INSTITUTE FOR
MEDICAID INNOVATION

Understanding Gender-Affirming Care:

A Resource for Medicaid Health Plans

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Introduction

Significant barriers to appropriate health care exist for transgender, gender-nonbinary, gender-diverse, gender-nonconforming, and intersex people or individuals born with intersex traits (TGI). These barriers to care reveal the stark reality of systemic discrimination and the urgent need for change.

TGI individuals are part of the lesbian, gay, bisexual, transgender, queer, intersex, asexual, Two-Spirit, and growing (LGBTQIA2S+) community, who individually have specific areas of care needs to improve overall health and quality of life. Within TGI communities, individuals consistently report meeting substantial bias and facing barriers when seeking medically necessary care. These barriers are associated with their gender, gender identity, intersex traits at birth, or diverse sex characteristics.[1,2]

Federal agencies do not collect demographic information that adequately captures the estimated 17.3 million adults who identify as LGBTQIA2S+.[3] These data gaps restrict our ability to address disparities in health care access and track outcomes among TGI enrollees in real time. Additionally, TGI populations are underrepresented by Medicaid managed care organizations (MCOs) in monitoring and assessing services affecting their health. Stigma, refusal of care, and verbal or physical abuse experienced by TGI individuals[4] further compound disparities, creating an imperative for MCOs and health plans to consider the unique health care needs of individuals of sexual and gender minority groups when working to reduce inequity in care.

Multiple national professional associations, including the American Medical Association,[5] American Academy of Family Physicians,[6] American Academy of Pediatrics,[7] American College of Obstetricians and Gynecologists,[8] American Academy of Nursing,[9] and American Psychiatric Association,[10] have recognized the benefits of receiving gender-affirming care (GAC). GAC promotes health, well-being, and safety of TGI individuals and is central to reducing adverse outcomes that affect an enrollee's ability to navigate health care, housing, legal documents, and state programs for TGI individuals. Restricting access to GAC leads to high rates of depression, anxiety, eating disorders, self-harm, and suicide. Moreover, access to care is a patchwork of regional and local resources, in which enrollees spend excessive time finding and navigating safe environments that validate their gender identity or body variances and provide knowledgeable information on care options and appropriate referrals. MCOs have substantial influence and responsibility in the crucial task of providing,

orchestrating, and optimizing the delivery of GAC. This care should follow best practices and be cost effective.

Health care systems often burden TGI Medicaid enrollees, minors, their parents or caregivers, adults, and seniors with the responsibility of educating their providers regarding their identities and health care needs. The stigma attached to being a TGI individual impacts health care enrollees and their families through the following:

Lack of safety

Not knowing how a provider treats TGI people can provoke anxiety. When a provider is unprepared to care for the patient appropriately, it creates ongoing trauma.

Lack of trust

Health care services from Medicaid carriers or government-related care are often triggering for enrollees. Enrollees may have experienced a past denial of benefits and services or biased or discriminatory care, or they may live in a state that criminalizes the care they need.

Negative effects on mental health

The need to continuously prove one's TGI identity to receive access to GAC, the feeling of being othered by the system, or the understanding that the health care system is not ready to treat those outside the gender binary causes stress and trauma.

Poor physical health outcomes

Even though enrollees spend much of their visit time educating providers, TGI individuals may not receive all recommended preventive care and referral options.

Inadequate access

Twenty-six states limit youth access to GAC, and 24 states impose professional or legal penalties on health care practitioners providing GAC to minors. Even where access is not limited by statute, it may be limited by a paucity of providers of GAC.

Considering the need for culturally competent care and the known gaps in the Medicaid system, MCOs trying to close these gaps should consider the perspective of those seeking care. This perspective will provide a foundation to create organizational and programmatic goals to improve gender-affirming services and care support for these communities. This paper reviews opportunities for MCOs to reduce barriers to care for their TGI enrollees and improve GAC programming and delivery.

Definitions are in Appendix A to help navigate the terms covered in this issue brief.

What Is Gender-Affirming Care?

The primary goal of GAC is to support and validate an individual's gender identity and body, acknowledging the significance of how they choose to align their physical and social aspects with their true gender. This starts with helping TGI patients to better understand their gender and body as well as offering interventions that align their physical characteristics and social identities with their gender identity. Care encompasses a comprehensive range of medical, surgical, pharmacologic, and mental health care; case management; and navigation services to support TGI patients.

The primary goal of GAC is to support and validate an individual's gender identity and body, acknowledging the significance of how they choose to align their physical and social aspects with their true gender.

GAC addresses a diverse array of individual care needs. This can include care for babies born with intersex traits, adolescents requiring mental health support to navigate the challenges of gender identity and societal expectations, and adults seeking hormone therapy, surgical interventions, or other therapeutic measures to align their physical attributes with their gender identity.

GAC can empower TGI individuals to live authentically and comfortably in their affirmed gender. It recognizes the importance of ending barriers and stigmas associated with gender diversity, ultimately promoting these individuals' physical and mental well-being.

Disparities Faced by TGI Individuals

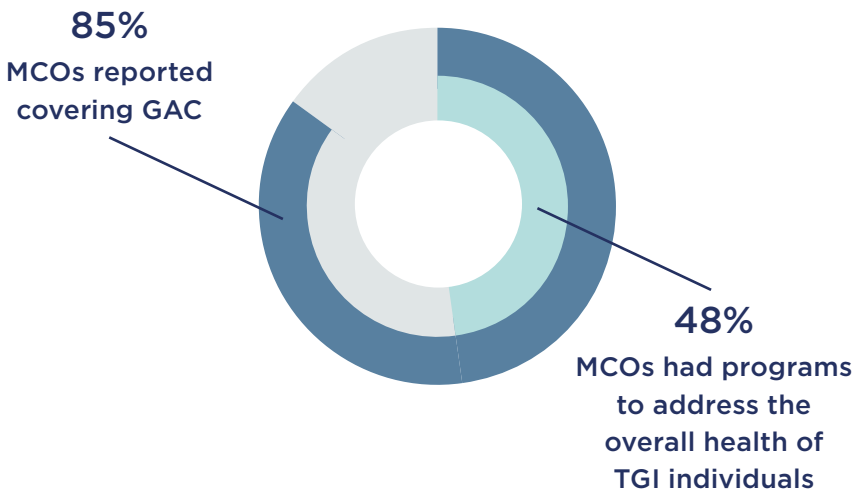
TGI individuals face systemic discrimination magnified by intersecting marginalized identities.[11] These disparities impact individual health care interactions, translating into health issues and added costs for the system. Discrimination, bias, and disrespect by providers affect TGI people in multiple negative ways, impacting all aspects of their lives and placing them at risk of believing their benefits and services are not there to help improve their health and well-being. Studies show the following:

