HRSA Health Center Ongoing Outreach and Enrollment (O/E) Assistance
Frequently Asked Questions (FAQs)
Updated October 18, 2016

For questions not addressed below, please contact BPHC's Outreach and Enrollment Assistance Team at bphc-oe@hrsa.gov.

Expectations for Ongoing O/E Activities

1) Can you summarize the O/E assistance supplemental funding that was provided to health centers, including any ongoing funding?

In July 2013 (FY 2013 funding), HRSA awarded $150 million to health centers through the O/E assistance supplemental funding for a 12-month period from July 1, 2013 through June 30, 2014. These awards included $5,000 in one-time funds. In December 2013 (FY 2014 funding), HRSA awarded an additional $58 million in one-time O/E supplemental funding to these health centers. In FY 2014, these health centers were awarded ongoing O/E funding that was prorated to align with the budget start date. In 2015, these health center grantees either have received or will receive annualized ongoing O/E funding in their FY 2015 base funding awards.

In October 2014 (FY 2015 funding), HRSA awarded $6.5 million to 91 health centers that did not receive O/E funding in FY 2013 for a 12-month period from November 1, 2014 through October 31, 2015.

In November 2015 (FY 2016 funding), HRSA awarded over $7 million to 93 health centers that received initial Health Center Program funding in FY 2015 for a 12-month period from November 1, 2015 through October 31, 2016. Ongoing O/E funding amounts will be adjusted in FY 2017 to align with grantees' FY 2017 budget periods.

2) Will Primary Care Associations (PCAs) continue to receive O/E funding to support health centers?

Yes. HRSA has similarly included O/E funding in PCA base awards to continue their work to provide training and technical assistance to support health center O/E assistance efforts.

3) What are HRSA's ongoing expectations for health centers' O/E activities and use of funds?

HRSA expects health centers that receive O/E funding to conduct in reach, outreach, and enrollment assistance throughout the year, with the understanding that health centers will likely have to adjust resources in order to meet the increased health center patient and service area needs during open enrollment periods to maintain a similar level of effort consistent with that which was supported by initial O/E supplemental funding. Ongoing activities supported by O/E funding may include the following:

- Conducting in reach to uninsured eligible health center patients;
- Conducting outreach in the health center's approved service area, including promoting the health center as a resource for enrollment assistance;
- One-on-one or otherwise customizable education sessions about affordable insurance coverage options;

- Securing access to Medicaid, CHIP and other available health, social service, pharmacy and other assistance programs;
- Assisting individuals with filing appeals and exemptions;
- Assisting individuals with requesting a special enrollment period;
- Assisting individuals with Medicaid, CHIP or Marketplace plan re-enrollment/renewals;
- Assisting newly insured individuals with understanding and utilizing their insurance;
- Ensuring that the health center is appropriately designated as an assister entity and is otherwise in compliance with all applicable federal and state laws and other requirements;
- Maintaining a sufficient and competent assister workforce, including:
    - Ensuring that health center assisters have met all applicable federal and state training and related requirements;
    - Providing or supporting participation in other training and related professional development;
- Planning and maintaining partnerships to maximize the impact of the health center in reaching uninsured eligible populations; and
- Identifying and incorporating lessons learned to improve the enrollment process for consumers and assisters and to more effectively target outreach to uninsured eligible populations.

4) Are health centers expected to maintain the same level of staffing for O/E activities throughout the year and from year to year?

HRSA expects health centers to maintain reasonable staffing levels that: 1) allow the organization to do proactive outreach and to meet the demand for enrollment assistance and related activities throughout the year; and 2) ensure that the organization is reasonably prepared and has sufficient numbers of trained assisters to conduct in reach and outreach activities to meet health center patient and service area needs during open enrollment periods. As funding for O/E activities has been maintained at initial funding levels (minus $5,000 in one-time funds), HRSA expects a similar level of effort to be dedicated to O/E activities on an ongoing basis.

5) Can our health center carry over unobligated O/E funds into our health center's next budget period?

Requests for carryover of unobligated balances from one budget period to the next require prior approval by HRSA. Requests to carry over operational O/E funds will not be approved, unless indicated in the term on the award describing the funding amount.

6) Must individuals hired by health centers as assisters continue to conduct only O/E-specific activities?

