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Authors

Bustamante, Arturo
Felix Beltran, Lucia
Majano, Rosario
et al.

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LIMITED ENGLISH PROFICIENT SPEAKERS AND THEIR ACCESS TO MEDICAID MANAGED CARE

Arturo Vargas Bustamante, Lucía Félix Beltrán, Rosario Majano, Esmeralda Melgoza, Ahmad Ismail, Silvia R. González

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The UCLA Latino Policy and Politics Institute acknowledges the Gabrielino and Tongva peoples as the traditional land caretakers of Tovaangar (the Los Angeles basin and Southern Channel Islands) and that their displacement has enabled UCLA's flourishing. As a land grant institution, we pay our respects to the Honuukvetam (Ancestors), 'Ahiihirom (Elders), and 'Eyoohiinken (our relatives nations) past, present, and emerging.

DISCLAIMER

The views expressed herein are those of the authors and not necessarily those of the University of California, Los Angeles. The authors alone are responsible for the content of this report.

FOR MORE INFORMATION

Contact: Lucía Félix Beltrán, luciafelix@ucla.edu

LIST OF ACRONYMS

ACA: Affordable Care Act
CHIP: Children's Health Insurance Program
CMS: Centers for Medicaid and Medicare Services
CT: Census Tract
ED: Emergency Department
FFS: Fee-For-Service
FPL: Federal Poverty Level
LEP: Limited English Proficiency
MSA: Metropolitan Statistical Area
MUA/P: Medically Underserved Areas/Populations

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EXECUTIVE SUMMARY

Medicaid plays a crucial role in enhancing health care access and reducing health disparities among marginalized communities. While the program has increased access to health care for low-income individuals, access to certain health care providers remains an ongoing challenge. Over the past 10 years, state Medicaid programs have gradually shifted from traditional fee-for-service models to Managed Care Organizations (MCOs) to improve health care quality and service administration. However, Latino/Hispanic and Asian Medicaid MCO patients with Limited English Proficiency (LEP) have reported worse experiences in terms of receiving timely care, communicating with their provider, and receiving help from staff. This policy report delves into the challenges LEP populations face when navigating health care through MCOs.

We examine the distribution of MCO Spanish- and Chinese-speaking providers and their overlap with; i) areas more likely to be populated by Spanish and Chinese speakers, and ii) areas classified by the federal government as medically underserved. We also compare Medicaid eligibility criteria across the three metropolitan statistical areas (MSAs) with the highest concentration of foreign-born individuals and LEP populations of Latino and Asian[1] heritage. These MSAs are Los Angeles-Long Beach-Anaheim (Los Angeles MSA) in California, Houston-Pasadena-The Woodlands (Houston MSA) in Texas, and New York-Newark-Jersey City (New York MSA).

We used multiple publicly available data sources, scraping of online Medicaid MCO health plan directories, and georeferencing techniques to first determine if Spanish- and Chinese-speaking providers were in areas with a high population of foreign-born Latino and Chinese populations. We then assessed whether the Spanish- and Chinese-speaking providers were in Medically Underserved Areas and Populations (MUA/P) designations, which identify the census tracts that lack access to primary care services.[2]

The key findings are:

1. State-level immigration policies influence access to Medicaid MCOs for LEP populations.
2. Spanish- and Chinese-speaking providers tend to cluster across all three MSAs as opposed to being evenly distributed.
3. Medically Underserved Areas (MUAs) overlap with census tracts with higher-than-county-average numbers of foreign-born Latinos.
4. Access to Medicaid navigation resources for LEP individuals varies significantly across states.

Based on our findings, we provide the following recommendations to reduce barriers to accessing high-quality health care for foreign-born LEP adults with Medicaid managed care:

1. States should continue to adopt Medicaid expansion efforts, either under the Affordable Care Act (ACA) to cover low-income adults or through state initiatives such as Medi-Cal expansions in California.
2. States should expand Medicaid coverage to immigrant communities.
3. Health care providers should extend language and translation

services beyond patient-clinician communication.

4. All state Medicaid programs should collect demographic information that includes data on primary language and LEP.
5. States should leverage the new Centers for Medicare and Medicaid Services (CMS) payment rule to include interpretation services for adult patients in their capitation rate.
6. States and health provider offices should retain and increase the number of bilingual staff serving LEP populations.

We conclude that Medicaid eligibility criteria can serve as the first barrier to access, depending on the state of residence. In addition, Spanish-speaking Medicaid providers in three MSAs overlap with the place of residence of foreign-born Latinos. Also, these areas were more likely to overlap with medically underserved census tracts. Finally, the presence of Chinese-speaking providers is less widespread in the three MSAs, but they are less likely to be in medically underserved areas.

INTRODUCTION

Medicaid is a federal program jointly administered and financed with state governments that provides health coverage, improves access to health care, and addresses health disparities among low-income, marginalized populations in the United States (U.S.).[3] This insurance program provides access to health care to about 82 million[4] individuals enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Medicaid beneficiaries comprise about 1 in 5 Americans or 21% of the country's population.[5] Specifically, this program provides health coverage to about 15% of non-elderly adults, 40% of children, 60% of nursing home residents, 15% of Medicare beneficiaries, and 30% of people with disabilities.[6] During the past decade, Medicaid payment systems have transitioned from volume-driven, fee-for-service (FFS) models, where providers are paid for each service provided, to the contracting of Managed Care Organizations (MCOs), where health plans pay providers a set amount each month for services rendered.

Although Medicaid eligibility has greatly expanded since the start of the COVID-19 pandemic, foreign-born individuals who might have gained access to health care through expansion policies often have Limited English Proficiency (LEP),[7] a structural barrier to continuity and quality of care. As of 2021, 25.7 million individuals in the U.S. had LEP, comprising 8% of the total U.S. population.[8] Spanish (63%) is the most commonly spoken language among LEP individuals, followed by Chinese (7%). Individuals with LEP are disproportionately concentrated in some states, with 25% of all LEP individuals living in California, followed by Texas (14%), Florida (10%) and New York (9%).[9]

In this policy report we examine the challenges and barriers encountered by immigrant and LEP adults when accessing primary health care through Medicaid Managed Care Organizations (MCOs). We first provide an overview of these barriers using existing research. Second, we describe geographic areas with a high concentration of foreign-born Spanish- and Chinese-origin individuals across three metropolitan statistical areas (MSAs): Los Angeles, Houston, and New York-New Jersey, and illustrate the availability of health care offices with at least one primary care provider who speaks Spanish and/or Chinese across the three MSAs. Finally, we compare access to Medicaid MCOs across these three MSAs and provide policy recommendations to address barriers.

BARRIERS TO HEALTH CARE AMONG THE LEP POPULATION

Based on existing research, adults with LEP are more likely to be foreign-born, low-income,[10] Latino/Hispanic, married, and to have lower educational attainment compared to English-proficient individuals.[11] LEP adults are also more likely to face multiple disparities along the health care continuum. For instance, they have higher rates of uninsurance and experience more disruptions in health insurance coverage.[12] Consequently, this translates to lower use of preventive care services,[13] higher rates of emergency department visits,[14] prolonged hospitalizations,[15] and frequent hospital readmissions.[16] These factors contribute to adverse health outcomes such as undiagnosed or uncontrolled hypertension,[17] poor glycemic control,[18] lower asthma control,[19] and unmet mental health needs.[20] Moreover, during emergency department visits, patients with LEP report receiving more diagnostic testing and have a higher likelihood of being admitted into the hospital, compared to their English-proficient counterparts.[21] These practices contribute to financial hardship among low-income families.[22]

Among LEP patients, barriers in accessing services in their native language and the stigma experienced by Latino families have led to a lower degree of satisfaction after receiving specialty or emergency care, compared to satisfaction among proficient English speakers and U.S. citizens.[23] Patients also preferred having a provider that speaks the same language as them, compared to having a conversation with a provider using an interpreter.[24] In fact, interviews with Latino LEP patients revealed that language discordance with a provider resulted in confusion, frustration, and perception of poor care.[25]

Latino and Asian Medicaid MCO patients with LEP have reported worse experiences in terms of receiving timely care, communicating with their provider, and receiving help from staff.[26] Conversely, the use of professional medical interpreting services for Medicaid patients with LEP was associated with longer and uninterrupted Medicaid enrollment, increased use of primary and specialty care, and decreased use of emergency care.[27]

Under federal law and the civil rights provision of the Affordable Care Act (ACA), health care providers receiving federal funds are required to post notices of non-discrimination and availability of language assistance services.[28] However, the lack of legislation regarding the enforcement of these requirements allows for disparities to persist. Moreover, states are not required by Medicaid to cover the cost of language interpretation services, but they have the discretion to consider language interpretation costs in their regular reimbursement rate.[29]

ABOUT MEDICAID AND MCOs

Medicaid is financed through a combination of state and federal funds. Some benefits and eligibility requirements are shared across all states, while other benefits are left to the state's discretion. For instance, all Medicaid programs are required to cover low-income children under the age of 19, low-income individuals who are pregnant, some low-income parents and caretakers, and individuals who are eligible to receive Supplemental Security Income (SSI).[30] Many states have also chosen to expand coverage through the ACA to low-income adults under age 65 whose income falls below 138% of the Federal Poverty Level (FPL). To date, Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming have not increased the income eligibility threshold to 138% FPL, leaving between 1.5 million and 2.3 million individuals ineligible for health coverage in these states.[31]

