



## **RCHN CHF Request for Proposals on Outreach and Enrollment Best Practices 2013**

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### **II. Brief Description of the RCHN Community Health Foundation**

Formed in 2005, the RCHN Community Health Foundation (“RCHN CHF” or the “Foundation”) is a not-for-profit operating foundation established to support community health centers (“CHCs”) through policy research, outreach, education, and strategic investment. RCHN CHF is the only foundation in the U.S. dedicated solely CHCs –the local, non-profit, community-governed health care providers that offer comprehensive primary and preventive care to underserved populations. RCHN CHF works to address community health centers’ primary challenges and establish opportunities to sustain health centers in the future.

This request for proposals (“RFP”) invites community health center and primary care association (“PCA”) applicants to apply for grant funds to support outreach and enrollment activities created by health reform. Proposals might target technology needs, training to address state-specific outreach and enrollment requirements, and/or unique strategies for identifying and enrolling the uninsured and other vulnerable populations. The Foundation seeks proposals that capitalize on existing strengths, maximize current resources, and innovate to address challenges in outreach and enrollment efforts.

### **III. Context for Funding Opportunity**

On March 23, 2010,<sup>1</sup> President Obama signed the Affordable Care Act (“ACA”) into law. The ACA focuses on expanding health insurance coverage, controlling health care costs, and improving the health care delivery system.<sup>2</sup> With an eye toward extending coverage, the ACA provides funding for states that choose to expand Medicaid to all nonelderly adults who are citizens or legal residents and have family incomes up to 138 percent of the federal poverty level (“FPL”).<sup>3</sup> (In 2013, 138 percent of FPL was \$15,856 for a single individual.) The Act also establishes new Health Insurance

Marketplaces (“Exchanges”) that offer subsidized health insurance plans (“qualified health plans” or “QHPs”) for small businesses and individuals or families with annual incomes between 100 percent and 400 percent of FPL (\$11,490 to \$45,960 for a single individual in 2013).<sup>4</sup> In addition, the ACA requires all individuals who can afford it to obtain insurance coverage, while requiring larger employers to share in the responsibility of creating affordable coverage for their workers.<sup>5</sup> Taken together, these changes are expected to expand coverage to over 30 million Americans.<sup>6</sup>

Because states may elect to either form their own Exchange, share responsibility with the Federal government through a partnership Exchange, or default to a federally-facilitated Exchange (“FFE”) run by the Federal government, operation of the Exchanges will vary widely (34 states have opted to have their residents use the federally-facilitated Exchange),<sup>7</sup> but every state will have a competitive marketplace available for consumers.<sup>8</sup> Furthermore, as of September 2013, 25 states and the District of Columbia have adopted the Medicaid expansion for low income adults.<sup>9</sup> Despite these variations, millions are expected to gain coverage in the coming years. Among the more than 8 million uninsured patients served by health centers in 2012,<sup>10</sup> the majority can potentially be expected to gain coverage by 2015 through either Medicaid (under existing rules or as a result of the ACA adult Medicaid expansion) or subsidized QHPs.<sup>11</sup>

The ACA also introduces reforms aimed at making it easier for individuals to get health insurance coverage and keep it. The law establishes a “Navigator” program to provide enrollment assistance and also provides for in-person assistance counseling. In addition, the United States Department of Health and Human Services (“HHS”) has invested more than \$150 million from the Health Center Trust Fund to enable health centers to build and strengthen their community enrollment assistance efforts.<sup>12</sup> These efforts will focus on a simplified, streamlined application for enrollment in any of three “insurance affordability programs” (Medicaid, Children’s Health Insurance Program (“CHIP”), or the premium subsidies and cost-sharing assistance available through the Exchanges).<sup>13</sup> However, many consumers may still require additional assistance with the application process given the complexity of enrollment and the variety of options.<sup>14</sup>

Health Centers and other primary care providers are expected to play a pivotal role in ACA implementation, particularly in outreach and enrollment efforts.<sup>15</sup> Health centers are often leaders in enrollment efforts because of their standing in the community, and because they already provide health services to a significant portion of the uninsured and offer linkages to enrollment assistance.<sup>16</sup> These services and relationships make community health centers an especially desirable place for people to seek enrollment assistance.<sup>17</sup> But given the new and complex systems and the unique needs of vulnerable populations, health centers must be prepared to adapt quickly to meet the needs of those they serve. Health centers will need to determine how to best:

1. educate their communities broadly about affordable health insurance options;
2. explain the enrollment process and insurance products to an audience unfamiliar with the new options and possibly, with health insurance in general;
3. gather and submit documentation via a system that may not be fully operational across programs;
4. utilize mobile technology and tools to facilitate enrollment; and
5. learn dynamically in real-time from other health centers and partners about best practices that overcome unique community requirements and program and systems limitations.

