Supporting Statement – Part A

Supporting Statement for Paperwork Reduction Act Submissions

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was also signed into law. The two laws collectively are referred to as the Affordable Care Act (ACA). Section 1002 of the ACA added section 2793 of the Public Health Service Act, which provides for grants to States to establish, expand, or provide support for, independent offices of health insurance consumer assistance or ombudsman programs, starting in FY 2010. For FY 2010, $30 million was appropriated to help States and Territories establish or enhance these activities, which we refer to here as Consumer Assistance Program (CAP) activities.

Consumer assistance or ombudsman programs assist consumers with filing complaints and appeals, and enrolling in health coverage. They also educate consumers on their rights and responsibilities. In addition, as a condition of receiving a grant, states must provide for CAPs to collect data on consumer inquiries and complaints to identify problems in the marketplace and strengthen enforcement. With the establishment of the new Exchange marketplaces, programs must also help consumers resolve problems with obtaining premium tax credits for Exchange coverage.

It is the priority of the consumer assistance program grants to increase CAPs' ability to fulfill these duties. As health reform continues to be implemented, consumers will need to understand new programs, avail themselves of new protections, and navigate the system to find the most affordable and secure coverage that meets their needs. Consumer assistance programs will be expected to provide the range of assistance services required by law, not only with respect to private health insurance and group health plans, but for high-risk pools and the new Pre-existing Condition Insurance Plan as well. At the outset, programs will not be expected to provide assistance related to the Medicaid and CHIP programs (titles XIX and XXI of the Social Security Act), but will be required to demonstrate that they can and do make appropriate referrals for such inquiries.

The ACA requires as a condition of receiving a grant that states ensure that CAPs report certain data to the Secretary of Health and Human Services (HHS) in order to strengthen oversight. Programs must report on the types of problems and questions consumers experience with health coverage, and how these are resolved. Reports will help identify patterns of problems and suspected noncompliance as well as best practices. HHS will share data reports with the U.S. Departments of Labor and Treasury, and with State regulators. Within HHS, reports can also provide the Center for Consumer Information and Insurance Oversight (CCIIO) one indication of the effectiveness of State enforcement, affording opportunities to provide technical assistance and support to State insurance regulators and informing the need for further federal investigation.

The Consumer Support Group, an office within CCIIO, provides significant support services for CAPs, including data reporting software and technical support, resource and training materials, and assistance on casework as it relates to questions arising from Federal law.

All States and Territories are eligible for the consumer assistance program grants. In order to receive a grant, applicants must propose a plan to use grant funds to develop or enhance their consumer assistance activities and demonstrate that eligibility criteria are satisfied.

B. Justification

1. Need and Legal Basis

Section 1002 of the Affordable Care Act added section 2793 of the Public Health Service Act, which provides for grants to States to establish, expand, or provide support for consumer assistance (or ombudsman) programs, starting in FY 2010.

In order to strengthen oversight, the law requires programs that receive grant funds to report data to the Secretary of the Department of Health and Human Services (HHS): "As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers" (**Sec. 2793 (d)).**

Analysis of this data reporting will help identify patterns of practice in the insurance marketplaces and uncover suspected patterns of noncompliance. The law provides that HHS must use the data to determine where more enforcement is needed, and must share program data reports with the Departments of Labor and Treasury, and State regulators. Program data also can offer CCIIO one indication of the effectiveness of State enforcement, affording opportunities to provide technical assistance and support to State insurance regulators and, in extreme cases, inform the need to trigger federal enforcement.

2. Information Users

Pursuant to section 2793(d) of the Public Health Service Act (PHSA), as added by Section 1002 of the ACA, as a condition for receiving a consumer assistance program grant, states must provide that CAPs will collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. Accordingly, program staff will need a system to maintain case files that will track these types of problems and inquiries. Problems and inquiries will be summarized and will be reported to HHS. The statute specifies that the Secretary of HHS will use the data for oversight, and will share these reports with the Department of Labor and Treasury, and with State insurance regulators for use in enforcement.

3. Use of Information Technology

A CAP is required as a condition of the grant to use some type of Database software to track all cases received by the CAP. All casework must be entered into the Database. The Database must be able to keep track of all caller information, such as caller demographics, type of coverage, problem type, and case resolution. The Database must also track cases that the CAP referred to the Federal and State regulators, Medicaid, CHIP, and other public programs.

