HRSA Health Center Outreach and Enrollment Assistance
Supplemental Funding
Frequently Asked Questions
Updated February 25, 2014

Purpose and Background

1. What is the purpose of the Health Center Outreach and Enrollment (O/E) Assistance supplemental funding opportunity?

These O/E assistance supplemental funds have been invested in health centers to expand current O/E assistance activities, and to facilitate enrollment of eligible health center patients and service area residents into affordable health insurance coverage through the Health Insurance Marketplaces, Medicaid, or the Children's Health Insurance Program.

2. Why did HRSA invest in O/E?

The next several months provide an unprecedented opportunity for health centers to contribute to nationwide efforts to increase access to care through the new affordable insurance options available beginning in 2014. By facilitating enrollment, health centers will be helping the uninsured enroll in affordable coverage options while also investing in their own future by increasing reimbursement opportunities for the health center and increasing access to the full spectrum of health care for the populations they serve.

3. How does this supplemental funding opportunity fit into the Affordable Care Act's broader O/E strategy?

This O/E supplemental funding opportunity complements and aligns with other federal efforts, such as the Navigator program, as well as state application assistance efforts. This funding provides one more way for community members to gain access to trained and knowledgeable assistance. As trusted community providers located in every state in the nation, health centers are uniquely positioned to assist their patients and other uninsured individuals in their service areas to determine their eligibility for and enroll in new affordable health insurance options.

4. How much funding was awarded under the O/E assistance supplemental funding opportunity?

HRSA awarded approximately $150 million under this supplemental funding opportunity.

5. Will this supplemental funding continue into the future?

Yes. The O/E supplemental funding was originally awarded on July 1, 2013 for 12 months through June 30, 2014 and included $5,000 of one-time funds. For FY 2014, the amount of O/E funds that is reflected in the Recommended Future Support (RFS) commitment on O/E awardees' most recent NoA is a pro-rated ongoing amount from July 1, 2014 to the start of the grantee's next Budget Period start date. For FY 2015 and beyond, the amount of O/E funds in the RFS reflects an annualized amount that matches the amount awarded in July 2013 less the $5,000 in one-time expenditures. More information on HRSA's O/E one-time supplemental funding is located at http://bphc.hrsa.gov/outreachandenrollment/oe_additional_faqs.pdf.

6. What is the source of HRSA O/E supplemental funds?

Health center O/E supplemental awards were made available through the mandatory FY 2013 appropriation for health centers under Section 10503 of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Healthcare and Education Reconciliation Act (P.L. 111-152), collectively referred to as the Affordable Care Act (ACA).

In-Reach and Outreach Activities

7. Can health center O/E assistance workers let consumers know which plans our health center participates in?

Health center O/E assistance workers in **Federally Facilitated Marketplaces (FFMs) and State Partnership Marketplaces (SPMs)** and trained as CACs may not offer recommendations to consumers or advise consumers on what plan to choose. However, in the interest of helping consumers understand their options, trained health center O/E assistance workers in FFMs and SPMs may provide information to consumers about the plans in which the health center participates, unless there are additional restrictions imposed by the state or by virtue of the health center O/E assistance workers serving in a capacity other than a CAC.

Health center O/E assistance workers in **State-Based Marketplaces (SBMs)** must comply with all conflict of interest requirements as determined by their state Marketplace and their consumer assistance role in the state and as outlined in their training.

8. Can I promote the services provided by health center as part of my O/E activities?

Health centers can announce an O/E event to be hosted by the health center and/or share information about the availability of the health center as a location where O/E assistance is available. These communications must be reasonable and consistent with the intent of the O/E supplemental funding opportunity and must not promote the health center or its services. In addition, to the extent possible, O/E messages to be used, in whole or in part, to describe the purpose of O/E activities and/or new affordable insurance options should rely on pre-approved federal and/or state materials.

While O/E events and one-on-one O/E consumer interactions must focus on assisting with enrollment in affordable insurance options rather than on promoting the health center, health centers may provide information about their services (e.g., brochures) to those interested and respond to any related questions.

9. Can health centers in FFMs/SPMs collect consumer personally identifiable information (PII), such as phone numbers and email addresses, in order to follow-up with consumers on applying for or enrolling into coverage?

