APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

Headquarters
One Kaiser Plaza Suite 850
Oakland, CA 94612
Main 415-954-9988
Fax 510-419-0263
www.apiahf.org

Washington D.C. Office
1629 K Street N.W. Suite 400
Washington, D.C. 20006
Main 202-466-7772
Fax 202-466-6444

National Advocates for Asian American, Native Hawaiian & Pacific Islander Health

January 4, 2021

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9912-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: **Comments on CMS-9912-IFC**
Center for Medicare and Medicaid Services Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

I am writing on behalf of the Asian & Pacific Islander American Health Forum (APIAHF) in response to the Centers for Medicare and Medicaid Services (CMS) Interim Final Rule "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency".

APIAHF is the nation's leading health policy organization working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AANHPI) across the U.S. and territories. APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage. We have longstanding relationships with over 100 community-based organizations across 34 states and the Pacific, to whom we provide capacity building, advocacy and technical assistance. Since 2012, APIAHF and partners have worked to outreach to, educate and enroll 1 million consumers through Action for Health Justice (AHJ), a national collaborative of more than 70 AANHPI national and local community-based organizations and health centers.

As such, we have a strong understanding of the needs and barriers experienced by AANHPI communities across the country and the community-based organizations working with them, and the impact that changes outlined in the Interim Final Rule (IFR) would have on those individuals and communities.

The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, includes an option for states to receive enhanced federal Medicaid funding. In exchange for the additional funds, states must agree to comply with maintenance of effort (MOE) protections. These protections help ensure individuals, including many immigrants eligible for Medicaid, are able to get and stay covered during the crisis and receive needed services. The FFCRA includes an explicit requirement to preserve enrollee's existing benefits – both their enrollment in Medicaid overall, and the services for which they have been eligible.

We are writing to express our deep concern about several provisions of this IFR. In a reversal of CMS's stated policy from March to October 2020, this IFR would now allow states to impose numerous types of coverage restrictions for individuals who are

enrolled in Medicaid. These provisions could particularly have a negative impact on immigrants and their families. Immigrants are essential workers, and many fulfill critical roles at the frontlines of the pandemic. Our healthcare system in particular relies heavily on immigrant workers, who account for nearly one in five health care staff and are overwhelmingly people of color.

We also oppose allowing states to receive enhanced funding despite refusing to cover COVID-19 vaccination for some Medicaid enrollees, which could significantly impact the ability of pregnant immigrant women enrolled in the Children's Health Improvement Program (CHIP) to obtain the COVID vaccine. We recommend that CMS withdraw these provisions.

Reductions in Services

The IFR would allow states to change the amount, duration, and scope of Medicaid services. For example, when states faced budget constraints after the Great Recession, some states placed numerical caps on benefits like physician visits and hospital days. While these capped services may have been adequate for some enrollees, in many cases they were likely not sufficient for other populations, such as some immigrants with chronic illnesses and disabilities. Given the disproportionate impact of many chronic conditions on communities of color, heightened by the impact of COVID-19, the full scope of Medicaid services are critical for these vulnerable populations.

Increased Cost-Sharing

The IFR would allow states to increase cost-sharing, which would also harm immigrants, persons who are low-income and communities of color. Research over the last four decades has consistently concluded that the imposition of cost-sharing on low-income populations reduces both necessary and unnecessary care and correlates with increased risk of poor health outcomes.

Further, the pandemic increases the harm caused by cost-sharing. The pandemic has significantly increased financial hardship among low-income families and families of color, making it less likely that they will be able to afford to pay additional cost-sharing. AANHPIs have been disproportionately impacted by the COVID-19 pandemic, facing higher rates of infection, death and economic consequences. For example, according to the UCLA COVID-19 Racial Data Tracker, NHPIs are the most likely to have contracted COVID-19 this year.[1] The social determinants of health that underlie these disparities in COVID-19 deaths include increased incidence of xenophobic hate and violence. AANHPI organizations have documented at least 1,900 hate incidents in 46 states.[2] In addition, AANHPIs have increased risk of adverse COVID-19 outcomes (e.g., burden of chronic conditions and multigenerational homes), and a large proportion of are frontline essential workers.[3]

In at least 10 states, AAs have a case fatality rate that is disproportionately higher than the general population, while the same is true for NHPIs in 8 states.[4] For example, in South Dakota, the case rate for

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[1] COVID-19 Racial Data Tracker. https://covidtracking.com/race.

