

HRSA SHAP Grant Coverage Expansion – WV CONNECT

WV Dept. of Health and Human Resources

Office of the Secretary

Building 3, Room 206

Charleston, WV 25305-1757

Project Liaison: Gerald Roueche

Phone: (304) 558-0684; Fax: (304) 558-1130

Email: Gerald.D.Roueche@wv.gov

Web: www.wvdhhr.org

Project Coordinator: Nancy Maleček

(304) 558-3707 ext 1175;

Nancy.Malecek@wvinsurance.gov

www.wvinsurance.gov

Project Abstract

West Virginia's proposal for funding through a State Health Access Program (SHAP) grant will expand health insurance coverage and access to care for working uninsured West Virginians, building on a decade of work by a diverse group of stakeholders, the opportunities presented by the American Recovery and Reinvestment Act (ARRA) and anticipated health care reforms at the national level. This initiative, called "WV CONNECT", utilizes the collaborative resources of community-based health care providers, private and public insurance programs and parties engaged in health improvement and using electronic health information technology (HIT) to expand access to high-quality, culturally-appropriate health care services to uninsured West Virginians.

The program links families and small business to health coverage options through a health information exchange and uses premium assistance stipends to assure basic primary and preventative care and some extended care through community-based medical homes. The program will assure that participants are encouraged to take an active role in health care decision-making and utilization of health care resources with the support and coordination of an appropriate medical home. It also intends to leverage the power of health information technology and health information exchange, consistent with HRSA programmatic objectives, to improve outcomes and reduce unnecessary costs.

WV CONNECT uses a series of connectors, much like a highway, to link People to Payers (the health insurance connector - to a source of insurance coverage for health care services) through a health insurance exchange; People to Providers (the medical home connector - to a source of health care in a local medical home) through premium assistance for low-income working families and in collaboration with the West Virginia Health Improvement Institute. WV CONNECT also links Providers to the Program through the third part of this health care triangle (the portal connector) to facilitate access to clinical information for health improvement and project evaluation and to facilitate use of personal health records by covered individuals. This initiative is a part of a larger plan of the State to address escalating health care costs that threaten to dramatically expand rather than reduce the number of uninsured citizens.

Data will be gathered from Web-based tools will include counters to determine the frequencies of use by prospective purchasers of insurance to the exchange and other WV CONNECT portals. Clinical information to establish baseline and key clinical indicators of primary prevention services (based upon appropriate evidence-based outcome measures from HRSA and other sources) will be integrated into the clinical portal to be established as part of the project. Information concerning the impact of WV CONNECT on the take-up of coverage and access to primary care will also be gathered by surveying customers and providers participating in the provider network

Roueché, Gerald D

From: DGMONGAEmail@hrsa.gov
Sent: Tuesday, September 01, 2009 6:04 PM
To: Roueché, Gerald D
Subject: Transmission of a HRSA Notice of Grant Award for H2PHS16402-01-00
Attachments: NGA.PDF

Dear Colleague,

The attached Notice of Grant Award, H2PHS16402-01-00 for State Health Access Program (SHAP) Grants to WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES, Charleston, West Virginia is provided by the Health Resources and Services Administration (HRSA). Please retain this notice for your official records, as a paper copy will not be provided. Please do not reply to this automatic email. Refer to the contacts section of the award notice for the name, phone number and email of your program and grants management contact. Also, refer to the Remarks portion of the NGA and the attached Terms and Conditions for the specific purpose of this action.

Note: To view the Notice of Grant Award, Acrobat Reader version 5 or above must be installed.

1. DATE ISSUED: 08/28/2009		2. PROGRAM CFDA: 93.256		DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH RESOURCES AND SERVICES ADMINISTRATION  NOTICE OF GRANT AWARD AUTHORIZATION (Legislation/Regulation) P.L. 108-447 P.L. 111-8 Section 301 of the Public Health Service Act as amended (42 U.S.C. 24(a))																																																					
3. SUPERCEDES AWARD NOTICE dated: except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.																																																									
4a. AWARD NO.: 1 H2PHS16402-01-00		4b. GRANT NO.: H2PHS16402	5. FORMER GRANT NO.:																																																						
6. PROJECT PERIOD: FROM: 09/01/2009 THROUGH: 08/31/2014																																																									
7. BUDGET PERIOD: FROM: 09/01/2009 THROUGH: 08/31/2010																																																									
8. TITLE OF PROJECT (OR PROGRAM): State Health Access Program (SHAP) Grants																																																									
9. GRANTEE NAME AND ADDRESS: WV Department of Health and Human Resources Office of the Secretary State Capitol Complex., Bldg 3 RM 206 Charleston, WV 25305-1757			10. DIRECTOR: (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR) Gerald Roueche WV Department of Health and Human Resources Capitol Complex RM 226 Charleston, WV 25305																																																						
11. APPROVED BUDGET: (Excludes Direct Assistance) <input type="checkbox"/> Grant Funds Only <input checked="" type="checkbox"/> Total project costs including grant funds and all other financial participation			12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE																																																						
<table border="0"> <tr><td>a. Salaries and Wages:</td><td>\$ 0.00</td></tr> <tr><td>b. Fringe Benefits:</td><td>\$ 0.00</td></tr> <tr><td>c. Total Personnel Costs:</td><td>\$ 0.00</td></tr> <tr><td>d. Consultant Costs:</td><td>\$ 0.00</td></tr> <tr><td>e. Equipment:</td><td>\$ 0.00</td></tr> <tr><td>f. Supplies:</td><td>\$ 0.00</td></tr> <tr><td>g. Travel:</td><td>\$ 0.00</td></tr> <tr><td>h. Construction/Alteration and Renovation:</td><td>\$ 0.00</td></tr> <tr><td>i. Other:</td><td>\$ 0.00</td></tr> <tr><td>j. Consortium/Contractual Costs:</td><td>\$ 0.00</td></tr> <tr><td>k. Trainee Related Expenses:</td><td>\$ 0.00</td></tr> <tr><td>l. Trainee Stipends:</td><td>\$ 0.00</td></tr> <tr><td>m. Trainee Tuition and Fees:</td><td>\$ 0.00</td></tr> <tr><td>n. Trainee Travel:</td><td>\$ 0.00</td></tr> <tr><td>o. TOTAL DIRECT COSTS:</td><td>\$ 11,906,071.00</td></tr> <tr><td>p. INDIRECT COSTS: (Rate: % of S&W/TADC)</td><td>\$ 0.00</td></tr> <tr><td>q. TOTAL APPROVED BUDGET:</td><td>\$ 11,906,071.00</td></tr> <tr><td> i. Less Non-Federal Resources:</td><td>\$ 5,562,171.00</td></tr> <tr><td> ii. Federal Share:</td><td>\$ 6,343,900.00</td></tr> </table>			a. Salaries and Wages:	\$ 0.00	b. Fringe Benefits:	\$ 0.00	c. Total Personnel Costs:	\$ 0.00	d. Consultant Costs:	\$ 0.00	e. Equipment:	\$ 0.00	f. Supplies:	\$ 0.00	g. Travel:	\$ 0.00	h. Construction/Alteration and Renovation:	\$ 0.00	i. Other:	\$ 0.00	j. Consortium/Contractual Costs:	\$ 0.00	k. Trainee Related Expenses:	\$ 0.00	l. Trainee Stipends:	\$ 0.00	m. Trainee Tuition and Fees:	\$ 0.00	n. Trainee Travel:	\$ 0.00	o. TOTAL DIRECT COSTS:	\$ 11,906,071.00	p. INDIRECT COSTS: (Rate: % of S&W/TADC)	\$ 0.00	q. TOTAL APPROVED BUDGET:	\$ 11,906,071.00	i. Less Non-Federal Resources:	\$ 5,562,171.00	ii. Federal Share:	\$ 6,343,900.00	<table border="0"> <tr><td>a. Authorized Financial Assistance This Period</td><td>\$ 6,343,900.00</td></tr> <tr><td>b. Less Unobligated Balance from Prior Budget Periods</td><td></td></tr> <tr><td> i. Additional Authority</td><td>\$ 0.00</td></tr> <tr><td> ii. Offset</td><td>\$ 0.00</td></tr> <tr><td>c. Unawarded Balance of Current Year's Funds</td><td>\$ 0.00</td></tr> <tr><td>d. Less Cumulative Prior Award(s) This Budget Period</td><td>\$ 0.00</td></tr> <tr><td>e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION</td><td>\$ 6,343,900.00</td></tr> </table>			a. Authorized Financial Assistance This Period	\$ 6,343,900.00	b. Less Unobligated Balance from Prior Budget Periods		i. Additional Authority	\$ 0.00	ii. Offset	\$ 0.00	c. Unawarded Balance of Current Year's Funds	\$ 0.00	d. Less Cumulative Prior Award(s) This Budget Period	\$ 0.00	e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	\$ 6,343,900.00
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			13. RECOMMENDED FUTURE SUPPORT: (Subject to the availability of funds and satisfactory progress of project)																																																						
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15. PROGRAM INCOME SUBJECT TO 45 CFR Part 74.24 OR 45 CFR 92.25 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:																																																									
A=Addition B=Deduction C=Cost Sharing or Matching D=Other [C]																																																									
Estimated Program Income: \$ 0.00																																																									
16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:																																																									
a. The grant program legislation cited above. b. The grant program regulation cited above. c. This award notice including terms and conditions, if any, noted below under REMARKS. d. 45 CFR Part 74 or 45 CFR Part 92 as applicable. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.																																																									
REMARKS: (Other Terms and Conditions Attached [X] Yes [] No)																																																									
<i>Electronically signed by Dorothy M. Kelley, Grants Management Officer on: 08/28/2009</i>																																																									
17. OBJ. CLASS: 41.45		18. CRS-EIN: 1556000771A1		19. FUTURE RECOMMENDED FUNDING:																																																					
FY-CAN	CFDA	DOCUMENT NO.	AMT. FIN. ASST.	AMT. DIR. ASST.	SUBPROGRAM CODE																																																				
09-3880693	93.256	H2PHS16402A0	\$ 6,343,900.00	\$ 0.00	N/A																																																				

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NGA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NGA. After you have completed the initial registration steps (i.e., created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit <https://grants.hrsa.gov/webexternal/login.asp> to use the system. Additional help is available online and/or from the HRSA Call Center at 1-877-464-4772.

Terms and Conditions

Failure to comply with the special remarks and condition(s) may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Conditions:

- 1. Due Date: Within 30 days of Award Issue Date**
The grantee will submit a revised budget for both Federal and non-Federal funds. Format the budget using the cost categories given in space 11 of this Notice of Grant Award. Use the same format for each subcontractor's budget. If the Principal Investigator's (Gerald Roueche's) position is not funded by the grant, indicate what percentage of his FTE the grantee is donating in-kind to the oversight of the grant. Include a detailed equipment list.
- 2. Due Date: Within 30 days of Award Issue Date**
The grantee will provide a narrative that addresses the items indicated to be contingent on Federal Reform, assuming Federal Reform will not happen during the first project year.

Grant Specific Terms:

1. Grantee will provide an implementation progress report no later than 6 months from the grant start date.
2. Grantee will provide an Annual Progress Report to HRSA, 30 days after the end of the 12-month budget period. The report will be developed and completed in a format and manner prescribed by the HRSA Project Officer.

Standard Terms:

1. All discretionary awards issued by HRSA on or after October 1, 2006, are subject to the HHS Grants Policy Statement (HHS GPS) unless otherwise noted in the Notice of Award (NoA). Parts I through III of the HHS GPS are currently available at <http://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf> and it is anticipated that Part IV, HRSA program-specific guidance will be available at the website in the near future. In addition, HRSA-specific contacts will be appended to Part III of the GPS which identifies Department-wide points of contact. Please note that the Terms and Conditions explicitly noted in the award and the HHS GPS are in effect. Once available, Part IV, HRSA program-specific guidance will take precedence over Parts I and II in situations where there are conflicting or otherwise inconsistent policies.
2. The HHS Appropriations Act requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments, shall clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.
3. Recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b)) and should be cognizant of the risk of criminal and administrative liability under this

statute, specifically under 42 U.S.C. 1320 7b(b) Illegal remunerations which states, in part, that whoever knowingly and willfully:

(A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR

(B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item

...For which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

4. Items that require prior approval from the awarding office as indicated in 45 CFR Part 74.25 [Note: 74.25 (d) HRSA has not waived cost-related or administrative prior approvals for recipients unless specifically stated on this Notice of Grant Award] or 45 CFR Part 92.30 must be submitted in writing to the Grants Management Officer (GMO). Only responses to prior approval requests signed by the GMO are considered valid. Grantees who take action on the basis of responses from other officials do so at their own risk. Such responses will not be considered binding by or upon the HRSA.

In addition to the prior approval requirements identified in Part 74.25, HRSA requires grantees to seek prior approval for significant rebudgeting of project costs. Significant rebudgeting occurs when, under a grant where the Federal share exceeds \$100,000, cumulative transfers among direct cost budget categories for the current budget period exceed 25 percent of the total approved budget (inclusive of direct and indirect costs and Federal funds and required matching or cost sharing) for that budget period or \$250,000, whichever is less. For example, under a grant in which the Federal share for a budget period is \$200,000, if the total approved budget is \$300,000, cumulative changes within that budget period exceeding \$75,000 would require prior approval). For recipients subject to 45 CFR Part 92, this requirement is in lieu of that in 45 CFR 92.30(c)(1)(ii) which permits an agency to require prior approval for specified cumulative transfers within a grantee's approved budget. [Note, even if a grantee's proposed rebudgeting of costs falls below the significant rebudgeting threshold identified above, grantees are still required to request prior approval, if some or all of the rebudgeting reflects either a change in scope, a proposed purchase of a unit of equipment exceeding \$25,000 (if not included in the approved application) or other prior approval action identified in Parts 74.25 and 92.30 unless HRSA has specifically exempted the grantee from the requirement(s).]

5. Payments under this award will be made available through the DHHS Payment Management System (PMS). PMS is administered by the Division of Payment Management, Financial Management Services, Program Support Center, which will forward instructions for obtaining payments. Inquiries regarding payment should be directed to: Payment Management, DHHS, P.O. Box 6021, Rockville, MD 20852, <http://www.dpm.psc.gov/> or Telephone Number: 1-877-614-5533.
6. The DHHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Such reports are kept confidential and callers may decline to give their names if they choose to remain anonymous. Contact: Office of Inspector General, Department of Health and Human Services, Attention: HOTLINE, 330 Independence Avenue Southwest, Cohen Building, Room 5140, Washington, D. C. 20201, Email: Htips@os.dhhs.gov or Telephone: 1-800-447-8477 (1-800-HHS-TIPS).
7. Submit audits, if required, in accordance with OMB Circular A-133, to: Federal Audit Clearinghouse Bureau of the Census 1201 East 10th Street Jefferson, IN 47132 PHONE: (310) 457-1551, (800)253-0696 toll free <http://harvester.census.gov/sac/facconta.htm>
8. EO 13166, August 11, 2000, requires recipients receiving Federal financial assistance to take steps to ensure that people with limited English proficiency can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services. The obligations of recipients are explained on the OCR website at <http://www.hhs.gov/ocr/lep/reviseblep.html>.
9. This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.htm>. If you

are unable to access this link, please contact the Grants Management Specialist identified in this Notice of Grant Award to obtain a copy of the Term.

Reporting Requirements:**1. Due Date: Within 90 days of Budget End Date**

The grantee must submit a Financial Status Report within 90 days after the budget period end date. This report should reflect cumulative reporting within the project period and must be submitted using the Electronic Handbook (EHB).

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

NGA Email Address(es):

tara.1.buckner@wv.gov;gerald.d.roueche@wv.gov;smorgan1@hrsa.gov

Note: NGA emailed to these address(es)

Contacts:

Program Contact: For assistance on programmatic issues, please contact Michelle Herzog at:

5600 Fishers Ln RM 12C-26

Rockville, MD 20857-0001

Phone: (301)443-0650

Email: mherzog@hrsa.gov

Division of Grants Management Operations: For assistance on grants administration issues, please contact Sarah Morgan at:

HRSA/OFAM/DGMO

5600 Fishers Ln RM 11A-02

Rockville, MD 20857-0001

Phone: (301)443-4584

Email: smorgan1@hrsa.gov

Fax: (301)443-6343

Responses to reporting requirements, conditions, and requests for post award amendments must be mailed to the attention of the Office of Grants Management contact indicated above. All correspondence should include the Federal grant number (item 4 on the award document) and program title (item 8 on the award document). Failure to follow this guidance will result in a delay in responding to your request.

STATE HEALTH ACCESS PROGRAM (SHAP)

Details of the changes posted in this announcement:

Modification was for administrative purposes only.

Announcement Information

Announcement Number	HRSA-09-226	Announcement Code	Not Available
CFDA Number	93.256	Provisional	No
Activity Code	H2P	Competitive	Yes
Fiscal Year	2009		

Purpose

This grant program is to support States ready to implement a health insurance coverage program designed for the uninsured. Two types of State grants are available: 1) target grants for States focusing on a particular population(s) at \$2-4 million a year for 5 years, subject to the availability of funds and; 2) comprehensive grants for large States or those planning more extensive coverage initiatives at \$7-10 million a year for 5 years, subject to the availability of funds. Matching funds and project sustainability beyond the 5-year period are required. FY 2009 Congressional Appropriations Bill, Public Law 111-8.

Legislative Information

P.L. 111-8

Application Information

Application Available	Apr 21, 2009	Application Deadline	Jun 16, 2009 8:00 PM ET
Explanation for Deadline	Not Available	Archive Date	Aug 14, 2009
Letter of Intent Deadline	Not Available. Letter of Intent is not required.		
Application Package	5161	Guidance Availability	Yes
Allow Electronic Submission	Yes		
Electronic Submission Instruction	Electronic submission is not available for this funding opportunity.		

General Information

Projected Award Date	Sep 15, 2009		
Estimated Project Period	Not Available		
Estimated Project Start Date	Not Available	Estimated Project End Date	Not Available

Estimated Amount of this Competition	\$75,000,000.00	
Estimated Number of Awards	10-15	
Estimated Average size of Awards	Not Available	
Cost Sharing	Yes Cost Sharing Ratio (Federal:Non-Federal): 80:20	Cooperative Agreement No

Matching Requirements

States shall be required to demonstrate their seriousness of intent by matching a portion of the Federal grant through non-Federal resources which could be a combination of State, local, private dollars from insurers, providers and other private organizations. Waiver of the matching requirement shall be possible if financial hardship is demonstrated. States shall also be required to demonstrate their ability to sustain the program without Federal funding after the end of the five-year grant period.

Contact Information

Michelle Herzog
301-443-0650
mherzog@hrsa.gov

Eligible Applicants

Others. See text field entitled "Additional Information on Eligibility" for clarification

Additional Information on Eligibility:

The Governor of each State or territory is invited to apply. The Governor can designate an individual or agency authorized to prepare the State's application on behalf of the State. Only a State entity can be the official recipient of a grant. Only one application per State is permitted.

Download Information

Purpose	Guidance	Filename	HRSA-09-226 SHAP FINAL.doc	Size	1.1 MB
Description					
Not Available					

Links to More Information

Not Available

Modification History

Modification 2 published on Apr 21, 2009
Modification was for administrative purposes only.

Modification 1 published on Apr 20, 2009 ([View Announcement](#))

Modification for admin purposes only.

