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Top 10 Suggestions for State Advocacy Regarding H.R. 1 Changes to Medicaid Eligibility for Immigrants

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Starting October 1, 2026, immigrants' eligibility for Medicaid will be significantly restricted. Under section 71109 of the 2025 Budget Reconciliation Act (H.R. 1), Congress eliminated mandatory Medicaid funding for individuals unless they are:

(1) a citizen of the United States;
(2) a lawful permanent resident (green card holder);
(3) certain Cuban & Haitian nationals; or
(4) persons residing under a Compact of Free Association (COFA) with Micronesia, Palau, or the Marshall Islands.

This means many individuals whose immigration status previously satisfied Medicaid eligibility criteria will be terminated from Medicaid. The statuses that are newly *ineligible* for federally-funded Medicaid include:

(1) individuals granted asylum or withholding of removal;
(2) refugees;
(3) survivors of domestic violence with a pending or approved application for lawful permanent residence under the Violence Against Women Act (VAWA);
(4) survivors of trafficking with a pending or approved T visa or Continued Presence;
(5) individuals paroled into the U.S. for a period of at least one year;
(6) individuals granted conditional entry;
(7) individuals granted Iraqi or Afghan Special Immigrant Visas and certain Afghan parolees;
(8) certain Ukrainian parolees; and
(9) American Indians born in Canada or members of a federal tribe (who do not have another eligible status).

This change applies to all states. However, states *can* still use state funding to provide coverage for the populations losing federal funding under H.R. 1 through their Medicaid program.

Furthermore, this legislation did not affect optional coverage for lawfully residing children and pregnant people[1] pursuant to the Children's Health Insurance Program Reauthorization Act (CHIPRA), nor the From-Conception-to-End-of-Pregnancy (FCEP) option for all pregnant immigrants, and states may continue to receive federal funding to provide coverage to these populations.

This legislation also did not amend the statute that establishes the five-year waiting period or, importantly, change those who meet an exemption from the five-year waiting period.[2]

Below are our Top 10 suggestions for actions states can take to mitigate the harm of this devastating loss of coverage for immigrant communities.

Top 10 Suggestions for State Advocates

[1] While the statute refers to "pregnant women," *see* 42 U.S.C. § 1396b(v)(4)(A), this issue brief uses the term "pregnant people" in recognition that people of all genders, gender identities, and expressions can become pregnant.
[2] A similar issue is currently being addressed through litigation. *See New York, et al. v. Rollins, et al.*, 6:25-cv-2186-MTK (D. Or., Nov. 26, 2025).

1. Adopt Coverage Option to Expand Coverage to Lawfully Residing Children and Pregnant People

While H.R. 1 may have further limited the types of immigration statuses that qualify for traditional Medicaid, it did not affect the state's ability to expand Medicaid and CHIP coverage to pregnant people and children if they are "lawfully residing."[3] The term "lawfully residing" is broad and encompasses immigrants who are otherwise ineligible for federal Medicaid funding, including asylees, refugees, parolees, survivors of trafficking, and others.[4] Lawfully residing pregnant people are entitled to 12 months of postpartum coverage if their state has elected that option.[5] Furthermore, all children eligible for Medicaid are entitled to one year of coverage regardless of a change in circumstance.[6]

The Centers for Medicare & Medicaid Services (CMS) lists the states that have taken up the options to cover lawfully residing children, pregnant individuals, or both. Advocates can review the list to determine whether their state has maximized allowable coverage (including the maximum age for children) and, if not, advocate for the state to do so. Typically, states implement this coverage through the adoption of a state plan amendment (SPA). A sample SPA and instructions for submitting the request to CMS are available online.[7] Adopting one or both options is a feasible approach for both advocates and states given that many states have adopted them, and Congress maintained the option post-H.R. 1.

In addition to coverage for certain lawfully residing immigrants, CHIP's From Coverage to End of Pregnancy (FCEP) option covers prenatal care regardless of the pregnant person's immigration status in order to promote the health of newborns.[8] Note, however, that the FCEP

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[3] Coverage for children can be extended up to age 19 for CHIP and age 21 for Medicaid. CMS, *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (July 1, 2010) (hereinafter "CMS Lawfully Residing Children and Pregnant Women"), https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10006.pdf.