50%	Fifty percent of intersex and 37% of transgender individuals report **postponing or avoiding needed medical care**, and more than 40% of TGI people **delay or neglect to have preventive screenings**.[12]
↑	TGI individuals have an **increased risk of chronic illnesses** like cardiovascular and pulmonary diseases.
↑	TGI individuals are at **increased risk of mental health comorbidities** like anxiety and depression, which can compound adverse health outcomes.[13,14,15]
26%	Twenty-six percent of TGI individuals report that they **had to teach their providers** about TGI people and GAC to receive care.[16]
13%	Thirteen percent said that a provider **used harsh or abusive words**, and 14% reported a provider **being rough or abusive** when treating the patient.
28%	Twenty-eight percent of TGI people reported that health insurance companies **denied them coverage for hormone therapy**, and 22% reported that health insurance **denied them coverage for gender-affirming surgery**.
15%	Fifteen percent reported that health insurance **denied them gender-specific preventive care**.
10%	Ten percent were **denied preventive care or screenings** in the prior year (omissions that could negatively impact both the individual's health and an MCO's quality data rating).[17]

For people with intersex traits, studies show the following:

59%	Fifty-nine percent reported that providers **used harsh or abusive language**.
>48%	More than 48% said that providers **were rough or abusive** when treating them.
66%	Sixty-six percent **had to teach their providers** about intersex people or specific intersex variations to receive appropriate care.[18]

In the Institute for Medicaid Innovation's 2022 MCO survey, 85% of MCOs reported covering GAC, but only 48% had programs to address the overall health of TGI individuals.[19] This gap in programming highlights an opportunity for MCOs to incorporate distinct efforts to improve access and health outcomes for TGI enrollees. Understanding existing barriers to appropriate care can help MCOs to understand and fully support patients seeking GAC. Thus informed, MCOs can accurately assess their enrollees' needs and effectively improve access, leading to improved outcomes.



Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

Finally, accounting for inequity in any population requires an understanding of the social determinants of health (SDOH) and associated data impacting health, functioning, and quality-of-life outcomes and risks, as well as a deeper look at economic stability, education, access to and quality of health care, and the environment surrounding the enrollee.[20] Studies have shown the following disparities for TGI people:

- TGI adults report having less education, lower incomes, higher unemployment, and less health insurance access, all of which lead to poorer health.[21]
- Black TGI individuals have an unemployment rate of 26%, two times the rate of the overall TGI population and four times the general population's rate.
- Black TGI people experience extreme poverty, with 34% having a household income of less than $10,000 per year, compared to 15% for transgender people of all races, 9% for the general Black population, and 4% for the general U.S. population.[22]

Obtaining GAC

MCOs are encouraged to integrate GAC into benefits and services. It is highly recommended that MCOs and providers use the World Professional Association for Transgender Health (WPATH) Standards of Care, version eight, to understand the delivery of benefits of GAC and make decisions on medical necessity. Providers delivering care should be well versed in the standards, data, and cultural competency of meeting the needs of TGI people.

In the case of patients under the age of 18, health care providers must know the laws of the state in which they practice and the best strategies to discuss comprehensive care with parents or caregivers.[23] These discussions should cover the child's specific needs throughout their physical, psychosocial, and developmental milestones and support their health needs.[24] When a child starts to grasp their gender identity and feel discordance between their sex assigned at birth and their true gender, health care providers should counsel the child and their parents or caregivers, emphasizing the importance of affirming the child's evolving gender identity while providing insight into appropriate interventions when and if applicable.[25] Providing guidance to parents and caregivers can positively affect enrollee health outcomes.[26]

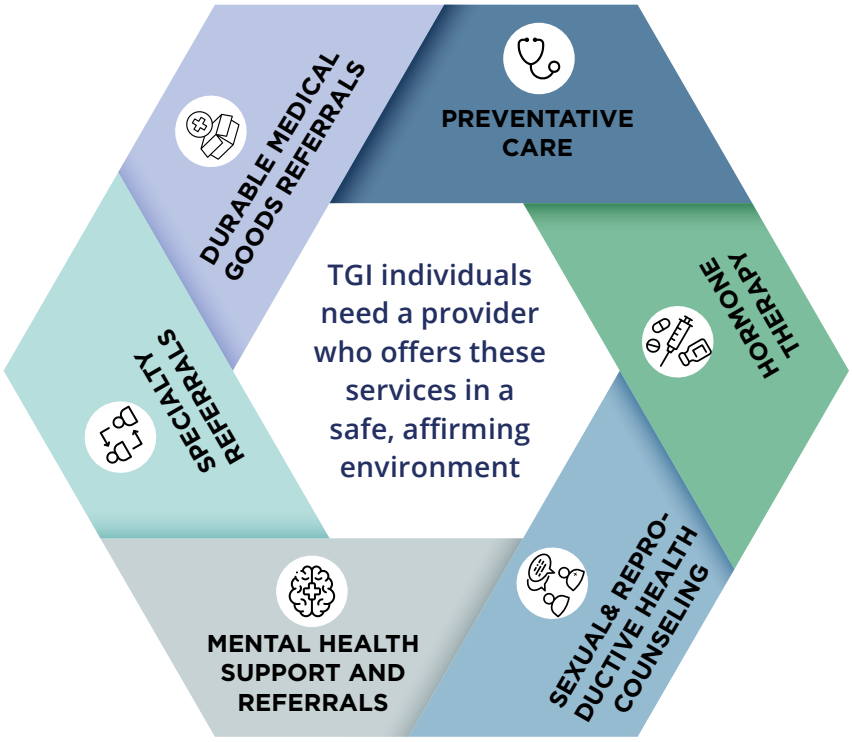
Providers should evaluate potential interventions in the context of the child's ability to participate in decisions about their body, balancing the urgency of alleviating expressed gender dysphoria against potential risks associated with irreversible clinical interventions. Opting to delay significant decisions until the individual can actively participate in discussions about their body is vital to facilitate informed consent and minimize the potential for irreversible physical and psychological harm.

