

## **Request for Information (RFI) on Access to Care and Coverage for People Enrolled in Medicaid and CHIP**

For submission via:

[https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV\\_6EYj9eLS9b74Npk](https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk)

**DUE MONDAY, APRIL 18**

*Obj 1(3): In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups?*

Individuals who are limited English proficient (LEP) make up a disproportionate share of the Medicaid population and are more likely than English proficient enrollees to experience barriers to Medicaid and CHIP enrollment and renewal. Approximately 8% of the US population is limited English proficient (LEP), meaning they speak little or no English. Among Asian Americans (AA), Native Hawaiians (NH), and Pacific Islanders (PI), about 1 in 3 are LEP, with percentages of LEP even higher in certain subgroup populations, such as Burmese and Chuukese. Having meaningful access to language services is critical to ensuring these populations understand their health care rights and are able to access and utilize health care services. Because of their dependency on language services to enroll and retain Medicaid and CHIP benefits, LEP persons experience the greatest risk of losing Medicaid coverage or experiencing a gap in coverage, even if they remain eligible for coverage.

**CMS should remind states that language access guidelines are minimum requirements and that states can always require additional and stronger language access protections, such as requiring taglines for all written materials for potential enrollees and enrollees that are not limited to vital documents.** Under Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act, state Medicaid agencies are required to provide meaningful access to people with LEP. This includes requiring covered entities to post notices of nondiscrimination and taglines that alert LEP individuals to the availability of language assistance services in at least the top 15 languages spoken by individuals with LEP within a service area for significant publications and communications. Taglines are designed to explain consumer rights and the availability of services to the widest possible audience and are especially important in the absence of written translated materials. The wider availability of taglines would better ensure that LEP enrollees are made aware of the availability of resources in their preferred language and/or language assistance services.

**CMS should also develop and disseminate clear messaging around Medicaid and CHIP eligibility and immigration status, including making this messaging available in the preferred language of LEP persons.** Many LEP persons are also immigrants who have faced barriers to enrollment and retention because of continuing fears of negative consequences on immigration status from accessing public benefits. Some of these fears stem from the 2019 public charge rule that expanded the list of public benefits that triggered inadmissibility on public charge grounds, including the use of Medicaid. In order to help dispel these misconceptions about accessing coverage and care, CMS should require states to develop clear messaging that obtaining covering through Medicaid and CHIP does not negatively impact the

ability to adjust immigration status and that this messaging should be made available in at least the top 15 languages spoken by LEP populations within the state.

To prevent untimely determinations due to delays in verifying immigration status, **CMS should also discourage states from reverifying immigration and identity status during the redetermination process, unless an applicant has stated a change in status.** The process of verifying may result in Medicaid/CHIP-eligible individuals from losing coverage because of mismatches from outdated federal data. For example, certain categories of immigrants, such as those under the Compacts of Free Association (COFA) who have resided in the U.S. for a long time, may require additional time beyond the response window to obtain copies of their I-94 because their I-94 documents were not entered into the Customs and Border Protection (CBP) online database.

*Obj 2(1): How should states monitor eligibility redeterminations and what is needed to improve the process? How could CMS partner with states to identify possible improvements?*

**CMS should foster stronger partnerships with vetted enrollment assistance entities, such as Navigators and certified assisters, to ensure that these entities are properly informed of Medicaid redetermination processes.** Navigators play a key role in helping LEP persons and underserved communities gain access to and maintain health coverage by helping them enroll in coverage through Marketplace, Medicare, Medicaid or CHIP. The Medicaid eligibility redetermination process often requires beneficiaries to respond to requests for information in English. We know that many limited English proficient (LEP) persons rely heavily on navigators and enrollment assisters to help them enroll as well as seek renewal for Medicaid and CHIP. For example, with consent from consumers, navigators can help beneficiaries provide support documentation needed to make eligibility determinations to state Medicaid agencies. In order to better ensure that beneficiaries receive assistance with enrollment and renewal through entities that are vetted and incentivized to provide accurate information to consumers, CMS should work with states to strengthen relations with Navigators and certified assisters.

**CMS should also encourage states to find ways to increase the rate of automatic (ex-parte) renewals so that redeterminations can be more streamlined, and loss or discontinuation of coverage can be minimized.** Medicaid regulations require state agencies to attempt to renew coverage *ex-parte* by reviewing available data sources. If the state agency is unable to verify eligibility information through this process, it requests that beneficiaries provide additional information. However, many eligible enrollees have lost Medicaid or CHIP coverage because they did not receive a renewal form or return it timely, or because the state agency did not process the documents. In order to minimize the risk of eligible enrollees losing coverage because of the untimeliness of the redetermination process, states should examine how the automatic renewals process can be improved to ensure that all redeterminations that can be renewed without contacting the beneficiary are done so. The need to improve the automatic renewal process is especially important as states prepare for the end of the public health emergency which will require them to initiate a full renewal for all individuals receiving coverage.

