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June 6, 2022

Alison Barkoff
Acting Assistant Secretary for Aging and Administrator
Administration for Community Living
Department of Health and Human Services

Submitted electronically via OAAregulations@acl.hhs.gov

Re: Request for Information: Older Americans Act Regulations, RIN: 0985-AA17

Dear Ms. Barkoff:

SAGE appreciates the opportunity to comment on the Administration for Community Living's (ACL) request for information (RFI) on recommended changes, additions, or deletions to regulations for programs authorized under Titles III, VI, and VII of the Older Americans Act, 42 U.S.C. § 3001 *et seq.*, (OAA). SAGE is the country's oldest and largest organization dedicated to improving the lives of lesbian, gay, bisexual, transgender, or queer ("LGBTQ+") older adults. SAGE offers supportive services and consumer resources to LGBTQ+ older adults and their caregivers, advocates for public policy changes that address their needs, and provides training for agencies and organizations that serve LGBTQ+ older adults.

As ACL is aware, LGBTQ+ older adults fare worse in many measures of socioeconomic wellbeing than their straight and cisgender peers. The same is true for older adults living with HIV or AIDS. Despite their significant need, these older adults are disproportionately unlikely to receive the services and supports they need to live independently. OAA's promise—that the "older people of our Nation are entitled to… a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their home[] … [and] retirement in health, honor, [and] dignity"—too often fails these communities.[1] Instead, their ability to access essential services and supports often depends on whether they live in a state or city that has recognized their disproportionate need, assesses those needs, requires targeted provision of services, and prohibits discrimination in the provision of services.

ACL should codify recognition of this need by regulation. Specifically, ACL should use its authority under 42 U.S.C. § 3027(a) to update the criteria for state units on aging to be eligible for grants under Title III of the OAA to: (1) define greatest social need to include LGBTQ+ older people and older people living with HIV/AIDS; (2) prohibit discrimination against these underserved communities, including based on LGBTQ+ identity and HIV/AIDS status; and (3) improve the efficacy of the Title VII ombudsman. We describe below the need for

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[1] 42 U.S.C. § 3001.

these protections, the statutory authority to implement them, and why doing so will be feasible. Our comments in this regard are based on SAGE's own experience as well as interviews with individuals who have worked in or with state units on aging.

I. ACL Should Promulgate Regulations under Title III of the OAA to Designate Specific Underserved Communities, including LGBTQ+ Older People and Older People Living with HIV/AIDS, as Populations of Greatest Social Need (45 C.F.R. part 1321).

ACL oversaw more than $3 billion in federal funds allocated under Title III of the OAA in fiscal year 2021.[2] These funds are provided to the states to help pay for a wide range of services—such as nutrition services, in-home services, transportation, legal services, elder abuse prevention, and caregiver support—that are critical to enable older adults to maintain their independence. Funding under the Act is distributed to 56 State units on aging (SUAs), more than 600 Area agencies on aging (AAAs), and approximately 20,000 local service providers (collectively, the Aging Network).[3]

To be eligible for those funds, states must submit plans to ACL that meet certain statutory requirements, as well as any criteria established by the Assistant Secretary.[4] The OAA further provides that a state's OAA-funded programs—which are typically available to all adults over 60—must target services towards "older individuals with greatest economic need and older individuals with greatest social need."[5] Consistent with this mandate, state plans must provide assurances that the SUA will conduct outreach efforts to identify these individuals, as well as periodic evaluations of the effectiveness of services provided to them.[6] State plans must also contain assurances that the SUA will collect data on the needs of these individuals and whether those needs are met by the aging network.[7]

The OAA defines greatest social need as:

> [T]he need caused by noneconomic factors, which include—(A) physical and mental disabilities; (B) language barriers; and (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that—(i) restricts

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[2] *See generally* Kirsten J. Colello & Angela Napili, Cong. Res. Serv., R43414, *Older Americans Act: Overview and Funding* 5 (2021), *available at* https://crsreports.congress.gov/product/pdf/R/R43414.

[3] ACL, *Older Americans Act* (July 8, 2021), https://acl.gov/about-acl/authorizing-statutes/older-americans-act.

[4] 42 U.S.C. § 3027(a) (providing that the Assistant Secretary "may by regulation prescribe" criteria that state plans must meet).

[5] *Id*. § 3025(a)(2)(E).

[6] *Id*. § 3027(a)(4), (16).

[7] *Id*. § 3027(a)(30).

> the ability of an individual to perform normal daily tasks; or (ii) threatens the capacity of the individual to live independently.[8]

As we detail below, and as ACL has already found,[9] LGBTQ+ older adults are at elevated risk of meeting these criteria. The same is true for older adults living with HIV/AIDS.[10] This interpretation is consistent with the statutory definition of greatest social need and is supported by the extensive evidence of need these communities face. But SUAs and AAAs have not consistently adopted these designations, leaving vulnerable older adults without essential services.

ACL has authority under the OAA to promulgate criteria for state plans, including a definition of greatest social need that specifically identifies underserved communities, such as LGBTQ+ older adults and older adults living with HIV/AIDS. It should do so. It will be feasible for SUAs and AAAs to incorporate these designations, but an explicit regulatory requirement is necessary for them to do so consistently.

A. Older Adults who are LGBTQ+ and/or are living with HIV/AIDS meet the OAA criteria for greatest social need but have not been consistently targeted for services by SUAs.

Research shows that LGBT[11] older adults have worse mental and physical health compared to heterosexual and cisgender older adults.[12] They have experienced high rates of

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[8] *Id*. § 3002(24).

[9] *Older Americans Act*, supra n. 3 (expand the "Targeting" subsection within the *Frequently Asked Questions* section).

[10] Memo. from Alison Barkoff, Acting Assistant Sec'y for Aging, to SUA Dirs., *available at* https://www.lgbtagingcenter.org/resources/pdfs/State%20Plan%20Guidance_Plans%20Due%20Oct%202022_ACL%20SUA%20Directors%20Letter%20_01_2021.pdf at 8.

[11] When the studies we cite discuss a particular subset of the LGBTQ+ community or use a different acronym to describe that community, the language in this comment mirrors the usage in the study.