Currently, many existing CAPs track cases they handle using Database software that predated the availability of the CAP grants. If their Database software can generate the types of information required to be reported to HHS, then the CAPs may continue to use their own Database software. However, CAPs, at their discretion, may choose to use the CCIIO-provided database, or the State-Based System (SBS) offered by the National Association of Insurance Commissioners (NAIC).

The CCIIO-provided database allows CAPs to collect and track casework and required data elements. As of October 2011, the Database has been used successfully to generate data collection reports required by

CCIIO. Templates for reporting will also be provided for use by CAPs that choose not to use the CCIIO database. Data collection reports sent to CCIIO will not contain personally identifiable information.

We anticipate that the CCIIO-provided Database will alleviate some reporting pitfalls that have been identified in other Database software used by CAPs. Accordingly, providing CAPs access to Database software developed specifically to satisfy the requirements under this grants program will reduce any reporting burdens. See Appendix 1, Screenshots of CCIIO-developed Database.

Government Paperwork Elimination Act (GPEA)

Is this collection currently available for completion electronically?

- Yes, CAPs are required to send reports to HHS electronically. Reports are uploaded to a secure government website.

Does this collection require a signature from the respondent(s)?

- CAP grantees submit reports using a password-protected account through which they can only submit reports on behalf of their CAP. This process was put into place to help ensure that the submission is made only by the person authorized to submit reports on behalf of the CAP grantee. As an additional method of report verification, HHS follows up with each respondent by phone to verbally ensure that the information received through a report submission was the information the respondent intended to submit.

If CMS had the capability of accepting electronic signature(s), could this collection be made available electronically?

- Not applicable since we will not require an e-signature.

If this collection isn't currently electronic but will be made electronic in the future, please give a date (month & year) as to when this will be available electronically and explain why it can't be done sooner.

- Not applicable.

If this collection cannot be made electronic or if it isn't cost beneficial to make it electronic, please explain.

- Not applicable since the collection is made available electronically.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

Not applicable since these are grants to States.

6. Less Frequent Collection

Many CAPs receive hundreds, if not thousands, of calls from consumers per month. Close monitoring, through data collection reports, of the nature of these calls will help identify patterns of problems and suspected noncompliance as they occur. Accordingly, this will provide early indication of the effectiveness of State enforcement, affording immediate opportunities to provide technical assistance and support to State insurance regulators and informing the need for further federal investigation. We believe that quarterly collection of this information is the minimum necessary to achieve these goals.

HHS will be in close contact with CAPs. Upon request by CAPs, HHS may allow less frequent reporting due to burden on program activities.

7. Special Circumstances

Explain any special circumstances that would cause an information collection to be conducted in a manner:

Requiring respondents to report information to the agency more often than quarterly;

- If States report specific findings, the Secretary may require a more focused report to study the nature of these findings.

Requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;

- If States report specific findings, the Secretary may require a more focused report to study the nature of these findings.

Requiring respondents to submit more than an original and two copies of any document;

- Not applicable. We will not require more copies than an original and two copies of any document.

Requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;

- The data collected by CAP grantees (respondents) is owned by the respondents. They are free to retain records beyond 3 years if they so choose, but are not required by PHS Act Section 2793 to do so.

In connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;

- Not applicable. Statistical surveys are not contemplated for this program. The complaints statistics that arise from this program are not generalizable, but will generate important information for regulators as they engage in oversight of the private health insurance market.

Requiring the use of a statistical data classification that has not been reviewed and approved by OMB;

- Not applicable. Statistical surveys are not contemplated for this program. The complaints statistics

that arise from this program are not generalizable, but will generate important information for regulators as they engage in oversight of the private health insurance market.

That includes a pledge of confidentiality that is not supported by authority established in statue or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or

- Not applicable. The data collection authority and sharing of reports with the Departments of Labor and Treasury and with State regulators is in the statute. PHSA §2793(d), as added by section 1002 of ACA.

Requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

- Not applicable. This is outside the scope of our reporting requirements.

