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*

November 7, 2022

Submitted via electronic submission at http://www.regulations.gov

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 2021

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes; CMS-2421-P**

Dear Secretary Becerra and Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule, Streamlining the Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (hereinafter "2022 Proposed Rule"). The Asian & Pacific Islander American Health Forum (APIAHF) and the undersigned organizations commend CMS for proposing changes that aim to streamline the application, eligibility determination, enrollment, and renewal processes for Medicaid, CHIP, and the Basic Health Program.

Most of the organizations represented work to advance the health and well-being of over 25 million Asian Americans, Native Hawaiians and Pacific Islanders (AA and NH/PI) across the U.S. and territories. Other signatories strongly support this work, even as our efforts focus primarily on other populations. We all aim to improve access to and the quality of care for communities who are predominantly immigrant, many of whom are limited English proficient (LEP) and may be new to the U.S. healthcare system. We aim to improve access to and the quality of care for communities who are predominantly immigrant, many of whom are limited English proficient (LEP) and may be new to the U.S. healthcare system. We draw upon our extensive experience and the relationships fostered to understand the needs and barriers faced by AA and NH/PI communities across the U.S. and territories, and the impact that changes outlined in the proposed rule would have on those individuals and communities.

According to the Pew Research Center, the AA and NH/PI population is projected to reach 46 million by 2060, making it the fastest growing demographic in the U.S.[1] AA and NH/PIs also have the widest disparities when it comes to economic well-being and health. Health insurance coverage rates among AA and NH/PI populations vary significantly by subgroup, with uninsured rates in 2019 as high as 10 percent for Korean Americans and 12 percent for NH/PIs.[2] In 2019, more than 2 million, or over 2 percent, of all Medicaid & CHIP enrollees, were AA and NH/PIs.[3] While the majority of AA and NH/PIs live in Medicaid expansion states, AA and NH/PIs also had overall lower coverage gains associated with Medicaid expansion than White, Hispanics and Blacks.[4] It was also found that NH/PIs are less likely to have private insurance and more likely to be covered by Medicaid, with 50 percent of NH/PI children being covered by Medicaid or CHIP.[5] In addition, there are more than 94,000 citizens from Compacts of Free Association (COFA) States[6] residing in the U.S., many of whom currently receive coverage, or are eligible for coverage, through Medicaid.[7,8] In short, Medicaid & CHIP provide a critical lifeline to coverage and care for millions of AA and NH/PIs and their families.

We support CMS finalizing the 2022 Proposed Rule as proposed, subject to the comments below. Finalizing the rule will help simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid, CHIP, and the Basic Health Program, removing barriers in access to health care coverage. These are especially important changes that could help reduce coverage gaps and losses for the over 89 million people currently covered by Medicaid and CHIP, especially for communities of color, who are predicted to be disproportionately

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[1] Abby Budiman and Neal G. Ruiz, *Key facts about Asian Americans, a diverse and growing population,* Pew Research Center (April 2021). Available at: https://www.pewresearch.org/fact-tank/2021/04/29/key-facts-about-asian-americans/.

[2] Assistant Secretary for Planning and Evaluation (ASPE), *Health Insurance Coverage Changes Since Implementation of the Affordable Care Act: Asian Americans and Pacific Islanders* (May 2021). Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265581/aspe-uninsured-trends-aapi-ib.pdf.

[3] Kaiser Family Foundation, *Distribution of the Nonelderly with Medicaid by Race/Ethnicity, 2019.* Available at: https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?dataView=0&currentTimeframe=0&selectedDistributions=asiannative-hawaiian-and-pacific-islander&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Assistant Secretary for Planning and Evaluation (ASPE), *Health Insurance Coverage Changes Since Implementation of the Affordable Care Act: Asian Americans and Pacific Islanders* (May 2021). Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265581/aspe-uninsured-trends-aapi-ib.pdf.

[5] Drishti Pillai, Nambi Ndugga, and Samantha Artiga. *Health Care Disparities Among Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) People,* Kaiser Family Foundation (May 2022). Available at: https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-care-disparities-among-asian-native-hawaiian-and-other-pacific-islander-nhopi-people/.

[6] For more information on the Compacts of Free Association, please visit: https://www.apiahf.org/resource/cofa-medicaid-factsheet/.

[7] Government Accountability Office (GAO), *Compacts of Free Association: Populations in U.S. Areas Have Grown, with Varying Reported Effects* (June 2020). Available at: https://www.gao.gov/assets/gao-20-491.pdf.