[12] Soon Kyu Choi & Ilan H. Meyer, Williams Inst., *LGBT Aging: A Review of Research Findings, Needs, and Policy Implications* 24-29 (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Aging-Aug-2016.pdf ("Williams LGBT Aging Report"); Karen Fredriksen Goldsen et al., *The Evolution of Aging with Pride–National Health, Aging, and Sexuality/Gender Study: Illuminating the Iridescent Life Course of LGBTQ Adults Aged 80 Years and Older in the United States*, 88 Int'l J. of Aging & Hum. Dev. 380, 380 (2019) ("Microaggressions were negatively associated with quality-of-life and positively associated with poor physical and mental health."); Anthony N. Carrero II & Kristy A. Nielson, *A Review of Minority Stress as a Risk Factor for Cognitive Decline in Lesbian, Gay, Bisexual, and Transgender (LGBT) Elders*, 24 J.of Gay & Lesbian Mental Health 2, 2 (2020) (Chronic minority stress "contributes to LGBT health disparities, including cardiovascular disease and depression, conditions that in turn increase risk for premature cognitive decline. Furthermore, long-term exposure to stress hormones is associated with

lifetime discrimination and physical and verbal abuse in relation to their sexual orientation and gender identity.[13] Further, lifetime disparities in earnings, employment, and retirement saving opportunities put LGBT older adults at risk of financial instability and poverty.[14] Many LGBT older adults are forced to rely on institutional and professional care and support; they are more likely to live alone and less likely to have children to help them than their heterosexual and cisgender peers.[15] Many may also be estranged or concealing their sexual orientation or gender identity from biological families due to fear of rejection.[16] The COVID-19 pandemic has exacerbated these needs. Research, including from the Centers for Disease Control, shows that the LGBT community is particularly vulnerable to serious illness related to COVID-19 infection due to several underlying health conditions.[17]

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accelerated brain aging."); Brandon C. Yarns et al., *The Mental Health of Older LGBT Adults*, 18 Current Psychiatry Reps. 59, 59 (2016) ("LGBT individuals have higher rates of anxiety, depression, and substance use disorders and also are at increased risk for certain medical conditions like obesity, breast cancer, and [HIV].").

[13] Williams LGBT Aging Report, *supra* n. 12, at 3, 13-14; Andraya Zelle & Tamatha Arms, *Psychosocial Effects of Health Disparities of Lesbian, Gay, Bisexual, and Transgender Older Adults*, 53 J. of Psychosocial Nursing and Mental Health Servs. 25, 25 (2015) ("Research suggests that health disparities are closely linked with societal stigma, discrimination, and denial of civil and human rights."); Carey Candrian & Kate L. M. Hinrichs, *The Impact of Intersectional Stigma on Health Outcomes: The Case of an Older Lesbian Veteran*, 33 J. of Gay & Lesbian Soc. Servs. 291, 292 (2021) (82% of LGBTQ people have been victimized because of their perceived sexual orientation or gender identity, with 64% having been victimized three or more times); Kyle L. Bower et al., *Narratives of Generativity and Resilience among LGBT Older Adults: Leaving Positive Legacies despite Social Stigma and Collective Trauma*, 68 J. of Homosexuality 230, 231 (2019) ("[D]iscrimination against gender and sexual minorities range from overt macroaggressions (e.g., laws, policies, hate crimes and violence) to subtle, and sometimes unintentional, microaggressions (e.g., misgendering trans people and heteronormative assumptions).").

[14] Williams LGBT Aging Report, *supra* n. 12, at 8-10; *see also* M.V. Lee Badgett et al., Williams Inst. *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community* (2013), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Poverty-LGB-Jun-2013.pdf. Studies also find that same-sex couples have higher rates of poverty compared to heterosexual married couples. *See* Williams LGBT Aging Report, *supra* n. 12, at 10. Lesbian couples over age 65 are twice as likely to be in poverty as heterosexual couples.

[15] *Williams LGBT Aging Report*, supra n. 12, at 6, 8.

[16] *Id.* at 8.

[17] Kevin C. Heslin & Jeffrey E. Hall. *Sexual Orientation Disparities in Risk Factors for Adverse COVID-19–Related Outcomes, by Race/Ethnicity — Behavioral Risk Factor Surveillance System, United States, 2017–2019*, 70 Morbidity & Morality Wkly. Rep. 149,151 (2021), https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7005a1-H.pdf; *see also* Charlie Whittington et al., Hum. Rts. Campaign, *The Lives & Livelihoods of Many in the LGBTQ Community are at Risk Amidst the COVID-19 Crisis* (2020), https://hrc-prod-requests.s3-us-west-2.amazonaws.com/files/assets/resources/COVID19-IssueBrief-032020-

Older adults living with HIV/AIDS, a population that overlaps significantly with older LGBTQ+ adults, also have disproportionate need. Nine percent of all LGBTQ+ older adults are living with HIV, with more than one in five bisexual older men and nearly one in seven gay older men having the disease.[18] Of those, 44% reported having AIDS.[19] Aging gay men living with HIV typically experience worse health than both their aging heterosexual and younger gay counterparts, including increased rates of cardiovascular disorders, certain cancers, substance use, depression, and suicidal ideation.[20] Many studies show that living with HIV/AIDS over long periods of time results in adverse effects on quality of life.[21] Compared with aging, HIV-negative LGBTQ people, those with HIV report higher rates of poor general health, disability, various types of disease, and depression, anxiety, and suicidal ideation.[22] Furthermore, 48% of those with HIV have experienced the death of a same-sex partner.[23] Although social isolation is a problem affecting many older adults in the LGBTQ community,[24] older, HIV-positive members of this community may be even lonelier due to HIV-related stigma and a fear of rejection.[25]

FINAL.pdf?mtime=20200811115717&focal=none; Carey Candrian et al., *LGBT Seniors in the Pandemic: Silenced and Vulnerable*, 1 Annals of LGBTQ Pub. & Population Health 277 (2020).

[18] Karen I. Fredriksen-Goldsen et al., *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults* 4 (2011), https://www.lgbtagingcenter.org/resources/pdfs/LGBT%20Aging%20and%20Health%20Report_final.pdf.

[19] *Id*. at 41.

[20] Daniel Colton Green & Elizabeth Mirizio Wheeler, *A Qualitative Exploration of Facilitators for Health Service Use among Aging Gay Men Living with HIV*, 18 J. of the Int'l Ass'n of Providers of AIDS Care 1, 1 (2019), https://journals.sagepub.com/doi/pdf/10.1177/2325958219880569.