Yes. CMS has revised its model consent form template (also referred to as an authorization form) to include the collection of limited contact information such as an email address or phone number to follow-up with consumers on the application and enrollment process. This follow-up contact information is optional and a consumer is not required to provide it. The CMS-developed consent form is provided as part of the CMS welcome package and is a model template. Your health center may develop its own consent form or modify the template as it chooses. In addition, your health center should follow internal policies and procedures for the handling of PII and any additional state requirements as appropriate.

10. HRSA O/E supplemental funding requires health centers to conduct both in-reach and outreach in the health center's approved service area. Does this conflict with CMS CAC guidelines/communications that have suggested that CACs in FFM/SPM states should not conduct outreach or otherwise proactively contact individual consumers about enrolling in the Marketplace?

Health centers that received supplemental funding for outreach and enrollment are required to conduct in-reach with current patients and outreach in their approved service area. Because the CAC rule does not require CACs to conduct outreach nor does it prohibit CACs from conducting outreach to the community, health centers can meet HRSA's requirement to conduct outreach without conflicting with CAC requirements. Likewise, health centers can contact current patients to inform them about the new affordable insurance options and the role the health center can provide in assisting with enrollment. Health centers should consult with their PCA to determine if there are any additional state laws that may restrict their ability to do in-reach or outreach. If such restrictions exist, health centers should conduct their activities accordingly and report those laws as "issues/barriers" in their quarterly progress reports (QPR) submitted to HRSA.

11. Can I do mass mailing as part of my O/E activities?

Broad-reaching communication efforts, such as mass mailings, may be used to announce an O/E event to be hosted by the health center and/or the availability of the health center as a location where O/E assistance is available. These communications must also be reasonable and consistent with the intent of the O/E supplemental funding opportunity and must not promote the health center or its services. In addition, to the extent possible, O/E messages to be used, in whole or in part, to describe the purpose of O/E activities and/or new affordable insurance options should rely on pre-approved federal and/or state materials.

12. What sorts of outreach activities are expected under this O/E assistance supplemental funding opportunity?

Health centers are expected to conduct "in reach" with currently uninsured health center patients and "outreach" to non-health center patients in their approved service area. Each health center should determine the best means by which to engage uninsured individuals based on their knowledge of the service area. Outreach activities may include hosting enrollment events focused on educating community members about new affordable insurance options and providing enrollment assistance.

Health Center O/E Assistance Roles

13. What is the role of health center O/E assistance workers in ensuring consumers provide accurate information in their applications?

Consumers are responsible for providing accurate information, including accurate reporting of their sources of income, when completing applications for affordable health care coverage through the Marketplace. The role of health center O/E assistance workers is to educate consumers about their coverage options and assist them in completing applications for affordable insurance as appropriate.

Health centers have developed different strategies to help clarify these respective roles. Some health

centers have established a form through which the consumer acknowledges one or more of the following: 1) that the information they provide is accurate, 2) that they are required to provide all sources of income in their application, 3) that the health center and the assister are not responsible for any information that is provided incorrectly or purposefully omitted from this application, and/or that 4) no attempt will be made by the assister to verify any information provided in a Marketplace application.

Other health centers having encouraged O/E assistance workers to use talking points prior to providing application support similar to those outlined above to clarify their role and the assistance they can provide to the consumer.

14. How can health center O/E assistance workers assist consumers in providing accurate information in their applications?

Consumers are responsible for verifying the accuracy of the information they provide to the Marketplace. Unless specifically outlined by state or other requirements, O/E assistance workers can remind consumers that they are responsible for and must attest to the accuracy of the information they provide to the Marketplace.

15. How should O/E assistance workers respond to consumers' complex tax questions?

Health center O/E assistance workers should not provide tax advice or other information that extends beyond the scope of their training and approved role in assisting consumers in their service area.

16. What should health center O/E assistance workers do if they encounter potential fraud, such as unsolicited calls to consumers from unknown parties asking for personally identifiable information?

Health center O/E assistance workers should report any suspected fraud to the resources cited here: https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/. O/E assistance workers in SBM states should also follow up with their state Marketplace.

Application Assistance

17. Where can I find information on health center strategies to address high demand for enrollment assistance?

HRSA has developed a quick reference guide with descriptions of enrollment assistance techniques that have been implemented by health centers. The guide is found at http://bphc.hrsa.gov/outreachandenrollment/enrollmentassistance.pdf.

