The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

November 16, 2023

Dear Administrator Brooks-LaSure:

CC: Daniel Tsai, Anne Marie Costello, Hannah Katch, Melanie Fontes Rainer, Rachel Pryor, and Perrie Briskin

We are writing as members of the Protecting Immigrant Families (PIF) Steering Committee and the PIF Medicaid Unwinding Task Force to share our concerns about barriers that immigrants and their families are facing as the Medicaid "unwinding" takes place across our nation. We fear that these barriers will result in unnecessary, disproportionate, and harmful coverage loss.

We recognize and greatly appreciate your efforts to ensure that everyone who is eligible – including people in immigrant families – retain Medicaid coverage. In particular, we commend you for the outreach toolkits translated into six languages; outreach grants to community based organizations that provide services to immigrants; and Secretary Becerra's outreach video in Spanish.

However, given the high numbers of procedural Medicaid terminations, and the obstacles to enrollment that immigrant families face under the best of circumstances, we remain concerned that eligible people in immigrant families are particularly vulnerable to coverage loss due to procedural failures. Today, more than one in four children –18 million children –live with an immigrant parent. Of those 18 million children, the vast majority are U.S. citizens and 43 percent live in families with low-incomes and are likely eligible for Medicaid.

PIF recently surveyed state advocates and community-based organizations (CBOs) to assess states' performance in setting up redetermination practices that conform with policies that ensure people in immigrant families can successfully retain health coverage. Our survey findings raise concerns about whether states are addressing families' immigration-related concerns; providing meaningful language access; publicly reporting data to measure impact and target outreach efforts; and engaging stakeholders.[1] In addition, recently published research by other entities (included in the attached memo under "additional research findings"), has heightened our concerns.

[1] Health Care At Risk For Immigrant Families, How Major Gaps in States' Medicaid "Unwinding" Performance Threaten Health and Health Equity, Protecting Immigrant Families Coalition,November 2023, available at: https://docs.google.com/presentation/d/1Y0y3CCLJagD6jYB-cpd8yym-1Rx6UmvxE_uTYxh6yfI/edit#slide=id.g291938a3ffd_0_23.

Given the findings outlined in the attached memo, we recommend that the Centers for Medicare & Medicaid Services (CMS) pause the unwinding in states that are out of compliance. CMS's August 23, 2023 letter notified states that they would have to pause procedural terminations if they were out of compliance with Medicaid's ex parte renewal process. Similarly, CMS should use its authority under the Consolidated Appropriations Act of 2023 to require states that are out of compliance with the tri-agency policy guidance and/or language access laws and policies to develop mitigation plans. CMS should then pause the unwinding if a state's mitigation plans are violated. The pause would stay in effect until the state makes changes needed to ensure that eligible individuals are not disenrolled from Medicaid. CMS should also clarify existing enrollment regulations to reflect the problems exposed during the unwinding.

In particular, we request that CMS use its authority to ensure that states:

1. **Do not request Social Security number (SSNs) or citizenship or immigration status when it violates federal policy.** Our survey found that many states are inappropriately requesting SSNs and citizenship or immigration status in the Medicaid redetermination process. People in immigrant families may become fearful when asked to disclose this sensitive information. And in almost all cases, people going through a redetermination of eligibility have already provided this information and applicable verification has already occurred when the individual originally signed up for coverage. Therefore, there is no need to request this information and doing so violates the federal requirement that "The agency may request from beneficiaries only the information needed to renew eligibility." 42 C.F.R. 435.916(e). CMS should take corrective action on states failing to comply with this requirement. Moreover, to the extent this information is also being asked from non-applicants, that action violates the 2000 tri-agency policy guidance.

2. **Communicate renewal messages that address public charge and other immigration-related fears.** Our survey found that the vast majority of states' renewal communications do not include messages that address public charge or other immigration-related fears. The absence of these messages may prevent families from renewing their coverage, particularly since public charge requirements have changed since renewals last occurred. While we appreciate that the population-specific fact sheets refer to this issue, CMS should revise its more general unwinding outreach toolkit to include messages that it is safe to apply for Medicaid. CMS should partner with other federal and state agencies that operate public assistance programs to conduct a broader-based outreach campaign to immigrants and their families.