A recent study of the outreach and enrollment experience of health centers in Massachusetts underscores these potential challenges, and highlights the need for out-stationed enrollment, intensive and repeated in-person assistance throughout the various stages of enrollment, offered in multiple languages, and ongoing support to aid patients in reporting changes in circumstances and completing renewals.<sup>18</sup>

First, effective outreach and enrollment strategies will likely need to extend beyond the confines of the health center facilities and broadly engage community members. This will be especially important for highly vulnerable patients such as persons who are homeless or farmworkers. Outreach and enrollment tools that go beyond the four walls of a health center and connect communities with information on insurance affordability programs will be highly valuable.

Health centers will also need to consider how to best reach new populations who have not used insurance in the past. Many people newly-eligible for insurance affordability programs, including low-income young adults, will be unfamiliar with the characteristics of health insurance plans, such as provider networks, formularies, premiums and deductibles. Information will likely need to be tailored for this new audience. Intensive in-person application assistance will be crucial to explaining the options and connecting individuals with the right coverage. Consumers will likely need assistance to gather documents to verify eligibility, enroll in a subsidy program, and select a plan, and will need help for renewals and redeterminations.

Health centers will need to adapt to new systems as they are made available. Information systems will be essential to reach, engage and enroll consumers, but the systems for verifying eligibility and transmitting information across and between agencies and organizations have not been fully implemented. Some systems may not work as envisioned and will need to be modified to support new functions over time. Health centers and their patients will benefit from working together to exchange information, identify effective strategies and optimize resources.

#### **IV. Specific Types of Investments to Build Outreach and Enrollment Strategies**

Enroll America, an organization specializing in outreach and enrollment in health reform,<sup>19</sup> has identified five categories of best practices to improve outreach and enrollment efforts. These practices include investment in outreach staff, improvement of technology and outreach materials, enhancement of staff training, better retention of insurance by patients, and procurement of new sources of funds to increase stability. These practices build upon one another and illustrate innovative ways that health centers and PCAs could develop effective outreach and enrollment strategies. As open enrollment nears, health centers will likely identify additional best practices through current, real-world experience.

##### **A. Investment in Outreach Staff**

Investing in outreach staff helps health centers keep their patients insured, and helps health centers financially because centers typically receive better reimbursement if a patient is insured.<sup>20</sup> Staff development also builds institutional knowledge that can serve health centers in their future work. For example, health centers that coupled application assistance with additional, out-stationed eligibility workers saw significant increases in the number of Medicaid applications submitted to the

state and led to enrollment in Medicaid or CHIP.<sup>21</sup> One health center saw a \$1.6 million increase in Medicaid and CHIP reimbursement during the first year it offered both application assistance and out-stationed eligibility workers.<sup>22</sup> Serious investment will be needed to transition outreach staff from the existing methods used to enroll patients in Medicaid and CHIP to the new electronic process of enrolling patients for coverage through the Exchanges.

## B. Technology and Outreach Materials

One of the most pressing concerns facing health centers is ensuring that outreach staff can transition to the electronically-focused enrollment process expected for the Exchanges. The ACA envisions a single, streamlined enrollment application; Exchanges may decide between an application developed by HHS in accordance with the ACA or an alternative single streamlined application developed by the state and approved by the HHS Secretary.<sup>23</sup> The Exchanges and states will be charged with ensuring these electronic applications function properly. However, health centers and PCA staff will have to learn how to use the new applications, and adapt to changes as the systems are rolled out.

In addition to training, this will require appropriate supplies and materials so that staff can use the information they have to design relevant and appropriate outreach programs, and put them in place in the field. Basic supplies include program manuals, materials for outreach events, computers or tablets with wireless cards for internet access, cell phones and printers/scanners.<sup>24</sup> Outreach work requires staff to be in the community, which may be problematic due to locational barriers. For example, some rural areas do not have adequate wireless signals required by internet-based devices. Solutions to this problem might include installing “apps” that do not require wireless signals and/or using wireless cards that have better/longer “reach.”