8. Federal Register/Outside Consultation

Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

- The Consumer Support Group has engaged in discussions with several consumer assistance programs that existed before the availability of CAP funds, and with one organization that, in the past, has conducted nationwide research on such programs. From this inquiry, we learned that consumer assistance programs regularly compile reports for various audiences (i.e. state insurance departments, state legislature, general public, etc.). Some of the information required in the data collection report are already collected by these programs and are reported to different agencies on either a quarterly or semi-annual basis. Other information required by CCIIO may already be collected as well; however it may be in a format that is not countable and reportable. For example, a few of the existing programs we've spoken to capture demographic information (i.e. age and income) in the case notes as opposed to an independent data field, thus making it impossible to generate a counting report on the average age or income of consumers calling with a health insurance problem.

- Comments received and responded to following the publication of the 2011 3-year CAP PRA resulted in further enhancements to the data collection software that CCIIO provided to CAPs in the areas of appeals and recovered benefits, grandfathered plans, and statements by consumers who benefitted from contacting CAPs.

- In an effort to further enhance reporting by CAPs, the Health Insurance Resource Specialists (Specialists) within the Consumer Support Group provided a number of CAP grantees the opportunity to test new reporting tools and templates and to provide feedback. This is an ongoing effort that is implemented by the Consumer Support Group to ensure that new reporting tools and templates are beneficial and are less burdensome to CAP grantees.

- The 60-day Federal Register notice published on July 27, 2012 and expired September 25, 2012. Received a total of 21 comments from the following four organizations: FamiliesUSA; Community

Service Society; Consumers for Affordable Health Care; and Vermont Legal Aid, Inc., Office of Health Care Ombudsman. All comments were summarized, consolidated (where overlap existed), and addressed in the attached document.

The majority of comments involved feedback on providing CAPs with more flexibility in collecting and reporting data. The implementation of a new progress report will allow CAPs to provide more information about their progress and activities.

In addition, CMS received comments suggesting that collection of all of the CMS-required data elements is difficult and that adjustments to pre-existing databases is too expensive and laborious. CMS recognizes these concerns and acknowledges that CAPs are in the best situation to determine the level of information that is able to be collected for any given consumer.

CMS also received comments suggesting that CMS provide guidance to CAPs on how to accurately measure savings to consumers. CMS has provided CAPs with suggestions on ways to calculate recovered benefits and will explore whether more comprehensive guidance is necessary.

Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years - even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

Under this grant, ongoing technical support will be provided to CAPs through the Specialists. Specialists provide direct training and support to grantees as they implement their programs. Specialists conduct information sharing conference calls; conduct training programs on federal law including the ACA; instruct CAPs in how to conduct consumer assistance casework; troubleshoot and assist with difficult consumer cases as necessary; and collect, track, and analyze data on consumer inquiries and complaints to help the Secretary identify problems in the marketplace and strengthen enforcement.

CMS prepares educational materials about consumer protections in the Affordable Care Act for the public at large, to be made available on HealthCare.gov, through the State Consumer Assistance Programs, and in future, through partnerships with consumer advocates and other stakeholder groups. This group will also be working with the CAPs and stakeholder groups to broaden consumer awareness of the CAP programs and the Affordable Care Act through a variety of means and media. Among the range of resources under consideration: providing speakers for stakeholder group meetings, producing short, instructional web videos.

The Consumer Support Group provides technical assistance on non-routine questions about the Affordable Care Act, particularly the Affordable Care Act's interaction with the law of a particular state. The team does legal research, develops resource materials for the staff of the Consumer Support Group as well as the staffs of state grantees, and assists in responding directly to consumer inquiries as requested.

9. Payments/Gifts to Respondents

- Not applicable. We will not provide any payments or gifts.

10. Confidentiality

Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.

- The Consumer Support Group does not collect personally identifiable information from consumer assistance program awardees. Data collection reports required by the Consumer Support Group include summaries of aggregate data on the types of problems and questions consumer experience with health coverage, how these are addressed, and how these are resolved.

11. Sensitive Questions

Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that we commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific use of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

- In order to conduct health insurance consumer assistance, CAPs may frequently need to ask clients information about their health status, income, employment status, citizenship and other characteristics that people might commonly consider private. Personally identifiable information will be used only to assist a client or with their permission to refer them to other assistance, but will never be forwarded to HHS. Awardees provide HHS with aggregated data on consumer problems broken down by client characteristics.

