United States Senate
WASHINGTON, DC 20510–6200

March 25, 2022

The Honorable Eugene L. Dodaro
Comptroller General
United States Government Accountability Office
441 G Street NW
Washington, D.C. 20548

Dear Mr. Dodaro:

We write regarding concerns that COVID-19 vaccination rates among Medicaid beneficiaries remain lower than rates for the general population. Recent reports have identified administrative and technological barriers that block or limit access to data that would help Medicaid programs identify and reach out to individuals who remain unvaccinated against this terrible disease. We are concerned that these data barriers may be impeding efforts to increase COVID-19 vaccination rates and address persistent health inequities exacerbated by the pandemic, particularly among communities of color and people with limited incomes who have been disproportionately affected by this disease.

The American Rescue Plan Act guaranteed Medicaid beneficiaries' access to COVID-19 vaccinations without out-of-pocket costs.[1] As Chairman of the Senate Special Committee on Aging and Chairman of the Senate Committee on Finance, we want to ensure every effort is made to ease vaccine access to these beneficiaries. Therefore, we request that the Government Accountability Office (GAO) conduct a study exploring factors contributing to lower COVID-19 vaccination rates for Medicaid enrollees versus the general public and identify barriers limiting state Medicaid programs' access to state immunization registries. In so doing, GAO should seek to review how these issues—including health inequities experienced by communities of color and low-wage workers who disproportionately receive Medicaid coverage—may contribute to low vaccination rates among Medicaid beneficiaries.

Recent press reports have highlighted how Medicaid enrollees continue to be vaccinated for COVID-19 at significantly lower rates than the general population—even in states with high overall vaccination rates. For example, an article published by *Kaiser Health News* in August noted that 49 percent of California's Medicaid enrollees ages 12 and over were at least partly

[1] Pub L. 117-2 (Mar. 11, 2021), Section 9811; see also, "Biden-Harris Administration Releases Medicaid and CHIP Guidance Targeting Vaccination and Testing for COVID-19," Newsroom, CMS.gov, posted August 30, 2021, https://www.cms.gov/newsroom/press-releases/biden-harris-administration-releases-medicaid-and-chip-guidance-targeting-vaccination-and-testing.

vaccinated for COVD-19 compared with 74 percent for Californians overall. The article also noted significant disparities in other states, including a 33 percentage point difference in vaccination rates between Medicaid enrollees and the general population in both Florida and Louisiana.[2] Similarly, in October, *Roll Call* reported disparities in several states, including Idaho (reporting a 40 percentage point difference in COVID-19 vaccination rates among Medicaid beneficiaries and the general population), Virginia (34 percentage points) and West Virginia (28 percentage points).[3] Furthermore, a December report by Duke University researchers noted a 15-20 percent difference nationally between Medicaid beneficiaries and people enrolled with other forms of health coverage.[4] These variations have been attributed to a variety of factors, including economic barriers, such as a lack of access to transportation, child care and sick leave. Surveys also indicate lower-income Americans report higher rates of vaccine hesitancy overall.[5] Most recently, *Kaiser Health News* reported last month that Medicaid vaccination rates across the Nation remain "far lower… than the general population despite vigorous outreach efforts by government officials and private organizations to get low-income people inoculated."[6]

In addition, administrative and technological barriers at the state level may undermine state Medicaid programs' efforts to identify which enrollees are vaccinated and which are not, limiting the ability of these programs to assess trends, conduct outreach and increase vaccination rates.[7] These barriers may include insufficient data-sharing across state Medicaid programs and other programs, including Immunization Information Systems (IIS), confidential databases that record when an individual has received a dose of vaccine.[8] Instances in which Medicaid programs have been granted timely access to these systems have been particularly helpful during the pandemic because of the widespread use of mass vaccination sites, many of which have not collected insurance information. This type of data sharing can be impeded by legal, regulatory and technological barriers, partly due to silos that often separate Medicaid programs from IIS and other data systems within states.[9] Effective data sharing may also be hampered by outdated or

---

[2] Phil Galewitz, "COVID-19: Medicaid Vaccination Rates Founder as States Struggle to Immunize Their Poorest Residents," *Kaiser Health News*, August 27, 2021, https://khn.org/news/article/medicaid-vaccination-rates-founder-as-states-struggle-to-immunize-their-poorest-residents/.