[4] *See* CMS Lawfully Residing Children and Pregnant Women.

[5] CMS, Dear State Health Official Letter, SHO #21-007, *Improving Maternal Health Coverage and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)* (Dec. 7, 2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

[6] CMS, Dear State Health Official Letter, SHO #25-001, *Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023* (Jan. 15, 2025), https://www.medicaid.gov/federal-policy-guidance/downloads/sho25001.pdf.

[7] CMS Lawfully Residing Children and Pregnant Women at 8-12.

[8] Tanesha Mondestin, *More States Expanding Medicaid/CHIP for Pregnant Women, Including Immigrants*, CCF (October 15, 2024) (hereinafter, "CCF, More States Expanding Medicaid/CHIP for Pregnant Women"), https://ccf.georgetown.edu/2024/10/15/more-states-expanding-medicaid-chip-for-pregnant-women-including-immigrants/.

population is not eligible for extended 12 months of postpartum coverage although states can elect to provide postpartum coverage through CHIP's Health Services Initiative (HSI) funds.[9]

2. Remind States to Transfer and Not Terminate Coverage for Those Who Continue to Qualify Under CHIPRA

In states where the CHIPRA options have been adopted, states must ensure they have implemented adequate screening procedures. States must screen Medicaid applicants for eligibility under CHIPRA on initial application. Similar screening procedures must be implemented for other optional coverages, like the FCEP program.[10] Additionally, as required for all Medicaid beneficiaries, where a state acts to terminate the eligibility of an individual under one category, it must review their eligibility under *all* other available categories before ending coverage outright.[11] If the state does not have adequate information to determine the individual's eligibility but suspects the individual may remain eligible under another category, then the state must send the individual a renewal form and give them 30 days to respond with information showing they continue to be eligible under another Medicaid category.[12] During the period in which the state is reviewing someone for other eligibility categories, it must continue coverage and only after completing this review can a state send a Medicaid termination notice with accompanying procedural rights discussed in further detail below.[13]

Thus, under the state's "*ex parte* review" obligation, where states have adopted one or both CHIPRA options, then – before terminating coverage – they must determine whether those individuals who are newly ineligible under H.R. 1 remain eligible as a lawfully residing child or

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[9] *See* CCF, More States Expanding Medicaid/CHIP for Pregnant Women.

[10] *See* CCF, *What Does 12-month Continuous Eligibility for Children Mean for CHIP Pregnancy Coverage?* (2023), https://ccf.georgetown.edu/2023/10/19/what-does-12-month-continuous-eligibility-for-children-mean-for-chip-pregnancy-coverage/.

[11] *See* 42 C.F.R. §§ 435.930(b), 435.916(f); *see also* CMS, CMCS Informational Bulletin, *Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders* (March 15, 2024), https://www.medicaid.gov/federal-policy-guidance/downloads/cib03152024.pdf (hereinafter "CMS, *Conducting Medicaid and CHIP Renewals"*); CMS, *Transitioning Individuals within Medicaid Eligibility Groups and Between Medicaid and CHIP at Renewal* (2023)**,** https://www.medicaid.gov/resources-for-states/downloads/transitions-in-medicaid-and-chip.pdf (hereinafter "CMS, *Transitioning Individuals*"); HCFA, Dear State Medicaid Director Letter (1997), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD020697.pdf (describing *ex parte* requirements following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996).

[12] CMS, *Conducting Medicaid and CHIP Renewals* at 4-6; CMS, *Transitioning Individuals* at 12; *see also* 42 C.F.R. 435.911(c)(2), (d)(1) (determining eligibility under categories other than a MAGI category).

[13] 42 C.F.R. §§ 435.930(b); *CMS, Conducting Medicaid and CHIP Renewals* at 2; *CMS, Transitioning Individuals* at 6.

pregnant person, including requesting additional information for those who appear they may be eligible and giving them adequate time to respond before issuing a Medicaid termination notice.