Adults and seniors seek GAC at any age, and all TGI enrollees will need similar pathways for medical care and support from providers and their MCOs to navigate GAC with minimal barriers.

Below is a generic pathway that members may seek that involves many but not all of the services provided within GAC. It highlights the many steps one must follow when seeking GAC and where barriers exist in the delivery of care.

Primary Care

Finding a provider versed in the unique and diverse health needs of TGI individuals in a safe, affirming environment is often difficult. TGI individuals need a provider who offers the following:



Preventive care (routine screenings, vaccination) and all other acute and chronic condition care

Hormone therapy:

- If the primary care provider does not offer this, a referral will be needed.
- Some MCOs require prior authorization, and some do not cover it.[27]

Sexual and reproductive health counseling

Mental health support and referrals

Specialty referrals

Durable medical goods referrals like binders or inserts

Subspecialty Care

TGI individuals oftentimes consider the barriers that they may encounter when choosing a pathway to access subspeciality gender-affirming care. Individuals may encounter the following issues when seeking specialists:

Finding a surgical provider versed in the unique and diverse health needs of TGI individuals in a safe, affirming environment often requires long travel, as specialty providers who give knowledgeable GAC therapies, treatments, and procedures are limited and most often found in urban areas or at a long distance for many enrollees.

Fulfilling prior authorization or referral requirements to meet the criteria for accessing services can be burdensome for the individual and the provider.

- MCOs should reduce burdensome criteria on the enrollee, such as
    a. additional mental health assessments and letters,
    b. control of another unrelated diagnosis before being eligible for surgery, and
    c. requiring hormone replacement therapy before surgery without evidence of need.
- MCOs should collaborate with vendors, if applicable, to assess for discriminatory barriers to reduce discrimination in variability in what is deemed medically necessary.

Navigating a referral process for primary care provider specialty and accompanying care can be challenging:

- Services covered by MCOs vary, with MCOs having inconsistent coverage of surgery.[28]
    a. Some states cover most surgeries, including orchiectomy, penectomy, labiaplasty, clitoroplasty, vulvoplasty, vaginoplasty, breast augmentation, hysterectomy, salpingo-oophorectomy, vaginectomy, colpectomy, metoidioplasty, phalloplasty, urethroplasty, urethromeatoplasty, penile prosthesis, mastectomy, breast reduction, and chest reconstruction.
    b. Some states cover additional therapies, including electrolysis or laser hair removal, glansplasty, facial feminization or masculinization procedures, tracheal shave, voice modification (surgery or therapy), hairline advancement, or hair restoration.
- Specialists place variable criteria based on practice preferences, including
    a. typical evaluation criteria: age, smoking status, capacity for surgery, and aftercare needs; and
    b. variable evaluation criteria: body mass index minimums, hormone therapy administration timelines, and additional mental health assessments.

Scheduling multiple presurgical appointments, completing preoperative medical requirements like graft-site preparation, and traveling to see a specialist all add additional time and costs, which are often not covered.

Navigating surgery can include various issues:

- Scheduling with the surgical care team can take months to more than a year.
- Many surgeries require multiple nights in the hospital for postoperative care.
- Some surgeries are completed as an outpatient but require follow-up visits with the surgeon days to weeks after surgery. Patients can face questions or complications without access to their surgical team if it is a weekend or nonbusiness hours. Follow-ups may be frequent and ongoing for many weeks to months.
    a. Emergency department visits for acute needs after surgeries are often not with knowledgeable providers, and the hospital may tell the enrollee to call their surgeon instead of treating the acute condition.
    b. Not all providers receive training in expected clinical outcomes for GAC versus complications or other conditions.

Navigating aftercare can include various issues:

- Many operations require weeks to months of recovery; patients often need postoperative care and time off from work.
- Aftercare supplies may include any of the following: wound care, drains, urinary catheters, dilation tools, pain control, and scar care.
- Some operations require revisions to ensure the best clinical and patient outcomes.

Much of the confusion around accessing gender-affirming surgeries is the variability in how MCOs and providers translate the WPATH Standards of Care and update policies based on their determination of medical necessity. MCOs are encouraged to use WPATH Standards of Care to understand how they administer benefits and internal operations and where decision points for access become bottlenecks for enrollees seeking appropriate and timely care. Clarity on these issues is crucial to prioritizing necessary changes to improve care areas voiced by TGI enrollees and communities. MCOs developing clear and transparent pathways to care for providers and enrollees can reduce redundancy in care and harmful interactions between the TGI person, their providers, and the MCO.

MCO Strategies and Opportunities

MCOs can assess the current care delivery to their TGI enrollees and prioritize needed improvements and collaboration across internal departments and expertise areas to optimize care delivery. Recognizing and addressing bottlenecks demands a comprehensive approach to optimize operational solutions. Departments or teams such as population health management, quality assurance and improvement, provider contracting, data analysis, compliance, communications, and clinical case management programs, along with a committee of TGI enrollees and identified providers well versed in GAC, can contribute to a sustainable strategy that aligns with the agency's goals and enrollee needs.

Sexual Orientation, Gender Identity, and Sexual Characteristics Data Collection

The need for uniform data must be weighed against the genuine concern of TGI communities who face mounting discrimination and surveillance threats. Though the evidence is clear that GAC improves health outcomes for TGI people[29] and that the medical model has changed from harmful conversion methods to affirmative models,[30,31] a political movement has restricted access to medically necessary care in some states. As of August 2024, 26 U.S. states have banned access to best practices in GAC.[32] According to the Human Rights Campaign, 39.4%, or 118,300, of trans youth age 13–17 are living in these states. Additionally, there have been examples of state attorneys general requesting and receiving Health Insurance Portability and Accountability Act–protected information on TGI individuals in states looking to ban GAC,[33,34] leaving individuals and their families scared and seeking access to care elsewhere or moving and leaving physicians confused about what care they can legally provide.[35]

Collecting sexual orientation, gender identity, and sexual characteristics (SOGISC) data is a priority initiative recognized by more than 20 federal departments and agencies to facilitate data-informed, evidence-based decisions to improve the health and well-being of LGBTQIA2S+ individuals.[36] Notably, 24% of TGI individuals report that their health insurance company does not update their records to reflect their current name or gender,[37] impacting all interactions and communications with the agency. Additionally, many MCOs have differing and inconsistent gender options and data flow for this demographic data, affecting programmatic data flow as well as financial and operational needs.

