Center for Health Care Strategies

# Medicaid Opportunities to Improve Health Care Access and Quality for LGBTQ+ Communities

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## TAKEAWAYS

- People in LGBTQ+ communities, including many who are enrolled in Medicaid, face unique health disparities and inequities often leading to low quality care and poor outcomes.
- Medicaid policies provide an essential opportunity to expand health care access and address health disparities for LGBTQ+ communities.
- This brief outlines key considerations for shaping Medicaid policies to improve health outcomes and quality of care for LGBTQ+ individuals, based on interviews with health care providers, LGBTQ+ Medicaid members, and state Medicaid staff.

People who are lesbian, gay, bisexual, transgender, queer, and other sexual and gender minorities (LGBTQ+) have well-documented health disparities and inequities.[1] This is due in part to persistent interpersonal discrimination related to homophobia and transphobia, systemic discrimination, and structural barriers. Compared to cisgender and heterosexual peers, LGBTQ+ communities have greater rates of certain cancers, HIV/AIDS, and behavioral health needs, along with other conditions.[2,3,4,5] Additionally, health disparities and discrimination are magnified across intersecting identities, including race, ethnicity, socioeconomic standing, age, disability, and citizenship status.[6]

LGBTQ+ communities are more likely to live below the poverty line and be enrolled in Medicaid.[7] As the primary health insurer for LGBTQ+ communities, Medicaid policies and programs are well positioned to help address the health disparities facing LGBTQ+ communities.

Over the last year, Federal agencies have started prioritizing LGBTQ+ health. The Centers for Medicare & Medicaid Services (CMS), for example, recently released guidelines for a new option for Medicaid agencies to collect sexual orientation and gender identity (SOGI) data to better understand where disparities exist and identify opportunities to improve care.[8] The U.S. Department of Health and Human Services (HHS) also recently reaffirmed protections for LGBTQ+ communities seeking health care and health insurance coverage under Section 1557 of the Patient Protection and Affordable Care Act, which includes a requirement that people be treated consistently with their gender identity.[9,10]

As the number of people who identify as LGBTQ+ increases across the U.S., it is crucial to meet their health needs.[11] However, LGBTQ+ health has become politicized in many states, resulting in state bans on gender-affirming care for youth and attacks on health care providers serving these communities.[12,13]

With increasing community pressure, needs, and federal and state interest, many state policymakers are exploring Medicaid opportunities to better address the health needs of LGBTQ+ members. This brief highlights key considerations to shape Medicaid policies that enhance health outcomes and quality of care for LGBTQ+ individuals.

## Identifying Medicaid Barriers and Levers to Improve LGBTQ+ Health

To identify opportunities for Medicaid policymakers to improve health care quality and outcomes of their LGBTQ+ members, the Center for Health Care Strategies (CHCS) interviewed health care providers serving LGBTQ+ communities enrolled in Medicaid and LGBTQ+ Medicaid members, and convened Medicaid policymakers from five geographically and demographically disparate states.

Although Medicaid policies impact LGBTQ+ communities in every state, a visible public focus on LGBTQ+ health may not be feasible for all Medicaid agencies. To understand the context of states across the political spectrum, CHCS sought conversations with a broad mix of states. CHCS spoke with Medicaid policymakers working in states with strong support of LGBTQ+ communities, including states with Medicaid coverage of gender-affirming care, as well as policymakers working in states with recent legislation imposing barriers to LGBTQ+ health in general, including active bans on gender-affirming care.