12. Burden Estimates (Hours & Wages)

I. APPLICATION

This is already captured in SF424 authority to collect information based on funding opportunity announcement requirements. (OMB#: 4040-0004)

II. DATA COLLECTION REPORTING

A. Data collected and reported

All the data elements enumerated in the CCIIO-developed database would not be collected in every case. HHS expects grantees to collect information that is relevant to the specific case under consideration. See Appendix 1, Screenshots of CCIIO-developed Database.

In the first year of CAP operations, grantees submitted aggregate data to CCIIO through the Health Information Oversight System (HIOS) three times: six months after the date of the FY 2010 award and quarterly thereafter. The Specialists downloaded the data submitted by grantees and analyzed it for classification. Following this analysis, Specialists transmitted a summary of the data to the grantees, who confirmed its accuracy.

Moving forward, the format of data reporting will also include four quarterly progress reports and an annual, end-of-year text document in addition to the quarterly data collection reports submitted through HIOS. See Appendix 2, Template for the Quarterly Progress Report. See also Appendix 3, Template for the Annual Report. The information to be collected for quarterly reports will be the following:

Contact Information

CAPs will collect contact information for the consumer, so that the program may contact the consumer with any necessary follow-up information. The consumer's English proficiency and any third party information will also be collected in order best serve consumers who may have difficulty communicating. Although any personally identifiable information will not be reported, CAPs will report data on English proficiency of the consumers they serve.

Caseload

CAPs will report on the number of consumer complaints and inquiries handled by the program. Programs will report on the status of these cases, such as the number of cases that are currently ongoing and cases that have been closed. The resolution of closed cases will also be reported as either problem resolved, no help available, help available but inadequate, information only (no complaint or problem identified), or case closed due to consumer unresponsiveness. Additionally, CAPs will report the number of consumers who are insured, insured in transition, insured with other problem, uninsured and unable to re-contact at the conclusion of each case.

Caller Demographics

CAPs will report the number of cases by demographic information. Demographic information will allow a more complete understanding of the consumer's health insurance problem. For example, collecting a consumer's employment status provides insight into the possibility of accessing employer-sponsored insurance; and collecting household income and number in household can determine if a consumer might be eligible for a low-income program through a federal program such as Medicaid or CHIP.

Insurance Status and Recent History

CAPs will report the number of cases reported by insurance status. Insurance status is defined as Uninsured, Insured in Transition, and Insured with Other Problem. Because access to health insurance options can differ based on health insurance status and health insurance history of the consumer it is important to collect the following information about the consumer to adequately identify insurance options that may be available:

Uninsured:

- length of uninsurance
- type of coverage last had, and
- reason(s) for coverage loss

Insured, In-Transition:

- type of coverage at initial contact
- whether the consumer is the primary insured or dependent of the primary insured, and
- the reason(s) for anticipated coverage loss

Insured with Other Problem:

- type of coverage at initial contact,
- whether the consumer is the primary insured or dependent of the primary insured, and
- the problem(s) with current coverage

In every case, the name of the employer plan, issuer, and/or third party administrator must be captured. Whether the plan is fully-insured, self-insured or self-insured non-governmental plan must also be collected. This information will enable the caseworker to identify the entities that may have to be contacted to help resolve the consumer complaint, and where compliance to federal and state laws is an issue, be able to contact the appropriate agency that has jurisdiction over enforcement of such laws.

Health Insurance Options

CAPs will report on health insurance options identified for consumers who called the program, and whether the options identified were obtained when needed, and if so, whether they were obtained with associated burdens, such as affordability of premium and inadequacy of coverage due to a pre-existing condition exclusion. If health insurance options were not obtained when needed, CAPs will report the reasons why coverage was not obtained. These may be due to ineligibility, waiting periods, imposition of pre-existing exclusion periods, denial, excessive premiums, just to name a few.