Original announcement posted on Apr 20, 2009 ([View Announcement](#))

Opportunity Title:	State Health Access Program (SHAP)
Offering Agency:	Health Resources & Services Administration
CFDA Number:	93.256
CFDA Description:	State Planning Grants Health Care Access for the Uninsu
Opportunity Number:	HRSA-09-226
Competition ID:	3576
Opportunity Open Date:	04/21/2009
Opportunity Close Date:	06/16/2009
Agency Contact:	Michelle Herzog Program Analyst State Health Access Program Telephone: 301-443-0650 Fax: 301-443-1221

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

* Application Filing Name: WV Dept. of Health & Human Resources

Mandatory Documents

	Move Form to Complete
	Move Form to Delete

Mandatory Documents for Submission

- Application for Federal Assistance (SF-424)
- Budget Information for Non-Construction Program
- Project Narrative Attachment Form
- Grants.gov Lobbying Form
- Budget Narrative Attachment Form
- Assurances for Non-Construction Programs (SF-42)
- HHS Checklist Form PHS-5161

Optional Documents

	Move Form to Submission List
	Move Form to Delete

Optional Documents for Submission

- Disclosure of Lobbying Activities (SF-424)
- Attachments

Instructions

- 1** Enter a name for the application in the Application Filing Name field.

 - This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
 - You can save your application at any time by clicking the "Save" button at the top of your screen.
 - The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.
- 2** Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

 - It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.
 - The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".
 - To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.
 - All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.
- 3** Click the "Save & Submit" button to submit your application to Grants.gov.

 - Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
 - Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
 - The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
 - You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): _____ * Other (Specify) _____
---	---	---

* 3. Date Received: Completed by Grants.gov upon submission.	4. Applicant Identifier: _____
--	--

5a. Federal Entity Identifier: _____	* 5b. Federal Award Identifier: HRSA-09-226
--	---

State Use Only:

6. Date Received by State: _____	7. State Application Identifier: State Government
---	--

8. APPLICANT INFORMATION:

* a. Legal Name: WV Department of Health and Human Resources

* b. Employer/Taxpayer Identification Number (EIN/TIN): 556000771	* c. Organizational DUNS: 824700611
---	---

d. Address:

* Street1: Office of the Secretary State Capitol Complex
Street2: Building 3, Room 206
* City: Charleston,
County: Kanawha
* State: WV: West Virginia
Province: _____
* Country: USA: UNITED STATES
* Zip / Postal Code: 25305-1757

e. Organizational Unit:

Department Name: _____	Division Name: _____
-------------------------------	-----------------------------

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: _____	* First Name: Gerald
Middle Name: _____	
* Last Name: Roueche	
Suffix: _____	
Title: Assistant to the Secretary	

Organizational Affiliation: WVDHHR	
* Telephone Number: 304-558-558-0684	Fax Number: (304) 558-1130
* Email: Gerald.D.Roueche@wv.gov	

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*** Other (specify):**

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.256

CFDA Title:

State Planning Grants Health Care Access for the Uninsured

*** 12. Funding Opportunity Number:**

HRSA--09--226

*** Title:**

State Health Access Program (SHAP)

13. Competition Identification Number:

3576

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

All of West Virginia

*** 15. Descriptive Title of Applicant's Project:**

State Coverage Expansion - WV CONNECT

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant

* b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="6,343,900.00"/>
* b. Applicant	<input type="text" value="1,600,000.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="3,962,171.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="11,906,071.00"/>

* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?

- a. This application was made available to the State under the Executive Order 12372 Process for review on
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)

Yes No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:
Middle Name:
* Last Name:
Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. BRSA SHAP	93.256	\$ 6,343,900.00	\$ 5,562,171.00	\$	\$	\$ 11,906,071.00
2.						
3.						
4.						
5. Totals		\$ 6,343,900.00	\$ 5,562,171.00	\$	\$	\$ 11,906,071.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program		(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	HRSA SHAP	\$ 1,600,000.00	\$	\$ 3,962,171.00	\$ 5,562,171.00
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)		\$ 1,600,000.00	\$	\$ 3,962,171.00	\$ 5,562,171.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$	\$	\$	\$	\$
14. Non-Federal	\$				
15. TOTAL (sum of lines 13 and 14)	\$	\$	\$	\$	\$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program		FUTURE FUNDING PERIODS (YEARS)			
		(b) First	(c) Second	(d) Third	(e) Fourth
16.	HRSA SHAP	\$ 6,343,900.00	\$ 8,852,930.00	\$ 6,255,031.00	\$ 7,871,579.00
17.					
18.					
19.					
20. TOTAL (sum of lines 16 - 19)		\$ 6,343,900.00	\$ 8,852,930.00	\$ 6,255,031.00	\$ 7,871,579.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:		22. Indirect Charges:	
23. Remarks:			

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
	<div style="border: 1px solid black; padding: 5px;"> ERSA SHAP </div>				
a. Personnel	\$ 1,770,756.00				\$ 1,770,756.00
b. Fringe Benefits					
c. Travel	8,400.00				8,400.00
d. Equipment	500,000.00				500,000.00
e. Supplies					
f. Contractual	9,626,915.00				9,626,915.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	11,906,071.00				\$ 11,906,071.00
j. Indirect Charges					
k. TOTALS (sum of 6i and 6j)	\$ 11,906,071.00				\$ 11,906,071.00
7. Program Income					

Authorized for Local Reproduction

Project Narrative File(s)

• Mandatory Project Narrative File Filenames:

To add more Project Narrative File attachments, please use the attachment buttons below.

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

* APPLICANT'S ORGANIZATION	
WV Department of Health and Human Resources	
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix: <input type="text"/>	* First Name: <input type="text" value="Tara"/> Middle Name: <input type="text"/>
* Last Name: <input type="text" value="Buckner"/>	Suffix: <input type="text"/>
* Title: <input type="text" value="Chief Financial Officer"/>	
* SIGNATURE: <input type="text" value="Completed on submission to Grants.gov"/>	* DATE: <input type="text" value="Completed on submission to Grants.gov"/>

Budget Narrative File(s)

* Mandatory Budget Narrative Filename:

To add more Budget Narrative attachments, please use the attachment buttons below.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

<p>* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p> <p>Completed on submission to Grants.gov</p>	<p>* TITLE</p> <p>Chief Financial Officer</p>
<p>* APPLICANT ORGANIZATION</p> <p>WV Department of Health and Human Resources</p>	<p>* DATE SUBMITTED</p> <p>Completed on submission to Grants.gov</p>

CHECKLIST

Public Burden Statement:

Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC.

Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT:

This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: [X] NEW [] Noncompeting Continuation [] Competing Continuation [] Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

- 1. Proper Signature and Date [X] Included [] NOT Applicable
2. Proper Signature and Date on PHS-5161-1 "Certifications" page [X] Included [] NOT Applicable
3. Proper Signature and Date on appropriate "Assurances" page [X] Included [] NOT Applicable
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)
[] Civil Rights Assurance (45 CFR 80)
[] Assurance Concerning the Handicapped (45 CFR 84)
[] Assurance Concerning Sex Discrimination (45 CFR 86)
[] Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)
5. Human Subjects Certification, when applicable (45 CFR 46) [] Included [X] NOT Applicable

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

- 1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required? [] YES [X] NOT Applicable
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100) [X] YES [] NOT Applicable
3. Has the entire proposed project period been identified on the SF-424? [X] YES [] NOT Applicable
4. Have biographical sketch(es) with job description(s) been attached, when required? [X] YES [] NOT Applicable
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included? [X] YES [] NOT Applicable
6. Has the 12 month detailed budget been provided? [X] YES [] NOT Applicable
7. Has the budget for the entire proposed project period with sufficient detail been provided? [X] YES [] NOT Applicable
8. For a Supplemental application, does the detailed budget address only the additional funds requested? [] YES [X] NOT Applicable
9. For Competing Continuation and Supplemental applications, has a progress report been included? [] YES [X] NOT Applicable

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made
Name: Prefix [] * First Name: Tara Middle Name: []
* Last Name: Buckner Suffix: []
Title: Chief Financial Officer
Organization: []
Address: * Street1: Capitol Complex bldg 3, Room 451
Street 2: []
* City: Charleston,
* State: WV: West Virginia Province: []
* Country: USA: UNITED STATES * Zip / Postal Code: 25305
* Telephone Number: 304-558-2069
E-mail Address: tara.l.buckner@wv.gov
Fax Number: 304-558-3329

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (if already assigned)

[] - 55-6000771 - []

PART C (Continued): In the spaces provided below, please provide the requested information.

Program Director/Project Director/Principal Investigator designated to direct the proposed project

Name: Prefix: * First Name: Middle Name:
 * Last Name: Suffix:
 Title:
 Organization:
 Address: * Street1:
 Street2:
 * City:
 * State: Province:
 * Country: * Zip / Postal Code:
 * Telephone Number:
 E-mail Address:
 Fax Number:

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: * (Agency)

on * (Date)

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in *Federal Register* on June 24, 1983, along with a notice identifying the

Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB

0348-0046

1. * Type of Federal Action: <input type="checkbox"/> a. contract <input checked="" type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. * Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. * Report Type: <input checked="" type="checkbox"/> a. Initial filing <input type="checkbox"/> b. material change
4. Name and Address of Reporting Entity: <input checked="" type="checkbox"/> Prime <input type="checkbox"/> SubAwardee * Name: WV Dept. of Health & Human Resources * Street 1: Capital Complex Bldg. 3 Rm. 206 Street 2: 1900 Kanawha Blvd., East * City: Charleston, State: WV: West Virginia Zip: 25305 Congressional District, if known:		
5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime: 		
6. * Federal Department/Agency: HRSA	7. * Federal Program Name/Description: State Planning Grants Health Care Access for the Uninsured CFDA Number, if applicable: 93.256	
8. Federal Action Number, if known: 	9. Award Amount, if known: \$	
10. a. Name and Address of Lobbying Registrant: Prefix: * First Name: Not Applicable Middle Name: Suffix: * Last Name: Not Applicable * Street 1: Street 2: * City: State: Zip:		
b. Individual Performing Services (including address if different from No. 10a) Prefix: * First Name: Not Applicable Middle Name: Suffix: * Last Name: Not Applicable * Street 1: Street 2: * City: State: Zip:		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure. * Signature: Completed on submission to Grants.gov * Name: Prefix: * First Name: Tara Middle Name: Suffix: * Last Name: Buckner Title: Chief Financial Office Telephone No.: 304-558-2069 Date: Completed on submission to Grants.gov		

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	HRSA SHAP Grant - Attachment	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Letter to USDHHS re HRSA-09-	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	HRSA SHAP grant workplan.pdf	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	HRSA SHAP grant Attachment 4	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	HRSA SHAP Grant Application	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	HRSA -- Interagency Memorandum	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	HRSA SHAP grant org chart.pdf	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment



State of West Virginia
Joe Manchin III
Governor

Office of the Governor
State Capitol
1900 Kanawha Boulevard, East
Charleston, WV 25305

Telephone: (304) 558-2000
Toll Free: 1-888-438-2731
FAX: (304) 342-7025
www.wv.gov

June 11, 2009

U.S. Department of Health and Human Services
Health Resources and Services Administration
Healthcare Systems Bureau
State Health Access Program

Re: Announcement Number HRSA-09-226, CFDA No. 93.256

To Whom It May Concern:

By this letter, I authorize the submission of a grant application on behalf of the State of West Virginia and designate the West Virginia Department of Health and Human Resources (WVDHHR), Office of the Secretary as the applicant and lead agency on this grant to act on behalf of the State. Martha Walker as the Secretary of WVDHHR has full authority to oversee and coordinate the activities proposed and to designate others with accountability to her to implement the activities set forth in the grant application. I have asked Secretary Walker, Insurance Commissioner Jane Cline and Medicaid Commissioner Marsha Morris to coordinate the activities contemplated in our grant application with the other parties that will be participating in these activities.

This grant application has my full support and is consistent with my charge to our state agencies and private partners to collaborate to expand access to affordable, high-quality health care for those who do not currently have health insurance.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Manchin, III".

Joe Manchin, III
Governor



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Secretary

State Capitol Complex, Building 3, Room 206
Charleston, West Virginia 25305
Telephone: (304) 558-0684 Fax: (304) 558-1130

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

June 12, 2009

U.S. Department of Health and Human Services
Health Resources and Services Administration
Healthcare Systems Bureau
State Health Access Program

Re: Announcement Number HRSA-09-226, CFDA No. 93.256

To Whom It May Concern:

The West Virginia Department of Health and Human Resources (WVDHHR), Office of the Secretary, has been designated as the lead agency for this grant opportunity by an accompanying letter from Governor Joe Manchin. WVDHHR will be responsible for overseeing the grant activities and carrying out the project in collaboration with Commissioner Jane Cline and her staff from the Offices of the Insurance Commissioner (OIC) and the other parties as set forth below or in the grant application. Funding is requested at the level of \$6,343,900 for the first year and for a total of \$36,883,119 over the five year grant period, subject to award.

The principal contact person for WVDHHR will be Gerald Roueche, Assistant to the Secretary, who may be contacted at (304) 558-0684. Nancy Malecek in the OIC will serve as the Project Coordinator and she may be reached at (304) 558-3707, ext 1175.

The participating agencies and organizations include but are not limited to the following: West Virginia Department of Health and Human Resources, West Virginia Offices of the Insurance Commissioner, the Bureau for Medical Services and our Medicaid Program within DHHR, Public Employees Insurance Agency, West Virginia Office of Technology and Chief Technology Officer Kyle Schafer, West Virginia Health Care Authority, West Virginia Health Information Network, Mountain State Blue Cross & Blue Shield, Governor's Office of Health Enhancement and Lifestyle Planning (GO HELP) (when formed), West Virginia Health Improvement Institute and West Virginia Telehealth Alliance. Additional participants will be added as needed to effectively complete the project plan.

Thank you for your consideration of our grant request on behalf of the uninsured citizens of West Virginia.

Sincerely,

A handwritten signature in cursive script that reads "Martha Yeager Walker".

Martha Yeager Walker
Secretary

	TIMETABLE	RESPONSIBLE PERSON/AGENCY	ANTICIPATED RESULTS	EVALUATION/ MEASUREMENT
TASK 1: DEVELOP COMBINED PRODUCT (Direct Service/Insurance Overlay)				
Action Steps				
1. Issue invitation to Participate to Clinics & Insurers	Jul-09	OIC/Murphy, Malecek	Acceptances	Numbers expressing interest
2. Develop standards, looking to WV Code §16-2J and in consultation w/ the WV Health Care Authority	Sep-09	OIC/Murphy, Malecek	Agreements with clinics	Number, proportion, geographic diversity of clinic agreements
3. Respond to Comments on Proposed Legislative Rules	Aug-09	OIC/Murphy, Malecek	Revised Rules preliminary Insurance Overlay products; re-priced options proposed in 2005 report	Extent to which Rules permit fulfilling project objectives
4. Meet with insurers and members of 2005 Affordable Insurance Workgroup	Oct-09	OIC/Murphy, Malecek OIC/Murphy, Malecek,		# insurers and # plans
5. Legal, regulatory review	Nov-09	Holliday, Cooper	OIC approval	# plans approved
6. Meet w/ agents & brokers to explain new product	Dec-09	OIC/Malecek/PublicEd person	training & marketing materials distributed	# contacts
7. Marketing and sales of new product	Jan-10	OIC/PublicEd person	PSAs, advrtsg placed, media interviews & stories, etc	estimated audience reached; # plans sold
8. Evaluate experience of Direct Service 669 plans since 2006	Jun-10	HCA/Chambers	Completed report of participation and satisfaction	Peer reviewers' assessment
TASK 2: DEVELOP & ADMINISTER PREMIUM ASSISTANCE PROGRAM				
Action Steps				
1. Refine estimates of uninsured working adults by income level, in tandem w/ AccessWV program development	Jul-10	OIC/Malecek	Sufficient data to design assistance program	
2. Establish eligibility criteria, select vendor for eligibility determination	Sep-09	DHHR	criteria established, vendor selected	Program parameters in place
3. Establish operational procedures	Mar-10	OIC/Malecek	sub-contracts w/ state Treasurer, Auditor; financial accounting process in place	Program operational standards in place

TASK 3: DEVELOP & IMPLEMENT WEB-BASED CONNECTOR

Action Steps

1. Hire staff and establish Connector program	Mar-10 OIC/	staff in place	Project orientation meetings
2. Staff and equipment acquired by IT Director	Jun-10 OIC/	staff & equipment in place	confirm functionality (IT Director)
3. Train Insurance Specialists/Counsellors	Jun-10 OIC/Assoc Dir for Content	staff trained and in place	successful completion of training evaluated ag educational objectives
4. add tutorials, insurance ed modules, FAQ	Sep-10 OIC/Assoc Dir for Content, Public Ed Dir	ed materials on line collaboration w/ HCA & data rec'd; other quality measures posted	
5. Healthcare quality & cost info added	Sep-10 OIC/Connector Project Manager	functionality in place	info sources validated measured against functionality objectives
6. Application & enrollment functionalities added to Connector	Jan-11 OIC/Connector Project Manager	functionality in place	measured against functionality objectives
7. Premium collection and remittance functionalities added to Connector	Jul-11 OIC/Connector Project Manager	functionality in place	measured against functionality objectives
8. Premium assistance program on-line	Jul-11 OIC/Connector Project Manager	functionality in place	measured against functionality objectives

TASK 4: DEVELOP & IMPLEMENT PUBLIC EDUCATION and MARKETING PROGRAM

Action Steps

1. Consultation on Choice Architecture	Jan-10 OIC/Public Ed Director	Specific recommendations for Public education/marketing design and assistance program	insights and types of actionable recommendations received
2. Develop or acquire a culturally-sensitive health insurance education program	Sep-10 OIC/Public Ed Director	ed materials on line	evaluated against educational learning objectives
3. Establish co-operative agreement w/ WV SHIP	Jun-10 OIC/Public Ed Director	Agreement concluded	Agreement concluded
4. Create volunteer health insurance advisors corps	Jun-10 OIC/Public Ed Director	Organization established	Organization established

**Attachment 4 – Descriptions for
KEY PERSONNEL**

OFFICE OF THE INSURANCE COMMISSIONER

PROJECT COORDINATOR/MARKET ANALYST

Coordinates work of Project Team to maximize efficiency and ensure completion of project objectives. Develops and coordinates contracts for services and consultations and works closely with other staff in implementing tasks.

PROJECT LIAISON/ DEPUTY COMMISSIONER (20%)

Advises and assists in project administration and coordination with the WV DHHR, and in managing project operations and developing and implementing policy.

LEGAL/REGULATORY COUNSEL (20%)

Advises and assists in establishing and interpreting legal policies, statutes, and Legislative Rules with respect to the project's programs, policies and procedures.

HEALTH INSURANCE EXCHANGE

EXECUTIVE DIRECTOR

Responsible for all aspects of Exchange functions, administration, and accountability.

FINANCIAL OFFICER

Chief Financial Officer for the Exchange, responsible for the accounting system; develops procedures and negotiates contracts for billing, payroll withholding, insurer remittances, insurer fees Exchange functions; works with State Treasurer and Tax Department.

ASSOCIATE DIRECTOR FOR CONTENT

Responsible for all information delivered through the Exchange, including quality control, updates, development of training programs for counselors and site content modifications and enhancements.

INSURANCE COUNSELORS

Individuals who receive specific training in health insurance and health care options in WV, who will staff the Exchange Call Center and Live Chat function to assist users.

West Virginia SHAP Grant Application – Attachment 5

Biographical Sketches of Key Personnel

Martha Y. Walker was appointed as the Cabinet Secretary of the West Virginia Department of Health and Human Resources by Governor Joe Manchin in 2005. Ms. Walker was elected to the West Virginia House of Delegates in 1990 and the state Senate in 1992 and 1996. In the Senate, she was Chair of the Senate Health and Human Resources Committee and a member of the Rules Committee. She also served as vice chair of the Human Services Committee for the National Conference of State Legislatures and was a member of the Health Chairs Project and Forum for State Health Policy Leadership for the National Conference of State Legislatures. She has received numerous citations for her dedication to health care issues by organizations recognizing her service in the legislature and her continuing public service. Prior to her appointment as Cabinet Secretary, Ms. Walker served as a Commissioner for the West Virginia Public Service Commission. She serves on a number of state and national organizations in her position as Cabinet Secretary and is a graduate of West Virginia University. She was the recipient of the Liberty Bell Award from the West Virginia Supreme Court of Appeals in 2006. She serves as the Governor's representative for health care matters in West Virginia.