## Key Terms

- “**Conversion therapy**” — or sexual orientation or gender identity change efforts — refer to the discredited practice of trying to change someone’s sexual or gender identity. Despite widespread condemnation from the medical community and many state bans, the practice still occurs in almost every state.[14,15,16,17] So-called “conversion therapy” significantly increases the likelihood of attempting suicide for those who undergo it.[18]
- **Deadnaming** refers to using an incorrect name for a transgender person, often their given name at birth that they no longer use. **Misgendering** refers to using the wrong pronouns when talking about someone. Whether intentional or not, both deadnaming and misgendering can cause significant psychological harm for transgender people.[19] A persistent and intentional pattern of using the wrong name and/or pronoun for a transgender person may constitute unlawful discrimination under Section 1557 and some state laws.[20]
- **Gender-affirming care** refers to care that is supportive of someone’s gender. Based on an individual’s goals and needs, gender-affirming care can consist of a wide variety of services, including social affirmation, medical and surgical services, behavioral health care, and more.[21]
- **Culturally competent care** refers to care that is centered on a particular population (e.g., LGBTQ+ individuals), avoids biases, and incorporates the patients’ individual beliefs, preferences, experiences, and needs.[22]

## ACKNOWLEDGEMENTS

CHCS is grateful for those we interviewed — including **providers**, **LGBTQ+ Medicaid members**, and **Medicaid policymakers** — who generously shared their insights to inform this analysis.

We appreciate our Technical Advisory Committee, who provided time, wisdom, and expertise:

- **Kellan Baker**, Whitman-Walker Institute
- **Lydia X. Z. Brown**, National Disability Institute
- **Jason Flatt**, University of Nevada, Las Vegas
- **Axel Torres Marrero**, Hyacinth Foundation
- **Asa Radix**, Callen-Lorde

Finally, we also thank **Adam Thompson**, who co-designed and facilitated our community conversations with LGBTQ+ individuals enrolled in Medicaid.

# Themes from Interviews with LGBTQ+ Members, Providers, and Medicaid Staff

Across conversations with LGBTQ+ Medicaid members, Medicaid policymakers, and health care providers serving LGBTQ+ communities, several key themes emerged for improving LGBTQ+ health in Medicaid.

## 1. Medicaid agencies play a critical role in covering care that improves LGBTQ+ health outcomes, including gender-affirming care services.

As the largest health insurer in the country, Medicaid policies often set precedents that impact private insurers. In some states where Medicaid covers gender-affirming care — including Maryland, Massachusetts, and Oregon — Medicaid policies are often more comprehensive than those of private insurers in the same state.[23,24,25,26] Medicaid can use several mechanisms to expand access to gender-affirming care, including covering specific services, revising medical necessity guidelines, streamlining prior authorization processes, and expanding managed care contract requirements.

Beyond gender-affirming care, providers and LGBTQ+ members shared stories of individuals moving across state lines to access better care in states with more comprehensive Medicaid coverage for a variety of services, including HIV treatment and behavioral health care.

Additionally, some state interviewees expressed interest in exploring coverage of assisted reproductive technologies, such as gamete preservation and in vitro fertilization.[27] While a variety of Medicaid members may benefit from this coverage, it would have a significant impact on LGBTQ+ members who are interested in family planning and may not otherwise be able to build families.

Throughout interviews, providers shared that, compared to privately insured patients, Medicaid members tend to experience fewer barriers getting gender-affirming care covered. While there are positive aspects of Medicaid coverage for the LGBTQ+ population, providers and Medicaid members also emphasized that Medicaid has significant room for growth in coverage of gender-affirming care, behavioral health, and increasing access to care overall.

## 2. There are not enough culturally competent providers serving LGBTQ+ Medicaid members.

Compared to private insurers, Medicaid programs often have fewer enrolled providers accepting new patients.[28] This shortage of health care providers affects all Medicaid members; however, this issue disproportionately impacts LGBTQ+ members, who also face the challenge of finding culturally competent providers.