SOGISC data include questions designed to measure and quantify an individual's sexual and gender minority status. These data help to accurately measure LGBTQIA2S+ populations on enrollment for Medicaid or on receiving medical care and other contracted services. Collecting SOGISC data aligns with the quintuple aim: to enhance the patient experience, improve health outcomes, lower costs, alleviate provider burnout, and reduce health disparities.[38]

MCOs that capture SOGISC data on enrollment and for internal systems, including provider assignment, customer service, case management, or other electronic health record–type usage files, must outline which is considered the most up-to-date record internally for the enrollee and which data MCO staff should use in care, outreach and programs, and data-aggregated data sets.

Although SOGISC data collection is essential for the MCO to deliver optimal care and to monitor and address quality, population health, SDOH, and care management, MCOs must balance it with the duty to protect privacy and ensure confidentiality when collecting SOGISC data. MCO policies should clearly define when an individual's deidentified data can be used, such as for auditing, quality improvement, external research, or legal responses to decisions regarding care. MCO staff should collaborate with TGI community enrollees, representative community-based organizations (CBOs), and care providers to create and review privacy and data-use policies. Transparency in data collection and privacy policies helps individuals feel secure in sharing this sensitive information, fostering trust in health care providers and systems.

Below are data streams in which TGI data can be collected and used and how each source intersects with MCO programs. Additionally, Appendix B includes best practices and resources for SOGISC data collection with recommendations based on specific populations.

Enrollment Data

MCOs can capture SOGISC data on enrollment and incorporate these data into demographic data tables and shared enrollment files. It is inaccurate to rely on enrollee state or legal identification for data collection, as the gender field may allow for only male or female options. Striking a balance between offering a wide range of identity options to enhance the enrollee experience, promote cultural competency, and meet inclusion standards while considering the limitations of data aggregation and the stratifications and transfers necessary for monitoring and reporting is crucial. Moreover, MCOs' questions must be formulated to be understandable to all respondents to extract the correct data points.[39]

The National Academies of Sciences, Engineering, and Medicine currently recommends the following questions for assessing sex assigned at birth and gender identity, allowing for free text so the MCO can capture data for different terms used for identities, provide more representative data, and signal cultural competence to TGI enrollees:

Question 1:
What sex were you assigned at birth on your original birth certificate?

- ○ Female
- ○ Male
- ○ Don't Know
- ○ Prefer Not to Answer

Question 2:
What is your current gender?
[Mark only one]

- ○ Female
- ○ Male
- ○ Transgender
- ○ Two-Spirit (if the respondent is American Indian or Alaska Native)
- ○ I use a different term: [free text]
- ○ Don't know
- ○ Prefer not to answer

The National Academies of Sciences, Engineering, and Medicine also recommends the following question with a yes, no, or I don't know answer field:

- Have you ever been diagnosed by a medical doctor or another health professional with an intersex condition or a difference of sex development, or were you born with (or developed naturally in puberty) genitals, reproductive organs, or chromosomal patterns that do not fit standard definitions of male or female?

Wording that may better suit Medicaid enrollees by meeting reading level and language needs for health literacy could be the following:

- Some people are labeled "boy" or "girl" at birth but are born with differences in sex anatomy, reproductive organs, chromosomes, and hormone function that do not fit the label they were given. Sometimes these differences show up at puberty. These differences are known as "variations in sex characteristics," "differences in sex development," or "intersex traits" or sometimes are known by specific medical terms (e.g., "congenital adrenal hyperplasia" or "androgen insensitivity syndrome"). Were you born with any of these physical differences?[40]

State and County Social Service Program Files

Federal programs administered by state and county departments offer various service files for care delivered through public health programs.[41] However, there is often minimal uptake and significant variability in how SOGISC data are collected by these programs. MCOs can play a crucial role by collaborating to set up uniform data standards for collection, data transfer, and usage to help fill data gaps and enrollees and improve GAC.

MCOs use data following Fair Information Practice Principles and agreement for any Health Insurance Portability and Accountability Act–protected information.[42] These principles encompass individual consent, data minimization, use limitation, and transparency regarding shared information. Collaborating with state and county programs and with data agreements can provide insights into where SOGISC data are collected and how programs use it to facilitate communication, gain new insights into network capacity and quality, and identify areas in which the MCOs need to improve service and benefit delivery.

Claims and Encounter Data

Claims and encounter data methods relying on International Classification of Diseases, Current Procedural Terminology, Healthcare Common Procedure Coding System, and Diagnostic and Statistical Manual of Mental Disorders codes may make assumptions about a person's gender identity, thus not capturing the entire population as a demographic engaging or not engaging in health care but instead as a collection of diagnoses. The landscape of gender-related health care coding has evolved significantly with each update to coding manuals (e.g., the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, replacing "gender identity disorder" with "gender dysphoria" and International Classification of Diseases, 11th revision, introducing a new diagnosis of "gender incongruence" with codes HA60, HA61, and HA6Z).[43] Recognizing the importance of addressing clinical distress rather than pathologizing gender identity underscores the need for sensitivity and precision in health care coding. Many codes still used for gender-related diagnoses may employ stigmatizing language, which can adversely affect TGI enrollees.

MCOs should use claims and encounter data following the same processes as other clinical and demographic data sets. Stratifying data by demographic data fields, such as SOGISC data, while exchanging Health Insurance Portability and Accountability Act–protected electronic health record information can supply correct insights and enhance the quality of care offered to TGI populations. When identifying TGI populations through diagnostic codes and demographic data sets from provider electronic health record domains, we recommend using only data as intended and outlined by accrediting agencies to create insights into utilization patterns and management, disease management, population health, and multicultural health care distinctions.

SDOH Data

MCOs already incorporate SDOH data into their information streams. SDOH data offer MCOs valuable insights into the complex web of factors that shape an enrollee's life, encompassing their social, economic, educational, physical infrastructure, and health care context.[44] Beyond the traditional assessment of disease prevalence and incidence across a population, understanding SDOH data situates an enrollee and their information within their lived experience. MCOs can use this holistic perspective to find vulnerable populations and craft targeted interventions that address the core areas for improving health outcomes.