3. Ensure that State Eligibility Notices Are Clear, Accessible, and Otherwise Comply with Due Process

While H.R. 1 will significantly restrict immigrants' eligibility for Medicaid, state implementation of these new restrictions must comply with due process. Medicaid applicants and enrollees have the right to notice and administrative hearings when a Medicaid agency issues an adverse determination based on an ineligible immigrant status.

Those whose Medicaid eligibility is terminated or denied based on immigration status must be provided a notice at least 10 days before the date of that adverse action.[14] The notice must be written in plain language and be accessible to individuals with disabilities and persons with limited English proficiency (LEP).[15] Advocates should ensure that states: (1) create translations of whole notices; (2) send in-language notices as opposed to taglines; and (3) when drafting new work requirement notices, translate them.

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[14] 42 C.F.R. § 431.211. Exceptions to the 10-day notice requirement can be found at 42 C.F.R. §§ 431.213 and 431.214 and include (a) The agency has factual information confirming the death of a beneficiary; (b) The agency receives a clear written statement signed by a beneficiary that (1) He no longer wishes services; or (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information. (c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services; (d) The beneficiary's whereabouts are unknown, and the post office returns mail directed to him indicating no forwarding address (see § 435.919(f)(4) of this chapter for procedures if the beneficiary's whereabouts become known); (e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; (f) A change in the level of medical care is prescribed by the beneficiary's physician; (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or (h) The date of action will occur in less than 10 days, in accordance with § 483.15(b)(4)(ii) and (b)(8).

[15] 42 C.F.R. §§ 435.916(g), 435.917(a), 431.206(e), 435.905(b); HHS, Office for Civil Rights, Dear State Health Official, *Ensuring Language Access for Limited English Proficient (LEP) Individuals and Effective Communication for Individuals with Disabilities During the States' Unwinding of the Medicaid Continuous Enrollment Condition* (Apr. 4, 2023), https://www.hhs.gov/sites/default/files/medicaid-unwinding-letter.pdf; CMS, *Accessibility Requirements in Medicaid and CHIP* (Feb. 2023), https://www.medicaid.gov/resources-for-states/downloads/accessibility-unwinding-slides.pdf.

Notices must be individualized and contain enough information to enable an individual to determine whether the agency has made a mistake and, if so, how to prepare for a hearing.[16] Notices communicating eligibility changes based on immigration status should (1) clearly explain that the eligibility rules are changing *and list* which statuses remain eligible; (2) list what status the state believes the *individual* has so the individual can identify whether the agency has made a mistake; (3) provide information specific to each household member (including who in the household remains eligible - *e.g.* citizen children - which is especially critical for mixed-status families); (4) specify whether individuals are ineligible because they do not have the required status *or* because they are an LPR but did not meet an exemption from or complete the five-year-bar, and identify available exemptions to the five-year bar; and (5) where applicable, include a statement that if a person is pregnant or a child, they may still qualify as a "lawfully residing" immigrant.[17]

Notices should also make clear that individuals have the right to challenge adverse decisions through an administrative hearing. This information should include instructions about how to request a hearing, the availability of interpreter services at no cost to the individual,[18] and the right to select a hearing representative of their choice (*e.g.*, a lawyer, a friend, or a relative).[19]

States may attempt to categorize the change in immigrant eligibility status as a "mass change" that would excuse them from providing hearings to those affected.[20] However, because the basis for the hearing does not solely turn on the change in federal law, but instead requires the state to undertake a fact specific analysis of whether an individual continues to meet immigrant eligibility criteria, the mass change exception does not apply and the state must grant a hearing if one is requested.