Because of this shortage, providers, members, and policymakers interviewed raised concerns that LGBTQ+ populations:

- Avoid or put off seeking needed health care;
- Face significant delays for primary care, surgery, and behavioral health care;
- Travel long distances at their own cost to receive care;
- Receive care in settings that are not affirming; and
- Receive care that is ineffective or unsafe.[29,30,31,32,33,34,35]

Multiple providers and LGBTQ+ members interviewed shared stories of LGBTQ+ individuals receiving care from non-culturally competent providers that was not best practice and may have resulted in harm. Additionally, when members avoid receiving care for fear of discrimination or due to lack of available providers, their health care costs increase due to untreated conditions.[36]

Providers rarely receive formal training on LGBTQ+ cultural competency. Those who do serve LGBTQ+ communities often seek trainings independently, if at all. This lack of training perpetuates a cycle of providers entering the health care system without awareness of the needs of LGBTQ+ communities.[37]

Simultaneously, providers shared that threats against LGBTQ+ health centers and providers — especially gender-affirming care providers — may be deterring new providers from entering the field and increasing staff turnover due to burnout.[38] Greater access to and requirement of LGBTQ+ cultural competency training by Medicaid agencies, managed care plans, and health systems may provide members with more culturally responsive care.

## 3. Medicaid staff need support to grow their knowledge of and comfort with LGBTQ+ health.

In addition to providers needing training, conversations with policymakers, providers, and members highlighted the need for LGBTQ+ cultural competency training for all Medicaid staff. Trainings may help frontline Medicaid staff increase their ability to provide patient-centered, culturally competent services to LGBTQ+ members. Additionally, required trainings on LGBTQ+ health needs may improve Medicaid staff's ability to design and implement programs and policies to improve care access for these communities. Some states — including California, Michigan, and New Mexico — require managed care organizations (MCOs) to develop and implement LGBTQ+ cultural competency trainings for all staff.[39,40,41] Other states interviewed shared examples of past efforts to encourage LGBTQ+ cultural competency training by offering continuing education credits to Medicaid clinical staff for participation.

Providers and Medicaid LGBTQ+ members shared stories of members being misgendered and facing other forms of discrimination when interacting with Medicaid agency staff. Both providers and members recounted spending months navigating administrative barriers to update Medicaid records with new legal names. Updating Medicaid records has implications for how members experience the health care system daily. Often the name associated with Medicaid records is the name on file for prescriptions, explanations of benefits, and appointment notices, which means members may be faced with their deadname multiple times a day while taking medications, opening mail, or receiving reminder calls. While the Medicaid system was not intentionally designed to be confusing, persistent deadnaming and misgendering can cause psychological harm.[42] Additionally, using inconsistent, outdated names for the same person across state programs may result in unnecessary flags for fraud, waste, and abuse investigations.[43]

## 4. Coverage of services does not guarantee access to care.

Providers and policymakers also expressed concerns that Medicaid policies may unintentionally exclude necessary care or make care difficult to access. For example, Medicaid members and providers shared stories of Medicaid policies that excluded coverage of certain hormone therapy formulations or methods of administration (i.e., topical, oral, injectable), resulting in members receiving care that did not align with clinical goals or needs. In some states, Medicaid covers only injectable formulations of estrogen, which may cause barriers for members with needle phobias.

Further, some Medicaid processes may create unnecessary hurdles for members to get the care they need. For example, in many states that cover gender-affirming care, Medicaid still requires multiple letters of support from providers for members to receive prior authorization approval for surgeries and hormone therapy. These requirements persist despite updates to the World Professional Association for Transgender Health’s Standards of Care guidelines that now recommend only one letter of support, if required to receive care.[44] Additionally, providers interviewed shared that Medicaid can be unclear on what information is required in these documents, making it difficult for providers to complete them correctly and for members to get coverage approval.

Providers, members, and policymakers from several states called out coverage of electrolysis as an example of a well-intentioned policy resulting in inaccessible care. While some states — including Colorado and Massachusetts — cover electrolysis as part of gender-affirming care, often there are limited, if any, Medicaid-enrolled providers who offer electrolysis.[45,46] Electrolysis is most commonly provided by electrologists, who are generally licensed through state boards of cosmetology. In part because of their licensure, Medicaid systems often do not recognize electrologists as health care providers. The most common providers for electrolysis, therefore, are unable to enroll with and bill Medicaid directly for their services even when Medicaid covers electrolysis. To get around this, policymakers and providers shared that electrologists often must contract with and practice under a dermatologist or other Medicaid-enrolled provider who will bill on their behalf. This set-up is cumbersome and difficult for electrologists to navigate.

