

**CMS Response to Public Comments Received for CMS-10333 - Consumer Assistance Programs (CAPs)
Docket: CMS-2012-0101**

The Centers for Medicare & Medicaid Services (CMS) received comments from four entities:

1. FamiliesUSA,
2. Community Service Society (which houses Community Health Advocates, New York State's designated Consumer Assistance Program),
3. Consumers for Affordable Health Care (Maine State's designated CAP), and
4. Vermont Legal Aid, Inc. Office of Health Care Ombudsman (Vermont State's designated CAP).

This is the reconciliation of the comments.

Comment:

CMS received the following comment from Consumers for Affordable Health Care: *Programs that received both the Limited Competition for Affordable Care Act Consumer Assistance Program Grant awarded on June 22, 2012 and the Affordable Care Act Consumer Assistance Program Grant awarded on August 24, 2012 have two open grants that are collecting the same data for reporting. Reporting periods for these grants should be adjusted and consolidated to not overlap and to reduce the burden to one report per quarter instead of two.*

Response:

CMS agrees that there should not be separate data/progress reports for each grant. Only one data report and one progress report will be required per quarter, and deadlines will be communicated to programs as such. These reports will reflect the experience of the CAP as a whole, not the activities from each specific grant. However, financial reporting is specific to each grant; therefore, financial reports must be submitted for each grant.

Comment:

CMS received the following comment from Consumers for Affordable Health Care asking for guidance on how to account for pending appeals cases, specifically: *In cases where an appeal is filed or where there is a referral for enforcement, the case may be open and pending over multiple reporting periods, and a program may only have pending cases to report during any one reporting period. Guidance should be issued to programs on how to account for these pending cases in the Progress report sections for "Enforcement Actions" and "Illustrative Examples." In addition, please address whether one particular case can be discussed in multiple quarterly progress reports (e.g., intake on a case may happen in quarter one, case may still be pending in quarter two with potentially partial "wins" to report in a complicated case with multiple issues, with full resolution of case in quarter 3).*

Response:

CMS provides CAPs with flexibility in how much information to include in the progress reports. The progress reports are designed for CAPs to provide narrative context, as they see appropriate, to explain or provide more information on progress/actions not reflected in the data reports. CAPs are free and encouraged to include information about pending cases in multiple quarterly reports,

particularly since CMS is interested in progress and outcomes that may not necessarily be reflected in the data reports. For example, a CAP may receive an appeals case in the first quarterly reporting period that can be discussed as an open case for that quarter. Subsequently, the same case could also be included in the third quarterly report as a closed case with an outcome once a final decision has been rendered.

Comment:

CMS received similar comments from Consumers for Affordable Health Care, Office of the Health Care Ombudsman, and FamiliesUSA suggesting that the scope of the progress reports be expanded so as not to focus solely on the Affordable Care Act: *Regarding “Illustrative Examples” in the progress report, please clarify if programs should include only cases relating to a specific Affordable Care Act provision or an enforcement action, or whether other cases may also be included where the Consumer Assistance Program positively impacted the case. The question asks for only ACA-related cases and enforcement cases, but the directions imply that other cases may be included.*

To best illustrate their work, CAPs should be able to report on case stories that resulted in successful resolution of any type of health care issue, rather than only stories related to ACA provisions or federal enforcement issues. CMS may also consider providing a field that allows case workers to describe a systemic issue that affected or prevented resolution of an individual case.

Response:

CMS recognizes that in some states, the CAPs have seen few cases specific to the Affordable Care Act and/or enforcement, so they may not have those types of illustrative examples to include in the progress report. Overall, CMS wants to know how CAPs have positively impacted consumers, so cases not specific to the Affordable Care Act are also encouraged to be included in the progress report. CMS is interested in seeing illustrative examples that resulted in successful resolution of any type of health care issue related to private health insurance. In addition, CMS will consider other ways by which case workers can report systemic issues that affected or prevented resolution of an individual case. However, programs should feel free to include this type of information in the progress reports.

Comment:

CMS received similar comments from the Office of the Health Care Ombudsman and Community Service Society suggesting that, while allowing CAPs with pre-existing databases to continue to use them is a good idea, collecting all of the CMS-required data elements is difficult and making adjustments to pre-existing databases is too expensive and laborious. Commenter suggested that, for CAPs using independent databases, aggregate data and statistical analysis should suffice to meet CMS' reporting requirements.

We appreciate being allowed to continue to use LegalEase, which was designed several years ago to manage cases, track data and create reports for the Health Care Ombudsman's funding sources. Much of the data collected is similar to the information requested by CMS. However, it is not identical, and to make it identical would entail considerable time and money and thus divert resources away from casework. We support a reduced requirement to upload data into HIOS for CAPs using their own databases.

