APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

October 31, 2011

Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attn: CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

File Code: CMS-2349-P (Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010)

Dear Secretary Sebelius and Administrator Berwick:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Department of Health and Human Services (HHS) for the opportunity to comment on eligibility changes to the Medicaid program under the Affordable Care Act (ACA) (Proposed Rule). For 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian and Pacific Islander communities (AA and NHPI) living in the United States and its jurisdictions. The Proposed Rule addressing eligibility, enrollment and coordination of the Medicaid and Children's Health Insurance Program (CHIP) programs will have a substantial impact on the access and quality of health care that Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities receive.

AAs and NHPIs stand to benefit significantly from the improvements to Medicaid and CHIP under the ACA. About 11 percent of the Asian American community and 14 percent of the Native Hawaiian and Pacific Islander community live below the poverty level, which exceeds the rate of non-Hispanic Whites.[1] There are currently 1.7 million AAs and NHPIs enrolled in Medicaid, while an estimated 1 in 10 Asian Americans and 1 in 8 Native Hawaiians and Pacific Islanders are expected to gain coverage through the Medicaid expansion in 2014. Thus, we urge CMS to ensure the streamlined and coordinated enrollment and eligibility processes contemplated in the Proposed Rule adequately meet the needs of diverse communities, including those that are immigrant and limited English proficient. In addition, we urge CMS to consider the following modifications and additions to the Proposed Rule.

A note about Medicaid and CHIP in the U.S. Pacific Island Territories

The Medicaid program works differently in the U.S. Territories compared to the program within the states and the District of Columbia. Although the ACA made special rules for the territories within the Health Insurance Exchanges and bolstered Medicaid allotments, considerable challenges still exist. For example, the Enrollment in the Medicaid and CHIP program in the U.S. Pacific Island Territories varies considerably with 89% of residents in American Samoa utilizing Medicaid and

[1] U.S. Census Bureau, 2007-2009 American Community Survey, 3 Year estimates.

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CHIP and 13% of residents in the Commonwealth of the Northern Mariana Islands.[2] Additionally, because Medicaid payments are also capped and statutorily set at a 50% FMAP, these limited dollars create eligibility rules that are different for the territories in determining who can be part of the programs. For example, only Guam uses the federal poverty income level of $21,200 for a family of four, while the Commonwealth of the Northern Mariana Islands utilizes the formula for Supplemental Security Income (SSI) in determining eligibility for the Medicaid program. These variations in Medicaid enrollment and eligibility illustrate the challenges that the U.S. Territories face in establishing exchanges.

We ask that HHS consider the unique structure of the Medicaid and CHIP programs in the territories when developing rules determining eligibility. CMS already works with the territories to administer the Medicaid and CHIP programs, and should continue to work individually with the territorial governments to coordinate eligibility and streamline enrollment in the territories.

Part 431 – State Organization and General Administration

§431.10 Single state agencies

We support the requirement for states to designate a single state agency to administer the Medicaid program. If a state chooses to delegate components of its eligibility screening, the single state agency is responsible for setting the rules of the program. We recommend that HHS continue to monitor this practice closely to ensure proper compliance.

We also support CMS in limiting eligibility determinations to a state agency and not to a contractor or private entity. This is particularly important as the rule proposes to delegate authority to make MAGI-based Medicaid determinations to Exchanges that are public agencies so long as the Medicaid agency retains discretion in administration/supervision of the plan.

We ask that CMS provide uniform guidance in the event that an exchange is a private entity. The preamble mentions that these entities can use co-location of Medicaid staff at the Exchange, however no standards are provided for what constitutes acceptable "co-location." We are concerned that states could have just one or two eligibility workers at sites where a private contractor or other non-governmental entity is processing huge numbers of applications. We suggest including a provision in the final rule that outlines specific standards for ensuring that co-located workers play a meaningful role in eligibility determinations, and provides some guidelines for adequate staffing levels if a state elects to utilize a non-governmental entity as its Exchange. As an alternative, we suggest that CMS consider requiring states with a non-governmental Exchange to contract with the

[2] U.S. House of Representatives Committee on Ways and Means (2009) "Social Welfare Programs in the Territories" Green Book 2008. Washington, DC.

state Medicaid agency to conduct eligibility determinations.

Lastly, we recommend that the final rule specify, where applicable, the requirement that the single state agency is solely responsible for setting eligibility policies, accountable for ensuring the program operates consistently with such policies, and accountable for ensuring the program operates consistent with federal law, including nondiscrimination laws.

Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa
Subpart A – General Provisions and Definitions

§431.10 and §431.11 Eligibility Determination by state agencies

We applaud CMS for requiring states to designate a single state agency to administer the Medicaid program. If a state chooses to delegate components of its eligibility screening, the single State agency is responsible for setting the rules of the program. We recommend that HHS continue to monitor this practice closely to ensure proper compliance. We also support the proposed rule that gives final determination of eligibility solely to a state agency and not to a contractor or private entity. This is particularly important as the rule proposes to delegate authority to make MAGI based Medicaid determinations to Exchanges that are public agencies so long as the Medicaid agency retains discretion in administration/supervision of the plan.

We ask that HHS provide uniform guidance in the event that an exchange is a private entity. The proposed rule mentions that these entities can use co-location of Medicaid staff at the Exchange. Much like other proposal it is the responsibility of a single state agency in setting eligibility policies. We ask that HHS create language and guidance that upholds existing privacy and non-discrimination laws. These Regulations should, where applicable, reiterate the requirement that the single state agency is solely responsible for setting eligibility policies, accountable for ensuring the program operates consistently with such policies, and accountable for ensuring the program operates consistent with federal law, including nondiscrimination laws.

§435.4 Definitions and use of terms

Agency

We recommend CMS clarify that "agency" includes state *and* territorial Medicaid agencies.