Affordable Care Act

CAPs will report the number of cases involving ACA-related questions, as well as the number of cases involving ACA compliance or violation. Accordingly, CAPs will need to determine, and be able to report which of these plans are grandfathered plans. In every case, CAPs must report the type of ACA issue:

- Early Retiree Reinsurance Program (ERRP)
- Dependent coverage to age 26
- Rescission
- Annual benefit maximum (including mini med plans)
- Lifetime benefit maximum
- Out-of-network emergency care
- PCP/Pediatrician choice
- OB/GYN access
- Pre-existing condition exclusion and denial for children
- Elimination of Pre-existing condition restrictions for adults
- Pre-existing Condition Insurance Plan (PCIP)
- HIPAA Opt-out by Self-Funded Non-Federal Government Plans
- Appeals and grievances
- Premium rate increase
- CO-Ops
- Essential Health Benefits
- Summary of Benefits and Coverage (SBC)
- Student Health Plans
- Prevention Services
- Medical loss ratio rebates (MLR)
- Fair premium rating factors
- Extension of guaranteed Issue to all Markets
- Guaranteed Renewability in all Markets
- Wellness programs
- Waiting period of over 90-days
- Coverage of Clinical Trials
- Discrimination based on salary
- Limitation on out-of-pocket cost and deductible

- Shared responsibility payments (employer and employee)

In cases with ACA compliance or violation issues identified, CAPs must collect and report the different agencies that they have contacted for enforcement action, as well as the disposition of each of the contact to determine if enforcement action was taken.

Appeals

CAPs will report the number of cases involving internal and external appeal. Along with reporting cases on appeal, it is essential that CAPs collect and report detailed information on the type of denial, the reason for the denial, the timeframe of the appeal (whether expedited or non-expedited), whether a fee is required for an external appeal, and when the appeal is successful, the amount of recovered benefits.

In every appeals case, the name of the employer plan, issuer, and/or third party administrator must be captured. Whether the plan is fully-insured, self-insured or self-insured non-governmental plan must also be collected. This information will enable the caseworker to identify the entities that may have to be contacted to help resolve the consumer complaint, and where compliance with federal and state laws is an issue, be able to contact the appropriate agency that has jurisdiction over enforcement of such laws.

Outreach and Education

CAP grantees are encouraged to conduct outreach events and provide information to consumers in innovative and comprehensive ways, ranging from distributing brochures to the public (often in multiple languages), to more intensive outreach such as one-on-one counseling, and targeted outreach and information to specific groups of consumers such as those who reside in counties with the highest percentage of uninsured residents. Some CAP grantees convene larger events such as "town hall meetings" to educate consumers on the services the grantee provides and new protections available under the ACA. Many programs also use social media outlets to reach their communities.

CAPs also provide education on general health insurance inquiries or provide information to consumers on how to contact the appropriate agency to help them resolve their problems. For example, Medicare or Medicaid beneficiaries having problems with their public health coverage would be provided referrals to the appropriate Medicaid or Medicare State Health Insurance Program (SHIP) office.

CAP grantees must report outreach and education efforts funded by CAP grants.

Exchange-Related Duties

CAP grantees may use the funds they receive to carry out duties that assist consumers seeking coverage through an Exchange. These duties must be within the scope of the five specific categories of duties as described in Section 2793(c). With the establishment of the Exchange marketplaces, programs must assist consumers by answering general questions about Exchanges; referring consumers to other consumer assistance programs (e.g., navigators); assisting with obtaining premium tax credits, and assisting with eligibility and enrollment in coverage sold in the Exchange.

Other Assistance Referred

CAPs will report the number of cases that were referred to another agency because they were beyond the scope of the program, such as Medicaid, CHIP, Medicare (SHIP), VA, and TRICARE.

Culturally and Linguistically Appropriate Services (CLAS)

CAPs reporting data to CCIIO shall demonstrate their ability to communicate effectively with consumers, including how they will provide services to those with limited English proficiency including, but not limited to, interpretive services and translation of materials about health insurance coverage. CAPs are also required to identify personnel who have the ability to provide assistance that is culturally and linguistically appropriate, in accordance with the guidelines on the Office of Minority health's website (http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15) for the national standards on culturally and linguistically appropriate services.

Examples of compliance with this requirement include the publication of brochures and other materials in languages of the prevalent non-English speaking population(s), and the use of language lines for real-time translation needs.

See Appendix 3 for an example of how compliance with the CLAS requirement will be reported to CCIIO on the Annual Reporting form.

B. Cost and Burden to Grantees

The Consumer Support Group makes the following assumptions about cost and burden to new CAP grantees associated with data collection and reporting:

Type of Personnel[1]	**Wage per hour**
Mid-Level Professional – GS-12 equivalent	$29
Mid-Level IT Professional – GS-12 equivalent	$29
Senior Executive Professional – GS 15 equivalent	$48

1. Initial Set-up of Database

The cost burden associated with the initial set up of the database will only apply to grantees that have never applied for CAP grants.

