

Outstationed Eligibility Workers and Community Health Centers: A Connecticut Case Study Spotlight on the States #6

November 2013



Introduction

In 2001, nine years prior to the Affordable Care Act (ACA), Federal regulation 42 USC 1396a(a)(55); 42 CFR 435.904 mandated that outstationed eligibility workers (OEW) must be available at Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals (DSH) to assist low-income pregnant women, children and youth. Under the same regulations agencies were given the opportunity to establish additional outstation locations at any other site where potentially eligible pregnant women or children receive services such as school service centers and family support centers¹. OEWs' functions include assisting individuals in the application process for public programs such as Medicaid and Children's Health Insurance Program. Per the federal regulation OEWs are authorized to perform all eligibility processing functions, including the eligibility determination.² OEW staff may include state employees, provider or contract employees or volunteers³.

Historically states have been required to establish outstation locations to process applications for certain low-income eligibility groups including pregnant women, children and youth⁴. Federal regulations require that OEWs must "provide for the receipt and initial processing of Medicaid applications from the designated eligibility groups at each outstation location"⁵. Initial processing is defined as "taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews"⁶.

Through the ACA and Medicaid expansion, millions of Americans will be newly eligible for Medicaid benefits. Outreach and enrollment efforts will be needed throughout communities to help individuals through the enrollment process. Outstationed eligibility workers provide these services and subsequently improve access to coverage.

State Status

According to NACHC's 2013 survey, of those who responded, Primary Care Associations (PCAs) in 10 states reported that their states are fully or mostly compliant with Medicaid outstationed eligibility worker

¹ "Code of Federal Regulations," U.S. Government Printing Office, <http://www.gpo.gov/fdsys/pkg/CFR-2001-title42-vol3/xml/CFR-2001-title42-vol3-sec435-904.xml>

² "Outstationing Eligibility Workers," National Association of Community Health Centers, <http://www.nachc.com/client/documents/issues-advocacy/state-issues/add-medicaid-info/Reviewofoutstationing.pdf>

³ "Code of Federal Regulations," U.S. Government Printing Office, <http://www.gpo.gov/fdsys/pkg/CFR-2001-title42-vol3/xml/CFR-2001-title42-vol3-sec435-904.xml>

⁴ *Ib id*

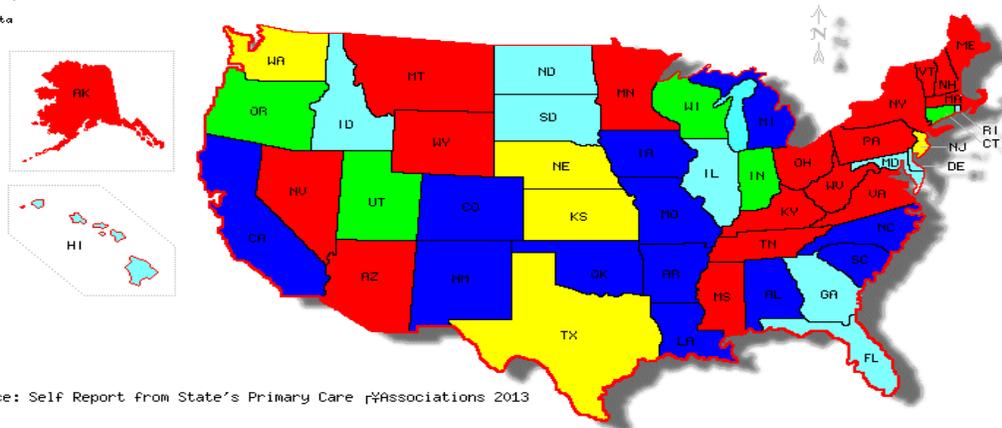
⁵ *Ib id*

⁶ *Ib id*

requirements while 30 reported that their states are partially or non-compliant⁷.

State Compliance with Medicaid Outstationed Eligibility Workers

- - Fully Compliant
- - Mostly Compliant
- - Partially Compliant
- - Non-Compliant
- - No Data



NOTES:
Data Source: Self Report from State's Primary Care Associations 2013

Funding

The federal government, through the Centers for Medicare & Medicaid Services (CMS) has made funds available specifically for enrollment. Through Federal Financial Participation (FFP) states are eligible for 50 to 75 percent match relating to eligibility determination processes. Certain costs associated with OEWs can qualify for the 75 percent FFP rate.

Federal Financial Participation (FFP)

To qualify for the 75 percent FFP relating to eligibility determination processes, states must meet the Seven Conditions and Standards and critical success factors. The conditions include: Modularity Standards, Medicaid Information Technology Architecture (MITA) Conditions, Industry Standards, Leverage Conditions, Business Results Conditions, Reporting Conditions and Interoperability Conditions. The Enhanced Funding Requirements: Seven Conditions and Standards can be found [here](#).⁸ An Operations Advance Planning Document must then be submitted to request funding.

The 75 percent FFP funds will be available when the approved system becomes operational and the funding will not expire⁹.

⁷ **Fully Compliant:** outstationed workers in every health center and every high volume site, paid for by the state. **Mostly Compliant:** outstationed workers in some health centers and some sites, paid for by the state. **Partially Compliant:** outstationed workers in some health centers and some sites, paid some by the state and some by the health center. **Non-Compliant:** no outstationed workers in any health centers or sites that are paid for by the state; if there are workers at centers, they are paid for entirely with health center dollars.

