best practice recommendations for transgender health care. *AMA Journal of Ethics*, 18(11): 1098-1106, available at <https://journalofethics.ama-assn.org/article/whats-guideline-developing-collaborative-and-sound-research-designs-substantiate-best-practice/2016-11>.

as missing a potential pregnancy<sup>22</sup> or active discrimination.<sup>23</sup> Decades of exclusion from clinical education about transgender healthcare continue to contribute to healthcare discrimination, resulting in poorer patient outcomes.<sup>24</sup>

**Inadequate federal health insurance coverage.** Even if transgender and gender diverse Americans are able to find an affirming provider, they may not have appropriate health insurance coverage. Unfortunately, while the federal government should be a leader in providing gender-affirming care, federal health insurance programs are strikingly inadequate. Specifically, Medicare, and health insurance plans for federal employees and their families, routinely deny coverage for medically necessary gender affirming treatments and procedures. We applaud the recently announced intention of the Department of Veterans Affairs to abandon its longstanding exclusion of gender-affirming surgeries;<sup>25</sup> and President Biden’s recent Executive Order on ensuring equitable treatment of federal workers, including LGBTQIA+ employees.<sup>26</sup> HHS and OPM should promptly address the restrictions on gender-affirming care in Medicare and in federal employee health plans.

**Failings of Federal Employee Health Benefit (FEHB) plans.** Transgender and gender diverse persons with health insurance through the FEHB program – as federal government employees or as dependents of federal employees – face many exclusions and coverage denials. In fact, the coverage available to such individuals is substantially inferior to coverage in many state Medicaid plans, employer-provided insurance, and many plans available in state and federal health insurance marketplaces under the Affordable Care Act.

*Coverage exclusions.* Most federal employee plans cover genital surgeries, gonadectomy, hysterectomy, and mastectomy only. Many plans explicitly exclude breast augmentation. Many other medically necessary treatments and procedures, including breast augmentation, facial surgeries, tracheal shave, voice therapy, body contouring, hair restoration, and non-genital hair removal, are excluded by many plans. Some FEHB plans even exclude genital surgeries. Even for procedures that are not explicitly excluded, many plans have overly restrictive eligibility requirements that conflict with WPATH’s Standards of Care.<sup>27</sup>

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<sup>22</sup> Stroumsa, D., Roberts, E. F., Kinnear, H., & Harris, L. H. 2019. The power and limits of classification—a 32-year-old man with abdominal pain. *New England Journal of Medicine*, 380(20): 1885, available at <https://sites.lsa.umich.edu/elizabethroberts/wp-content/uploads/sites/89/2019/05/classification.pdf>.

<sup>23</sup> Washick, M. J., Wesley, K., Bevis, E., & Zappa, M. J. 2020. Minnesota EMS providers share results of research on EMS care of transgender patients. *JEMS*, available at <https://www.jems.com/patient-care/minnesota-ems-providers-share-results-of-research-on-ems-care-of-transgender-patients/>.

<sup>24</sup> White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions, *supra* n.16.

<sup>25</sup> *VA Begins Action to Allow for Gender-Affirming Surgeries in VA Health Care Coverage*, <https://www.patientcare.va.gov/lgbt/> (visited June 25, 2021); *Transgender Care Coordination: External Frequently Asked Questions*, <https://www.patientcare.va.gov/LGBT/docs/Transgender-Care-External-FAQs-18June21.pdf#> (visited June 25, 2021).

<sup>26</sup> *Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce*, June 25, 2021, *supra* n.14.

<sup>27</sup> WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th ed. 2011), [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf). See also WPATH, *Transgender Medical Benefits* (2018), [https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/6\\_June/Transgender%20Medical%20Benefi](https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/6_June/Transgender%20Medical%20Benefi)

*Coverage denials.* Even when medically necessary procedures and treatments are not excluded by the language in FEHB plans, patients of the health centers submitting these comments routinely encounter restrictions and denials of coverage. Our providers, care navigators and patient advocates frequently are forced to pursue lengthy, resource-intensive appeals – sometimes successful, sometimes unsuccessful despite solid medical evidence.

