



**COVER**  
**MISSOURI**

**MFH Expanding Coverage Initiative**

**Expanding Coverage Through Consumer  
Assistance Program**

**Funding Cycle 6**

**Evaluation Core Data Set**

Updated August 2018



Center for Public Health Systems Science  
GEORGE WARREN BROWN SCHOOL OF SOCIAL WORK



**Washington**  
**University in St. Louis**

## Introduction

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As the external evaluator of the Expanding Coverage Initiative, the Center for Public Health Systems Science (CPHSS) focuses on answering important questions about the overall initiative. To answer these questions, we rely on multiple data sources. These include: 1) surveillance data routinely collected by state, counties, etc.; 2) data collected by CPHSS and MFH; 3) data collected by Expanding Coverage Through Consumer Assistance (ECTCA) grantees. The data collected by grantees are considered the “Core Data Set” for the Initiative evaluation. This Core Data Set is based on the evaluation questions identified by CPHSS and MFH.

In the following pages, the Core Data Set is described. Each grantee is responsible for submitting these data to CPHSS through an online data collection system. Grantees will be required to report data at three time points: 1) Monthly, 2) Weekly, and 3) After each CAC enrollment counseling session.

Please incorporate the data requirements into your evaluation efforts starting September 1, 2014 forward. Use the following pages to guide the incorporation of the data requirements into your current program evaluation activities. If you have any questions or would like assistance with this, please contact:

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# Monthly Reporting



## Monthly Data Reporting

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Monthly data reporting will focus on gathering information about your MFH grant. It is recommended that each grantee designate one staff person to enter their grant management data. Data are due one week after the end of the month (e.g., September 2014 data are due on October 8, 2014). Grantees are encouraged to identify a method for tracking this information throughout the month.

## RESOURCES

*This information only pertains to resources you received in addition to your MFH grant funding this month. Please do **NOT** include your MFH grant funding in the information below.*

### Funding Sources

Excluding your MFH funding, did you receive any additional funding that was used to implement your grant activities?

- Yes (complete information below for each funding source)     No

Name of funding source: \_\_\_\_\_

Specify the funding opportunity name: \_\_\_\_\_

Amount of funding received: \_\_\_\_\_

Start date of funding: \_\_\_\_\_

End date of funding: \_\_\_\_\_



### In-Kind Resources

Did you utilize/receive any of the following in-kind resources this month to support your grant activities? *Check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> Staff Time                      | <input type="checkbox"/> Space for enrollment or outreach activities |
| <input type="checkbox"/> Computers                       | <input type="checkbox"/> Supplies                                    |
| <input type="checkbox"/> Other, please specify:<br>_____ | <input type="checkbox"/> Did not utilize any in-kind resources       |

## PARTNERSHIPS

*This information pertains to the number and type of partnerships utilized by your grant this month. A partnership is a relationship between you and another organization that exists in the interest of achieving a common goal. Partners can share expertise, funding, staff, technology, or other resources.*

*For the purposes of the evaluation, there are two types of partnerships: 1) Contracted Partners and 2) Partners. Contracted Partners are under contract with you, and they are receiving payment from you through your MFH grant. Partners are NOT receiving payment from you but may or may not have a Memorandum of Understanding (MOU) with you.*

### Contracted Partners

*Contracted Partners are both under contract with you **AND** receiving payment from you through your MFH grant.*

Total number of Contracted Partners you worked with this month: \_\_\_\_\_

For each Contracted Partner identified above, please complete the following:

Name of Contracted Partner: \_\_\_\_\_

Activities conducted by or with this Contracted Partner: *Check all that apply*

- Conducted enrollment activities
- Conducted outreach and education activities
- Offered collaborative learning and training opportunities
- Other, please specify \_\_\_\_\_

## Partners

*Partners are NOT receiving payment from you but may or may not have a Memorandum of Understanding (MOU) with you.*

Total number of Partners you worked with this month: \_\_\_\_\_

For each Partner identified above, please complete the following:

Name of Partner: \_\_\_\_\_

Activities conducted by the Partner this month: *Check all that apply*

- Conducted enrollment activities
- Conducted outreach and education activities
- Offered collaborative learning and training opportunities
- Other, please specify \_\_\_\_\_

## CERTIFIED APPLICATION COUNSELORS (CACs)

*This information pertains to the Certified Application Counselors you are working with each month.*