As noted in other FAQs (see questions 3 and 4), health centers receiving O/E funding are expected to continue O/E activities post open enrollment and be prepared to respond to increased demand for assistance in the next open enrollment period at levels similar to those conducted in the first open enrollment period. However, during times when demand for O/E activities are lower, as appropriate, staff previously dedicated exclusively to O/E assistance may be used to contribute support to other

health center efforts to expand access to care and/or to provide comprehensive primary care services (e.g., patient/community education and other support/enabling services).

7) UPDATED - What are the ongoing O/E quarterly progress reporting (QPR) requirements for health centers?

HRSA will continue to require health centers to submit QPRs until December 31, 2016. Future O/E data will be captured in the annual Uniform Data System (UDS) submission (see PAL 2017-01 at http://bphc.hrsa.gov/programrequirements/pdf/pal2017021.pdf for more information). More information on health center reporting requirements can be found in the QPR Frequently Asked Questions, located at http://bphc.hrsa.gov/about/healthcentersaca/outreachenrollment/.

8) How should health centers account for O/E spending?

HRSA does not require separate budget reporting for O/E activities. However, HRSA expects O/E funds to be spent in accordance with a health center's approved budget and work plan, and that grantees can account for spending as needed. See Policy Information Notice (PIN) 2013-01, Health Center Budgeting and Accounting Requirements located at http://bphc.hrsa.gov/programrequirements/policies/pin201301.html for more information.

9) Our health center was successful at promoting the availability of health center O/E assistance to residents of our service area via earned media and mailers. Are these activities allowable under the new regulations that state that "CACs may not solicit consumers for application or enrollment assistance by going door-to-door, or through other unsolicited means of direct contact, including calling a consumer, unless the consumer initiates contact or the consumer has a pre-existing relationship with the assister organization?"

Health centers may use earned and paid media, mailers, go door-to-door or make direct calls, and other broad-based strategies to do unsolicited outreach and education to the public to promote the availability of health center enrollment assistance to non-health center patients. If a health center makes unsolicited direct calls to consumers for outreach and education purposes, the health center may not use "robocalls," meaning an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the health center or individual CAC has a pre-existing relationship with the consumer (e.g., consumer is a patient of the health center), so long as other applicable state and Federal laws are complied with. If, when providing unsolicited outreach and education to a consumer, the consumer requests assistance with application or enrollment, the assister may provide assistance at that time or follow-up with the consumer, as appropriate. In addition, these communications must be reasonable and consistent with the intent of HRSA O/E funding and must not promote the health center or its services.

10) May our health center use O/E resources for paid media or other means to raise awareness of the availability of our enrollment assistance?

Health centers that have conducted outreach and have sufficient resources to meet demand for enrollment assistance may utilize O/E funding to support broader state or local media or other external communication efforts to increase awareness of and demand for health center O/E assistance with enrollment into affordable insurance options. These communications must be reasonable and consistent with the intent of HRSA O/E funding and must not promote the health center or its services.

11) Revised-What are HRSA's guidelines for health centers that are considering working with agents or brokers to further enhance the health center's O/E efforts?

Health center assisters should not refer consumers to any specific agent or broker, or any set of agents or brokers. Assisters may inform consumers about the general availability of licensed, Marketplace-trained health insurance agents and brokers as an additional resource that may be able to provide recommendations to the consumer or answer complex health insurance issues. In general, health centers follow the parameters and guidelines outlined in Certified Application Counselor (CAC) training or the equivalent in their state, CMS Common Questions and Answers for CACs, and the CMS Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors Final Rule to determine the appropriate parameters for health center relationships with agents, brokers and other similar intermediaries. A few relevant resources include the following:

- 2017 Federally-facilitated Marketplace (FFM) Assister Training: https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html
- Common Questions and Answers for CACs: https://marketplace.cms.gov/outreach-and-education/downloads/common-qandas-about-cac-designation.pdf
- CMS - Center for Consumer Information & Insurance Oversight (CCIIO): https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/assistance.html
- CMS Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf
- CMS Exchange and Insurance Market Standards for 2015 and Beyond: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf%20http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf

12) Are there restrictions on health centers allowing agents or brokers to lease space or otherwise have a presence at the health center?

Health centers should not allow agents or brokers to provide assistance on site at the health center unless those arrangements are managed in such a way that they are consistent with the parameters outlined in the question and answer above.

Training and Certification Requirements

13) What are HRSA's minimum training expectations for health center assisters?

Awardees must ensure that assisters working on behalf of the health center have successfully completed all required federal and/or state training (certified application counselor (CAC) or equivalent, at a minimum) to assist individuals with enrollment through the applicable marketplace type for the state for the current open enrollment period.