Jane L. Cline was appointed West Virginia Insurance Commissioner January 15, 2001. In addition to her responsibilities as Insurance Commissioner, Ms. Cline serves as President-Elect of the National Association of Insurance Commissioners (NAIC), as well as Chair of the Management Committee of the Interstate Insurance Product Regulation Commission. During her tenure she has held various leadership positions with the NAIC. As West Virginia Insurance Commissioner, Ms. Cline is responsible for the regulation of the insurance market as well as administering the transition of the state's workers' compensation system from a state monopolistic system to a competitive private system and has successfully prepared the market place for the entrance of private carriers beginning July 1, 2008. The Commissioner's responsibility to manage the workers' compensation claims that the State has retained continues. Before her appointment as Insurance Commissioner, Ms. Cline operated a government consulting firm and served as Commissioner of the West Virginia Division of Motor Vehicles (DMV) from November 1989 to October 1997. While she was DMV Commissioner she served in several positions with the American Association of Motor Vehicle Administrators and was treasurer and President of the Southeastern Zone.

Gerald Roueche has served as Assistant to DHHR Secretary Martha Walker since her appointment by Governor Manchin in 2005. Prior to assuming that position, Mr. Roueche served as Assistant to the Director of Public Employees Insurance Agency and was instrumental in achieving passage of the Small Business Insurance Act, and previously served as policy coordinator for Sec. Walker while she was Chair of the Senate Health Committee. He represents the Secretary and DHHR on a number of boards, commissions and councils. He has an extensive business background and previously had responsibility for overseeing grants management and compliance in the

private sector. He is a graduate of Michigan State University, B.S. Urban Planning and the West Virginia College of Graduate Studies, MPA.

Bill Kenny has served as Deputy Insurance Commissioner since May 1, 2002. Prior to his appointment as Deputy Insurance Commissioner, he was Assistant to Insurance Commissioner. Before entering state government, Mr. Kenny owned an investment firm. Mr. Kenny served City Manager of the City of Charleston from May 1995 to November 1998. During his tenure, he led the restructuring of the City of Charleston's compensation health benefits and personnel policy. He oversaw the budgeting and strategic planning processes as well as economic development activities. Prior to appointment as City Manager, Mr. Kenny held senior management positions in marketing, materials management, logistics and fulfillment. A native of New York, the Deputy Commissioner holds a Bachelor of Science degree in Business Administration from the University of Charleston.

Marsha Morris is the Commissioner of the Bureau for Medical Services within the West Virginia Department of Health and Human Resources. As Commissioner, Morris manages approximately 85 employees and a budget of \$2.5 billion. The Bureau for Medical Services administers all of DHHR's Medicaid programs and benefits. Prior to her appointment as Commissioner, Ms. Morris worked within state government for approximately 16 years. She worked for the West Virginia Legislature, serving as counsel for the Senate and House Health and Human Resources Committees, the Banking and Insurance Committee, the Finance Committee and numerous interim committees. Prior to attending law school, Ms. Morris was a registered nurse, having graduated from Charleston General School of Nursing. Ms. Morris obtained her Bachelors degree in political science at the University of Louisville and her Juris Doctorate from Indiana University - Bloomington.

Nancy Malecek has held the position of Health Policy Analyst for the West Virginia Offices of the Insurance Commissioner since October 2008, after a three-year hiatus on the Olympic Peninsula of Washington state. As of January 1, 2009, she assumed responsibilities for AccessWV, the state's high-risk pool. As Health Analyst, she is working with Commissioner Jane Cline and Deputy Commissioner Bill Kenny to consider healthcare reform proposals, estimating costs and benefits, and communicating with others within the state and with other State Insurance Commissions. She was responsible for pricing medical services for the WV Workers' Compensation Commission, and collaborated with the medical department and WVU School of Medicine in designing, implementing, and analyzing research initiatives. She formerly served as Fiscal Officer in the Governor's Cabinet on Children and Families. She has Bachelor's and Master's degrees in Economics from Indiana University (Bloomington, IN) and the University of Washington (Seattle, WA), and is licensed as a Certified Public Accountant.

Timothy R. Murphy has been employed at the Offices of the Insurance Commissioner since October 2004 and, as Associate Counsel in the Legal Division, he is involved in most OIC matters related to health care issues. His duties at OIC include the drafting

of legislation/rules and appearing before legislative committees. Prior to OIC, he was counsel to the WV State Senate Judiciary Committee for five legislative sessions and served as a law clerk to Judge K.K. Hall, U.S. Court of Appeals for the 4th Circuit, for ten years. He has also worked for the Legal Aid Society and as legal director for WV Advocates, the designated state disability rights organization. He received a Bachelors degree from the College of the Holy Cross and a J.D. degree from the WVU School of Law.

Tara L. Buckner is the Chief Financial Officer for the WV Department of Health and Human Services. She has served in a number of financial management positions within DHHR over the past twelve years. She is a Certified Public Accountant and has her Masters of Business Administration from Marshall University. She has extensive experience administering the complex financial aspects of DHHR operations and cooperative agreements within State government, including experience administering various federal grants, including those from HRSA to DHHR. She is also a member of the WV Hospital Finance Authority Board of Directors.

Roger Chaufourmier is the coordinator and interim Executive Director of the West Virginia Health Improvement Institute. He is also President and CEO of the Center for Strategic Innovation. Prior to the formation of the company in October 2006, Mr. Chaufourmier has founded and served in a leadership position with a number of private companies, including Patient Infosystems, STAR Advisory Group and Managed Care Assistance Corporation. Mr. Chaufourmier was a former Assistant Dean for Strategic Planning for the Johns Hopkins University School of Medicine (1993-96). In addition, Mr. Chaufourmier spent twelve years in progressive leadership positions with the George Washington University Medical Center (1981-1993). Mr. Chaufourmier was a three time Examiner with the Malcolm Baldrige National Quality Award and has served as the national facilitator for the federal Bureau of Primary Health Care chronic disease collaboratives.

Interagency Memorandum of Collaboration

This Interagency Memorandum of Collaboration is made as of this 1st day of June, 2009 by and between the West Virginia Department of Health and Human Resources, Office of the Secretary (Martha Y. Walker) and the Offices of the Insurance Commissioner (Jane L. Cline).

The parties to this Memorandum of Collaboration wish to pursue an undertaking to expand access to health insurance coverage for uninsured West Virginians, particularly those that are working and yet do not have health insurance coverage, and the parties wish to mutually pursue funding for this undertaking through a HRSA State Health Access Program (SHAP) grant (HRSA-09-226) (the "Grant") and the parties have collectively engaged in a number of initiatives to address the plight of the uninsured, particularly the working uninsured, and this initiative is consistent with Governor Manchin's Strategic Vision and Action Plan issued in 2007 and he has issued a letter in support of the project as part of the application process. Accordingly, the parties agree to the following:

1. WVDHHR, at the request of and by designation of the Governor, will act as the lead agency for this project. DHHR will maintain overall direction and responsibility for the project. The nature of the project and the roles and responsibilities of the parties are set forth in the Project Narrative and accompanying documents that comprise the SHAP grant application.
2. The DHHR project liaison will be Gerald Roueche, Assistant to Secretary Walker. Mr. Roueche will be accountable to Secretary Walker and responsible for coordinating the interaction between DHHR and OIC, with Bill Kenny, Deputy Commissioner of OIC, who reports directly to Commissioner Cline. Tara Buckner, CFO of DHHR, will serve as the grants manager and she and her staff in DHHR Grants Management will oversee financial administration of the grant. Nancy Maleček, Insurance Market Analyst in the Research and Executive Division of the OIC, will serve as overall project coordinator to assist the Project Team with various coordination activities and will oversee data collection and analysis, actuarial studies, and policy analysis work. The project contemplates use of contractors, including the West Virginia Health Improvement Institute and the West Virginia Telehealth Alliance, the West Virginia Health Policy Research Institute to perform certain project functions as contractors and/or sub-recipients. The Secretary and the Commissioner shall jointly designate members of the Project Team from within State Government resources and appropriate external consultants and contractors. The Project Team shall assist in administering the program, while the Steering Committee shall provide strategic guidance on program implementation.
3. The Office of the Secretary, as the applicant for the grant, will designate a project Steering Committee consisting of representatives of the collaborating organizations, including the OIC, the Medicaid program, the West Virginia Health Improvement Institute, the Health Care Authority and WVHIN, the West Virginia Telehealth Alliance, the Office of Technology and Chief Technology Officer, GO HELP (and others as appropriate). Contractors will be retained as needed to complete the tasks contemplated in the project plan to complement the resources within the organizations of the collaborating public and

private participants. Contractors will be selected and retained based upon experience and qualifications relative to the assigned tasks and scope of work for which they are being sought to provide services as part of the project implementation. Representatives of participating health insurance carriers may be utilized by the OIC to assist in the formation and operation of the health insurance exchange segment of WV CONNECT.

4. Each participating organization serving on the Steering Committee will designate a Project Coordinator who will be responsible to the Steering Committee and Project Team for assuring that the project tasks and assignments under the Workplan are completed in a timely fashion in accordance with the project budget. The Steering Committee will make recommendations for the resolution of any project delays or impasses that may arise, and these issues will be coordinated with GO HELP as contemplated by statute, but the final resolution lies with WVDHHR, as the lead agency with respect to all issues pertaining to administration of the SHAP grant and use of grant funds, and the Office of the Secretary of WVDHHR. The Secretary may resolve such issues in consultation with the Governor to assure consistency in the administration of the program with the Governor's strategic vision for health care policy.

5. The lead agency will also be responsible for preparation and timely submission of all progress and other reports due for the grant. The WVDHHR Office of Grants Management, which works closely with HRSA on a number of grants to the State, will oversee preparation and submission of all required reports and will administer all audit and supervisory responsibilities in accounting for grant fund disbursement. WVDHHR will also work closely with HRSA staff to comply with audit requirements of the Office of Management and Budget (OMB) Circular A-133, submit Payment Management System Quarterly Reports, submit a Financial Status Report (FSR) within 90 days of the end of the grant period, and submit all required reports to HRSA and HRSA contractors in a timely fashion, following the prescribed HRSA formats. The lead agency may use the resources of the Steering Committee and/or one or more contractors, including the West Virginia Health Improvement Institute and the evaluation team retained to perform the evaluation of the program, to assist in the preparation and submission of the required reports.

6. The parties may amend this Memorandum at any time and may enter modify or supersede this arrangement as necessary for purposes of completing the project and administering the Grant, if awarded.

The parties have caused this Memorandum of Collaboration to be executed as of the date first written above.

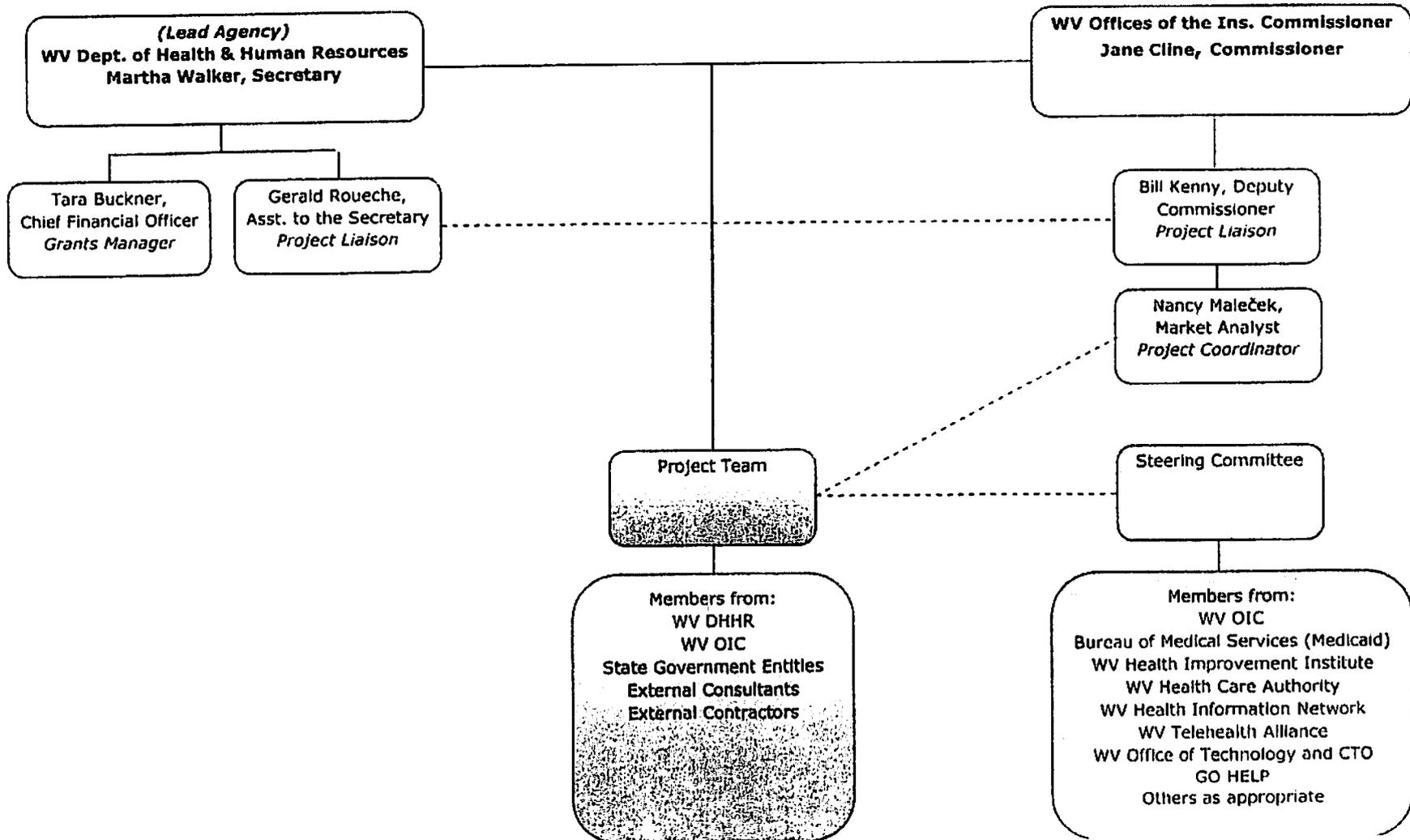
West Virginia Department of
Health and Human Resources

Offices of the Insurance Commissioner

By: Martha Yeager Walber
Cabinet Secretary

Janet Cline
By: _____
Commissioner

WV CONNECT ORGANIZATIONAL INFORMATION



**WEST VIRGINIA STATE HEALTH ACCESS PROGRAM GRANT
WEST VIRGINIA CONNECT - PROJECT NARRATIVE**

INTRODUCTION: West Virginia’s proposal for funding through a State Health Access Program (SHAP) grant will expand health insurance coverage and access to care for uninsured West Virginians, building on a decade of work by a diverse group of stakeholders and the opportunities presented by the Recovery Act and anticipated health care reforms at the national level. This SHAP grant application outlines a multi-faceted approach to expanding coverage for the uninsured in a coordinated, cost-effective fashion. This initiative utilizes the collaborative resources of community-based health care providers, private and public insurance programs and parties engaged in health improvement and electronic health information technology (HIT) efforts, coordinated to maximize the impact of federal, state, private and participant funds (including incentives and funds made available under the American Recovery and Reinvestment Act (ARRA)) for the purpose of affording access to high-quality, culturally-appropriate health care services to uninsured West Virginians.

This program, called “WV CONNECT”, is focused on improving access to health care coverage and improving the health of those that are currently uninsured. The program links families and small business to health coverage options that assure basic primary and preventative care and some extended care through community-based medical homes. The program will assure that participants are encouraged to take an active role in health care decision-making and utilization of health care resources with the support and coordination of an appropriate medical home. It also intends to leverage the power of health information technology and health information exchange, consistent with HRSA programmatic objectives, to improve outcomes and reduce unnecessary costs (with these savings reinvested to sustain the coverage expansion). This initiative also seeks to preserve jobs and promote economic development consistent with the intent of ARRA by investing in a healthy, productive workforce that can compete in today’s world economy and extending this opportunity for meaningful work to all West Virginians, regardless of economic or health conditions.

The goal of the WV CONNECT initiative is simple and straightforward – expand access to health care coverage for those citizens that are currently uninsured. While the goal is simple, the nature of the problem presents many layers of complexity. Accordingly, WV Connect contemplates a three-part approach that will be implemented in phases to address the problem. Research has demonstrated that addressing the multitude of challenges in expanding coverage for the uninsured cannot utilize a ‘one-size fits all’ approach. The WV CONNECT implementation plan has been developed based upon the recommendations developed from prior HRSA-funded State Planning Grants (SPGs), the experience from SPG and Pilot Programs in other States and the work and recommendations of national experts in this field. One of the factors driving an incremental approach to a comprehensive solution is the reality of a finite and limited amount of resources to apply to the solution – not only are the financial resources limited, but most of West Virginia is medically-underserved or has a health profession shortage area. Expanding access to health care must address not only coverage through an insured

source of payment, but also real access to needed services through a medical home that coordinates access to inpatient and specialty services.

WV CONNECT uses a series of connectors, much like a highway, to link People to Payers (the health insurance connector - to a source of insurance coverage for health care services) through a health insurance exchange; People to Providers (the medical home connector – to a source of health care in a local medical home) through premium assistance for low-income working families and in collaboration with the West Virginia Health Improvement Institute. WV CONNECT also links Providers to the Program through the third part of this health care triangle (the portal connector) to facilitate access to clinical information for health improvement and project evaluation and to facilitate use of personal health records by covered individuals.

This initiative is a part of a larger plan of the State to address escalating health care costs that threaten to dramatically expand rather than reduce the number of uninsured citizens. In the first quarter of 2009, the Governor and members of the Legislature were provided with two reports that estimated the State's future costs for health care services over the next decade. The first was from Emory economist Dr. Kenneth Thorpe, who was contracted by the Legislature to analyze the operation and effectiveness of the State's health care system. The report was presented in March 2009; the second report was from the State's actuaries, CCRC Actuaries, LLC, completed in April 2009. CCRC Actuaries project that health care costs (defined as allowed charges) will increase from \$13.1 billion in 2009 to \$24.4 billion in 2019; and Dr. Thorpe projects that health care costs, absent recommended reforms and initiatives, will increase from \$11.5 billion in 2008 to \$22.5 billion in 2018. These cost estimates serve as a clarion call to action, and WV CONNECT is part of the State's response to this challenge.

In light of the current economic climate, budget constraints and fragile nature of our health care delivery system (with demand for services exceeding available resources), Governor Manchin has directed the state agencies involved in this proposal to develop a scalable and manageable approach to the problem. Accordingly, WV CONNECT is designed to accommodate expected changes at the national level expanding coverage for uninsured working families and individuals. The project plan will adapt to establishment of a health insurance exchange at either the national level or through a series of connected state exchanges. The project plan is also consistent with expected national reform legislation that encourages access to preventive and health management services for the uninsured through affordable coverage; these reform as contemplate utilization of medical homes by those that are currently uninsured and often "medically homeless". The national reforms also contemplate using HIT to help finance this expansion by driving administrative efficiencies (as reflected in the WV CONNECT project plan). The WV CONNECT plan is designed to accommodate the number of proposals currently under consideration at the national level by Congress and President Obama, including those that would expand Medicaid or Medicare coverage (even for low-income adults without dependent children) for the uninsured.

NEEDS ASSESSMENT – State's Insurance Expansion Program

Characteristics of the State’s uninsured as well as the uninsured population targeted in the proposed program including their characteristics and a discussion of the linguistic composition of the State: West Virginians without health insurance:

According to a series of detailed studies on the uninsured, on any given day in West Virginia 236,174 non-elderly adults (aged 19-64) are without health insurance. This represents 21.5% of the non-elderly adult population and over 60% of these uninsured have some connection to work. Many of the working uninsured are employed in seasonal, temporary or part-time jobs that do not afford insurance benefits or full-time jobs that pay low wages without health coverage. Many work in small businesses that cannot afford to offer comprehensive employer-sponsored health insurance (referred to herein as “ESI”). Many also have difficulty finding affordable insurance due to the way the insurance marketplace currently is structured or due to pre-existing medical conditions.