### Certified Application Counselors

Total number of ACTIVE certified and licensed Certified Application Counselors (CACs) engaged with your grant activities this month: \_\_\_\_\_

*(This is the total number of certified and licensed CACs you are currently working with to enroll people/small businesses into the Missouri Health Insurance Marketplace. To be considered active, the CAC must be providing services during the reporting period. If no CACs were active please enter zero.)*

Total number of NEWLY certified and licensed CAC's this month: \_\_\_\_\_  
*(ONLY include those individuals who received their certification and licensure this month. This includes CACs who may or may not be actively engaged with your grant activities during this reporting period. Do NOT include a CAC who had their certification and licensure prior to this reporting month. If no CACs received their certification and licensure this month please enter zero.)*

For each newly certified and licensed CAC identified above, please complete the following:

Name of CAC: \_\_\_\_\_

CAC's Certification Date: \_\_\_\_\_



# Weekly Reporting





## Weekly Data Reporting

Weekly data reporting will focus on gathering information about education, awareness, and enrollment activities. Grantees and Contracted Partners will receive a link to enter this information online. Grantees will need to establish a plan for receiving this information from Partners, since they will not have their own link to enter data. It is recommended that grantees establish a follow up plan with Contracted Partners to ensure they are entering their information every week. Data are due one week after the end of the week (e.g., September 1 - 7, 2014 data are due on September 12, 2014).

### EDUCATION, AWARENESS, AND ENROLLMENT ACTIVITIES

*This information pertains to the education and awareness activities conducted this week. For the purposes of the evaluation, there are two types of education and awareness activities: 1) education, awareness, and enrollment events and 2) mass media activities. Education, awareness, and enrollment events serve to create awareness, educate the public on, and enroll people in the Missouri Health Insurance Marketplace. These events can include efforts targeting individuals/families and/or small business such as booths at an event, an educational program, or efforts inside a clinic. Mass media activities include publishing or airing media messages about the Missouri Health Insurance Marketplace and related awareness, educational, and enrollment activities supported by the MFH grant (e.g., radio ads, TV ads, newspaper ads).*

#### Education, Awareness, and Enrollment Events

*Education, awareness, and enrollment events serve to create awareness, educate the public on, and enroll people in the Missouri Health Insurance Marketplace. These events can include efforts targeting individuals/families and/or small business such as booths at an event, an educational program, or efforts inside a clinic. Events which focus on health insurance literacy (how to choose, use, and keep health insurance) are considered education events.*

Did you conduct any education, awareness, or enrollment events this week?

- Yes (complete information below for each event)  No

What type of event was conducted? *Check all that apply*

- Educational (e.g., formal presentations about the Missouri Health Insurance Marketplace or health insurance literacy)
- Awareness (e.g., community interaction events, booth at a health fair)
- Enrollment (e.g., enrolled individuals/families and/or small businesses in the Missouri Marketplace or SHOP Marketplace)

If selected Education or Awareness event, what was the focus of the CAC(s)' work at the event?  
*Check all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> How to enroll in health insurance<br><i>(e.g., Missouri Marketplace, Medicaid)</i>  | <input type="checkbox"/> Understanding health insurance<br><i>(e.g., definition of terms, different types of plans, cost-sharing)</i> |
| <input type="checkbox"/> How to use health insurance and navigate the health care system<br><i>(e.g., selecting a doctor, paying for services)</i> | <input type="checkbox"/> Affordable Care Act <i>(e.g., what is it, how it affects consumers)</i>                                      |
| <input type="checkbox"/> SHOP Marketplace  | <input type="checkbox"/> Other, please specify _____  |

Which strategies did the event utilize: *Check all that apply*

- Distributed awareness/educational materials  
*(e.g., brochures, fact sheets, flyers, promotional items)*
- Presented in the community  
*(e.g., made a presentation at a community meeting on the Missouri Health Insurance Marketplace)*
- Organized or participated in a community event or meeting  
*(e.g., health fairs, festivals, sporting events)*
- Enrolled individuals/families and/or small businesses in the Missouri Health Insurance Marketplace
- Presented MU-Extension Health Insurance Education curriculum  
*(either by CAC or MU Extension staff)*
- Showed health insurance literacy video(s)
- Other, please specify \_\_\_\_\_

If presented MU-Extension curriculum, what module(s) was used? *Check all that apply*

**Using Health Insurance**

How to use health insurance

**Individuals & Families**

Basic

In depth

Special groups

Employee

Medicare

**Business**

Basic

Calculating employer size

Small Business

Large Business

Additional information for businesses (*e.g., wellness programs, tax changes*)

Who conducted the event?