[2] Ko JY, Danielson ML, Town M, et al. Risk Factors for COVID-19-associated hospitalization: COVID-19-Associated Hospitalization Surveillance Network and Behavioral Risk Factor Surveillance System. *medRxiv*. Published online July 27, 2020:2020.07.27.20161810. doi:10.1101/2020.07.27.20161810.

[3] Kaholokula JK, Samoa RA, Miyamoto RES, Palafox N, Daniels S-A. COVID-19 Special Column: COVID-19 Hits Native Hawaiian and Pacific Islander Communities the Hardest. *Hawaii J Health Soc Welf*. 2020;79(5):144-146. See also Krisberg K. Essential workers facing higher risks during COVID-19 outbreak: Meat packers, retail workers sickened. *The Nation's Health*. 2020;50(6):1-16. See also Jurado L-FM, Saria MG. Filipino nurses in the United States. *Nursing Management*. 2018;49(3):36–41. doi:10.1097/01.NUMA.0000530423.71453.58.

[4] Testimony from the National Council of Asian Pacific Islander Physicians to the Committee on Ways and Means (June 9, 2020). Available at:

AAs is 6 times higher as a proportion of their population in the state.[5] These numbers may be larger, but many states are not reporting out data in sufficient enough detail to evaluate disparities, while the CDC has not reported out any data about AANHPI subpopulations, many of whom often face distinct health disparities.[6]

Across the country, Pacific Islanders are being hospitalized with COVID-19 at up to 10 times the rate of other racial groups. In Oregon, Pacific Islanders make up .4% of the population, but represent nearly 3% of all COVID-19 infections. Summarily, in Arkansas, Pacific Islanders make up .3% of the population, but account for 8% of COVID-19 cases. In Hawaii, Pacific Islanders make up 4% of the population, but 25% of COVID-19 cases.[7]

AA businesses were some of the earliest to report declines in business due to the COVID-19 pandemic and are overrepresented in some of the hardest hit sectors. Further, AA unemployment rates have increased by 450 percent from February to June 2020, a rate higher than any other racial group.

These data points illustrate the impact of the harm of COVID-19 on AANHPIs and the resulting hardships they would face if required to contribute to cost-sharing.

General Eligibility Exceptions

Additionally, the IFR authorizes states to terminate coverage for individuals that should be protected under the FFRCA. This violates Congress' intent and should be rescinded.
Under the Immigrant Children's Health Improvement Act (ICHIA) option, states can cover lawfully present immigrant children and pregnant women in Medicaid and CHIP without a 5 year wait. However, once these children turn 21 and these women finish their 60-day postpartum period, the IFR requires states to restrict their eligibility to only services covered through emergency Medicaid. CMS is essentially saying that the MOE does not apply to these immigrants – an exclusion that is particularly troubling because immigrant communities have been disproportionately affected by COVID-19. Depending on the state, COVID-19 testing and treatment may not be covered under emergency Medicaid. Furthermore, affected immigrants will not have coverage for the management of chronic conditions, worsening health outcomes and potentially increasing the risk of death from COVID-19.

We also oppose the other eligibility exceptions under the maintenance of effort requirement.

Valid Enrollment

Under the IFR, CMS narrows the definition of "valid enrollment" to exclude some enrollees who should be considered properly enrolled and covered by the protections of the FFRCA.

CMS states that individuals eligible by presumptive eligibility are not "validly enrolled" for the purposes of the continuous coverage provision, on the theory that these individuals "have not received a determination of eligibility under the state plan." However, the Medicaid statute consistently describes

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https://mcusercontent.com/d7f02dd24377959c916d14de6/files/5ebe9b24-21f8-4d67-93d2-4f218db2e323/NCAPIP_Statement_to_House_Ways_and_Means_Committee_on_COVID_19_Disparities.pdf.

[5] Wen, Leana and Nakisa Sadeghi, Addressing Racial Health Disparities In The COVID-19 Pandemic: Immediate And Long-Term Policy Solutions, *Health* Affairs. Published July 20, 2020. Available at: https://www.healthaffairs.org/do/10.1377/hblog20200716.620294/full/.