The WV CONNECT plan addresses these challenges in a strategic fashion. The plan is built upon a detailed series of studies about the uninsured (funded by prior HRSA SPGs). In 2001, the West Virginia University Health Policy Institute (HPI) coordinated the first *West Virginia Healthcare Survey* of 16,493 households to learn about West Virginians who did not have health insurance – who they were, what the circumstances of their lives were, and what relationship the lack of insurance had to their health status and their access to healthcare services. As a result, state health programs and agencies, as well as other stakeholders, had information related to health insurance coverage by age, economic and social conditions, region, and county. The survey was updated in 2003, and the survey was repeated a third time in 2007. The 2003 and 2007 surveys provide valuable statewide measures of change, but were not large enough to provide county-level estimates. The results of these surveys have been used by policy makers and planners to design a series of steps to address this problem. The WV CONNECT project is built upon these prior efforts, ranging from the work of the Affordable Insurance Workgroup (described in subsequent sections of this narrative) to legislative committees that have developed legislation also described in this narrative and the work of the state agencies and private parties that are collaborating on this effort.

Assessing Changes in Healthcare in West Virginia Between 2001-2007: The Non-Elderly Adult Report, is an updated report by the HPI based on the *West Virginia Healthcare Survey, 2007* and includes the following findings (the corresponding implications for the project design of West Virginia CONNECT):

- The finding that 236,174 non-elderly adults had no insurance represents an increase of 8.3 percent, or 18,241 people from 2001. The number of adults who were uninsured for part or all of 2007 increased 6.3 percent from 2001, representing 307,478 people, or approximately one out of every 3.6 West Virginia adults. **Implications for project design:** The uninsured in West Virginia is a large and diverse population. There are a number of independent and intertwined social, economic, educational and health condition factors that must be addressed in meaningful coverage expansion. This is a chronic problem that has defied simple solutions. As reflected from the statistics above, a large segment of this population teeters between having health insurance and having

none. This means the WV CONNECT project will have to utilize a number of strategies for outreach, education, enrollment and monitoring of coverage status that take into account cultural and literacy barriers. As contemplated by national reform measures, enrollment and purchasing opportunities for health care coverage must be decentralized to meet uninsured workers in the work and marketplaces and in medical homes.

- 75%% of uninsured adults in West Virginia (over 177,000 adults) have been without health insurance for a year or longer. The largest increase between 2001 and 2007 was seen in those without insurance for periods of between one and ten years. **Implications for project design:** While some of the target population moves from insured to uninsured on a fluid basis, there is a large segment of the population that is chronically uninsured. Many of these individuals are disabled or have other barriers to employment, are in low-paying jobs that offer no chance of insurance coverage or have other significant barriers to coverage in the commercial marketplace. They also have very limited means to participate financially in maintaining coverage and may have pre-existing conditions that make experience rated coverage difficult.

- The high cost of premiums, co-pays and deductibles remains the biggest obstacle to obtaining health insurance according to those surveyed, and has increased as the reason given for lack of coverage compared to the 2001 survey. **Implications for project design:** Cost sensitivity is an important consideration in the project design and includes not only the monthly cost of coverage, but also co-pays and deductibles which can preclude access to care even for those with some coverage. One example of the interplay of pricing and enrollment can be found in Vermont’s health reform efforts. Dr. Thorpe, who provided guidance on many of the West Virginia efforts, devised a “take-up rate” formula for Vermont’s health reform to assess how many uninsured would enroll. Dr. Thorpe used a measure of price elasticity based upon economic theory, including the formula used by the Congressional Budget Office to estimate enrollment in public programs. “Price elasticity” is the measure of how individuals respond to price changes for a particular good. Dr. Thorpe estimates price elasticity for health insurance at -0.5. This means for every 10 percent decline in the price of insurance, 5 percent of the uninsured will enroll. In addition to the price sensitivity of enrollment, Dr. Thorpe takes into account the share of the health premium as part of household income, and the amount of the public subsidy. (Overview of Catamount Health. Kenneth E. Thorpe. February 23, 2006)

Dr. Thorpe’s Take-up Formula

Percent FPL	Monthly Premium, <i>Most</i> Enroll	Premium as % income	Monthly Premium, <i>Nearly All</i> Enroll	Premium as % income
150% FPL	\$27	2.2%	\$15	1.2%
301% FPL	\$175	6.8%	\$83	3.4%
500% FPL	\$288	6.9%	\$138	3.4%

- Between 2001 and 2007, there has been a decline in the percent of adults who were self-insured, which may reflect increased costs of health insurance. **Implications for project design:** As noted elsewhere in this narrative, the individual market is constrained in West Virginia and there are significant challenges in attempting to expand coverage

based upon individual lines. In many cases, individual coverage is a last resort for those changing jobs and losing coverage due to layoffs or economic adjustments. It is also the only last resort for many self-employed small business owners that operate as sole proprietors. In concert with anticipated national reforms, the health insurance exchange is a vital component to making individual coverage more available and affordable.

- The risk of being uninsured is greatest for younger adults (aged 19-34), and this risk has been increasing for this age group over time. In contrast to the earlier survey, males now constitute the majority (50.3% or more than 118,000 individuals) of uninsured adults. **Implications for project design:** This population nationally is somewhat problematic since it is comprised of young individuals that may be in entry positions, or less-educated workers that are in minimum-wage type positions. Since males do not need maternity coverage, it usually costs less to insure males in this age range and their utilization of health care services is usually less than females in this age range.

- Regionally, the highest rates of those without health insurance occur in the southern part of the state, and the rate of those without health insurance have increased for all regions except the eastern panhandle (Editorial note: there has been more positive economic activity in the eastern panhandle of the state associated with proximity to the Washington, DC metropolitan area). **Implications for project design:** Many of the areas with high rates of uninsured also are medically underserved or are in health profession shortage areas. Some of the more rural areas are also economically disadvantaged, contributing to the problem. The WV CONNECT project plan takes into account the unique conditions of each region of the state; flexibility and scalability are key implementation considerations for the plan.

- Being uninsured is strongly linked to socioeconomic conditions. Persons with less than a high school education, and who are unemployed or employed in low paying jobs, are at substantially greater risk of being uninsured. 75% of adults without insurance (over 177,000 individuals) have a high school education or less; 65% of unemployed adults do not have health insurance. The overall profile of a typical person without insurance is a male, aged 19-34, who is unemployed and has a high school education. **Implications for project design:** The WV CONNECT program must balance the need for immediate coverage expansion with the State's workforce and economic development objectives. Outreach and education efforts of the program and access to the health insurance exchange must assist those that lack skills to otherwise navigate the insurance marketplace to make wise purchasing decisions. As noted above, a significant number of these uninsured have been without health insurance for a long period of time and will have pent-up demand for health care services when linked with a medical home.

- Almost 19% of working adults did not have health insurance. Working adults without health insurance, compared to those with insurance, report poorer health status and fewer visits to a healthcare provider. Persons without insurance are less likely to have access to a physician's office and to a usual health care provider, compared to persons with insurance. Furthermore, almost 90% of uninsured adults have been unable to fill at least one prescription medicine because of cost. A higher percentage of uninsured persons

report their health to be poor or very poor in 2007 compared to earlier surveys. Uninsured persons report worse health status than insured persons. **Implications for project design:** The project must have strong health improvement components. Linkage to a medical home is important to maintain long-term financial sustainability and it is anticipated that there will be little initial cost savings (overall health care spending for the uninsured population enrolled) due to pent-up unmet demand for health care services. Many uninsured workers report that they “can’t afford to miss work” so they do not go to a health care provider for regular visits or preventative health care services. It is also important to link these low-income workers with medical homes that offer extended hours since access to care must be coordinated with work schedules for many of these workers. Excessive absenteeism can cost some of these workers their jobs. WV CONNECT has a strong focus on low-income workers for the coverage expansion for two important policy reasons: it is important to keep capable workers gainfully employed from a social and economic standpoint and workers with income (even in low-income jobs) are better able to share some of the cost of health insurance coverage than their non-working counterparts.

- Among those who are employed, health insurance is more likely to be offered by large firms and for full-time workers. Persons who enjoy comprehensive health insurance coverage constitute a smaller percentage of insured persons compared to the 2001 survey, while persons whose coverage is limited to catastrophic care have increased as a percent of insured persons. More than 60% of the uninsured adults (more than 144,000 individuals) have some connection to work, either as employed or self-employed workers. **Implications for project design:** Expanding coverage for small businesses is a unique challenge, but a challenge that must be met; the most recent data show that West Virginia has 31,186 small employers and they employ 96.4% of the State’s workforce.

Fluctuations in coverage and relationship of adult coverage to that of children: The most recent healthcare survey notes that in 2007, 177,176 adults were uninsured for the entire year and another 130,302 were uninsured for part of the year. Although the number of the State’s employed adults had increased by 58,725 to 699,899 in 2007 (compared to the 2003 number), only 459,653 of that increased number were eligible for employer health insurance, down nearly 50,000 from 2003. **Implications for project design:** The prevalence of employer sponsored health insurance (ESI) has been impacted by changing economic conditions and a shift to a service economy with lower paying jobs. The most recent economic downturn has affected businesses of all sizes and families face continuing pressure to make ends meet and take jobs without health insurance coverage.

While the report shows, as noted above, that on any given day 236,174 or 21.5% of the adult population was uninsured, the story is quite different for children. In 2007, the overall number of children in the state had dropped by 6 percent (403,092) from the prior survey. Aided by the SCHIP and Medicaid programs, 91.4 % of these children had health insurance and only 3.1% were uninsured all year. **Implications for project design:** Coordination of benefit design in low-income working families that have multiple sources of coverage (i.e., coverage of adults under ESI or some other public

coverage, with children covered by Medicaid or SCHIP) presents a challenge to be considered and addressed in the implementation of the WV CONNECT project.

Health insurance and employment in West Virginia: The information reported in the WVU Policy Institute reports is consistent with similar information on those without insurance in West Virginia as reported by authorities and sources such as Kaiser Foundation State Health Facts. By using information from these multiple sources, a statistical composite of the challenge presented by this project to cover the uninsured emerges:

West Virginia Employment (2006)

Employment Status by Household	
At least 1 full time worker	1,192,980
Part time workers	133,200
Non-workers	475,740
Total	1,801,920
Classification of Workers:	
Permanent Worker	675,793
Temporary Worker	26,317
Total	702,110
Source: Kaiser - State Health Facts	

Implications for project design: There is a significant connection to work for most households. However, West Virginia has one of the highest rates of non-participation in the workforce and alternative sources of coverage for non-workers will need to be utilized. The health insurance exchange for individuals will be a key means of increasing coverage for those without a connection to work or for the self-employed.

Insurance Status of Non-Elderly Adult West Virginians (2007)

Type of Insurance:	Estimated Number of Adults	2007 %
Private Employer	453,858	41.73%
Public Employer		
PEIA	139,096	12.80%
FEHB	41,324	3.80%
VA/CHAMPUS	10,016	0.92%
Medicaid	95,807	8.80%
Self-Purchased Health Insurance	31,126	2.86%
Medicare < 65 yrs	38,092	3.50%
COBRA	12,621	1.16%
UMWA/Railroad Retirement/Other Union	6,047	0.56%
Other	23,347	2.15%
Uninsured	236,174	21.72%
Total	1,087,508	100.00%

Source: West Virginia Healthcare Survey 2007

The uninsured rate in West Virginia is 25% higher than the national average of 17%.

Employment Status of the Uninsured in West Virginia

Employed	109,821	46.50%
Self-Employed	34,481	14.60%
Unemployed	33,064	14%
Homemaker	31,411	13.30%
Disabled	12,990	5.50%
Student	8,975	3.80%
Retired	5,432	2.30%
Total	236,174	100.00%

Source: West Virginia Healthcare Survey 2007

Implications for project design: Sixty percent of the non-elderly uninsured adults are employed as employees or as self-employed.

Key health issues related to access to care and uninsurance: A new Kaiser Foundation report indicates that there is a strong correlation to income levels, access to health insurance and health status. The report states: “The gaps in our health care system affect people of all ages, races and ethnicities, and income levels; however, those with the lowest income face the greatest risk of being uninsured. Despite strong ties to the workforce—over eight in ten uninsured come from working families—about two-thirds of the uninsured are individuals and families who are poor (incomes less than the federal poverty level or \$21,203 for a family of four in 2007) or near-poor (with incomes between one and two times the poverty level). Not having health insurance makes a difference in people’s access to needed medical care and their financial security. The barriers the uninsured face in getting the care that they need means they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact can also be severe. Uninsured families already struggle financially to meet basic needs, and medical bills, even for minor problems, can quickly lead to medical debt. Nearly one-quarter of uninsured adults say that they have forgone care in the past year because of its cost—compared to 3% of adults with private coverage. Part of the reason for this is that slightly more than half of uninsured adults do not have a regular place to go when they are sick or need medical advice.” **Kaiser Foundation, The Uninsured, 2008.** The lack of a “medical home” is a particular problem for the uninsured in West Virginia according to the 2007 Healthcare Survey:

Usual Place of Care – Medical Home

	Est. Unins. Adults	%	Working Unins.
No Medical Home	115,725	49.00%	70,708
Physician Office	47,235	20.00%	28,860
CHC	46,385	19.64%	28,341
Hosp.Outpatient Clinic	3,495	1.48%	2,136
Hospital ER	13,131	5.56%	8,023
Free Clinic	5,314	2.25%	3,247
Other	4,889	2.07%	2,987
Total	236,174	100.00%	144,302

These results emphasize the need for the medical home component of the WV CONNECT project.

According to a policy paper published by the West Virginia Hospital Association on the issue of the uninsured, West Virginia hospitals “provided uncompensated care to patients that was valued in excess of \$578 million. Because the uninsured are much more likely to require expensive crisis care for conditions that could have been treated earlier through less costly ambulatory care, the uninsured can add to overcrowding in hospital emergency departments. The Henry J. Kaiser Family Foundation reports that 20 percent of the uninsured (versus three percent of insured) use hospital emergency departments as their usual source of care. The Institute of Medicine reports the uninsured are 30 to 50 percent more likely to be hospitalized for an avoidable condition, with an average cost of \$3,300 per hospital stay.” The WVHA notes that in addition to expanded coverage for children through SCHIP, West Virginia hospitals support covering the uninsured population by expanding “public and private insurance through Medicaid and SCHIP and tax credits to purchase insurance for low-income families.”

Lack of health insurance is a very real problem in West Virginia: In designing the WV CONNECT program, it is easy to see the magnitude of the problem from the staggering array of facts, figures, statistics and charts pertaining to the issue. It is important for everyone associated with this initiative to remember that this is a very real, personal and profound problem that touches so many lives each day. As part of its work on this issue, the West Virginia University Health Policy Institute published “*The Uninsured in West Virginia: Putting a Human Face on the Problem of Uninsurance*” in 2003 based upon the many encounters they experienced during the surveys that were part of the information-gathering process. The following vignettes from that report are indicative of the impact that lack of access to health insurance has on access to health care, to the financial problems this lack of access creates and the stress of depending upon the kindness and charity of the medical community to afford access to the disadvantaged. The names have been changed to protect the privacy of those involved, but the following are real stories of those touched by this issue:

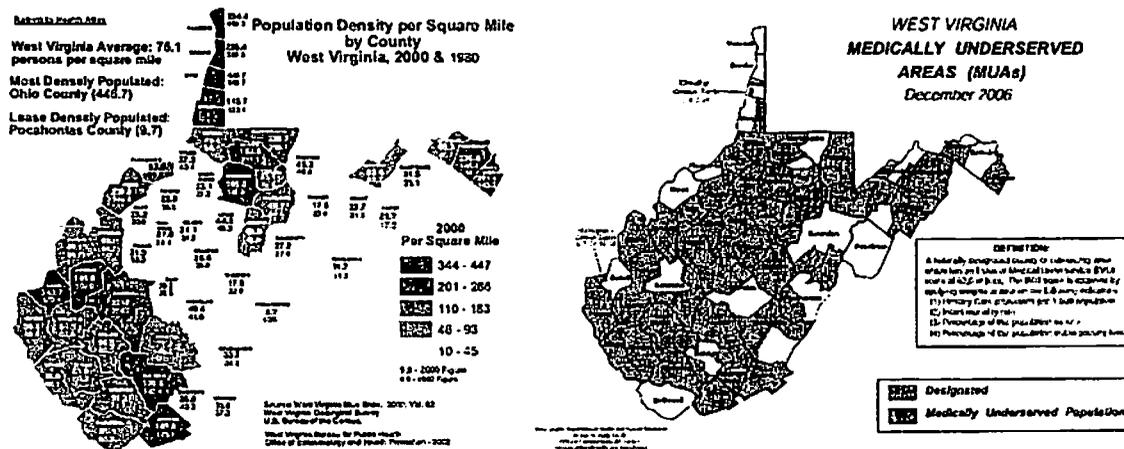
“Tonya is the single parent of a 10-year old boy who suffers from cerebral palsy. Tonya’s son Christopher has a medical card, but Tonya has encountered problems getting him the care he needs. Christopher’s condition requires him to be seen regularly by a physician, but Tonya could not find any local doctors who were willing to treat her son. Tonya and Christopher now travel several hours to Pittsburgh, Pennsylvania for his medical care. Meanwhile Tonya has been without insurance for seven years. During that time, Tonya has accumulated a significant amount of debt at her local hospital on which she makes payments each month. Tonya says that she often puts off seeking medical care if she can help it. But even when she does seek medical care, she hasn’t always been able to afford the treatment or procedures the doctors have recommended. For instance, last August doctors advised Tonya that she needed to have her gallbladder removed. Not wanting to go further in debt, Tonya still has not had the recommended surgery, despite the discomfort she often experiences. “You just have to tough it out sometimes,” she says. Tonya was finally offered a full time position by her employer and will be eligible for health insurance after her six-month probation period is over. Tonya is looking forward to having health insurance. Although she continues to pay on the debt she accumulated while uninsured, she is relieved that she will soon be able to seek medical care without

the fear of going deeper into debt.” (Note: The Kaiser Foundation report on the uninsured cited above finds that: “Most of the uninsured have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured households had \$600 or less in total assets (not including their house and cars) in 2004, compared to median assets of \$5,500 for insured households. Moreover, after households' debts are subtracted from assets, the median net worth of uninsured households drops to zero—leaving many of the uninsured with no financial reserves to pay unexpected medical bills.” The **American Journal of Medicine** recently reported nearly 62 percent of all personal bankruptcies today involve unpaid medical expenses.)

“Yvonne and Stephen are married with three children. Yvonne and Stephen both own small businesses and are unable to provide health coverage for their family. When asked if she had ever looked into purchasing health insurance for herself and her family, Yvonne indicated that she had, but she stated that the choices were very limited. Yvonne found that the health insurance plans offered by reputable insurance agents covered so little, and were so expensive that she could not afford them. Meanwhile, she was also very concerned about purchasing coverage from a less-established insurance agency. Even though the insurance plans were cheaper, Yvonne was concerned that if she purchased a policy from an agency without a well-established record, she might encounter problems with coverage, or even worse, find out that the company was a scam. Yvonne and Stephen have had a lot of difficulty when seeking medical care for their children. Yvonne’s oldest son suffered from swollen tonsils and adenoids, making it very difficult for him to breathe at night. In order to get her son the treatment he needed, Yvonne had to pay \$500 in advance to cover the surgeon’s fees before a tonsillectomy could even be performed. After the surgery, Yvonne was left with over \$4,000 in hospital bills on which she makes monthly payments. Yvonne has also experienced difficulty finding a physician who will provide routine treatment to her family. When asked about her husband’s and her own health, Yvonne stated that she has had problems with her blood pressure, but that she has received very little treatment for this condition. Yvonne attributes part of the trouble she has had obtaining health care services to the fact that very few physicians or health care facilities are willing to work with uninsured individuals to make payment arrangements.” (The Kaiser report also finds that “uninsured adults are more than twice as likely as the insured to have used up all or most of their savings to pay medical bills. One-quarter of uninsured adults report that at some point in the past five years they spent less on basic needs, such as food and housing in order to pay medical bills.”)