Contracted Partner  
*(Under contract and receive payment from the MFH grantee.)*

MFH Grantee  
*(Organization was the direct recipient of the MFH grant)*

Partner  
*(Receive no payment from the MFH grantee.)*

Other, please specify \_\_\_\_\_

How many partner organizations were involved in conducting this event? \_\_\_\_\_

*(In order to have partnered on an event the organization needs to assist with conducting the event. This is more than requesting you to provide an event at their organization. Examples of the types of activities the partner may perform are: conducting advertising or providing CACs. Generally, these partners should be listed as a contracted partner or partner in your monthly reporting. If no partners were involved in the event, enter zero.)*



What type of organization was the partner?

- MFH ECTCA grantee       Non-MFH grantee       Both

Please specify the partner organization(s) involved: \_\_\_\_\_

Marketplace audience targeted by the event: *Check all that apply*

- Individuals/Families       Small Businesses (SHOP)

Populations targeted by the event: *Check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> General Population                            | <input type="checkbox"/> Disabled  |
| <input type="checkbox"/> Young Adults, 18-34                           | <input type="checkbox"/> Low Income  |
| <input type="checkbox"/> Adults, 35-64                                 | <input type="checkbox"/> Rural   |
| <input type="checkbox"/> Lesbian, Gay, Bisexual,<br>Transgender (LGBT) | <input type="checkbox"/> High Risk Individuals<br><i>(e.g., individuals with HIV/AIDS,<br/>chronic conditions)</i> |
| <input type="checkbox"/> Limited English Proficiency                   | <input type="checkbox"/> Small Businesses  |
| <input type="checkbox"/> African Americans                             | <input type="checkbox"/> Latinos   |
| <input type="checkbox"/> Immigrants and refugees                       | <input type="checkbox"/> Your organization's consumers<br><i>(e.g., clients, patients, etc.)</i>                   |
| <input type="checkbox"/> Other, please specify _____                   |  |

In what setting was the event held?

- |  |  |
|--|--|
| <input type="checkbox"/> Neighborhood/Community  | <input type="checkbox"/> University/College                          |
| <input type="checkbox"/> School  | <input type="checkbox"/> Faith-Based Organization                    |
| <input type="checkbox"/> Business<br><i>(e.g., retail, small business,<br/>worksite)</i> | <input type="checkbox"/> Hospital/Clinic/Health Care<br>Organization |
| <input type="checkbox"/> Other, please specify _____                                     |  |

Counties targeted by the event: \_\_\_\_\_

Zip code where the event took place: \_\_\_\_\_

If you did not have a partner for the event:

The approximate number of people reached through the event: \_\_\_\_\_

If you partnered on an event:

The approximate total number of people reached by all partners involved in the event (both ECTCA grantee and non ECTCA grantee partners): \_\_\_\_\_

*If you partnered with both ECTCA and non ECTCA organization on an event you must report the **total** number of people reached as a result of all partners' efforts. If each organization staffed an event at different times of the day then you would need to add all the partner organizations' reach estimates together. It may require getting in contact with partner organization(s) after an event to confirm how many people were reached at the event. This means that if partnering organizations included an ECTCA grantee, ECTCA grantees will report the same number of people reached.*

The approximate number of people reached by only ECTCA grantee partners: \_\_\_\_\_

*If you partnered with an ECTCA organization on an event you must report the **total** number of people reached as a result of all grantee partners' efforts. If each organization staffed an event at different times of the day then you would need to add all the ECTCA partner organizations' reach estimates together. It may require getting in contact with any ECTCA organization(s) that you partnered with after an event to confirm how many people were reached at the event. This means that partnering ECTCA organizations will report the same number of people reached.*

The number of people enrolled through the event: \_\_\_\_\_

*(If no one was enrolled at the event, enter zero)*

### Mass Media Activities

*Mass media activities include publishing or airing media messages about the Missouri Health Insurance Marketplace and related awareness, educational, and enrollment activities supported by the MFH grant (e.g., radio ads, TV ads, newspaper ads).*

*Record the total number of mass media activities conducted during the reporting period for each category below.*

Did you conduct any mass media activities this week?