[8] When the compacts were initially signed in 1986, citizens of COFA countries were eligible for Medicaid; however, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act removed this eligibility. After decades of being denied access to Medicaid, in December 2020, access to Medicaid was restored for COFA migrants residing in one of the 50 states and the District of Columbia who meet all of the eligibility criteria in their state.

impacted by the resumption of Medicaid eligibility redeterminations when the continuous coverage requirement comes to an end.[9]

Our comments on the 2022 Proposed Rule provisions are below.

## A. Facilitating Medicaid Enrollment

***Verification of citizenship and identity (§ 435.407)***

**We support CMS' proposal regarding citizenship documentation requirements.** Under current regulation, individuals whose citizenship is electronically verified through a match with a State's vital statistics records or with the U.S. Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program, must still provide proof of identity to prove citizenship. This additional verification step is redundant as identity is already verified when verifying citizenship, whether through a State vital statistics agency or through DHS SAVE program. By allowing state vital statistics systems and data from DHS to be used as "standalone" proof of citizenship in addition to SSA data, the proposed regulation would reduce the burden on individuals and increase administrative efficiency without increasing the risk of erroneous eligibility determinations.

## B. Promoting Enrollment and Retention of Eligible Individuals

***Timely determination and redetermination of eligibility (§435.907 and §435.912)***

**We generally support these proposed changes to better ensure timely determinations and redeterminations, without sacrificing the accuracy of eligibility determinations.** The changes would ensure that applicants and enrollees have adequate time to furnish all requested information and that states complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances.

**We support the proposal to provide most applicants with at least 15 days, from the date the request is sent, to respond with additional information**. This proposal will help ensure that new applications can be acted upon in a timely manner. We also agree that applicants applying on the basis of disability should be provided with at least 30 days to return additional information, since such information may be more challenging to gather. In general, the timelines and changes that CMS discusses in the preamble appropriately account for the need to prevent denials of coverage without an accurate determination of ineligibility while at the same time minimizing the need to extend coverage beyond an enrollee's period of eligibility.

Although we support giving applicants more time to return requested information, when needed, we urge CMS not to change the timeliness requirement for application processing if applicants are given more time. CMS should retain the current 45- and 90-day processing timelines to ensure that eligibility determinations are made in a timely manner: extending

[9] Assistant Secretary for Planning and Evaluation (ASPE), *Health Insurance Coverage Changes Since Implementation of the Affordable Care Act: Asian Americans and Pacific Islanders* (May 2021). Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265581/aspe-uninsured-trends-aapi-ib.pdf.

the timelines could needlessly delay eligibility determinations and would not be in the best interests of beneficiaries.

*Recommendation*

- CMS should clarify the regulatory text to ensure that the final rule accurately reflects an approach that prevents denials of coverage without an accurate determination of ineligibility while at the same time minimizing the need to extend coverage beyond an enrollee's period of eligibility.
- CMS should use calendar days to assure timely determinations. Doing so is consistent with how most states currently calculate deadlines and thus would be less operationally challenging to implement.
- CMS should require states to include a deadline based on when the item is expected to be sent (rather than the date the notice is generated – which can be days before it is mailed – or requiring individuals to calculate deadlines based on postmarks).

## C. Eliminating Barriers to Access in Medicaid

***Remove optional limitation on the number of reasonable opportunity periods (§435.956 and §457.380)***

**We support this change because allowing states to limit the number of reasonable opportunity periods (ROPs) would make it harder for eligible people to enroll, disproportionately impacting certain groups, including COFA migrants, for whom electronic verification of status or identity may be difficult.** When an applicant attests to citizenship or a satisfactory immigration status, but the state is unable to verify such status, the state is required to provide a reasonable opportunity period (ROP) of 90 days (or longer) for verification. During the ROP, states must furnish Medicaid/CHIP benefits. Under current law, states have the option to limit the number of ROPs an individual may receive, though no state currently does so. Proposed §435.956 would remove this option in Medicaid and CHIP (by an existing cross reference in §457.380).

Removing limits on ROPs would help COFA citizens and other immigrants, who have resided in the U.S. for a long time and are eligible for Medicaid, to maintain coverage while gathering the necessary documents. This additional time to gather these documents may be necessary for some because documentation may be difficult to obtain if individuals have moved or misplaced the documentation. Specifically, copies of I-94 cards which indicate arrivals and/or departures into the U.S., can be difficult to replace once lost because the Customs and Border Protection (CBP) automatically cuts off online access to these cards after 10 years and the data may not be available online for migrants who entered prior to April 2012.[10]

[10] Anita Hofschneider, "Pacific migrants will soon find it easier to access key documents," *Honolulu Civil Beat* (May 2022). Available at: https://www.civilbeat.org/2022/05/pacific-migrants-will-soon-find-it-easier-to-access-key-documents/.