Caretaker relative

We recommend CMS amend the proposed definition of "caretaker relative" as follows:

> *Caretaker relative* means a relative of a dependent child by blood, adoption,

or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes), including the child's natural, adoptive, or step-parent; another relative of the child based on blood (including those of half-blood), adoption, or marriage; the spouse or domestic partner of such parent of relative, even after the marriage is terminated by death or divorce; and a parent or relative standing *in loco parentis*.

Dependent child
We also support the codification of the definition of a "dependent child." We are pleased that CMS has codified the state option to: 1) eliminate the deprivation requirement, and 2) establish a higher number of working hours as the threshold for determining unemployment if deprivation is considered.

Pregnant woman
We support codification of the definition of "pregnant woman" to incorporate the post-partum period.

Part 435, Subpart B – Mandatory Coverage

Consolidation of Eligibility Groups

We support the consolidation of existing mandatory and optional eligibility groups into three categories starting in 2014: parents and other caretaker relatives (§435.110), pregnant women (§435.116), and infants and children under age 19 (§435.118). We understand that these categories will complement the new adult group (§435.119).

§435.116 Pregnant Women

This section of the proposed rule assumes states will provide the full range of Medicaid services to all pregnant women covered under this section by default, unless a state elects to provide only pregnancy-related services for certain groups of women. We are concerned that the state option to provide some pregnant women with a limited benefit package that only covers "pregnancy related services" will be problematic. States are only required to cover full-scope Medicaid for women with incomes below the AFDC income standard in effect as of May 1, 1988, which is significantly less than 133% FPL. This authorizes states to provide fewer services to pregnant women than to adults in the 133% adult expansion group who are not pregnant.

In addition, pregnant women will not qualify for the new adult expansion category because they are excluded by statute. And, those who are under 133% FPL cannot qualify for coverage through the Exchange. Thus, some low-income women may not have full-scope health insurance under any of the ACA's options.

We recommend that CMS eliminate the state option to provide limited benefits to pregnant women. Instead, pregnancy-related services should be broadly defined since almost any medical condition can impact or complicate a pregnancy. Most states already recognize that all health services provided to pregnant women are pregnancy-related. As such, CMS should mirror the policy adopted by most states and align coverage for pregnant women with the coverage provided to all other adults.

Inconsistency with Exchange Regulations

The proposed Exchange regulation 45 C.F.R. §155.345 requires all individuals applying through the Exchange to receive a "basic screening" for non-MAGI eligibility. But the same is not required of the Medicaid agency in these regulations. This inconsistency could lead to different results based on where the individual applies for Medicaid coverage.

We support the recommendation proposed by the National Health Law Program to clarify in the final regulations that applicants have the right to request and receive an eligibility determination under non-MAGI based rules, and explicitly state that the applicant has the right to coverage in the best eligibility category that they qualify for.

In addition, we recommend CMS require all states to ask in their applications (streamlined or otherwise) whether the applicant or someone in the applicant's household is disabled. If the answer is "yes" to the disability question, CMS should require a "duty to assist" on the part of the State Agency or other entity taking the application to make sure the individual is enrolled in the best eligibility category they qualify for (even if that is a non-MAGI category).

We also urge the inclusion of additional accountability measures to enable CMS to monitor states' implementation of these rules and ensure beneficiaries receive the most appropriate form of coverage. CMS should review states' policies and practices to ensure individuals with disabilities and "medically frail" individuals receive the coverage they are entitled to.

Part 435, Subpart C—Options for Coverage

§435.218 Individuals above 133% FPL

We support the creation of this new eligibility group which provides states with a mechanism for covering individuals whose income exceeds 133% FPL, but is at or below the state's approved income standard for mandatory coverage. APIAHF is especially pleased that children not already eligible for Medicaid are included in this optional group.

States that currently cover children with incomes above 133% FPL in a separate CHIP program and adopt coverage under this group will shift the children from CHIP to Medicaid. As such, CMS should work with states to consider how best to leverage the information they currently have to transition children from CHIP to Medicaid. For example, many states may have all the demographic eligibility information they need for children enrollees from CHIP applications to permit seamless transfer to Medicaid. States such as Massachusetts and Washington have had great success in creating user-friendly, seamless transitions.

Part 435, Subpart E – General Eligibility Requirements

§435.403 State Residence

We strongly support elimination of the term "permanently and for an indefinite period," and adoption of the term "reside." Codification of this revision will help ensure seamless coverage for individuals and families who move between Medicaid, CHIP and the health insurance exchanges, and reinforces the statutory requirement that individuals must be considered state residents even if they lack a fixed address. The new standard will also help ensure that migrant and temporary workers are able to establish residency.

Residency rules for children
We support codification of the definition of state residency for persons under age 21 and appreciate the clarification that under the Proposed Rule, states may not determine residency of a child based solely on the residency of the parent. We welcome this clarification because in the past, some states have erroneously denied Medicaid to eligible children, mistakenly believing that children cannot establish state residency independently.

We share the concerns of the National Health Law Program, however, that state Medicaid agencies will continue to have flexibility to establish state-specific rules governing residency for students. This is particularly troubling because the Exchange residence definition allows the parent to choose a child's residence. We believe it is desirable to have one federal definition of state residence for students and that it be the state chosen by the parent. A consistent definition will avoid the creation of conflicting rules in different states. Otherwise, there is a risk that an out-of-state student could be left with no state of residence. Moreover, a uniform rule will help promote establishment of the coordinated eligibility and enrollment system established under ACA §§ 1413 and 2201.

Part 435, Subpart G — General Financial Eligibility Requirements and Options

§435.603 Application of modified adjusted gross income

We are pleased the Proposed Rule retains the "point in time" rules traditionally

applied in the Medicaid program to ensure eligibility is determined based on monthly versus annual income. In addition, we support the proposal to retain state flexibility to take into account future changes in income that can be reasonably anticipated, but to continue to have processes to ensure eligibility is maintained as long as annual income based on MAGI methods remains at or below the Medicaid standard. We are concerned, however, that persons experiencing changes in income may experience coverage gaps. HHS should examine coverage options for those who fall into these gaps, like a bridge program through the Exchanges that allow an individual to qualify for subsidies to purchase health insurance or to qualify for state aid if available.