Yes (complete information below for all mass media activities)

No

Number of each type of mass media activity conducted: "Earned" indicates the activity was free.

____ Paid Newspaper	____ Earned Newspaper
____ Paid Radio	____ Earned Radio
____ Paid Other Print (e.g., utility bill inserts, newsletter, horse circular, etc.)	____ Earned Other Print (e.g., utility bill inserts, newsletter, horse circular, etc.)
____ Paid Television	____ Earned Television
____ Social Media	____ Billboards
____ Web (e.g., website, web ad)	____ Other, please specify _____ _____

Of these mass media activities, did you partner with an ECTCA grantee? (Check all that apply)

*(In order to have partnered on a mass media activity the organization needs to assist with conducting the activity. Examples of the types of activities the partner may perform are: co-branding, sharing the cost of an advertisement, or developing messages for a mass media activity together. An example of an activity in which partnering did **not** take place is retweeting another grantee's tweet. Generally, partners should be listed as a contracted partner or partner in your monthly reporting.)*

- ECTCA grantee
- Did not partner with any ECTCA grantees

Which ECTCA grantee(s) did you partner with? (Check all that apply)

- Central Missouri Community action
- Community Action Agency of St Louis County
- CoxHealth (SW Hub)
- East Missouri Action Agency
- International Institute of Metropolitan St. Louis
- Legal Services of Eastern Missouri
- Ozark action, Inc
- Planned Parenthood of the St. Louis Region and Southwest Missouri (St. Louis Hub)
- Primaris/KMA (Central Hub)
- Randolph County Caring Community Partnership
- Saint Louis Effort for Aids

Number of each type of mass media activity conducted with [ECTCA grantee name] (answer question for each ECTCA grantee that was a partner)?

*"Earned" indicates the activity was free.*

\_\_\_ Paid Newspaper

\_\_\_ Earned Newspaper

\_\_\_ Paid Radio

\_\_\_ Earned Radio

\_\_\_ Paid Other Print  
*(e.g., utility bill inserts,  
newsletter, horse circular, etc.)*

\_\_\_ Earned Other Print  
*(e.g., utility bill inserts,  
newsletter, horse circular, etc.)*

\_\_\_ Paid Television

\_\_\_ Earned Television

\_\_\_ Social Media

\_\_\_ Billboards

\_\_\_ Web  
*(e.g., website, web ad)*

\_\_\_ Other, please specify \_\_\_\_\_  
\_\_\_\_\_

Number of mass media activities targeting each audience: *Check all that apply*

Individuals/Families

Small Businesses (SHOP)

Number of mass media activities targeting each population: *Check all that apply*

General Population

Disabled

Young Adults, 18-34

Low Income

Adults, 35-64

Rural

Lesbian, Gay, Bisexual,  
Transgender (LGBT)

High Risk Individuals  
*(e.g., individuals with HIV/AIDS,  
chronic conditions)*

Limited English Proficiency

Small Businesses

African Americans

Latinos

Immigrants and refugees

Your organization's consumers  
*(e.g., clients, patients, etc.)*

Other, please specify \_\_\_\_\_





# Counseling Session Reporting



## Counseling Session Data Reporting

Counseling session data will focus on gathering information about what happened as a result of a counseling session (in-person or by phone) conducted by the Certified Application Counselor (CAC). Each CAC will receive a link to enter this information online. CACs are responsible for entering this information after a counseling session even if a counseling session did not result in an enrollment. It is recommended that grantees establish a follow up plan with CACs to ensure they are entering their information after each session.

### ENROLLMENT COUNSELING SESSION

An enrollment counseling session is defined as a direct interaction of a CAC (by phone or in-person) with an individual, family, or small business who is trying to enroll in the Missouri Health Insurance Marketplace or who needs assistance after they have enrolled. Do **NOT** count an interaction that only includes the distribution of awareness and education materials or consumer interactions with non-CAC staff at your organization (e.g., administrative assistant, scheduling assistants). A counseling session may or may not include starting an enrollment application, but should result in the CAC identifying a next action step with the consumer.