⁸ "Enhanced Funding Requirements: Seven Conditions and Standard," <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>

⁹ "FAQ Medicaid and CHIP Affordable Care Implementation," *Centers for Medicare & Medicaid Services*, <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/FAQ-Medicaid-and-CHIP-Affordable-Care-Act->

If a state can demonstrate that “their eligibility determination system will be operationally ready” and meet the aforementioned standards by October 1, 2013 then training costs may also be matched at the 75 percent FFP. “Costs associated with the training of eligibility workers directly engaged in the operation of the new eligibility system may be eligible to be matched at the enhanced rate during the three months (or less) prior to the start of operations” pending prior approval by CMS¹⁰.

“States may claim 75 percent FFP for the costs of certain personnel closely associated with operating claims processing and related systems under” Medicaid Management Information Systems (MMIS), this includes customer services such as call center activities and OEW activities related to eligibility¹. Other “direct costs allocable to the development or operation of an MMIS” can be claimed at the 75 percent FFP including: utilities, rent, telephone services, etc. Indirect costs such as “staff costs associated with agency-wide functions such as accounting, budgeting and general administration” are matched at a 50 percent FFP¹¹.

Documentation
<ul style="list-style-type: none"> • CMS-64-10 and 37-10 forms: <i>Specific to Eligibility Determination Workers at enhanced match:</i> • line 28E – Eligibility Determination staff cost of in-house activities- 75 percent FFP • line 28F – Eligibility Determination staff – cost of private sector contractors – 75 percent FFP <i>Eligibility Determination Workers staff eligible for regular administrative match:</i> • line 28G – Eligibility Determination staff- cost of in-house activities – 50 percent FFP • line 28H – cost of private sector contractors – 50 percent FFP

Case Study: Connecticut

The state of Connecticut has utilized Medicaid Outreach (MO) workers since the early 1990s and is fully compliant with the federal requirements relating to OEWs. Community Health Center Association of Connecticut (CHCACT) is contracted through the Connecticut Department of Social Services (DSS) to administer the Medicaid Outreach Program. CHCACT subcontracts with each of the 14 FQHCs within Connecticut to provide outreach and application assistance. Through these subcontracts the FQHCs are required to hire a MO worker for 25-27 hours per week. CHCACT’s responsibilities include providing ongoing training and technical assistance to MO workers and to report program evaluations and progress back to DSS.¹²

Funding

CT DSS has funded the MO Program since 1991. In Fiscal Year 2013 (July 1, 2012-June 30, 2013) CHCACT received \$515,388 from CT DSS through which each of the 14 FQHCs received \$34,356. The remaining \$34,404 was utilized by CHCACT to administer the program.

CT DSS funding supports 0.05 FTE, 2 hours per week, for the Director of Clinical Programs and 0.41 FTE or approximately 16 hours per week for the Clinical Program Coordinator at CHCACT.¹³ Approximately 0.5 Full Time Employee (FTE) for MO per FQHC is funded through the contracts with CHCACT. However, many FQHCs must supplement funding for additional hours to meet the needs of their populations. Individual FQHCs

[ACA-Implementation.html](#)

¹⁰ Ib id

¹¹ Ib id

¹² Lori-Anne Russo, Community Health Center Association of Connecticut, email message to author, August 13, 2013

¹³ Ib id

have received Health Resources and Services Administration (HRSA) outreach and enrollment funding which will financially support outreach and enrollment efforts not funded through the state.

Results

From July 1, 2012 to June 30, 2013 the CT FQHCs reported that application assistance was provided to 10,322 individuals. Of those who received assistance 4,770 were reported as having been granted benefits by June 30th. (This number may be underestimated as the processing of applications through DSS may be delayed).¹⁴

Innovations

There is an opportunity to identify Medicaid eligible patients through other public programs such as Supplemental Nutrition Assistance Program (SNAP). CHCACT has identified this opportunity as a potential method to streamline the process of identifying and enrolling eligible individuals into multiple public programs. CHCACT is contracted through Connecticut to administer SNAP outreach from October 1, 2013 through September 30, 2015. CHCACT has subcontracted with 10 of the 14 FQHCs in the state to hire 1-1.15 FTE for SNAP outreach. Through the SNAP contract, CHCACT has also purchased the license for a software program that has been able to streamline the screening process. The outreach worker enters the applicant's information and the screening tool determines eligibility for 24 different public benefits, including SNAP and Medicaid. Then, the program populates the appropriate fields for each benefit in the application form for DSS. The software program also has the ability to store information and track progress. For example, if an application is misplaced, the outreach worker does not have to re-enter the data. In addition, outreach workers can follow up with DSS and monitor successful enrollment.

Within the first three quarters of this contract SNAP outreach workers screened 9,775 households for benefits and submitted 2,661 applications. CHCACT is in the process of starting a discussion with the DSS Commissioner regarding the potential to further streamline the application process.

Streamlining the application process would allow OEWs to provide more holistic application assistance. Simplifying screening and reducing the number of applications needed to apply for different programs, as well as improved methods for tracking and follow up would increase the efficiency and efficacy of OEWs. This would have a large public health impact on the population within the state.

¹⁴ Ib id

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