One method of alerting individuals to potential eligibility changes is to include trigger questions in eligibility assessments and the single streamlined application. Trigger questions can address issues such as expected changes in income or employment and allow enrollees to plan accordingly. In addition, applications can be developed to ensure that if an application filer answers a question suggesting a future change in income or income history with substantial changes, the filer can be directed to contact a customer assistance provider. We hope that HHS includes rules that also standardize how contractors who work on determining eligibility can implement this process uniformly across state lines.

§435.603(a)(3)

We support codification of the requirement that for individuals currently enrolled in Medicaid, methodologies based on MAGI will not be used until the next regularly-scheduled redetermination if it would result in an individual loosing eligibility. We share the concerns of the National Health Law Program and urge that the final rule protect eligibility and that regulatory language not suggest that many individuals will become ineligible. We support the following revision to the proposed rule recommended by the National Health Law Program:

> When applying the new methodologies, no individual shall become ineligible who would have been eligible under existing rules established under the Medicaid Act or under the State Plan or a waiver of the State Plan regarding sources of countable income. Further, no income eligibility thresholds shall be established by a state or approved by CMS that would result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

In addition, we recommend CMS require that in such cases where MAGI methodologies will result in loss of coverage, the Exchange provide notice to the enrollee describing the remaining period of coverage, date annual redetermination would occur, information about other insurance affordability programs, and contact information for consumer assistance functions. This will allow persons who may be ineligible under the new

MAGI methodologies to plan accordingly to prevent gaps in coverage.

§ 435.603(b) Definitions
The proposed rule defines family size as the number of persons counted as members of an individual's household. For determining family size for a pregnant woman, the pregnant woman is counted as two persons. However, in the case of determining family size for other individuals who have a pregnant woman in the household, the pregnant woman can count, at state option, as either 1 or 2 person(s).

Currently in Medicaid, a pregnant woman is always counted as two persons for purposes of determining Medicaid eligibility, whether or not she lives alone or is part of a family. Where a pregnant woman would be ineligible for Medicaid if counted as a family of 1, the existing Medicaid rule promotes early access to critical maternal health services for which the pregnant woman might otherwise be ineligible. These services are particularly important for women of color, who disproportionately rely on Medicaid to receive maternity care and are more likely to suffer from complications such as low birth weight and preterm birth. Further, the rule anticipates the inevitable change in household size for a pregnant woman.

We share the concerns expressed by the National Health Law Program and other consumer organizations that the state option to count a pregnant woman as either 1 or 2 in determining eligibility for other individuals in the household could result in some families being temporarily split between eligibility for Medicaid and for the Exchange. We strongly urge CMS to amend the rule to require states to count a pregnant woman as a family of two for purposes of determining Medicaid eligibility for herself and any family she resides with. We believe eliminating the state option to count a pregnant woman as one will reduce the likelihood that families will move back and forth between Medicaid and the Exchanges, disrupting coverage and possibly delaying access to maternal health services for low-income pregnant women. We also believe this would take into account the reasonable assumption that a pregnant woman's family size will inevitably grow by an additional member at the conclusion of her pregnancy.

§435.603(e) MAGI-based income
This section of the proposed regulation creates income-counting rules that closely track section 36B(d)(2)(B) of the Internal Revenue Code of 1986. We support the recommendation provided by the National Health Law Program to exclude Social Security benefits in income calculations for Medicaid eligibility. HHS should minimize the negative consequences of any potential modifications, especially given the already negative effect of some of the new income rules for some households, such as income deeming from stepparents and stepsiblings, contrary to current Medicaid rules. We urge CMS not to support a modification of the current federal law in this area to disregard Social Security Benefits in income calculations under the MAGI methodology. Following the IRS' 36B rules on income counting will align with the goal of ensuring a streamlined eligibility process and avoid gaps in coverage.

§ 435.603(i) Eligibility Groups for which modified MAGI-based methods do not apply

The preamble requests comments on how to deal with eligibility of caretaker relatives who are 65 and older given the statutory exception to the use of MAGI for individuals in this category. If MAGI is not used to determine their eligibility, a state would have to apply its AFDC financial methodologies in determining their eligibility. The preamble offers the option of using SSI methodologies or interpreting the MAGI exclusion to apply only to groups based on age. We recommend using MAGI to align this group with the treatment of other caretaker relatives.

Part 435, Subpart J – Eligibility in the States and District of Columbia Applications

§435.905 Availability of Program Information

We support the requirement that program information be made available electronically through a website, in addition to providing information to applicants both orally and in writing. APIAHF is also pleased with that the proposed rule specifies that such information must be provided in simple and understandable terms, and in a manner that is accessible to limited English proficient (LEP) individuals. We recommend, however, that CMS strengthen this requirement to include additional materials and specific requirements for translating program information materials.