[3] Sandhya Raman, "Income Inequity Persists in COVID-19 Vaccination Rates," *Roll Call*, October 27, 2021, https://rollcall.com/2021/10/27/income-inequity-persists-in-covid-19-vaccination-rates/.

[4] Rebecca Cooper et al., "Strategies to Increase COVID-19 Vaccination Rates in Medicaid Enrollees: Considerations for State Leaders," Duke University, Margolis Center for Health Policy, at 2, December 2021, https://healthpolicy.duke.edu/sites/default/files/2021-12/Strategies%20to%20Increase%20COVID-19%20Vaccination%20Rates%20in%20Medicaid%20Enrollees.pdf.

[5] Sandhya Raman, "Policy: Medicaid Beneficiaries Less Likely to get COVID-19 Shots," *Roll Call*, June 30, 2021, https://www.rollcall.com/2021/06/30/medicaid-beneficiaries-less-likely-to-get-covid-19-shots/; and "American COVID-19 Vaccine Poll," African American Research Collaborative, 2021, https://covidvaccinepoll.com/app/aarc/covid-19-vaccine-messaging/#/.

[6] Phil Galewitz, "From Alabama to Utah, Efforts to Vaccinate Medicaid Enrollees Against Covid Run Into Obstacles." *Kaiser Health News*, February 22, 2022, https://khn.org/news/article/medicaid-covid-vaccine-obstacles-states/.

[7] *Supra*, note 4, at 3.

[8] *Supra*, note 2; see also "About Immunization Information Systems," Immunization Information Systems, Centers for Disease Control and Prevention, last reviewed June 7, 2019, https://www.cdc.gov/vaccines/programs/iis/about.html.

[9] Katie Greene et al., "Improving Immunization Information Sharing to Support Targeted COVID-19 Vaccination Outreach," Duke University, Margolis Center for Health Policy, at 6-7, July 2021, https://healthpolicy.duke.edu/sites/default/files/2021-07/Improving%20Immuniz%20Info%20Sharing.pdf.

incompatible technology, lack of geographic specificity[10] and limited or irregular access to data. As a result, we understand that a number of state Medicaid programs may not have full access to vaccination data of beneficiaries. Further, to the extent states have overcome data barriers, we want to ensure the time and money spent standing up these systems endure, given the clear benefits of improving public health, prioritizing health equity, lowering costs for Medicaid and being better prepared for future pandemics.

The lack of data can hinder a state's ability to assess and address health disparities that contribute to low vaccination rates among Medicaid beneficiaries. For example, in a report seeking to advance the use of data to address health equity shortfalls, Grantmakers in Health found that implementation of IIS vary "from system to system, with major implications for completeness and quality," and that "race and ethnicity data were available for only 62%" of COVID-19 vaccine recipients as of October 2021.[11] As recently as March 2022, race or ethnicity data remained unavailable for 26 percent of individuals who had received at least one dose of a vaccine for COVID-19.[12] Duke University's researchers stated that good data is necessary to "monitor progress, identify disparities, and facilitate outreach" to address vaccination disparities that persist across the Medicaid program.[13] A lack of good data hurts our ability to get shots in arms, which can prolong the pandemic and put high risk groups in even greater danger.

Barriers to vaccinating Medicaid enrollees are particularly troubling given the program's importance for persons of color and low-wage workers. According to one analysis, an estimated 5 million front-line workers are enrolled in Medicaid, making that program a "crucial source of coverage" for individuals who have risked exposure to COVID-19 in order to maintain our Nation's economy, including the health care system and other critical services.[14] Meanwhile, the Kaiser Family Foundation details a higher level of Medicaid enrollment among Black people (33 percent), Hispanics (30 percent) and American Indian/Alaskan Natives (34 percent) compared to the general population (21 percent).[15] The Centers for Disease Control and Prevention has similarly noted that persons of color are disproportionately represented among COVID-19 cases.[16] Addressing the disparity in vaccination status for Medicaid enrollees and ensuring greater data sharing among different programs is therefore vital for protecting essential workers and for addressing health equity concerns related to the pandemic.