At its most severe, lack of awareness of the needs and experiences of LGBTQ+ members can result in coverage of inappropriate and unsafe care that puts members at risk of harm. For example, policymakers in some states shared concerns that their Medicaid agencies may be unknowingly paying for sexual orientation or gender identity change efforts, or so-called “conversion therapy,” when providers bill for the “therapy” using Medicaid covered codes for behavioral health care. Not only is this practice dangerous to those who undergo it, paying for a service with no medical value that causes psychological harm resulting in worse health outcomes is a waste of state resources.[47] Twenty-three states have passed legislation banning “conversion therapy.”[48] Policymakers interviewed expressed a desire to develop internal processes to ensure Medicaid does not inadvertently cover this practice.

## 5. Policymakers, plans, and providers need guidance for collecting, storing, and using SOGI data.

Collecting SOGI data is critical to effectively track health disparities, understand the needs of LGBTQ+ communities, and provide appropriate, culturally responsive, and equitable care.[49] Despite recent guidance from CMS, state policymakers interviewed shared they are still unsure of how to draft and implement meaningful SOGI data collection and reporting guidelines.[50]

One area of concern for policymakers was proxy reporting — the practice of one person providing health-related information on behalf of other household members. Proxy reporting most often impacts youth, older adults, and people with disabilities, all populations from which it can be challenging to collect data. Policymakers worried that proxy reporting could result in inaccurate data or force household members to out themselves, resulting in potentially unsafe living environments. Yet, research indicates that SOGI questions are not more difficult to answer by proxy than other non-SOGI items (e.g., employment, income, and disability).[51]

Resistance from providers and health plans to collect SOGI data was another concern for policymakers. According to policymakers, providers and plans worry that providers lack training on how to ask SOGI-related questions and may therefore avoid collecting SOGI data, even if required. Policymakers also shared that state systems lack interoperability to store and compare SOGI information across state and federal programs, making it difficult to determine how to manage and use the data. As the federal government continues to support state public health data modernization and improvement efforts, states might consider prioritizing the funds to support interoperability where possible.[52]

Policymakers in some states also shared concerns about SOGI data being used to target and discriminate against LGBTQ+ communities. However, since our interviews with policymakers took place, in April 2024 the HHS Office of Civil Rights released a final rule specifying that Section 1557 protects those seeking health care and health insurance coverage from discrimination on the basis of sex, inclusive of gender identity and sexual orientation.[53] This clarification is intended to offer legal protection against discrimination for LGBTQ+ individuals.[54]

Some states have advanced SOGI data collection and reporting at various levels. Beginning in 2018, the Oregon Health Authority (OHA) convened a SOGI data collection workgroup, which includes both internal experts and external LGBTQ+ community members.[55] The workgroup recently released recommendations to inform the state's efforts to collect SOGI data through Medicaid.[56] In Massachusetts, the Medicaid agency tracks which MCOs collect and maintain SOGI data for members.[57] Massachusetts' Medicaid program also includes tracking of demographic information — including SOGI — as a quality withhold measure for One Care plans for those dually enrolled in Medicaid and Medicare.[58] Further, the National Committee for Quality Assurance includes SOGI requirements in their health equity accreditation standards for plans.[59] Creative innovations like these can help standardize SOGI data collection, and ultimately give state agencies and their partners the information they need to better address inequities in the LGBTQ+ population.

## Promising Practices for Medicaid to Better Support LGBTQ+ Members

The interviews with members, providers, and Medicaid staff elevated several promising practices for improving quality of care and health outcomes for LGBTQ+ Medicaid members. While adopting these practices may improve health care for LGBTQ+ communities, these practices may also benefit other populations as well.