Asian Americans, Native Hawaiians and Pacific Islanders trace their heritage to more than 50 countries and speak more than 100 different languages. Data from the Census Bureau's American Community Survey reveal that more than 9 million people in the United States speak Asian and Pacific Island languages at home and more than 4 million of them are considered "limited English proficient," meaning they speak English less than "very well" or not at all.[3]

Linguistic and cultural barriers prevent many in these populations from accessing health coverage or attaining quality health care. Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs.[4] Poor communication between providers and patients can also lead to medical errors that are dangerous to patients and cost the U.S. health care system more than $69 billion every year. The need to address language barriers is so important that it continues to be a top priority of many HHS strategic plans and initiatives—such as the HHS National Partnership for Action and the CLAS Enhancement Initiative—and many hospitals, health plans, and private physician offices have voluntarily adopted language

[3] U.S. Census Bureau, 2010American Community Survey 1-Year Estimates.
[4] *See* Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health (2002).

access practices in an effort to increase patient safety and improve quality.[5]

All state Medicaid agencies are already subject to the requirements of Title VI of the Civil Rights Act of 1964. Title VI prohibits recipients of federal financial assistance from discriminating on the basis of race, color or national origin, and requires recipients to take "reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons." The ACA also includes a number of provisions that seek to reduce language barriers and enhance an individual's ability to communicate, shop for, enroll and maintain health insurance coverage and services. For example, Section 1331 of the ACA requires all notices provided by health plan issuers be written in "plain language," which includes presenting materials in a culturally and linguistically appropriate manner. Similarly, Section 2715(b)(2) of the Public Health Service Act (PHSA), as added by the ACA, requires all information provided in the summary of benefits and coverage be presented in a "culturally and linguistically appropriate manner." Lastly, Section 1557 of the ACA reinforces and expands the non-discrimination provisions in Title VI by prohibiting any federally conducted program, or entity that receives funding or assistance from discriminating on the grounds of race, color, national origin, gender and disability.

For these reasons, we urge CMS to apply a threshold of 5% or 500 LEP individuals of the Medicaid agency's service area for written translations. The 5% threshold is utilized in both the Department of Justice and HHS' LEP Guidance, CMS' Language Access Strategic Plan, as well as recently revised regulations from CMS governing marketing by Medicare Part C & D plans. The numeric 500 LEP individuals threshold reflects current DOL regulations. We further suggest CMS define the "service area" as to be the state plus any service area of a particular Medicaid agency office.

In addition, we strongly believe CMS should require Medicaid agencies to provide taglines in at least 15 languages informing LEP applicants and enrollees on how to access language services. Taglines should be provided regardless of whether the threshold for translation is met in a given service area, and already exists in government practice. Notably, the Social Security Administration regularly translates its materials in 15 languages, and CMS' Language Access Strategic Plan calls for translating many of its Medicare forms and other vital documents into 15 languages in addition to Spanish. Using taglines is also a cost-effective method of informing LEP enrollees of the availability of language services, and will help Medicaid agencies determine if additional materials and documents should be translated in their service area. Having a standardized tagline in all CMS required applications, forms, and notices will help LEP individuals begin to recognize the standardized language.

[5] *See* "Hospitals, Language, and Culture: A Snapshot of the Nation," The Joint Commission (2007). Available at http://www.jointcommission.org/assets/1/6/hlc_paper.pdf. *See also* Mara Youdelman and Jan Perkins, National Health Law Program, "Providing Language Services in Small Health Care Provider Settings: Examples From the Field" (April 2005). Available at http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf.

We also strongly urge CMS to reinforce the need fore Medicaid agencies to provide oral interpretation services to all LEP individuals regardless of whether thresholds to provide written materials are met. Medicaid agencies are subject to Title VI—and by extension, Section 1557 of the ACA—to provide oral interpretation services to every individual, therefore we urge the Department to ensure that oral interpretation is available to all LEP applicants and enrollees.

Lastly, Medicaid agencies should be required to collect data on all Medicaid applicants and beneficiaries pursuant to Section 4302 of the ACA. This provision directs the Secretary to develop data collection standards for the statutorily required categories of race, ethnicity, sex, primary language and disability status, and applies these data categories to all HHS programs, activities and surveys. Medicaid is a publicly administered health program, and therefore must comply with the Section 4302 data standards.

§435.907 Applications

We strongly support codification of the single, streamlined application form. The application will play a significant role in enrolling eligible children, pregnant women, individuals with disabilities and adults in the correct program without the burden and potential confusion of having to complete multiple forms to determine eligibility for subsidies. We strongly support this provision of the proposed rule, which codifies Section 1413 (b)(1)(A)(i) of the ACA and requires agencies to use a single, streamlined application to determine eligibility for Medicaid, CHIP, Basic Health (if applicable), premium credits, cost-sharing reductions.

§435.907(a)

The rule states that state Medicaid agencies must require an application for insurance affordability programs. We are concerned that the requirement could be interpreted to negate the automatic enrollment option allowed by section 203 (a)(1)(D) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows agencies to automatically enroll children in Medicaid and CHIP without an application. To complete an eligibility determination using this option states must have sufficient information about children from express lane agencies or other data sources. The express lane option requires states to provide families with information about services provided through Medicaid (or CHIP), cost sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consent to the enrollment of children but they are not required to complete an application. This option has allowed some states to increase enrollment of eligible children by using data from other state agencies like SNAP. The final rule should clarify that the automatic enrollment option is still allowable.[6]

[6] While express lane eligibility is scheduled to sunset prior to the start of the required ACA Medicaid expansion, we are presuming that it will be reauthorized.

§435.907(c)
Any alternative application used by states should be approved by HHS and conform to the same criteria outlined in §435.907(b). The final rule should require that the Secretary approve any alternative applications and supplemental forms when first developed and when substantive changes are made. The rule should also require that these forms require only the minimum additional information necessary to determine an applicant's eligibility, and be structured to maximize an applicant's ability to complete the forms as required by section 1413 (b)(1)(A) of the ACA.

With respect to non-MAGI eligibility categories, we recommend that the single streamlined application contain trigger questions alerting potential applicants to these eligibility categories. Including more tailored trigger questions will help alert applicants to the programs and coverage options that they are eligible for.

§435.907(d)
We support the requirement that an individual must be able to file an application in person, online, over the phone and by mail. For many people, enrollment in the Exchanges will be confusing and only complicated by cultural, literacy, language and disability barriers. While we understand the need to minimize paperwork and rely on electronic applications to improve efficiency, paper applications must be available for those that are unable to complete electronic applications. Providing paper application and in-person assistance recognizes the digital divide as many low-income communities and communities of color lack access to the Internet in their homes, as well as the fact that some populations may not be comfortable with technology.