Incorporating LGBTQIA2S+ Voice, Culture, and Community

Population Health Management

MCOs can integrate various population health management strategies and programs for health promotion, disease prevention, health literacy, disease management, and provider enhancements. To enhance care for TGI enrollees, MCOs should take a systematic approach, examining their current operations compared to an ideal state, given the MCO programming availabilities outlined below, and then develop strategic pathways and collaborative efforts necessary to prioritize progress.

Health Equity

Health equity aims to address and reduce disparities in health and health care outcomes, particularly for those historically facing systemic discrimination and marginalization. By creating an infrastructure to address enrollee access, cultural competency, and relevant SDOH areas, an MCO can effectively make the programs and linkages necessary to close disparities in the data and enrollee health outcomes.

Performing a community needs assessment and gap analysis of all underserved populations can guide and prioritize improvement efforts. Creating a health-equity role or team can centralize all actions into one place. Placing this role high on an organizational chart to ensure the correct scope over enrollee-facing programs to account for how historical decision-making points have led to health inequity is essential. A health equity strategy should involve all MCO programmatic teams or departments as well as an enrollee advisory group with lived experience.

A diversity, equity, and inclusion tool to develop and then evaluate programs or projects can be another way to reduce bias within the operations of programs and create concrete steps to minimize gaps found. Although many existing tools focus on improving outcomes based on race and ethnicity, MCOs can easily tailor these tools to include added underserved communities such as TGI and LGBTQIA2S+. Examples of diversity, equity, and inclusion tools are provided in Appendix B.

Last, MCOs should ensure that GAC and TGI cultural competency training is provided to staff and providers to increase knowledge of and reduce bias in the programs or projects they are working within.

Quality Improvement

The MCO's quality improvement team can collaborate with all stakeholders to look at currently available data for TGI enrollees and assess TGI enrollee needs and gaps in care to prioritize, create, and implement interventions to measure improvement rates or evaluate outcomes of the MCO for effectiveness reports. Quality improvement team members and data analysts can also help the MCO collaborate with other teams requiring enrollee, provider, and community engagement. These teams are well suited to be briefed on TGI care and SOGISC data collection and to help merge the qualitative and quantitative data, creating a comprehensive plan for internal and external program coordination and improvement.

Provider Engagement

An MCO can use provider engagement strategies to understand and improve care by those directly providing the services. Provider engagement teams can work within provider networks to teach about cultural competency and SOGISC data collection and benefit contracting gaps that could improve health outcomes for TGI enrollees. Through provider newsletters, provider meetings, and training sessions for providers and their staff, the MCO can share best practices in delivering care to TGI enrollees.

Provider training should cover best practices such as the following:

- overview of TGI identities, barriers to care, cultural competency, social and medical transition, health care, and support
- covered benefits and services to TGI enrollees and how to submit prior authorizations (if needed) and referrals for patients appropriately, including navigation or case management services for a provider or MCO staff to help enrollees with the process
- state laws regarding provision of care to TGI children and adults
- WPATH Standards of Care endorsed by the United States Professional Association for Transgender Health and the harms of providing care without appropriate training or understanding of the standards of care
- SOGISC data capture, including pronouns used and preferred name for enrollees whose legal identification does not match the name or gender currently being used by the enrollee
- documentation of an organ inventory (i.e., penis, testes, prostate, breasts, vagina, cervix, uterus, ovaries) if the electronic health record does not allow for such a data collection
- prescribing gender edits and medications that have gender edits removed for enrollee access
- other standards such as language access, health education, and cultural competency measures that improve health equity

MCOs with value-based payment provider programs can consider adding measures to improve TGI care to their monitored quality rates where payment occurs for improvement. This might be data collection, wait-time reduction, or other areas that the MCO has prioritized for improving GAC or creating equity in care; value-based payment staff can work with the MCO's provider networks to develop meaningful measures to be monitored and evaluated for outcomes in populations of focus.

MCOs can collaborate with CBOs working with CBO-enrollee navigators, case managers, and community health workers to strengthen the MCO's identification of trusted providers, working to improve individual health and population health outcomes and health equity. CBO representatives can serve as subject matter experts in community relationship building and delivering culturally competent care for the MCO's population of focus and the CBO's community. Outreach and collaboration with a CBO may be enhanced through grant funding.

Enrollee Engagement

MCOs' enrollee engagement programs can improve care through specific outreach and communications initiatives to populations whose data and programs show disparities in care or who may be at considerable risk of adverse outcomes.

Most MCOs have an enrollee or consumer advisory committee to discuss quality and improvement efforts and assess for gaps that their benefits or services have in care delivery. MCO staff receive feedback from enrollees for quality and improvement initiatives, program development use cases, website and benefits, and health education materials development for enrollee outreach efforts. Representation from multiple voices and communities that experience disparities in care helps an MCO to ensure inclusive policies, identify gaps in care, and set up ongoing trusted relationships to incorporate practical, flexible, and needed changes as Medicaid program changes occur.

Consider the following topics for inclusion in discussion guides for TGI focus groups:

- member-perceived education and training needs for MCOs and providers
- providers and networks that MCOs may want to contract with for improved access to GAC services
- denials for medically necessary care and coverage like preventive screenings, labs, formulary, or pharmacy benefit manager edits based on gender fields, traditionally pulled from legal identification documents. Such denials require overrides or appeals to seek approval. (Note that documentation for legal identification updates can be cost prohibitive due to fees and required travel to process an application to change gender fields.)
- positive and negative customer service experiences when receiving services from the MCO's staff
- transparent, culturally competent, and user-friendly ways to navigate GAC services, including collecting user stories and care mapping to inform MCO communications

Care Management and Coordination Programs

For TGI individuals, navigating the requirements for obtaining medically necessary GAC services requires multiple provider types and visits with various levels of coverage. In many organizations, it is left solely to the patient to understand who within their health plan coverage may be a safe choice for the culturally competent GAC they seek. Although MCOs currently train their care managers and care coordinators to supply culturally competent case management, navigation, clinical and behavioral or mental health connections, and care solutions, training staff on the specifics of GAC can improve TGI enrollee interactions with the MCO. This will allow the MCO to understand and address barriers and trends through health equity, quality, provider, and enrollee engagement efforts.