[21] E.G. Bing et al., *Health-Related Quality of Life among People with HIV Disease: Results from the Multicenter AIDS Cohort Study*, 9 Quality of Life Rsch. 55, 55 (2000), https://link.springer.com/content/pdf/10.1023/A:1008919227665.pdf; Karl A. Lorenz et al, *Associations of Symptoms and Health-Related Quality of Life: Findings from a National Study of Persons with HIV Infection*, 134 Annals of Internal Med. 854 (2001), https://www.acpjournals.org/doi/10.7326/0003-4819-134-9_part_2-200105011-00009?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed; Christine Zinkernagel et al, *Quality of Life in Asymptomatic Patients with Early HIV Infection Initiating Antiretroviral Therapy*, 13 AIDS 1587 (1999), https://journals.lww.com/aidsonline/Fulltext/1999/08200/Quality_of_life_in_asymptomatic_patients_with.24.aspx.

[22] Karen I. Fredriksen-Goldsen et al., *supra* note 18, at 41-42.

[23] *Id*.

[24] *See* Karen I. Fredericksen-Goldsen, *Promoting Health Equity Among LGBT Mid-Life and Older Adults*, 38 Generations 86 (2014).

25 Mark Brennan-Ing, Emerging Issues in HIV and Aging, Prepared for the HIV Aging Policy Action Coalition, https://www.sageusa.org/wp-content/uploads/2020/07/emerging-issues-in-hiv-

ACL has already concluded that these are communities likely to have greatest social need. In 2012, ACL expressly found that older LGBTQ+ older adults may have "greatest social need" because "in some communities . . . isolation due to sexual orientation or gender identity may restrict a person's ability to perform normal daily tasks or live independently."[26] Relatedly, the 2020 Congressional reauthorization of the OAA imposed new requirements that SUAs and AAAs engage in outreach to identified underserved communities—including, by reference, LGBTQ+ older adults—and collect data on services needed by underserved communities and on whether they are meeting those needs. Specifically, it required outreach to and data collection regarding older people whose needs were the focus of all centers that received specifically identified funding.[27] SAGE's National Resource Center on LGBTQ+ Aging was funded under the subchapter referenced, meaning that LGBTQ+ older people, on whose needs it focuses, are included in these statutory requirements.[28] Thereafter, ACL's 2021 guidance for states developing their multiyear state plans stated that it:

> encourage[d] states and AAAs to take a broad approach to ensuring services are reaching older adults in greatest social need … These populations include: individuals who are Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons who live in rural areas.[29]

The 2021 guidance also said that states should describe their plans and include objectives and measures they would use to demonstrate progress towards serving older adults living with HIV/AIDS and determining services needed and effectiveness of programs for certain underserved older adults, including older LGBTQ+ persons.[30]

Despite ACL's longstanding guidance and the new requirements in the OAA itself, many state plans do not even acknowledge the existence of LGBTQ+ older adults or those living with HIV/AIDS, much less set forth requirements as to data collection or targeting of services. Of the 56 SUAs, only seven have designated LGBTQ+ older adults as a population of greatest social need (CA, DC, IL, MA, PA, VA, and VT), and only four have done so for older adults living

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and-aging-may-2020.pdf (May 2020); Eric W. Scrimshaw & Karolynn Siegel, *Perceived Barriers to Social Support from Family and Friends among Older Adults with HIV/AIDs*, 8 J. of Health Psych. 738, 740 (2003).

[26] *Older Americans Act*, supra n. 3 (expand the "Targeting" subsection within the *Frequently Asked Questions* section).

[27] 42 U.S.C. § 3026(a)(18), (19); 42 U.S.C. § 3027(a)(3).

[28] *See* Colello & Napili, *supra* n. 2, at 8; *see also* Memo. from Alison Barkoff, *supra* n. 10.

[29] Memo. from Alison Barkoff, *supra* n. 10, at 3.

[30] *Id*. at 8.

with HIV/AIDS (CA, DC, IL, and VT).[31] Approximately fourteen other states include any reference to LGBTQ+ older adults in their state plans, only a handful do so for older adults living with HIV/AIDS. The remainder of the state plans are entirely silent on these vulnerable populations. As a result, AAAs and service providers do not receive clear information about the needs of these older adults or feel compelled to serve them.

Further, even though some states are moving towards inclusive services, others have been inconsistent or moved in the wrong direction. This backsliding results from changes in state political administrations and the persistent refusals by parts of the country to acknowledge that LGBTQ+ older adults and those living with HIV/AIDS should be able to present their authentic selves. These reversals in policy have consequences for vulnerable adults, because they limit their ability to consistently access inclusive services.

For example, Tennessee's state plan on aging for 2017-2021 included several specific requirements regarding inclusive service for the LGBTQ+ community as part of its objective to "provide awareness and training to ensure that services are provided to older individuals and adults with disabilities in underserved communities."[32] The plan for 2021-2025 no longer identifies LGBTQ+ communities as among the underserved, or references them in any other way.[33] The same is true for Florida—the 2017-2020 plan provided specifically for educating service providers about the "unique needs" of "elders facing cultural or social isolation, including LGBT individuals" and insuring that their unique needs are met.[34] But Florida's 2021-2025 plan is entirely silent about LGBTQ+ older adults.[35]

Other states have been inconsistent. For example, Maine's state plan for 2012-2016 included a strategy to "[e]xpand outreach and advocacy to Maine's … GLBT" elders among other groups.[36] But its plan for 2016-2020—under a different gubernatorial administration—did

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[31] The New York State Legislature passed a bill that includes both designations in its 2022 session. It is currently awaiting the Governor's signature.

[32] Tenn. Comm'n on Aging & Disability, *Tennessee State Plan on Aging October 1, 2017-September 30, 2021* at 24, 119 (2017), https://www.tn.gov/content/dam/tn/aging/documents/TN_State_Plan_on_Aging_2017-2021.pdf.

[33] Tenn. Comm'n on Aging & Disability, *Tennessee State Plan on Aging October 1, 2021-September 30, 2025* (2021), https://www.tn.gov/content/dam/tn/aging/images/TN%20State%20Plan%20on%20Aging%202021%20-%202025.pdf.

[34] Fla. Dep't of Elder Affs., *State Plan on Aging Fed. Fiscal Years 2017-2020* at 27, 31 (2016), http://www.advancingstates.org/sites/default/files/Florida_2017-2020_State_Plan_on_Aging.pdf.

[35] la. Dep't of Elder Affs., *Florida State Plan on Aging 2022-2025* (2021), https://elderaffairs.org/wp-content/uploads/FINAL-Florida-State-Plan-on-Aging-2022-2025-10182021.pdf.