4. Educate Stakeholders About the Requirements for Immigration Status Verification & the Relationship to Confidentiality

A major concern for many immigrants is how information provided to a Medicaid agency could be used in the future. Details on how CMS is sharing data with DHS are not completely transparent and are changing. It will, therefore, be important to educate stakeholders about

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[16] *Goldberg v. Kelly*, 397 U.S. 254 (1970), 266, 268.
[17] States cannot provide full-scope Medicaid coverage to certain qualified immigrants who entered the U.S. on or after August 22, 1996 until five years after their date of entry into the U.S. with a qualified immigration status. 8 U.S.C. §§ 1613(a) (establishing the five-year bar), 1613(c)(2)(a) (indicating that individuals subject to the five-year bar are eligible for emergency Medicaid). Generally, individuals who entered the U.S. prior to August 22, 1996, but obtained qualified immigrant status on or after that date, are not subject to the five-year bar.
[18] *See* 42 C.F.R. § 431.205(e) (incorporating the rights set forth in 435.905(b)(1) & (3)).
[19] 42 C.F.R. § 431.206(b)(3).
[20] See 42 C.F.R. § 431.220(b).

the requirements for verifying immigration status and residency, including what information must be provided to apply for, and retain, Medicaid and any protections against submitting information regarding non-applicant household members. Information that is not submitted cannot be shared.

Verifying citizenship and immigration status

Unlike other eligibility requirements, states cannot accept attestation of citizenship or immigration status and must verify this applicant information for full-scope Medicaid.[21] These declaration and verification requirements do not apply when an individual applies only for emergency Medicaid.[22]

To verify U.S. citizenship, states generally require applicants to provide certain documentation or search the individual's Social Security number (SSN) with the Social Security Administration. However, deemed newborns (i.e. babies born to Medicaid-enrolled parents) are considered to have their citizenship verified and states are prohibited from further verification efforts.[23]

For eligible non-U.S. citizens, applicants must first declare under penalty of perjury that they have satisfactory immigration status and provide the required immigration documentation or A-number. That information is used to verify an individual's status through a data match with the Department of Homeland Security's (DHS) Systematic Alien Verification for Entitlements (SAVE) program.

Importantly, the citizenship or immigration status of non-applicant household members is not relevant to the eligibility determination, and states are prohibited from requiring individuals to disclose the status of non-applicants.[24] States are permitted to *ask* for a SSN for non-applicants, which can be useful to facilitate verification of the household's income. But states must explain (1) that it is voluntary, and (2) how the SSN will be used.[25] Non-applicants, however, may refuse to provide an SSN, even if asked, and states must attempt to verify income through other means if the individual elects not to provide an SSN.[26] State eligibility systems and caseworker training materials must clearly explain these standards, as the

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[21] *See* 42 U.S.C. §§ 1320b-7(d), 1396a(a)(46)(B), 1396b(x), 1396a(ee); 42 C.F.R. §§ 435.406, 435.407, 435.956.

[22] 42 U.S.C. § 1320b-7(f); 42 C.F.R. § 435.406(b).

[23] 42 U.S.C. 1320b-7(x)(2)(D); *see also* 42 C.F.R. § 435.406(a)(iii)(E)(1); CMS, Dear State Health Official Letter, SHO No. 09-009 (Aug. 31, 2009), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf ("individuals who are initially eligible for Medicaid or CHIP as deemed newborns . . . will not be required to further document citizenship or identity at any subsequent Medicaid or CHIP eligibility redetermination").

[24] 42 CFR § 435.907(e).

[25] *Id.*

[26] *See* 42 CFR §§ 435.907(e)(3)(iii), 435.910(f)–(h).

requirements for non-applicants to produce information is often misrepresented.[27]

Residency

States may accept attestation to establish residency, and many do.[28] If a state does not currently accept attestation, advocates can encourage their state to change their policy. This can be done without a state plan amendment, simply by updating the verification plan provided to CMS.