### 1. Use state funds to cover LGBTQ+ cultural competency trainings for providers.

A scarcity of LGBTQ+ culturally competent providers was one of the top themes that emerged throughout conversations with policymakers, providers, and members. As outlined above, lack of providers results in poor quality of care and can lead to members receiving care that is ineffective and at times even unsafe.

Some states have found success in allocating state public health funding or managed care-related funding to support LGBTQ+ cultural competency trainings for providers or offer continuing education credits around LGBTQ+ cultural competencies for health care staff. Colorado, for example, requires MCOs to provide LGBTQ+ health trainings to enrolled providers.[60] By using these funding streams, community-based organizations (CBOs) and MCOs can offer trainings for providers interested in learning more about LGBTQ+ cultural competency. Access to trainings like this is especially important for rural communities where providers may be resource constrained and have less access to LGBTQ+ cultural competency trainings.[61] By ensuring that these trainings are offered to a diverse array of providers, including specialists, states can help expand access and minimize travel time for LGBTQ+ members.

## 2. Create public-facing resources to help members and providers understand covered services for LGBTQ+ members and how to access them.

Medicaid LGBTQ+ members shared a common experience of struggling to understand and keep track of which services and providers are covered by Medicaid or their managed care plan. Medicaid resources geared toward improving communication with LGBTQ+ communities may help Medicaid agencies improve the effectiveness, timeliness, efficiency, and patient-centeredness of their care.

Providers and LGBTQ+ Medicaid members expressed frustration with difficulties in determining which services are covered by Medicaid. Both groups recommended that Medicaid agencies develop easy-to-understand resources outlining covered services and how members can access those services. Some states have begun to address this need by creating resources focused on transgender, nonbinary, and gender-diverse communities. For example, Massachusetts' MassHealth and Washington State's Apple Health have websites detailing information on gender-affirming care coverage.[62,63] Colorado Medicaid has a provider billing manual that outlines the billing codes and requirements for gender-affirming care covered services.[64]

Some managed care plans also have member-facing materials that outline covered services for LGBTQ+ communities. In California, the San Francisco Health Plan includes resources for LGBTQ+ members to learn more about covered services.[65] Beginning in March 2025, all Medicaid managed care plans in California will be required to include a list of in-network providers who specialize in gender-affirming care in their member-facing provider directories.[66]

Across all groups interviewed, there was a shared desire for greater resources to support members in identifying LGBTQ+ culturally competent providers covered by Medicaid. While some non-Medicaid public-facing resources exist — including the *LGBTQ+ Healthcare Directory* — Medicaid policymakers expressed concerns about sharing resources without first independently validating providers' cultural competencies.[67]

## 3. Hire care navigators to support LGBTQ+ members seeking care.

To receive care, LGBTQ+ Medicaid members shared stories of navigating multiple confusing systems and provider networks, including:

- Identifying Medicaid-enrolled, culturally competent providers accepting new patients, including surgeons, behavioral health providers, hair removal providers, and other specialists;
- Completing Medicaid's prior authorization process, including potentially appealing for denied care; and

- Scheduling and attending appointments, often across multiple health systems, and with the requirement that appointments occur within limited prior authorization timeframes approved by Medicaid.

This level of complex care coordination requires substantial time, effort, and understanding of the health care system. Some providers shared that their health systems have full-time care navigators on staff to help patients access gender-affirming care. Similarly, the U.S. Veterans Affairs Health System employs LGBTQ+ Veteran Care Coordinators in every VA health system across the country.[68] These care coordinators support LGBTQ+ veterans in accessing quality care that aligns with their needs, including and beyond gender-affirming care.[69]

Within Medicaid, Washington State's Apple Health program has staff with dedicated time to support members and providers who reach out via email to navigate gender-affirming care coverage.[70] In New York, Amida Care — a Medicaid managed care community health plan that focuses on people living with HIV/AIDS, people who are transgender, and people who are experiencing homelessness — includes an integrated care team for all members.[71] This care team includes a care coordinator who helps members navigate available health and social services.