Historically, through the Medicaid FFS model, states paid providers directly for each service they delivered, such as a blood test or doctor visit.[32] However, this arrangement was inefficient and costly as it encouraged miscommunication among providers and lower quality care for patients.[33] For instance, because there is no coordinating entity under the FFS model, there are both redundancies and gaps in patient care.[34] Other criticisms of the FFS model include low payment rates, lower level of physician participation, and high administrative burden, compared to Medicare or private insurance.[35] As a result, many state Medicaid programs have shifted to paying groups of providers and hospitals to provide Medicaid-enrolled patients with a wide range of healthcare services. These groups are MCOs, and their payment model reduces costs because care can be delivered in a more efficient manner and at a lower price than through an FFS provider.[36] MCOs are paid a fixed monthly fee for each patient covered, known as a capitation rate, set by individual state Medicaid

programs.[37] This capitation rate incentivizes MCOs to minimize costs and increase efficiency of care,[38] which includes a larger emphasis on preventive care as opposed to treating patients once their conditions have worsened.[39] In addition, MCOs improve the health outcomes of patients with complex health needs by developing targeted care and efficiently managing resources.[40] Now, most states use MCOs to deliver care to the majority of Medicaid beneficiaries (85%).[41]

RECENT UPDATES TO MEDICAID AND MCOs

Medicaid Expansions

During the COVID-19 pandemic, between February 2020 and March 2023, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) increased by 23.3 million enrollees. The federal policies enacted during the public health emergency and the adoption of Medicaid expansion under the ACA in additional states (e.g., Missouri and South Dakota) enabled this increase in enrollment. However, as of September 2024, Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming have not increased the income eligibility threshold to 138% FPL, leaving between 1.5 million and 2.3 million individuals ineligible for health coverage in these states.[42]

Medicaid Unwinding

In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA) in March 2020.[43] Among other provisions, the legislation authorized the federal government to administer additional funds to states in exchange for providing continuous coverage to Medicaid and CHIP enrollees during the COVID-19 public health emergency period (January 31, 2020, to May 11, 2023).[44] This meant that beneficiaries were automatically renewed for coverage during this time. This provision led to large increases in the number of individuals covered by public insurance and a decrease in the uninsured rate. Between February 2020 and March 2023, Medicaid and CHIP enrollment grew by an estimated 23.3 million individuals,[45] and in early 2022, the national uninsured rate reached a record low of 8%.[46] Enrollment growth was higher in states that expanded Medicaid eligibility under the ACA.[47] In December 2022, President Biden signed the Consolidated Appropriations Act of 2023, which included a provision to decouple continuous enrollment from the public health emergency.[48] This initiated the "unwinding" of the continuous coverage provision under the FFCRA and allowed states to resume involuntary disenrollment from Medicaid beginning April 1, 2023.[49]

The unwinding of Medicaid disproportionately affects foreign-born LEP populations as enrollees with LEP are more likely to encounter language barriers.[50] As the unwinding of the continuous enrollment provision unfolds, MCOs will play a crucial role in ensuring that LEP enrollees retain Medicaid coverage or can transition to another coverage source. Some states are implementing strategies to help MCOs navigate the unwinding, such as waivers under section 1902(e)(14)(A) of the Social Security Act to allow MCOs to reenroll beneficiaries automatically; outreach campaigns regarding redetermination applications in linguistically accessible communications; and data management efforts to update beneficiary contact information.[51] States can reduce coverage gaps for LEP populations by streamlining their renewal process and providing linguistically accessible renewal information.[52]

New Medicaid Managed Care Rule and Implications for MCO Compensation to Providers

In April 2024, the Centers for Medicare and Medicaid Services (CMS) finalized its Medicaid, CHIP Managed Care Access, Finance, and Quality rule (CMS-2439-F) that includes a regulation to bolster states' authority to determine how much MCOs compensate providers and hospitals for health care services.[53] Traditionally, Medicaid has paid below both Medicare and private commercial rates for health care services.[54] In recent years, however, CMS has granted states flexibility to direct MCOs to pay up to the average commercial rate for health care services.[55] These are known as "state-directed payments."[56] The final rule codifies this flexibility and sets average commercial rates for health care services as a ceiling for state-directed payments. By increasing Medicaid payment rates, CMS seeks to improve provider network size and capacity for Medicaid patients, as previous research has found that low Medicaid physician fees are associated with lower physician participation in the program and lower acceptance of new Medicaid patients.[57] The new rule will have implications for more than 75 million Medicaid beneficiaries enrolled in managed care.[58]

RESEARCH APPROACH

This policy report delves into the challenges LEP populations face when navigating health care through MCOs. To understand the availability of MCO providers amongst the LEP Latino and Chinese population, we examine the distribution of foreign-born individuals who are Latino or Asian and delve into Medicaid eligibility criteria across the three MSAs with the largest concentration of Spanish and Chinese speakers, as Spanish and Chinese are the most frequently spoken language among Latino -and Asian foreign-born individuals, respectively. The MSAs with the highest number of foreign-born individuals and LEP populations of Latino and Asian[59] heritage are Los Angeles-Long Beach-Anaheim (Los Angeles MSA) in California; Houston-Pasadena-The Woodlands (Houston MSA) in Texas; and the New York-Newark-Jersey City (New York MSA), which includes counties in New York and New Jersey (see Table 1).[60]

Table 1. Foreign-Born Population of Latino and Asian Origin and LEP Population in Los Angeles, Houston, and New York MSAs, 2021

	Los Angeles		Houston		New York	
	Total (U.S. Born and Foreign-Born Population)	Foreign-Born Population	Total (U.S. Born and Foreign-Born Population)	Foreign-Born Population	Total (U.S. Born and Foreign-Born Population)	Foreign-Born Population
Total	12,997,353	4,231,132	7,206,841	1,734,249	19,768,458	5,818,266
Asian	2,157,561 (16.6%)	1,349,731 (31.9%)	583,754 (8.1%)	397,143 (22.9%)	2,312,910 (11.7%)	1,565,114 (26.9%)
Latino	5,900,798 (45.4%)	2,153,646 (50.9%)	2,774,634 (38.5%)	1,035,347 (59.7%)	5,001,420 (25.3%)	2,036,393 (35%)
Speak English less than "very well"	2,859,418 (33%)	2,347,044 (55.7%)	1,174,715 (16.3%)	903,544 (52.1%)	3,261,796 (16.5%)	2,594,947 (44.6%)

Created with Datawrapper

Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates

Note: Individuals with Limited English Proficiency (LEP) are those who report speaking English less than "very well." Data for Latinos include Latinos of any race. Estimations at the MSA level correspond to racial/ethnic categories (Asian and Latino), not language spoken (Spanish and Chinese)

Using publicly available data from the American Community Survey (ACS), we first identified the census tracts where foreign-born Latinos and foreign-born Chinese individuals are heavily concentrated using the county average as our benchmark. We calculated the average number of foreign-born Latino and Chinese individuals for each county in the MSAs of interest (see county list in Table 2). Second, we determined the number of foreign-born Latino and foreign-born Chinese individuals for each census tract. We then classified census tracts as either having foreign-born individuals above or below a county's average.

Because of the high population of foreign-born Latino and Chinese individuals represented in these census tracts, we expected to find health offices with providers that speak Spanish and or Chinese in these census tracts or nearby. To identify bilingual Spanish and Chinese speaking providers in these census tracts, we used geographic information systems (GIS)[61] to identify the corresponding

ZIP codes that fall within each tract. Using these ZIP codes, we searched MCO plan online directories to locate offices (e.g., clinics, hospitals) with at least one Spanish- and/or Chinese-speaking provider (for a list of MCO health plans in each MSA, see Table 2). Finally, we used Medically Underserved Areas and Populations (MUA/P) designations to identify the census tracts that lack access to primary care services (see maps in Appendix).[62] We expected to find a lower number of health offices with providers in areas that spoke languages other than English.

Table 2. Medicaid Enrollees Covered by an MCO in Los Angeles, Houston, and New York MSAs, December 2023

MSA	State	Counties	Number of MCO Plans	Medicaid Population Covered by MCOs
Los Angeles	California[a]	Los Angeles Orange	3	4,615,810
Houston	Texas[b]	Austin Brazoria Fort Bend Galveston Harris Liberty Montgomery Waller Chambers	5	1,000,255
New York	New York[c]	Bronx Kings New York Queens Richmond Nassau Putnam Rockland Suffolk Westchester	10	3,657,173
New York	New Jersey[d]	Bergen Essex Hudson Hunterdon Middlesex Monmouth Morris Ocean Passaic Somerset Sussex Union	5	1,458,036

Created with Datawrapper

Notes: The number of plans available as Managed Care Organizations (MCOs) can vary from year to year. The latest available Medicaid MCO enrollment data for Texas are preliminary for November 2023. We exclude VNS Choice Special Needs Plan (SNP) from the MCO plans list in New York because it is a Medicaid Advantage Plus plan (for dual-eligible individuals with special needs). We also exclude VNS Choice SNP enrollees from the New York Metropolitan Statistical Area (MSA) Medicaid Population covered by an MCO (3,394 enrollees as of December 2023).

Sources:
[a] California Health and Human Services, "Medi-Cal Managed Care Enrollment Report."
[b] Texas Health and Human Services, "Medicaid and CHIP Enrollment."
[c] New York State, "Medicaid Managed Care Enrollment Reports."
[d] State of New Jersey Department of Human Services, "NJ FamilyCare Beneficiaries."