§435.907(e) Information related to non-applicants
APIAHF commends CMS for proposing to codify the policy against requiring non-applicants to provide Social Security numbers (SSNs) or information regarding their citizenship, nationality or immigration status. This requirement aligns with long-standing federal policy and codifies the Tri-Agency Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, CHIP and other programs issued in 2000.

In addition, we recommend CMS strengthen these protections by adding the following requirements in any application:

- Notify consumers about their privacy rights before and during enrollment;
- Provide an explicit disclosure explaining the purpose of collecting personal information, what the intended use is, and how an applicant's information will be shared with other agencies for purposes of eligibility;
- The paper application should also comply with all appropriate privacy and security measures. The Tri-Agency Guidance provides key examples and principles for the paper collection of personal information based on the Privacy Act of 1974 and Title VI of the Civil Rights Act of 1964.

In cases where a state voluntarily requests a SSN of a non-applicant, we support the three requirements outlined in the Preamble to ensure non-applicants understand

the purpose for which information is being collected. We note, however, that voluntary requests for SSNs of non-applicants can be confusing for application filers, lead to misunderstandings and could be construed as a *requirement* for applying for coverage.

In addition, we recommend questions regarding citizenship and eligibility be crafted with immigrant and mixed-status families in mind. Immigrants comprise a substantial portion of this nation's diverse populations and may include refugees, asylees and naturalized citizens. The challenges in eligibility they face deserve special attention and outreach efforts. Many newly arriving, low-income immigrants, for instance, cannot access Medicaid because they have not completed the five-year waiting period required under PRWORA. In addition, many eligible immigrants may be deterred from enrolling in Medicaid coverage without appropriate directions and in-language instructions on enrollment forms. Specifically, many immigrants may fear that enrollment in the Exchanges may adversely affect their immigration status or deem them as "public charges." As such, we recommend that the final rule clarify that Medicaid and CHIP agencies should not inquire about the citizenship or immigration status of non-applicants in their application forms or procedures.

Language access
To ensure meaningful access for limited English proficient persons, the single streamlined application should comply with the accessibility and readability requirements in our comments to §435.905. In addition, we ask that the final rule specify that certain information must be provided in a manner that is accessible to LEP individuals, as it does in §435.905(b).

§435.908 Assistance with application and redetermination

We commend CMS for codifying the need for Medicaid agencies to provide applicants and beneficiaries, particularly limited English proficient (LEP) individuals and individuals with disabilities, with application and redetermination assistance. To strengthen these requirements and ensure meaningful access for individuals that need assistance, we recommend that CMS adopt our recommendations in §435.905, and specify the following types of language services that must be provided:

- Oral language assistance by competent interpreters for all LEP individuals
- Sign language interpreters, large print and Braille materials for all individuals that require them
- Translated materials in accordance with §435.905 and §435.907.

We also recommend CMS codify the following requirements for Medicaid call centers:

- Assistance must be available outside of normal business hours
- Staffing levels must be adjusted in anticipation of periods of higher call volumes
- Call centers must have the capacity to provide assistance to consumers on a

broad range of issues, including but not limited to:

- Location and availability of linguistically and culturally competent providers;
- Categories of assistance available, including advance payments of the premium tax credits and cost-sharing reductions as well as assistance available through Medicaid, CHIP and Basic Health Plans (BHP);
- Eligibility screening and assistance prior to starting an application, especially in regard to immigrant and mixed-status families;
- The application process for enrollment in coverage through the Exchange and other programs, including information about the types of information needed;
- Referrals to Navigators and other consumer assistance programs;
- Referrals for persons ineligible to participate in the Exchanges, Medicaid, CHIP or BHP to allow for purchasing coverage outside the Exchange.

In addition, we encourage CMS require State agencies to coordinate with their Exchange to conduct outreach and education activities targeted to vulnerable and underserved populations about the changes to Medicaid under the ACA, particularly those who experience health and health care disparities as a result of factors such as race, ethnicity, language barriers and low health literacy. Outreach efforts should be conducted in various non-English languages and written between a fourth and sixth-grade reading level or below, as provided in recommendations by the National Institutes of Health (NIH).[7] In addition, CMS should encourage states to go further and conduct outreach efforts based not only on population size, but also upon which communities demonstrate the most need due to health disparities and social factors such as poverty and uninsured rates.

For example, to outreach effectively to Asian American, Native Hawaiian and Pacific Islander populations, states should assess where these communities are located and base outreach efforts in those localities. These efforts may include leaving in-language brochures in local pharmacies and health clinics, conducting in-language health fairs, presentations at local churches, and working with local media.

States should request continual stakeholder input to inform education and outreach activities. Moreover, states should partner with community-based organizations and leaders. These organizations and individuals have significant knowledge about their communities and are connected to existing communication networks among community members.

§435.911 Determination of eligibility

We applaud CMS for drafting the proposed regulations to ensure that all low-

[7] U.S. National Library of Medicine, National Institutes of Health, *How to Write Easy-to-Read Health Materials*. Bethesda, MD, 2011, http://www.nlm.nih.gov/medlineplus/etr.html.

income people have access to Medicaid as quickly as possible, without requiring additional complex screening for other factors like disability. We endorse the goal of this section, as stated in the preamble, of ensuring continuous coverage for those who may be eligible for Medicaid on a basis other than MAGI.

§435.911(c)(1) Eligibility for Mandatory Coverage on the Basis of Modified Adjusted Gross Income

We are pleased that this provision will allow an applicant who may be Medicaid eligible as disabled or medically needy to immediately enroll into the newly created adult group so long as the applicant meets the non-financial and financial MAGI eligibility criteria. We are, however, concerned that as currently written the regulation does not require further screening of these individuals for non-MAGI programs for which they may qualify unless the individual affirmatively asks for further screening. If these individuals are not also screened for non-MAGI categories of Medicaid eligibility they may end up with a less generous Medicaid benefit. Given that the proposed guidance on benefits has not been released, we ask that unless the benefit is equal to the benefits under non-MAGI Medicaid these individuals must be screened for and enrolled into the non-MAGI programs for which they might qualify. The individual, who is unlikely to be aware of the various categories of eligibility, should not bear the burden of asking for such screening.

