February 28, 2013

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-10440
Appendix A: List of Questions in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program
Appendix C: FA Paper Application
Appendix D: Non-FA Paper Application

Dear Sir/Madam:

We greatly appreciate the efforts of the Centers for Medicare & Medicaid Services to develop a single, streamlined application to facilitate enrollment in Medicaid, CHIP, and the new health insurance Exchanges. The efforts to create a user-friendly product, emphasis on readability, plain language and especially additional scrutiny on language access per requirements of § 156.250(c) is also appreciated. Language access is critical as we work to provide access to a diverse population base of which many or the under and uninsured are from Limited English Proficient communities of color. Because of that, we support collecting race and ethnicity demographic data of all applicants. **We also strongly recommend that CMS collect language data of all applicants, not merely of the household contact.** This data is critical for Washington State. Washington ranks as one of the top ten states with Limited English Proficient (LEP) residents and is also one of the states with the largest growth of LEP populations in the nation. (Migration Policy Institute; LEP Data Brief; December 2011)

In the supporting statement released with the draft paper application and list of questions in the online application, CMS stated that it plans to collect data elements ***pursuant to § 4302*** of the Affordable Care Act.[1] We greatly appreciate the recognition of the need to collect comprehensive demographic data. As § 4302 states:

> The Secretary ***shall ensure*** that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey. . . collects and reports, to the extent practicable – (A) data on. . .primary language. . .***for applicants, recipients or participants***. *(emphasis added)*

We are thus concerned that CMS did not follow the statutory instructions and include language data collection of all applicants on the draft applications. CMS recognizes collecting demographic data is practicable by including race and ethnicity collection from all applicants on the application. There is no basis for excluding primary language data

[1] HHS, *Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies* at 6.

collection of all applicants. Moreover, by only requesting language data information from the household contact, CMS also impedes its compliance with § 4302 since it will not have language data of recipients and participants (unless it implements post-enrollment collection which historically has been very difficult[2]).

Comprehensive language data is essential to ensuring nondiscrimination and compliance with Title VI of the Civil Rights Act and § 1557 of the Affordable Care Act. Having comprehensive language data is also critical to address health disparities and service planning. Exchanges need to know the languages of applicants so they can ensure provision of appropriate language services – both oral and written – in their offices, call centers, and by subcontractors. Collecting this data once on the application will save time and money since the Exchange can share this data with health plans, providers, navigators, assisters, certified application counselors, brokers and others who will be assisting limited English proficient individuals.

Further, only collecting this data from the household contact will likely misrepresent and significantly undercount the needs of LEP individuals. Given the well-documented barriers LEP individuals face in accessing services and healthcare,[3] it is likely that if a household has an English-speaking member, that individual will be the household contact. Yet an estimated 23% of Exchange applicants will speak a language other than English at home, demonstrating the significant need to identify language needs so that appropriate assistance can be provided for ***all*** applicants.

We have a historic opportunity to comprehensively collect important demographic data collection through the single, streamlined application. We urge CMS to seize this opportunity and ensure comprehensive language data collection for the same reasons we support comprehensive race and ethnicity data collection.

Thank you,

Diane Narasaki, Executive Director
Asian Counseling and Referral Service

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[2] *See*, *e.g.*, Institute of Medicine, *Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement (2009), at* http://www.ahrq.gov/research/iomracereport/reldata5.htm. The Institute of Medicine notes that health plans may have limited opportunities for direct contact with enrollees during which the data can be collected and the need for the data explained. Further, Aetna had only limited success collecting race, ethnicity and language data of its enrollees. The upper limit of data collection by health plans with presently known direct methods may be far below the level necessary for identifying disparities in quality of care through stratified analysis.

[3] *See*, *e.g.*, Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (2002), at* http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx*, and Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement (2009), at* http://www.ahrq.gov/research/iomracereport/.