MEDICAID ELIGIBILITY, MCO PLANS, AND BILINGUAL PROVIDERS ACROSS THE THREE MSAs

Los Angeles-Long Beach-Anaheim

As of July 2023, over 15 million California residents were enrolled in Medi-Cal, California's Medicaid program.[63] Individuals are eligible for Medi-Cal if they have a low household income (see Table A.1 in the Appendix for more information on income eligibility), are 65 years or older, are blind or have a disability, are pregnant, are in a nursing home or intermediate care home, are younger than 21 years, or are a refugee temporarily living in the U.S.[64] Individuals may also qualify if they are enrolled in one or more of the following programs: CalFresh, Supplemental Social Security Income (SSI) and State Supplementary Payment (SSP), CalWorks, Refugee Assistance, or California's Foster Care or Adoption Assistance Program.[65] As of January 1, 2024, California implemented its Ages 26 through 49 Adult Full Scope Medi-Cal Expansion policy that broadens access to Medi-Cal to residents of all ages regardless of their immigration status,[66] modeled after prior expansions.[67] Of the 15 million Medi-Cal enrollees, 91% receive coverage from a Medi-Cal managed care plan.[68] Currently, there are 24 plans contracted by the Department of Health Care Services (DHCS) to provide Medi-Cal managed care services to beneficiaries in the state of California.[69]

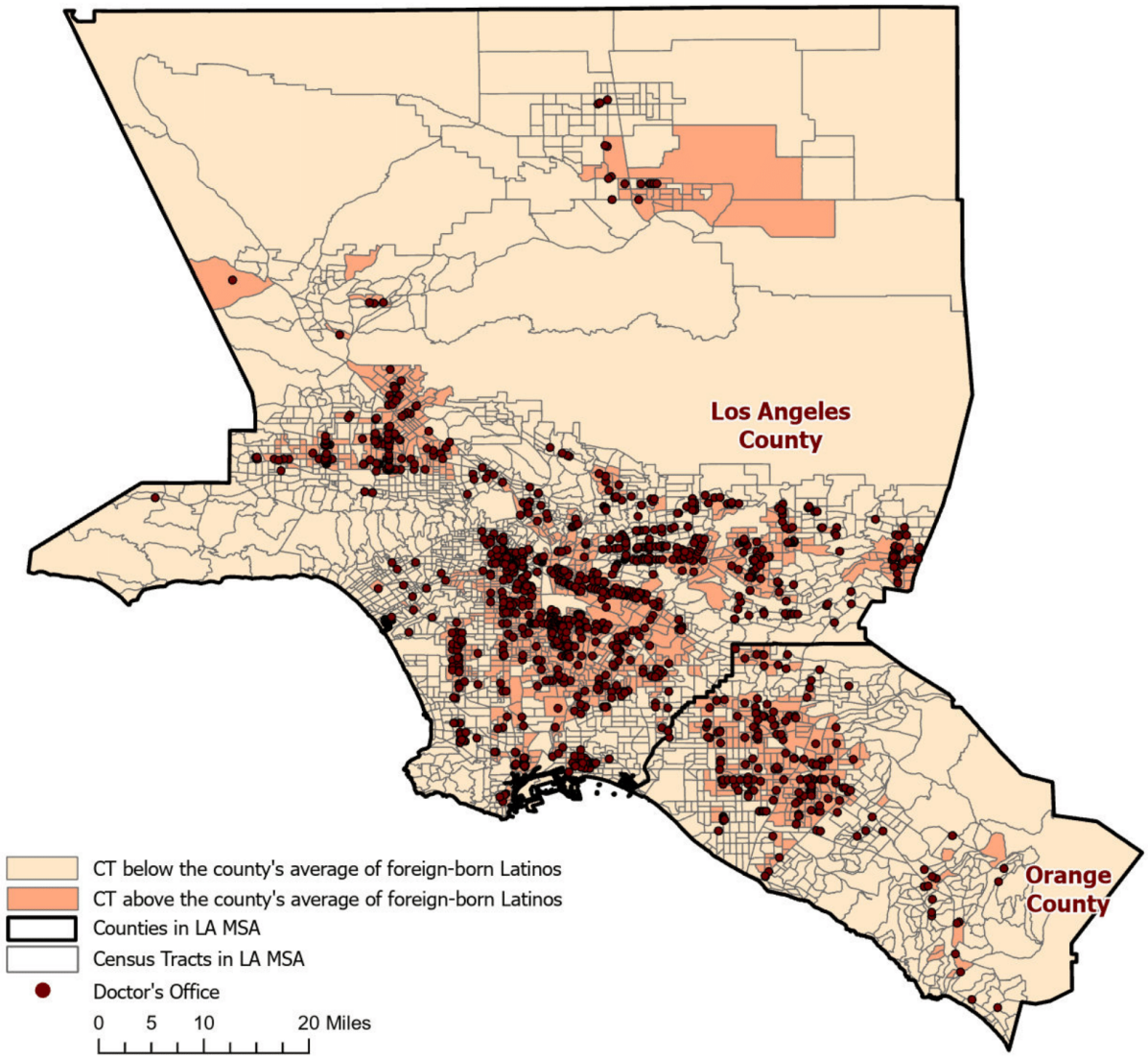
Medi-Cal enrollees living in the Los Angeles MSA, which includes Los Angeles and Orange Counties, are serviced by three local health plans: L.A. Care Health Plan, Health Net, and CalOptima. Together, these MCOs cover over 4.6 million enrollees and are the three plans with the highest enrollment in the state (see Table 2).

Offices with Spanish-and-Chinese-speaking Healthcare Providers in the Los Angeles MSA

Maps 1 and 2 show the Los Angeles MSA by county and census tract, overlaid with dots that represent the health offices of MCO providers listed on the Medicaid MCO health plans' online provider directories as having at least one Spanish-speaking provider or a Chinese-speaking provider. Medicaid MCO providers in both Los Angeles and Orange County are present in a relevant share of the census tracts with above average Latino foreign-born populations and are well located to service this community (see Map 1). However, the coverage of bilingual Medicaid MCO providers is more sparing for Chinese foreign-born residents (see Map 2), with fewer doctors' offices available in census tracts with higher-than-county-average numbers of Chinese foreign-born residents in both Los Angeles and Orange counties. Map A.1 in the Appendix shows data for MUA/P by census tract within the Los Angeles MSA.

Comparing Maps 1 and 2 to the distribution of MUA/Ps in Map A1 in the Appendix, Latino foreign-born populations appear more likely to live in areas classified as a MUA/P, particularly in Los Angeles County. Despite what appears to be a good overlap between Medicaid MCO providers that are apt to service Latino foreign-born populations (Map 1), these areas are still medically underserved.

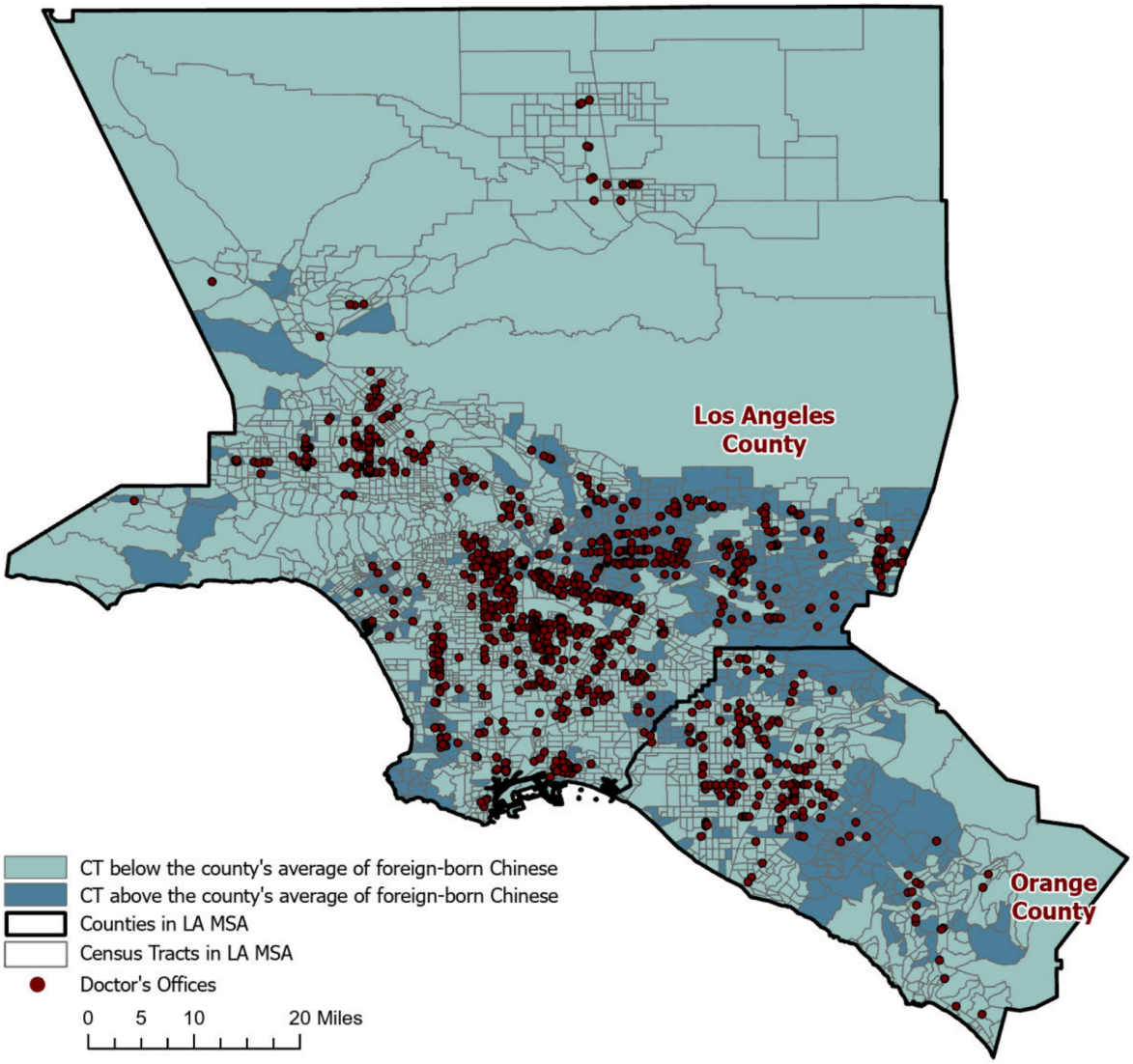
Map 1. Latino Foreign-Born Populations and Health Offices Accepting Medicaid Managed Care with Spanish-Speaking Providers in the Los Angeles Metropolitan Statistical Area (MSA)



Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates

Notes: Doctor's offices were identified using search engines available through Health Net, L.A. Care Health Plan, and CalOptima websites. The dots represent health offices from those health plans that listed at least one Spanish-speaking provider. The Catalina Islands are part of the MSA but are not shown because only one office is located there. CT=Census Tract

Map 2. Chinese Foreign-Born Populations and Health Offices Accepting Medicaid Managed Care with Chinese-Speaking Providers in the Los Angeles Metropolitan Statistical Area (MSA)



Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates

Notes: Doctor's offices were identified using search engines available through Health Net, L.A. Care Health Plan, and CalOptima websites. The dots represent health offices from those health plans that listed at least one Chinese-speaking provider. The Catalina Islands are part of the MSA but are not shown because only one office is located there. CT=Census Tract

Houston-Pasadena-The Woodlands

Currently, 4.8 million residents in Texas are enrolled in the state's Medicaid program,[70] and eligibility criteria differs from the LA and NYC MSAs because Texas has not expanded Medicaid eligibility under the ACA. Currently, populations eligible to enroll are: pregnant persons, individuals responsible for a child 18 years of age or younger, individuals who are blind or have disabilities, and adults ages 65 and older.[71] All eligible groups must be considered low income (earning less than 16% of the FPL; see Table A1 in the Appendix) and have one of the following immigration statuses: U.S. national, citizen, or legal permanent resident.[72] In addition, the state places further restrictions on eligibility for specific populations. For example, adults with disabilities are only eligible for full-scope Medicaid if they are not able to work.[73] If they are employed and meet the disability and income criteria, they qualify for a Medicaid Buy-In program that offers Medicaid services at a reduced cost.[74]

Additionally, Texas remains one of 10 states that have not adopted the ACA's Medicaid expansion program.[75] As a result, Texas has the lowest income eligibility for adults, and 42% of uninsured adults in the U.S. coverage gap[76] reside in Texas.[77] Texas adults living in poverty do not qualify for Medicaid on income alone. To qualify, adults must be pregnant, have a disability, be age 65 or older, or be a related caretaker for a child who is already enrolled in Medicaid (i.e., CHIP) in addition to having a low-income status.[78] Finally, exceptions to undocumented immigrants qualifying for Medicaid in Texas are only allowed in the event of an emergency medical condition.[79] Undocumented immigrants may qualify for coverage during their emergency period, assuming they meet the aforementioned criteria.

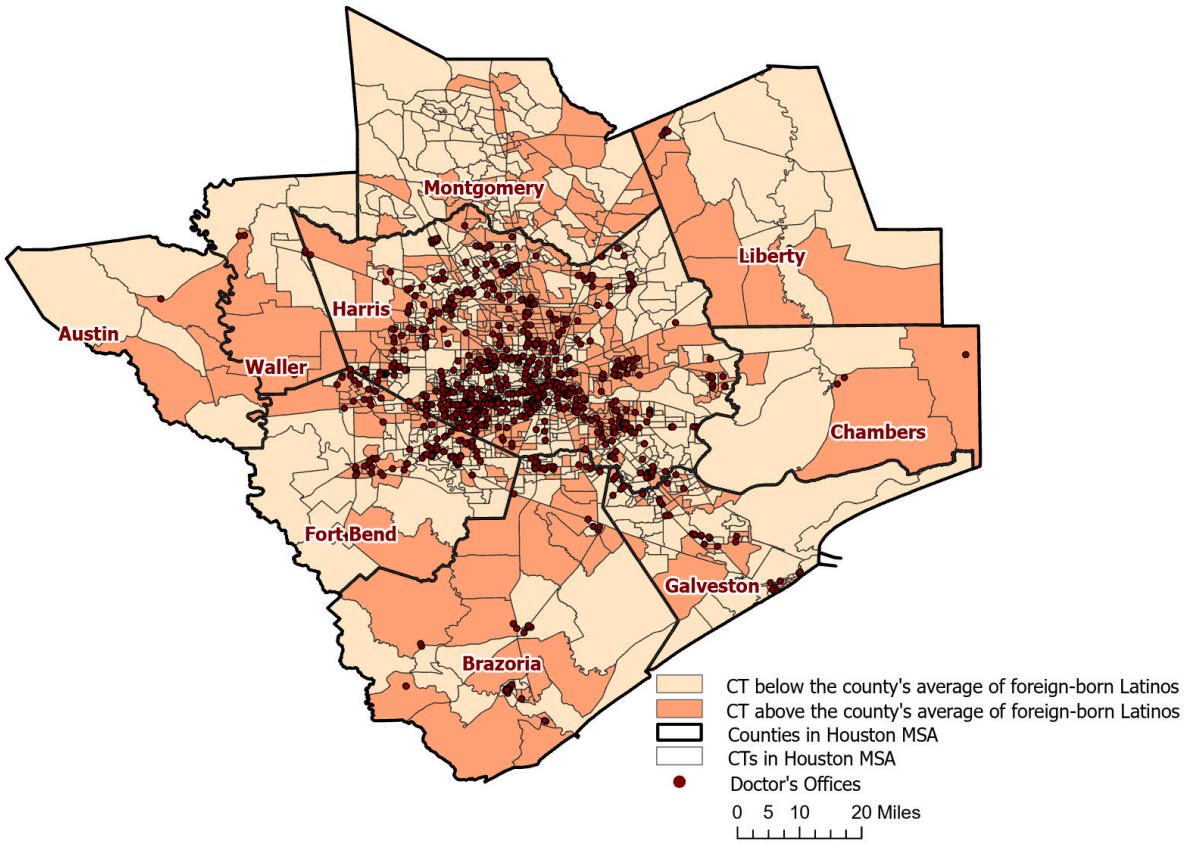
In Texas, the Medicaid managed care program that provides access to most adult Medicaid beneficiaries is the State of Texas Access Reform (STAR) Program, which services qualifying children, newborns, pregnant women, and caretakers.[80] The Houston MSA comprises 1.1 million STAR beneficiaries living in the following counties: Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller County. For Medicaid delivery, Texas divides the state into service areas. The Harris service area covers all counties in the Houston MSA except Chambers County, which is covered by the Jefferson service area.[81] MCO plans available to the Harris and Jefferson service areas are offered by Amerigroup, UnitedHealthcare, Texas Children's Health Plans, Molina Healthcare of Texas, and Community Health Choice (see Table 2).[82]

Offices with Spanish and Chinese-speaking Health Care Providers in the Houston MSA

Given the large share of the Latino population in the Houston MSA, census tracts with higher-than-average Latino foreign-born populations outnumber the census tracts with higher-than-average Chinese foreign-born populations (see Maps 3 and 4, respectively). Although every Spanish-speaking MCO provider included in the map is located in a census tract representing above-average Latino foreign-born residents, most Latino communities outside of Harris County remain underserved by a bilingual Medicaid MCO provider (see Map 3). Census tracts with above-average Chinese populations, however, have a higher concentration of bilingual providers, except for communities in Waller, and Fort Bend Counties, where the availability of bilingual providers is generally sparse (see Map 4)This is most evident in Waller and Fort Bend counties and is consistent with the need for bilingual MCO providers observed in these counties in Map 3.

Regarding medically underserved designations in the Houston MSA (Map A2 in the Appendix), census tracts and Latino foreign-born populations are more likely to overlap with medically underserved areas than Chinese foreign-born populations.

