Protecting People with Disabilities and People with Limited English Proficiency during the Unwinding of the Continuous Coverage Provision

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Introduction

Over ninety million individuals will face a Medicaid eligibility redetermination during the unwinding of the continuous coverage provision. The unwinding process is expected to cause significant stress on state eligibility and enrollment systems. Although these systems are always under obligations to not discriminate, states need to comprehensively assess their processes and systems, especially any changes implemented for unwinding, to protect against discrimination against people with disabilities and people with limited English proficiency (LEP).

State Medicaid agencies are subject to compliance with nondiscrimination requirements outlined in Section 1557 of the Affordable Care Act (ACA), Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973.[1] These civil rights requirements prohibit discrimination on the basis of disability and "national origin," which has been interpreted by the Supreme Court to include the language one speaks and thus limited English proficient individuals.[2]

From previous examples of state eligibility and enrollment systems under stress, such as with the implementation of the ACA, nondiscrimination requirements seem to fall by the wayside. During the ACA implementation, people with disabilities and with LEP struggled through dysfunctional administrative barriers and often were denied or lost coverage because they could not navigate the poorly working systems, especially without the information or assistance they should have received. States are well aware of the upcoming unwinding and

[1] 42 U.S.C. § 18116; 42 U.S.C. § 12132; 29 U.S.C. § 794a; 42 U.S.C. § 2000d.
[2] *See Lau v. Nichols,* 414 U.S. 563 (1974).

must adequately prepare their systems, policies, and procedures; train staff, especially frontline and Call Center staff; properly notify beneficiaries; and set up systems of compliance.

Importantly, nondiscrimination does not mean that when a system is serving everyone poorly, people with disabilities, limited English proficiency, or others are provided the same access to that malfunctioning system.[3] Nondiscrimination in the provision of Medicaid benefits means that protected classes of people receive some degree of positive effort and a more comprehensive approach to ensuring access to benefits.[4] States must not only ensure that there is language access, accessible formats, interpreters, etc., but that their methods of administration do not discriminate.[5]

The unwinding of the continuous coverage period has a high risk of discriminatory impact on certain populations which are often the same ones facing significant harm from coverage loss. Predictions about coverage loss during the unwinding indicate that of the 8.2 million who will lose coverage, 6.8 million will be disenrolled despite being eligible.[6] States should be making efforts to ensure their administrative processes and policies do not create barriers for people with disabilities and LEP. This brief offers a series of questions (although not an exhaustive list) that states should consider as they develop their unwinding plans. Advocates and stakeholders should initiate conversations with their state Medicaid agencies to ensure that nondiscrimination requirements are met and effective plans are in place to ensure that people with disabilities and people with limited English proficiency are not left even further behind during the unwinding.

Preventing Discrimination against People with Disabilities

States have obligations to not discriminate against people with disabilities in the operation of the Medicaid program, including how the state provides reasonable accommodations and how policies, procedures, and other methods of administration impact people with disabilities. Importantly, the definition of disability under the Americans with Disabilities Act as amended is

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[3] *See, e.g., Henrietta D. v. Bloomberg,* 331 F.3d 261 (2d Cir. 2003).
[4] *Id.* at 275-76 *citing L.C. ex rel. Zimring v. Olmstead*, 527 U.S. 581, 598 (1999).
[5] *See, e.g.,* 28 C.F.R. §§ 35.130(b)(3); 41.51(b)(3); 80 C.F.R. §§ 80.3(b)(2), 80.4(b)(2).
[6] APSE, *Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches* 6-7 (Aug. 19, 2022), https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf.

to be broadly construed and provide expansive coverage.[7] When thinking about how a state must meet the needs of people with disabilities, it is important to think beyond the commonly cited accommodations such as alternative format, *e.g.,* braille, for those with visual impairments, but to also think about whether call centers or other front line staff are trained to provide accommodations to individuals with traumatic brain injury or other cognitive disabilities that may require a front line staffer to speak more slowly, repeat information, and send follow up in writing. Many of the questions about the state's preparations should include specific details to ensure equal access for people with disabilities. Disability access questions include:

Identification of People with Disabilities. How is the state identifying those who need accommodations, including those that have a prior or current need for alternative format notices, in-person assistance or other accommodations. What are they doing to follow up where needed?

- For example, does the state have a system so that people who have requested alternative format or accommodations in the past will get those accommodations again?
- How is the state identifying need in the population and doing outreach to offer accommodations or at least ensure that people know they can get assistance?

In Person Assistance. Is the state prepared to provide in-person assistance to meet demand? Will that in-person assistance be accessible, including appropriate training, time allowed per appointment, in physically accessible locations, or accessible virtually as may be appropriate?

- How will states advertise or otherwise make sure beneficiaries are aware of in-person assistance? Any targeted outreach to ensure beneficiaries who need the assistance to access Medicaid benefits know about it and how to access it?

Training. What training are call centers workers or other front line staff receiving to recognize requests for accommodations? The language "I need an accommodation" will rarely be used, so how are call center workers trained to listen for requests for accommodations or otherwise facilitate access?

- Are the call centers accessible? Do they have appropriate training on video relay calls, helping callers who have disabilities that are hard of hearing or may have cognitive disabilities, etc.?

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[7] 28 C.F.R. § 35.108.

- What is the state's plan to ensure access to people with disabilities when the call center may have long wait times?
    - Ex: People with disabilities may have someone helping make the call for only a limited period of time and may not have that person available to wait for hours to get through a long wait time. Is there capacity for the call center to make appointments for callers with disabilities?

Assessments of Accessibility.

- How has the accessibility of processes and procedures been assessed?
- What about the accessibility of outreach?