In many cases that our attorneys and other patient advocates have pursued, OPM officials have taken the position that OPM is not responsible for the restrictions imposed by the insurance companies that offer health plans for federal employees and their dependents – that coverage decisions are up to the insurance companies, not the federal government. Many of our patients and legal clients are quite distressed to learn that their federal agency employer, or the federal agency employer of their parent, spouse or other relative, provides less coverage than private employers, and (in many states) even less coverage than Medicaid.

Our providers and patient advocates look forward to working with OPM to implement President Biden’s recent Executive Order, directing OPM to “take actions to promote equitable healthcare coverage and services for enrolled LGBTQIA+ employees (including their beneficiaries and their eligible dependents), LGBTQIA+ beneficiaries, and LGBTQIA+ eligible dependents, including coverage of comprehensive gender-affirming care, through the Federal Employees Health Benefits Program.”<sup>28</sup>

**Medicare failure to cover gender-affirming care.** While the ban on Medicare coverage for gender-affirming care was removed in 2014 in response to a Departmental Appeals Board proceeding, there is currently no National Coverage Determination (NCD) or uniform clinical policy to make coverage decisions. With no NCD, coverage decisions move to the Medicare Administrative Contractors (MACs) and Medicare Advantage plans. Because of a lack of safeguards, there are many discriminatory denials that have severely limited access to medically necessary and gender-affirming surgeries.

There is only one MAC that has a gender affirming clinical policy, and it is restrictive and discriminatory. Palmetto GBA (responsible for Alabama, Georgia, Tennessee, North and South Carolina, West Virginia, and parts of Virginia) has a Local Coverage Article that covers most top and bottom surgeries but excludes medically necessary procedures (e.g., facial surgeries) as cosmetic. Medicare Advantage plans rely on clinical policies for their commercial plans and have widespread restrictions for procedures such as breast augmentation, facial surgeries, electrolysis and voice therapy and surgery. When claims are filed or the Medicare Advantage pre-authorization process is used, there are widespread denials without conducting a medical necessity review. More robust and expansive regional policies from MACs for gender-affirming care are needed. In the absence of an NCD for gender affirming care, a non-discrimination paragraph should be added to the Medicare Policy Manual, such as:

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*ts.pdf*; WPATH, *Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* (Dec. 21, 2016), [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf).

<sup>28</sup> *Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce*, *supra* n.14.

Coverage exclusions and reasonable-and-necessary determinations must not discriminate on the basis of race, color, national origin, age, disability, or sex (including on the basis of sexual orientation, gender identity, or transgender status), including categorical limiting otherwise-covered services based on age or in relation to gender transition.”

Another issue is the lack of a prior authorization process for Original Medicare. Without a pre-authorization process, most providers do not take transgender patients because there is no guarantee of payment, and, even if the claim is approved, the reimbursement rates are not sustainable for surgeons to continue taking Medicare patients. Since many, if not most, transgender individuals are low income, they cannot sign waivers guaranteeing payment in the absence of coverage, so this leaves gender affirming surgery out of their reach. People who are dual-eligible for Medicaid also run into barriers because the claim must go through Original Medicare first. Adding a pre-authorization process is critical to increasing access to care, and this is something the Center for Medicare and Medicaid Innovations could test.

In addition to the uncertainty of receiving payment, there is a lack of qualified providers who accept Medicare due to low reimbursement rates and inappropriate coding. Medicare will not accept specific CPT codes regularly used for gender-affirming surgeries, and providers must use codes that correspond to simpler procedures. Providers are reimbursed at meager rates for complex operations. By improving billing codes and corresponding reimbursement rates, CMS could guarantee higher reimbursement rates for providers, which would allow more qualified providers, especially surgeons, to accept Medicare.