## C. Maximize Staff Impact

Health centers may also want to leverage their existing resources by providing core training for all staff on coverage options and processes, and by partnering with other organizations, including PCAs, that are committed to enrollment. PCAs often provide training and technical assistance to health centers to help staff develop the knowledge and skills necessary to conduct outreach and enrollment assistance.<sup>25</sup> Some PCAs, for instance, provide application and outreach training, eligibility screening tools, promotional materials, and policy-related information to health centers.<sup>26</sup> By providing receptionists and other front-facing staff with basic understanding of the enrollment process, health centers can ensure that patients have their questions answered consistently and are referred to the appropriate team members.<sup>27</sup> Health centers may want to build and extend relationships with local organizations that provide referrals to the health center outreach staff, and strengthen existing relationships so that staff are better informed about services available in the community. This could help outreach staff better assist their patients, and avoid duplication of efforts.<sup>28</sup>

## D. Keeping Patients Enrolled and Insured

Enrolling patients is central to the overall success of health reform, but the ultimate aim must be to enroll patients for coverage and to *keep* them enrolled thereafter. Similar to the Medicare program, the Exchanges will have an open enrollment period. For 2014, the enrollment begins on October 1, 2013 and extends until March 31, 2014.<sup>29</sup> For 2015 and subsequent years, the enrollment period will

begin on October 15 and extend until December 7 of the year preceding the coverage year.<sup>30</sup> Individuals may also qualify for special enrollment periods outside of open enrollment if they experience certain events including moving to a new state, certain changes to income, or events that result in a change in family size such as divorce, marriage, or birth of a child.<sup>31</sup> Minimizing gaps in coverage and keeping patients continuously enrolled will entail, among other considerations, keeping them informed about upcoming enrollment periods.

Health centers and PCAs can use innovative approaches to keep patients engaged and draw on past experience to facilitate re-enrollment. Health centers might, for example, remind patients of the need to re-enroll by sending post cards and text messages as insurance renewal time draws near, by placing “apply and renew” messages in public waiting spaces with information about how to connect to outreach and eligibility workers, and by calling patients to remind them to renew and offering application assistance.<sup>32</sup> One group of health centers implemented an innovative Migrant Care Network, which allowed enrolled families to maintain and use their Medicaid coverage while they were temporarily out of state for employment purposes.<sup>33</sup> One PCA facilitated coverage renewals through a systematic, technology-based reminder system coupled with one-on-one assistance.<sup>34</sup> Families were contacted about renewal through text messages, automated voice messages, and direct mail offering renewal assistance. They were presented with an array of options for renewal, including face-to-face help, a call center and a text response option.<sup>35</sup>

#### E. Seek Resources that Ensure Stability

Federal initiatives are providing significant funding for community-based organizations and CHCs. On July 10, 2013, HHS Secretary Sebelius announced \$150 million in grant awards to 1,159 community health centers to support in-person enrollment assistance.<sup>36</sup> On August 15, 2013, the Center for Medicare and Medicaid Services awarded \$67 million to 105 entities to serve in the federally-facilitated and partnership Exchanges as Navigators.<sup>37</sup> Many health centers, however, were precluded from receiving Navigator funds because of conflicts of interest rules.<sup>38</sup> Further, in most instances, these grants are intended to extend other resources, but not supplant them. Clearly, health centers and PCAs will need to supplement these resources and develop creative strategies for both the initial outreach and enrollment efforts and ongoing programs.

## IV. Description of Funding Opportunity

This new RCHN CHF initiative will support community health center and PCA proposals to develop and implement programs focused on enhancing outreach and enrollment strategies through the use of technology, training, or development of best practices. The Foundation is especially interested in innovations that move the enrollment process into the community for special populations and the most at risk patients, and reach populations might otherwise be missed, including all low-income young adults, community college students, people in employment and job training or GED programs, and the especially vulnerable homeless, those who are served by shelters, food banks, and meal programs. In addition, strategies could focus on training, development of current staff skills, investment in outreach staff and technology, creation of outreach materials, relationship building with community organizations, and methods to improve patient retention of health insurance coverage. Proposals should capitalize on existing strengths and community relationships and familiarity with the uninsured population. Proposals should also maximize existing resources such as the capacity of current staff and familiarity with public health insurance programs.