18. Can health centers in FFMs/SPMs assist consumers by directly filling out the application?

Certified application counselors and navigators can assist consumers by directly filling out the application when working face-to-face with that consumer. If you are working face-to-face with a consumer and they request your help in filling out their application (for example, if the consumer has a disability or asks you to help them use the computer), you are free to do so. However, if you are providing enrollment assistance to a consumer by phone, you should not fill out an application on their behalf, as it would require the consumer to share with you their Marketplace user name and password over the phone. To assist a

consumer by phone, you may answer general questions, or walk through the application with the consumer as they enter their own information, but you may not enter their personal information on the application without the consumer being physically present.

19. We are in a FFM and work with populations who do not use computers and/or who do not have email addresses. What should we do?

Assisters can help consumers set up an email account if they do not already have one. In order to begin an application on HealthCare.gov, consumers need to create a "My Account" first. To create this account, consumers need to provide an email address, and need to verify their account by checking their email and clicking on a verification link they will receive from HealthCare.gov.

- Applicants who do not yet have email addresses can still apply online, but they will need to set up a free email account by choosing one of the links at the bottom of the account creation page. You can help them set up an email account, and verify their HealthCare.gov "My Account" using the verification link, before continuing to the application. For this purpose, it is important that computers which are going to be used for the application process do not block access to popular email sites.

- If you do help an applicant set up an email account, please make sure the applicant knows his/her email address and password. You should not keep the applicant's password.

- If the individual is unwilling or uncomfortable with establishing an email address, the Marketplace Call Center will assist him or her in applying for coverage without an electronic account/email address. That number is 1-800-318-2596 or 1-855-889-4325 (TTY).

20. Does Federal Tort Claims Act (FTCA) include liability coverage for errors or omissions on the part of health center O/E assistance workers?

FTCA coverage for health centers is limited to the performance of medical, surgical, dental, or related functions within the scope of the approved Federal section 330 grant project, which includes sites, services, and other activities or locations, as defined in the covered entity's grant application and any subsequently approved change in scope requests. For more information see http://bphc.hrsa.gov/ftca/healthcenters/index.html.

21. Can health centers refer consumers to or contract with insurance agents or brokers?

No. It is not allowable for a health center to contract with or refer a consumer to an insurance broker for O/E assistance because this would conflict with the health center's obligation to share the full range of options available to consumers, including all Qualified Health Plans and Insurance Affordability Programs for which persons may be eligible.

22. Can our health center O/E assistance worker assist individuals with enrollment in the Marketplace before completing all of the required federal and/or state training?

No. Health center O/E assistance workers should not provide assistance with Marketplace enrollment until they have completed all of the required federal and/or state Marketplace training. However, individuals who have historically assisted with Medicaid eligibility and/or enrollment can continue to do that work to the

extent they can outside the Marketplace and report their Medicaid/CHIP activities until they are able to complete the official Marketplace training.

Sliding Fee Scale Requirements

23. 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 scale (SFDS)?

Health centers should educate consumers about affordable insurance options, including the benefits 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, 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, assess eligibility for the SFDS based on family size and income, and charge the patient in accordance with the health center's SFDS for the service(s) provided, as appropriate.

24. Will the sliding fee discount scale (SFDS) Health Center Program requirement be made obsolete by the Affordable Care Act (ACA)?

No. As the ACA 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. Health centers must continue to assess these individuals for eligibility for SFDS based on family size and income and charge accordingly.

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

Health centers must continue to provide eligibility assistance by educating consumers about affordable insurance options, including the benefits that extend beyond the services provided by the health center (e.g., access to specialty care and hospitalization), and providing assistance with enrollment for eligible individuals. However, if a current or new patient is not able to, is exempt from, or chooses not to enroll, the health center must assess the patient's eligibility for the SFDS based on family size and income and, as appropriate, charge the patient in accordance with the health center's SFDS for the service(s) provided.

26. If a patient below 200% of the Federal Poverty Guidelines 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 scale (SFDS)?

Yes. If after being informed of the benefits of receiving care from a provider in their QHP network and how to access that care, the patient chooses to continue receiving care at the health center, the health center must assess eligibility for the SFDS based on family size and income and charge the patient in accordance with the health center's SFDS for the service(s) provided.

27. NEW 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 (see the response to FAQ #26 above), the health center would inform/educate the patient 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 requested by the patient to do so 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 the patient chooses to receive care from the health center prior to the effective date of a reassignment or chooses not to pursue reassignment, the health center would assess eligibility for SFDS in accordance with health center policies and procedures and charge the patient in accordance with the health center's SFDS for the service(s) provided.