Data will be collected and reported by a mid-level professional at an hourly rate of approximately $29 per hour. The mid-level professional will devote 16 hours to the initial submission. A mid-level IT professional will spend 4 hours implementing the database system. A senior executive will devote 8 hours to overseeing the initial submission, including reviewing the system to ensure its readiness, SOPs, ensure training of the mid-level professional.

Hours: 16 hours + 4 hours + 8 hours = 28 hours
Costs: 16 hours x $29 = $464
4 hours x $29 = $116
8 hours x $48 = $384
Total for Initial Set-up: $464 + $116 + $328 = $964

2. *Quarterly Submissions*

[1] Source: Office of Personnel Management, 2012 General Schedule (GS) http://www.opm.gov/oca/12tables/pdf/gs_h.pdf

Data collection reports

The cost burden associated with the quarterly Data Collection Reports will apply to all CAP grantees. There will be four quarterly reports. CCIIO estimates that a mid-level professional will take up to 24 hours to compile the report. A senior level executive will take up to 5 hours to review and grant clearance to the report. For CAP grantees that use the CCIIO-developed database, CCIIO estimates that a mid-level professional will take up to 2 hours to compile the report and a senior level executive will take up to 1 hour to review and grant clearance to the report.

CCIIO Database User:
Hours: 2 hours (mid-level time) x 4 (four quarterly submissions) + 1 hour (senior level professional time) x 4 (four quarterly submissions) = 12 hours
Costs: 8 hours x $29 (mid-level wage rate) = $232
4 hours x $48 (senior staff wage rate) = $192
Total for Quarterly Data Collection Reports (CCIIO Database User): $424

Non-CCIIO Database User:
Hours: 24 hours (mid-level time) x 4 (four quarterly submissions) + 5 hour (senior level professional time) x 4 (four quarterly submissions) = 116 hours
Costs: 96 hours x $29 (mid-level wage rate) = $2784
20 hours x $48 (senior staff wage rate) = $960
Total for Quarterly Data Collection Reports (Non-CCIIO Database User): $3744

Total for Quarterly Data Collection Reports: Ranging from $424 to $3744

Progress Report

The cost burden associated with the Quarterly Progress Reports will apply to all CAP grantees. There will be four quarterly reports. CCIIO estimates that a mid-level professional will take 16 hours to draft and compile the report. A senior level executive will take 2 hours to review and grant clearance to the report. See Appendix 2, Template for the Quarterly Progress Report.

Hours: 16 hours (mid-level time) x 4 (four quarterly submissions) + 2 hours (senior level professional time) x 4 (four quarterly submissions) = 72 hours
Costs: 64 hours x $29 (mid-level wage rate) = $1856
8 hours x $48 (senior staff wage rate) = $384
Total for Quarterly Progress Reports: $1856 + $384 = $2240

Total for All Quarterly Submissions: Ranging from $2664 to $5984

3. Annual Report

Grantees' reporting requirements include the submission of an Annual Report due within 90 days from the end of the project/budget period. See Appendix 3, Template for the Annual Report.

Hours: 40 hours (mid-level staff wage rate) x 1 annual report + 5 hours (senior staff wage rate) x 1 annual report = 45 hours
Cost: 40 hours x $29 (mid-level wage rate) = $1160

5 hours x $48 (senior staff wage rate) = $240
Total for Annual Report = $1160 + $240 = $1400

Total for All Submissions (Quarterly Submissions + Annual Report): Ranging from $4064 to $7384

Total Cost Burden to New Grantees (Database setup + Quarterly Submissions + Annual Report): Ranging from $5028 to $8348

Total Cost Burden to Former Grantees (Quarterly Submissions + Annual Report): Ranging from $4064 to $7384

	# of Respondents	Frequency	Responses	Annual Burden Hours	Annual cost
Quarterly Submissions	56	8	448	84 - 216	$2664 - $5984
Annual Report	56	1	56	45	$1400
Total	56	9	504	129 - 261	$4064 - $7384

13. Capital Costs

The grant announcement indicates that preference will be given to applicants with a proven track record of consumer assistance and expertise in consumer education and problem resolution. Therefore, we do not anticipate that programs will need additional capital or startup costs. Start-up programs that need capital or start-up are not likely to apply for funding based on the limited funding available under this grant opportunity.