CBOs such as community health centers, federally qualified health centers, county services, or LGBTQIA2S+ resource centers have often provided trusted, comprehensive health services to communities whose health care delivery has been inequitable. Plans can partner with or contract with local organizations to identify and use effective interventions and navigation strategies already in place. The partners providing medical services, behavioral or mental health, case management, and housing services can have navigation built into their operations to adapt to the silos in services. Recognizing the expertise and experiences that GAC providers can bring to collaborations and processes is an asset to MCOs working to close disparities in care.

Administration and Oversight of Benefits

Although it is known that GAC improves the lives and health of TGI individuals, only 60% of states' and territories' Medicaid programs currently cover GAC in benefits packages.[45] This patchwork of coverage creates geographic barriers to care and highlights the need for uniform coverage for TGI enrollees seeking GAC. Cost should not be prohibitive in supplying GAC. Recent studies in a commercial-plan population showed that medical affirmation–related services cost an estimated six cents per member per month,[46] a small price with a high payoff. When an MCO creates the systems to administer these benefits, enrollee engagement and health should improve. Without these systems, enrollees may not be connected to care, placing them at considerable risk for poorer outcomes and ultimately making them a higher cost to the MCO.

MCOs can work internally and with their vendors to ensure they use up-to-date GAC benefits and service criteria. Using the WPATH Standards of Care and applying needed services through the lens of

TGI enrollees, they can be sure they are not discriminatory in their benefits administration and that all necessary services have a knowledgeable network of providers to meet enrollees' health care needs.

As GAC evolves, new surgical techniques and medications may be offered to patients in response to their unique needs. MCOs will benefit from a process to understand what new services TGI enrollees need and to explicitly ensure policies do not exclude medically necessary care. Further, plans must be aware of adjunct therapies before gender-affirming surgery, such as mental health visit requirements by surgeons and hair removal for specific procedures. For example, a 2019 survey revealed that 95% did not have coverage for hair removal,[47] placing the cost burden on enrollees already faced with multiple access barriers.

An MCO chooses which services require prior authorization. Contracting with providers with expertise in GAC could reduce the need to subject selected GAC services to utilization review, removing services with high first-pass approval rates from prior authorization requirements. In contrast, high denial and appeal rates may prompt the health plan to reevaluate its utilization management criteria to decide whether it meets current professionally accepted standards of care. To view a list of common surgical procedures included in GAC, please see Appendix C.

The MCO can develop a known network of GAC-preferred providers and then map GAC access pathways to be shared with enrollees, staff, and providers. The MCOs can use the policies and procedures outlining GAC in health education, health literacy, and cultural competency requirements to strengthen outreach, preventive care measures, and other monitored rates in quality assurance, quality improvement, enrollee engagement, and health equity for this population.

Marketplace Contracting

Network adequacy for providers knowledgeable in the delivery of GAC is important for MCOs when looking to provide TGI populations with appropriate access to care. In 2020, 23% of transgender people reported that their health insurance company covered only some kinds of GAC, and 26% said that their health insurance company covered GAC surgery but had no surgical providers in their network.[48]

Many formalized medical, surgical, and mental health care training programs in GAC exist in the United States; however, the pace of adding culturally informed services has not kept up with the need to meet standards of care for access. An MCO's annual network adequacy and enrollee satisfaction surveys can assist in contracting GAC providers where the MCO sees gaps or areas of concern. MCOs can survey

current network providers specifically for their willingness and ability to provide GAC, along with a comprehensive list of their services, their training history, continuing medical education, continuing education units, and other education received in GAC. These surveys give the MCO insights into their benefit delivery for GAC services and areas needing added access, training, or other action. Provider collaboration to build capacity and access can also assist in expanding the network of competent providers. MCOs can create a provider-of-choice list or directory for enrollees seeking GAC services.

Finally, efforts to invest in contracting and offer telehealth strategies can expand access to GAC. Earlier programs have shown the benefit of telehealth in delivering specialty care to patients in underresourced communities.[49]

Overview of Opportunities for Managed Care Plans

Managed care plans have a critical role in improving the health of TGI individuals. Throughout this issue brief, we have named crucial areas for improvement in helping TGI people obtain care. MCOs have many opportunities to improve their enrollees' health by prioritizing changes and strategizing their current-to-ideal state. MCOs can use the companion document "Gender-Affirming Care: Tools for Medicaid Health Plans" to create and implement specific changes to strengthen GAC.

Appendix A.

Glossary

Term	Definition
Agender	A person not identifying with any gender.
Bigender	A person identifying as two genders, commonly (but not exclusively) male and female. Sometimes, people can feel like two genders simultaneously, and sometimes they fluctuate.
Cisgender	A person identifying as a gender congruent with their sex assigned at birth. The word "cisgender" can also be shortened to "cis."
Gender (Identity)	The internal feeling of one's gender and how one labels oneself, based on their alignment with what one understands gender to be—understanding is often conflated with one's sense of biological sex or sex assigned at birth.
Gender Binary	The classification of sex and gender into distinct and opposite forms of masculine and feminine.
Gender Expression	The external display of one's gender through clothing, grooming, demeanor, social behavior, and other factors; it can also be referred to as "gender presentation."
Gender Fluid	An identity and general term used for moving between genders or fluctuating gender identity.
Intersex	An identity and a general term used for various traits or conditions in which a person is born with a combination of chromosomes, gonads, hormones, internal sex organs, or genitals that differs from the two patterns of male or female.
Nonbinary	An umbrella term or specific identity for people when the gender binary does not accurately reflect their gender.
Polygender	A gender identity encompassing two or more distinct genders simultaneously, or the individual experiences shifts in their gender identity over time.

Sex Assigned at Birth	The designated gender a provider assigns a child based on the external genitalia, and the assigned gender on the birth certificate can be within the gender binary options of male and female or have a third gender choice. State access to changed sex on birth certificates varies.
Sexual Orientation	The sexual, romantic, or emotional or spiritual attraction one can feel for others. Sexual orientation is usually labeled based on the gender identity of the individual and of the people they are attracted to.
Stealth	A term that refers to an individual who has medically and socially transitioned but who does not identify as transgender but rather as their posttransition gender only, often due to unsafe or stigmatizing environments.
Transgender	An umbrella term or specific gender identity for people whose gender, expression, or behavior differs from that associated with their assigned sex at birth. The word "transgender" can also be shortened to "trans."
Transman	An identity label sometimes adopted by female-to-male transgender people to signify they are men while affirming their history as assigned female sex at birth.
Transwoman	An identity label sometimes adopted by male-to-female transgender people to signify they are women while affirming their history as assigned male sex at birth.
Two-Spirit	A term used by some Indigenous cultures in North America to describe a person who embodies both masculine and feminine qualities or has a unique gender identity that goes beyond the binary concept of male and female.