## **VII. The Distinct Needs of Persons With Intersex Traits Should Be Addressed**

Federal funding of research or programs that include intersex genital mutilation/surgical intervention on children born with variations in sex characteristics should be prohibited. Federal funding should not be utilized for unnecessary, nonconsensual early surgeries on intersex children. Additionally, clinical provider, patient, and family education should be implemented through a public education campaign to address unnecessary, nonconsensual early surgeries on intersex children. Federal health care and research grants and reimbursement rules should be clarified to ensure meaningful informed consent. This necessarily includes prohibiting sterilizing or genital surgeries where a patient is not old enough to consent and there is no immediate risk of physical harm.

In addition, intersex people should be prioritized in grant priorities for underserved communities. The intersex community should be expressly identified wherever LGBTQIA+ communities are identified in grant funding priorities. And, as noted in Section I, the federal government should develop and test questions on intersex traits for health studies and records, and population surveys.

## **VIII. The Distinct Needs of Sexual and Gender Diverse Elders Should Be Addressed**

Primary care providers support older adults with an array of chronic disease management and psychosocial services. Issues of finances, housing, nutrition, transportation/mobility, and social and family support are increasingly linked to the health and well-being of older adults. Older LGBTQIA+ people face even greater challenges than their heterosexual, cisgender peers,



due to decades of discrimination and marginalization. A recent study of Massachusetts LGBT older adults aged 50 to 75 found that they were less likely to own their home than straight, cisgender age peers, and more likely to struggle to pay rent and to pay for food.<sup>29</sup> Many LGBTQIA+ older adults struggle with acute isolation due to a lack of familial support or supportive community spaces. Research shows that older LGBTQIA+ people have higher rates of behavioral health issues like depression and suicidality. They are more likely than their straight, cisgender age peers to fall or be injured by a fall in the past year, and to struggle to pay for food and housing.<sup>30</sup> Older people living with HIV (PLWH), most of whom are gay and bisexual men or transgender women, often experience multiple comorbidities. Older LGBTQIA+ people and older PLWH can experience stigma and discrimination from straight, cisgender and HIV-negative age peers. Traditional senior services can be alienating due to the lack of appropriate knowledge and resources.

It is critically important to ensure that elder care providers offer affirming and nondiscriminatory care, as well as care that is clinically competent. All elder care providers, including home care aides and nursing home staff, should be trained in how to provide appropriate care to older PLWH and older LGBTQI+ people. Funding to better support older LGBTQIA+ adults would help to address social determinants of health and improve health outcomes. Funding to support partnerships with organizations such as SAGE can increase LGBTQIA+ competency around the specific needs of this age group and ensure that sexual and gender diverse older adults receive the level of care necessary to achieve optimal health and wellness.

## **IX. The Distinct Needs of LGBTQIA+ Immigrants and Persons with Limited English Proficiency Should be Addressed**

As noted in Section III, in May 2021 HHS restored some of the nondiscrimination provisions of the Section 1557 rule that were repealed by the prior Administration. However, the agency has not yet restored language in the 2016 rule guaranteeing language access for patients with limited English proficiency. We urge the federal government to strengthen access to translation services for patients with limited English proficiency. It is important to note that elderly patients with hearing loss may not be able to access interpretation services via a listening device. More effective ways to guarantee language access for elderly patients with limited English proficiency are needed.

In addition, as discussed in Section V, federal insurance programs, including Medicaid and ACA subsidized health insurance exchanges, are not available for undocumented immigrants and even for many with legal status. As a matter of equity and also to promote the public health, insurance coverage needs to be substantially expanded for immigrant populations.

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<sup>29</sup> Cahill S., *LGBT Aging 2025: Strategies for Achieving a Healthy and Thriving LGBT Older Adults Community in Massachusetts*, Fenway Institute, <https://fenwayhealth.org/wp-content/uploads/LGBT-Aging-2025-Report-December-2020.pdf> (visited July 3, 2021).