*The information below pertains to the outcomes of **EACH** counseling session conducted by a Certified Application Counselor (CAC).*

#### General Information

Name of CAC who conducted counseling session: \_\_\_\_\_

Source of CACs funding:

- |   |  |
|---|--|
| <input type="checkbox"/> MFH ECTCA grant                  | <input type="checkbox"/> CMS Navigator grant |
| <input type="checkbox"/> In-kind (Organization supported) | <input type="checkbox"/> HRSA                |
| <input type="checkbox"/> Other, specify _____             |  |

Permanent Enrollment Site, Mobile Enrollment Site, or Event where counseling session occurred: \_\_\_\_\_

**Permanent enrollment site** – Locations where CACs hold office hours and schedule appointments on a regular basis. These sites can be found on the Cover Missouri Find Local Help page.

**Mobile enrollment site** – Locations where a CAC meets with a consumer outside of a permanent enrollment site's regular office hours. Examples of mobile enrollment sites include restaurants and a consumer's home.

**Event** – In-person events where CACs have provided counseling sessions. If an event is selected as the location where the counseling session took place, an event would also be reported in a grantee’s weekly report.

Examples of when the location of a counseling session would be reported as a mobile site or an event:

- A permanent site becomes a mobile site when it is being used outside of the organization’s regular office hours at the location. For example, if CAC schedules a Saturday appointment at a site that is usually open Monday through Friday, the CAC would report that the session took place at a mobile site.
- Events can also take place at a permanent site. Events are advertised as a stand-alone activity and are held outside of the permanent site’s regular hours. If a CAC does a counseling session during an event at a permanent site, they would report Event as where the counseling session took place.

County where counseling session occurred: \_\_\_\_\_

County where consumer lives: \_\_\_\_\_

How counseling session was conducted:

- In-person                       Phone (CAC CANNOT enter information on HealthCare.gov for the consumer)

Type of applicant who received counseling:

- Individual                       Family                       Small Business

Number of all lives covered by the application: \_\_\_\_\_

Was this a new enrollee or re-enrollee?

*A re-enrollee is someone who previously elected a Qualified Healthcare Plan (QHP) in the Missouri Health Insurance Marketplace and has returned with the intention of modifying a QHP or electing a QHP again. One way to determine if the consumer is a re-enrollee is if he or she has an existing account on HealthCare.gov. If a person was seeking assistance with a plan in which they were already enrolled and no assistance enrolling was provided, select ‘only post-enrollment assistance was provided.’*

- New                       Re-enrollee                       Only post-enrollment assistance was provided

How did the applicant hear about your organization's enrollment assistance services?

- |  |   |
|--|---|
| <input type="checkbox"/> Family/friend/previous client   | <input type="checkbox"/> Newspaper                              |
| <input type="checkbox"/> Event in the community  | <input type="checkbox"/> Radio                                  |
| <input type="checkbox"/> Print ads (e.g., utility bill insert, newsletter, horse circular)                   | <input type="checkbox"/> Television                             |
| <input type="checkbox"/> CoverMissouri.org website   | <input type="checkbox"/> Billboard                              |
| <input type="checkbox"/> Awareness/education materials (e.g., flyer, promotional item, brochure, fact sheet) | <input type="checkbox"/> Social media (e.g., Facebook, Twitter) |
| <input type="checkbox"/> Internal referral (e.g., referred by other department within grantee organization)  | <input type="checkbox"/> Employer                               |
|  | <input type="checkbox"/> Other, please specify:<br>_____        |

Number of counseling sessions applicant has attended with **ANY** CAC at **ANY** organization including today's visit: \_\_\_\_\_

*(This is ONLY for counseling sessions related to the enrollment in which they are seeking assistance.)*



What was the outcome of the counseling session? *Check all that apply*  
*Unless otherwise specified, the choices below apply to sessions with individuals and families and consumers in the SHOP Marketplace.*