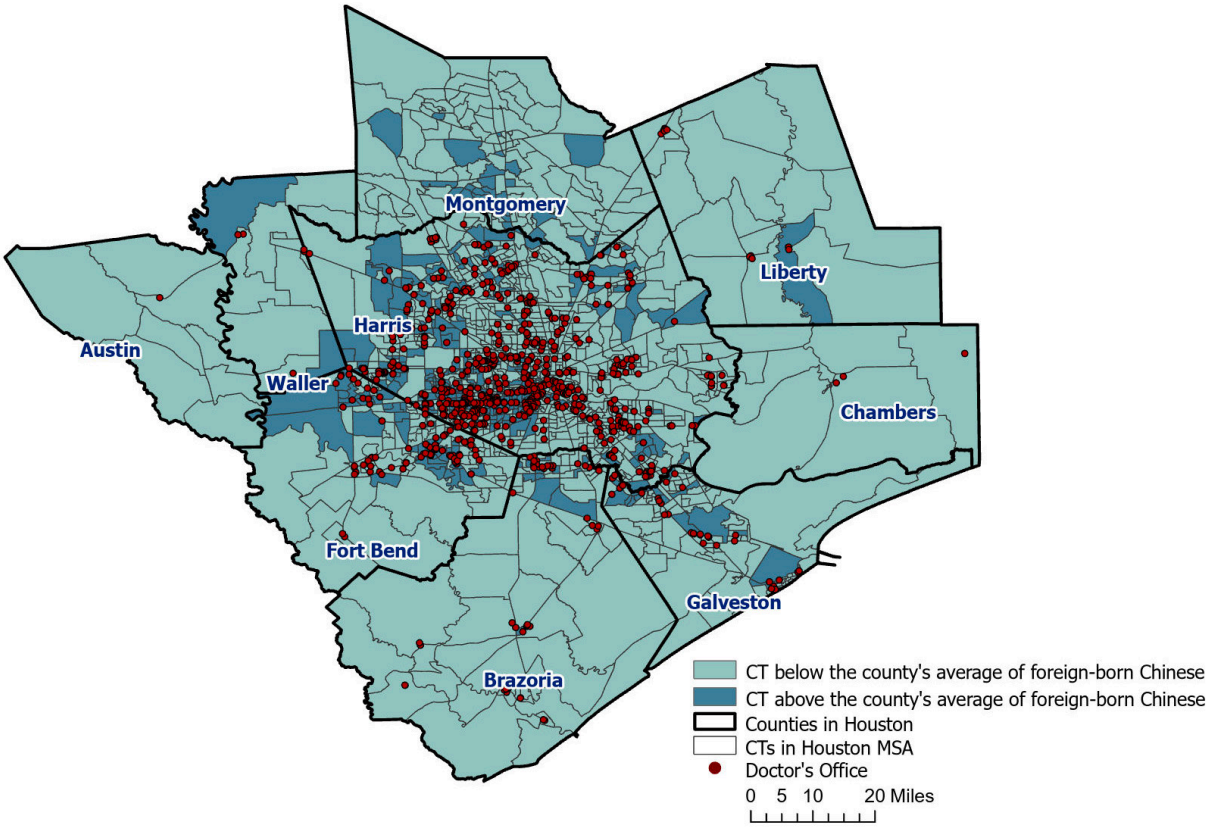
Map 3. Latino Foreign-Born Populations and Health Offices Accepting Medicaid Managed Care with Spanish-Speaking Providers in the Houston Metropolitan Statistical Area (MSA)



Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates.

Note: Doctor's offices were identified using search engines available through Amerigroup, Community Health Choice, Molina Healthcare of Texas, United Healthcare, and Texas Children's Health Plan websites. The points represent health offices from those health plans that listed at least one Spanish-speaking provider. CT=Census Tract

Map 4. Chinese Foreign-Born Populations and Health Offices Accepting Medicaid Managed Care with Chinese-Speaking Providers in the the Houston Metropolitan Statistical Area (MSA)



Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates

Note: Doctor's offices were identified using search engines available through Amerigroup, Community Health Choice, Molina Healthcare of Texas, United Healthcare, and Texas Children's Health Plan websites. The dots represent health offices from those health plans that listed at least one Chinese-speaking provider. CT=Census Tract

New York-Newark-Jersey City MSA

As of December 2023, 7.5 million New York state residents are enrolled in the state's Medicaid program, which the New York State Department of Health manages, along with a legacy system known as the Welfare Management System.[83] In addition to the eligible populations of low-income persons, children, pregnant persons, and individuals who are blind or have a disability, New York residents with medical debt may also be eligible for Medicaid even if their income is higher than what is allowed for Medicaid eligibility.[84] New York also grants full-scope Medicaid to three categories of immigrants: those who are known to U.S. immigration authorities and are not at risk of deportation, short-term visa holders, and, beginning January 1, 2024, undocumented immigrants over the age of 65.[85] Emergency Medicaid is available to undocumented and temporary immigrants residing in New York if they meet the requirements for Medicaid but are ineligible because of their immigration status.[86] Among beneficiaries, 71% are enrolled in a managed care plan.[87]

Residents of the 10 New York counties found in the New York MSA are serviced by the following managed care plans: Amida Care, Fidelis Care, Health First Plan, HealthPlus, Health Insurance Plan of Greater New York, MetroPlus Health Plan, MetroPlus Health Plan, Molina Healthcare of New York, UnitedHealthcare of New York, and the MVP Health Plan. Together, these plans account for approximately 37% of all New York Medicaid enrollees (see Table 2).[88]

As of December 2023, 2.1 million New Jersey residents were enrolled in NJ FamilyCare, the state's Medicaid program.[89] In addition to individuals who are blind or have a disability, low-income adults and pregnant persons are eligible for Medicaid in New Jersey.[90] If an individual is not a U.S. citizen or national, they must have legal permanent resident status in the U.S. for at least 5 years before they qualify for NJ Family Care.[91] Exceptions include but are not limited to children under 19, refugees, asylees, and immigrants aged 19 and 20 whose income is 138% of the FPL (see Table A1 in the Appendix).[92] Pregnant women who are lawfully present are also eligible regardless of the date they entered the U.S.[93] Although New Jersey has many exceptions, the state does not offer blanket coverage for all immigrants. New Jersey's Medical Emergency Payment Program covers emergency services for New Jersey residents who do not qualify for NJ FamilyCare because of their immigration status.[94] Lastly, beginning January 1, 2023, New Jersey expanded Medicaid coverage, through the Cover All Kids initiative, to children younger than 19 years of age, regardless of their immigration status.[95]

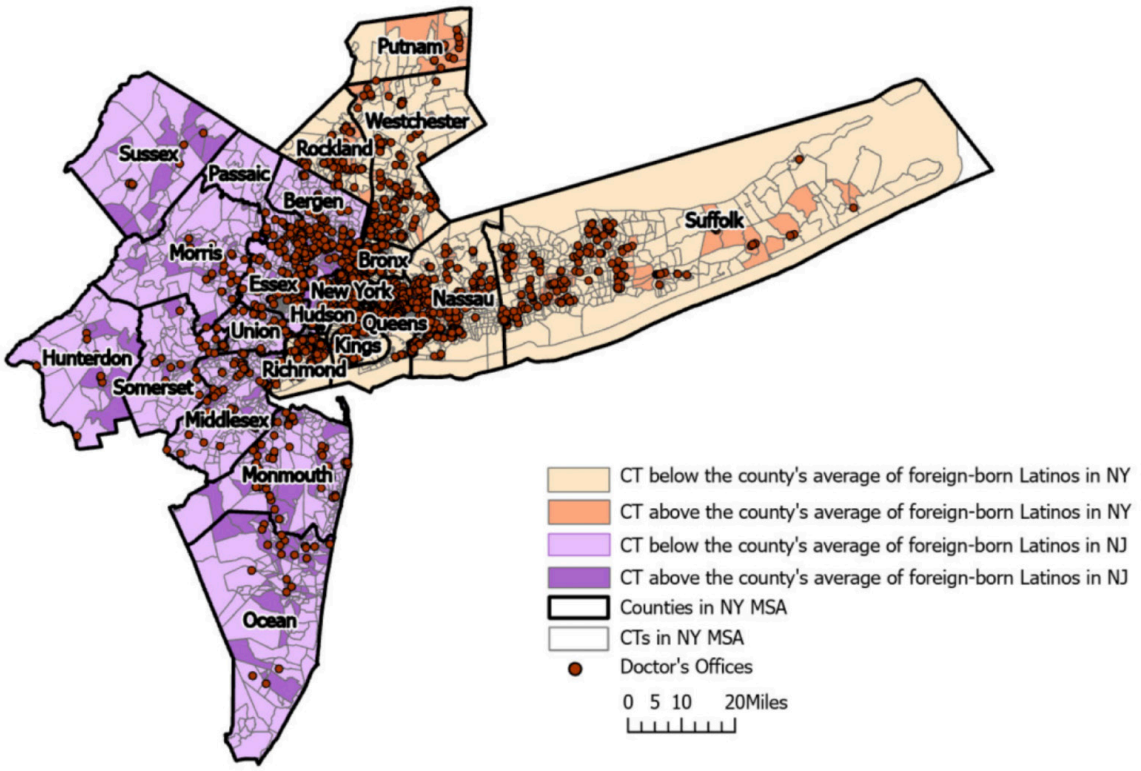
Currently, the five MCOs participating in NJ FamilyCare are Aetna Better Health of New Jersey, Horizon NJ Health, Fidelis Care, UnitedHealthcare Community Plan, and Wellpoint.[96] Together, they service 1.4 million Medicaid beneficiaries[97] living in the 12 New Jersey counties represented in the New York MSA (see Table 2).

Offices with Spanish- and-Chinese-speaking Healthcare Providers in the New York MSA

Provider accessibility to bilingual Medicaid MCO offices is sparse for census tracts with higher-than -average foreign-born Latino and foreign-born Chinese communities living on the outskirts of the New York MSA, especially in New Jersey counties, including Sussex, Passaic, Morris, Hunterdon, Somerset, Middlesex, Monmouth, and Ocean (see Maps 5 and 6). The greater number of census tracts with above average Chinese foreign-born populations in these counties suggests that the lack of available bilingual providers impacts Chinese communities more than Latino foreign-born

populations (see Map 6). In addition, bilingual providers in the New York MSA are most concentrated in the Essex, Hudson, and Nassau counties, and in New York City (i.e., Bronx, New York, Queens, Richmond, and Kings counties), providing coverage to census tracts representing both above-average foreign-born Latino and foreign-born Chinese populations (see Maps 5 and 6). However, despite what looks to be a high concentration of bilingual providers in these counties, MUA/P designations are mostly located in New York City, specifically in Brooklyn and Kings Counties, where they overlap most with eligible census tracts representing Latino foreign-born populations (see Map 9 in the Appendix).

