The Case for Designating LGBT People as a Medically Underserved Population and as a Health Professional Shortage Area Population Group

THE FENWAY INSTITUTE

INTRODUCTION

The U.S. Health Resources Services Administration (HRSA) is currently considering designation of Medically Underserved Populations (MUP) and Health Professional Shortage Area (HPSA) population groups. Due to significant health disparities and documented barriers to accessing health care, the lesbian, gay, bisexual and transgender (LGBT) population should be designated a Medically Underserved Population (MUP). Because few health providers are trained to provide culturally competent and affirming care to LGBT people, the LGBT population should also be designated a Health Professional Shortage Area (HPSA) population group.

BACKGROUND

The Affordable Care Act of 2010 (ACA) required the Secretary of Health and Human Services (HHS) to appoint an expert Negotiated Rule Making Committee (NRMC) to develop new methodologies for designating medically underserved populations, populations experiencing shortages in health professionals available to serve them, and populations experiencing high levels of unmet health care needs. HRSA defines Medically Underserved Populations as follows:

> "[p]opulation groups requested for MUP designation should be those with economic barriers (low-income or Medicaid-eligible populations), or cultural and/or linguistic access barriers to primary medical care services."[1]

According to HRSA, HPSAs can be designated in primary medical care, dental care, and mental health care. Geographical areas, population groups, and facilities can be designated HPSAs.[2]

Many LGBT researchers and policy advocates—including leaders from the Fenway Institute, the National Coalition for LGBT Health, and others—testified before the NRMC in 2011 in support of designating the LGBT population as both a MUP and a population group HPSA. The testimony presented to the NRMC focused on research showing that the LGBT population experiences disparities in health outcomes and access to health care. LGBT people also experience a shortage of primary medical care and mental health providers trained and able to serve them in a culturally competent, nondiscriminatory, and affirming manner.

MUP population groups "should be those with economic...or cultural...access barriers to primary medical care services." -HRSA

In October 2011 the NRMC voted 23-2 in favor of a summary report that recommended LGBT inclusion in the revised MUP and population group HPSA designations. Full implementation by HHS of this overwhelming recommendation would significantly increase the availability of culturally competent health care providers for the LGBT population and would be an important step forward in effectively addressing LGBT health and health care access disparities.

LGBT HEALTH DISPARITIES

The LGBT population experiences health disparities that are significant both from a clinical and a public health perspective. For instance, lesbians are more likely than heterosexual and bisexual women to be overweight and obese, increasing their risk for cardiovascular disease, lipid abnormalities, glucose intolerance, and morbidity related to inactivity.[3] Lesbians and bisexual women experience cervical cancer at the same rate as heterosexual women, but are much less likely to get routine Pap tests to screen for cervical

cancer.[4,5] The Massachusetts Behavioral Risk Factor Surveillance Survey found poorer health among bisexual respondents compared with gay, lesbian, and heterosexual respondents, as well as higher rates of mental health issues and smoking.[6] Overall, LGBT people as a group are 1.5 to 2.5 times more likely than other Americans to smoke.[7] Gay and bisexual men and transgender women experience high rates of HIV and sexually transmitted infections,[8] and transgender individuals experience high rates of minority stress and mental health burden.[9]

LGBT DISPARITIES IN ACCESSING CARE

LGBT people experience cultural barriers to accessing primary care. These barriers include a lack of providers trained to address the specific health care needs of LGBT people[10]; low rates of health insurance coverage for same-sex couples[11], LGB individuals[12,13], and transgender individuals, especially Black transgender people[14]; discrimination in health care[15]; and a lack of access to culturally appropriate health care, including preventive services.[16]

POVERTY AMONG LGBT PEOPLE AND ITS CONNECTION TO THE MUP AND HPSA DESIGNATIONS

Since its original establishment in 1975, the MUP designation has been primarily geographical and based on four criteria: poverty rate, ratio of primary care physicians to population, infant mortality rate, and percentage of the population age 65 and older. The HPSA designation is based on similar criteria of geography and physician-to-population ratio: According to the Rural Policy Research Institute (RPRI), "[a]reas with concentrations of poor, minority, and/or linguistically isolated populations have achieved population group HPSA designations based on their limited access to physicians."[17]

Economic and cultural barriers to LGBT people accessing care include lack of trained providers, discrimination in health care, and low rates of insurance coverage.

