

September 27, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brooks-LaSure:

On behalf of UnidosUS, I write to thank you for the invitation to participate in the listening session on August 3, 2021 and to highlight several key issues worth further exploration. We are grateful for the Biden administration's commitment to advancing health equity and reducing health disparities for racial and ethnic minorities. We share these goals and would like to partner with the administration in this effort.

UnidosUS, previously known as NCLR (National Council of La Raza), is the nation's largest Hispanic civil rights and advocacy organization. Through its unique combination of expert research, advocacy, programs, and an Affiliate Network of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic, and political barriers at the national and local levels.

As you know, the COVID-19 pandemic and the disproportionate impact on racial and ethnic minorities have exposed historical inequities in the U.S. health care system, and long-standing barriers impact the ability of immigrants and Latinos to access medical care. For us to build back better as a nation we must, among other things, fully commit to closing racial and ethnic disparities in access to health coverage and care.

Prior to the pandemic, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) was declining,¹ especially for Latino children.² However, these trends have reversed largely due to protections created by Congress during the COVID-19 Public Health Emergency (PHE). The Centers for Medicare and Medicaid Services (CMS) should continue to build on the success of pandemic-era policies to maintain these coverage gains and to ensure that all eligible beneficiaries remain enrolled in Medicaid, including after the PHE ends.

Specifically, we recommend the following:

- CMS should take the necessary steps to ensure that people who are eligible for Medicaid and CHIP remain enrolled and to reduce churn.
- CMS should restore marketing, outreach, and enrollment funding and make focused investments to increase awareness of eligibility for programs and access to application assistance for Latinos.
- CMS should reduce barriers to health coverage for noncitizens and mixed-status families, including people granted Deferred Action for Childhood Arrivals (DACA).
- CMS should improve the quality of health coverage for Latinos, including those who are limited English proficient (LEP).

Introduction

Pandemic-era policies have protected health coverage, and the administration should maintain this progress.

As described above, prior to the pandemic, enrollment in Medicaid and CHIP was declining, and the percentage of people uninsured was rising. From December 2017 through December 2019, Medicaid enrollment declined overall by 3% (a decline of 2.2 million enrollees).³

Prior to this period, rates were better; in 2016, the overall number of uninsured nonelderly people in the U.S. had achieved a historic low of 10%. This welcome trend then reversed course, and the rate of uninsured increased steadily through 2019, when it hit 10.9%.⁴ Nonelderly Hispanics experienced the largest increase in the rate of uninsurance over this period and accounted for more than half of the 1.1 million of the total nonelderly uninsured between 2018 and 2019.⁵

Research shows that Medicaid enrollment declines prior to the pandemic were attributable to several factors, including:

- State Medicaid policies that made it harder for people to get enrolled and stay enrolled in coverage
- Severe cuts to marketing and outreach and enrollment assistance funding
- Noncitizens and their families avoiding government programs due to fear of deportation or immigration-related consequences⁶

Each of these factors disproportionately impacted low- and moderate-income Latinos, which in turn caused a greater increase in the uninsured rates for Latino children and families.⁷

Thanks to the Medicaid Maintenance of Effort (MOE) provision in the Families First Coronavirus Response Act (FFCRA), the decline in enrollment in Medicaid has reversed course, and beneficiaries have generally been able to maintain their health coverage throughout the pandemic. As a result, 10.4 million more people had coverage through Medicaid and CHIP in February 2021, compared to February 2020.⁸

Medicaid is currently working as it should, as a counter-cyclical effort to support families during an unprecedented national emergency. States must prepare for the possibility that the national emergency declaration ends before the need for Medicaid coverage subsidies. For this reason, we are grateful to CMS for the updated guidance regarding the end of the PHE sent in the State Health Officials letter on August 13, 2021. This guidance takes important steps to minimize the number of eligible beneficiaries who lose Medicaid coverage at the end of the PHE for procedural reasons or because the state has not requested up-to-date information on a family's circumstances.⁹

This letter identifies additional strategies that CMS should implement to meet the urgent health care needs created by the pandemic and to continue to protect health coverage for Latinos and build back better.

Strategy 1

Ensure that people who are eligible for Medicaid and CHIP remain enrolled in the program and reduce churn.

Strategy 1.1: Make renewals as automatic as possible.

CMS should enforce the statutory requirements in Medicaid for states to perform administrative renewals and use reliable third-party data. At the end of the PHE, states should greatly reduce the number of eligible beneficiaries who churn off the Medicaid program by improving their administrative renewal processes, including the use of available third-party data to renew Medicaid coverage instead of relying on information from beneficiaries.