[36] Me. Off. of Aging & Disability Servs. & Me. Dep't of Health & Hum. Servs., *State Plan on Aging October 1, 2012 – September 30, 2016* (2012), https://digitalmaine.com/cgi/viewcontent.cgi?article=1001&context=oads_docs.

not discuss LGBTQ+ older adults at all.[37] The 2020-2024 State plan reversed course again, with an objective to "[i]mprove access to services and programs for underserved populations … such as … LGBT older adults" and included specific strategies to do so.[38] While this is good news, older Mainers should not face the loss of access to inclusive services when a new governor is elected.

These failures of implementation have continued for new state plans since the 2020 OAA reauthorization, which, as discussed above, requires data collection and targeting services to LGBTQ+ older adults.[39] While we view this statutory requirement as unambiguous, it is not explicit. SAGE is aware of at least one head of a SUA saying publicly that their State did not interpret the 2020 OAA reauthorization to require targeting services to LGBTQ+ older adults. Similarly, Texas's draft state plan for 2023, submitted to ACL on July 1, 2022, well after the 2020 OAA reauthorization and ACL's 2021 Guidance, does not mention LGBTQ+ older adults at all. And while it includes limited data on new HIV cases per year, it contains no information about data collection or targeting of services to older adults living with HIV/AIDS. Several other states, such as Mississippi, North Dakota, and Kansas, whose state plans became effective after the requirements of the 2020 OAA reauthorization also fail to mention LGBTQ+ older adults entirely.

Further, certain states, such as Georgia, are quite prescriptive with respect to how data is collected and how AAAs may assess individual needs for services. AAAs in Georgia cannot collect demographic data not authorized by the state, nor can they adjust the tool to assess need for services. Even if a particular AAA viewed older LGBTQ+ adults as having greatest social need, it would be limited in acting on this assessment given the state's failure to do so.

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[37] Me. Off. of Aging & Disability Servs., *Maine State Plan on Aging 2016-2020* (2016), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/STATEPLANONAGING2016-2020FINALDRAFT.pdf.

[38] Me. Dep't of Health & Hum. Servs. & Me. Dep't of Health & Hum. Servs., *Maine State Plan on Agin 2020-2024* at 21, 25 (2020), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine_State%20Plan%20on%20Aging_2020-2024.pdf.

[39] 42 U.S.C. § 3026(a)(18) (Area agencies on aging plans' must "provide assurances that the area agency on aging will collect data to determine—(A) the services that are needed by older individuals whose needs were the focus of all centers funded under subchapter IV in fiscal year 2019; and (B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals[.]"); 42 U.S.C. § 3027(a)(30)(A) ("The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under subchapter IV in fiscal year 2019[.]"). SAGE's National Resource Center on LGBT Aging was funded under the subchapter referenced, meaning that LGBT older people, on whose needs it focuses, are included in these statutory requirements. *See also* Memo. from Alison Barkoff, *supra* n. 10, at 8.

Based on our experience and the interviews we conducted for this comment, state plans have not consistently focused on LGBTQ+ older adults or those living with HIV/AIDS because there is no explicit federal requirement that they to do so. As a result, states with hostile political leadership or those that have competing priorities, a lack of interest, and/or limited staff time and resources need not make the effort to ensure that services are provided equitably. The progress that has been made in some states affirmatively designating LGBTQ+ older adults and those living with HIV/AIDS has been slow and painstaking, requiring tremendous time and effort by advocates and state policymakers. While we are pleased with these outcomes, a uniform federal policy would allow equity-focused states and advocates to focus on effective implementation, not obtaining the designation itself.

B. The OAA authorizes ACL to designate LGBTQ+ older adults and older adults living with HIV/AIDS as having greatest social need, and ACL should do so.

Congress has explicitly delegated broad authority to ACL to establish criteria for state plans by regulation.[40] The only limitations on this authority specified by the statute are not relevant.[41] Nor have any court decisions interpreted ACL's authority to be more limited than the clear statutory language. Where, as here, "Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to elucidate a specific provision of the statute by regulation."[42] Thus, ACL's "power . . . to administer" Title III of the OAA "necessarily requires the formulation of policy and the making of rules to fill [the] gap left . . . explicitly[] by Congress."[43] Indeed, courts have recognized that delegations of rulemaking authority that "confer[] some measure of discretion"—like the delegation at issue here—encompass the authority to "fill[] gaps in the definition of [statutory terms]."[44] Regulations promulgated under

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[40] 42 U.S.C. § 3027(a) ("[E]ach State, in order to be eligible for grants from its allotment under this subchapter for any fiscal year, shall submit to the Assistant Secretary a State plan for a two-, three-, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe.").

[41] *Id*.

[42] *Chevron v. NRDC*, 467 U.S. 837, 843-44 (1984).

[43] *Id.* at 843. Moreover, even if there were not an express delegation, "it can still be apparent from the agency's generally conferred authority and other statutory circumstances that Congress would expect the agency to be able to speak with the force of law when it addresses ambiguity in the statute or fills space in the enacted law." *U.S. v. Mead Corp.*, 533 U.S. 218, 229 (2001). Thus, "[w]hen a gap exists, a court may assume that Congress implicitly delegated the interpretive function to the agency." *Outdoor Amusement Business Ass'n, Inc. v. Dep't of Homeland Sec.*, 983 F.3d 671, 684 (4th Cir. 2020) (citing *Public Citizen v. FTC*, 869 F.2d 1541, 1553 (D.C. Cir. 1989)). As discussed below, such a gap plainly exists with respect to the definition of "greatest social need."

[44] *Cargill v. Barr*, 502 F. Supp. 3d 1163, 1186 (W.D. Tex. 2020). *See also Veteran Warriors, Inc. v. Sec'y of Veterans Aff.*, 29 F.4th 1320, 1326-27 (Fed. Cir. 2022) (recognizing an agency's authority to define ambiguous statutory terms under the agency's statutory authority to establish a program to assist family caregivers of eligible veterans); *Ass'n for Cmty. Affiliated Plans v.*

such authority will therefore be "given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute."[45]

ACL has authority to promulgate regulations establishing criteria for how state plans assess greatest social need, including by identifying specific populations not mentioned in the OAA.[46] In particular, the statute directs state plans to identify populations of greatest social need[47] and contemplates that additional populations of greatest social need would be later identified based on factors not thought of by Congress at the time of the statute's enactment. As noted above, the statute defines "greatest social need" to mean the "need caused by noneconomic factors," including three identified categories.[48] The third such category is particularly expansive: "cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that--(i) restricts the ability of an individual to perform normal daily tasks; or (ii) threatens the capacity of the individual to live independently."[49] ACL correctly understands that, while this definition explicitly includes isolation caused by racial or ethnic status, "the definition is not intended to exclude the targeting of other populations that experience cultural[,] social or geographic isolation due to other factors."[50] It is therefore within ACL's rulemaking authority to designate specific populations of greatest social need that state plans must identify and target.