The RPRI further notes that "[m]any designations are significantly outdated, governed by indicators from the 1970s" and adds that the new designation methodology for MUPs and HPSAs mandated by the ACA should "incorporate into the methodology...[s]tatistical and epidemiological surveillance that is sensitive to the emergence of inequalities in health care access for new population groups." Given the substantial and growing body of recent research documenting higher rates of poverty among LGBT people[18] and the striking health disparities affecting the LGBT population[19], this population should be designated as both a MUP and a population group HPSA.

MUP AND HPSA DESIGNATIONS ARE ESPECIALLY IMPORTANT FOR COMMUNITY HEALTH CENTERS SERVING LGBT PEOPLE

Community health centers and other safety net providers are lifelines to essential care for many LGBT people and their families. Because the needs of the LGBT population are not considered under the current MUP and HPSA designations, however, these providers frequently have difficulty accessing desperately needed funding and other support.[20] If HHS acts on the NRMC's recommendations to revise these designations to reflect a more accurate assessment of vulnerability and need across population groups experiencing health disparities, including the LGBT population, many vital programs and health care facilities will gain greater access to the financial resources and other support they need to properly serve all those in their communities

who need their services.

Specific policy recommendations made by the NRMC regarding LGBT designation as a MUP and population group HPSA

The NRMC's 2011 final report[21] includes five particularly important recommendations for supporting providers and facilities serving the LGBT population.

1. Consistently list the LGBT population among population groups eligible for MUP, population group HPSA, or the new magnet facility population designations. (Pages 36, 46, 49 of NRMC report)

As discussed above, sources such as the Institute of Medicine[22] and Healthy People 2020[23] report that LGBT individuals experience significant health disparities related to their minority sexual orientation and/or gender identity. The designations considered in the 2011 NRMC report have the potential to be extremely valuable tools for addressing these disparities, and HHS rulemaking on this matter should thus include the LGBT population in any list of population groups eligible for designation as an MUP, population group HPSA, or magnet facility population.

2. Include population rational service areas (RSAs) among the qualifying standards for MUP and population group HPSA designations. (Page 22)

An important consideration in the MUP and population group HPSA designations is that underserved populations may face difficulty accessing medical services not only on the basis of geography but also on the basis of the availability of clinicians with appropriate cultural and/or clinical competence. Recognizing this, the NRMC recommends requiring MUP and population group HPSA applicants to produce data indicating that the service area for which population group data are provided is a Rational Service Area (RSA) for that population group.

Importantly from the perspective of population groups such as the LGBT population, people living with HIV/AIDS, and people with disabilities, such population RSAs may be larger than the current concept of geographically determined RSAs. This reflects the fact that these population groups may be dispersed throughout the general population in a large area and that individuals may travel long distances to access care from providers offering specific culturally and/or clinically competent services. An example is the catchment area for community health centers that have traditionally served the LGBT population, such as Fenway Health in Boston, Legacy Community Health Services in Houston, and Howard Brown Health Center in Chicago. These centers report that LGBT individuals frequently travel from across catchment areas much larger than geographically determined RSAs to receive care from providers familiar with LGBT community concerns and health issues.

3. Ensure the MUP and population group HPSA application processes do not exclude population groups, including the LGBT population, for which limited national data currently exist. (Pages 39, 47)

The NRMC report recognizes that data for the general population may not adequately reflect the primary care needs of specific population groups and/or that data specific to these population groups may not exist. Accordingly, the report recommends that the MUP application process allow the consideration of local population-specific data across all four components (population-toprovider ratio, health status, barriers to care, and ability to pay) whenever nationally compiled data for the local area or population group are not available.

LGBT people may be dispersed across a larger geographic area than the traditional Rational Service Area.

Similarly, the report recommends that the population group HPSA application process also include a local data option. This option would allow local population-specific data to be taken into consideration when determining the provider-to-patient ratio, standardized mortality ratio (SMR), and percentage of low-income population.