Moreover, even in states where individuals must provide a residential address, states must have a process for enrolling individuals who have no fixed address.[29] Members are permitted to have different residence and mailing address. A P.O. box or other address can be used as mailing address, which could be convenient for individuals who live in non-traditional housing or are unhoused. States must also provide individuals with a choice to receive notices in an electronic format as an alternative to regular mail, make clear that the election can be changed, and provide instructions on how to change the election in the future.[30]

Under H.R. 1, starting January 1, 2027, states must create a process to regularly obtain Medicaid members' address information.[31] This provision will likely increase the frequency of address verifications, but HHS has not yet finalized the process and standards.[32] States must verify member residency independent of immigration status determinations.[33]

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[27] For example, state agencies cannot "deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA or if the individual meets one of the exceptions in…" 42 C.F.R. § 435.910(h) including that the person is ineligible for an SSN. *See* 42 C.F.R. § 435.910(f).

[28] *See* 42 CFR § 435.945(a). CMS posts verification plans for each state, which indicate whether a state accepts attestation of residency or requires additional verification. *See* CMS, *Verification Plans*, https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans (last visited Nov. 10, 2025). As of October 2025, the following states indicated they accept attestation of residency: AL, AK, AR, CO, DC, DE, HI, IA, MI, MN, MT, NH, NJ, NY, RI, TX (for children), WV (for individuals not known to the state already, i.e. via SNAP or TANF). Several states accept attestation, but note they will request additional verification if they receive or have conflicting information in the case file: CA, FL, GA, ID, KS, LA, ME, MD, MS, MO, NE, NV, NM, ND, OH, OR, PA, SC, SD, VT, VA, WA, WI. The following states require verification of residency through electronic data check or other sources: AZ, IL, IN, KY, MA, NC, OK, TN, TX (for adults), UT, WY.

[29] *See* 42 U.S.C. § 1396a(b)(2).

[30] 42 C.F.R. §§ 435.918(a) & (b).

[31] 42 U.S.C. §§ 1396a(a)(88), 1396a(vv).

[32] *See* 42 U.S.C. § 1396a(uu).

[33] 42 C.F.R. § 435.956 (c)(2).

5. Prevent States from Re-Verifying Immigration Status within the Same Verification Period

To implement the eligibility changes beginning October 1, 2026, states will need to determine whether current enrollees have one of the remaining eligible statuses. Of course, because the class of previously eligible immigrants remain entitled to benefits until October 2026, states cannot act to terminate them based on immigration status any earlier than that date. Advocates should work with states to ensure that individuals are not asked to reverify their immigration status unnecessarily[34] or repeatedly which could have a chilling effect and lead to procedural terminations.

Over the course of the next year, states will conduct regularly scheduled renewals of Medicaid and continue coverage for those immigrants who, post H.R. 1 implementation, may or may not be newly ineligible on and after October 1, 2026.

Depending on the functionality of their eligibility systems, however, states will vary in whether they can automatically sort and identify individuals by a particular status. Some states may include details such as "LPR exempt from 5-year bar" while others may simply have a field indicating that an individual has verified a "satisfactory immigration status." If states' eligibility systems cannot easily determine a particular immigration status, it could mean more manual work for case workers to review individual cases before October 1, 2026, or worse, the need for individuals to re-supply immigration status information.

States can take advantage of the coming year to capture more granular information regarding the present status of the enrollee in a format within the eligibility system that can later be used to determine eligibility under the new rules. This process would eliminate the need for states to undertake unnecessary requests for verification. It will also decrease the likelihood of procedural terminations for individuals who do not respond timely to a second request.

States that do not have the ability to catalogue individual Medicaid enrollees' immigration status should consider creating an *ad hoc* report that retains that information for a temporary period of time and that can be queried prior to October 2026 so the state does not have to send the enrollee duplicate requests for verification.

Regardless of approach, states—in relying on the data previously collected—should assess continued eligibility *ex parte* when it is time to apply the new immigrant eligibility criteria and should not need to request additional information from individuals who remain eligible via the *ex parte* process.

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[34] For example, immigration status does not need to be re-verified if it is not likely to change (*e.g.*, lawful permanent resident status) unless the individual reports such a change occurred. *See* Sarah Grusin and Catherine McKee, Nat'l Health Law Prog., *Medicaid Coverage for Immigrants: Eligibility and Verification* (2021). https://healthlaw.org/resource/medicaid-coverage-for-immigrants/.