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

No. Sliding fee requirements apply to individuals based solely on income and family size. Therefore, individuals of comparable income and family size would need to be treated uniformly. See the response to FAQ #29 below for a specific example.

29. 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 are required to determine patient eligibility for sliding fee discounts based solely on the patient's income and family size. Some of these eligible patients may also have third party health insurance, such as a qualified health plan (QHP), which does not cover or only partially covers health care services, resulting in "out-of-pocket" costs (e.g., co-insurance or co-pays). In these cases, the health center would apply the sliding fee discount by charging the patient in a given SFDS pay class an amount no greater than what would be charged to a patient that has no public or private insurance. For example, insured health center *Patient A* receives a health center service. His/her insurance co-pay, under his/her QHP, is indicated to be $60 for this service. The health center has also determined that this patient is at 160% of the federal poverty guidelines (FPG), and thus, also qualifies for the health center's SFDS. Under the SFDS, a patient at 160% FPG would be charged $45 for this same service. Thus, the health center would have *Patient A* pay no more than $45 out-of-pocket, consistent with its SFDS.

Please note that health centers are responsible for ensuring adherence to Federal and state laws and regulations and for following the terms and conditions of their contracts with third party insurers. Health centers with questions on the applicability of federal and state law and/or the terms and conditions of their private payor contracts should consult with private legal counsel.

Quarterly Progress Reports

30. What are the reporting requirements for health centers receiving O/E supplemental funds?

O/E Quarterly Progress Report (QPR) FAQs and a sample reporting form are located at http://bphc.hrsa.gov/outreachandenrollment/.

Special Populations

31. Where do I find more information on how the ACA intersects with American Indian and Alaska Native populations?

More information on the ACA's impacts on American Indian and Alaska Native populations can be found at: https://www.healthcare.gov/if-im-an-american-indian-or-alaska-native-what-do-i-need-to-know-about-the-marketplace/, and the Indian Health Service website at: http://www.ihs.gov.

32. A consumer may be eligible for a Veterans Affairs (VA) care program. Where do I go to help them apply and enroll?

For questions on VA care program enrollment refer to www.va.gov/healthbenefits/enroll, call 1-877-222-VETS (8387), or visit your local VA health care facility.

Training

33. What are health center O/E assistance worker training requirements?

Training requirements to assist consumers with enrollment through the Marketplace vary by state. More information on FFM and SPM training requirements is located at: http://bphc.hrsa.gov/outreachandenrollment/ffm_spmtrainingfaq.pdf. More information on SBM training requirements is found at: http://bphc.hrsa.gov/outreachandenrollment/sbmtrainingfaq.pdf.

Funding Opportunity Requirements

34. With whom should I be collaborating in my state?

Health center O/E assistance workers should collaborate with other health centers (grantees and look-alikes) and other providers in their service areas to ensure that O/E activities are coordinated with other local, regional, and/or state-wide O/E efforts and training requirements. Your Primary Care Association can serve as a resource to assist in the coordination of efforts across your state. You can find your Primary Care Association at http://bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html.

35. I receive general Community Health Center funding (section 330(e)) and Healthcare for the Homeless funding (section 330(h)). How should I allocate my efforts for the O/E supplemental funding opportunity?

O/E activities should be consistent with a grantee's current scope of project. A grantee who receives both general health center and special population funds should conduct O/E activities that target those populations.

36. I am a homeless-only grantee. Do I have to conduct O/E activities with non-homeless residents in my service area?

Homeless-only (or other special populations-only) grantees who receive O/E funds should focus outreach

activities to individuals in their target population, consistent with their scope of project. However, all health center O/E assistance workers are required to assist any resident seeking O/E assistance.

37. Do O/E efforts have to go beyond my target population?

O/E assistance efforts should target eligible uninsured residents in the approved service area, consistent with the grantee's approved scope of project.

38. Do I have to provide application assistance to everyone, even those from outside my service area or from a neighboring state?

Where practical, health center O/E assistance workers are expected to provide application assistance to non-residents of their service area or a neighboring state. If a health center cannot support non-residents, or does not have O/E assistance workers who are trained and certified to work with other state Marketplaces, referral to other O/E assistance programs is acceptable.

39. Do I need to capture O/E assistance activities on Form 5C: Other Activities?

Yes. Health centers should add these activities to Form 5C: Other Activities in the H80 grant folder as "Non-Clinical Outreach" or update the existing "Non-Clinical Outreach" entry (e.g., update frequency and locations).