4. Allow local data testifying to a need for MUP designation on the basis of health status or barriers to care to include indicators specifically relevant to the LGBT population. (Pages 37-38)

The 2011 NRMC report notes that applicants may find that the health status indicators for MUP designation recommended by the committee (standardized mortality rate, low birth weight, and diabetes) do not reflect the most significant health disparities experienced by the population seeking designation. The report thus recommends that applicants be allowed to substitute up to two other indicators of health disparities related to primary care. This recommendation is particularly important for the LGBT population, which experiences substantial disparities in indicators not currently allowable in MUP designation applications, such as HIV/AIDS, mental health burden, and smoking.

Similarly, the report recommends that applicants be allowed to submit data for the barriers to care component that document population-specific local barriers not included in the Medically Underserved Area (MUA) model. Importantly, the report notes that such barriers could include stigma and discrimination related to sexual orientation, gender identity, or HIV status. To avoid furthering the erroneous perception that LGBT and HIV-positive populations are coterminous—although they are significantly overlapping, as two-thirds of new HIV infections occur among men who have sex with men—barriers to care related to anti-LGBT discrimination or lack of LGBT competency should not be interpreted as automatically referring to barriers related to HIV status, and vice versa.

The concept of "magnet facilities" is especially important for LGBT-focused health centers, and HIV care providers.

Moreover, the concept of "barriers to care" reflects the socioeconomic determinants that play such a significant role in the health disparities and medical underservice experienced by various population groups, including the LGBT population. In order to incorporate this important factor, the NRMC recommends that the MUP application process assign a higher weight of 40 percent to the barriers to care component.

5. Maintain the proposed magnet facility HPSA designation. (Page 49)

The NRMC also proposes a new magnet facility designation. HHS rulemaking regarding the facility HPSA designation should incorporate the concept of magnet clinics that draw many of their patients from long distances seeking culturally sensitive care. A magnet facility should be defined as a clinic where primary care clinicians provide more than 50 percent of encounters to one or two population groups nationally recognized as experiencing health disparities. These population groups may include, but should not be limited to, those eligible for MUP designation, including the LGBT population, people living with HIV/AIDS, and low-income populations. For example, a clinic whose patient population is comprised of 33 percent LGBT individuals and 40 percent low-income individuals (for a total exceeding the 50 percent threshold, even assuming some overlap) would qualify for the magnet clinic designation.

CONCLUSION

Designating the LGBT population as a MUP and population group HPSA will dramatically increase access to culturally and clinically competent health care for LGBT people.

Over the past five years the Health Resources Services Administration and the U.S. Department of Health and Human Services as a whole have taken significant steps toward recognizing and addressing the health disparities affecting the LGBT population. These steps have included increasing sexual orientation and, to a degree, gender identity data collection on population-level surveys and through the Meaningful Use program, establishing new LGBT-inclusive nondiscrimination provisions, expanding health care access for LGBT people and people living with HIV, and increasing research and prevention services targeting LGBT health. The 2011 Negotiated Rule Making Committee report offers a potent opportunity to continue this important work by helping ensure that medically underserved and other vulnerable populations—including LGBT people—can access timely, affordable, and culturally competent health care. It is critical that HHS undertake rulemaking on these designations as quickly as possible and that the department incorporate the NRMC's recommendations, particularly the five recommendations discussed above, in that rulemaking. Designating the LGBT population as a MUP and population group HPSA will dramatically increase access to culturally and clinically competent health care for LGBT people and will play a critical role in addressing persistent disparities in health care access and outcomes.

If you have any questions about this policy brief, please contact Sean Cahill (scahill@fenwayhealth.org) or Kellan Baker (kbaker@americanprogress.org).

The Fenway Institute
The Center for American Progress
Human Rights Campaign
GLMA: Health Professionals Advancing LGBT Equality

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REFERENCES

1. HRSA, Medically Underserved Areas/Populations: Guidelines for MUA and MUP Designation. No date. http://bhpr.hrsa.gov/shortage/muaps/

2. HRSA, Primary Medical Care HPSA Designation Overview. No date. http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/primarycarehpsaoverview.html

3. Boehmer U, Bowen DJ, Bauer GR. Overweight and obesity in sexual minority women: evidence from population-based data. Am J Pub Health. 2007; 97: 1134-1140. Cited in Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: What we know and what needs to be done. Am J Public Health. 2008: 98: 989-995.