CSS also offered these comments: *CHA's current database currently captures 45 percent of the fields in the proposed CCIIO-developed database that appear to be mandatory reporting fields. In approximately 15 percent of these fields, CSS could conduct an in-house modification of our data base in order to capture these lines of inquiry. However, CSS would need to contract with an outside vendor to modify our data base for an additional 40 percent of these proposed fields. Such a modification would be expensive and time-consuming. At this point, CSS estimates that this process would take between six months and one year, and would require obtaining multiple estimates in order to accurately measure the cost and time burden.*

It is uncertain from the guidance if CAPs that opt to use their own data system would still be required to upload data into CCIIO's database, or if they would be able to conduct their own data analysis and submit statistical reports accompanying the templates provided in Appendices 2 and 3. CHA recommends that only aggregate data should be required, considering that the process to upload individual case information is technically challenging and very time consuming for CAPs.

Response:

CMS appreciates the concerns expressed by the commenters. CMS understands that mapping data from and/or making adjustments to an independent database can be difficult and time consuming. CMS recognizes and appreciates the efforts the CAPs put forth in doing so during the 2010-2011 period of performance. The data reporting requirements will continue during the 2012-2013 period of performance. CAPs that opt to use their own data systems are still required to upload quarterly data reports. With the addition of the quarterly progress reports, CAPs will now have the opportunity to provide information about the program's progress, activities, accomplishments, and consumer service that is not reflected in the data reports.

Comment:

*CMS received similar comments from the Vermont Office of the Health Care Ombudsman, Community Service Society, and FamiliesUSA suggesting that *only information relevant and available to each individual case should be required. Flexible data reporting requirements will ensure that data collection does not create barriers for consumers requesting assistance or general information, or create unnecessary burden for caseworkers that may compromise their ability to resolve cases quickly and efficiently. Data fields should provide an option to indicate that a consumer did not have access to or did not wish to share certain information.**

CSS is concerned that if an advocate is required to obtain every listed item of information in order to provide a needed service, it could restrict some clients' access to needed advice and guidance.

Response:

CMS appreciates the concerns and suggestions provided by the commenters. In order to accurately document coverage and access trends in the insurance marketplace, CMS encourages CAPs to collect all of the information listed in the Supporting Statement section on Insurance Status and Recent History. However, CMS acknowledges that collection of this information is not realistic in certain situations and may be too burdensome, particularly when the information is not necessary to resolve a case. CMS acknowledges that CAPs are in the best situation to determine the level of information that is able to be collected for any given consumer. In addition, a number of data fields contain the

drop-down value “Unknown” as an option in order to allow the case worker to acknowledge that the consumer was not able to or did not wish to provide certain information.

Comment:

CMS received a comment from Community Service Society suggesting that CMS provide more clarity on its expectations for required data elements. Instead of requiring multiple mandatory fields, Community Service Society urged CMS *to prioritize collecting data that demonstrates the important functions served by CAPs, in areas such as: consumers’ savings, successful appeals, numbers of clients served, and capacity to serve diverse populations.*

Response:

CMS thanks the commenter for the suggestion and will take it into consideration.

Comment:

CMS received a comment from Community Service Society applauding *CMS’ well-balanced demand for qualitative and quantitative data. No matter how large a data set is, there are always important aspects of the health insurance system that escape a quantitative data analysis. Since November 2010, CHA has identified multiple systemic issues through a combination of anecdotal evidence, detailed case notes and statistical analysis. These issues include problems with the State’s External Appeals Application form, incorrect denials of breast reconstruction services to commercially insured individuals, out-of-network billing, and more. By giving enough weight to the qualitative data that CAPs obtain, CMS can obtain important elements for the analysis of consumers’ experiences in the world of health insurance.*

Response:

CMS appreciates the sentiments provided by this commenter. CMS recognizes the importance of qualitative data and has instituted quarterly progress reports to help CAPs provide more information and details on cases that are not reflected in the data reports.