40. If we lease a temporary site for O/E assistance activities under this supplement, do we need to submit a change in scope request to add that site to our Form 5B: Service Sites?

O/E funds cannot be used to support the provision of primary health care services. Therefore, any temporary sites leased for O/E activities would not be considered a service site for Form 5B purposes and instead should be listed as a location under the "Non-Clinical Outreach" entry for O/E activities on Form 5C: Other Activities.

Use of Supplemental Funds

41. Does our health center need errors and omissions or other insurance to cover liabilities associated with O/E assistance workers? If so, can we purchase this insurance with O/E supplemental funds?

Health centers should consult with their legal counsel to determine what insurance coverage is appropriate for their organization. If the health center determines that additional insurance coverage is necessary, it is allowable for health centers to use O/E supplemental funds to pay for any portion of that coverage that specifically addresses the activities of O/E assistance workers.

42. Can health centers use O/E supplemental funds to purchase envelopes and stamps to assist consumers with mailing the paper application?

Yes, purchasing envelopes and stamps to assist consumer with mailing paper applications is an allowable use of HRSA O/E supplemental funds.

43. NEW How can health centers use their O/E supplemental funds after the open enrollment period ends on

March 31, 2014?

Ongoing O/E funds may be used for activities that support continued health center outreach, education and enrollment assistance that will continue beyond March 31 and into the next open enrollment period. These activities include, but are not limited to, outreach and education to support awareness of affordable insurance options and related assistance provided by health centers, providing assistance in securing access to Medicaid, CHIP and other available health, social service, pharmacy and other assistance programs, assisting individuals with filing appeals and exemptions (as appropriate) or with qualifying life events/special enrollment periods, assisting newly insured individuals with utilizing their insurance, professional development/training, and/or planning for the next open enrollment period.

44. NEW Our health center would like to utilize some of our health center O/E supplemental funding to support a local media campaign to raise awareness of our enrollment assistance. Is this an allowable use of funds?

O/E resources must be used to provide outreach and enrollment assistance to current uninsured patients and residents in the health center's approved service area. 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 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 the O/E supplemental funding opportunity and must not promote the health center or its services.

45. Can health centers use part of their O/E supplemental budget to support coordination or technical support functions of primary care associations or national cooperative agreements?

HRSA has provided funding to PCAs to support health centers in O/E activities. The intent of the O/E supplemental funds is for health centers to hire new health center O/E assistance worker FTEs, provide them with required federal and/or state training, and support O/E assistance workers in conducting outreach and enrolling individuals in affordable health insurance options.

46. What are the funding limitations for the O/E assistance supplemental funding opportunity?

Grant funds should support activities that enable health centers to raise awareness of insurance options and provide eligibility and enrollment assistance to uninsured patients and residents in their service areas. Health centers may not use O/E assistance supplemental funds to supplant other resources (federal, state, local or private) intended to support O/E assistance activities.

Please refer to Section 7 of the funding opportunity, "Allowable and Required Use of Funds" for information on allowable and unallowable expenses.

Please note that cost principles under section 330 apply to O/E assistance activities conducted with this supplemental funding.

47. Can we support administrative or other clinical staff using O/E assistance supplemental funding?

No. The O/E supplemental funds are intended to hire new health center O/E assistance workers and/or

expand upon the existing capacity of workers who will be trained and engaged in directly enrolling individuals into affordable health insurance. The O/E funds cannot be used to support other positions such as administrative or support staff. Only health center O/E assistance worker FTEs are allowable personnel costs for O/E funds.

48. How do I define the 1.0 minimum full-time equivalents (FTEs) to be supported by this supplemental funding?

To assure that grantees have adequate staffing allocated to O/E assistance, eligible applicants must hire at least 1.0 full time equivalent (FTE) to support new and expanded health center assistance efforts.

49. Can I support O/E supervision with O/E supplemental funds?

Health centers may use O/E supplemental funds to support a portion of time for a health center O/E assistance worker to coordinate and/or supervise other assistance workers; however, all health center O/E assistance workers supported by these funds must be trained and focused on directly enrolling individuals into affordable health insurance, in addition to providing supervision.

50. How do I count existing staff as FTEs under this funding opportunity?

O/E funds are not intended to replace the current salaries of existing health center O/E assistance workers or other staff. New FTEs may include additional hours for existing O/E assistance worker staff and/or new personnel hired specifically to be trained and engaged in enrolling individuals into affordable health insurance.