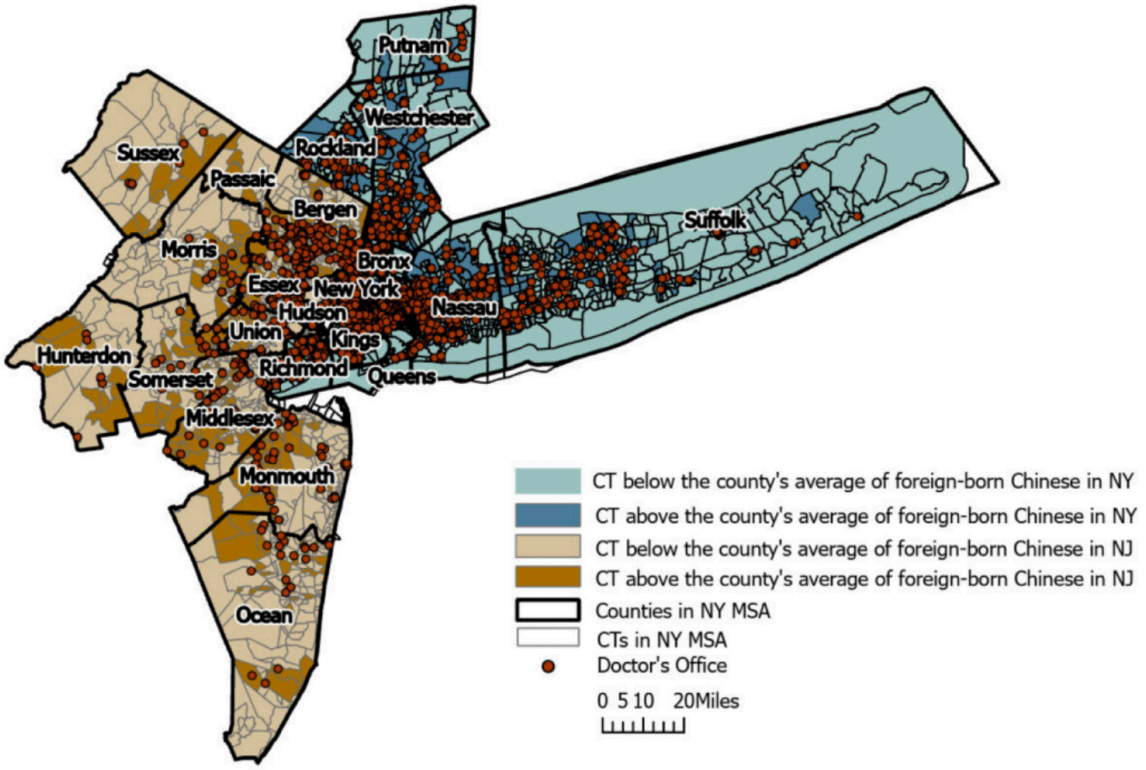
Map 5. Latino Foreign-Born Populations and Health Offices Accepting Medicaid Managed Care with Spanish-Speaking Providers in the New York Metropolitan Statistical Area (MSA)



Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates.

Note: Doctor's offices were identified using search engines available through Amida Care, Fidelis Care, Healthfirst, HealthPlus, Emblem-Health, MetroPlus Health Plan, Molina Healthcare of New York, UnitedHealthcare of New York, VNS Health, MVP, Health Care, Aetna Better Health of New Jersey, Horizon New Jersey, UnitedHealthcare of New Jersey, and WellCare of New Jersey. The dots represent health offices from those health plans that listed at least one Spanish-speaking provider. CT=Census Tract

Map 6. Chinese Foreign-Born Populations and Health Offices Accepting Medicaid Managed Care with Chinese-Speaking Providers in the New York Metropolitan Statistical Area (MSA)



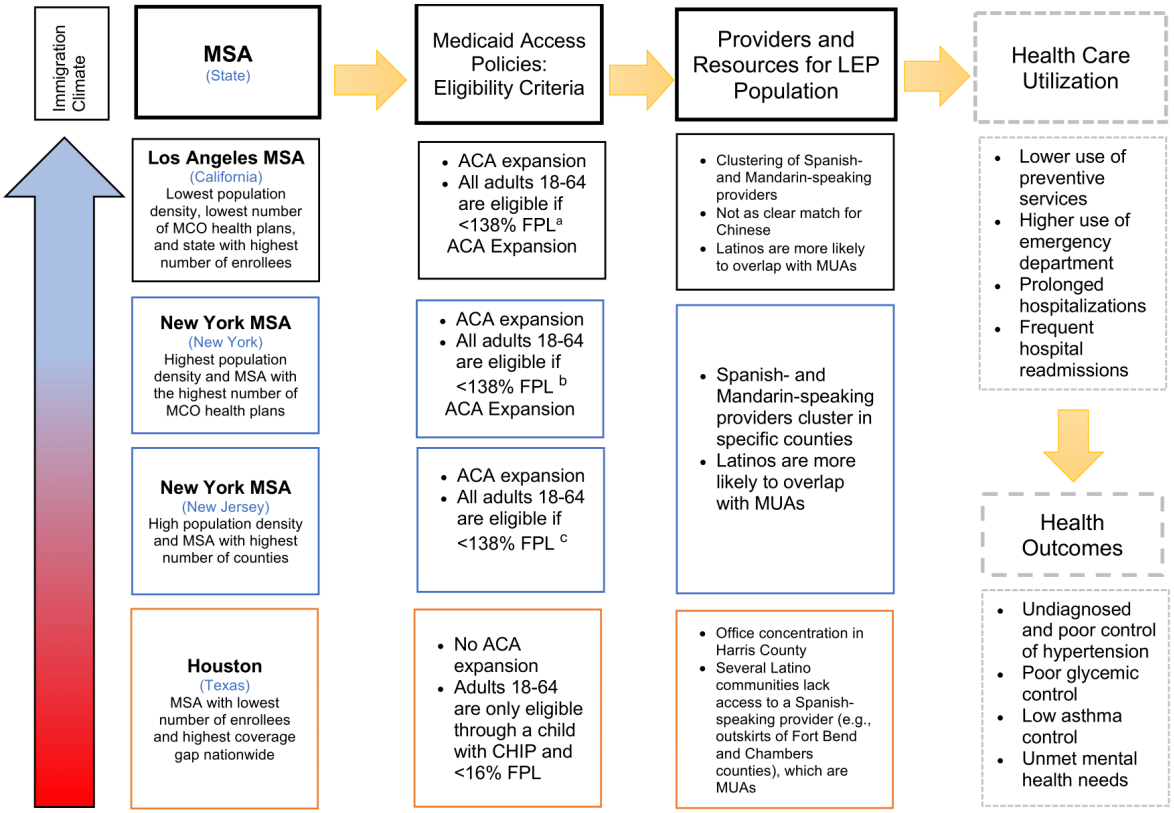
Source: U.S. Census Bureau, 2021 American Community Survey 1-year estimates.

Note: Doctor's offices were identified using search engines available through Amida Care, Fidelis Care, Healthfirst, HealthPlus, Emblem-Health, MetroPlus Health Plan, Molina Healthcare of New York, UnitedHealthcare of New York, VNS Health, MVP, Health Care, Aetna Better Health of New Jersey, Horizon New Jersey, UnitedHealthcare of New Jersey, and WellCare of New Jersey websites. The dots represent health offices from those health plans that listed at least one Chinese-speaking provider. CT=Census Tract

FINDINGS

Our analysis suggests that the ease or difficulty that LEP individuals experience in accessing Medicaid MCOs varies depending on where they reside (see Figure 1 below). The eligibility criteria can exacerbate barriers to accessing to Medicaid MCOs among LEP patients. State policies also set the groundwork for the availability of resources, such as the existence of providers that speak more than one language—a point that our geographic analysis corroborates, and which directly affects health care use and health outcomes. Our findings have implications for such utilization and outcomes, which exceed the scope of this research but are widely documented in the literature[98] as being worse for LEP than non-LEP individuals.

Figure 1. Barriers and Policies to Accessing Managed Care Organizations among Foreign-Born Individuals with Limited English Proficiency (LEP) Who Speak Spanish or Chinese in Los Angeles, Houston, or New York Metropolitan Statistical Areas (MSAs)



Note: Prescriptions and exceptions for foreign-born individuals
[a] Foreign-born individuals are eligible regardless of immigration status
[b] Foreign-born individuals are eligible if they are known to U.S. authorities and not at risk of deportation, short-term visa holders and undocumented immigrants over the age of 65
[c] Foreign-born individuals who have been Legally Permanent Residents for at least 5 years, refugees, asylees and immigrants ages 19 and 20 with low-incomes
Each MSA is indicated by a different color box. Health care utilization and health outcomes are in grey because they are not part of our research findings but are the domains in which health disparities are more evidently observed. **ACA**=Affordable Care Act, **LEP**=Limited English Proficiency **MCO**=Managed Care Organization, **MUA**=Medically Underserved Area, **FPL**=Federal Poverty Level, **ED**=Emergency Department

Key Finding 1: State-level Immigration Policies Influence Access to Medicaid MCOs for LEP Populations

State Medicaid Eligibility Criteria Is Heterogeneous across States

State-level policies generate a "climate" of settlement and incorporation of immigrants, who are often LEP. California has the most inclusive climate, as Medi-Cal's eligibility rules grant access to all children and low-income adults, regardless of immigration status. On the contrary, adults in Texas—one of the few non-ACA expansion states—can only access STAR as caretakers of CHIP beneficiaries, must meet a very low-income eligibility threshold (16% below the FPL), and immigrants can only gain access as documented immigrants. While the states of New York and New Jersey have exceptions that grant access to Medicaid for immigrant populations, these are nuanced and often unclear, and generate a difficult enrollment process, which may add administrative and logistical burdens to access health care for foreign-born residents and LEP individuals.