<sup>30</sup> *Id.*

## **X. The Distinct Needs of LGBTQIA+ Persons Living With Disabilities Should be Addressed**

An estimated 3 to 5 million LGBTQIA+ people have disabilities in the US, yet many LGBTQIA+ people with disabilities struggle to access affirming and accessible resources and services.<sup>31</sup> They often experience invisibility within both communities. LGBTQIA+ youth with disabilities experience higher rates of bullying than LGBTQIA+ youth without disabilities. They are overrepresented in juvenile justice systems. LGBTQIA+ people with disabilities often struggle to access employment. We encourage government agencies focused on equity to prioritize the unmet needs of sexual and gender diverse people living with disabilities. This includes ensuring that insurance companies cover and decrease barriers to access home healthcare services, durable medical equipment, and assistive devices.

## **XI. The Administration Should Address Challenges Faced by Many LGBTQIA+ People in Nutrition and Housing**

Health and wellness are not simply a matter of access to good quality, affordable healthcare. Many aspects of an individual's or family's economic, educational, social, physical, and legal environment are powerful influences on their ability to achieve and maintain good health. Among the most important social determinants of health<sup>32</sup> are nutrition and housing. LGBTQIA+ people are more likely to face substantial challenges than the general population in these essential resources. We urge the Administration to pay particular attention to the following needs.

**Nutrition.** According to a leading study, "LGBT adults experience food insecurity and participate in [the] SNAP [Program] at higher rates than non-LGBT adults."<sup>33</sup> In April 2020, a study by the Williams Institute found that 27% of LGBTQIA+ adults had experienced food insecurity during the past year.<sup>34</sup> Job and housing losses, and other financial stresses resulting from the COVID pandemic, have increased the risk of going hungry faced by many LGBT persons and their families.<sup>35</sup> We appreciate the Biden Administration's rejection of attempts during the Trump years to curtail the SNAP and other food assistance programs, and urge the Administration to increase funding for these essential resources.

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<sup>31</sup> Movement Advancement Project, *et al.*, *LGBT People with Disabilities*, <https://www.lgbtmap.org/file/LGBT-People-With-Disabilities.pdf> (visited June 28, 2021).

<sup>32</sup> Centers for Disease Control and Prevention, *Social Determinants of Health: Know What Affects Health*, <https://www.cdc.gov/socialdeterminants/about.html>.

<sup>33</sup> Taylor N. T. Brown, Adam P. Romero, and Gary J. Gates, *Food Insecurity and SNAP Participation in the LGBT Community*, July 2016, Williams Institute, <https://williamsinstitute.law.ucla.edu/publications/lgbt-food-insecurity-snap/> (visited July 1, 2021).

<sup>34</sup> Williams Institute, *One in Four LGBT People Experienced Food Insecurity in the Past Year*, April 27, 2020, <https://williamsinstitute.law.ucla.edu/press/lgbt-food-insecure-press-release/> (visited July 1, 2021).

<sup>35</sup> Bianca D.M. Wilson and Kerith J. Conron, *National Estimates of Food Insecurity: LGBT People and COVID-19*, April 2020, <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-COVID19-Apr-2020.pdf> (visited July 1, 2021).

**Housing.** It is well-established that housing is a substantial factor promoting, or undercutting, health and wellness.<sup>36</sup> LGBTQIA+ youth are more than twice as likely to face homelessness as their heterosexual, cisgender counterparts. Family rejection accounts for sixty-eight percent of LGBTQIA+ youth homelessness.<sup>37</sup> Moreover, because shelters are often gender segregated, transgender and gender non-conforming people face severe harassment, assault, and discriminatory refusals of services at shelters. Our healthcare providers find that these patients experience worsened health outcomes including depression, physical and mental abuse, intimate partner violence, and other traumas. Funding to support LGBTQIA+ homeless youth programming will help to expand existing services and support primary care providers in improving health outcomes and connecting patients to needed social services.

LGBTQIA+ adults also experience housing discrimination, despite existing protections. A study by the Urban Institute found that LGBTQIA+ individuals and couples experienced housing discrimination when seeking rental housing by receiving fewer available options than their heterosexual and cisgender counterparts.<sup>38</sup> Current efforts to support youth and older adult housing should be expanded to ensure all LGBTQIA+ communities have access to housing. Funding to support LGBTQIA+ training and education in federally supported housing programs will help to generate increased cultural humility and competency regarding LGBTQIA+ considerations related to housing for all ages.