If the state cannot verify that the Medicaid enrollee has an eligible immigration status based on the information in its case file, individuals should be provided written notice that details: (1) the change in law; (2) the current immigration status the state has on record; (3) what immigration statuses continue to qualify; and (4) an opportunity to attest to an eligible status and instructions on how to verify that status. If an enrollee attests to having a status that remains eligible, enrollees should then be granted a reasonable opportunity period to gather and submit the documentation necessary to prove they continue to be eligible.[35] Again, all written notice must be accessible.[36]

After the reasonable opportunity period expires, if an individual is still unable to prove they meet the new immigration status criteria, then the state can send a notice of adverse action with all associated rights (fair hearing and continued benefits pending appeal if timely requested), as described above in Section 3.

If a state cannot guarantee it will re-verify immigration status *ex parte*, state advocates should broadly publicize the changes to immigrant eligibility, including developing and distributing educational materials to consumers and immigrant friendly communities to mitigate confusion and fear that multiple requests for immigration status verification may cause.

6. Encourage States to Conduct Robust Testing of their Computer Systems

Errors can occur any time states are required to make changes to their eligibility systems.[37] This can be especially problematic when changes involve more complicated eligibility rules or processing data from external data sources—such as SAVE, which is used to verify immigration status—because test environments do not typically test with real cases (and their complex facts) or real data extracted from those data sources. As a result, errors in the implementation of the computer system changes may not be discovered until real Medicaid enrollees' cases are processed.

For instance, in Arizona, the computer system was not programmed to account for certain exemptions to the five-year waiting period for LPRs.[38] Specifically, the computer system only verified an individual's current status, but had no way to verify or store data related to a prior status that would exempt individuals from the five-year waiting period, such as a refugee or asylee. Thus, while testing may have revealed that the system was correctly verifying whether

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[35] Akash Pillai et al., Kaiser Family Found., *How States Verify Citizenship and Immigration Status in Medicaid* (2025), https://www.kff.org/immigrant-health/how-states-verify-citizenship-and-immigration-status-in-medicaid/.
[36] *See supra* note 14.
[37] Sarah Grusin, Nat'l. Health Law Prog., *A Promise Unfulfilled: Automated Medicaid Eligibility Decisions* (2021), https://healthlaw.org/a-promise-unfulfilled-automated-medicaid-eligibility-decisions/.
[38] *Id.*

someone held LPR status and for how long, it did not uncover the errors in how it was processing exemptions.

To minimize these types of errors and the harms they cause, prior to the eligibility changes being implemented, advocates should provide states with detailed test case scenarios—such as examples of individuals who remain exempt from the five-year bar for LPRs—to use before the eligibility system changes "go live." Advocates can also encourage their state to include advocates in the in-person testing of new changes to the system, as California routinely does.[39]

To monitor issues after implementation, Medicaid and legal services advocates can identify and deepen relationships with community partners (*e.g.* refugee settlement organizations) who interact with the immigrant populations who are likely losing eligibility and who will be able to flag problems when they arise. Managed care plans may be able to identify any recurring errors early on. Finally, advocates can submit public records requests for change orders, work-arounds, and policy guidance for caseworkers regarding the eligibility system changes to immigrant eligibility.[40] These documents will help advocates identify where the state has known difficulty determining immigrant eligibility.

If you encounter difficulties with your state's eligibility system, please reach out to NHeLP and the Benefits Tech Advocacy Hub.[41]

7. Confirm Enrollee Facing Websites, Applications, and Other Consumer Interactions Comply with Language and Access Standards

Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act both prevent discrimination against individuals who have limited English proficiency (LEP).[42] These rules apply to virtually all entities that provide health insurance and care;[43] they require that "covered entities" take reasonable steps to provide meaningful access to each individual with limited English proficiency.[44]

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[39] A.B. 1296, Ch. 641, Reg. Sess. (Cal. 2011).
[40] Nat'l Health Law Prog., *Public Records Request Guide*, https://www.btah.org/resources/public-records-request-guide.html (last visited Nov. 13, 2025).
[41] *Id.*
[42] 42 U.S.C. § 2000d; 42 U.S.C. § 18116.
[43] *See* HHS, Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37522 (May 6, 2024). A "covered entity" is a recipient of federal financial assistance, the Department of Health and Human Services, and entities established under Title I of the Affordable Care Act.
[44] 45 C.F.R. § 92.201.