For states seeking to improve quality of care for LGBTQ+ members, hiring care navigators as Medicaid agency staff or requiring MCOs to have navigators on staff may increase access to and the timeliness, efficiency, and patient-centeredness of the care that LGBTQ+ members receive. States can also consider either explicitly incorporating an LGBTQ+ health focus into leadership positions or developing leadership roles focused exclusively on LGBTQ+ health.

## 4. Integrate services to address health-related social needs with clinical care to better meet LGBTQ+ member needs.

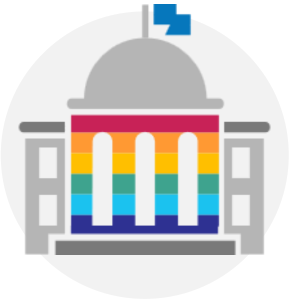
Policymakers and providers elevated the need for increased resources for addressing health-related social needs (HRSN) for LGBTQ+ communities. LGBTQ+ communities face significant HRSN disparities.[72] For example, compared to their heterosexual and cisgender peers, LGBTQ+ adults are significantly more likely to have experienced homelessness.[73,74] In addition to housing instability, LGBTQ+ communities also face higher rates of food insecurity and violence victimization.[75,76] These disparities are magnified for LGBTQ+ people of color who face more HRSN disparities.[77,78]

Lack of stable housing, food insecurity, experiences of violence, and other needs are all associated with worse health outcomes.[79] Thus, efforts to improve LGBTQ+ health may benefit from complementary efforts related to increasing access to basic needs such as food, housing, employment, and social support.

Prominent LGBTQ+ health centers have long histories of incorporating HRSN services. In Detroit, the Ruth Ellis Center provides rental assistance and intensive case management, including employment supports for LGBTQ+ youth.[80] The Los Angeles LGBT Center provides housing support for youth experiencing homelessness and LGBTQ+ older adults struggling with housing insecurity.[81,82] HousingWorks in New York City, which provides health care for people living with HIV and AIDS, also provides some housing support, including connecting eligible patients with New York City's Department of Social Services' HIV/AIDS Services Administration program, which provides intensive care management.[83,84]

Medicaid can support this type of service integration through using its various authorities — including Section 1115 demonstration waivers, state plan amendments, managed care contracts, and more — to fund programs that support access to HRSN services.[85] For example, Arizona's recent 1115 waiver included housing supports and case management for those with certain health conditions, like HIV/AIDS, who are experiencing or at risk of homelessness.[86] In California, the state Medicaid program uses Community Supports (or "*in lieu of* services") through managed care plans to provide nutritional, food, and other HRSN services to those eligible.[87] As more Medicaid programs begin to incorporate HRSN services, policymakers may want to consider supporting efforts that specifically respond to the needs of LGBTQ+ communities.

## Medicaid Policy Considerations to Improve Health for LGBTQ+ Members



As state Medicaid agencies explore options to improve LGBTQ+ health outcomes, including the promising practices outlined above, they can consider how to incorporate community voices, acknowledge the diverse needs within LGBTQ+ communities, engage managed care organizations, and leverage quality improvement efforts.

### 1. Collaborate with LGBTQ+ members and providers on policy creation and implementation.

Engaging the community members who will be most impacted is a best practice for equitable policy design and implementation.[88] LGBTQ+ members and providers offer valuable insight into how policies will impact access to care. Conversations with providers and members mentioned recommendations for Medicaid and revealed instances of well-intentioned policies that miss the mark. For example, several Medicaid policymakers shared that they were unaware of continuing coverage of "conversion therapy" or the barriers to accessing electrolysis until providers and members shared their experiences.