We also identified differences in the health care delivery organization. The Los Angeles MSA had three health care plans and two counties, while the Houston MSA and NY MSA had more than five plans, several counties, and divisions within the states of Texas, New York, and New Jersey. This fragmentation could potentially make it harder for beneficiaries to enroll in the program. However, a similarity between the three MSAs and respective states is that over 70% of Medicaid beneficiaries are covered by MCO health plans.

Key Finding 2: Spanish- and Chinese-speaking Providers Tend to Cluster across All Three MSAs as Opposed to Being Evenly Distributed

While we identified clustering of Spanish- and Chinese-speaking providers across the three MSAs, we observed differences between language groups and within counties in MSAs. In all three MSAs, most offices with a Spanish-speaking provider also had a provider who spoke Chinese. In the Los Angeles MSA, Spanish-speaking providers in both Los Angeles and Orange counties are located close to where more Latino foreign-born populations reside, indicating that they are located to service this community. However, the presence of Medicaid MCO Chinese-speaking providers is more sparse in both counties, indicating less availability for the foreign-born Chinese-speaking population. We observed a slightly similar pattern in the Houston MSA, where we found an overlap between availability of providers in both languages, but steeply clustered in Harris County. Montgomery, Fort Bend and Waller counties lack both Spanish- and Chinese-speaking providers and have a high concentration of MUAs. In the New York MSA, the presence of providers of both languages is low in the state of New Jersey, particularly in the outskirts. Like in the Los Angeles and Houston MSAs, in the New York MSA, Spanish- and Chinese-speaking providers cluster in certain counties such as Essex, New York, Hudson, Kings, and Queen (all in New York City or adjacent).

Key Finding 3: Medically Underserved Areas Overlap with Census Tracts with Higher-Than-County-Average Numbers of Foreign-Born Latinos

Relative to census tracts that represent above average Latino and Chinese foreign-born populations, the overall presence of Chinese-speaking providers is lower compared to Spanish-speaking providers across all three MSAs. Despite having a lower presence overall, Chinese-speaking providers were more commonly observed in census tracts identified as MUAs. Conversely, across

the three MSAs, medically underserved, understaffed, and under-resourced census tracts overlap with census tracts that have a higher-than-county-average number of foreign-born Latinos more so than census tracts with above average Chinese foreign-born populations. IIn the Los Angeles MSA, we observe this pattern in LA County; in Houston, in Montgomery, Waller and Fort Bend counties; and in New York, in Brooklyn and Kings counties. These medically underserved areas point to a generalized health workforce shortage, including lower availability of primary care services, which potentially accentuates health disparities between LEP and non-LEP Latino communities.

Key Finding 4: Access to Medicaid Navigation Resources for LEP Individuals Varies Significantly across States

Medicaid websites for all states (except Alaska) provide translated information in other languages.[99] In some cases, translation issues are present due to the websites' use of automated translation systems, such as Google Translate. Most states (46 out of 50 states) also included tagline notices about how to access language assistance services.

Given the growth of telehealth due to the COVID-19 pandemic, it is important to understand the challenges that individuals with LEP face in this new and growing area of health care delivery. During the pandemic, nationwide telehealth use increased tenfold, with 53 million telehealth visits between April and December 2020, compared to 5 million in all of 2019.[100] While telehealth use has decreased since the beginning of the pandemic, its use remains higher than pre-pandemic levels.[101] Past studies have shown that the likelihood of having a telehealth visit was lower for Medicaid and Medicare patients, compared to those with private insurance coverage.[102] Additionally, Latino and Asian patients were less likely to use telehealth compared to white patients.[103] Research has also highlighted the importance of focusing on LEP as a critical dimension in promoting telehealth equity and decreasing digital divides.[104]

CONCLUSION

Eligibility criteria for Medicaid enrollment can be the first barrier to access, particularly in states that have not adopted the ACA expansion. Our area-level analysis of bilingual Medicaid providers across three MSAs shows an overlap between Spanish-speaking providers and the place of residence for foreign-born Latinos. In addition, medically underserved census tracts also have a clear overlap with the Latino foreign-born population, highlighting that barriers to access to bilingual providers exist *within* the Latino foreign-born community. The supply of Chinese speaking providers is less wide-spread in the three MSAs, but they are less likely to be located in medically underserved areas.

POLICY RECOMMENDATIONS

Based on our findings, we provide the following recommendations to reduce barriers to accessing high-quality health care for foreign-born LEP adults with Medicaid managed care:

Medicaid Expansion

1. States should continue to adopt Medicaid expansion efforts, either under the ACA to cover low-income adults or through state initiatives such as Medi-Cal expansions in California.
   a. Medicaid expansion under the ACA would afford coverage to all adults under the age of 65 with incomes up to 138% of the FPL.
   b. For low-income LEP adults living in one of the 10 states that have not adopted the ACA's Medicaid expansion program, their first barrier to accessing Medicaid is their state's eligibility criteria. In these states, county initiatives can also often make up for the pitfalls and inequalities generated by state policies.
2. States should expand Medicaid coverage to immigrant communities.
   a. Only three West Coast states currently offer state-funded coverage for adults regardless of immigration status.
   b. Studies have shown that immigrants residing in states with more expansive coverage policies are more likely to be insured and receive care promptly as opposed to postponing or going without care.[105]

Enforcement of Linguistically Appropriate Care

3. Health care providers should extend language and translation services beyond patient-clinician communication.
   a. Although health care providers receiving federal funds are required to take steps to provide meaningful access to individuals, existing guidelines focus primarily on the interaction between provider and patient.[106]
   b. Information in native language and translation services needs to be available across the different steps that LEP individuals must navigate in the health care system (e.g., scheduling appointments, enrollment, and re-enrollment in Medicaid).[107]

Data Infrastructure

4. All state Medicaid programs should collect demographic information that includes data on primary language and LEP.
   a. In their most recent quality assessment of primary language data, CMS found that 37 states collect and report on primary languages and only four report LEP data.[108]
   b. Consistent data collection on primary language and LEP will allow for more accurate insights and targeted interventions to address health disparities among this marginalized population.

Federal Compensation for Interpretation Services

5. States should leverage the new CMS payment rule to include interpretation services for adult patients in their capitation rate.
    a. States are not required to reimburse Medicaid providers for the cost of language services; however, states do have discretion to claim reimbursement at a 50% match rate for these services under medical assistance-related expenses or administration.[109] Furthermore, states that expanded Medicaid under the ACA may receive a 90% match.[110]
    b. Currently, only 18 states and Washington, D.C. directly reimburse providers for language services. Of these, only six leverage the capitation rate through MCOs to include interpretation services.[111]

Health Care Workforce

6. States and health provider offices should retain and increase the number of bilingual staff serving LEP populations.
    a. Implement Foreign Language Incentive Pay to current and prospective employees to retain and increase the number of bilingual staff who can assist patients with LEP.[112]
    b. Recruit racial, ethnic, and linguistically diverse medical students, residents, and physicians. Low diversity in the physician workforce results in poor patient-provider communication and culturally inadequate care.[113]

APPENDIX

The ACA expanded Medicaid coverage to all adults under the age of 65 with incomes up to 138% of the Federal Poverty Level (FPL). The FPL is calculated every year and is determined by household size and the combined income of that household. Some states may opt to set a higher FPL threshold for Medicaid eligibility, but the minimum for states that have expanded under the ACA remains at 138%. Among states that have not expanded Medicaid eligibility, Texas, has the lowest FPL threshold at 16%.[114] Table A1 presents annual income limits by FPL and dollar amounts for adults under 65 in California, New York, New Jersey, and Texas. Annual income limits presented for Texas are for adults who are parents of caretakers of children 18 or younger, because childless adults do not qualify for Medicaid.[115]