Creative proposals that are informed by community needs and leverage available resources are encouraged. We are especially interested in local models that may be applicable to or replicated across broader geographies.

Fundable proposals may include the following elements, combinations thereof, or other ideas:

- a. developing and implementing outreach and enrollment training for staff at all levels;
- b. drafting and implementing training on electronic applications for insurance affordability programs;
- c. developing strategies that foster communication across and between health centers and allow for real-time shared learning in outreach and enrollment;
- d. investing in and testing new technologies that move outreach and enrollment into the community;
- e. partnering with local organizations for community outreach, consumer referrals, or other steps in the enrollment process,
- f. developing tools for patient outreach during enrollment periods;
- g. building a strategy to implement and participate in the Navigator program, Certified Application Counselor program, or similar state/local programs; or
- h. developing specific strategies for outreach and enrollment targeted at the uninsured and other vulnerable populations.

While we recognize that some outreach and enrollment projects may require facility development, this RFP is not geared toward capital, facilities, or significant infrastructure needs.

## **V. Award Information**

The Foundation expects to fund up to 5 awards under this RFP, with a grant of approximately \$200,000.00 per award. The Foundation anticipates making these awards for single-year funding, so proposals should be developed with a focus on up-front costs, and describe plans for future sustainability. Extensions of awards may be funded at the end of Year One to bring ideas to scale or replicate in other locations.

## **VI. Eligibility Information**

Entities that are currently designated by the HHS' Health Resources and Services Administration's ("HRSA's") Bureau of Primary Health Care as federally-qualified health centers ("FQHCs") or FQHC Look-Alikes, as well as state PCAs (if the PCAs are specifically proposing in the application to sub-grant to FQHCs or FQHC-Look-Alikes for a portion of the project) are solely eligible to receive these awards. FQHC applicants must document that the entity is currently in good standing as a FQHC with the Bureau of Primary Health Care by attaching a copy of the current Notice of Grant Award from HRSA or as a Look-Alike by attaching a copy of the current Designation Letter from HRSA. If PCA applicants receive federal funding from HRSA, they should also include a copy of their current Notice of Award. Proposals received from health centers that are not currently in good standing with the Bureau of Primary Health Care as FQHCs or FQHC Look-Alikes will not be reviewed. To meet the Foundation's funding requirements, all applicants must also submit proof of their federal tax exemption as 501(c)(3) tax exempt not-for-profit

organizations. This may either be in the form of an IRS tax exemption letter or the most recently filed Form 990.

Please note that while the applicant must be a designated FQHC, Look-Alike, or state PCA working with FQHCs or Look-Alikes, the Foundation welcomes collaborative proposals. Applicants may include other entities in the proposed project, such as other health centers, or local community agencies, colleges or universities. Such additional entities would be listed in the application as Identified Partners, not as the applicant

## VII. Application Requirements

Applications should not exceed 50 pages including all attachments, with 12-point font and 1 inch margins. All pages of the application should be sequentially numbered and should be in only one (1) or two (2) comprehensive files (not a separate file for each section). The application's narrative should include and discuss all of the following elements:

- a. A cover sheet listing the health center or PCA name, project name, name of primary staff contact, and contact person's phone number and email address
- b. A brief description of the organization;
- c. Discussion of need, including:
  - i. A summary of the history, nature and scope of the enrollment and eligibility problems experienced by or anticipated to be experienced by the health center or PCA;
- d. Proposed project for funding:
  - i. The proposed model to be created, implemented or expanded by the applicant;
- e. Project goals;
  - i. List and description of at least 3 specific and measurable goals or objectives for the initiative;
- f. Measure of project success;
  - i. Quantitative and qualitative benchmarks;
  - ii. Considerations regarding replicability and sustainability;
- g. List of Lead Personnel;
- h. List of Identified Partners;
  - i. Such as other health centers, PCAs, networks;
- i. Line Item Project Budget;
- j. Budget Narrative/Justification; and
- k. Attachments (Contribute to the page limit and are required as a part of the application);
  - i. Proof of 501(c)(3) status from the IRS;
  - ii. If an FQHC or Look-Alike applicant, then documentation of current FQHC or Look-Alike status (copy of current Notice of Grant Award or Designation Letter);
  - iii. If a PCA that receives funding from HRSA, a copy of current Notice of Grant Award;
  - iv. Bios or background of each of the listed Lead Personnel; and

- v. Letters of support or collaboration from all Identified Partners (see VII.g, above).