- |  |  |
|--|--|
| <input type="checkbox"/> Assisted consumer with enrollment questions, concerns, etc.                                 | <input type="checkbox"/> Assisted consumer with <b>post</b> -enrollment questions, concerns, needs, etc. |
| <input type="checkbox"/> Created an email address  | <input type="checkbox"/> Determined eligibility  |
| <input type="checkbox"/> Created or updated a Marketplace account  | <input type="checkbox"/> Elected a Qualified Healthcare Plan   |
| <input type="checkbox"/> Reported life changes to Marketplace (e.g., changes in income, family size)                 | <input type="checkbox"/> Declined to elect a Qualified Healthcare Plan (QHP) at this time                |
| <input type="checkbox"/> Filed for/qualified for advance payment tax credits   | <input type="checkbox"/> Elected Medicare ( <i>choose only if there is NOT a Part A premium</i> )        |
| <input type="checkbox"/> Filed for/qualified for cost-shared reduction   | <input type="checkbox"/> Provided referral (e.g., send to someone else for assistance)                   |
| <input type="checkbox"/> Applied for/qualified for hardship exemption  | <input type="checkbox"/> Sent application to MO HealthNet  |
| <input type="checkbox"/> Completed an enrollment/ Marketplace application for a SEP                                  | <input type="checkbox"/> Provided translation services (e.g., used an interpreter)                       |
| <input type="checkbox"/> Did not qualify for a SEP enrollment  | <input type="checkbox"/> Provided education about health insurance                                       |
| <input type="checkbox"/> Appealed a Marketplace decision   | <input type="checkbox"/> Selected a dental plan  |
| <input type="checkbox"/> Submitted an enrollment/Marketplace application   | <input type="checkbox"/> Started an enrollment/ Marketplace application but did not submit it            |
| <input type="checkbox"/> Submitted payment for 1 <sup>st</sup> insurance premium payment (selected 'pay now' option) | <input type="checkbox"/> Other, please specify: _____  |
| <input type="checkbox"/> Elected Medicaid Managed Care Plan  |  |

**Specific to SHOP Marketplace**

- Employer selected health plan/price level to offer to employees in SHOP Marketplace
- Triggered Employee Open Enrollment in SHOP Marketplace
- Employer submitted a SHOP application



If submitted an application, what type of application was completed? (Check all that apply)

- Used electronic application
- Used paper application
- Used phone application  
(ONLY choose this option if consumer was in presence of a CAC who utilized the Marketplace Call Center to complete the application)

If employer submitted a SHOP application, number of lives covered by the application: \_\_\_\_\_

If an application was sent to MO HealthNet, number of lives covered by MO HealthNet application: \_\_\_\_\_

If a Medicaid Managed Care Plan was selected, number of lives covered by the plan:  
\_\_\_\_\_

If completed an application for an SEP, what type of SEP?

- Qualifying life event (*e.g.*, marriage, birth, loss of eligibility/determined ineligible for Medicaid, death of spouse, job loss)
- Enrollment error (*e.g.*, insurance company unable to process enrollment due to technical error between Marketplace and insurance company)
- Exceptional circumstance (*e.g.*, natural disaster or unexpected hospitalization kept consumer from enrolling)
- Systems errors related to immigration status (*e.g.*, error in system caused incorrect immigration eligibility result)
- Misinformation (*e.g.*, misconduct by a Marketplace or non-Marketplace enrollment assister)
- Display errors on HealthCare.gov (*e.g.*, incorrect plan data was displayed, consumer allowed to enroll in different area)
- Misrepresentation/error by insurance company (*e.g.*, consumer was enrolled in wrong plan, provider chosen for them against their wish, provider network issues)
- Medicaid/Marketplace transfers (*e.g.*, consumer was incorrectly sent to Medicaid from Marketplace, consumer did not get answer about eligibility in Marketplace before the end of Open Enrollment)
- Other, please specify:  
\_\_\_\_\_

If an application was completed for life change event/SEP, specify the type of life change event/SEP:

- |  |   |
|--|---|
| <input type="checkbox"/> Marriage  | <input type="checkbox"/> COBRA expiration   |
| <input type="checkbox"/> Birth   | <input type="checkbox"/> Death of spouse  |
| <input type="checkbox"/> Adoption/placed child for adoption or in foster care                                | <input type="checkbox"/> Lost coverage because of divorce or legal separation       |
| <input type="checkbox"/> Moved residence   | <input type="checkbox"/> Lost coverage on parents' plan (e.g., turned 26 years old) |
| <input type="checkbox"/> Gained citizenship  | <input type="checkbox"/> Loss of eligibility to Medicaid or CHIP                    |
| <input type="checkbox"/> Lost health coverage (e.g., graduated from college, job loss or reduction in hours) | <input type="checkbox"/> Re-entry from incarceration                                |
| <input type="checkbox"/> Other please specify:<br>_____  |   |