Steps that covered entities should take to improve language access include:

- Provide language assistance services including electronic and written translated documents and oral interpretation, free of charge and in a timely manner;
- Ensure the quality of translated written documents, such as notices, including that they are written at an appropriate grade level and use terminology that can be understood by the population;
- Ensure oral interpretation and language services, both at call centers and in-person at Medicaid offices;
- Memorialize these standards into written policy, and train staff on the policy;[45]
- Proactively provide information to enrollees and applicants on how to access language assistance services, reasonable modifications, and auxiliary aids and services;
- Prohibit AI/machine translations and note the requirement under Section 1557 regulations for qualified human translators to review any critical documents whenever AI is used for initial translation;[46]
- Monitor comparative wait times and other barriers to receiving assistance in languages other than English;
- Apply these standards throughout all interfaces including informal letters, telephonic services, websites, chatbots, and apps.

Federal regulations require that all language assistance services be provided by "qualified" individuals.[47] Covered entities can decide whether to use in-person or remote interpreters.

8. Offer Suggestions to Adequately Prepare Call Centers for Increased Immigrant Related Questions

Call centers are often the primary way that enrollees interact with the Medicaid agency. Many states have moved away from directing people to local offices and instead have pushed people to use online portals and centralized call centers. Unfortunately, national and state specific surveys have found that state agency call centers are not equipped to handle current demand,

[45] 45 C.F.R. § 92.201(e) (explaining that states cannot require individuals with limited English proficiency to provide their own interpreter, pay the cost of their own interpreter, or rely on non-qualified family members to provide interpretation except temporarily in emergency circumstances).
[46] 45 C.F.R. §§ 92.4; 92.201(c)(3) (stating that the use of machine translation must, in most circumstances, be reviewed by a qualified translator).
[47] 45 C.F.R. § 92.4.

let alone demand stemming from historical changes to Medicaid eligibility.[48] Over the next few years, as states implement these changes, call center demand will likely increase dramatically.

To prepare for that demand and mitigate stress on agency communication systems, agencies should consider developing detailed call center scripts about the changes to immigrant eligibility in addition to providing in-depth training to call center staff. This should supplement any policy guidance agencies release to staff. The training and scripts should include information about the agency's obligation to maintain benefits during the reasonable opportunity period, the application and exemptions to the five-year waiting period for LPRs, the availability of coverage for lawfully residing children and pregnant individuals in states with that option, the right to request a fair hearing (even where the changes to eligibility are the product of federal law), and the right to continued benefits pending appeal. State Medicaid agencies should consider broadening the modalities they use to communicate with enrollees and applicants, including a chat function built into customer-facing portals and the agency's website. Chat functions can serve as a more efficient platform for both applicant/enrollees and states. However, these functions cannot be used as substitutes for adequately staffed call centers and storefronts.[49] States must also provide individuals the option of speaking with a live agent.

As mentioned previously in this publication, these communications, like all agency communications, should be accessible to those who have limited English proficiency and people with disabilities. NHeLP has published guidelines about ensuring language accessibility in call centers.[50]

9. Focus on Immigrant Eligibility at MAC/BACs

In May 2024, CMS updated regulations requiring states to establish Medicaid Advisory Committees (MACs) and Beneficiary Advisory Councils (BACs). The new regulations were designed to enhance the role of Medicaid enrollees and other stakeholders in state Medicaid

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[48] Tricia Brooks and Allexa Gardner, CCF, *A Closer Look at Medicaid Call Center Options as the Unwinding Kicks into High Gear* (2023), https://ccf.georgetown.edu/2023/05/10/a-closer-look-at-medicaid-call-center-options-as-the-unwinding-kicks-into-high-gear/; UnidosUS, *New Report Finds Florida's Medicaid Call Center Continues to Fail Families, Putting Health Coverage at Risk for Thousands* (2025), https://unidosus.org/press-releases/new-report-finds-floridas-medicaid-call-center-continues-to-fail-families-putting-health-coverage-at-risk-for-thousands/.