*Recommendation*

- We urge CMS to engage in oversight on states' implementation of this provision to ensure that states utilize ROPs correctly and individuals receive benefits during the ROP.

***Remove or Limit requirement to apply for other benefit (§ 435.608)***

**We strongly support CMS' proposal to remove the requirement for applicants and enrollees to apply for other benefit programs as a condition of Medicaid eligibility**. We agree that changes in Medicaid eligibility have made such a requirement outdated. Congress and the Clinton administration eliminated the Aid to Families with Dependent Children (AFDC) program and thereby delinked Medicaid eligibility for a significant number of enrollees. The ACA requires states to use Modified Adjusted Gross Income (MAGI) methodologies for many Medicaid eligibility categories, which must follow IRS rules and consider taxable income actually received. As CMS correctly observes, "there is no statutory mandate for the rule in § 435.608(a) that currently requires application for other benefits by Medicaid applicants and beneficiaries." (87 Fed. Reg. 54803.) Requiring individuals and families to apply for pensions, annuities, and other benefits as a condition of Medicaid eligibility impedes access to medical care, unduly burdens applicants and enrollees, and ultimately harms people by delaying needed care.

**However, we disagree with the alternative approaches CMS suggests, including making the requirement a post-enrollment activity.** Such a requirement may seriously limit the amount and scope of benefits for which an individual may be eligible. For example, most adults in the United States may apply for Social Security benefits at age 62. However, delaying until age 67 or 72 can significantly increase the amount of benefits received. Medicaid applicants and enrollees should not have to forgo their full, earned Social Security benefit to access Medicaid.

***Agency action on returned mail (§435.919 and §457.344)***

**We support provisions in the proposed rule that would require states to take reasonable steps to determine beneficiaries' correct addresses by checking available data sources and making multiple attempts at contacting beneficiaries, through multiple modalities, before terminating coverage.** Current Medicaid and CHIP regulations do not specify steps states must take to follow up on mail that is returned as undeliverable, even though returned mail leads to a significant number of eligible people losing coverage. The proposed requirements for acting on mail returned with in-state, out-of-state, and no forwarding addresses represent reasonable approaches to ensure that individuals who are likely still eligible remain so and that individuals who have moved out of state do not remain enrolled. This is especially pertinent given the uptick in the number of people who moved, especially during the first year of the pandemic.[11] Finalizing new standards regarding returned mail will help avert coverage losses that are anticipated when the COVID-19 public health emergency comes to an end.

[11] Tim Henderson, "The pandemic prompted people to move, but many didn't go far." *Stateline* (March 2023), Available at: https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/23/the-pandemic-prompted-people-to-move-but-many-didnt-go-far.

*Recommendation*

- We encourage CMS to require states to accept information it receives from reliable sources, even if the enrollee does not respond to a request to confirm it.

### D. Recordkeeping (§431.17, §435.914, §457.965)

**While we support the proposal to detail specific records and documentary evidence that must be retained as part of each applicant's and beneficiary's case record, we urge CMS to consider maintaining individual case records for a minimum of 10 years, rather than the 3 years in the proposal.** The 2022 Proposed Rule would require that state Medicaid agencies retain the records for a minimum of 3 years after the applicant or beneficiary's case is no longer active. Current regulations require that state Medicaid agencies' records for applicants and beneficiaries include sufficient content to substantiate the eligibility determination made by the state but are unclear and lack specificity as to records retention.

*Recommendation*

- We suggest that state Medicaid agencies be required to maintain individual case records for a **minimum of 10 years** after the case is no longer active. This would more closely align the retention policy for these records with that for Medicaid managed care organizations under 42 C.F.R. § 438.3(u) and for drug manufacturers participating in the Medicaid Drug Rebate Program under 42 C.F.R. § 447.510(f).

**We support updating the regulations to require keeping applicant and beneficiary case records in electronic format, and we support making them available on request to CMS and Federal and state auditors.** The 2022 Proposed Rule would require that the state agency maintain the records in an electronic format and make the records available within 30 days of request to the Secretary, Federal and state auditors, and "other parties" who request and are authorized to review such records. **However, we do not support making these records available to "other parties" who request and are authorized to review such records.** The regulation should specify who has a legitimate program integrity purpose for accessing individual beneficiary records. At a minimum, the regulation should require that the authorization for any "other party" to access these records be provided under federal law, so that federal privacy protections clearly apply.