3. **Improve compliance with federal language access laws.** Our survey found that multiple states' are failing to communicate with Medicaid enrollees with limited English proficiency, particularly if they speak languages other than Spanish. In addition, recent research shows that even when states attempt to provide language access, services are often out of reach due to long wait times and unhelpful prompts. This indicates that many states are not providing equitable language access in violation of Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act. While we appreciate the

letter from the Office for Civil Rights outlining responsibilities and best practices, we encourage CMS to work directly with states to provide meaningful language access in outreach, in-person assistance, call centers, notices, forms, and online renewal portals. CMS should also ensure that taglines in multiple languages –providing information about how to get language assistance –are included in various state communications. HHS should enforce compliance with federal law by conducting “secret shopper” testing or other monitoring and pause the unwinding when meaningful language access is not provided, including when call center wait times are long for language assistance.

4. **Report more specific data**. Our survey found that few states are reporting data by county, zip code, race, or primary language. This lack of data makes it difficult for state advocates and CBOs, not to mention state and local governments, to target outreach and direct services to those who need it most. Moreover, national survey data indicates that Hispanic adults are losing Medicaid faster than other racial and ethnic groups. These findings would be most helpful when coupled with more specific state data. CMS should explore ways to ensure all Medicaid data is reported by different groups and categories: including by race/ethnicity, primary language, county and zip code. This type of data reporting would ensure that states are not discriminating and are in compliance with Title VI of the Civil Rights Act of 1964, and Sec.1557 of the Affordable Care Act. This would also help community based organizations, states, and CMS target outreach and assistance where it is most needed. CMS should also compile data that already exists from states that are reporting it to at least begin to understand national trends.

More details, including key survey findings, are available in the attached memo. **We would like to meet with you at your earliest convenience to discuss opportunities to reduce denials of coverage for eligible immigrants and their family members**.

Sincerely,

African Bureau for Immigration and Social Affairs (ABISA)
Arkansas Immigrant Defense
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations (AAPCHO)
California Immigrant Policy Center
California Pan-Ethnic Health Network
Center for Law and Social Policy
Centro Hispano de East Tennessee
Centro Savila
Charlotte Center for Legal Advocacy
Children's Defense Fund-Texas
Colorado Center on Law and Policy
Community Catalyst
Community Legal Services of Philadelphia
ECHOS
El Centro

Every Texan
Food Research & Action Center
Florida Health Justice Project
Health Action New Mexico
Health Law Advocates
Hispanic Services Council
Immigrant Legal Resource Center
Indiana Justice Project
Legal Aid Society of Columbus
Massachusetts Immigrant and Refugee Advocacy Coalition
Michigan League for Public Policy
MomsRising/MamásConPoder
Montgomery County Federation of Families for Children's Mental Health, Inc.
National Health Law Program
National Immigration Law Center
Nebraska Appleseed
NM Center on Law and Poverty
Refugee & Immigrant Voices in Action
Shriver Center on Poverty Law
Tennessee Justice Center
UnidosUS
Virginia Poverty Law Center
Voices for Utah Children
William E. Morris Institute for Justice

From:	**Protecting Immigrant Families Coalition (PIF)**
To:	**Federal Officials**
Re:	**New research raises concerns about Medicaid renewals for immigrants and their family members: recommendations for the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS)**.
Date:	**November 16, 2023**

PIF's Medicaid Unwinding Task Force recently fielded a survey of state advocates and community-based organizations (CBOs) to ask how their states were providing access to renewals for immigrants and their families. The survey asked how states were addressing immigration concerns; providing language access; reporting data, and engaging the immigrant community. Advocates and CBOs from 28 states responded to the survey. In addition, recently published research has heightened our concerns about these barriers. Below we walk through each topic, sharing our survey findings[2] and related research of concern and recommendations for the Centers for Medicare & Medicaid Services (CMS).

Section 1: Addressing Immigration Concerns: Most states are failing to address immigration-related concerns in their outreach about the unwinding, and many other states are acting in violation of the 2000 tri-agency policy guidance, and 42 C.F.R. 435.916(e) regarding inquiries into citizenship, immigration status and social security numbers (SSNs) in the Medicaid redetermination process.

PIF Survey Findings: Our survey asked state advocates and CBOs if their state shared outreach messages that it is safe to re-enroll in Medicaid and use health services, prepopulated renewal forms with immigration status and SSNs; and refrained from questioning non-applicants about immigration status and social security number.