We also recommend CMS specify that SSI and SSDI recipients are eligible for coverage under the new adult coverage.

Lastly, the phrase "promptly without undue delay" is vague and should be revised to provide explicit time standards for eligibility determinations, enrollment and notice.

§435.911(c)(2) Eligibility on Basis Other than Applicable Modified Adjusted Gross Income Standard

We support the requirement that the Medicaid agency retain responsibility for making determinations of eligibility for non-MAGI factors. Where a state enters into an agreement with the Exchange to undertake these determinations, the state agency must retain accountability over the process.

As we state in our comments above, the phrase "promptly without undue delay" is vague and should be revised to provide explicit time standards for eligibility determinations, enrollment and notice.

§435.916 Periodic redetermination of Medicaid eligibility

We commend CMS for proposing simplified data-driven renewal policies and procedures that aim to balance program integrity with the need to maintain individuals in coverage for as long as they are eligible. We thank CMS for addressing many of the problems individuals have had in renewal processes, including burdensome requests for paperwork and accidental loss of coverage. These barriers are costly, create administrative burdens for both enrollees and

agencies administering programs and tend to cause gaps in coverage.

§435.916(a)(3)
Specifically, we support the requirement that states schedule a regular annual redetermination for beneficiaries whose eligibility is based on MAGI, and additional redeterminations for beneficiaries who report a change in circumstances, as needed. We strongly support codification of the requirement that agencies renew eligibility for beneficiaries by first evaluating electronic data from reliable data sources, which is consistent with section 1413(c)(3) of the ACA. Requiring agencies to make determinations of continued eligibility using electronic data sources, when coupled with required notices, will greatly decrease administrative burdens on the part of the individual beneficiary and agency. As part of this process, we support the requirement that a state agency provide an individual with a pre-populated renewal form. A pre-populated renewal form will assist beneficiaries in determining what data is accurate and relevant and help to eliminate confusion.

In addition, we strongly support the proposal to add a reconsideration period for individuals who lose coverage for failure to complete the renewal process within 30 days. We support the 90-day period as it will prevent individuals from having to reapply for coverage if the individual completes the process within a reasonable period of time, while providing state agencies with a finite period for which they must apply retroactive coverage.

§435.916(a)(4)
We strongly support codification of the requirement that the agency assess an individual's eligibility for other insurance affordability programs and transmit the electronic information to the appropriate entities for beneficiaries no longer eligible for Medicaid. In addition, if the agency determines a person is ineligible for Medicaid and all other insurance affordability programs, the agency should refer the individual to an appropriate consumer assistance program so the individual can seamlessly purchase insurance outside the Exchange.

§435.916(c) and (d)
Similar to our comments in §155.335(c), a beneficiary should receive notice and an opportunity to correct any inaccurate information through a variety of electronic and non-electronic means. As a required notice, the Medicaid redetermination notice must comply with the plain language, accessibility and readability requirements we outlined in §435.905. In addition, we recommend CMS codify the following requirements to be included in the notice:

- Date redetermination will become effective;
- Procedures to correct errors in data obtained or used in the enrollee's most recent eligibility determination, including the 30 day requirement to report changes specified in §155.916(a)(3);
- Where individuals may obtain additional information or assistance, including the state Medicaid agency;
- Notice of a right to an interpreter, available at no cost to the LEP individual,

provided in at least 15 in-language taglines.

§435.945 General Requirements

We strongly support the proposal to allow Medicaid agencies to accept self-attestation of all eligibility criteria other than citizenship and immigration status, and limit requests for additional information from applicants to cases where information is not available electronically. Allowing self-attestation of eligibility information will reduce paperwork burdens on individual applicants and reduce barriers to enrollment. CMS already has a long-standing policy of accepting attestations of certain eligibility information from the applicant, spouse, parent, caretaker or a representative filing on behalf of an applicant, and data sharing systems will allow states to provide "real time" verifications. Self-attestation is particularly helpful for individuals and families whose income, housing situation, or birth date are not recorded in a traditional manner, including homeless families, families fleeing domestic violence or natural disaster situations, and individuals who may face barriers to securing documentation such as seniors and people with disabilities.

§435.945(f)
We support codification of the requirement that before a request for information from a third-party data source is initiated, an individual must receive notice of the information being requested and its use. To promote efficiency, we support inclusion of this notice in the application process. As we have noted in our comments to §155.260, immigrant communities and those from high conflict zones may have strong aversions to sharing private information with government entities. To alleviate these concerns, we strongly encourage CMS to apply the principles of the Tri-Agency Guidance to all notices requesting or sharing information and include an explanation describing why data is being collected and what entities it will be shared with. In addition, such notices should clearly state that information collected will have no effect on a person's immigration status.

§435.945(i)
We support the requirement for states to establish formal written agreements with other agencies before releasing or requesting data from those agencies, and commend CMS for codifying the need to include safeguards for limiting the use and disclosure of such information.

§435.948 Verification of Financial Eligibility

In a teleconference hosted by CMS on October 17, 2011, CMS staff described the verification procedures required in accordance with the proposed rules, including the application of a "reasonable compatibility" standard. We support the definition provided in this teleconference, in which reasonable compatibility between an individual's attestation and the available electronic data are relatively consistent and do not vary in a way that is meaningful for eligibility. For example, if an individual's attestation of income and the income information available through IRS

or other databases differ, but both are below the Medicaid eligibility threshold, the individual should be considered eligible and enrolled without delay. As such, we understand this standard to mean that the two sources of data need not match one another if both lead to the same eligibility determination. We recommend CMS add a definition of reasonable compatibility as information that is relatively consistent and does not vary in a way that is meaningful for eligibility. This crucial definition is absent from the regulations.