Moreover, LGBTQ+ older adults and adults living with HIV/AIDS clearly fall within the statute's broad definition of "greatest social need." The key question under the OAA is not whether the reason for isolation is one of the examples identified in the statute, but instead whether the isolation results in a restriction on the ability to perform normal daily tasks or threatens the capacity to live independently.[51] Race and ethnic status are the kinds of identities that can cause the type of isolation the OAA is concerned with, but they are not the only such possible identities.

ACL has extensive expertise about groups of older adults experiencing the type of harmful isolation described by the OAA. It should rely on this expertise to establish specific criteria for State plans' assessment of greatest social need by regulation. These criteria should

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U.S. Dep't of Treasury, 966 F.3d 782, 785 (D.C. Cir. 2020) ("Congress delegated the task of defining" an ambiguous statutory term when it authorized the agency to "promulgate such regulations as may be necessary or appropriate to carry out [the statute]"); *Nat'l Rifle Ass'n v. Brady*, 914 F.2d 475, 479-80 (4th Cir. 1990) (recognizing an agency's authority to define statutory terms under a general provision of rulemaking authority).

[45] *Chevron*, 467 U.S. at 844.

[46] 42 U.S.C. § 3027(a).

[47] *Id*. § 3027(a)(16).

[48] *Id.* § 3002(24).

[49] *Id*. § 3002(24)(C).

[50] *See Older Americans Act*, *supra* n. 3 (expand the "Targeting" subsection within the *Frequently Asked Questions* section).

[51] 42 U.S.C. § 3002(24)(C).

identify the groups of older adults who ACL assesses are isolated such that they regularly or disproportionately experience these restrictions and threats to their ability to age successfully. Based on our experience, in addition to LGBTQ+ older adults and older adults living with HIV/AIDS, these groups will likely overlap significantly with the underserved communities described in President Biden's Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. 86 Fed. Reg. 7,009 (Jan. 20, 2021).

In promulgating these regulations, ACL should explain that the more general definition of greatest social need in the OAA, the 2020 OAA reauthorization's implicit requirement that SUAs target LGBTQ+ older adults, and ACL's guidance to date have not been effective in obtaining nationwide, or even widespread, targeting of OAA services to LGBTQ+ older adults. On the contrary, despite relentless advocacy by groups like SAGE, as discussed above there has been backsliding in several states and failures by other states to adopt equitable policies. In the face of this experience, it is reasonable for ACL to proceed with issuing binding requirements.

Further, an explicit federal requirement will promote consistent implementation of the policy over time. This consistency will both improve the quality of the services (as equitable services become the norm and providers' cultural competency improves and is established), create useful data sets showing changes over time, and develop a sense of security among older LGBTQ+ adults and those living with HIV/AIDS that services will be provided in an inclusive manner, which in turn will promote uptake of those services.

C. It will be feasible for SUAs and AAAs to implement these requested greatest social need designations.

Designating a group of older adults as having greatest social need imposes certain requirements on SUAs and AAAs. Their plans must evaluate the services needed by and effectiveness of services provided to those groups.[52] And they must target outreach to designated groups.[53] Based on our experience, it will be feasible to implement these requirements for LGBTQ+ older adults and for older adults living with HIV/AIDS. ACL should proceed with confidence that SUAs and AAAs will be able to implement such requirements successfully.

Our experience working with SUAs and AAAs shows that for the most part staff and service providers have empathy for older adults suffering from social and cultural isolation and desire to serve them effectively. But lack of education about needs and cultural competency are barriers to doing so. These issues are surmountable with motivation—which a new federal requirement will help provide—education, technical assistance, and training. In this regard, SAGE, SAGECare, and the associated National Resource Center on LGBTQ+ Aging (NRC) are well situated to support SUAs and AAAs in complying with the requirements of a new greatest social needs designation. We provide training, technical assistance, and education resources

[52] 42 U.S.C. § 3026(a)(1); *Id.* § 3027(a)(4).

[53] 42 U.S.C. §3026(a)(4); *Id*. § 3027(a)(16)(A)(iii).

focused on improving the quality of services and supports offered to LGBTQ+ older adults, older adults living with HIV/AIDS, their families and caregivers.[54]

Further, several states have successfully implemented state plans focusing on the needs of LGBTQ+ older adults and older adults living with HIV/AIDS. For example, since 2019, Pennsylvania has taken significant steps to better serve older LGBTQ+ adults in its OAA-funded programs, including through data collection, cultural competency training, specific objectives targeting LGBTQ+ older adults in its current state plan, and a state designation that this population has greatest social need.[55] Pennsylvania has 52 AAAs, more than any state except New York, which serve diverse communities from urban to very rural. As a representative of the State Department of Aging shared with us, the Department received very little resistance from the AAAs in implementing the greatest social need designation for older LGBTQ+ adults. The Department has found that sharing information about the social isolation that LGBTQ+ older adults are likely to experience is eye-opening and motivating to AAAs and service providers, most of whom chose their work to be of service to people in need. The only hesitation of which the Department is aware came from a lack of experience, not hostility. For example, at least one AAA representative asked for additional resources to better understand how to conduct the data collection appropriately, noting that that AAA served a predominantly rural area where comfort discussing LGBTQ+ identity publicly was low. The Department was able to support that AAA (and others) with resources on cultural competency (examples of which we discuss in more detail below), which helped assuage this discomfort. We understand that Maine has been similarly successful in implementing its most recent, inclusive, state plan without resistance from AAAs.

We have heard from people working in more traditionally conservative states that state political actors may resist efforts towards data collection and outreach to older LGBTQ+ adults by aging network staff, but that an explicit federal requirement could give those staff a sound basis to develop these equitable policies. For example, when the NRC offered cultural competency training to AAAs and service providers in Georgia, trainings sold out. The appetite for receiving them was tremendous. They are not required, however, and have not been consistently available. Consistent federal requirements are necessary to develop successful and lasting programs in the face of changes in state politics and in limited staff time, focus, and other priorities. We have also heard that it is possible to develop equitable policies with consistent

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[54] NRC receives financial assistance from ACL to do this work. The NRC publishes LGBT aging best practice guides, which have been downloaded more than 120,000 times. From 2015-2020, it helped with nearly 800 requests for technical assistance. Along with SAGECare, another SAGE project, the NRC trained more than 650 ACL-funded organizations on culturally competent services. *See* NRC, *Celebrating Ten Years of Knowledge* (2020), *available at* https://www.lgbtagingcenter.org/resources/pdfs/SAGE%20NRC%20Top%20Ten%20Final.pdf. Many of SAGECare's trainings, which include trainings on HIV, are available online and on demand. *See* SAGECare, *Staff Development/Training*, https://sageusa.care/our-services/coaching-training/ (last visited June 6, 2022).