14. Cost to Federal Government

I. APPLICATION

The review of the applications from states for consumer assistance grants will be initially performed in-house by federal employees.[2] A reviewing panel of outside experts will then be convened to evaluate applications and assist in the selection process.

A. Application Review by Federal Employees

We anticipate that 56 states and territories will submit an application. Each application is a maximum of 10 pages, excluding supporting documentation. Each application will require one hour for an initial review. Total staff time for review will be 56 hours. The applications will be reviewed by mid-level staff. CCIIO assumes that all 56 eligible states/territories will apply.

Hours: 56 (applications/states and territories) x 1 hour (initial review) = 56 hours
Costs: 56 hours x $29 = $1344
Total for Application Review by Federal Employees: $1344

B. Outside Panel Review

[2] Source: Office of Personnel Management, 2012 General Schedule (GS) Locality Pay, http://www.opm.gov/oca/12tables/pdf/gs_h.pdf

1. Identification of potential reviewers

Senior staff will have to identify a panel of outside reviewers. If there is a panel of ten, senior staff will take about 2 hours to identify potential reviewers. Mid-level staff will make an estimated 40 calls to identify and confirm participation with the 10 panelists. Each call will take 15 minutes.

Hours: 2 hours (senior level staff) + 40 (15-minute calls by mid-level staff, totaling 600 minutes or 10 hours) = 12 hours
Costs: 10 hours x $29 = $290
2 hours x $48 = $96
Total for Identification of Potential Reviewers = $386

2. Training Panel of Reviewers

Two senior level staff (one CCIIO and one CMS OAGM staff) will provide a one-hour training, via phone conference call, to the selected panel of reviewers to go over the process, responsibilities and expectations.

Hours: 1 hour x 2 (senior level staff) = 2 hours
Costs: 2 hours x $48 = $96
Total for Training Panel of Reviewers = $96

3. Call with Chairperson

One senior level staff from CCIIO will discuss with the Chair of the panel of reviewers the review process, CCIIO's expectations and the Chair's responsibilities. This will be a .5 hour call.

Hours: .5 hour x 1 (senior level staff) = .5 hours
Costs: .5 hour x $48 = $24
Total for Call with Chairperson = $24

4. Participation in the panel review

Outside subject matter experts will participate as panel experts to review applications. In addition, two federal employees participate in the panel review (one CCIIO senior level staff and one CMS Office of Acquisitions and Grants Management senior level staff) to answer questions from the panel of experts. CCIIO assumes the review process will take two eight-hour days for a total of 16 hours.

Hours: 2 (senior level staff) x 16 hours (two 8-hour work days) = 32 hours
Costs: 32 (senior level staff) hours x $48 = $1536
Total for Federal Employee Participation in Panel Review: $1536

C. Follow-up

Some applications will require follow-up phone calls and other attempts to clarify information or seek additional information. CCIIO estimates that 30 applications will require follow-up review. One mid-level staff from CCIIO and one mid-level staff from OAGM will require one hour each for follow-up.

Hours: 30 (follow-up applications) x 1 hour (mid level CCIIO staff) + 1 hour (mid level

OAGM staff) = 60 hours
Costs: 60 hours x $29 = $1740
Total for Follow-up: $1740

D. Award Announcement and Grantee Notification

Mid-level staff will be devoted to developing rollout materials (factsheets, FAQs, website language, press release, etc.) and follow-up notifications to grantees. CCIIO assumes that developing rollout materials will take 16 hours. A senior level staff will take two hours review these materials. Further, mid-level staff will notify grantees of the award. This will take 30 minutes per grantee. CCIIO assumes that all eligible states/territories will receive an award.

Development of rollout materials
Hours: 16 hours (mid-level staff) x 1 (development) + 2 hours (senior level staff) x 1 (development) = 18 hours
Costs: 16 hours x $29 = $464
2 hours x $48 = $96
Total for Award Announcement: $560

Grantee notification
Hours: 56 (# of grantees) x .5 hour = 28 hours
Costs: 28 hours x $29 = $812
Total for Grantee Notification: $812

Total for Award Announcement and Grantee Notification: $1372

Total Cost for Application Review: $1344 + $386 + $96 + $24 + $1536 + $1740 + $1372 = $6498

II. DATA COLLECTION REPORTING

The review of the data submitted by CAPs per question 12(II) will be reviewed in-house by federal employees.