*Obj 2(2): How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage?*

As discussed previously, CMS should require states at minimum to communicate all notices regarding eligibility redeterminations in at least the top 15 languages spoken by LEP populations in each service area. This includes having taglines for such notices so that LEP persons are aware of the availability of resources in languages other than English. In addition, CMS should continue to work with trusted community partners, such as Navigators and assisters, to provide assistance with communicating with beneficiaries about how to prevent a gap in coverage or disenrollment.

**CMS should also encourage states to use as many modes of communication (email, text, phone) as possible to notify beneficiaries that they are at-risk of disenrollment and a gap or loss in coverage.** During the COVID-19 pandemic, many Americans experienced instability in housing and as a result, mail is not the best way to communicate with people. States have been employing different communication modes to reach beneficiaries. For example, in [Arkansas](#), a call center has been organized to reach beneficiaries by phone to help them update their mailing address and contact information. Text messaging has also become a widely used form of communication for many who are not reachable by phone or a physical address.

*Obj 3(5): What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP?*

**CMS should require states to establish minimum standards for serving communities in ways that address cultural competency and language preferences.** For example, CMS should require states to make widely available directories of providers who are able to provide services in-language as well as those who have received cultural competency training. The requirement for providers to have completed training on culturally appropriate care would better ensure that providers are vetted for their ability to provide culturally competent care. Making this information publicly and widely available would allow beneficiaries to choose providers who can address the language and cultural needs of communities.

In addition, **CMS should encourage states to employ strategies to recruit more providers that provide in-language and culturally competent services by incorporating incentives and expanding outreach to providers.** The shortage of culturally and linguistically competent Medicaid and CHIP providers is especially dire for some AA and NHPI communities. While there may be many reasons why providers are hesitant to enroll as Medicaid/CHIP providers, one financial incentive that states could employ to facilitate greater recruitment of diverse providers is to include language service costs in the regular reimbursement to Medicaid/CHIP providers. Other incentives include allowing greater flexibility in how culturally competent providers provide care, such as through telehealth as well as allowing licensure across state lines. CMS should also encourage states to expand outreach to potential providers by engaging more with medical schools and provider organizations to educate providers on Medicaid/CHIP.

*Obj 4(5): How can CMS best leverage T-MSIS data to monitor access broadly and to help assess potential inequities in access?*

**CMS should take steps to require states to standardize the Transformed Medicaid Statistical Information System (T-MSIS) data that is collected on enrollees, according to the 2011 HHS Data Collection Standards which disaggregate data specifically related to race, ethnicity, and language.** All state Medicaid agencies collect self-reported data on race, ethnicity and language and states can opt for more granular reporting as long as the categories reported can be rolled up to the Office of Management and Budget (OMB) standards. While the current T-MSIS race and ethnicity data elements allow for reporting race, ethnicity and language data to align with the 2011 HHS Data Collection Standards for Race, Ethnicity, Sex, Primary Language and Disability Status (which disaggregate certain AA and NHPI subgroups), most states' Medicaid applications collect race and ethnicity according to Office of Management and Budget (OMB) standards, meaning that this data is not collected at a granular level. For example, OMB standards for the Classification of Federal Data on Race and Ethnicity have categories for "Asian" and "Native Hawaiian and other Pacific Islander," but does not include disaggregated subgroup categories such as Vietnamese or Marshallese. Because of the inconsistency in the level of detail collected by states, it is not possible to analyze any potential correlations between Medicaid enrollment/disenrollment and demographic factors related to race, ethnicity, and language across states or at a national level. Thus, at minimum, CMS should require all states to collect race, ethnicity and language data according to the 2011 HHS Data Collection Standards so that there is both consistency and disaggregation in the data that is collected. The collection of disaggregated data on race, ethnicity, and language would allow CMS to more accurately identify and assess inequities experienced by specific underserved communities in accessing Medicaid and CHIP.

*Other Feedback: Any additional comments you have for the RFI that does not apply to one of the previous questions.*

**CMS should revise its October 2021 [guidance](#) to states on Compacts of Free Association (COFA) migrants' Medicaid eligibility for those who have adjusted to Lawful Permanent Resident (LPR) status.** According to current CMS guidance, if a COFA migrant applies for an adjustment of status to a LPR, the individual could be subject to the five-year waiting period for Medicaid benefits, depending on when the individual was granted the adjustment of status. This guidance is confusing and contradicts the intent of the December 2020 extension of Medicaid eligibility to COFA migrants which requires states to provide full Medicaid benefits to COFA migrants who are residing in one of the fifty states of the District of Columbia without a five-year waiting period. Under current guidance, COFA migrants receiving Medicaid benefits may be at risk of experiencing a disruption in coverage if they wish to apply for LPR status. To minimize the risk of COFA migrants losing or experiencing a gap in coverage, CMS should reconsider its interpretation of section 208 of Division CC of the Consolidated Appropriations Act 2021 and revise its guidance to ensure that eligible COFA migrants receiving Medicaid benefits continue to have coverage.