Appendix B.

Resources for Sexual Orientation, Gender Identity, and Sexual Characteristics Data Collection and Care Delivery Best Practice

Data Collection

- **Measuring Sex, Gender Identity, and Sexual Orientation** (National Academies of Sciences, Engineering, and Medicine)
- **LGBTQ+ Data Availability: What We Can Learn from Four Major Surveys** (Center on Children and Families at Brookings)
- **Intersex Data Collection: Your Guide to Question Design** (InterACT)

Standards of Care and Policies

- **Standards of Care for the Health of Transgender and Gender Diverse People, Version 8** (*International Journal of Transgender Health*)
- **Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies** (InterACT and Lambda Legal)
- **Affirming Primary Care for Intersex People 2020** (Fenway Institute)
- **Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies** (Lambda Legal, Human Rights Campaign, Hogan Lovells, and New York City Bar)

Diversity, Equity, and Inclusion Tools

- **DEI Toolkit** (University of Michigan School of Social Work)

Additional Resources

- **Understanding the Well-Being of LGBTQI+ Populations** (National Academies of Sciences, Engineering, and Medicine)
- **Inaugural State of LGBTQ Health National Survey 2022** (National Coalition for LGBTQ Health)
- **Prohibiting Gender-Affirming Medical Care for Youth** (UCLA School of Law Williams Institute)
- **Mapping Transgender Equality in the United States** (Movement Advancement Project)
- **2022 National Survey on LGBTQ Youth Mental Health** (The Trevor Project)
- **Trans 101** (Advocates for Trans Equality)

Appendix C.

Common Surgical Procedures Included in Gender-Affirming Care

breast augmentation
clitoroplasty
colpectomy
electrolysis or laser hair removal
facial feminization or masculinization procedures
glansplasty
hairline advancement
hair restoration
hysterectomy and/or salpingo-oophorectomy
labiaplasty
mastectomy, breast reduction, or chest reconstruction
metoidioplasty
orchiectomy
penectomy
penile prosthesis
phalloplasty
tracheal shave
urethromeatoplasty
urethroplasty
vaginectomy
vaginoplasty
voice modification (surgery or therapy)
vulvoplasty

References

1 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**

2 Human Rights Watch & InterACT. (2017). *"I want to be like nature made me": Medically unnecessary surgeries on intersex children in the US*. **https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us**

3 Deng, B., & Watson, T. (2023). *LGBTQ+ data availability: What we can learn from four major surveys*. **https://www.brookings.edu/wp-content/uploads/2023/04/20230417_CCF_DengWatson_MAF-1.pdf**

4 Ayhan, C. H. B., Bilgin, H., Uluman, O. T., Sukut, O., Yilmaz, S., & Buzlu, S. (2019). A systematic review of the discrimination against sexual and gender minority in health care settings. *International Journal of Social Determinants of Health and Health Services, 50*(1), 44–61. **https://doi.org/10.1177/0020731419885093**

5 McBride, N. (2021). *Private law book reviews: 2015–2020*. SSRN. **https://doi.org/10.2139/ssrn.3761396**

6 Middleton, J. (2022, June 13). Supporting transgender and gender questioning teens. *American Family Physician*. **https://www.aafp.org/pubs/afp/afp-community-blog/entry/supporting-transgender-and-gender-questioning-teens.html**

7 Wyckoff, A. S. (2023). *AAP reaffirms gender-affirming care policy, authorizes systematic review of evidence to guide update*. American Academy of Pediatrics. **https://publications.aap.org/aapnews/news/25340/AAP-reaffirms-gender-affirming-care-policy?autologincheck=redirected**

8 Committee on Gynecologic Practice and Committee on Health Care for Underserved Women. (2017). *ACOG committee opinion number 823: Health care for transgender and gender diverse individuals*. **https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals.pdf**

9 Sedlak, C. A., & Boyd, C. J. (2016). Health care services for transgender individuals: Position statement. *Nursing Outlook, 64*(5), 510–512. **https://www.nursingoutlook.org/article/S0029-6554(16)30120-8/fulltext**

10 Drescher, J., & Haller, E. (2018). *APA official actions: Position statement on access to care for transgender and gender diverse individuals*. American Psychiatric Association. **https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf**

11 Erickson-Schroth, L. (2014). *Trans bodies, trans selves: A resource by and for transgender communities*. Oxford University Press.

12 Medina, C., & Mahowald, L. (2023). *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022*. Center for American Progress. **https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/**

13 Herman, J. L., Brown, T. N. T., & Haas, A. P. (2019). *Suicide thoughts and attempts among transgender adults: Findings from the 2015 U.S. Transgender Survey*. UCLA School of Law Williams Institute. **https://williamsinstitute.law.ucla.edu/wp-content/uploads/Suicidality-Transgender-Sep-2019.pdf**

14 The Trevor Project. (2022). *2022 National Survey on LGBTQ Youth Mental Health by state*. **https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State.pdf**

15 Witcomb, G. L., Bouman, W. P., Claes, L., Brewin, N., Crawford, J. R., & Arcelus, J. (2018). Levels of depression in transgender people and its predictors: Results of a large matched control study with transgender people accessing clinical services. *Journal of Affective Disorders, 235*(8), 308–315.