Summary of the State’s current delivery system (e.g., managed care penetration, access to primary care, variations in coverage, insurance carrier penetration, etc.) and the impact on access to care: West Virginia faces a number of unique challenges in expanding coverage for the uninsured due to the rural nature of the state. West Virginia is the second most rural state in the country, with 45 of the state’s 55 counties designated as “rural”. Nearly two-thirds (64%) of West Virginians live in rural areas, with more than eighty percent of the state’s residents living in communities of fewer than 5,000 people. Forty-nine of the state’s 55 counties are designated fully or in part as Health Professional Shortage Areas and/or Medically Underserved Areas. Chronic conditions are more

prevalent among rural populations, with nearly half (46.7%) of the adult rural population having one or more chronic condition(s) compared with 39.2% in urban areas. Most rural residents rely upon community health centers (CHCs) as a critical source of care. CHCs serve as the medical home for 1 of every 6 West Virginians (1 of 4 living in rural areas). This is one of the reasons that the CHCs play a vital role in the project design aspects of WV CONNECT.



The shortage of physicians in West Virginia’s sparsely populated rural areas is severe. The state ranks about 30th nationally in the ratio of physicians to population, and there are unfulfilled requests for more than 120 primary care physicians to meet needs in underserved rural areas. There are a disproportionately low number of physician specialists in rural areas; only about 10% of medical specialists practice in rural areas, compared with about 25% of family and general practice physicians. According to health workforce studies, West Virginia has fewer physicians, nurse practitioners, dentists and dental hygienists per 100,000 population than the U.S. average. These factors are significant considerations in designing a program that not only affords health insurance coverage but also affords real access to needed health care services.

Despite its rural nature and the cited health shortages, West Virginia enjoys an extensive network of hospitals, clinics and health care professionals to serve as the foundation for the WV CONNECT provider network. A composite picture of the health care delivery system in West Virginia is summarized, with care provided by:

- 54 acute care community hospitals, 18 critical access hospitals, with a total of 70 hospitals;
- Seven state-operated facilities, 2 behavioral health facilities, four long-term care, one community hospital;
- 14 behavioral health centers, and 65 certified intermediate care facilities;
- 34 nonprofit primary care center organizations, with more than 150 primary care service sites (including 48 school-based health centers), providing services in or to 47 counties;
- 54 local health departments, 73 home health agencies, 20 hospice organizations and 63 rural health clinics;

- 3,743 MDs and 507 DOs active and practicing in West Virginia according to the respective licensing boards. Approximately one-third of West Virginia's physicians are self-employed in a solo practice. More than one-third of West Virginia's physicians provide primary care.

Behavioral health: For individuals with behavioral health needs, West Virginia operates a number of behavioral health and community support programs. However, a number of studies show that access to appropriate behavioral health services is an issue for the uninsured and use of the Medical Home model in this project contemplates integration of primary care and behavioral health services in the medical home setting. A Kaiser study notes: "the chances of being healthy decline with income. One in five (19%) of poor adults describe their general health as being only fair or poor. One in seven poor adults has only fair or poor mental health. The poor are over three times as likely as those with incomes of 200% or more of poverty to describe their level of mental health as fair or poor (14% vs. 4%). (Low-Income Adults Under Age 65 —Many are Poor, Sick, and Uninsured, June 2009). Assuring access to behavioral health services is an important aspect of benefit design for the program.

Challenges presented by prevalence of chronic disease in West Virginia: West Virginia ranked 2nd highest nationally in 2004 and 2005 in reporting the general health of adults as either "fair" or "poor." A number of individuals (with or without insurance) needed medical care within the past year and could not afford it (19.3%) and do not have a specific personal doctor or health care provider (22.9%). West Virginia also has the second highest percentage of its population over age 65 (17.9% second only to Florida) and the fifth highest percentage of its population living at or below the poverty level (18.5%).

All of these factors contribute to a high degree of health disparities and unfavorable outcomes in West Virginia and the associated high expenditures on health care services. The most costly factor in the \$11.5 billion spent on health care in West Virginia last year is the high incidence of chronic illness which accounts for 70% of hospital admissions; 80% of hospital days; 72% of physician visits and 88% of prescriptions filled; nearly 60% of ER visits and 70% of health insurance costs paid by employers and workers. Twenty percent of hospital charges in West Virginia are related to diabetes and eight of every ten hospital discharges are related to cardiovascular disease.

The prevalence of these chronic conditions is a significant barrier to achieving the intended health improvement objectives of the project. The cost of treating and managing these chronic conditions (thereby driving the overall cost of health care and the cost of maintaining health care coverage) is a key determinant in plan design and sustainability. A strong focus on prevention is essential, especially for those insurance products that are experienced-rated. Integrating the Medical Home model and aligning the primary care provider network with this model is a key consideration in this coverage expansion initiative, to assure meaningful access to health care services for those who are extended coverage through WV CONNECT and to establish a regular connection to a medical home to manage health and use of health care services.

Overview of the health insurance marketplace: Public and private health insurance options and coverage: Public health insurance: Enrollment in West Virginia’s Medicaid Program: The West Virginia Medicaid program provides health insurance coverage for approximately 22% of the population. West Virginia has a lower percentage of covered adults (due in part by a low FPL threshold) and a higher percentage of disabled than the national averages for the Medicaid-covered population:

	WV	WV	US	US
	#	%	#	%
Children	188,000	47.90%	29,182,400	49.70%
Adults	57,800	14.70%	14,879,700	25.30%
Elderly	39,500	10.10%	6,116,200	10.40%
Disabled	107,300	27.30%	8,536,500	14.50%
Total	392,600	100.00%	58,714,800	100.00%

West Virginia Children’s Health Insurance Program (WVCHIP, referred to nationally as SCHIP) is a low-cost health care plan for children 18 and younger. West Virginia expanded eligibility for the program in early 2007 to families with incomes between 200 percent and 220 percent of the federal poverty guidelines. In 2007, average enrollment in WVCHIP was in excess of 25,000 children.

West Virginia Public Employees Insurance Agency (PEIA) is the predominant insurer of public employees in the state of West Virginia and provides coverage to approximately 212,000 individuals. However, this plan is open only to employees of the State or designated governmental units. As noted in other sections of this narrative, from time to time policymakers and lawmakers have used various elements of the PEIA program in coverage expansion efforts.

Action in other states expanding Medicaid coverage as instructive to West Virginia in project design: Many states have chosen to expand Medicaid coverage above the minimum federal levels. The federal rules give states flexibility in how income eligibility is calculated within these groups. This flexibility as well as coverage expansions through federal waivers has created a large amount of variation from state to state in Medicaid eligibility thresholds. There are states that cover parents with incomes up to 275 percent of the federal poverty level (FPL) while other states require parental income to be below 20 percent FPL to receive Medicaid.

West Virginia has elected to maintain a relatively low threshold for coverage of adults with children (one of 14 states with a threshold under 50% of FPL) due to the significant costs associated with a higher percentage of disabled individuals covered by the program (and the higher medical costs associate with the needs of this population). However, these coverage thresholds may be revisited in light of proposed national health care reforms addressing Medicaid expansion. West Virginia has a favorable FMAP percentage (currently 73.73%, increased to 81.61% under ARRA) that makes Medicaid expansion an attractive option for eligible uninsured populations.

Using Medicaid reform to drive realignment of the health care delivery system: integration of medical homes and personal responsibility: West Virginia was one of the first states in the country to have a Medicaid transformation plan approved under the Deficit Reduction Act of 2005 (“DRA”) which provides states with the flexibility to redesign Medicaid programs to meet specific health care needs. The Medicaid transformation project is innovative in a number of ways: Medicaid members are expected to take personal responsibility for their health; to take prescribed medications; keep appointments; use the emergency room only for emergencies and participate in health improvement programs. The Medicaid program, in collaboration with a number of health care organizations, created the West Virginia Health Improvement Institute (WVHII) to prepare health care providers to qualify as patient-centered medical homes and to participate in performance-based health outcome incentives. The WV CONNECT project will build upon the lessons from the Medicaid program in using a network of medical homes and the work of the WVHII in developing this cadre of community-based providers.

Coordination with the West Virginia Health Improvement Institute: As noted above, the WVHII is a West Virginia non-profit corporation that was initially formed by the West Virginia Medicaid program but has grown to represent a multi-party collaboration of state agencies, public and private insurers, professional healthcare organizations representing physicians, community health centers, hospitals, behavioral health providers, dieticians, academic healthcare (including the state’s three medical schools) and ancillary service providers, business (through the West Virginia Chamber of Commerce), labor (through the West Virginia AFL-CIO), consumers (such as AARP and the Bureau of Senior Programs) and advocates (such as West Virginians for Affordable Health Care). This diverse group of stakeholders is actively engaged with WVHII to promote:

- patient personal responsibility and self-management through a shared focus on prevention, patient education and empowerment, personal health plans and personal health records;
- use of the planned care model for health improvement and patient-centered medical homes;
- adoption of electronic health information systems with an integrated system of local, regional and statewide health information exchange; and
- modifications to both insurance and public programs to reward individuals and providers for pro-active engagement to improve health outcomes.

The WVHII is also being co-sponsored by the West Virginia Public Employees Insurance Agency (PEIA) and Mountain State Blue Cross & Blue Shield (MSBCBS) in recognition of the alignment of common interests in health promotion by these agencies.

One of the important aspects of the WVHII is the development of an “Innovation Community” to assist health care providers in making the transition to the Medical Home care model. WVHII is also assisting providers with the integration of HIT as part of the Medical Home transition. More than 200 care teams have joined the Innovation

Community to make this transition and WV CONNECT will leverage the experience of WVHII in working with this provider network as part of the project implementation plan.

Health insurance marketplace in West Virginia: One of the important aspects of examining health insurance coverage in West Virginia and the status of the marketplace is that health insurance is provided in two ways: either as a fully insured product subject to regulation by the OIC or as a self-funded benefit program that is regulated by ERISA (a federal law that preempts state regulation of self-funded plans). In a self-funded plan, the employer sets aside assets to pay for employee health coverage. The employer assumes all financial risk but may contract with an insurer or some other party to provide administrative services (usually referred to as “third-party administration” or “TPA” services). In a fully-insured plan, the employer buys an insurance plan from an insurer. The employer pays a monthly premium to the insurer, who assumes financial risks associated with health costs. For a variety of reasons, most self-funded plans are established by large employers or union benefit funds.

The following information on health insurance regulated by the OIC will apply only to fully-insured health coverage and will not include self-funded coverage. The difference between the covered lives listed by the OIC with fully-insured coverage and the total number of individuals with ESI represents the individuals covered in self-funded ERISA plans. According to the 2008 annual report of the Office of the Insurance Commissioner (OIC), comprehensive major medical health insurance (defined as insurance coverage that provides hospitalization, physician services, lab services and medications and referred to in this narrative as “major medical”) resulted in earned premium revenues of \$786 million in 2007 and covered approximately 215,166 lives in West Virginia. The OIC reports major medical insurance sold by commercial providers in the State by large groups (*employers with over 50 eligible employees*), representing 53% of the covered lives and small groups (*employers with 2 to 50 eligible employees*) representing 39% of covered lives (with the balance of 8% representing individual covered lives).

In West Virginia, employer groups account for ninety-two percent of covered lives for major medical products. The OIC reports that “2007 was marked by relative stability in the major medical lines of business. West Virginia’s top five companies for large group sales account for about 93 percent of premium earned and nearly 90 percent of covered lives. The number of carriers in this line of business declined to 22 for 2007 from the 26 which were observed in 2006.

Top 10 Carriers of Large Group Major Medical Coverage

<i>Premium (\$)</i>	<i>Company Name</i>	<i>Covered Lives</i>
\$171,064,583	<i>Mountain State BlueCross BlueShield (Highmark)</i>	41,331
\$73,249,668	<i>The Health Plan of the Upper Ohio Valley</i>	21,811
\$55,823,265	<i>Carelink Health Plans, Inc.</i>	13,811
\$37,871,408	<i>Coventry Health & Life Insurance Company</i>	9,790
\$35,685,451	<i>United Healthcare Insurance Company</i>	9,647
\$6,551,662	<i>Aetna Life Insurance Company</i>	2,775
\$5,269,384	<i>Connecticut General Life Insurance Company</i>	2,786

\$3,659,721	<i>THP Insurance Company</i>	1,347
\$2,653,417	<i>Consumers Life Insurance Company</i>	1,233
\$2,446,648	<i>State Farm Mutual Automobile Insurance Co.</i>	573
\$6,958,538	<i>Others (12)</i>	2,122
\$401,233,745	<i>Totals (22)</i>	107,226

The OIC reports that “the number of carriers in the small group market decreased from the 2006 total (30) back to the 2005 level of 27. Earned premium volume increased approximately 14 percent over 2006 for the combined sales of large and small group major medical. While at the same time, the number of covered lives decreased by nearly 7% for these group markets.”

Top 10 Carriers of Small Group Major Medical Coverage

<i>Earned</i>		
<i>Premium (\$)</i>	<i>Company Name</i>	<i>Covered Lives</i>
\$162,029,170	<i>Mountain State BlueCross BlueShield (Highmark)</i>	40,152
\$41,868,043	<i>Coventry Health & Life Insurance Company</i>	12,878
\$25,376,798	<i>Carelink Health Plans, Inc.</i>	5,490
\$13,814,190	<i>United Healthcare Insurance Company</i>	5,083
\$9,277,927	<i>Principal Life Insurance Company</i>	2,367
\$8,929,211	<i>The Health Plan of the Upper Ohio Valley</i>	2,227
\$5,551,645	<i>Union Security Insurance Company</i>	1,106
\$5,319,156	<i>First Health Life & Health Insurance Company</i>	1,033
\$5,096,802	<i>Consumers Life Insurance Company</i>	1,530
\$5,031,363	<i>Medical Benefits Mutual Life Insurance Company</i>	1,445
\$14,662,570	<i>Others (17)</i>	3,730
296,956,875	<i>Totals (27)</i>	77,041

The OIC report also notes the challenges facing individuals attempting to purchase individual coverage for major medical. The report notes “the individual buyer is likely to have a job that does not provide healthcare or have no job at all, and the younger and healthier individuals of this market segment often abstain from purchasing healthcare coverage altogether or simply purchase lower levels of coverage. This results in a general *adverse selection* problem in the individual insurance market (i.e. those with individual insurance are most likely to be individuals who have a medical need and will utilize these products)”. This observation is consistent with the findings by the Kaiser Foundation that “non-group insurance premiums vary by age and health status and can be more expensive and less comprehensive than group plans purchased by employers. Obtaining coverage in the individual market can be difficult—in 2005, nearly three in five adults who considered buying coverage had difficulty finding a plan they could afford, and one in five was denied coverage, charged a higher price based on their health status, or had a specific health condition excluded from coverage.” Because the market for health insurance is very concentrated among a few carriers, the organization of the health insurance exchange will be somewhat simplified compared to efforts in other States; however, extension of the proposed national health insurance exchange into West Virginia may require additional coordination as part of the project plan.

Top 10 Carriers of Individual Major Medical Coverage

<i>Earned Premium (\$)</i>	<i>Company Name</i>	<i>Covered Lives</i>
\$36,437,253	<i>Mountain State BlueCross BlueShield (Highmark)</i>	8,910
\$5,664,108	<i>Time Insurance Company</i>	2,887
\$2,779,807	<i>John Alden Life Insurance Company</i>	1,480
\$945,894	<i>The Health Plan of the Upper Ohio Valley</i>	264
\$658,975	<i>Continental General Insurance Company</i>	86
\$330,659	<i>Aetna Life Insurance Company</i>	125
\$247,126	<i>American Republic Insurance Company</i>	43
\$162,771	<i>Metropolitan Life Insurance Company</i>	148
\$117,562	<i>American National Insurance Company</i>	30
\$107,794	<i>Prudential Insurance Company of America</i>	397
\$449,889	<i>Others (28)</i>	1,025
47,901,838	Totals (38)	15,395.

Cost of health insurance coverage: The OIC annual report (cited above) notes the monthly earned premiums per covered life for the listed carriers. From this amount, it is possible to calculate a rough approximation of the cost of individual comprehensive health insurance coverage on a monthly basis:

Average Annual Cost per Insured (Major Medical)

Policy Type	2005	Increase =>	2006	Increase =>	2007
<i>Large Group</i>	\$3,182.12	0.85%	\$3,209.46	14.23%	\$3,741.94
<i>Small Group</i>	\$3,338.51	8.12%	\$3,633.60	5.73%	\$3,854.53
<i>Individual</i>	\$2,715.32	7.71%	\$2,942.18	5.44%	\$3,111.52

The report states “These costs provide a useful benchmark of health care insurance cost. For a family of four, we could estimate that a total premium may be about \$10,852 per year, or about \$904 per month under an average major medical policy.” The calculations by the OIC are consistent with similar national amounts reported in the Kaiser study, which states: “In 2008, annual employer-sponsored group premiums averaged \$4,704 for individual coverage and \$12,680 for family coverage. Total family premiums have doubled since 2000. The employee’s share of a family premium has also doubled since 2000, averaging \$3,354 in 2008. From 2000 to 2007, there were declines in both the percentage of employees offered employer-sponsored insurance and the percentage of those offered coverage that elected to enroll. Both of these trends were most pronounced among workers in low-income families (families below 200% of poverty or \$42,406 for a family of four). In 2007, 58% of all low-income employees were offered and eligible for employer-sponsored coverage, leaving more than four in ten without access to this coverage.” These low-income uninsured workers are forced to resort to the individual market if not eligible for some other type of public coverage (such as Medicaid).

Managed care in West Virginia: West Virginia has a much smaller penetration of managed care in the marketplace than nationally due to its rural setting, its high cost and the organization of the commercial markets. As of July, 2008, there were 271,895 individuals covered in managed care programs in West Virginia, representing a market penetration of 15%. The lack of managed care penetration is illustrated by the managed

care enrollment in West Virginia's Medicaid program (44.6% compared to the national average of 64.1%).

Past efforts of the State's government, both the executive and legislative branches, to reduce the number of uninsured residents by increasing access to public and/or private health care coverage and how those efforts have informed the current approach and program design: Efforts to expand access to health insurance have a long history in West Virginia and there have been numerous initiatives over the years. The most recent efforts can be traced to 2002, when West Virginia University's Institute for Health Policy Research (IHDR) created a 70-member Health Advisory Council (HAC) to address health insurance availability. In 2003, the IHPR conducted the first survey (as outlined in prior sections of this narrative) that made it clear how critical health insurance problems had become - about 238,000 West Virginia adults ages 19 to 64 were uninsured. The HAC set a goal of insuring 5,000 uninsured West Virginia adults within three years. The group formulated two incremental solutions, the West Virginia Small Business Plan and AccessWV:

Small Business Plan -- In 2004, a program was enacted by statute that allowed small employers (2-50 employees) to use the reimbursement rates set by PEIA. In addition to a six-month look-back (with no exceptions), participating employers had to contribute at least 50% of the cost of their employees' premiums. Although there has been limited participation to date – employer costs are not reduced enough to entice participation because the reduction in premium realized through the use of lower reimbursement rates is often insufficient to offset the costs of the mandatory 50% match. Despite low participation, the program is still available. The Small Business Plan now covers more than 600 individuals.

AccessWV -- Also in 2004, the Legislature enacted the NAIC model for the establishment of a high-risk pool. Funded by both premiums, which are set by OIC at between 125-150% of a "standard risk rate", and an assessment on hospitals, this plan has about 500 subscribers.