[2] Health Care At Risk For Immigrant Families, How Major Gaps in States' Medicaid "Unwinding" Performance Threaten Health and Health Equity, Protecting Immigrant Families Coalition,November 2023, available at: https://docs.google.com/presentation/d/1Y0y3CCLJagD6jYB-cpd8yym-1Rx6UmvxE_uTYxh6yfI/edit#slide=id.g291938a3ffd_0_23.

Survey respondents from 27[3] states indicated that:

- 16 states are not consistently following the tri-agency guidance that requires them to refrain from asking non-applicants for their immigration status, social security number, and other information during the renewal process.
- 12 states are not consistently pre-populating the renewal form with SSN and immigration status. This means that individuals are being asked to re-supply this information.
- 24 states' renewal communications do not include messages that address public charge or other immigration-related fears.

Additional Research Findings: A host of recent-research outlines the effect anti-immigrant policy and rhetoric have had on immigrant communities' in the past several years. The damage done during the Trump administration has not been reversed: immigrant families remain hesitant to enroll in health and nutrition programs. This "chilling effect" is real and remains a significant problem. The following research presents clear evidence of this damage:

- The chilling effect of Trump's public charge policy holds steady at 25 percent in 2023, which is essentially the same as it was under the Trump administration (27 percent). Despite the Biden administration's efforts, news of the current regulations did not penetrate immigrant communities, or if it did and, even in the instances where it did, the message was insufficiently compelling and/or convincing to reduce anxiety. (Urban Institute's Wellbeing and Basic Needs Survey)
- Well-child visit schedule adherence for children of immigrant parents fell by an average of 5 percent at the time of Trump's election, and by 8 percent at the time the first draft of his public charge rule was leaked in January 2017. These findings also indicate decreased rates for early childhood vaccinations, health and developmental screenings, and family support. (Children's Health Watch).
- WIC participation declined among pregnant immigrants when the Trump public charge rule was announced and published. Compared to U.S. born citizens, the odds of WIC participation by prenatal immigrants were 11.4 lower after the public charge rule was announced in September 2018, and 19 percent lower after the rule was published in August 2019. Similarly, this indicates that the chilling effect spilled over into programs like WIC that are only rhetorically linked to public charge, but were never actually considered in a public charge determination. (Journal of Immigrant and Minority Health).

Conclusion:

- The vast majority of states' renewal communications do not include messages that address public charge or other immigration-related fears that may prevent families from renewing their coverage, particularly since public charge requirements have changed since renewals last occurred.
- Many state Medicaid agencies are re-asking Medicaid participants for their immigration status and SSN when the agency already has this information and there is no need. These questions are out of compliance with 42 C.F.R. 435.916(e) that requires that state Medicaid agencies "may request from beneficiaries only the information needed to renew eligibility." Medicaid agencies are also asking family members who are not renewing Medicaid for themself for their immigration status and SSN. This violates the

[3] Advocates in one state did not answer questions in this section so we only received 27 responses.

longstanding tri-agency policy guidance that prohibits states from asking non-applicants to provide their immigration status and SSN. These actions are immediately detrimental to the goal of encouraging eligible people in immigrant families to stay enrolled in public benefits.

Recommendations:

- CMS should revise its unwinding outreach toolkit to include messages indicating that it is safe to stay enrolled in Medicaid. CMS should also undertake a targeted outreach campaign to immigrants and their families. PIF has created a set of outreach materials with some sample messages and we are happy to provide feedback on updates.
- CMS should take corrective action on states failing to comply with the 2000 tri-agency policy guidance. and 42 C.F.R. 435.916(e) to ensure widespread compliance with these regulatory requirements, and pause the unwinding until these policies are in place.

Section 2: Language Access

Multiple states are failing to communicate with Medicaid enrollees who have limited English Proficiency (LEP), particularly if they speak languages other than Spanish. And, even when they attempt to provide language access, services are often out of reach due to extremely long wait times and unhelpful prompts.

PIF Survey Findings: Our survey asked advocates and CBOs if their state provided the following in English only, Spanish only, or Spanish and at least one other language: 1) outreach materials; 2) call center language lines; 3) in person language assistance; 4) taglines in other languages on mailed notices; 5) translations of language in notices; and 6) translated websites for online renewal systems.