§435.948(c)(2)
We support codification of the current Medicaid policy that information be requested by SSN, but that when an SSN is not available, the agency should attempt to obtain needed information using other personally identifying information otherwise available in the individual's account. In addition, we support the requirement that when an SSN is not available, the agency assist the individual in obtaining a SSN.

§435.948(d)
We support the requirement that where states use alternative data sources, such sources must meet applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, subject to the Secretary's approval. However, we urge CMS to recognize that this flexibility in information collection should allow individuals, such as those working in the informal economy, to establish their actual earnings through alternative means. This flexibility will help ensure that agencies capture an accurate picture of an individual's earnings.

§435.949 Verification of information through an electronic service

We support the proposed "federal data services hub" in which HHS serves as an intermediary between the Medicaid agencies, the Exchanges and other federal agencies. Establishing strong data sharing requirements for the purpose of verifying eligibility will help to create a system that promotes efficient and streamlined enrollment and eligibility determinations. As such, we strongly support the requirement that where information is available from the federal data services hub, states are required to obtain data from those sets first.

We also support the flexibility given to states to utilize alternative mechanisms for collecting and verifying applicant information.

To the extent that information passes through a range of different entities and individuals – either within the federal hub or through alternative means, it is critical to ensure that the privacy protections and limits on disclosure and use of the information exchanged or transmitted apply to each entity receiving or transmitting the information, at each stage of the eligibility determination. We therefore appreciate the requirement in paragraph (f) of this section that, prior to requesting information for an applicant, the agency must inform the individual that the agency will obtain and use the information to verify income and eligibility or for other purposes directly connected to administering the state plan. We also appreciate

the requirement in paragraph (h) that state Medicaid agencies execute written agreements with other agencies before releasing data to or requesting data from those agencies – and that such agreement must limit the use and disclosure of the information exchanged.

§435.952 Use of information and requests for additional information

We support the proposed requirement that where information provided by an individual is reasonably compatible with information the agency has obtained from other trusted sources, the agency must act on such information and may not request additional information from the individual. To that end, we support the "reasonable compatibility" standard governing when additional information can be requested and the requirement to first consult electronic data sets. We appreciate that the proposed rule provides flexibility to apply this standard, however we emphasize the need to interpret the "reasonable compatibility" standard consistently across states and agencies. Consistent, reliable interpretation of the standard will facilitate administrative simplicity and smooth the no wrong door approach to health program enrollment at the determination and redetermination stages. In addition, we recommend that the final rule specify that the reasonable compatibility period be set for 90 days.

Consistent with our comments to §435.948, we also recommend CMS codify that the use of such information meet existing requirements relating to the confidentiality, disclosure and maintenance of information from whatever source it is received.

§435.956 Verification of other non-financial information

We support the general verification scheme allowing states to use attestation or electronic data sets where necessary. In addition, for verification of state residency, states should accept methods of proof such as school enrollment and voter registration, in addition to self-attestation.[8]

Consistent with our comments in §435.949, we urge CMS to include protections to ensure that non-financial information such as state residency, social security numbers, pregnancy status, age, and date of birth verified through other sources (1) be used only for the purpose of verifying eligibility for enrollment, premium tax credits, or cost-sharing reductions under the exchanges or federal health coverage programs and (2) that pending verification, coverage not be delayed, denied, reduced, or terminated.

Residency rules for eligible immigrants
We commend CMS for clarifying that documents providing information about one's immigration status may not be used alone to determine state residency. We

[8] Creating California's "No Wrong Door" for Health Coverage: Recommendations from Consumer Advocates, Western Center on Law & Poverty, July 2011.

appreciate that the preamble notes the distinction between immigration documents and residency determinations. We believe such individuals should be given every opportunity to establish their residency within the state.

To ensure that individuals have this opportunity, we urge CMS to amend the State Medicaid Manual and delete contradictory guidance. In the Manual, HHS instructs states that certain individuals are ineligible for Medicaid because of their temporary admission status, including "foreign students [and] temporary workers including agricultural contract workers. . ." HHS, State Medicaid Manual, §3211.10. This is inconsistent with HHS' recognition that a temporary or time-limited status does not preclude state residency and should be removed from the Manual to eliminate any possible confusion.

In addition, we encourage CMS to amend paragraph (c)(2) by striking "alone" to ensure that these determinations are made independently, and to reduce any potential confusion.

Part 435, Subpart M – Coordination of eligibility and enrollment between Medicaid, CHIP,
Exchanges and other insurance affordability programs

§435.1200 Medicaid agency responsibilities

We thank CMS for their guidance on the responsibilities and coordination of eligibility and enrollment processes among the various insurance affordability programs. The proposed regulations will help inform applicants of their eligibility for programs, provide sufficient information to allow applicants to make informed choices about their coverage and payment options, and prevent duplicative requests for information. We support the use of shared systems to the greatest extent possible, however we believe there is a need for more specific standards regarding the timeliness of actions, how consumers will be informed and notified, and how issues that will arise between the various coverage programs will be resolved.

§435.1200(c) General Requirements
We support requiring state Medicaid agencies to enter into agreements with the Exchange and other agencies administering insurance affordability programs to ensure coordination. This must be retained in the final rule, and we suggest that CMS provide model agreements for this purpose.

Moreover, we recommend codifying the requirement that where the Exchange or other entities perform eligibility functions, all such functions must be consistent with the rules adopted by the Medicaid agency. This is consistent with the §431.10 requirement for a single state agency to operate the Medicaid program, and ensures seamless and coordinated eligibility and enrollment. In addition, we recommend CMS provide more specific guidance on how compliance and oversight

should work in an integrated system.