**Improving Participation in the Medicare Savings Program**

**We strongly support the provisions in the proposed rule that would significantly improve participation in the Medicare Savings Programs (MSPs).** These programs — the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program and the Qualifying Individual (QI) program — provide critical financial assistance to low-income older adults and people with disabilities also eligible for Medicare. For individuals with incomes below 100 percent of the federal poverty line, the QMB program covers Medicare Part B premiums (and Part A premiums, if applicable) and Medicare deductibles and other cost-sharing. The SLMB and QI programs pay for Part B premiums for individuals with incomes between 100 and 120 percent of the federal poverty line and 120 and 135 percent of the poverty line respectively. To give a sense of the value of these benefits, the standard monthly Part B premium in 2022 is $170.10 or $2,041.20 annually.

Despite legislative and administrative improvements over the past two decades that were intended to increase MSP participation among eligible low-income Medicare beneficiaries, participation remains relatively low. In 2019, 10.3 million, or only 16 percent of all Medicare beneficiaries were enrolled in a Medicare Savings Program.[12] Moreover, of the 1.6 million beneficiaries enrolled in Part D Low-Income Subsidy but not receiving premium or cost-sharing assistance through MSP, over 1.1 million were eligible but not enrolled.[13] Low participation is a concern because lack of cost sharing assistance can reduce beneficiary use of services.

As the Medicaid and CHIP Payment and Access Commission (MACPAC) has previously reported, QMB participation is estimated to be only 53 percent. Among those eligible for SLMB, participation is only 32 percent and among those eligible for QI, participation is only 15 percent. Moreover, participation is lower among older adults on Medicare than those under age 65 who are eligible for Medicare due to disability. For example, QMB participation is 48 percent among those aged 65 and older, compared to 63 percent among those aged 18-64. SLMB participation is 28 percent among those aged 65 and older, compared to 42 percent among those aged 18-64. MACPAC finds that along with a lack of beneficiary awareness, barriers to enrollment, such as differences between state Medicaid eligibility rules and those for the Medicare Part D Low Income Subsidy (LIS) — which covers Medicare premiums and cost-sharing related to prescription drugs — and lack of automated and streamlined enrollment, were key factors in low participation.[14]

***Proposed Information Collection Requirements (ICRs) Regarding Facilitating Enrollment Through Medicare Part D Low-Income Subsidy "Leads" (§435.601, §435.911, §435.952)***

**We support efforts to facilitate and streamline enrollment in the Medicare Savings Program through the use of Social Security Administration (SSA) data from processing Part-D Low-Income Subsidy (LIS) applications, or "leads" data.** Under the proposed regulation, states would be required to accept the SSA LIS leads data and treat receipt of that data as an application for Medicaid and promptly determine MSP eligibility without requiring submission of a separate application. CMS estimates that states would be able to adjudicate over 90 percent of MSP applications for LIS enrollees without gathering additional documentation from the applicants. This provision would reduce the administrative burden on states as well as for beneficiaries and ultimately contribute to easier enrollment in MSPs for LIS enrollees who are eligible.

*Recommendation*

- CMS should require states to fully implement procedures to accept as verified the information sent by the Social Security Administration and automatically initiate an application for MSPs, while refraining from requesting information already provided through leads data.

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[12] Meredith Freed, Juliette Cubanski, Anthony Damico, and Tricia Neuman, "Help with Medicare Premium and Cost-sharing assistance varies by State," *Kaiser Family Foundation,* (April 2022). Available at: https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/.

[13] Id.

[14] Medicare and CHIP Payment and Access Commission, "Report to Congress on Medicare and CHIP," June 2020, https://www.macpac.gov/publication/june-2020-report-to-congress-on-medicaid-and-chip/.

**Conclusion**

Given that a projected 17 percent of Medicaid and CHIP enrollees will leave the program when Medicaid's continuous enrollment provision comes to an end with the expiration of the public health emergency, swift and timely implementation of the 2022 Proposed Rule will be critical to ensuring that those who are eligible are able to access and maintain coverage through Medicaid and CHIP.

Thank you for the opportunity to provide comments on the 2022 Proposed Rule. All citations included in this letter should be considered as part of the formal administrative record for purposes of the Administrative Procedure Act. If you have further questions, please contact policy@apiahf.org.

Sincerely,

**National Organizations**

Asian & Pacific Islander American Health Forum (APIAHF)
Association of Asian Pacific Community Health Organizations (AAPCHO)
Center for Law and Social Policy (CLASP)
Empowering Pacific Islander Communities
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum
National Council of Asian Pacific Americans
National Japanese American Memorial Foundation (NJAMF)
OCA-Asian Pacific American Advocates
South Asian Public Health Association
Texas Muslim Women's Foundation Inc.
UnidosUS

**State & Local Organizations**

Korean Community Services of Metropolitan NY, Inc.
NICOS Chinese Health Coalition
NOELA Community Health Center
Oklahoma Micronesian Coalition
Papa Ola Lōkahi
The Cambodian Family Community Center