One of the findings from the survey was that "of small and midsize employers surveyed in 2003, 18 to 25 percent indicated they would be willing to pay \$100 in monthly premiums for health insurance; uninsured consumers strongly prefer low co-pays and deductibles." This finding has been incorporated into the planning for WV CONNECT. The challenges encountered in the prior efforts to expand coverage and the lessons learned have also been incorporated. "It's tougher than we thought it was going to be," said Sally Richardson, Director of the IHPR, concerning the Health Advisory Council's goal to decrease the number of uninsured.

In early 2005, the Health Advisory Council transformed into a leaner 25-member Affordable Insurance Workgroup (AIW). In December 2005, the AIW, in collaboration with the West Virginia Health Care Authority (HCA) and IHPR, issued a report and recommendations on how to expand access to affordable health insurance. In 2006, the

Manchin Administration began the implementation of several of those recommendations. These include:

Limited benefits plans I-- In 2006, OIC drafted and the Legislature enacted a bill creating a program to permit insurance companies to design and OIC to approve low-cost health insurance plans (individual and group) that contained fewer than all state mandated benefits, such as mental health and nursing services. To avoid crowd-out, some restrictions were placed on eligibility: Group plans could only be offered to part-time, seasonal or temporary workers who were neither covered by nor eligible for employee-sponsored coverage, and individual plans could only be offered to persons who had not been covered and had not been eligible for an employer plan in the last year (subject to exceptions, such as the loss of coverage due to a “qualifying event”). W. Va. Code §33-15E-3 & 33-16F-2. Although some plans were submitted and approved, sales were minimal, due in no small part to the restrictions on eligibility. Moreover; the low cost of these plans acted as a disincentive for carriers and agents to market the products, and no attempt was made to reduce the burdens inherent in administering the group plans, such as payroll deductions.

Prepaid clinic plans I -- A year after the statutory authority for the affordable plans was put in place, another product of the Affordable Insurance Workgroup was put in the Code. In response to a private clinic’s efforts to offer prepaid memberships and the OIC’s concerns that such a program, while not technically an insurance product, was largely unregulated by any government entity, the Legislature created a pilot program that permitted primary care clinics statewide to apply to the state Healthcare Authority (“HCA”) for approval to offer prepaid memberships, with OIC being delegated the task of reviewing fees, forms and marketing. A license would be required, and the licensee would be required to offer a minimum set of preventative and primary service established in rule. This pilot program, now in its third year, permits clinics to sell memberships to any person, the only restriction being a six-month look-back that is subject to the same “qualifying event” exceptions as the low-cost insurance plans. The program has met with some success, with 5 clinics currently licensed and serving approximately 557 subscribers. The average monthly cost ranges from \$25 per month (with co-pays) to \$83 (without co-pays) for individual coverage. HCA is now conducting the required evaluation of the program.

In April 2007, Governor Joe Manchin issued a strategic outline for healthcare in West Virginia. Captioned “**Towards A Healthy West Virginia: A Strategic Vision and Action Plan**”, the Governor articulated a series of precepts to guide future action, including the development of this coverage expansion initiative. The Governor stated “as the Affordable Insurance Workgroup noted in its December 2005 report, ‘in the absence of a comprehensive national health insurance program, it is indeed a challenge to address the needs of the uninsured at the state level.’ Despite the challenges inherent in improving access to affordable coverage, there are actions that states can take, and the Manchin Administration is committed to working towards solutions that achieve the goal of affordable access to health care for everyone...The Administration will move forward with the implementation of the new initiatives begun in 2006 and closely monitor their

impact on access to affordable health care. Finally, the Administration will work to find other potential mechanisms for containing costs and improving access to care, such as assessing the potential for a reinsurance program for protection against catastrophic health care costs.’ The Governor also noted the passage of legislation in 2007 that allows many young adults in West Virginia to remain on their family insurance policies up to age 25, regardless of student status.

The Governor also laid out the following cornerstones of the State’s health care policy:

- The ultimate purpose of West Virginia’s health system should be to ensure the best possible health outcomes for all West Virginians; prevention and health promotion must be cornerstones of West Virginia’s health policy and all West Virginians should be informed and active partners in taking care of their own health.
- All West Virginians should be informed and active partners in taking care of their own health, making wise use of health care resources, and contributing financially to their health care to the extent they are able – and all should have the opportunity to obtain the information they need to do so. All West Virginians should have the opportunity to obtain health care that is affordable.
- The health care system must provide care of the highest value and efficiency for the resources allocated. Responsible use of government funds to ensure high-quality, affordable health care requires a partnership between the private sector and government. The overall costs of the health system must be sustainable over time for individuals, families, government, and employers.

Limited benefits plans II (552 Plans)-- In 2009, the Legislature enacted an OIC-sponsored bill that superseded the 2006 affordable plan program and broadened the persons and groups who could be covered by similar plans. S.B. 552 (effective April 11, 2009. Modeled somewhat on the Cover Florida program instituted last year, this new “552 program” invites carriers to submit proposals for low-cost plans that can be sold to *any* person who has not been covered in the last six months and is not currently eligible for a public or employer plan; exceptions to this look-back exclusion include (1) persons who lose coverage due to an event such as loss of a job or death of a spouse; (2) persons who have lost coverage under a public program due to inability to meet income or categorical requirements; and (3) persons eligible for or enrolled in a COBRA plan. W. Va. Code § 33-16F-5. Similarly, group plans may be sold to any group that has not had coverage in the prior six months. A rule to implement the program is currently out for public comment. <http://www.wvsos.com/adlaw/proposed/114-88.pdf>

The plans under this bill must include certain primary care services, and each applicant must include an alternative plan that also includes catastrophic coverage. Like its predecessor affordable plan program enacted in 2006, the Insurance Commissioner can forbear from applying any statutory or regulatory requirement that impedes the goals of the program (W. Va. Code §33-16F-7(d)), thereby assuring OIC maximum flexibility in its review and oversight of the program. Additional flexibility is afforded by the provision authorizing emergency rules; the effect of this is that OIC is able to promulgate rules that are not initially subject to legislative review, and these rules can be effective for up to 18 months.

OIC is currently drafting the invitation to prospective applicants and guidelines to govern the review process. In addition to expanding the universe of eligible individuals and groups –the 6-month look-back is the only restriction – the bill attempts to reduce costs by mandating the OIC “develop a public awareness program” to promote the approved products, including assistance from state health benefits advisors.

Prepaid clinics II -- In 2009, an adjustment to the prepaid clinic program was made to allow the combination of clinic plans with high-deductible insurance plans in both the group and individual markets: OIC and HCA are required to draft a rule that provides for notice to subscribers regarding how prepaid clinic fees count, if at all, toward the deductible in the insurance plan. S.B. 669 (amending W. Va. Code 33-2J-3) (effective July 9, 2009). A rule has been proposed and is currently out for public comment. <http://www.wvsos.com/adlaw/proposed/114-87.pdf>

AccessWV II – The high risk pool statute was also amended to grant that program’s governing board additional flexibility to address its mandate to cover those unable to find coverage elsewhere. A bill enacted in the 2009 session gives the board of directors the authority to add categories of persons who can escape the usual 6-month pre-existing exclusion period and permits the use of surpluses to subsidize premiums for low-income enrollees. H.B. 3278 (2009). Implementing rules are currently out for public comment.

GO HELP – The product of a year-long study (called “Roadmap to Health”) headed by Kenneth Thorpe, Ph.D., this bill creates a new agency to “coordinate all state health care reform initiatives” among all state agencies. The Governor’s Office of Health Enhancement and Lifestyle Planning (GO HELP) is charged with, among other things, the duty of initiating strategies that will “result in greater access to health care, assure greater quality of care and result in reduced cost for health care delivery services to the citizens of West Virginia.” W.Va. Code §16-29H-4(a)(7). This agency has not yet been formed as the bill does not become effective until August, 2009.

This legislative and policy framework will guide the development and implementation of WV CONNECT as part of the Governor’s overall strategic vision for health care in the State. The program will also build upon the framework developed from the prior efforts at extending coverage.

Current political and economic environment as contributors to the potential success of the program: The WV CONNECT project is an example of the public-private collaboration contemplated by the GO HELP legislation and the SHAP grant will be coordinated among WVDHHR, the Insurance Commissioner and the Medicaid Commissioner, with the collaboration of the West Virginia Health Improvement Institute and consistent with Governor Manchin’s strategic vision stated above. WV CONNECT will also permit the State to coordinate efforts in the context of anticipated national health care reform. As outlined elsewhere in this narrative, the availability of ARRA funds provide a window of opportunity to launch this expansion initiative that may close soon based upon the projected future health care costs outlined above. There is also momentum to launch the project in concert with anticipated national health care reform.

National activities and other State approaches informing the State’s own approach to expanding affordable health care coverage. The planners of WV CONNECT have been guided by the work of the state groups such as the HPRI, AIW, WVHII and the workgroups involved with the legislative “Roadmap” project. The planners have also been guided by the numerous pilots to expand coverage and national studies and resources such as the coverage initiatives pursued in other states detailed in repositories such as the Robert Wood Johnson State Coverage Initiative (SCI) website. The results of the State Planning grants for other States are also instructive (**HRSA State Planning Grant Update: A Review Of Coverage Strategies And Pilot Planning Activities – Commonwealth Fund, 2005**) as well as the lessons learned from the implementation of Washington’s Basic Health Plan.

Many states have used Medicaid and SCHIP programs to expand coverage for the uninsured. Medicaid plays a critical role as a safety net for low-income populations. As people lose employment in times of economic downturn, incomes fall and health insurance is lost. Because so many working families without insurance transition on and off of Medicaid, there is growing recognition that any coverage initiative must be coordinated with, if not integrated into an expansion of, the state Medicaid program. The contemplated expansion of Medicaid under proposed national health care reform also necessitates close coordination with Medicaid as part of this WV CONNECT project.

As noted throughout this narrative, the design for WV CONNECT is driven in part by the unique needs of West Virginia and in part by the concepts outlined for national health care reform. The use of a series of “connectors” as part of this project is designed to permit the State to coordinate with national reforms that may include a national health insurance exchange, reform of the individual and small group markets, expansion of Medicare and/or Medicaid and use of medical homes for prevention. The project plan will also allow the State to proceed with coverage expansion if national reforms are scaled back or delayed.

Coverage expansion integrated with healthcare system reform: The previous coverage expansion experiences in West Virginia demonstrate that it is very difficult to enact and sustain expansion of health insurance coverage without addressing the healthcare delivery system. As noted by SCI, “in order for states to address health reform they have to look more broadly than just solving the problem of the uninsured. Over the past few years, state reform efforts reflect a greater understanding among policymakers that the issues facing the states cannot be remedied by focusing just on coverage and access issues. Yet, there is also increasing recognition that coverage expansions are still necessary to have an effective and efficient health care system. Consequently, more than ever, states are aiming to improve health care from a systemic perspective - tackling the challenges of cost, quality, and access in tandem to improve the value in the health care system.”

Applicability and replication of WV CONNECT in other States: The West Virginia coverage expansion project has great potential for other rural states to model. Since West Virginia has a higher percentage of uninsured than the national average with one of the

oldest, poorest and sickest populations, the success of WV CONNECT will have great value as other States seek to adapt the programmatic and technology solutions developed as part of this project in meeting the particular needs of that State. West Virginia Insurance Commissioner Jane Cline is currently serving as Vice-Chairperson of the National Association of Insurance Commissioners and, as the incoming Chairperson, is in a position to share the lessons learned in West Virginia with other Insurance Commissioners and to coordinate work on the national exchange through NAIC.

Utilization of safety net providers in the State's health care coverage expansion program: Safety net providers make a significant contribution to the health care of the uninsured population and thus are of vital importance in the design of the coverage expansion. In West Virginia, the formal health care safety net includes free clinics, primary care centers, local health departments, certain women and children's services, hospitals providing uncompensated care and critical access hospitals in underserved rural areas. These providers, either through a mandate or because of their mission, are committed to serving the uninsured, Medicaid beneficiaries and other vulnerable populations, who together comprise a significant proportion of their patient populations. Although not obligated to do so, rural health clinics may also serve the uninsured. Physicians in private practice who serve uninsured patients might be considered part of the informal safety net. For purposes of the coverage expansion project, the safety net providers integrated into the program include all of the foregoing; the primary focus of the expansion effort is to maximize use of the primary care (community health) centers statewide and the free clinics in the urban areas.

Community health centers: West Virginia has one of the most extensive networks of community health centers (CHCs) in the country. Also referred to Federally-Qualified Health Centers (FQHCs), they are located in high-need areas identified as having elevated poverty, higher than average infant mortality, and where few physicians practice; are open to all residents, regardless of insurance status or ability to pay; tailor services to fit the special needs and priorities of their communities, and provide services in a linguistically and culturally appropriate manner; provide comprehensive primary and other health care services, including services that help their patients access care, such as transportation, translation, and case management; provide high quality care, reducing health disparities and improving patient outcomes; and are cost effective (reducing costly emergency, hospital, and specialty care, and saving the health care system nationally between \$9.9 to \$17.6 billion annually) (Source: National Association of Community Health Centers).

West Virginia's 30 Federally-Supported Health Centers (out of 34 CHC organizations - also called Section 330-funded health centers in reference to the section of the Public Health Act that governs this federal funding) maintain over 145 delivery sites and provide care for 327,048 patients, including 1,459 migrant/seasonal farm worker patients and 6,408 homeless patients. These centers had 1,221,427 encounters with patients last year and provided over \$125 million in health care services and nearly \$15 million in sliding fee discounts to uninsured and low-income patients. According to NACHC, the services provided by West Virginia's CHCs saved \$180,480,804 in avoidable ER visits

and produced nearly \$300 million in local economic benefit, largely in salaries and jobs created or preserved.

Comparison of Population served by Health Centers	WV Centers	WV Overall	US Overall
Percent at or Below 100% of Poverty, 2007	61%	19%	17%
Percent Under 200% of Poverty, 2007	92%	41%	36%
Percent Uninsured, 2007	29%	14%	12%
Percent Medicaid, 2007	22%	16%	13%
Percent Medicare, 2007	14%	16%	15%
Percent Hispanic/Latino, 2007	1%	1%	15%
Percent African American, 2007	4%	4%	13%
Percent Asian/Pacific Islander, 2007	1%	1%	5%
Percent American Indian/Alaska Native, 2007	0%	0%	1%
Percent White (Including Hispanic/Latino), 2007	96%	95%	80%
Percent Rural, 2007	92%	63%	16%

Health centers are also a cost-effective source of care. According to NACHC, West Virginia health centers provided care at an annual average cost per patient of \$345 for medical cost and \$257 for dental care, with a total annual cost per patient of \$488. The average cost per patient encounter was \$106 for medical and \$122 for dental. These costs are lower than most other medical costs for similar services received from other sources due to sliding fee programs that are available and federal and state grants that partially offset the cost of uncompensated care. Studies have found that health center Medicaid beneficiaries were 11% less likely to be hospitalized and 19% less likely to use the ER for preventive conditions compared to Medicaid beneficiaries seen by other providers (NACHC).

The foregoing statistics highlight the value demonstrated, contributions to improved health outcomes and experience in providing for the health care needs of the uninsured of community health centers. It is for these reasons that the health centers will serve as the nucleus for the development of a network of community health providers to serve as medical homes for the target uninsured, particularly the working uninsured population.

On March 27, the Department of Health and Human Services (HHS) released \$338 million in Recovery Act grants to expand services offered by Community Health Centers and enable them to serve more patients. Under the ARRA, the twenty-nine existing Section 330-funded CHCs recently received \$6,672,135 under “Expanded Capacity” funding to cover the next two year period. This expanded capacity is projected to provide new access to health care for 20,820 uninsured citizens and 55,852 new patients overall (source: HRSA.gov/recovery). Also under the ARRA, Belington Community Medical Services Association, Inc received \$1,150,532 in funding under HHS’ “New Access Point” program and recognition as a new Section 330-funded program to expand medical capacity to serve 5,940 patients. This ARRA funding provides a source of funding to expand medical capacity to serve the uninsured to complement the HRSA SHAP grant

funds requested (but these ARRA funds will not supplant any existing funds nor be counted as match as part of the HRSA SHAP program funding).

The role of free clinics within the safety net: West Virginia has 10 free clinics located for the most part in the more populated areas of the state. The state's 10 free clinics and their approximately 2100 volunteers handled 54,925 patients during 229,844 patient visits and filled 496,930 prescriptions in fiscal year 2008-2009. Free clinics are dedicated to serving persons with household incomes below the Federal Poverty Level (FPL) who do not have insurance or who are underinsured. Ongoing medical expenses are taken into account in determining household income. Free clinics are thus vital to two groups: low income uninsured adults (non-elderly) and low-income seniors who do not have drug coverage. Free clinics provide only limited care to children since low-income children are eligible for public programs in West Virginia. They may serve Medicaid recipients on a limited basis for services not covered by that program (for example, dental care in the case of adults). Some clinics may also serve persons with slightly higher incomes.

Much like the community health centers, free clinics serve as an important point of access to care for the uninsured. However, because the free clinics depend upon volunteers and are located primarily in urban areas, they have less capacity to handle a large influx of new uninsured patients and to serve rural uninsured; accordingly, these clinics will complement the role of community health centers in the development of a provider network to serve as the medical home for the target population.

Rural health clinics: Rural health clinics (RHCs) are located in a medically underserved or health professional shortage area. Designation as a rural health clinic entitles a facility to enhanced reimbursement from Medicare and Medicaid. The clinic may be a private physician office or a facility-sponsored site. There were 57 rural health clinics in West Virginia in 2008 according to CMS records. While they are vital providers in the underserved areas of the state, the designation of “rural health clinic” alone does not oblige a facility to provide free or low cost care to the uninsured although some may do so. A national survey of rural health clinics in 2000 found that 36 percent of independent clinics and 29 percent of provider-based clinics wrote off from 5-14 percent of their charges as free or reduced cost care. Thirteen percent of the independent clinics and 16 percent of the provider-based clinics wrote off 15 percent or more of their charges. These clinics will also be integrated into the provider community as “medical homes” for the uninsured in conjunction with the community health centers and free clinics.

Barriers in the State and/or shortcomings with the existing infrastructure of coverage that the States’ health care coverage expansion program aims to overcome and residents to be served by the State’s health care coverage expansion program including demographic data to illustrate the targeted population(s) and their unmet health needs: Summary of Need: From the foregoing information, some clear patterns emerge that dictate the design of the WV CONNECT coverage expansion initiative. The barriers to the existing infrastructure of coverage can be summarized as follows:

- Sixty percent of the uninsured work but are uninsured. It appears that a great many of these workers are either part-time employees or in low-income jobs that

do not offer coverage or cannot afford the required employee contribution if coverage is available through the employer. Efforts to expand coverage to small businesses or those with pre-existing conditions have not widely utilized to date, as evidenced by the enrollment numbers for the Small Business Plan and AccessWV listed above.

- A large number of the uninsured are chronically uninsured and have no connection to work. Expansion of employer sponsored health care coverage will not address this population of uninsured. Expansion of Medicaid is an option, but will not address those that are uninsured adults without children in the absence of some change in federal regulations.
- A multi-faceted approach is required due to the complex nature of the underlying causes of being uninsured. While a great deal of information is available from surveys and national studies, there is still much to be learned about the best avenues to afford health care and coverage for this population.
- There is a solid health care infrastructure that has experience in dealing with the uninsured in West Virginia represented by a network of community health centers, free clinics, rural health centers and critical access hospital outpatient clinics. Incentives and premium assistance subsidies will be needed to expand the capacity of these community-based organizations to serve as the medical home for the uninsured. Cost savings will be reinvested in the program.