[55] Pa. Dep't of Aging, *State Plan on Aging 2020-2024* at 24, 28, 29-31, 40, https://02f0a56ef46d93f03c90-22ac5f107621879d5667e0d7ed595bdb.ssl.cf2.rackcdn.com/sites/26793/uploads/41772/2020_%E2%80%93_2024_State_Plan_On_Aging20201026-23796-13d6fgz.pdf.

work over time that includes representatives from impacted and underserved communities, especially at the advisory council and AAA level.

While concerns about the abilities of SUAs and AAAs to conduct effective data collection on the needs of LGBTQ+ older adults have been raised in the past, recent advances in sexual orientation and gender identity (SOGI) data collection research and techniques have put those concerns to rest.[56] For example, the Census Bureau's Household Pulse Survey has been successfully asking respondents about their sexual orientation and gender identity for almost a year.[57] SAGE and NRC also provide training and technical assistance focused on data collection.[58] We are prepared to continue, and expand, these efforts to help the State agencies and AAAs assess and address the needs of LGBT older adults to minimize any burden caused by the data collection requirements and make the most effective use of the information collected.

In our conversations with people familiar with state plan implementation of SOGI data collection requirements, they universally said that doing so was not complicated. It was feasible to add the relevant questions to the demographic section of existing data collection efforts. Several states relied on information provided by SAGE's National Resource Center on LGBTQ+ Aging (NRC) guidance on inclusive data collection.[59] Among these, Missouri's recent state plan

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[56] Among the scholarly research, earlier this year, an ad hoc panel of the National Academies of Sciences, Engineering, and Medicine issued a groundbreaking consensus report focused on advancing data collection on SOGI and sex, including variations in sex characteristics. The report synthesizes existing research; offers guiding principles for including lesbian, gay, bisexual, transgender, and intersex (LGBTQI+) people in data collection efforts; provides detailed recommendations for how to ask questions on sex, sexual orientation, and gender identity; and highlights areas for future research. The report emphasizes that expanding, improving, and standardizing data collection is crucial to better understand and address challenges that LGBTQI+ communities face across key areas of life. Nancy Bates et al., Nat'l Acads. of Sciences, *Measuring Sex, Gender Identity, and Sexual Orientation* (2022), *available at* https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation.

[57] Thom File & Jason-Harold Lee, *Household Pulse Survey Updates Sex Question, Now Asks About Sexual Orientation and Gender Identity*, U.S. Census (Aug. 5, 2021), https://www.census.gov/library/stories/2021/08/household-pulse-survey-updates-sex-question-now-asks-sexual-orientation-and-gender-identity.html.

[58] These include the live training, "Asking Demographic Questions about Sexual Orientation and Gender Identity" and free materials such as "Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity." NRC, *Inclusive Questions for Older Adults:A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity* (2016), *available at* https://lgbtagingcenter.org/resources/resource.cfm?r=601.

[59] SAGE, *How to Collect Data on Sexual Orientation & Gender Identity*, SAGE Blog (Apr. 15, 2015), https://www.sageusa.org/how-to-collect-data-on-sexual-orientation-gender-identity/.

[59] Press Release, White House, Fact Sheet: Biden-Harris Administration Releases Recommendations for Advancing Use of Equitable Data (Apr. 22, 2022),

survey now includes SOGI questions in its demographic section. Fully ten percent of respondents identified as LGBTQ+, strongly suggesting that respondents are not widely reluctant to reveal this information. For Maine, respondents were more likely to answer the SOGI questions than those about income. Pennsylvania successfully relied on HealthIT.gov's recommendations for SOGI data collection. Accordingly, ACL should not hesitate to require SUA and AAA data collection be equitable—a priority of this Administration[60]—and include SOGI and HIV/AIDS status. ACL should also consider providing recommended question language to SUAs and AAAs to maximize the likelihood of effective implementation. And ACL should require regular cultural competency training related to data collection to ensure AAA staff are comfortable with asking questions regarding sexual orientation and gender identity.

So far, the decennial Census does not capture sexual orientation or gender identity information. ACL should, accordingly, provide guidance to SUAs and AAAs about how to use this demographic information when underlying census data is not available, including by permitting flexible use of funding formulas to ensure that LGBTQ+ older adults receive an appropriate level of OAA funding, despite their omission from the Census.

D. ACL should take certain steps to promote effective implementation.

Based on our experience and the information we have gathered, there are other specific actions that ACL can take to promote effective implementation of the requested inclusion of specifically identified underserved communities, including older LGBTQ+ adults and those living with HIV/AIDS in a new greatest social needs definition.

First, 45 C.F.R. Part 1321 should consistently incorporate the new definition of greatest social need and require SUAs and AAAs to be accountable for outreach to and data collection for the various populations identified. For example, in 45 C.F.R. § 1321.17's description of how state plans should address greatest social need, it should require the plans to describe specifically the communities of greatest social need they are serving (including LGBTQ+ older adults and older adults living with HIV/AIDS) and how outreach efforts will reach those identified communities. The same should be true for all references to needs assessments by SUAs and AAAs in Part 1321: state plans should be required to explain how they will assess the needs of specific populations with greatest social need and how those needs are being met.

Without this specific requirement, SUAs will not be accountable to the unique needs of LGBTQ+ older adults and those living with HIV/AIDS, as opposed to planning for underserved populations generally. It has also been our experience that reluctant states will be more likely to comply fully if the requirements are detailed and explicit in all relevant circumstances. The experience of the incomplete implementation of the 2020 OAA reauthorization requirement also supports this conclusion.

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https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/22/fact-sheet-biden-harris-administration-releases-recommendations-for-advancing-use-of-equitable-data/.

[60] https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/22/fact-sheet-biden-harris-administration-releases-recommendations-for-advancing-use-of-equitable-data/

Next, ACL should require state plan assurances to discuss the state plan's efforts as to the populations of greatest social need specifically designated in the new regulation. ACL currently requires information about greatest social need generally, asking states to "[d]escribe the mechanism(s) for assuring that preference will be given to providing services to older individuals with … greatest social need … and include proposed methods of carrying out the preference in the State plan."[61] ACL should make these assurances more specific, requiring detailed information as to the underserved communities included in the new regulation (including LGBTQ+ older adults and older adults living with HIV/AIDS), the same way it currently does for older individuals residing in rural areas and other specifically identified groups.[62] ACL should, of course, carefully review those assurances provided by states for their plans as to LGBTQ+ older adults and those living with HIV/AIDS, and require revisions when the assurances are inadequate.