If a referral was given, reason for referral: *Check all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> Consumer needed translation services  | <input type="checkbox"/> No CAC appointments were available in a timely manner  |
| <input type="checkbox"/> Consumer needed special accommodations (e.g., disability)   | <input type="checkbox"/> Consumer Assistance Site's hours of operation are too limited                                    |
| <input type="checkbox"/> Consumer Assistance Counselor was not certified and/or licensed   | <input type="checkbox"/> Consumer had transportation issues   |
| <input type="checkbox"/> Closer/more convenient enrollment location  | <input type="checkbox"/> Consumer needed post enrollment assistance or had an insurance complaint                         |
| <input type="checkbox"/> Consumer required in-person assistance  | <input type="checkbox"/> No CAC on site or on call to provide enrollment assistance                                       |
| <input type="checkbox"/> Consumer needed additional information to enroll (e.g., email address, tax forms, information about coverage available to family) | <input type="checkbox"/> Eligible for insurance through another program/source (e.g., Medicaid, employer, Medicare, etc.) |
| <input type="checkbox"/> Didn't qualify/not eligible for SEP   | <input type="checkbox"/> Not eligible for financial assistance through the Marketplace                                    |
| <input type="checkbox"/> Consumer fell in the Medicaid Gap   | <input type="checkbox"/> Cannot afford premium  |
| <input type="checkbox"/> Other, please specify: _____  |   |

Where was the applicant referred: *Check all that apply*

- |   |   |
|---|---|
| <input type="checkbox"/> Federal Navigator                            | <input type="checkbox"/> Federal Marketplace Hotline (1-800-318-2596) |
| <input type="checkbox"/> Another CAC or Consumer Assistance Site      | <input type="checkbox"/> Healthcare.gov website                       |
| <input type="checkbox"/> Missouri Department of Insurance             | <input type="checkbox"/> CoverMissouri.org website                    |
| <input type="checkbox"/> Missouri Department of Social Services       | <input type="checkbox"/> MO HealthNet                                 |
| <input type="checkbox"/> Health Insurance Consumer Assistance Program | <input type="checkbox"/> Medicare                                     |
| <input type="checkbox"/> VA   | <input type="checkbox"/> TRICARE                                      |
| <input type="checkbox"/> Gateway to Better Health                     | <input type="checkbox"/> Other State Agency, please specify:<br>_____ |
| <input type="checkbox"/> General list of agents/brokers               | <input type="checkbox"/> Other, please specify:<br>_____              |



If an enrollment/Marketplace application was started but not submitted, reason for not submitting the application? *Check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> Ran out of time/consumer had to leave                       | <input type="checkbox"/> Not eligible for subsidies/tax credits  |
| <input type="checkbox"/> Did not have required documentation to complete application | <input type="checkbox"/> Decided they were not interested in insurance                                 |
| <input type="checkbox"/> Wanted to discuss with family/friend/spouse                 | <input type="checkbox"/> Could not afford insurance premium  |
| <input type="checkbox"/> Opted to pay the penalty                                    | <input type="checkbox"/> Language barrier  |
| <input type="checkbox"/> Exploring hardship exemption                                | <input type="checkbox"/> Not a U.S. Citizen or legal immigrant   |
| <input type="checkbox"/> Wanted additional information                               | <input type="checkbox"/> Fell within the Medicaid coverage gap   |
| <input type="checkbox"/> Covered under their employer                                | <input type="checkbox"/> Technical difficulties with the enrollment site                               |
| <input type="checkbox"/> Unknown   | <input type="checkbox"/> SHOP information sent to employees for review (SHOP Marketplace <b>only</b> ) |
| <input type="checkbox"/> Other, please specify _____                                 |  |



If a consumer declined to elect a Qualified Health Plan (QHP), reason for not electing a plan?  
*Check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> Ran out of time/consumer had to leave                       | <input type="checkbox"/> Not eligible for subsidies/tax credits          |
| <input type="checkbox"/> Did not have required documentation to complete application | <input type="checkbox"/> Decided they were not interested in insurance   |
| <input type="checkbox"/> Did not like the plan options                               | <input type="checkbox"/> Wanted to discuss with family/friend/spouse     |
| <input type="checkbox"/> Could not afford insurance premium                          | <input type="checkbox"/> Opted to pay the penalty                        |
| <input type="checkbox"/> Language barrier  | <input type="checkbox"/> Exploring hardship exemption                    |
| <input type="checkbox"/> Exploring hardship exemption                                | <input type="checkbox"/> Wanted additional information                   |
| <input type="checkbox"/> Not a U.S. Citizen or legal immigrant                       | <input type="checkbox"/> Fell within the Medicaid coverage gap           |
| <input type="checkbox"/> Covered under their employer                                | <input type="checkbox"/> Technical difficulties with the enrollment site |
| <input type="checkbox"/> Unknown   | <input type="checkbox"/> Other, please specify                           |
- 