14) Do current health center assisters have to get recertified?

Yes. CMS regulations require assisters to be recertified and trained on at least an annual basis. More information and FAQs regarding the training and recertification requirements for assisters are available at: https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.htmlAdditionally, assisters and their supporting organizations who conduct O/E activities without having completed required training on at least an annual basis may face civil monetary penalties, as described in the new CMS rules for assisters. The new rules describe assister rights, responsibilities, and a remediation process in case of violations. The new rules are described in detail at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf. A general overview of these rules is available at: https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html

15) What are the training and recertification requirements for the November 1, 2016-January 31, 2017 open enrollment period?

For assisters in Federally-facilitated Marketplaces, including State Partnership Marketplaces, CMS has released the updated 2017 plan year training curriculum for assisters (including CACs, Navigators, and non-Navigator assistance personnel). A guide for accessing the updated training is now available at: https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html
Assisters in both State Partnership and Federally-facilitated Marketplaces must be recertified on an annual basis. Each State Partnership Marketplace runs its own assister program and develops its own assister-specific training, so health centers in State Partnership Marketplace states should contact their Primary Care Association to determine the recertification requirements and process.

16) Updated -Does my health center need to be designated as a CAC organization before my O/E assistance workers can be trained?

Organizations can have their individual staff members and volunteers take the CAC training course as soon as the organization's CAC organization application is approved; however, the organization should not certify individuals as CACs until it has been formally designated and entered into an agreement with the Centers for Medicare & Medicaid. Please review this presentation on *How to Become a Certified Application Counselor Organization in a FFM*.

This includes look-alikes and other health centers that have not received HRSA O/E supplemental funds but which intend to provide outreach and/or enrollment assistance activities. Certified application counselors (CACs), Navigators, and in-person assisters in the Federally-facilitated Marketplaces (FFMs) can access the 2017 Assister Training on MLMS through the CMS Enterprise Portal. FAQs related to the CAC application process are located at https://marketplace.cms.gov/technical-assistance-resources/training-materials/mlms-questions.PDF.For additional assistance with questions on the MLS assister training, please submit inquiries to MLMSHelpDesk@cms.hhs.gov. For assistance with CAC program questions, submit inquiries to CACQuestions@cms.hhs.gov

If you are in a State Partnership Marketplace you must comply with all organization and individual assister requirements as determined by Federal regulations and your state. Health centers in State Partnership Marketplace should contact their Primary Care Association and/or Marketplace to determine organizational certification requirements and processes.

17) Where can I learn more about additional training requirements in my state?

Primary Care Associations (PCAs) are available to help health centers to better understand the assister training requirements in your state. Contact information for the PCA in your state is located at http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html. You can also contact your state marketplace for additional information.

18) Must health center assisters who are not supported by HRSA funding complete assister training?

Yes. Anyone performing enrollment assistance on behalf of the health center, including health center staff, volunteers, or contracted individuals, must, at a minimum, complete all training requirements applicable for enrollment assisters in that state. This includes look-alikes and other health centers that have not received HRSA O/E supplemental funds and intend to provide outreach and enrollment assistance.

19) If my staff are only providing assistance with Medicaid or CHIP enrollment directly through the state Medicaid agency, must they complete all training applicable to providing assistance with enrollment through the marketplace?

It is up to each health center to ensure that staff are appropriately prepared to assist with Medicaid enrollment through their state Medicaid agency. HRSA requires that each health center have staff available to assist consumers with enrollment in Medicaid, CHIP, and Marketplace coverage.

20) Our state law requires that organizations that facilitate enrollment be licensed and perform background checks on all individuals providing enrollment assistance. Does HRSA require that our organization be licensed and/or complete background checks on employees?

HRSA requires that health centers and their assisters comply with all applicable state laws and requirements that apply to their O/E assistance role in their state.

Sliding Fee Scale Requirements

21) What should we advise patients who do not want to pursue affordable insurance options through the Marketplace in favor of continuing to receive services at the health center on a sliding fee discount schedule (SFDS)?

Health centers must educate consumers about affordable insurance options, including the benefits of insurance that extend beyond the services provided by the health center (e.g., access to specialty care and hospitalization), and provide assistance with enrollment for eligible individuals. However, health centers cannot require patients to enroll in public or private insurance and/or related third party coverage. In addition, the health center must have systems in place to assess all patients for income and family size, and based on that information, provide SFDS discounts as appropriate. Thus, if a current or new patient is not able to, is exempt from, or chooses not to pursue affordable insurance coverage, the health center must continue to serve that patient and charge the patient in accordance with the health center's SFDS for the service(s) provided, as appropriate.