As of January 2020, 21 states were unable to complete renewals without action from the clients more than half of the time,¹⁰ and the success rate for some of those states was significantly lower than 50%. For example, in Texas (a state in which half of the people receiving Medicaid are Latinos), fewer than 10% of Medicaid applications are processed without action from the client. In contrast, Arizona's Medicaid program—which also serves a large Latino population—is able to administratively renew 55% of all Medicaid applications.¹¹ Arizona's effective and efficient renewal process reduces the administrative burden on clients during renewal and creates operational efficiencies, allowing agency staff to focus more resources on processing new applications.¹²

During the pandemic, many beneficiaries experienced volatility in their life circumstances. Latinos were more likely than other groups to report that they or someone in their household moved during the pandemic¹³ and to report experiencing eviction or foreclosure.¹⁴ Furthermore, in a survey conducted by the Commonwealth Fund, 31% of Latinos reported that they or their spouse were laid off or furloughed during the pandemic.¹⁵

Improvements to state processes for renewals can help mitigate the impact that this volatility will have on churn in the Medicaid program at the end of the PHE. These improvements will also benefit Medicaid clients during future renewals, reducing churn in the program over the longer term.

Specifically, CMS should:

- **Enforce the Affordable Care Act (ACA) statutory requirement** that states first attempt to renew Medicaid coverage using available third-party data before requesting updated information from the client.
- **Require the use of third-party data** (e.g., quarterly wage data, Supplemental Nutrition Assistance Program (SNAP) data, and IRS income tax data) unless the state can explicitly demonstrate that the cost of accessing the data exceeds its expected benefits.
- **Prevent states from creating arbitrary rules** that limit the use of reliable electronic data sources (for example, arbitrary limits on the age of useable data).
- **Issue guidance and provide technical assistance** on best practices and reliable data sources in keeping mailing addresses up-to-date, and require states to use the United States Post Office change-of-address records to better locate beneficiaries.

Strategy 1.2: Ensure that mid-year income checks by states do not increase churn.

The Trump administration issued a letter on June 20, 2019, touting periodic data matching as a best practice to “enhance program integrity” by identifying “beneficiaries who may have had a change in circumstance that affects their eligibility.”¹⁶

Yet, even prior to the pandemic, periodic data matching, or the practice of using third-party data to attempt to identify changes in a beneficiary's income, likely contributed to the decrease in child enrollment in Medicaid and CHIP.¹⁷ A 2021 report from the Assistant Secretary for Planning and Evaluation (ASPE) noted that 30 states use periodic data matching between regular renewals. The report raised concerns that periodic data matching can increase churn in Medicaid, especially if the time frame for recipients to respond to a request for information is too short.¹⁸ Further, periodic data matching can disproportionately impact Latino households because they experience more income volatility compared to White households.¹⁹

For example, data from the Texas Medicaid agency show that on average each month in 2019, nearly 8,400 families were asked to provide additional income verification because they "failed" an automated income check. Of those:

- Thirty percent (2,515) responded with income verification that proved their income was still below the income limit. Thus, the periodic data matches were inaccurate *at least* 30% of the time.
- Sixty-five percent (5,446) were automatically denied Medicaid because they failed to provide income verification. However, the agency never confirmed that the children in these families were ineligible; instead, the clients were denied coverage because they did not respond to a request for income verification within 10 days of the date that the system created the notice.
- Only five percent (432) returned income verification that confirmed they were ineligible for Medicaid (the majority of these children were eligible for CHIP).²⁰

As a result of these income checks, more than 65,000 Texan children lost Medicaid coverage in 2019 for a procedural reason, not because they were ineligible. While recent Texas legislation has directed the agency to reduce the number of income checks performed and to provide more time for clients to return information,²¹ the agency will continue to perform income checks mid-year and has made no changes to improve the accuracy of the automated process.

To reduce the impact that such practices have on the Medicaid program, CMS should:

- **Clarify the circumstances under which periodic data matching can be used** and require Medicaid agencies to prove that their automated systems are accurate in identifying changes in income that make a person ineligible.
- **Require states to provide at least 30 days for a request for missing information** and enforce this requirement. Currently states must provide 30 days to respond to a request for renewal; however, many states do not adhere to this rule.²² For requests made outside of the annual renewal process, CMS published guidance in December 2020 which states that "[i]f additional information is needed, it may be reasonable for states to allow beneficiaries 30 days to respond and provide any necessary information."²³ This was reiterated in the August 13, 2021 State Health Officials letter.²⁴ However, we urge the administration to strengthen this guidance by making it a requirement in regulation.