[49] *See* 42 C.F.R. § 435.908(a) (requiring application and renewal assistance be provided in person, over the telephone *and* online, all in an accessible manner for those with disabilities and who are limited English proficient).

[50] Elizabeth Edwards and Mara Youdelman, Nat'l Health Law Prog., *Medicaid Eligibility Call Centers: Questions for LEP & Disability Access* (2023), https://healthlaw.org/wp-content/uploads/2023/08/Call-Center-Qs-NHeLP.pdf.

policy development and to "promote transparency and accountability between the state and interested parties."[51]

States are directed to recruit MAC/BAC members in a way that reflects "a wide range of Medicaid interested parties (covering a diverse set of populations and interests relevant to the Medicaid program), place a special emphasis on the inclusion of the beneficiary perspective, and create a meeting environment where each voice is empowered to participate equally."[52] As states grapple with the implementation of H.R. 1, MACs and BACs can provide an opportunity for meaningful engagement about how H.R. 1 implementation will impact immigrants' access to Medicaid. Recruiting members from immigrant communities, and their advocates, will help ensure MACs/BACs focus on their concerns.

It will also be important to recognize and eliminate the barriers that could prevent immigrants from engaging with state MAC/BACs. Advocates can engage with their state agency to ensure compliance with 42 C.F.R. § 431.12 and to push for states to establish best practices.[53] For example, as discussed above, states are required to take reasonable steps to provide meaningful access to individuals with limited English proficiency.

Advocates can push for practices that would increase immigrant participation such as:

- Advising states to proactively anticipate and meet the needs of the largest linguistic minority groups without requiring them to ask by providing materials in their languages such as BAC applications, meeting agendas, etc. and by arranging services for any other language upon request to ensure that no one is excluded from participation due to their native language.
- As Medicaid is complicated, with agencies, plans, regulations, and acronyms that can be overwhelming, even for experienced advocates, bringing people onboard as members of the MAC and BAC meetings requires training and support such as Medicaid policy training. Some state advocates have volunteered to provide that training for MAC/BAC members.
- All MAC/BAC members including agency, staff, and continuing members should be trained in active listening and centering and understanding enrollee perspectives and experience. There can be significant differences in power dynamics between new members, community members, and agency staff due to differences in experience, familiarity with policy proposals, and comfort with participating in large group

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[51] CMCS, Medicaid Advisory Committees & Beneficiary Advisory Councils – Implementation Considerations (Jan. 2025), https://www.medicaid.gov/medicaid/access-care/downloads/medicaid-advis-coite-benf-advis-councl-toolkit.pdf.
[52] 42 C.F.R. § 431.12(f)(7).
[53] For a comprehensive review, see Daniel Young and Wayne Turner, Nat'l Health Law Prog., *Medicaid Advisory Committees: Best Practices for Effective Stakeholder Engagement* (2024), https://healthlaw.org/resource/medicaid-advisory-committees-best-practices-for-effective-stakeholder-engagement/.

discussions. All participants should be able to recognize and name those power dynamics and have the necessary skills to mitigate imbalances.

10. Identify A Single Point of Contact

Even with careful planning, questions and problems will emerge when H.R. 1 implementation starts. Advocates should begin identifying who within their state agency has responsibility for implementing changes relating to immigrant eligibility, training caseworkers, updating call center scripts and building relationships with advocates and immigrant populations in advance. Advocates should request that the state establish working groups now that meet regularly, review state materials, and solicit stakeholder input on forthcoming policy changes. Ideally, advocates could encourage the state to identify a single point of contact for questions that relate to immigrant eligibility. That way, problems can be quickly identified and escalated to the appropriate agency staff.