## VIII. Proposal Submission Information/Foundation Point of Contact

### **Deadline for Applications:**

The deadline for submission of complete applications is: **5:00 pm eastern time on Monday, November 4, 2013** and no exceptions will be made. Incomplete proposals will be deemed unresponsive and will not be reviewed.

### **Submission:**

Both hard copies and electronic copies are required. Four (4) hard copies of the complete proposal (including all attachments) should be submitted to Feygele Jacobs, the Foundation's point of contact for this proposal. We request that copies be sent via USPS, FEDEX or UPS. Please do not use local messenger carriers. In addition, an email version of the complete package (pdf'd or otherwise saved as only one (1) or two (2) attached files) should be sent to the Foundation at the email address below.

### **Mailing address for hard copies:**

Feygele Jacobs, President and CEO  
RCHN Community Health Foundation  
1633 Broadway 18<sup>th</sup> Floor  
New York, New York 10019

### **Phone number (for FedEx or UPS purposes only):**

(212) 246-1122, extension 700

**Please do not call to enquire about the status of your application or whether it was received.**

### **Email submission of electronic copies:**

All electronic submissions should include in the subject line ***"RFP RESPONSE" and the APPLICANT NAME***, and be submitted to: [fjacobs@rchnfoundation.org](mailto:fjacobs@rchnfoundation.org). If the email does not contain both in the subject line, your application will not be reviewed.

The entire application should be reduced to only one (1) or two (2) attached files, with all pages sequentially numbered. Any emails containing more than two (2) file attachments or containing more pages than 50 total shall be deemed unresponsive and your application will not be reviewed.

### **To be considered timely received:**

1. The emailed version must be received by the deadline (**5:00 pm eastern time on Monday, November 4, 2013**). Please include an email tracker on your email and check your spam filter and bounce backs to ensure your proposal has gone through. Note: You will not receive any response from the Foundation about whether or not your application was received, hence the need for a tracker. Please do not email or call the Foundation to see if your submission went through.
2. The mailed copies **must be postmarked by the deadline** to be considered timely.

3. If only an emailed version is received, the proposal will be considered untimely and will not be reviewed.

### **Anticipated Award Notification Date:**

The Foundation's anticipated notification date of awards is no later December 31, 2013.

## **IX. Application Review Information**

The Foundation will consider the following criteria when assessing applications:

- a. The project fills a community need not currently or adequately addressed;
- b. The applicant is capable of rapidly implementing and sustaining over time the project in terms of staff, organizational infrastructure and/or technology, experience and knowledge, and community support;
- c. The applicant is willing and able to select, collect, and report on impact criteria and progress in meeting goals;
- d. The request fits the Foundation's objectives; and
- e. The Foundation's potential to make an impact with a grant for this project.

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<sup>1</sup> 42 U.S.C. §18001(a)(2010).

<sup>2</sup> See Summary of the Affordable Care Act, Kaiser Family Foundation, (April 2013), available at <http://kff.org/health-reform/factsheet/summary-of-new-health-reform-law/>

<sup>3</sup> See *NFIB v. Sebelius*, 132 S. Ct. 2566, 2580 (2012).

<sup>4</sup> 45 C.F.R. §155.105.

<sup>5</sup> 26 U.S.C. §5000(a).

<sup>6</sup> Leighton Ku et. al, *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, Policy Research Brief No. 19, 1, Geiger Gibson/RCHN Community Health Foundation Research Collaborative (June 30, 2010).

<sup>7</sup> See Sara Rosenbaum, *Medicaid Expansion and Health Insurance Marketplaces: One Map that Tells the Whole Story*, available at <http://www.healthreformgps.org/resources/medicaid-expansion-and-health-insurance-marketplaces-one-map-that-tells-the-whole-story/>

<sup>8</sup> 45 C.F.R. §155.105.

<sup>9</sup> Sara Rosenbaum, *Medicaid Expansion and Health Insurance Marketplaces: One Map that Tells the Whole Story*, available at <http://www.healthreformgps.org/resources/medicaid-expansion-and-health-insurance-marketplaces-one-map-that-tells-the-whole-story/>

<sup>10</sup> National Association of Community Health Centers, *America's Health Centers Fact Sheet*, January 2013, available at [www.nachc.com/client/documents/America's\\_Health\\_Centers\\_2013.pdf](http://www.nachc.com/client/documents/America's_Health_Centers_2013.pdf).