A. Costs of Review of Quarterly Data Submissions

Mid-level staff will be performing a review of the quarterly data submissions, which includes discussions with the grantee about the data submitted. CCIIO assumes that it will take two hours to review each quarterly Data Collection Report and one hour to review each quarterly Progress Report. A senior level staff will take 2 hours to review the aggregate report each quarter. CCIIO further assumes that all 50 states, the District of Columbia, and 5 territories are awarded grants and submit quarterly data.

Hours: 56 (Data Collection Reports) x 4 (submissions per budget year) x 2 hours (mid level staff review) + 56 (Progress Reports) x 4 (submissions per budget year) x 1 hour (mid level staff review) + 4 (aggregate reports) x 2 hours (senior level staff) = 680 hours
Costs: 672 hours x $29 = $19,488
8 hours x $48 = $384
Total for Costs of Review of Quarterly Data Submissions: $19,872

B. Costs of Review of Annual Reports

Mid-level staff will review annual report submissions from CAP grantees. CCIIO assumes that it will take 1 hour to review each annual report. CCIIO further assumes that all 50 states, the District of Columbia, and 5 territories are awarded grants and submit an annual report.

Hours: 56 (Annual Reports) x 1 (submission per budget year) x 1 hour (mid level staff review) = 56 hours
Costs: 56 hours x $29 = $1624
Total for Costs of Review of Annual Reports: $1624

C. Development of CAP White Paper

Mid-level staff will draft a white paper for CCIIO leadership and the Secretary on CAP data and will use the data to facilitate senior staff discussions, initiatives and projects. CCIIO assumes that the preparation of the white paper will require 32 hours of mid-level staff time and 4 hours of senior level staff time for review.

Hours: 32 hours (mid-level staff) + 4 hours (senior level staff) = 36 hours
Costs: 32 hours x $29 (mid-level wage rate) = $928
4 hours x $48 (senior staff wage rate) = $192
Total for Development of CAP White Paper: $1120

D. Other Data-Related Projects

Additional staff time devoted to data-related projects and initiatives is difficult to estimate. Given the importance of the data, mid-level staff may spend 80 additional hours per year on follow-up, data-related projects and initiatives. Senior staff may spend 20 hours performing review and follow-up activities.

Hours: 80 hours (mid-level staff) + 20 hours (senior level staff) = 100 hours
Costs: 80 hours x $29 (mid-level wage rate) = $2320
20 hours x $48 (senior staff wage rate) = $960
Total for Other Data-Related Projects: $3280

Total Cost for Data Collection Reporting: $19,872 + $1624 +$1120 + $3280 = $25,896

Total Cost to the Federal Government (Application Review + Data Collection Reporting) = $32,394

Description	Cost
Application review by federal employees	$1,344
Outside panel review	$2,042
Follow-up	$1,740
Award announcement and grantee notification	$1,372
Costs of review of quarterly data submissions	$19,872
Costs of review of annual reports	$1,624

Development of CAP white paper	$1,120
Other data-related projects	$3,280
Total	**$32,394**

15. Changes to Burden

Due to additional reporting requirements, we anticipate there will be an increase in annual time burden and annual cost burden. The additional reporting includes four quarterly progress reports and an annual end-of-year report. Due to additional staff hours required to develop, collect, monitor, and review the new progress reports and annual report, we anticipate the annual time burden will increase to 16,184 hours (from the originally approved 4,800), and the annual cost burden will increase to $467,488 (from the originally approved $190,000).

16. Publication/Tabulation Dates

- By law, the Secretary of HHS is required to share data collection reports with the Departments of Labor and Treasury and State insurance regulators to strengthen enforcement. Consumer Support Group staff will convey reports to these regulatory entities and in so doing will highlight and summarize key findings from these reports. In addition, in 2012, CMS released the CAP White Paper based on data submitted by CAPs in their first year of operations (October 15, 2012 through October 14, 2011). A PDF of the paper can be found here http://cciio.cms.gov/resources/files/csg-cap-summary-white-paper.pdf.pdf.

17. Expiration Date

- We expect that the Database software we provide to awardees will be used into the future. Note that programs are authorized to continue permanently. CAP operations will continue so long as there is continued funding.

18. Certification Statement

- No exceptions apply.