[6] For example, APIAHF analysis of 2018 American Community Survey data shows that while the overall uninsured rate for Asian Americans is 6.2%, the uninsured rate for Nepalese is 13.4% and 9.4% for Pakistanis.

[7] *Id.*

presumptive eligibility as (for example, under hospital presumptive eligibility) "*determining*, on the basis of preliminary information, whether any individual is eligible for medical assistance…" (emphasis added).[8] CMS's attempt to distinguish presumptively eligible populations is therefore inconsistent with the Medicaid statute. Moreover, pandemic-related circumstances are making it extremely difficult for many people to complete a full Medicaid application before their presumptive eligibility period ends. For example, 25 million Americans are limited English proficient and face major barriers to navigating day-to-day life in English, let alone completing complex applications such as Medicaid. COVID-19 has created considerable logistical and economic burdens on all communities, and particularly those who are low-income resulting in job loss and loss of child-care. We should be expanding presumptive eligibility for everyone, including immigrants, during a pandemic.

Availability of COVID-19 Vaccines

Immigrants and communities of color have been one of the groups hardest hit by the pandemic, with millions serving as frontline essential workers and often ineligible for many public programs or COVID relief. Public health experts agree that widespread use of a safe and effective preventive vaccine will be essential to curb this deadly pandemic.

With the recent emergency use authorization for both the Pfizer and Moderna vaccines and passage of the December 21 omnibus COVID relief packages, Congress properly recognized the vital importance of coverage and access to COVID-19 vaccines when it enacted the FFCRA. Congress provided that state Medicaid programs receive enhanced federal funding if they cover approved COVID-19 vaccines, and provide access without cost sharing, during the period of the public health emergency.

However, CMS is inexplicably seeking to *limit* access to COVID-19 vaccines, allowing states to exclude coverage of vaccinations. To date, states that operate CHIP separate from their Medicaid programs have covered vaccines for all CHIP enrollees. This includes many pregnant immigrants who may obtain CHIP eligibility through their state's adoption of the Immigrant Children's Health Improvement Act (ICHIA) option or through coverage of the fetus of a pregnant immigrant. Yet the IFR says that states do not have to cover vaccines for pregnant and post-partum women in separate CHIP programs. If a state chose to do this, a very vulnerable population could not get a critical vaccine in the midst of a public health emergency. This not only violates principles of health equity, it seeks to undermine the entire national vaccine strategy which is dependent upon broad levels of vaccination, and particularly amongst the most vulnerable.

Use of an Interim Final Rule

We do not believe CMS should have implemented these policies – which directly and materially impact access to health care for tens of millions of enrollees during a pandemic – as an interim final rule. There is no significant exigency associated with a notice and comment period for the policy contained in this IFR, whereas reducing health care eligibility, decreasing benefits, and increasing costs during a pandemic without an opportunity to comment will lead to immediate harms to many immigrants and their families. These policies will cause substantial harms before HHS has time to finalize the rule – harms that could have been avoided had CMS solicited public comments, like ours, before the rule went into effect.

Other Provisions

In addition to the provisions mentioned above, we also oppose the changes to allow states to:

- increase utilization management;

[8] 42 U.S.C. § 1396(a)(47)(B).

- modify the post-eligibility treatment of income rules;
- move enrollees from one tier of benefits in Medicaid to another;
- terminate people during the pandemic;
- determine individuals ineligible due to procedural issues; and
- allow modifications to the Section 1332 waiver process to reduce public input.

Conclusion

This is an unprecedented pandemic, and Congress took unprecedented measures under the Families First Coronavirus Response Act to ensure all Medicaid enrollees, including immigrants, can access the services they need. HHS IFR is contrary to law and would dramatically impact immigrants and their families at a time when health care is more important than ever. **We strongly oppose the discussed provisions of the IFR and urge HHS to withdraw these provisions immediately.**

Finally, we have included citations and direct links to research and other materials. We request that HHS consider the full text of material cited, along with the full text of our comment, part of the formal administrative record for purposes of the Administrative Procedures Act. If HHS is not planning to consider these citations part of the record, we ask that HHS notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to comment on this important issue. Please do not hesitate to contact my staff at policy@apiahf.org if you have any questions or need any further information.

Sincerely,

Juliet K. Choi
Chief Executive Officer
Asian & Pacific Islander American Health Forum