4. Valanis BG, Bowen DJ, Bassford T, Whitlock E, Charney P, Carter RA. Sexual orientation and health: Comparisons in the Women's Health Initiative sample. Arch Fam Med. 2000;9(9):843-853.

5. Kerker BD, Mostashari F, Thorpe L. Health care access and utilization among women who have sex with women: Sexual behavior and identity. J Urban Health. 2006;83(5):970-979.

6. Conron, KJ, Mimiaga, MJ, Landers, SJ. A population-based study of sexual orientation identity and gender differences in adult health. Am J Pub Health. 2010; 100(10); 1953-1960.

7. Lee, J., Griffin, G., & Melvin, C. (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. Tob Control. Aug 2009; 18(4):275-282.

8. Centers for Disease Control and Prevention (2010, September). HIV Among Gay, Bisexual, and Other Men who Have Sex with Men (MSM): Fact Sheet. http://www.cdc.gov/nchhstp/Newsroom/docs/FastFacts-MSM-FINAL508COMP.pdf

9. Institute of Medicine. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press, 2011. Available at: http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx

10. Obedin-Maliver J, Goldsmith E, Stewart L, et al. White, W, Tran, E, Brenman, S, Wells, M, Fetterman, DM, Garcia, G, Lunn, MR. Lesbian, gay, bisexual and transgender-related content in undergraduate medical education. JAMA. 2011; 306: 971-977.

11. Ponce N, Cochran S, Pizer J, Mays V: The effects of unequal access to health insurance for same-sex couples in California. Health Aff. 2010;29:1539–1548.

12. Badgett L. Civil rights, civilized research: Constructing a sexual orientation anti-discrimination policy based on the evidence. Paper presented at Association for Public Policy Analysis and Management Research Conference, San Francisco, 1994. Cochran S. Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? American Psychologist. 2001;56(11): 931-947. Diamant A, Wold C, Spritzer K, Gelberg L. Health behaviors, health status, and access to and use of health care: A population-based study of lesbian, bisexual, and heterosexual women. Archives of Family Medicine. 2000; 9(10): 1043-1051.

13. Durso L, Baker K, Cray A. LGBT Communities and the Affordable Care Act: Findings from a National Survey. Washington, DC: Center for American Progress, 2013. Available from http://www.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACAsurvey-brief1.pdf

14. Grant J, Mottet L, Tanis J, Harrison J, Herman J, Keisling M. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011

15. Lambda Legal. When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV. New York: Lambda Legal. 2010. Smith D, Mathews W. Physicians' attitudes toward homosexuality and HIV: Survey of a California medical society-revisited (PATHH-II). Jnl Homosexuality. 2007; 52(3-4):1-9.

16. Mayer K, Bradford J, Makadon H, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: What we know and what needs to be done. Am J Public Health. 2008: 98: 989-995.

17. Coburn A, Lundblad J, MacKinney A, et al. Designating Health Professional Shortage Areas and Medically Underserved Populations/Medically Underserved Areas: A Primer on Basic Issues to

Resolve. Columbia, MO: Rural Policy Research Institute, 2010. http://www.rupri.org/Forms/Health_NPRM_Issues_August2010.FINAL.pdf

18. Badgett M, Durso L, Schneebaum, A. New patterns of poverty in the lesbian, gay and bisexual community. Los Angeles: Williams Institute, UCLA School of Law, 2013. http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf. Grant et al., 2011.

19. Institute of Medicine, Board on the Health of Select Populations, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities; The Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) People: Building a Foundation for Better Understanding, Washington, DC: National Academies Press, 2011. http://www.nap.edu/catalog.php?record_id=13128

20. Rosenbaum, Jones and Shin (August 2010). Community Health Centers: Opportunities and Challenges of Health Reform. Washington: Kaiser Family Foundation. http://www.nhchc.org/wp-content/uploads/2011/09/KaiserCHCsandhealthreformAug2010.pdf

21. Negotiated Rule Making Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas. Final Report to the Secretary. October 31, 2011. http://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf

22. Institute of Medicine. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press, 2011. Available at: http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx

23. U.S. Department of Health and Human Services. Healthy People 2020. Lesbian, gay, bisexual and transgender health. No date. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

1340 Boylston St. Boston, MA 02215