Comment:

CMS received comments from FamiliesUSA suggesting that CAPs should have the flexibility to use tailored database software. Specifically, *we would also recommend that CMS build into their database functionality that allows CAPs to add categories to drop down menus or to auto-fill categories that do not apply in their state. For example, not all states charge fees for external appeals. Some CAPs may also want to collect data on state-specific issues that generate lots of consumer calls. Allowing CAPs to use their own systems or make adjustments to CMS database software will minimize unnecessary burden for case workers and will enable CAPs to collect data on consumer issues that are state- or region-specific.*

Response:

CMS thanks the commenter for the suggestions. CMS built and is continuing to update the CAP database tool for CAP users. At this time, CMS is unable to provide customized versions of the database based on the state. For example, tailoring the tool based on state laws (i.e., whether a state

charge fees for external appeals) would require considerable burden on the federal government in terms of cost and capacity. CMS currently allows CAPs the choice of using their own data collection system or the CCIIO-created database at no cost. If there are CAPs that use the CCIIO-created database who are interested in tailoring the software for their own needs (e.g., state- or region-specific issues), CMS will provide the source code to them at no cost. The downside is that CAPs doing so would need to make future enhancements on their own and not be able to download the newest versions of the CAP tool without again having to re-configure the database to their specific modifications.

Comment:

CMS received a comment from FamiliesUSA suggesting that *data collection should allow CAPs to report quantitative data on a broader range of case types. For example many CAPs provide assistance with enrollment and retention of coverage through public or state subsidized programs, gaining access to care, or resolving medical debt. In many cases consumers are not anticipating a loss of coverage, but instead have difficulty accessing or using coverage, or getting needed medical care if they are uninsured or do not have adequate coverage. CAPs should be able to report data on these types of consumer problems. In addition, some coverage denial cases may be resolved through negotiation, without needing to file an appeal or grievance, and case workers should be able to record this information. HHS could consider adding fields based on CAP input, or allow programs to add fields for these additional types of cases.*

Response:

CMS thanks the commenter for this suggestion and will take it into consideration. CAPs do have the ability to report data on coverage denial cases that are resolved through negotiation. CMS provides guidance to programs on how to reflect these types of situations in the data reports. While CMS recognizes the value of collecting quantitative data on a broader range of case types, the data CMS requires is statutorily-directed and focuses specifically on consumer experiences and concerns with respect to group health plans and health insurance coverage. The PHS Act (42 U.S.C. § 300gg-91(b)(1)) defines “health insurance coverage” as “benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.” The regulation (45 C.F.R. § 144.103) adds to the statutory definition with “[h]ealth insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.”

Comment:

CMS received similar comments from FamiliesUSA and Community Service Society suggesting that CMS provide guidance to CAPs on how to accurately measure savings to consumers. *Determining savings for consumers represented in appeals of benefit denials is generally a straightforward process where CAPs refer to cost information available on consumers’ Explanation of Benefits. However, comprehensive guidance would greatly assist CAPs in developing comprehensive estimates of consumers’ savings in different types of cases (e.g. assistance with enrollment into subsidized programs or public health insurance). We believe that that CAPs are underreporting savings to consumers absent uniform standards and comprehensive guidance in this area.*

FamiliesUSA suggested *CMS consult CAPs to develop a methodology for collecting comprehensive data on consumer savings.*

Response:

CMS thanks the commenters for the suggestions. CMS has provided CAPs with suggestions on ways to calculate recovered benefits and will explore whether more comprehensive guidance is necessary.

Comment:

CMS received a comment from FamiliesUSA suggesting that CMS collect data on how CAPs provide services to people with disabilities. CMS should collect data that requires CAPs to demonstrate their ability to communicate effectively with consumers who have disabilities, such as physical or cognitive disabilities and hearing or vision impairment. This information may be collected in a manner similar to data collection on cultural and linguistically appropriate services. CAPs should describe how they accommodate the needs of individuals with disabilities to provide accessible, appropriate and timely assistance, including technology used, availability of materials in alternative formats and personnel qualified to assist individuals with particular needs.

Response:

CMS appreciates the suggestion provided by this commenter and will take it into consideration.

Comment:

CMS received a comment from FamiliesUSA suggesting that CMS collect data on additional provisions of the ACA. The duties of CAPs related to Health Insurance Exchanges are described in Supporting Statement – Part A, however not all of the relevant provisions are included in the list of ACA issues that CAPs will report on. This list should include other ACA provisions that are effective in 2014, for example premium tax credits, cost-sharing reductions, Exchange coverage eligibility and enrollment, and Medicaid coverage eligibility and enrollment (including through the streamlined coverage application beginning in October 2013). CAPs will be both a critical resource for consumers who access coverage through exchanges and an invaluable source of information about how these new coverage and enrollment options are working for consumers. CAPs will also be integrated into the broader consumer assistance function of exchanges and the list of entities to which they can refer consumers should be expanded to reflect new resources, for example Navigator programs.

Response:

CMS appreciates the suggestion provided by this commenter. CMS agrees that CAPs will continue to play a critical role for consumers as the health insurance market changes. CMS is in the process of developing updates to Affordable Care Act-related data values that will include late provisions of the Affordable Care Act.