ACL should also revise its regulations on AAA advisory councils at 45 C.F.R. § 1321.57 to require more inclusive membership. The regulations currently require that the composition of the council be made up of "[m]ore than 50 percent older persons, including minority individuals who are participants or who are eligible to participate in programs under this part.[]"[63] They should be amended to require that these older person representatives also include members of the populations of greatest social need specifically designated in the new regulation. ACL should also amend the later reference to "[r]epresentatives of older persons" to include members of organizations advocating for the needs of the populations of greatest social need specifically designated in the new regulation.[64] In our experience, effective implementation of equity requirements requires consistent involvement of people with lived experienced and their advocates at all levels, including local implementation. This proposed modification will promote that participation.

II. ACL Should Promulgate Requirements for Non-Discrimination Protections & Cultural Competency Training (45 C.F.R. part 1321).

To further ensure that underserved populations have access to effective services, ACL should promulgate requirements that state plans include nondiscrimination protections and plans for cultural competency training. Specifically, state plans should be required to prohibit discrimination in OAA grant programs based on age, disability, sex, race, color, national origin, religion, sexual orientation, gender identity, and any other characteristic that defines a population of greatest social need.[65] Likewise, state plans should be required to include a training program designed to ensure that all services are provided to and data collection related to populations of

[61] Memo. from Alison Barkoff, *supra* n. 10, at 34.

[62] *Id*. at 35.

[63] 45 C.F.R. § 1321.57(b)(1).

[64] *Id.* § 1321.57(b)(2).

[65] By prohibiting discrimination on the basis of "any characteristic that defines a population of greatest social need," the nondiscrimination provisions would protect older people living with HIV/AIDS, as well as any population that is designated as having greatest social need in the future.

greatest social need are provided or conducted in a manner that is culturally competent and nondiscriminatory.

A. OAA regulations do not provide broad non-discrimination protections.

As explained above and in previous comments submitted by SAGE, LGBTQ+ older adults—and those living with HIV/AIDS—are highly vulnerable to systemic discrimination. Due to a lifetime of discrimination and unique challenges, these populations are more likely to experience poorer physical or mental health outcomes, to live in poverty, and to suffer from discrimination than their peers.[66] As a result, older adults who identify as LGBTQ+ and/or live with HIV/AIDS are particularly likely to rely on social services, including those provided through OAA grant programs. Because LGBTQ+ older adults are already vulnerable and continue to face discrimination as they age, it is vital that OAA services be provided in a non-discriminatory manner.

While the OAA's implementing regulations currently incorporate some nondiscrimination protections, those provisions protect only against discrimination on the basis of race, disability, and age.[67] The regulations are therefore silent regarding discrimination on the basis of religion, sexual orientation, and gender identity, leaving certain populations vulnerable to discriminatory treatment.

B. ACL has authority to promulgate state plan requirements for non-discrimination protections and cultural competency training.

As noted above, ACL has broad authority to promulgate criteria for state plans, which must be approved by the agency before states are eligible for grants under the OAA.[68] Under this authority, ACL can promulgate requirements—to be codified at 45 C.F.R. § 1321.17—necessitating that plans include comprehensive nondiscrimination protections and cultural competency training. Imposing these criteria on state plans is consistent with the statute's broader purposes of ensuring that older adults are able to "retir[e] in health, honor, and dignity."[69]

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[66] SAGE & Movement Advancement Project, *Understanding Issues Facing LGBT Older Adults* at 6, 10, 15 (2017), https://www.lgbtmap.org/policy-and-issue-analysis/understanding-issues-facing-lgbt-older-adults.

[67] 45 C.F.R. § 1321.5(c), (e), (f).

[68] *Supra* page 9-10; *see also* 42 U.S.C. § 3027(a) ("Except as provided in the succeeding sentence and section 3029(a) of this title, each State, in order to be eligible for grants from its allotment under this subchapter for any fiscal year, shall submit to the Assistant Secretary a State plan for a two-, three-, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe.").

[69] 42 U.S.C. § 3001(6).

With respect to nondiscrimination protections, we urge ACL to require state plans to provide a general assurance that the SUA will prohibit discrimination in OAA grant programs based on age, disability, sex, race, color, national origin, religion, sexual orientation, gender identity, and any characteristic that defines a population of greatest social need—or more broadly if ACL deems doing so appropriate. The regulations should require state plans to provide assurances that discriminatory practices prohibited under this general language will include, but need not be limited to, the denial of services based on a protected characteristic of the individual and harassment or creation of a hostile environment, including the knowing refusal to use an individual's preferred name or pronouns after being clearly informed of the individual's preferences.

Finally, any forthcoming rulemaking should require state plans to further specify: (1) that the SUA will include provisions prohibiting such discrimination in any cooperating grant agreements it enters into directly with AAAs or other subgrantees; (2) that the SUA will require AAAs to include the same provisions in contracts they enter with other subgrantees; (3) the means by which the SUA will ensure that subgrantees comply with those provisions; and (4) the means by which SUAs, AAAs, and subgrantees will ensure that older people are made aware of their rights and any process by which they can submit a complaint about discriminatory services.

As for cultural competency training, ACL should require state plans to provide assurances that the state will develop a program that requires all service providers—including the SUA, AAAs, and any subgrantees—to undergo appropriate and ongoing training to provide services and collect data in a culturally competent and nondiscriminatory manner. As part of this requirement, the state plan should provide assurances that the training program will be require training at reasonable intervals (e.g., once every two years). State plans should also describe how the training program will address sensitive cultural issues relating to all populations of greatest social need. Further, ACL should require state plans to describe how they will ensure that AAAs and other subgrantees will comply with the training program requirements.

ACL should also consider requiring that the information and referral programs offered by AAAs (which rely on standards from the Alliance of Information and Referral Systems) must include cultural competency training. It should do the same for the ACL-funded eldercare locator. Any such training programs should also be required at reasonable intervals (e.g., once every two years). And along with any new regulation, ACL should provide SUAs, AAAs, and service providers with best practices for how to target hard to serve communities.

C. Implementation of these requirements is feasible.

Implementing the requested requirements should be feasible for SUAs. In fact, adding broad nondiscrimination protections to their contracts with subgrantees should be relatively straightforward. SAGE understands that most SUAs already have some (albeit limited) nondiscrimination protections in place.