Some Medicaid agencies have begun to proactively collaborate with LGBTQ+ members and providers. As mentioned earlier, OHA's SOGI data collection workgroup recently released recommendations for the state Medicaid's SOGI data collection efforts. To meet the needs of all Oregonians, these recommendations include options for gender identity and sexual orientation categories not currently included in the recent CMS SOGI data collection recommendations.[89]

The OHA recommendations also include questions related to pronouns and titles to help the state better communicate with existing and potential members. The OHA workgroup offers an example of how incorporating community input can result in policy recommendations that are more tailored to the needs of their state.

In April 2024, CMS released the *Ensuring Access and Eligibility in Medicaid* final rule, which elevates the central role Medicaid members should play in shaping Medicaid program and policy changes by establishing Medicaid Advisory Committees (MACs) and Beneficiary Advisory Councils (BACs).[90,91] Including LGBTQ+ Medicaid members on MACs and BACs will be a key opportunity to gather their unique experiences with the Medicaid programs in their states.

Additionally, compensating community members for their time, expertise, and input is critical to ensuring more equitable participation.[92] Policymakers shared that determining ways to adequately compensate community members can be a barrier to engagement. Using flexible payment options, including gift cards, may help address some of those concerns. Remembering to use appropriate names and pronouns when working with transgender, nonbinary, and gender-diverse individuals can help build trust and respect. States can determine if it is feasible to address payment using the individual's chosen name, as well, if that name is not their legal name.

## 2. Create policies to address different needs within the broader LGBTQ+ community.

While discrimination based on sexual orientation and gender identity is a common experience across LGBTQ+ communities, these populations are not a monolith. Flattening experiences of millions of people based on sexual orientation and gender identity is a disservice to their diversity and may result in policies that fail to meet the needs of specific populations.[93] As outlined earlier in this brief, health disparities and inequities facing LGBTQ+ communities are magnified by intersecting identities.

During interviews, Medicaid members, providers, and policymakers acknowledged that within LGBTQ+ communities there are differing experiences based on multiple aspects of identity, including sexual orientation and gender identity. For example, transphobia and discrimination in the health care setting based on gender identity impact transgender communities, resulting in higher rates of negative health care experiences compared to their cisgender peers.[94] While focusing on covering gender-affirming care is beneficial, efforts to improve health outcomes and quality of care for transgender, nonbinary, and gender-diverse Medicaid members can also include policies aimed at eliminating discrimination and increasing cultural competency.

For LGBTQ+ members with HIV/AIDS, providers and members shared that providers often focus on primarily HIV-related services, as opposed to considering their care as a whole. Siloed care is a systemic issue not unique to LGBTQ+ communities or people living with HIV/AIDS. Yet, this approach can lead to fragmented care, with members seeing multiple providers, each addressing one aspect of their care across various identities. For example, an individual might receive gender-affirming care in one health system, behavioral health and social support in another system, and HIV/AIDS care in a third system. As a community disproportionately impacted by trauma and social stressors, taking a whole-person approach to care, rather than isolating certain health conditions, may help providers better address the needs and concerns of their patients.[95] Policymakers can consider ways to better integrate care for LGBTQ+ members living with HIV/AIDS.

As Medicaid staff work to identify opportunities to improve LGBTQ+ health, SOGI data and robust community engagement are promising strategies for identifying the specific needs across diverse LGBTQ+ communities within their states.[96] Developing policies tailored to meet the unique needs of specific populations may result in improved access to care that is more effective and equitable.

## 3. Engage managed care plans to better meet the needs of LGBTQ+ members.

MCOs can play a significant part in improving LGBTQ+ health given their role in the delivery of care nationally.[97] Some MCOs, like Amida Care in New York, have programs specifically for the care needs of LGBTQ+ members. In states with challenging political environments, MCOs may be able to use their resources to meet the needs of LGBTQ+ members in a way that state agencies cannot. For example, some policymakers and providers shared stories of MCOs funding trainings for providers beyond what state agencies would directly fund.