Strategy 1.3: Improve transitions to the Marketplace for those who are no longer eligible for coverage.

Ending the Public Health Emergency will trigger drastic drops in Medicaid enrollment and related increases in the number of uninsured, because many currently enrolled adults will ultimately fall into the coverage gap created by states that did not expand Medicaid. Recent analysis shows that Medicaid enrollment growth during the pandemic has been fastest for nonelderly, nondisabled adults in nearly all

states. The eligibility groups with the most growth have been non-expansion adults (parents and pregnant women), followed closely by expansion adults. Certain non-expansion states (Florida, Missouri, North Carolina, and Texas) experienced enrollment growth of more than 50% among adults.²⁵

To mitigate this risk, CMS should take all the steps necessary to ensure that eligible beneficiaries remain enrolled in the program, as described above. In addition, it is important to ensure that those who are no longer eligible are successfully transferred to other programs for which they are eligible.

In many states, the “no wrong door” vision created by the ACA has not been fulfilled. Fragmented eligibility systems are preventing otherwise eligible individuals from enrolling in coverage. The ACA requires states to provide a single, streamlined application and access to Eligibility for Insurance Affordability Programs, regardless of whether a family applies with the state Medicaid or CHIP agency or through the Marketplace.

Yet, inappropriate levels of regulatory flexibility are allowing for the continued fragmentation of eligibility systems. Consumers and enrollment assisters report that clients must complete multiple applications and documentation procedures when they are transferred between the state Medicaid agency and the Marketplace, or vice versa.

For example, in the 28 states with a Federally-facilitated Marketplace (FFM),²⁶ when a person’s Medicaid coverage has ended their account is transferred to HealthCare.gov, which then provides them with a notice letting them know that the state Medicaid agency has indicated to the Marketplace that they may be eligible for an Advance Premium Tax Credit (APTC). However, this notice provides little direction to consumers on how they can enroll in Marketplace coverage. If the consumer does visit HealthCare.gov to apply, they often must start the application process from the beginning.

At the end of the PHE there will be large numbers of people who will lose Medicaid eligibility, especially in non-expansion states, and many will be eligible for Marketplace coverage. CMS should work with states and stakeholders to improve “no wrong door” processes to increase the successful transition of people from Medicaid to ACA Marketplace coverage.

Strategy 2

Restore marketing, outreach, and enrollment funding, and make focused investments to increase awareness of eligibility for programs and access to application assistance for Latinos.

A lack of awareness of affordable coverage options has historically been one of the largest barriers to decreasing the number of uninsured individuals, and this lack of awareness is often higher among Latinos.²⁷ Yet the need is acute; in an unpublished survey conducted in Texas and Florida in July 2021 by UnidosUS, about a quarter of Latinos (24% in Texas and 26% in Florida) listed “expensive health insurance premiums” as the challenge that is most difficult for their family when it comes to health care issues.

The same survey showed that more than half of Latinos surveyed in Texas (55%), as well as half in Florida (50%), were unaware that the American Rescue Plan Act (ARPA) contained provisions making coverage more affordable on the Marketplace. The law represents the greatest expansion of affordable

health coverage since the passage of the ACA, yet many Latinos are still unaware of this important development.²⁸

Strategy 2.1: Invest in culturally competent and linguistically appropriate outreach.

For their primary source of news or recent information, our survey also showed that Latinos in both Florida and Texas predominantly look to television, and secondarily to online sources (not including social media). Notably, more than 70% of Latinos surveyed prefer to receive information in English, while between 20% and 25% prefer Spanish.²⁹

To increase the effectiveness of outreach to Latino families, CMS should:

- **Invest in culturally competent and linguistically appropriate outreach for Latino communities,** specifically on TV and online news sources—Latinos’ primary sources for news. In its own evaluation of the state’s marketing and outreach efforts, Covered California found that in addition to spending more time online than non-Hispanics, Latinos “pay more attention to ads created specifically for Latinos or ads created for the general population that include Latinos.”³⁰
- **Allocate 30% of marketing dollars to Latino-focused outreach.** Latinos make up nearly 30% of the overall remaining uninsured, have the second-highest uninsured rate among racial or ethnic groups, and have an outsized capacity to benefit from these new ARPA changes. For this reason, 30% of new funding should be used for targeted investment in outreach and education to the Latino community.

Strategy 2.2: Invest in targeted outreach and enrollment assistance for Latinos.