16 Medina, C., & Mahowald, L. (2023). *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022*. Center for American Progress. **https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/**

17 Medina, C., & Mahowald, L. (2023). *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022*. Center for American Progress. **https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/**

18 Medina, C., & Mahowald, L. (2023). *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022*. Center for American Progress. **https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/**

19 Moore, J. E., Adams, C., Glenn, N., Landucci, R., Serino, N., & Depriest, K. (2021). *Medicaid access & care in 2020: Results from the Institute for Medicaid Innovation's 2021 Annual Medicaid Health Plan Survey*. Institute for Medicaid Innovation. **https://medicaidinnovation.org/wp-content/uploads/2022/12/IMI-2021_Annual_Medicaid_MCO_Survey-Report.pdf**

20 Healthy People 2030. (n.d.). *Social determinants of health*. U.S. Department of Health and Human Services. **https://health.gov/healthypeople/priority-areas/social-determinants-health**

21 Koma, W., Rae, M., Ramaswamy, A., Neuman, T., Kates, J., & Dawson, L. (2020). *Demographics, insurance coverage, and access to care among transgender adults*. KFF. **https://www.kff.org/health-reform/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/**

22 National Black Justice Coalition, National Center for Transgender Equality, & National Gay and Lesbian Task Force. (n.d.). *Injustice at every turn: A look at Black respondents in the National Transgender Discrimination Survey*. **https://nbjc.org/wp-content/uploads/2020/11/trans-adjustment-web.pdf**

23 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23*(sup1), S1–S259. **https://doi.org/10.1080/26895269.2022.2100644**

24 Jorge, J. C., Valerio-Pérez, L., Esteban, C., & Rivera-Lassen, A. I. (2019). Intersex care in the United States and international standards of human rights. *Global Public Health, 16*(5), 679–691. **https://doi.org/10.1080/17441692.2019.1706759**

25 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G., A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23*(sup1), S1–S259. **https://doi.org/10.1080/26895269.2022.2100644**

26 Carpenter, M. (2020). The OHCHR background note on human rights violations against intersex people. *Sexual and Reproductive Health Matters, 28*(1), 1731298. **https://doi.org/10.1080/26410397.2020.1731298**

27 Gomez, I., Ranji, U., Salganicoff, A., Dawson, L., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). *Update on Medicaid coverage of gender-affirming health services: Appendices*. KFF. **https://www.kff.org/report-section/update-on-medicaid-coverage-of-gender-affirming-health-services-appendices/**

28 Gomez, I., Ranji, U., Salganicoff, A., Dawson, L., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2022). *Update on Medicaid coverage of gender-affirming health services: Appendices*. KFF. **https://www.kff.org/report-section/update-on-medicaid-coverage-of-gender-affirming-health-services-appendices/**

29 Mann, S., Campbell, T., & Nguyen, D. H. (2022). *Access to gender-affirming care and transgender mental health: Evidence from Medicaid coverage*. SSRN. **https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4164673**

30 Keuroghlian, A. S., Keatley, J., Shaikh, S., & Radix, A E.. (2022). The context, science and practice of gender-affirming care. *Nature Medicine, 28*(12), 2464–2467. **https://www.nature.com/articles/s41591-022-02082-w**

31 Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology, 62*(2), 221–227. **https://psycnet.apa.org/record/1994-34347-001**

32 Movement Advancement Project. (2024). *Healthcare laws and policies: Bans on best practice medical care for transgender youth*. **https://www.lgbtmap.org/img/maps/citations-youth-medical-care-bans.pdf**

33 Alder, S. (2023). *VMUC faces lawsuit over disclosure of medical records of transgender patients to state AG*. The HIPAA Journal. **https://www.hipaajournal.com/vumc-faces-lawsuit-over-disclosure-of-medical-records-of-transgender-patients-to-state-ag/**

34 Associated Press. (2023, April 15). *Hospital sues Missouri's top prosecutor over trans care data*. **https://apnews.com/article/transgender-care-missouri-attorney-general-hospital-lawsuit-217e78b46cfd50432c97e3cc759f9717**

35 Redfield, E., Conron, K. J., Tentindo, W., & Browning, E. (2023). *Prohibiting gender-affirming medical care for youth*. UCLA School of Law Williams Institute. **https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf**

36 Executive Office of the President of the United States. (2023). *Federal evidence agenda on LGBTQI+ equity*. **http://www.whitehouse.gov/wp-content/uploads/2023/01/Federal-Evidence-Agenda-on-LGBTQI-Equity.pdf**

37 Medina, C., & Mahowald, L. (2023). *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022*. Center for American Progress. **https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/**

38 Nundy, S., Cooper, L. A., & Mate, K. S. (2022). The quintuple aim for health care improvement: A new imperative to advance health equity. *JAMA, 327*(6), 521–522. **https://doi.org/10.1001/jama.2021.25181**

39 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G., A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23*(sup1), S1–S259. **https://doi.org/10.1080/26895269.2022.2100644**

40 InterACT. (2023). *Intersex data collection: Your guide to question design*. **https://interactadvocates.org/intersex-data-collection/**

41 Executive Office of the President of the United States. (2023). *Federal evidence agenda on LGBTQI+ equity*. **http://www.whitehouse.gov/wp-content/uploads/2023/01/Federal-Evidence-Agenda-on-LGBTQI-Equity.pdf**

42 Privacy Policy Guidance Memorandum. (2008). U.S. Department of Homeland Security. **https://www.dhs.gov/sites/default/files/publications/privacy_policyguide_2008-02_0.pdf**

43 Baker, K., & Restar, A. (2022). Utilization and costs of gender-affirming care in a commercially insured transgender population. *Journal of Law, Medicine & Ethics, 50*(3), 456–470. **https://doi.org/10.1017/jme.2022.87**

44 Agency for Healthcare Research and Quality. (2020). *About SDOH in healthcare*. **https://www.ahrq.gov/sdoh/about.html**

45 Movement Advancement Project. (2024). *Healthcare laws and policies: Medicaid coverage for transgender-related health care*. **https://www.lgbtmap.org/img/maps/citations-medicaid.pdf**

46 Baker, K., & Restar, A. (2022). Utilization and costs of gender-affirming care in a commercially insured transgender population. *Journal of Law, Medicine & Ethics, 50*(3), 456–470. **https://doi.org/10.1017/jme.2022.87**

47 Thoreson, N., Marks, D. H., Peebles, J. K., King, D. S., & Dommasch, E. (2020). Health insurance coverage of permanent hair removal in transgender and gender-minority patients. *JAMA Dermatology, 156*(5), 561–565. **https://doi.org/10.1001/jamadermatol.2020.0480**

48 Medina, C., & Mahowald, L. (2023). *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022*. Center for American Progress. **https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022**

49 Agency for Healthcare Research and Quality. (2020). *Project ECHO*. **https://www.ahrq.gov/patient-safety/settings/multiple/project-echo/index.html**