Uninsured in WV – Category Matrix			FPL	FPL	FPL
			100%	100-200%	200+%
Uninsured age group	by Estimated Number of Adults	%	31%	37%	32%
19-25	61,878	26.20%			
26-34	54,556	23.10%			
35-44	56,918	24.10%			
45-54	35,899	15.20%			
55-64	26,923	11.40%			
Total	236,174	100.00%	73,214	87,385	75,575
	Working Unins.	%			
19-25	36,797	25.50%			
26-34	37,230	25.80%			
35-44	39,827	27.60%			
45-54	20,202	14%			
55-64	10,246	7.10%			
Total	144,302	100.00%	44,734	53,392	46,176
Working parents			15,000	20,000	16,000
Working non-parents			29,734	33,392	30,176

Total			44,734	53,392	46,176
Non-working parents			7,000	6,000	6,500
Non-working non-parents			21,480	27,993	22,899
Total			73,214	87,385	75,575
Working Married	-	48.90%	21,875	26,109	22,579
Working non-married		51.10%	22,859	27,283	23,597

METHODOLOGY - DESCRIPTION OF THE 5 YEAR HRSA-FUNDED PROJECT ACTIVITIES

WV CONNECT: A three-part plan in response to the needs of the West Virginia uninsured and in contemplation of national health care reform:

The WV CONNECT project consists of three interrelated components: the creation of a state-specific health insurance exchange or the capacity to link with and facilitate integration with a proposed national health insurance exchange; expanding coverage through linkage of segments of the uninsured, particularly the working uninsured, with a community-based medical home as an extension of the pre-paid clinic model authorized by statute with a limited coverage wrap-around; and use of HIT resources to facilitate streamlined administrative processes for gathering of service and clinical information from pre-paid clinic and wrap-around providers to facilitate program evaluation and to measure the health improvement of the newly insured through the WV CONNECT program.

WV CONNECT and national health care reform: On May 14, 2009, the Senate Finance Committee issued a document captioned “Description of Policy Options - Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans”. The proposals set forth in this document include: changes related to rating, issuance and benefit structure of small employer (under 50 employees) and non-group health insurance; provision of certain tax credits to encourage coverage by employers and low-income individuals; establishment of one or more health insurance exchanges (HIEs); possible establishment of a federal public health insurance program (or a state-run program) as an alternative for those not covered by private insurance; expansion of Medicaid for children, parents and pregnant women up to 150% of FPL (financed by 100% FMAP for expanded eligibility to 2015, with phase down of FMAP after that date); premium assistance for those eligible for Medicaid but covered by employer sponsored insurance (ESI); tax credits for childless adults under 115% of FPL to subsidize health coverage through private or Medicaid coverage through HIE or coverage of childless adults under 50% of FPL through Medicaid expansion; mandatory provisions for individuals to maintain (and certain employers to contribute to the cost of) health

insurance coverage; and certain incentives for prevention and healthy lifestyle programs. These proposals are not in the form of legislation, but rather are concepts that are being considered in the context of the national health care reform discussions.

In response to proposals such as that of the Senate Finance Committee, President Obama outlined his goals in the health reform process (in a letter dated June 2 to Senator Kennedy and Senator Baucus):

“At this historic juncture, we share the goal of quality, affordable health care for all Americans. But I want to stress that reform cannot mean focusing on expanded coverage alone. Indeed, without a serious, sustained effort to reduce the growth rate of health care costs, affordable health care coverage will remain out of reach. So we must attack the root causes of the inflation in health care...The plans you are discussing embody my core belief that Americans should have better choices for health insurance, building on the principle that if they like the coverage they have now, they can keep it, while seeing their costs lowered as our reforms take hold. But for those who don't have such options, I agree that we should create a health insurance exchange -- a market where Americans can one-stop shop for a health care plan, compare benefits and prices, and choose the plan that's best for them, in the same way that Members of Congress and their families can. None of these plans should deny coverage on the basis of a preexisting condition, and all of these plans should include an affordable basic benefit package that includes prevention, and protection against catastrophic costs. I strongly believe that Americans should have the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest.”

The WV CONNECT plan has been formulated with these proposed national health care reform plans in mind to accommodate and adapt to the final configuration of the national reform package.

WV CONNECT – Part One: Health Insurance Exchange: WV CONNECT will build upon the experiences in other states such as Massachusetts and Connecticut in developing a full-scale or componentized health insurance exchange (depending upon the course of national health care reform legislation). The exchange will follow the general model that a successful health insurance exchange operates “similar to a stock market or farmers market, by serving as a market organizer and central clearinghouse for buying and selling health insurance and managing related information and financial transactions. An exchange performs the administrative functions associated with individuals choosing and paying for health insurance within the context of employer-sponsored coverage, thereby allowing individuals to obtain portable individual health insurance within the federal-law construct of “employer-sponsored” plans. As such, an exchange functions like a common human resources department for participating employers and their workers.” (Health Insurance Exchange, RWJ, April, 2009)

To facilitate expanded access to insurance products and knowledge, reduced administrative costs, and increased product and price transparency, the OIC will establish

a web-based health insurance exchange or “connector” and the features and functionality of this “Connector” will be phased-in over the grant period. These functions will include:

- Information on all available health insurance products filed in the state of West Virginia, including commercial insurance plans for individuals, small groups, and associations;
High-risk pool (AccessWV) for medically uninsurable and federally-eligible individuals;
Direct service plans (prepaid clinic services authorized under SB662 Preventive Care Pilot Programs);
Small-Business Plan;
Temporary and Seasonal Workers Plan;
New affordable health plans developed under the 552 program later this year;
Combined products offering clinic services for a monthly subscription fee PLUS a limited benefit health insurance overlay.
- Information on available sources of healthcare, including Community Health Centers, free clinics, rural health clinics and other community-based providers that provide services to the uninsured on a discounted or sliding-fee basis.
- Call Center/Live Chat for health insurance questions and assistance, modeled after and incorporating elements of the State Health Insurance Assistance Program for Medicare <http://www.wvseniorservices.gov/Portals/0/pdf/SHIP.pdf>.
- Health insurance education, tutorials, FAQs.
- Quality measures of participating healthcare providers.
- Online enrollment for insurance plans.
- Premium collection and remittance (Preliminary discussions with the Tax Department have occurred to establish employer premium payroll withholding and remittance with taxes-WV CONNECT would perform accounting functions to remit to the various insurers and brokers.
- Eligibility determination and processing for premium subsidies.
- Premium subsidy program administration.
- Linkage to a national exchange (if established).

It is contemplated that WV CONNECT will permit small businesses to voluntarily sign up to designate the WV CONNECT (and all the insurance products sold through it) as its employer group "plan" for its workers. Because this arrangement qualifies as an employer-sponsored "plan" for purposes of federal law, the employer's workers could purchase coverage of their choice through the exchange on a pre-tax basis. Employers who participate in the exchange would be relieved of most of the burdens of selecting and administering group coverage for their workers. Part of the grant proceeds will be used to determine the advisability of folding components of the current individual insurance market into WV CONNECT (depending upon the scope of the national reforms) and using the exchange to administer premium support contributions to supplement individual and employer funding for one or more categories of low-income residents. The planners of the project note that Massachusetts's exchange has taken on both of these roles.

The web-based “connector” will also accommodate expanded enrollment options for the uninsured under anticipated national reforms that would permit enrollment in Medicaid or other expanded coverage options through community-based providers and DMV offices. The applications could also be expanded to accommodate enrollment in other programs available to support low-income working families. An example of this one-stop approach is illustrated by the “One-e-App” web-based tool designed to streamline enrollment in public programs such as Medi-Cal, Healthy Families, and other local and state health and social services programs in California. The automated process enables members of a family to apply for all of the programs for which they may be eligible, without having to go to other locations or submit separate applications. It also identifies the programs for which each family member might be eligible to enroll or participate. This approach is consistent with Governor Manchin’s E-government initiative to make more state services available online and one of the reasons the SHAP grant application is being coordinated by WVDHHR and OIC.

Linking low-income working uninsured adults with oral health care: One of the significant health care needs of many low-income working adults is access to oral health services. As noted by the Kaiser Foundation: “Oral health problems can be early signs of and even lead to other types of serious diseases. Untreated oral health conditions can cause disfiguring tooth loss and decay that can limit employment options and lower self-esteem. While regular dental care can prevent and treat many oral health problems, financial barriers pose significant dental access problems for many low-income families. Private health insurance plans often exclude dental coverage, and those that do include a dental benefit often require high levels of cost-sharing that put care out of reach for many low-income families. Similarly, dental coverage for adults in Medicaid is limited or nonexistent in most states. Those without adequate dental coverage must turn to a health care safety net that often does not focus many resources on oral health, leaving them potentially unable to access needed care.”

As part of the initiative to link working low-income uninsured adults to medical homes through WV CONNECT, a part of the grant funds will be used to create a “virtual referral network” for those adults deemed to have a “medically necessary” need for oral health services (due to an oral health condition that exacerbates a co-morbid chronic condition (or may cause a health risk for expectant mothers). The project will create a virtual referral network linking medical homes with oral health professionals that will provide uncompensated care services (or provide care on a sliding fee basis). This initiative will leverage the work of the Benedum Foundation, a private foundation with significant grant activity in West Virginia focused on oral health.

Virtual extension network: Another aspect of the launch of WV CONNECT contemplates use of video conferencing and distance learning facilities in collaboration with the West Virginia Health Improvement Institute and its partner organization, the West Virginia Telehealth Alliance (WVTA) (a newly organized West Virginia non-profit corporation dedicated to advancing telehealth use and capabilities throughout the state). WVTA is one of 69 programs from across the U.S. that has been selected to participate in the FCC’s Rural Health Pilot program. WVTA will act as coordinator of the virtual

network to be utilized for this part of the project. The web-based and video conferencing technology tools will permit the operation of a “virtual extension service” to support the project. These facilities and applications will permit counselors and advisors with WV CONNECT to interact with prospective insurance purchasers and to facilitate out-stationed eligibility and enrollment specialists to interact with program staff from health centers and other participating community-based providers as contemplated in national reform proposals (such as DMV offices). This virtual network will create efficiencies and reduce travel costs in implementing and maintaining the program.

Enabling education and outreach: The technology platform for WV CONNECT is an important part of the education, marketing and outreach necessary to effectuate the intended coverage expansion and the investment of a portion of the grant proceeds to establish and maintain this infrastructure is justified by the experiences of other States in launching new coverage initiatives. The 552 Plan legislation attempts to reduce costs by requiring the OIC to promote the approved products, including providing assistance from state health benefits advisors. Recognizing the role of social marketing and the power of peer-groups (both important to the success in similar efforts focused on reducing rates of tobacco use) WV CONNECT will employ the latest and most sophisticated thinking available on this social marketing aspect of the project. Similarly, the contributions of behavioral economics will be incorporated in the pricing, placement, and promotion of new affordable health plans (similar to the price sensitivity analysis provided by Dr. Thorpe for the Vermont plan). Existing cadres of insurance advisors through the WV State Health Insurance Assistance Program (SHIP) will be utilized and expansion to a much larger trained-volunteer program such as Washington’s State Health Insurance Benefits Advisors (SHIBA) <http://www.insurance.wa.gov/shiba/index.shtml> will be undertaken. These advisors will be linked to remote “WV CONNECT” stations via the virtual extension network outlined above.

Due to the uncertainty at the time of this grant submission as to the scope of the national reforms being considered, the WV CONNECT project plan must be flexible to accommodate multiple scenarios at the national level and will be adjusted when the final national package is completed. Legislation may be required to effectuate portions of WV CONNECT related to the connector (exchange), depending upon the scope of the national reform legislation and delegation of authority to State Insurance Commissioners under such legislation. Many portions of this section of the program could be accomplished under existing legislative and rule-making authority. According to the OIC “development of a connector poses no foreseeable legal problems to the extent it is used to collect and distribute fees and premiums. Marketing of the products envisioned by the proposal, through a connector or otherwise, is clearly permitted by the 552 program as to the insurance component, and the combination of these plans with the clinic component also poses no problem. While legislation may be necessary to require employers to deduct and send fees/premiums, the issue is being explored with the state tax department.”

WV CONNECT - Part Two: Medical Homes, Prepaid Clinic Model and Premium Assistance: WV CONNECT will link the uninsured with a suitable medical home

through expansion of the Prepaid Clinic Pilots. In Dr. Thorpe's final 2009 report to the Legislature, a strong recommendation was made to "develop new medical home models, in particular through the development of community health teams that would work closely with smaller physician practices and patients to prevent and better manage multiple chronic health care conditions." Based in part on this recommendation, the Legislature passed the GO HELP bill (described in a preceding section of this narrative) which authorizes the GO HELP office to coordinate four expanded pilot programs:

(1) Chronic Care Model Pilots. -- This model shall focus on smaller physician practices. Primary care providers shall work with payers and providers to identify various disease states. Through the collaborative effort of the primary care provider and the payers and providers, programs shall be developed to improve management of agreed-upon conditions of the patient. Through this model, the primary care provider may utilize current practices of multi-payer workgroups. These groups shall be comprised of the medical directors of the major health care payers and the state payers along with medical providers and others.

(2) Individual Medical Homes Pilots. -- These pilots shall focus on larger physician practices. They shall seek certification from the National Committee on Quality Assurance. That initial certification will be Level I certification. This would be granted by virtue of certifying the provider is in the process of attaining certification and currently have met provisional standards as set by the National Committee on Quality Assurance. This provisional certification lasts only one year with no renewal.

(3) Community-Centered Medical Home Pilots. -- This approach shall link primary care practices with community health teams which would grow out of the current structure in place for federally qualified health centers. The community health teams shall include social and mental health workers, nurse practitioners, care coordinators and community health workers. These personnel largely exist in community hospitals, home health agencies and other settings. These pilots shall identify these resources as a separate team to collaborate with the primary care practices. The teams would focus on primary prevention such as smoking cessation programs and wellness interventions as well as working with the primary care practices to manage patients with multiple chronic conditions. Within this pilot all health care agencies are connected and share resources. Citizens can enter the system of care from any point and receive the most appropriate level of care or be directed to the most appropriate care. Any financial incentives in this model would involve all health care payers and could be used to encourage collaboration between primary care practices and the community health teams.

(4) Medical Homes for the Uninsured Pilots. -- These pilots shall focus on medical homes to serve the uninsured. They shall include various means of providing care to the uninsured with primary and preventative care. Through this mechanism, a variety of pilots may be developed that shall include screening, treatment of chronic disease and other aspects of primary care and prevention services. The pilots will be chosen based on their design meeting the requirements of this subsection and the resources available to provide these services.

Consistent with the strategic vision of the Governor and the policy directive of the Legislature embodied in GO HELP (and prior legislation seeking to expand coverage of the uninsured as outlined in the prior sections of this narrative), WV CONNECT seeks to demonstrate that significant improvement of the health of the uninsured population can be advanced through the creation of a legal/regulatory environment that permits the offering of affordable insurance with related products and programs that permit access to the health care system, particularly at the primary care level. A bill introduced during the most recent session of the Legislature would have created clinic-based plans that, for a monthly fee of not more than \$40, provided access to a designated list of primary and preventative services. This bill incorporated use of the administrative services of PEIA to reduce the participating clinics' overhead.

OIC believes that similarly-priced plans are possible, but that provision should also be made for the costs associated with medical problems that cannot be handled at the clinic level. Thus, the proposal as part of this WV CONNECT initiative is to combine two components into one product – essentially unlimited access to the primary care offered by a clinic for a capitated amount (Prepaid Clinic Plans), plus a layer of hospitalization insurance to cover larger medical problems (552 plans), with a target price of less than \$100 per month.¹ The legal and regulatory environment is currently receptive to such a product. OIC believes that the flexibility granted the Insurance Commissioner in her development of the 552 program will permit her to approve a proposal that covers only major medical if it either covers the preventative services mandated by the 552 statute (e.g. childhood immunizations) or is sold in conjunction with a Prepaid Clinic Plan that covers these services. Consideration is being given to embodying that concept in the 552 rules now out for comment.

The incorporation of a strong primary care focus (integrating medical home concepts) is justified by a number of national studies:

- The Commonwealth Fund 2006 Health Care Quality Survey showed that when adults have health insurance and access to a medical home—defined as timely, well-organized care with enhanced access to providers—racial and ethnic disparities are reduced or eliminated.

¹ A prepaid program was recently the subject of an article in the 6-6-09 NY Times http://www.nytimes.com/2009/06/07/health/07health.html?_r=1&scp=1&sq=Direct%20Practice&st=cse: “Dr. Sacks charges patients a direct monthly fee of \$54 to \$129 based on age, and she doesn't take insurance. Her office calls its philosophy “direct practice” because it's a direct contract between doctor and patient. But she advises patients to obtain insurance plans to cover large, unexpected health costs like those to treat cancer or a heart attack. “We say it's like having a car and paying for your own oil changes and tune-ups, but getting insurance in case you need a big repair,” she said. Dr. Garrison Bliss, who in 2007 founded the group where Dr. Sacks works, has offered direct-practice services since 1997. He says patients can save 15 to 40 percent of their medical costs by using this model, based on his examination of insurance rates and his belief that good primary care can fill most of a patient's needs. Insurance plans that cover every little thing can be very expensive, Dr. Bliss said. He said that a patient who paid an annual fee at his clinic and took out a higher-deductible insurance plan would usually come out ahead, even if the patient's health needs meant that he or she had to pay the entire deductible.

- In the United States, adults with a primary care physician had 33 percent lower health care costs and were 19 percent less likely to die from a manageable chronic care condition than were those who received care from a specialist (after adjustments for demographic and health characteristics).
- A Mercer analysis showed that North Carolina Community Care operations in State Fiscal Year 2004 saved \$244 million in overall healthcare costs for the state while improving overall health outcomes for select illnesses. Similar results were found in 2005 and 2006.

Design of benefit and coverage structure: The benefit and coverage design for WV CONNECT is premised on the work and recommendations of the Affordable Insurance Workgroup (AIW) described in prior sections of this narrative. The AIW report includes the following suggests which serve as the basis for designing the expansion of the Prepaid Clinical Plan with the limited benefit wrap-around: “The AIW spent a considerable amount of time attempting to develop a meaningful, non-employment based product for low income individuals. The target population for this product is the 58,600 uninsured non-elderly adults with total family annual income of between \$20,000 and \$30,000 a year (roughly 25% of the total uninsured non-elderly adults). The West Virginia Healthcare Survey completed in the winter of 2003/2004 indicates that 450,320 non-elderly adults (under 65) live in households with incomes at or under \$29,999. That level coincides with the income estimate for a family of four at 150% of the federal poverty level (\$29,025). Based on the information available to us, we worked to develop products that would carry a monthly premium of roughly \$100 to \$150, believing this to be a reasonably affordable product for our target population.”

“Low, and hence affordable, premiums can be obtained only by limiting benefits and/or increasing co-pays and deductibles. Our focus on creating affordable insurance has led us to craft two types of benefit packages that meet many (but not all) of the anticipated medical needs of most policyholders. The first type of plan – the Adult Basic Plan (ABP) – provides most standard insurance coverage, but caps the benefits available under the plan. The second type of plan – the Individual Health Access Plan (IHAP) – reduces cost by providing a benefit package that offers only preventive and primary care coverage, plus a minimal amount of hospital and out-patient coverage. A total of five versions of these two benefit plan frameworks are offered for consideration. For all the various plan options described, the following preventive services are covered, with no co-pay due from the insured: pap smears, prostate and colon cancer screenings, annual mammograms, well child examinations and immunizations, and adult routine examinations. These services do not count against any benefit or maximum cost limits specified for the individual plan options.”

All the plans described contemplate the use of PEIA provider reimbursement rates, and would be sold in the commercial marketplace by insurance companies interested in underwriting and marketing these products. A flat administrative expense of \$16.00 per member per month is included in the pricing of each of these products (an amount that is significantly less than the industry average of some 26 percent). For those plans described that include prescription drugs, the plans include a much lower co-pay for

generic drugs (\$5) as an incentive to encourage the use of generics. The use of emergency rooms is discouraged in the plans described below by the imposition of a \$100 co-pay for emergency room services if the individual is not admitted to the hospital.”