<sup>11</sup> See Leighton Ku, *Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations*, RCHN Community Health Foundation, July 23, 2009, available at <http://www.rchnfoundation.org/wp-content/uploads/2013/02/chcs-health-reform-7-23.pdf>.

<sup>12</sup> Health Center Outreach and Enrollment Assistance Fiscal Year 2013, HRSA-13-279, CFDA # 93.527, at 2-3 (May 9, 2013).

<sup>13</sup> 45 C.F.R. § 155.405.

<sup>14</sup> Health Centers' Important Role in Outreach and Enrollment. Enroll America's Best Practice Institute, 2, Enroll America (September 2012).

<sup>15</sup> Issue Brief: Analyzing the Impact of State Medicaid Expansion Decisions, The Kaiser Commission on Medicaid and the Uninsured, 3 (July 2013).

<sup>16</sup> Health Centers' Important Role in Outreach and Enrollment. Enroll America's Best Practice Institute, 2, Enroll America (September 2012).

<sup>17</sup> Lake Research Partners, *Preparing for 2014: Findings from Research with Lower-Income Adults in Three States* (Washington: Robert Wood Johnson Foundation, June 2012), available at <http://www.rwjf.org/files/research/74456fullreport.pdf>.

<sup>18</sup> Julia Paradise, *Providing Outreach and Enrollment Assistance: Lessons Learned from Community Health Centers in Massachusetts*, Kaiser Family Foundation (September 24, 2013), available at: <http://kff.org/health-reform/issue-brief/providing-outreach-and-enrollment-assistance-lessons-learned-from-community-health-centers-in-massachusetts/>.

<sup>19</sup> Enroll America, a non-partisan, non-profit organization whose mission is to maximize the number of Americans who enroll in health care coverage made available by health reform. See Enroll America, About Us, available at <http://www.enrollamerica.org/>

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- <sup>20</sup> National Association of Community Health Centers, *Health Centers and Health Care Reform: Payment and Participation* (Washington: National Association of Community Health Centers, April 2010), available at <http://www.nachc.com/client/Health%20Reform%20Fact%20Sheet%20-%20Payment%20%20Participation.pdf>.
- <sup>21</sup> Health Centers' Important Role in Outreach and Enrollment. Enroll America's Best Practice Institute, 2, Enroll America September 2012.
- <sup>22</sup> *Id.*
- <sup>23</sup> See 42 C.F.R. §433.112.
- <sup>24</sup> Issue Brief, Profiles of Medicaid Outreach and Enrollment Strategies: One-on-One Assistance through Community Health Centers in Utah, Getting into Gear for 2014, The Kaiser Commission on Medication and the Uninsured, March 2013.
- <sup>25</sup> *Id.*
- <sup>26</sup> *Id.*
- <sup>27</sup> Health Centers' Important Role in Outreach and Enrollment. Enroll America's Best Practice Institute, 2, Enroll America September 2012.
- <sup>28</sup> *Id.*
- <sup>29</sup> See Healthcare.gov, Open Enrollment Period, at <https://www.healthcare.gov/glossary/open-enrollment-period/>
- <sup>30</sup> *Id.*
- <sup>31</sup> Healthcare.gov Glossary, "Special Enrollment Period" available at <https://www.healthcare.gov/glossary/special-enrollment-period/>
- <sup>32</sup> *Id.*
- <sup>33</sup> Issue Brief, Profiles of Medicaid Outreach and Enrollment Strategies: One-on-One Assistance through Community Health Centers in Utah, 9, Getting into Gear for 2014, the Kaiser Commission on Medication and the Uninsured, March 2013.
- <sup>34</sup> *Id.*
- <sup>35</sup> *Id.*
- <sup>36</sup> Department of Health and Human Services, Press Release, Health centers to help uninsured Americans gain affordable health coverage, July 10, 2013, available at <http://www.hhs.gov/news/press/2013pres/07/20130710a.html>.
- <sup>37</sup> Department of Human Services, Press Release, New resources available to help consumers navigate the Health Insurance Marketplace, August 15, 2013, available at <http://www.hhs.gov/news/press/2013pres/08/20130815a.html>
- <sup>38</sup> See 45 C.F.R. §155.210 (d).