Survey respondents from 28 states indicated that:

- 8 states do not provide an online renewal system in a language other than English, and another 15 provide online renewals in English and Spanish, but not other languages.
- 5 states provide notices in English only, and 11 additional states provide notices in English and Spanish, but no other languages.
- 10 states provide written notices only in English and Spanish with taglines only in English and Spanish
- 17 states provide written notices with taglines in languages other than English and Spanish

Additional Research Findings: PIF's survey did not ask about wait times on the in-language call lines, but other recent research shows that wait times present an additional hurdle for people with limited English proficiency. For example, The National Immigration Law Center (NILC) recently analyzed Medicaid websites and calls centers across all 50 states and found that only 19 states even provided phone prompts for people who speak English and Spanish. NILC also found that 13 states provided language options in their phone tree beyond English and Spanish and a general "other language" prompt, and in some of these, the prompts were spoken in English (for example, saying ""Spanish" rather than "Español"). Moreover, UnidosUS recently found that in Florida the wait times for Spanish-language callers were nearly two and half hours long – four times the average wait time for English language callers. Anecdotally, we have heard from PIF's survey respondents that wait times in other states are similarly

inequitable, creating an enormous burden on application assisters as well as the LEP families they serve.

Medicaid households include a large share of people with limited English proficiency. Nearly one in five (16%) of nonelderly adults living in households with at least one Medicaid enrollee have LEP, and nearly a quarter (23%) of children enrolled in Medicaid have a parent that speaks English less than very well. Eighty-nine percent of people with LEP are people of color. If materials are not provided in their language, Medicaid enrollees with LEP face added challenges understanding and completing tasks or forms due to language barriers, and may be disenrolled for procedural reasons even though they are still eligible for Medicaid.

Conclusion: The absence of adequate and equitable language access provisions at the state level presents a significant obstacle to enrollment for LEP individuals. This failing also imposes a time-and resource-intensive burden on enrollment assisters. Furthermore, states that are not providing equitable language access are in violation of Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act.

Recommendations:

- While we appreciate the letter from the Office for Civil Rights outlining responsibilities and best practices, CMS should work directly with states to ensure that they provide meaningful language access in outreach, in-person assistance, call centers, notices,forms and online renewal portals. CMS should also ensure that taglines in multiple languages –providing information about how to get language assistance –are included in various state communications.
- HHS should enforce compliance with federal law by conducting “secret shopper” testing or other monitoring and pause the unwinding when meaningful language access is not provided, including when call center wait times are long for language assistance.
- CMS should also pause the unwinding when meaningful language access is not provided, including when call center wait times are long for language assistance, and pause the unwinding when meaningful language access is not provided.

Section 3: Data Reporting

The baseline data that states must report to CMS only provides the total number of Medicaid enrollees terminated at renewal because they are ineligible or because of procedural reasons. Additional data are needed for state-level stakeholders and CMS to ensure states are not discriminating based on race or primary language. It would also enable state-level stakeholders and CMS to better target their efforts to provide specific and useful outreach.

PIF Survey Findings: Our survey asked state advocates and CBOs if their state was reporting renewal data by U.S. citizenship status, primary language, race/ethnicity, zip code, or county. Survey respondents from 28 states indicated that:

- 28 states do not report by U.S. citizenship status;
- 25 states do not report by language;
- 23 states do not report data by race; and

- 26 states do not report by zip code;
- 18 do not report by county.

Additional Research Findings: Although our survey did not capture it, a recent analysis of the Household Pulse Survey showed that the share of Hispanic adults with Medicaid coverage fell by 5.5 percentage points from March to September 2023, more than twice the rate of decline for the next most impacted racial or ethnic category in that time period. This analysis offers a clear warning that Hispanic adults, including some who are immigrants, are having a harder time than others staying enrolled in Medicaid during this unwinding period. (State Health Access Data Assistance Center).

Conclusion:

With so few states reporting data by county, zip code, race, or language, it's difficult for state advocates and CBOs, not to mention state and local governments, to target outreach and direct services to those who need it most. Moreover, national survey data indicating that Hispanic adults are losing Medicaid faster than other racial and ethnic groups would be most helpful when coupled with more specific state data. This type of data reporting would ensure that states are in compliance with Title VI of the Civil Rights Act of 1964, and Sec.1557 of the Affordable Care Act.

Recommendations:

- CMS should explore ways to ensure all Medicaid data is reported by different groups and categories: including by race/ethnicity, primary language, county and zip code.
- CMS should also compile data that already exists from states that are reporting it to at least begin to understand national trends.