---

[10] For example, Pennsylvania Medicaid officials told Aging Committee staff that data at the ZIP code level would help the program to better target outreach efforts to increase vaccination rates.

[11] Cara James et al., "Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity," Grantmakers in Health, at 13, December 2021, https://www.gih.org/wp-content/uploads/2021/12/GIH-Commonwealth-Fund-federal-data-report-part-2.pdf.

[12] Nambi Ndugga et al., "Latest Data on COVID-19 Vaccinations by Race/Ethnicity," Kaiser Family Foundation, published March 9, 2022, https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-by-race-ethnicity/.

[13] *Supra*, note 4, at 3.

[14] Matt Broaddus, "5 Million Essential and Front-line Workers Get Health Coverage Through Medicaid," Center on Budget and Policy Priorities, August 4, 2020, https://www.cbpp.org/blog/5-million-essential-and-front-line-workers-get-health-coverage-through-medicaid.

[15] "Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity," Kaiser Family Foundation, accessed March 21, 2022, https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[16] "Disparities in COVID-19 Illness," COVID-19, Centers for Disease Control and Prevention, last updated December 10, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/increased-risk-illness.html.

In order to better understand the issues that contribute to persistent disparities in COVID-19 vaccination rates among Medicaid beneficiaries and the data barriers interfering with the ability of Medicaid programs to improve outreach and address existing health inequalities, we request the GAO to conduct a study that addresses the following questions:

(1) In states that have applicable vaccination data, what factors contribute to Medicaid vaccination rates remaining lower than the that of the general population? For example, what is known about the extent to which health inequities and socioeconomic disparities contribute to these low rates?

(2) How have states used data to improve COVID-19 vaccination rates among Medicaid enrollees, including among core groups such as older adults, persons with disabilities, communities of color, low-income workers, children and enrollees who are dually eligible for Medicare and Medicaid? How have state Medicaid programs used data, including data from state IIS, to help address vaccination disparities during and prior to the COVID-19 pandemic?

(3) Researchers have noted that IIS, like other public health infrastructure, "have sometimes operated in funding and operational silos that have discouraged or limited coordination with health care partners."[17] Please identify, describe and, to the extent possible, quantify examples of state Medicaid programs that either have no access or limited access to COVID-19 vaccination data from their state IIS. For Medicaid programs that have secured adequate access to IIS data, what processes have been used to grant such access, and overcome any legal, regulatory, budgetary, technological or other barriers? For states that have allowed Medicaid to access their IIS, will Medicaid have access to vaccination data beyond the current public health emergency, or will that access need to be negotiated again in the event of a future pandemic?

(4) What factors, if any, contribute to differences in the completeness of COVID-19 vaccination data among Medicaid enrollees across states? What differences exist across states in regard to the collection and availability—including timeliness and specificity—of COVID-19 vaccination data, including factors such as insurance coverage, disability status, community, income, geographic location, gender and race? What factors, if any, contribute to these differences, including differences in the data available for state Medicaid programs?

(5) What federal funding opportunities exist for states to improve vaccination outreach, uptake and data monitoring among Medicaid enrollees, including opportunities to improve data sharing between Medicaid programs and IIS and to update outdated or incompatible IIS technology? What other federal support exists to promote outreach to Medicaid beneficiaries, improve access to such services and improve applicable data sharing, including technical guidance and model data sharing agreements, and how often do states make use of these forms of assistance?

[17] *Supra*, note 9, at 6-7.

Thank you for your attention to this important matter. If you or your staff need additional information, please contact Doug Hartman with the Aging Committee staff and Melissa Dickerson with the Senate Finance Committee.

Sincerely,

Robert P. Casey, Jr.
Chairman
Senate Special Committee on Aging

Ron Wyden
Chairman
Senate Committee on Finance