Navigators and other enrollment assisters are an essential component of efforts to increase the number of Americans with health insurance. Research shows that more than one in four consumers sought help when attempting to enroll or re-enroll in ACA or Medicaid coverage in 2020.³¹

Further, Latinos are significantly more likely than other groups to seek out and use enrollment assistance.³² Enrollment assisters help demystify the complexity of applying for and using health insurance, especially for those with potentially complex situations such as immigrants and mixed-status families, as well as individuals who have limited English proficiency. Enrollment assisters also help reduce health disparities by improving health literacy for underserved communities, including Latino communities.³³

Simply put, in-person, culturally competent enrollment assistance from a trusted community organization is essential to achieving robust Latino enrollment in Marketplace, Medicaid, and CHIP coverage. In-person assistance is also especially critical in rural and underserved communities in which many people do not have reliable access to a computer or telephone.

Specifically, CMS should:

- **Reinstate the requirement that each Exchange include at least two Navigator entities** and that at least one of them is a community and consumer-focused nonprofit group.
- **Reinstate the requirement that Navigators receiving grants maintain a physical presence in the Exchange service area** to provide in-person outreach and enrollment support.³⁴ This is consistent with CMS’s own analysis that “[e]ntities with a physical presence and strong relationships in the Federally-Facilitated Exchange (FFE) service areas tend to deliver the most effective outreach and

enrollment results.” If needed, CMS could allow specialized groups to provide targeted assistance to vulnerable populations under special circumstances across state lines, as long as the agency determines that it does not undermine access to community-based, in-person assistance.

- **Target funding to Latino-serving community-based organizations.** As future funding is made available for health coverage enrollment assistance—such as grants to Navigators and the Connecting Kids to Coverage grants—CMS should include targeted support for Latino-serving organizations. Targeted funds should support organizations who can act as trusted messengers, such as community health workers or *promotores de salud*, available to assist with outreach and education to communities who remain uninsured and who may be unaware about their eligibility for affordable health coverage under the ACA.

Strategy 3

Reduce barriers to health coverage for noncitizens and mixed-status families.

Beginning as early as January 2017, media started reporting the possibility of the Trump administration making changes to the public charge test used during the green card application process. Ultimately, the Trump administration passed a final rule making drastic changes to the definition of public charge. Among low-income immigrant households with children, one in three reported avoiding a public benefits program in 2019 for fear of risking future green card status.³⁵

This rule was vacated by the courts in March 2021. However, it could take years to reassure mixed-status households that the use of public programs such as Medicaid, CHIP, and ACA Marketplace subsidies does not jeopardize their immigration status.

While 95% of Latino children are U.S. citizens, about half live in a household with at least one noncitizen parent.³⁶ Therefore, it is vital that those in mixed-status households receive information in a way that reflects their unique experiences to ensure that all who are eligible for assistance programs are aware of, and can access, the support they need.

Strategy 3.1: Continue to invest in outreach on public charge.

The reversal of the public charge rule requires investments in culturally competent and linguistically appropriate outreach, education, and enrollment programs that reach all eligible children and families who have avoided public benefits due to fear imposed by the public charge rule.

UnidosUS is grateful to CMS for the recent Informational Bulletin regarding public education on public charge. However, CMS must continue to focus time and resources on outreach and education regarding public charge to counteract the chilling effect described above and to restore trust from immigrant communities.

Specifically, CMS should:

- **Provide states with a resource tool kit which includes:**
 - **Consumer-facing materials translated in multiple languages** which dispel misinformation about the use of Medicaid, CHIP, or the ACA and immigration-related consequences. Whenever possible, these materials should include official logos from CMS or the U.S. Citizenship and

- Immigration Services (USCIS). According to reports from stakeholders on the ground, materials with official branding are most helpful in convincing families that the information is reliable.
- **Training for state staff and stakeholders** about the changes to the public charge rule
 - **Model language regarding clarifications of the public charge rule** for use in paper and online applications
 - **Require states to create an implementation plan** that outlines how they plan to use the tool kit to educate state staff, beneficiaries, and the public about the public charge rule.
 - **Make the public charge outreach tool kit available to community-based organizations and other stakeholders**, and CMS regional staff should be available to support community members with public education efforts aimed at addressing the chilling effect created by the public charge rule.

Strategy 3.2: Address long-standing barriers to public benefits for mixed-status families.

In addition, the administration should address long-standing barriers to public benefits for mixed-status families. Specifically, CMS should ensure that programs do not continue to request Social Security Numbers (SSNs) or immigration status for non-applicants.³⁷

The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture have sent clear guidance to state agencies that immigration status should not be requested for non-applicants and that SSNs may be requested, but that this information must be clearly labeled as optional.³⁸ However, several analyses of state application processes continue to find that this guidance is not always followed.³⁹

CMS should do a thorough review of all public benefit applications, including online applications, and seek corrective action when states inappropriately request information from a non-applicant.