22) Will the Marketplace insurance coverage make the sliding fee discount schedule (SFDS) Health Center Program requirement obsolete?

No. As the Marketplace insurance coverage continues in future years, there will be individuals who are not eligible to enroll, are exempted from the mandatory coverage requirement, and/or who may choose not to enroll in public or private insurance. In addition, individuals may be enrolled in insurance options that do not cover or only partially covers fees for certain health center services. Health centers must continue to assess all patients for eligibility for sliding fee discounts based on family size and income, regardless of insurance status, and charge accordingly.

23) Can health centers require proof of application/proof of denial for insurance or other documentation (e.g., exemptions) before offering services on a sliding fee discount schedule (SFDS)?

No. The health center must have systems in place to assess all patients for income and family size, and based on that information, provide SFDS discounts as appropriate. Health centers cannot require patients to enroll in public or private insurance and/or related third party coverage. If a current or new patient is not able to, is exempt from, or chooses not to pursue affordable insurance coverage, the health center must continue to serve that patient, and charge the patient in accordance with the health center's SFDS for the service(s) provided, as appropriate.

24) If a patient at or below 200 percent of the Federal Poverty Guidelines (FPG) is enrolled in a Qualified Health Plan (QHP) with which the health center does not have a contract and that patient wants to continue to receive services at the health center, must the health center provide those services on a sliding fee discount schedule (SFDS)?

Yes. The health center must have systems in place to assess all patients for income and family size, and based on that information, provide SFDS discounts as appropriate. Patients at or below 200 percent of

the FPG are eligible for sliding fee discounts, regardless of insurance status. If after being informed of the benefits of receiving care from a provider in their QHP network and how to access that care, patients choose to continue receiving care at the health center, the health center must charge the patients in accordance with the health center's SFDS for the service(s) provided.

25) Are we required to charge patients for services provided at the health center in accordance with our health center's sliding fee discount schedule (SFDS) if they are auto-assigned to another Medicaid managed care provider and either choose not to or have not yet been reassigned to the health center?

Consistent with previously published responses, the health center would inform/educate patients regarding their option to receive care from the primary care provider to whom they have been assigned. The health center may provide assistance with the process of reassignment if patients request it and if this is consistent with health center policies and procedures and any additional guidance provided by the state Medicaid agency or state law. If patients choose to receive care from the health center prior to the effective date of a reassignment or choose not to pursue reassignment, the health center would assess patients for income and family size, in accordance with health center policies and procedures, and charge patients in accordance with the health center's SFDS for the service(s) provided.

26) May health centers offer different sliding fee discount schedules (SFDS) based on eligibility for subsidies through the Marketplace or insurance status?

No. The requirements for sliding fee discounts apply to individuals based on income and family size only. Health centers are only allowed to utilize multiple sliding fee discount schedules based on services or mode of delivery. Therefore, individuals of comparable income and family size must be treated uniformly. See the response to FAQ #27 for a specific example.

27) Are patients who are covered by a QHP eligible for sliding fee discounts? If so, how is the sliding fee discount schedule (SFDS) applied?

Health centers may serve patients with third party insurance that does not cover or only partially covers fees for certain health center services. These patients may also be eligible for the SFDS based on income and family size. In such cases, subject to potential legal and contractual limitations (as may be specified by applicable federal and state law for Medicare, Medicaid, and/or terms and conditions of private payer contracts), the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

For example, *John Doe*, an insured patient, receives a health center service for which the health center has established a fee of $100, per its fee schedule. Based on *John Doe's* insurance plan, the co-pay is$60 for this service. The health center has also determined, through an assessment of income and family size that he is at 150 percent of the Federal Poverty Guidelines (FPG) and thus qualifies for the health center's SFDS. Under the SFDS, a patient at 150 percent of the FPG receives a 50 percent discount of the $100 fee, resulting in a charge of $50 for this service. Rather than the $60 co-pay, the health center

charges *John Doe* no more than $50 out-of-pocket, consistent with its SFDS, as long as this is not precluded by the insurance contract terms.

Note that if an insured patient's out-of-pocket costs do not exceed his/her SFDS pay class charge, the health center is permitted but not obligated to provide an additional discount, as long as this is not precluded by the insurance contract terms.