Table A1. Medicaid Income Guidelines for 2024

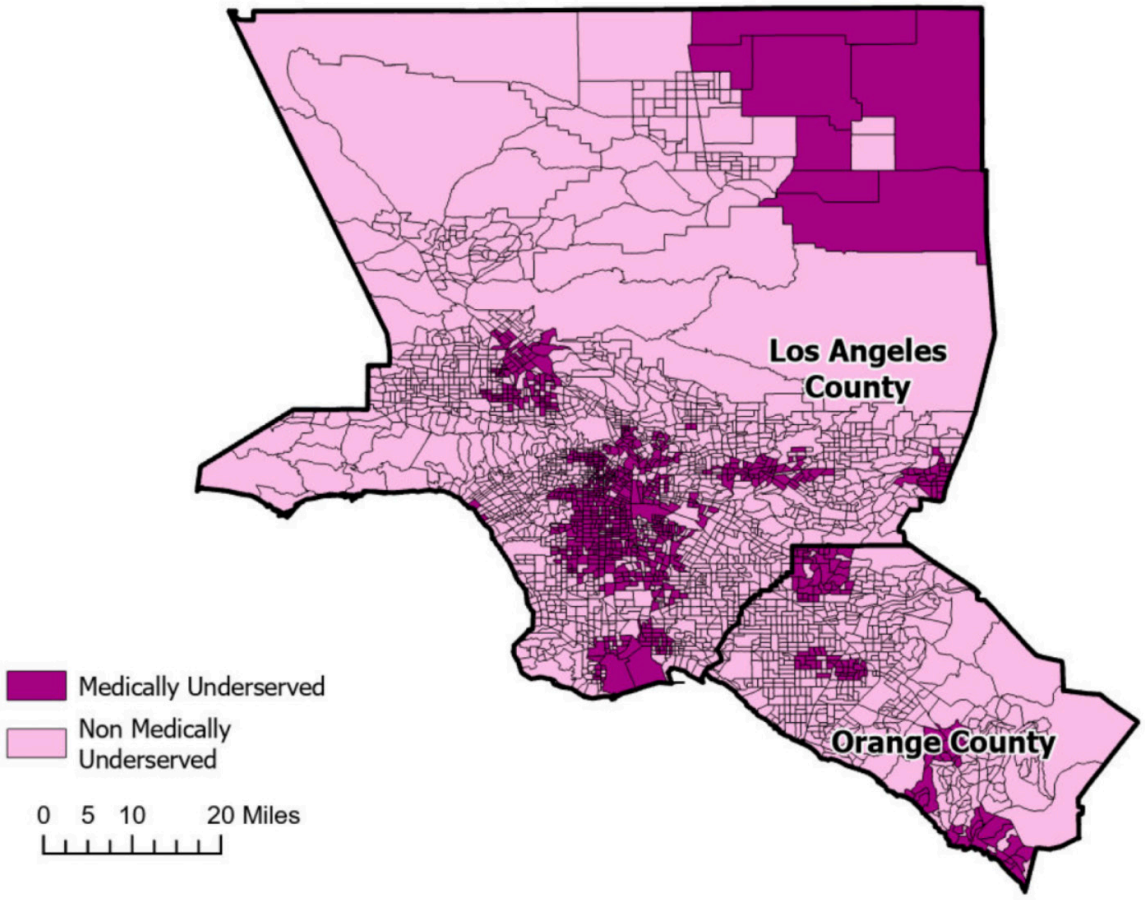
	Annual Income Limits	
Federal Poverty Level Threshold	138%[a]	16%[b]
Household Size		
1	$20,783	-
2	$28,207	$3,270
3	$35,632	$4,131
4	$43,056	$4,992
For each additional person, add:	$7,424	$861

Created with Datawrapper

Sources:
[a] U.S. Health and Human Services, "2024 Poverty Guidelines."
[b] KFF, "How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion"

Note: We calculated the annual income limit for Texas by multiplying the state's Medicaid federal poverty level (FPL) threshold reported by the Kaiser Family Foundation (16%) by the the FPL for each household size. For example, in 2024, the FPL was $25,820 for a family of three."

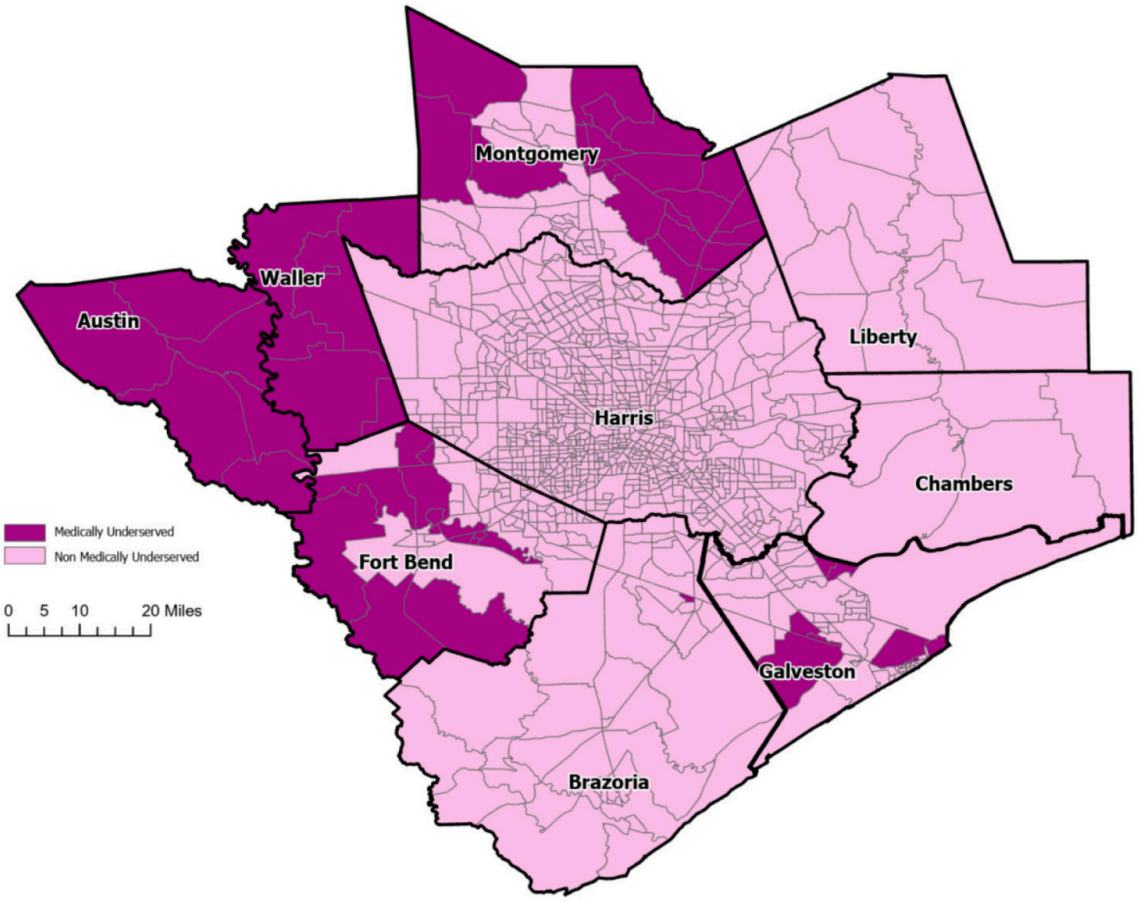
Map A1. Medically Underserved Communities in the Los Angeles Metropolitan Statistical Area (MSA)



Source: U.S. Health Resources & Services Administration, "Medically Underserved Area and Medically Underserved Population Designations," 2024

Note: Data for medically underserved designations are only available using 2010 census tract boundaries.

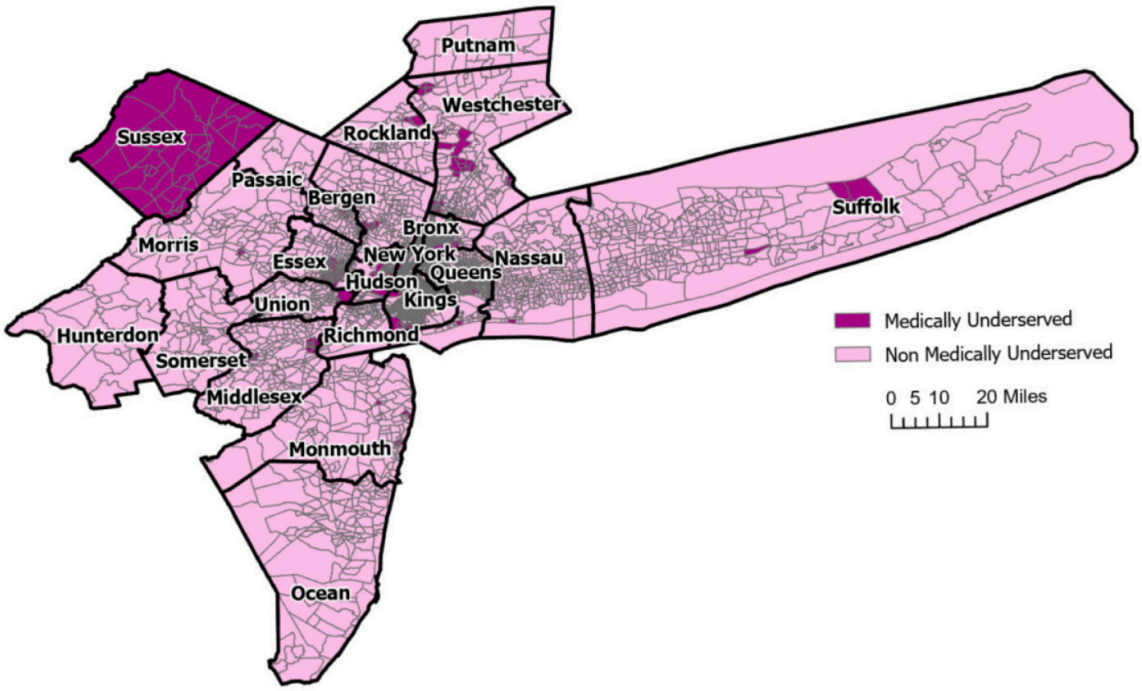
Map A2. Medically Underserved Communities in the Houston Metropolitan Statistical Area (MSA)



Source: U.S. Health Resources & Services Administration, "Medically Underserved Area and Medically Underserved Population Designations," 2024.

Note: Data for medically underserved designations are only available using 2010 census tract boundaries.

Map A3. Medically Underserved Communities in the New York Metropolitan Statistical Area (MSA)



Source: U.S. Health Resources & Services Administration, "Medically Underserved Area and Medically Underserved Population Designations," 2024

Note: Data for medically underserved designations are only available using 2010 census tract boundaries.

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UCLA Latino Policy & Politics Institute

@UCLAlatino

latino@luskin.ucla.edu