For example, Georgia's Department of Health and Human Services includes language in its contracts requiring AAAs to provide services in compliance with federal and state laws about discrimination. Georgia's contracts also state that if the AAAs engage a subcontractor, the

subcontractor is also bound by the relevant nondiscrimination laws and regulations. Similarly, Pennsylvania includes the following provision in its three-year contracts with AAAs:

> Neither the Contractor nor any subcontractor nor any person on their behalf shall in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the [Pennsylvania Human Relations Act] and applicable federal laws, in the provision of services under the contract.

Likewise, the State of Maine includes nondiscrimination language in its contracts that is like that used by Pennsylvania.

These examples demonstrate a mechanism by which states can provide some protections. Implementing the suggested nondiscrimination protections would therefore be relatively simple. For those states with existing nondiscrimination protections, they need only update their provisions to include any additional protections required by the regulation. Georgia, for example, would merely be required to update the general nondiscrimination language in its contracts to explicitly prohibit discrimination based on based on age, disability, sex, race, color, national origin, religion, sexual orientation, gender identity, and any characteristic that defines a population of greatest social need. In the unlikely event that a state's contracts lack nondiscrimination protections of any kind, that state could easily add language like that used by Pennsylvania and Maine.[70]

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[70] It is possible that states could encounter a refusal to comply—or a request for an exemption—from service providers who wish to discriminate, based on religious beliefs or for other reasons, against older adults who identify as LGBTQ+ or who live with HIV/AIDS. SAGE does not believe that this will undermine implementation, however, for two reasons.

First, such instances seem unlikely to occur in great numbers. To our knowledge, litigation stemming from refusals to provide services funded by government grants has occurred primarily in other contexts. We believe, and the experience of states with nondiscrimination protections for LGBTQ+ older people and those living with HIV/AIDS shows, that direct refusals to comply with explicit protections would be relatively uncommon in the context of OAA-funded services.

Second, to the extent providers do refuse to comply, the non-discrimination protections suggested here will pass constitutional muster so long as they are applied in a neutral and generally applicable way. *See Fulton v City of Philadelphia*, 141 S. Ct. 1868, 1876 (2021) ("laws incidentally burdening religion are ordinarily not subject to strict scrutiny under the Free Exercise Clause so long as they are neutral and generally applicable"). Doing so should be possible so long as the states do not provide "a mechanism for individualized exemptions," *id*. at 1877, and enforce the protections "neutral[ly] and respectful[ly]," rather than with "clear and impermissible hostility toward sincere religious beliefs," *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Comm'n*, 138 S. Ct. 1719, 1729 (2018). Likewise, states who enforce the nondiscrimination protections will be able to defend against Religious Freedom Restoration Act claims by asserting that they have a "compelling government interest" in ensuring that critical services are available in a nondiscriminatory manner and that prohibiting such discrimination is "the least restrictive means of furthering that . . . interest." 42 U.S.C. §§ 2000bb-1(a), (b).

The implementation of nondiscrimination protections would be enhanced by the requirements that SUAs and AAAs adopt a cultural competency training program. In our experience, such training helps service providers to better understand and empathize with LGBTQ older adults—as well as those who live with HIV/AIDS—who suffer from social and cultural isolation. This will in turn decrease the likelihood of discrimination and improve the effectiveness of OAA services.

Adopting such a training program is also feasible. In fact, multiple states have already done so. As noted above, Pennsylvania successfully launched cultural competency training in 2018 for its OAA-funded programs which was well-received by the AAAs in its state. Likewise, other jurisdictions—including California,[71] D.C.,[72] and Massachusetts[73]—have enacted laws that require LGBTQ cultural competency training at regular intervals for either aging services providers or licensed long-term care facilities. Further, as discussed above, based on our conversations with people familiar with the operation of SUAs in relatively conservative states, we believe that SUAs and AAAs will have an appetite for such training even in states with administrations that are politically resistant to such endeavors.

Moreover, states will not need to design their training programs from scratch. ACL can and should offer technical assistance to help SUAs get their programs off the ground. And, as we have noted multiple times, SAGE and the National Resource Center on LGBTQ+ Aging are available to support SUAs and AAAs in their training efforts. In fact, we provide the very training, technical assistance, and education resources needed to make a cultural competency training program successful.

III. ACL Should Add Protections to The Regulations Implementing Title VII's State Long-Term Care Ombudsman Program (45 CFR part 1324).

ACL could improve equity and inclusiveness for all older Americans receiving long-term care services, including for older LGBTQ+ adults and those living with HIV/AIDS, with certain changes to its regulations regarding the state long-term care Ombudsman program (45 CFR part 1324).

While the Ombudsman's office currently is required to identify, investigate, and resolve complaints by or on behalf of long-term care residents,[74] the Ombudsman is not required to track whether these complaints relate to discrimination on any protected bases. ACL should revise the regulations to mandate such tracking, including requiring tracking for complaints related to LGBTQ+ identity or HIV/AIDS positive status. Doing so is necessary to assess the prevalence

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[71] Cal. Health & Safety Code § 1562.3 (West 2021); Cal. Health & Safety Code § 1569.616 (West 2021); Cal. Welfare & Institutions Code § 9719 (West 2014).

[72] D.C. Code Ann. § 7-503.09 (West 2020); D.C. Code Ann. §§ 2-1402.101-.105 (West 2020).

[73] Mass. Gen. Laws Ann. ch. 19A, § 43 (West 2018); 2018 Mass. Legis. Serv. ch. 154 (West).

[74] 42 U.S.C. § 3058g; 45 C.F.R. 1324.13.

and trends of discrimination in long-term care facilities, which in turn is necessary for meaningful remedial action.

Further, the training requirements for the Ombudsman's office[75] should be updated to require cultural competency training with respect to underserved communities, including with respect to LGBTQ+ older adults and older adults with HIV/AIDS. This training is necessary to ensure that representatives of the office can identify problems faced by these underserved communities and effectively remedy those problems. Among other topics, the training should include information about identifying and responding to mistreatment by other residents as well as by the staff of the facility.

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Thank you for considering our submission. If you have any questions or would like to discuss the information in this comment, please contact Robin Thurston or Kristen Miller, counsel for SAGE, at rthurston@democracyforward.org or kmiller@democracyforward.org.

Sincerely,

/s/ *Aaron Tax*

Aaron Tax
Managing Director of Government Affairs & Policy Advocacy
SAGE

[75] 45 C.F.R. § 1324.13(c)(2).