51. Can I contract for FTEs?

Yes. FTEs may be acquired either through direct hire or a contractual arrangement.

52. Can I use O/E supplemental funds to provide incentives for O/E assistance activities?

No. O/E assistance supplemental funds cannot be used to provide incentives.

53. Can overhead or indirect costs be applied towards this funding opportunity?

Applicants may include federally-approved indirect costs under “other” on the budget form and must explain these costs in the budget narrative justification.

54. Is travel an allowable cost?

Local travel in support of O/E activities supported by this supplemental funding is an allowable cost.

55. Is training an allowable cost?

Yes. Training and examination fees for health center O/E assistance workers are allowable uses of HRSA O/E supplemental funding.

56. We plan on using our mobile medical van for outreach. Are the van costs for these O/E-specific trips

allowable?

No. The costs of operating the van should be included in your existing budget, which would be expected to cover the costs of its operation for the purposes of this grant as well.

57. Can the O/E supplemental funds support enrollment efforts not based in the ACA changes, such as programs that expedite SSI/SSDI determination and the related Medicaid or Medicare benefit?

As a part of their regular scope of activities, Health Center Program grantees are required to have systems in place to maximize reimbursement by accessing all payer sources for which a patient is determined eligible. The O/E supplemental funds are provided to expand that capacity in order to specifically support the enrollment of uninsured individuals into the new affordable insurance options offered through the Health Insurance Marketplaces, Medicaid or CHIP.

58. What are allowable educational materials?

Educational materials may be used for activities such as directing potential enrollees to an enrollment site or explaining the available affordable health insurance options. Health centers should utilize materials made available through state or federal agencies. Materials are currently available in numerous languages at http://marketplace.cms.gov/getofficialresources/get-official-resources.html.

59. Is staff time or resources for planning and applying for this award application an allowable cost?

No. O/E funds are intended to directly support the recruitment, training, and payment of outreach workers, and any supporting materials or supplies that they need in order to do their work. Staff time or resources for program planning or the application itself are not allowable costs.

60. What qualifications must health center O/E assistance workers have in order to perform the duties outlined in the O/E assistance funding opportunity?

All health center O/E assistance workers (current and newly supported) must comply with all applicable federal and state training requirements related to the development of expertise in eligibility, enrollment, and program specifications. More information on FFM and SPM training requirements is located at http://bphc.hrsa.gov/outreachandenrollment/ffm_spmtrainingfaq.pdf. More information on SBM training requirements is located at: http://bphc.hrsa.gov/outreachandenrollment/sbmtrainingfaq.pdf.

61. Does the one FTE-minimum need to equate to one person?

No. FTEs can be allocated to new personnel and/or to expanded hours of existing personnel. The addition of 1.0 FTE requirement is a minimum. HRSA expects that many health centers may increase the health center O/E assistance worker personnel by multiple FTEs.

62. Are there specific requirements for use of the one-time funding?

One-time funds are provided to support one-time expenditures in support of O/E activities. However, applicants do not need to specify how the one-time funds will be used on the budget form or in the budget narrative justification.

63. How should we account for the $5,000 in one-time funding in our budget, and what are the allowable costs under that funding?

The $5,000 in one-time funding is intended to help defray upfront costs, such as laptops or necessary office supplies. There is no need to break out the one-time expenditures separately in the budget, provided that all expenses are allowable and justified according to the requirements in the guidance.

64. If an item costs more than $5,000, can other funds be used to make up the difference?

No. Equipment (defined as any individual item valued at $5,000 or more) is not an allowable cost under this award. O/E funds cannot be used to purchase equipment, even in conjunction with other funding sources.

65. O/E funds cannot be used for equipment or supply items costing $5,000 or more. Is this limit per item or for all equipment in total?

This $5,000 limit is per item; each individual item must be valued at less than $5,000.

66. Do I need to track O/E costs separately from my other H80 funds?

HRSA does not require separate budget reporting for this supplemental funding opportunity. However, HRSA expects that funds would be spent in accordance with the approved budget and work plan, and that grantees could account for spending if necessary.

67. Can the cost of additional hours for current health center O/E assistance workers be covered by O/E funds?

Yes, the cost of the additional hours is allowable and should be counted in the additional FTE total.

68. I have other questions related to allowable and unallowable costs. Whom should I contact?

For any O/E supplement questions, contact BPHC's Outreach and Enrollment Assistance team at bphc-oe@hrsa.gov.