A few of the MCO strategies mentioned earlier to better address the needs of the LGBTQ+ community, include mandated trainings for MCO staff and SOGI data collection. Following are additional ways that Medicaid agencies can use MCOs to improve care for LGBTQ+ populations:

- **Performance Improvement and Quality Improvement Projects**. States can direct MCOs to develop projects that focus on improving LGBTQ+ health outcomes through addressing health disparities, promoting preventive care, increasing access to gender-affirming care, and more. As part of the state's quality withhold program, Michigan instituted an LGBTQ+ Care Quality Improvement Project to better understand the LGBTQ+ health landscape.[98] The state requires plans to submit annual reports describing activities that address the needs of LGBTQ+ members, including details on SOGI data collection, anti-discrimination trainings, and access to clinical services, including HIV/STI care, gender-affirming care, and culturally competent cancer screenings.
- **Provider Network Requirements**. Robust provider networks include providers who are culturally competent in caring for LGBTQ+ communities. States can use MCO contracts to require managed care plans to contract with LGBTQ+ affirming and competent providers.

Some states, like New Mexico and California, require Medicaid MCOs to report if providers serve LGBTQ+ communities.[99,100] Colorado also requires MCOs to actively recruit LGBTQ+ culturally competent providers.[101] Beginning in December 2024, Maryland Medicaid will require managed care plans to report on their networks for gender-affirming care.[102]

- **Member Outreach and Education**. CBOs serving LGBTQ+ communities often have established trust among the communities they serve and can act as critical conduits for Medicaid to reach LGBTQ+ members. During the 2022 mpox outbreak, LGBTQ+-focused CBOs in Oregon were central in encouraging vaccination and testing. OHA developed communications toolkits for CBO partners to use.[103] States can use MCO contracts to require CBO partnerships and support health education and outreach to LGBTQ+ communities. Rhode Island, for example, requires MCOs to describe their approach to health education and literacy for LGBTQ+ members.[104]

MCOs may also present challenges for LGBTQ+ health equity. Providers and members interviewed shared stories of struggling to get prior authorization from MCOs for Medicaid-covered services and medications, including treatment for HIV/AIDS, hormone therapy, and gender-affirming surgery. At times, providers shared they reached out to Medicaid agency staff directly to appeal MCOs' coverage decisions. To minimize these experiences, some states have opted to carve out gender-affirming care from MCO oversight. In Washington State, for example, gender-affirming surgeries are covered directly through the state's Apple Health program instead of through the state's MCOs.[105]

## 4. Leverage quality improvement efforts to address the health and social needs of LGBTQ+ members.

As providers, policymakers, and members shared, the discrimination LGBTQ+ communities face in health care settings impacts all six domains of quality of care — safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[106] Improving the health outcomes and experiences of LGBTQ+ members is a quality-of-care issue.

As more entities begin collecting SOGI data, selecting quality metrics related to documented health needs of LGBTQ+ communities, like treatment and prevention of HIV/AIDS, screenings for certain cancers, and HRSN screenings, can allow states to identify key disparities through population-stratified data. Once identified, states can require MCOs and providers to develop and implement efforts to eliminate those disparities. Additionally, a highly visible focus on LGBTQ+ health equity is not politically feasible in many states. Focusing on improving quality of care overall may offer Medicaid agencies, MCOs, providers, and community partners a path forward for improving the health of those who are most impacted by Medicaid inequities, including LGBTQ+ communities.

# Looking Ahead

Medicaid can play a pivotal role in improving LGBTQ+ health. While federal agencies and some states have begun prioritizing LGBTQ+ health, the politicization of LGBTQ+ health exacerbates existing disparities and inequities. Despite these obstacles, there are promising practices and opportunities Medicaid agencies can use to improve health outcomes and quality of care.

Effective strategies hinge on collaboration with Medicaid members and providers, underscoring the importance of inclusive policy development. Through incorporating community voices into policy creation and recognizing the diversity of LGBTQ+ identities, Medicaid agencies can develop more equitable and effective policies. Medicaid can serve as a catalyst for advancing LGBTQ+ health equity.

## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

## ENDNOTES

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