## Health Insurance Literacy and Post Enrollment Assistance

**Health insurance literacy** is the ability to use, choose, and keep health insurance.

What type of health insurance literacy or post-enrollment assistance was provided during the session? *Check all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> Shared information about health insurance ( <i>e.g.</i> , definitions of key terms, how insurance and the Marketplace works, financial assistance available, understanding insurance documents) | <input type="checkbox"/> Taught skills needed to assess healthcare/health insurance needs, obtain and/or use health insurance ( <i>e.g.</i> , how to compare plans, find a provider, calculate costs, access insurance information, how to contact insurance company) |
| <input type="checkbox"/> Showed consumer health insurance literacy video(s)  | <input type="checkbox"/> Provided written materials about health insurance ( <i>e.g.</i> , handouts, brochures)   |
| <input type="checkbox"/> Selected or changed primary care provider   | <input type="checkbox"/> Contacted insurance company to assist in resolving issues  |
| <input type="checkbox"/> Accessed information on healthcare providers, formularies, or health care services covered by insurance   | <input type="checkbox"/> Printed a temporary insurance card   |
| <input type="checkbox"/> Updated Marketplace account to resolve post-enrollment issues ( <i>e.g.</i> , loss of APTCs, uploaded documents for identification verification)  | <input type="checkbox"/> Filed an appeal with the Marketplace   |
| <input type="checkbox"/> Called the Marketplace Call Center to resolve post-enrollment issues  | <input type="checkbox"/> Contacted health care provider ( <i>e.g.</i> , primary care physician, pharmacy)   |
| <input type="checkbox"/> Other (please specify): _____   | <input type="checkbox"/> None of the above  |

Approximate time spent providing assistance during the counseling session: \_\_\_\_\_  
(Time should be reported in minutes.)

# Regional Hub Reporting Monthly



## Regional Hub Data Reporting

Only grantees that were funded as a hub will be required to track this information. Regional hub data will focus on gathering information specific to their hub activities. Information specific to your other grant requirements will be tracked in the monthly, weekly, and counseling session data. Data are due one week after the end of the month (e.g., September 2014 data are due on October 8, 2014). Hub grantees are encouraged to designate a data entry staff person and identify a method for tracking this information throughout the month.

### HUB ACTIVITIES

*This information pertains to only those activities conducted as part of your regional hub responsibilities and should not include information about your other grant responsibilities.*

#### General Information

In what ways did you convene sites in your region this month (virtually or in-person)? Choose all that apply and indicate the number of opportunities offered by type

- Provided/hosted a training to sites in your hub region

Total number of trainings offered \_\_\_\_\_

Specify the training topic(s), \_\_\_\_\_ [limit 100 characters]

Approximate number of people reached per training \_\_\_\_\_

- Provided opportunities for shared learning and networking to sites in your hub region (e.g., conference calls, email updates, in-person meetings)

Total number of opportunities offered \_\_\_\_\_

Approximate number of people reached for all opportunities offered \_\_\_\_\_

- Did not convene sites within your hub region this month



What other hub related activities did you conduct this month for sites within your region?  
*Choose all that apply*

- |   |   |
|---|---|
| <input type="checkbox"/> Created/refined a method or strategy for sharing information or learning                                   | <input type="checkbox"/> Coordinated outreach and/or enrollment efforts with non MFH grantees ( <i>e.g., events, volunteers</i> ) |
| <input type="checkbox"/> Shared resources or information with other consumer assistance sites/CACs                                  | <input type="checkbox"/> Assessed needs or resources for consumer assistance sites and CACs                                       |
| <input type="checkbox"/> Mentored other grantees, consumer assistance sites, or CACs  | <input type="checkbox"/> Worked with the TA provider (Community Catalyst)   |
| <input type="checkbox"/> Established a system of referrals for consumer assistance sites  | <input type="checkbox"/> Utilized the online community ( <i>In The Loop</i> )   |
| <input type="checkbox"/> Coordinated outreach and/or enrollment efforts with other MFH grantees ( <i>e.g., events, volunteers</i> ) | <input type="checkbox"/> Did not conduct any additional hub activities this month for my region                                   |
| <input type="checkbox"/> Other, specify _____   |   |