## **XII. Ending the Opioid Overdose Epidemic**

Safe Consumption Spaces are supervised sites for people who use drugs to do so with overdose prevention support easily accessible. Studies show that LGBTQIA+ individuals use drugs at much higher rates than heterosexual and cis-gender populations. The US Trans Survey found that overall, 29% of the transgender people surveyed reported illicit drug use in the past month, nearly three times the rate of the US population; 7% used prescription drugs that were not prescribed to them in the past month compared with 2% of the US population.<sup>39</sup> The US opioid epidemic and overdose rates show no signs of slowing, especially now with the introduction of fentanyl in many drugs currently circulating. In fact, overdoses due to accidental fentanyl consumption are increasing dramatically each year (e.g., from 2018 to 2019, overdoses increased by 16%). Studies show that supervised spaces for drug consumption are vital in significantly reducing or eliminating needle sharing, overdose fatalities, do not increase drug use in local areas, and serve as linkage sites for people that use drugs to gain access to other medical and social services, including drug treatment services. Legalizing Safe Consumption Spaces in

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<sup>36</sup> See, e.g., HealthyPeople.Gov, *Housing Improvements for Health and Associated Socio-economic Outcomes*, <https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/housing-improvements-for-health-and-associated-socio-economic-outcomes>; America's Health Insurance Plans, *Safe and Affordable Housing: Social Determinants of Health*, September 2018, <https://www.ahip.org/wp-content/uploads/2018/09/SDOH-Housing-IB-FINAL.pdf> (visited July 1, 2021).

<sup>37</sup> Maya Brennan, Ally Livingston, and Veronica Gaitán, *Five Facts About Homelessness for LGBT People*, June 13, 2018, Urban Institute Housing Matters, <https://housingmatters.urban.org/articles/five-facts-about-housing-access-lgbt-people> (visited July 2, 2021).

<sup>38</sup> *Id.*

<sup>39</sup> James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. 2016, *The Report of the 2015 U.S. Transgender Survey*, National Center for Transgender Equality, <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf> (visited July 6, 2021).

federally funded institutions is crucial to curbing both the opioid overdose and the HIV epidemics.

### **XIII. Conclusion**

We greatly appreciate President Biden's commitment to equity for all Americans, and his recognition of the challenges faced by sexual and gender diverse communities. Our providers, researchers and advocates stand ready to assist OMB, and any and all federal agencies whose mission includes health, with the issues discussed in these comments.

Respectfully submitted,

APLA Health (Los Angeles and Long Beach, CA), <https://aplahealth.org/>  
Apicha Community Health Center (New York), <https://www.apicha.org/en/home>  
Callen-Lorde Community Health Center (New York), <https://callen-lorde.org/>  
Chase Brexton Health Care (Baltimore), <https://www.chasebrexton.org/>  
CrescentCare (New Orleans), <https://www.crescentcare.org/>  
Equitas Health (Ohio), <https://equitashealth.com/>  
Fenway Health and Fenway Institute (Boston), <https://fenwayhealth.org/>  
Howard Brown Health (Chicago), <https://howardbrown.org/>  
JWCH Institute (Los Angeles), <http://jwchinstitute.org/>  
Legacy Community Health (Houston and Beaumont, Texas),  
<https://www.legacycommunityhealth.org/>  
Lyon Martin Health Services (San Francisco), <https://www.healthright360.org/agency/lyon-martin-health-services>  
Mariposa Community Health Center (Santa Cruz County, CA), <https://mariposachc.net/>  
NorthLakes Community Health Clinic (Northern Wisconsin), <https://nlccwi.org/>  
Transhealth Northampton (Massachusetts), <https://www.transhealth.org/>  
Whitman-Walker Health and Whitman-Walker Institute (Washington, DC),  
<https://www.whitman-walker.org/>

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July 6, 2021