Strategy 3.3: Address DACA eligibility and Special Immigrant Juvenile Status (SIJS), and clarify that people with either status are “lawfully present” for ACA coverage purposes.

While an estimated 89% of people with DACA were employed in 2019, only about half had health insurance—substantially lower than the total rate of insurance among all U.S. adults (89%).⁴⁰ Without insurance, many people with DACA are unable to access affordable and timely health care and often delay care for fear of the financial cost and the impact of medical debt on their immigration status prospects.⁴¹

We are all safer when everyone has access to health care—including coverage for COVID-19 testing, treatment, and vaccinations. Unless CMS acts as soon as possible to address the arbitrary exclusion of DACA recipients, these young workers will continue to face health risks resulting from the pandemic, many without the protection of health insurance coverage.

In the same action, we also urge the agency to clarify that individuals granted SIJS, in addition to those applying for that status, are “lawfully present” for the purposes of ACA coverage, given that SIJS recipients are facing green card backlogs that were not considered when the original regulation was drafted.

Specifically, CMS should:

- **End the exclusion of DACA recipients** from the definition of “lawfully present” for the purposes of eligibility for Marketplace coverage.
- **Clarify that individuals granted Special Immigrant Juvenile Status**, as well as those applying for that status, are “lawfully present” for the purposes of ACA coverage.

For more detail on access to health care for people granted DACA, please see our recent brief: [Supporting People with DACA and Boosting Our Economic Recovery by Extending Access to Affordable Health Care](#).

Strategy 4

Improve the quality of health coverage for Latinos, including those who are LEP.

The health crisis resulting from the pandemic has made it clear that everyone must be able to access key information in a language one understand, including the 25 million individuals in the U.S. who are limited English proficient—more than 60% of whom speak Spanish.⁴²

Civil rights protections can also play a vital role in coverage for LEP Latinos. Since 1964, Title VI of the Civil Rights Act has guaranteed that no one may be discriminated against in federal programs, such as Medicaid or CHIP, based on their race, color, or national origin.⁴³ After implementation of Section 1557 of the ACA and additional civil rights protections for LEP individuals, the uninsured rate of LEPs decreased from 50% to 34.6%.⁴⁴

The Trump administration weakened these protections—including during a pandemic—by revoking these language protections, including those that required notice and requirements to assist people in learning about their rights and key information. We appreciate that HHS has indicated that it will issue a new notice of proposed rulemaking to reverse many of the changes made to Section 1557 by the Trump administration.⁴⁵

In the interim, CMS can build on the Office of Minority Health’s National Culturally and Linguistically Appropriate Services (CLAS) Standards, which provide a blueprint for health care organizations, including health plans, doctor’s offices, hospitals, and states to advance health equity, improve quality, and eliminate health disparities for LEP individuals.

Specifically, CMS should:

- **Require payers and providers to demonstrate how they are implementing CLAS standards** and report publicly on their CLAS implementation score.

The long-standing systemic barriers that LEP Latinos face in the health care system were more clearly exposed since the onset of the pandemic. CMS must take bold steps to reinforce civil rights provisions that have proven successful in the past, and to ensure that all Latinos have access to the information they need to make important health care decisions.

The indicators are troubling. A recent study showed that the gaps in health care spending, when comparing Latino adults who are LEP with non-Latino adults who are English-proficient, widened between 1999 and 2018, raising concerns that language barriers may be preventing access to care and result in underuse of medical services by LEP adults.⁴⁶ In addition, according to the Kaiser Family

Foundation, about one in four Spanish-speaking Latino adults had trouble accessing information about COVID-19 vaccines or being unable to communicate in their own language when signing up or getting vaccinated.⁴⁷

Conclusion

Racial equity in access to health care must be a top priority in plans to build back better.

The COVID-19 pandemic and the disproportionate impact on racial and ethnic minorities have exposed historical inequities in the U.S. health care system. For us to build back better as a nation we must fully commit to closing racial and ethnic disparities in access to health coverage and care. We are grateful for the opportunity to work in partnership with CMS on these issues to ensure that the needs of Latinos are addressed in efforts to increase health equity.

Should you have any questions or need any further information, please contact Melissa McChesney, Health Policy Advisor, at mmcchesney@unidosus.org.

Sincerely,



Eric Rodriguez
Senior Vice President, UnidosUS

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