§435.1200(d) Internet website

The website must provide sufficient information and access to consumer assistance tools to allow consumers to find and enroll in coverage that meets their needs. The eligible Exchange and Medicaid population will be diverse in age, disability status, computer literacy, language spoken, race, ethnicity and geography. Certain groups, such as mixed-immigration status families, will be navigating multiple enrollment requirements in multiple programs. As such, many of these eligible persons and families will need significant assistance to ensure they are educated about their coverage options.

We thank CMS for specifically addressing the unique needs of individuals with disabilities and persons who are limited English proficient (LEP) in accessing the internet website. We recommend CMS codify the requirement that all resources and consumer assistance functions provided through the internet website referenced in this section comply with the accessibility and readability recommendations provided in our comments on §435.905.

At a minimum, to ensure meaningful access for LEP persons, the website should provide in-language taglines in at least 15 languages, using standardized language that explain how LEP applicants and beneficiaries can receive language assistance resources and reach in-language hotlines. We recommend CMS provide model taglines in the top 15 language groups likely to use the website using state Census data. In addition, for those individuals who do not have internet access, states should make available written materials that provide the same information provided on their agency websites.

§435.1200(e) Provision of Medicaid for individuals found eligible for Medicaid by the Exchange

APIAHF appreciates CMS' effort to ensure that individuals found eligible for Medicaid by the Exchange receive their benefits "to the same extent and in the same manner as if such individual had been determined eligible for by the Medicaid agency." This process should be seamless to ensure the individual is promptly made aware of the determination and their ability to enroll in coverage. We also commend CMS for requiring Medicaid agencies to use a secure electronic interface to receive such information, and for ensuring applicants will not need to furnish the same eligibility information to the Medicaid agency.

§435.1200(f) Transfer of applications from other insurance affordability programs to the state Medicaid agency

We are pleased that the proposed regulations prohibit the state Medicaid agency from requesting an applicant to provide information or documentation that is already contained in the transferred application. To reinforce this prohibition, we ask that Medicaid agencies use verifying information already known to other State entities or utilize data sharing technologies before requesting additional information from the applicant.

We also support the requirement that the Medicaid agency electronically transfer applications of individuals determined not eligible for Medicaid to other insurance affordability programs, assuming compliance with all of the usual privacy protections and safeguards.

§435.1200(g) Evaluation of Eligibility for the Exchanges and Other Insurance Affordability Programs

We applaud codification of the requirement that the Medicaid agency evaluate an individual who is ineligible for Medicaid or CHIP for other insurance affordability programs. This requirement will promote seamless enrollment and minimize burdens on the individual. In addition, we reiterate that if an individual is found ineligible for all insurance affordability programs, they should be referred to a consumer assistance program or navigator who can provide information on obtaining coverage outside the Exchange.

In addition, we strongly support the requirement that the Medicaid agency conduct a full Medicaid eligibility determination for individuals with household incomes above the applicable MAGI standard.

Part 457 – Allotments and Grants to States

§457.330 Application

We commend CMS for applying the relevant requirements for a single, streamlined application equally to CHIP and Medicaid. We ask that CMS incorporate our comments in §435.907 consistently throughout the CHIP application.

§457.335 Availability of program information and Internet Website

Please refer to our comments and recommendations to §435.905 and §435.1200(d).

§457.340 Application and Enrollment in CHIP

We support the proposal to remove the reference to enrollment caps in §457.340(a). CHIP agencies should be required to accept the single streamlined application regardless of whether CHIP enrollment is capped. In addition, if CHIP enrollment is capped, the CHIP agency must forward the individual's application for further screening to determine eligibility for other insurance affordability programs.

We also offer support and thank CMS for proposing to codify the Tri-Agency Guidance with respect to the collection of social security numbers (SSN) from non-applicants. However, we question the necessity for CHIP programs to impose an SSN *requirement* for applicants, which will pose a barrier for some individuals and families. States that have elected the CHIP program's "fetus" option, for example,

will not be able to collect SSNs from these applicants. To conform to the language in the preamble, the text of the regulations should make it clear that SSNs may be required only of individuals who have them. We appreciate the reminder that SSNs cannot be required of non-applicants in the CHIP program, and are pleased that the proposed rule prohibits the delay or denial of services to otherwise eligible applicants pending the issuance or verification of the SSN.

In addition, we appreciate the explicit requirement to provide assistance to families in understanding and completing CHIP applications in a manner that is accessible to individuals living with disabilities and those who are limited English proficient (LEP). To strengthen this requirement, we recommend CMS include specific language about the types of language services that must be provided, including oral language assistance, translated written materials in accordance with §435.905 and §435.907, and sign language interpreters, large print and Braille materials for all individuals who require them.

§457.343 Periodic Redetermination of CHIP Eligibility

We support the proposal to require CHIP coverage be continued until the end of the month following the end of the appropriate termination notice period. This proposal would align CHIP coverage requirements with Medicaid and ease administrative burdens by ending coverage for all applicable persons on the same date, and help persons transition from CHIP to the Exchanges. Please refer to our comments on §435.916(c) and (d) for recommendations for strengthening the notice requirement.

§457.380 Verification of Eligibility

We support the proposed verification of eligibility provisions as they largely align with those in Medicaid and the Exchanges. We support the proposed method of verification allowing self-attestation where applicable, and limiting requests for additional information from applicants to cases where information is not available electronically.

Moreover, consistent with our comments to §435.948(d), we recommend that all alternative verification methods meet the applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information.

Conclusion

In summary, we appreciate the opportunity to comment on the implementation of changes under the ACA in the Medicaid program and eligibility determinations. We thank CMS for their guidance in proposing to develop a streamlined enrollment and eligibility system that meets the needs of diverse populations. Please contact APIAHF Policy Director, Priscilla Huang, at phuang@apiahf.org with any questions. We welcome future opportunities to work together on this important aspect of health reform implementation.

Respectfully,

Kathy Lim Ko
President & CEO
Asian & Pacific Islander American Health Forum