Automations. How will automations impact people with disabilities—are they accessible? Are they harder for people with disabilities to manage/use?

- For example, if the state is using QR codes for documents and that document has to be attached to submitted documents, that may be difficult for people with limited dexterity to meet. Or whether the QR codes are read properly by screen readers such that a person using a device would know what it is and how to attach it.
- Are apps or other online sites accessible?
- Do automations require facility with technology that may be inaccessible for people with intellectual or cognitive disabilities?

Monitoring. How will the state monitor:

- If people are losing eligibility who should not (*e.g.,* many people with disabilities have eligibility situations that are unlikely to change like Disabled Adult Child)?
- Whether disability-based or associated categories are disparately impacted by procedural denials?
- Whether accommodations are being provided?

Complaints. What complaint system is available for people to raise problems?

- How are people aware of the complaint system?
- Are there clear processes with timelines and appeal rights?
- What policies and procedures will the state follow so that people understand the processes and decision making criteria?

Overall, how is the state ensuring that the processes and procedures they are using, including worst case scenario situations such as very long call center wait times and lack of access to assistance, will not be methods of administration that screen out or otherwise discriminates against people with disabilities.

Preventing Discrimination against People with Limited English Proficiency

Approximately 16 percent of Medicaid households include a person who is LEP.[8] In some states, over 20 percent of Medicaid households include LEP individuals, including California, Florida, Massachusetts, New Jersey, New York and Texas.[9] An individual is considered limited English proficient if the individual's primary language for communication is not English and the person has a limited ability to read, write, speak, or understand English. A limited English proficient individual may be competent in English for certain types of communication (*e.g.*, speaking or understanding), but still be limited English proficient for other purposes (*e.g.*, reading or writing).[10]

Medicaid agencies have specific requirements to provide language access. Although the services to be provided may be slightly different, many of the questions about the state's preparations are similar to the questions regarding equal access for people with disabilities. Language access questions include:

Identification of People with Limited English Proficiency.

- How is the state identifying those who need language services, including those that have a prior or current need for translated notices, in-person assistance by qualified bilingual staff or with qualified interpreters, or other language services? What are they doing to follow up where needed?
- How is the state identifying need and capacity for language services based on known information about the Medicaid population, prevalence of language needs in that population within the state, and what services the state needs to have available to meet the expected need?

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[8] Sweta Haldar, Samantha Artiga, Robin Rudowitz, Anthony Damico, *Unwinding of the PHE: Maintaining Medicaid for People with Limited English Proficiency*, Kaiser Family Found. (Mar. 3, 2022), https://www.kff.org/medicaid/issue-brief/unwinding-of-the-phe-maintaining-medicaid-for-people-with-limited-english-proficiency/.
[9] *Id.*
[10] HHS Office for Civil Rights, *Notice of Proposed Rulemaking: Nondiscrimination in Health Programs and Activities,* 87 Fed. Reg. 47824 (Aug 4. 2022), https://www.govinfo.gov/content/pkg/FR-2022-08-04/pdf/2022-16217.pdf.

Training. What training are call centers workers or other front line staff receiving to recognize the need for language services?

Assessments of Language Access.

- How has the accessibility of processes and procedures to provide language services been assessed?
- What about the accessibility of outreach?[11]
    - Are materials being produced in non-English languages and/or translated?
    - Are interpreters available at outreach events?
    - Is outreach being conducted to ethnic media and CBOs serving LEP individuals?
- Is funding being provided to CBOs that serve LEP individuals to assist?

Automations. How will automations impact people with limited English proficiency—do they provide language access? Are they harder for people with LEP to manage/use?

Monitoring. How will the state monitor:

- If people are losing eligibility who should not (*e.g.,* many people with LEP may not respond to English notices).
- Whether language services are being provided.

Complaints. What complaint system is available for people to raise problems?

- How are people aware of the complaint system?
- Are there clear processes with timelines and appeal rights?
- What policies and procedures will the state follow so that people understand the processes and decision making criteria?

Call Centers. How do LEP individuals get through a state's call center (or chat feature if it uses one) if it uses integrated voice prompts (IVP) only in English (and possibly Spanish)? That is, how does an LEP person get to an actual call center representative if the LEP person cannot understand what numbers to press and just holding on the line will not ultimately connect to a representative?

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[11] *See, e.g.,* CMS, *Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operations* 8-9 (Nov. 2021), https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf.

In Person Assistance. What in-person assistance will be available for LEP individuals and how will language services be provided? How does a person request and access such assistance?

Overall, how is the state ensuring that the processes and procedures they are using, including worst case scenario situations, such as very long call center wait times and lack of access to assistance, will not discriminate against people with limited English proficiency.

Conclusion

Ensuring that no one who is eligible for Medicaid loses their coverage during the unwinding period should be the goal of Medicaid agencies, advocates, stakeholders and policymakers. As we approach a time of intense stressors on eligibility and enrollment systems, states must not only plan to ensure access, but have plans to recognize and then address access issues affecting these populations. Assuming new policies, processes, and technology will work for people with disabilities and with LEP fails to take the necessary steps to ensure access. Not all populations will be affected similarly by changes or by problems. States have obligations to prepare adequately for access; monitor for adverse impacts on people with disabilities and with LEP; and make both proactive and reactive changes to ensure these populations are able to access their Medicaid benefits. If states are not taking concrete steps to ensure accessibility for people with disabilities and people with limited English proficiency, they are practicing the same casual disregard toward such populations that laws like the ADA were put in place to address.

If advocates are identifying problems in their states, NHeLP may be able to help. Please contact Elizabeth Edwards (edwards@healthlaw.org) about issues related to people with disabilities and Mara Youdelman (youdelman@healthlaw.org) about issues related to people with limited English proficiency.