The price sensitivity work of Dr. Thorpe for his work in Vermont is also instructive in designing pricing models for low-income working families and considering the need for premium assistance on a sliding scale as outlined in the subsequent sections of this narrative. A report by Holahan, Hadley, and Blumberg from the Urban Institute examined health spending for low- and moderate-income individuals. According to their data, middle-income individuals typically pay 8.5 percent of their after-tax income for health insurance (including cost-sharing). Assuming that an affordability scale should be progressive, this research indicates that 8.5 percent of income spent on health care premiums should be the “upper bound” of the scale. Individuals and families with lower incomes should be expected to pay less than this amount. (J. Holahan, J. Hadley, and L. Blumberg, “Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts,” 2006.).

A study by Missouri in determining feasibility of coverage expansion indicates “research into health care reform in other states suggests that how affordability is defined and enacted into policy greatly affects the viability of the proposed programs. To accommodate variations in demographics, geography, and life circumstances, policymakers should consider the following when designing health coverage policies for Missouri:

- Any affordability schedule should utilize a progressive scale as incomes increase. A progressive sliding scale will prevent people with lower incomes from paying a disproportionately higher share of their income for health insurance.
- Research shows that many low-income people struggle to pay for basic necessities and are likely to have negative cash flow. Studies of household budgets in Missouri indicate that individuals below about 150 percent FPL (\$15,600) and families below about 200 percent FPL (\$35,200 for a family of three) may not earn enough to cover their basic needs. People at these income levels should pay only nominal amounts of health costs and will need public programs and subsidies to obtain insurance.
- A progressive sliding scale of affordability is needed. For those earning enough to make some contribution to their health care (although not necessarily the full cost), a sliding scale of affordability is recommended as a protection from financial hardship. In Missouri, this scale should progress from 1.8 percent to 8.5 percent of income for individuals earning between 150 and 500 percent FPL (\$15,600 and \$52,000).”

The planners of WV CONNECT have taken all of these concepts and findings into account to fashion assumptions for developing the implementation plan for the coverage expansion under WV CONNECT. Based upon the experiences of the Small Business, WVAccess and Prepaid Clinic Plans, together with the recommendations of the AIW and the survey results indicating \$100 is the threshold for employer willingness to pay for coverage, the targeted monthly cost for the Prepaid Plan and insurance wrap-around is \$90 per month. Actual cost will be determined by market response and pricing work to be done during the pre-implementation phase. The project plan also assumes a national

expansion of Medicaid to cover children, parents and pregnant women up to 150% of FPL and tax credits for childless parents up to 115% of FPL. Accordingly, the WV CONNECT initiative will be targeted for uninsured working adult parents between 150% and 250% of FPL and uninsured childless working adults between 115% and 250% of FPL. It is estimated (from the available Health Survey and other statistical surveys) that there are approximately 53,432 working individuals in this population. One of the pre-implementation activities is to update the Survey information to better identify individuals in this targeted class.

Health insurance premium assistance: The implementation plan contemplates a phased roll-up and that a portion of the requested SHAP grant funds will be used to provide premium assistance for the cost of the insurance overlay and the participant’s share of the Prepaid Clinic Plan, reducing the premium cost for low-income individuals and families and increasing the number of people with access to care through the combined Clinic Plan plus insurance wrap-around. As noted by a number of studies, expansion of coverage for low-income families does not appear to be viable in the absence of some subsidy or benefit design intervention. If commercial solutions were viable without such interventions, the rate of those with out insurance would already be lower. The exact nature and level of the premium assistance cannot be determined until the scope of the national reform efforts are known (for example, expansion of Medicaid up to 150% of FPL (or higher) as currently proposed under some national reform scenarios would obviate the need for addressing this segment of the uninsured population, but WV CONNECT could be used to implement this expansion in coordination with the WV Medicaid program and could cover the uninsured childless adults that are not eligible under the national expansion. For purposes of the developing the project plan and the project budget, the following scenario has been projected based upon the assumptions set forth above:

WV CONNECT	# Unins.	Prem.	Year One	Cost*	Premium
	Working Adults	Assist %	20% enrollment	\$1,080/yr	Assistance*
115% to 150% FPL*	17,840	60.0%	3,568	\$3,853,440	\$ 2,312,064
151% to 200% of FPL	21,356	30.0%	4,272	\$4,613,760	\$ 1,384,128
201% to 250% of FPL	14,236	15.0%	2,848	\$3,075,840	\$ 461,376
Total	53,432		10,688	\$11,543,040	\$ 4,157,568
			Year Two-Three		
			25% enrollment	\$1,120/yr	
115% to 150% FPL*	17,840	60.0%	4,460	\$4,995,200	\$ 2,997,120
151% to 200% of FPL	21,356	30.0%	5,340	\$5,980,800	\$ 1,794,240

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201% to 250% of FPL	14,236	15.0%	3,559	\$3,986,080	\$ 597,912
Total	53,432		13,359	\$14,962,080	\$ 5,389,272
			Year Four-Five		
			33% enrollment	\$1,200/yr	
115% to 150% FPL*	17,840	60.0%	5,941	\$ 7,129,200	\$ 4,277,520
151% to 200% of FPL	21,356	30.0%	7,112	\$ 8,534,400	\$ 2,560,320
201% to 250% of FPL	14,236	15.0%	4,740	\$ 5,688,000	\$ 853,200
Total	53,432		17,793	\$21,351,600	\$ 7,691,040

* Full first year cost calculated; however, for budget purposes assume 2/3 year for start-up.

The WV CONNECT project plan contemplates 29,867 uninsured working parents up to 150% of the FPL will be covered under a national Medicaid expansion. The project plan also contemplates that 18,842 uninsured childless working adults up to 115% of the FPL will also be covered under a national Medicaid expansion. The project plan contemplates that by the end of the 5 year project period, 40% of the 31,940 working uninsured adults above 250% of FPL will purchase self-funded coverage of at least a basic package (Prepaid and wrap-around) through WV CONNECT without need for premium assistance under this program. As noted above, the project plan contemplates that by the end of the 5 year project period, 17,793 of the estimated 53,432 uninsured working adults between the assumed Medicaid coverage threshold of 115% of FPL for childless adults and 150% of FPL for parents, up to 250% of FPL will be covered through WV CONNECT with premium assistance provided in part through the SHAP grant. Through the combination of these programs, the percentage of uninsured working adults covered with some health insurance coverage at the end of the project period will be near 55%, a reduction of over one-third in the total number of uninsured in the State.

The foregoing costs can be compared to the overall cost projected for covering all of the uninsured and the various segments using the estimated costs for the Basic Prepaid Clinic cost (average of \$40/mo), the limited package (\$90/mo) and comprehensive (\$400/mo) to demonstrate the need to phase-in coverage:

West Virginia Coverage Expansion Worksheet		Annual	Annual	Annual
Cost computations	Covered	Total cost	Total cost	Total cost
Category:	Lives	Primary care	Ltd package	Comprehensive
		\$40/mo - \$488/yr	\$90/mo - \$1,080/yr	\$400/mo - \$4,800/yr
Total uninsured	236,174	\$115,252,912	\$255,067,920	\$1,133,635,200
Working uninsured	144,302	\$70,419,376	\$155,846,160	\$692,649,600
Working uninsured to 100% FPL	44,734	\$21,830,192	\$48,312,720	\$214,123,200
Working uninsured	53,392	\$26,055,296	\$57,663,360	\$256,281,600

100% to 200% FPL				
Working uninsured over 200% FPL	46,176	\$22,533,888	\$49,870,080	\$221,644,800

Coordination with GO HELP and authorizing legislation: This grant application is being submitted prior to the effect date of the GO HELP legislation (August 26, 2009). Accordingly, GO HELP has not been formed, nor has a director of this office been appointed by the Governor at this time; as a practical matter, GO HELP cannot be made a party to the application at this time, but all of the activities of WV CONNECT will be coordinated with GO HELP subsequent to creation of that office. It does not appear that any additional legislation will be needed to effectuate this portion of WV CONNECT (depending upon the nature and scope of any federal health care reform that may impact this aspect of the project).

Coordination with WVHII and the Medical Home model: The work of the West Virginia Health Improvement Institute has been detailed in previous sections of this narrative. Given the number of individuals with anticipated expanded coverage under the project plan and the prevalence of chronic disease in the general population (as previously discussed), it is vitally important that this initiative be carefully coordinated with the ongoing Medical Home and chronic disease management efforts being directed by and through the Innovation Community of the WVHII. A number of the pilot projects planned and underway within the WVHII will complement the aspects of the WV CONNECT effort and the project plan contemplates using WVHII to coordinate many of the linkage activities to support connection to a medical home for the uninsured that will be participating through WV CONNECT in this project. A portion of the project budget (and requested grant funds) will be used to establish this linkage. It is also contemplated that WVHII will oversee and coordinate the evaluation of the project related to health improvement and impact on outcomes for the uninsured that are extended coverage through the project. This will also necessitate linkage with the WVHII initiatives encouraging use of HIT for health improvement.

Medical homes and HIT: The recent enactment of the American Recovery and Reinvestment Act of 2009 (ARRA) has provided additional funding opportunities for states to support the medical home infrastructure through HIT and information sharing. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the ARRA, authorized roughly \$36 billion in federal outlays over six years for HIT. This Act requires the implementation of a policy framework to support the design, development and operation of a nationwide HIT infrastructure to allow the electronic use and exchange of health care information with the goal to avail each U.S. citizen an electronic health record by 2014. Part of the WV CONNECT project plan is to use HIT systems as part of the connector infrastructure. The project also leverages prior investments in HIT through the Medicaid Transformation grants (MTG) awarded pursuant to the Deficit Reduction Act of 2005 (DRA). Out of 42 MTG grants awarded, West Virginia is one of just eight states that have chosen to use MTG funds to develop the technology infrastructure for medical home programs.

Medical homes, personal health records and health information exchange: To compliment the adoption of EHRs by medical home practices, WV CONNECT will accommodate the integration of personal health records (PHRs) for project participants. Personal health records not only aid in care coordination and health management, but they can also serve as an important self-management tool and facilitate interaction with the patient's medical home care team. Research indicates that adoption of HIT and use of PHRs can result in significant cost saving that can be reinvested in access to care. Most individuals want electronic access to health information: 66% surveyed prefer electronic access to their health records and 70% surveyed want access to health records to check for errors.

To facilitate the development of a health information exchange system in the state, the West Virginia Health Information Network ("WVHIN") was established in 2006 by the Legislature at the request of the Governor to promote the design, implementation, operation and maintenance of a fully interoperable statewide network of health care organizations. The WVHIN was recently awarded funding under the Nationwide Health Information Network (NHIN) 2 initiative to continue these interoperability efforts. WV CONNECT would also permit integration with the WVHIN through the clinical portal to facilitate another avenue for health information exchange.

WV CONNECT- Part Three: Use of HIT and centralized clinical portal: West Virginia is one of the leaders in HIT adoption, particularly in the area of open source solutions. The State of West Virginia has implemented "Open Vista" (an adaptation of the Veteran Administration's "Veterans Health Information Systems and Technology Architecture" ("Vista") open-source software) in seven state-run facilities. Every State healthcare facility in West Virginia's network of acute, long-term and ambulatory treatment centers now has an open source electronic health records system. This is in addition to the 4 VA hospitals in West Virginia that also use Vista. The West Virginia Primary Network, Inc., dba Community Health Network of West Virginia (CHNWV) (a HRSA grantee) is the first health-center controlled network in the country to successfully adapt a version of the Resource and Patient Management System ("RPMS") open-source clinical information system used by Indian Health Service ("IHS") for use in the community health center setting. The RPMS system is also an adapted version of Vista. RPMS is currently being used by CHNWV members in 27 clinical locations for over 50,000 patients; both numbers are expected to double by the end of 2009. Other community health centers have adopted Healthe WV through Wheeling Jesuit University or are using other commercial EHRs. Collectively, by the end of 2009, it is projected that 70% of all community health centers in West Virginia will have an EHR (compared to the national average of less than 20%). This is another compelling reason to use these organizations as the hub for the community-based provider network under the project plan.

With HIT adoption being strongly supported through incentives in the ARRA and with the stated goal of facilitating use of personal health records by every citizen by 2014, the WV CONNECT project offers an opportunity to leverage these investments through creation of a clinical portal to allow providers participating in the Prepaid Clinic/Wrap-

around coverage initiative to submit service and clinical information that is needed to properly evaluate the effectiveness of the program on improving the health of the uninsured receiving coverage through the project. The portal can also serve as an exchange to facilitate the population of personal health records for patients. The portal can be linked to the medication management portal being developed by the State Medicaid program. As part of the Medicaid redesign and transformation initiative, the Medicaid Program is creating a web-portal that will allow prescribers and pharmacists to view medical and pharmacy claims as they are submitted, allowing Medicaid providers to view their patient's medical and pharmacy history. The linkage of these portals will provide payers, providers and patients with a more robust picture of the health of participating patients and the appropriate care management needed to keep them healthy.

A portion of the HRSA SHAP grant funds will be used to design the clinical portal functions of WV CONNECT to coordinate with WVHIN and Medicaid as these systems for health information exchange develop. One of the evaluation weaknesses of the current system is there is a limited database to evaluate the impact of the coverage expansion on the health of the uninsured and their utilization of health care services. Since the uninsured do not have health insurance, analysis of "claims data" is of limited use. While the West Virginia Health Care Authority has a significant data base for hospital use, there is not a corresponding reliable data base for tracking ambulatory care.

By facilitating real time submission of clinical data through the WV CONNECT portal data can be gathered, sorted and analyzed to determine the impact of the program on access to care, outcomes, reduced inappropriate use of ER and hospital services, access to medications and compliance with medication management, use of preventive services and chronic care management needs of the uninsured.

No part of the requested SHAP funds will be duplicative of or displace any ARRA or other funding for health information exchange and the implementation plan for this part of the program will be adapted to the plans of GO HELP and WVHIN as those are developed in conjunction with the WV Medicaid program and others in concert with national HIT initiatives. The technology components of WV CONNECT will also be coordinated with the WV Office of Technology and the State's Chief Technology Officer, Kyle Schafer. The implementation of this portion of the project is not expected to require any additional legislation (depending upon the nature and scope of any federal health care reform that may impact this aspect of the project).

Project plan for implement and financing of start up costs of the health care coverage expansion program: The project plan calls for a phased approach. The first year will be used to create the infrastructure for the expansion project. The OIC will engage one or more consultants to assist with the design of the health insurance exchange depending on the scope of national health care reform and the nature of any national exchange structure. WVDHHR will coordinate with the West Virginia Health Improvement Institute the engagement of the medical home community to enroll the provider network for the expansion of the Prepaid Clinic Model in coordination with the OIC, who will develop the limited benefit wrap-around with licensed carriers. These

organizations will work with one or more contractors to develop the technical infrastructure, including web-portals and video links (with the cooperation of the West Virginia Telehealth Alliance) contemplated in the project plan. WVDHHR will also engage one or more contractors to assist with the design of the clinical portal in collaboration with the State Medicaid program, the West Virginia Health Care Authority, the WVHIN, GO HELP and the OIC. WVDHHR will also engage one or more contractors to assist with the Evaluation process and data collection, management and analysis to meet the project evaluation goals and to assist with periodic reporting of the outcomes of the project.

It is contemplated that each of the project implementation action steps will be coordinated among the participants according to the Workplan. The first year of the project will require planning and development of infrastructure based upon the pilots and evaluation that serve as the foundation for the WV CONNECT initiative. The parameters for the implementation of WV CONNECT will need to be adjusted and adapted to the proposed national health reform measures and synchronized with the time frame for implementation of these measures. It is contemplated that the infrastructure and development phase of the WV CONNECT project will be phased in over the first 18 to 24 months of the project period. The targeted population of uninsured (as identified above) will be evaluated and the categorization of this population will be updated through surveying and other sampling techniques. The strategy to engage this community through outreach, enrollment and education will be refined to permit implementation of the program to begin as projected. The enrollment of the targeted population will be enrolled in phases to permit refinement and expansion of the program as the results of each phase of the project are evaluated and the process is improved based upon the experiences of each phase.

The start-up costs for the WV CONNECT program will be financed through the SHAP funds as outlined in the budget narrative and through matching sources of State appropriations, in-kind support and participant contributions (i.e., exchange fees, participant costs for sliding fee coverage and health care access represented by any co-pays or deductible payments, registration and enrollment fees). The exact nature of these costs and funds are set forth in more detail in the project budget narrative.

Plan for meeting the twenty (20) percent matching requirement: The grant's twenty percent matching requirement can be met based upon existing sources of state appropriations to support the program and thus the projected participant contributions and in-kind support will only enhance the program viability and long-term sustainability and can be used to offset any reduction in future appropriations. The SHAP grant funds will not be used to take the place of current funding for any activities described in the project plan. No part of the requested SHAP grant funds will be used to supplant current activities or the funding of personnel costs. The sources of the 20 percent match include over \$1 million in funding for the program in the OIC budget and over \$1 million in funding for uncompensated care activities in support of the uninsured in the WVDHHR budget. Under state law, each appropriation is annual and is subject to continuing appropriations by the Legislature in future budgets; however, the appropriations in

question have been in the State budget for some time and the Legislature has demonstrated continuing support for expansion of coverage of the uninsured, as evidenced by the legislation highlighted in this narrative and the most recent GO HELP legislation.

Uses of SHAP grant funds to support and enhance the implementation of the State's health care coverage program expansion: The SHAP grant funds are an essential part of the WV CONNECT project plan. The requested grant funds will complement and leverage the existing State support for the initiative and the prior investment of HRSA grant funds for the State Planning activities that are the foundation for the expansion efforts. The SHAP grant funds will permit the development of vital infrastructure, programmatically and through technology to support the on-going efforts and also permit coverage subsidies to jump-start the coverage expansion for uninsured low-income working families. The SHAP funds will also leverage the ARRA funds that are being invested in HIT at the provider level to permit greater efficiencies within the health care delivery system that can be reinvested to sustain the coverage initiative when the SHAP grant funds are exhausted. Most of the SHAP grant funds will be used for one-time or start-up costs so the program can be continued from operational revenue and existing State appropriations after the SHAP grant funds are exhausted.

Status of necessary State and local statutory or regulatory changes required to implement the health care coverage expansion program: These issues have been addressed in the prior sections of the narrative. There is sufficient statutory and regulatory authority to implement the WV CONNECT program without changes; however, changes and additional authority may be necessitated by pending national health care reform legislation and the Governor and Legislature have created a framework with the recently enacted GO HELP legislation that will facilitate any addition changes that may be required.

Description of existing critical program components and timetable of pre-implementation, implementation and post-implementation tasks for WV CONNECT: The existing critical program components have been described throughout the narrative and consist of the prior work of the Health Policy Institute's Surveys to identify the nature and scope of the challenges facing those without health insurance, and the work of the Affordable Insurance Workgroup and legislative workgroups in developing the programmatic framework (within the OIC and WVDHHR) for implementation of the program, along with the work of the West Virginia Health Improvement Institute (WVHII) (funded through Medicaid Transformation Grants) in organizing medical homes to be used as part of the project implementation. The work of the WVHIN and various workgroup of the WVHII focused on the adoption and use of HIT for health improvement and use of the medical home model have set the stage for implementation of the project plan related to health improvement. The tasks associated with implementation of WV CONNECT, including the pre- and post-implementation activities have been outlined throughout the narrative and are set forth in the Workplan. The timeline for these tasks is also set forth in the Workplan.

Plan for maximizing enrollment to those eligible: To extend health insurance and access to health care to the maximum number of eligible uninsured individuals, the WV CONNECT plan contemplates using outreach and enrollment programs with a phased approach to leverage available resources. As noted in other sections of the narrative, providing comprehensive coverage to all of the currently uninsured residents has an associated price tag of over \$1 billion and is only possible if national health care reform expands the avenues to accomplish this objective. The WV CONNECT plan is to connect as many uninsured individuals as possible through the exchange to at least basic, primary and preventive coverage as can be accomplished within program resources. As national incentives for HIT adoption by providers commence in 2011, savings from system efficiencies that are expected can be reinvested by payers and other health system participants to continue the expansion efforts. The project plan contemplates using community health centers as the focal point for initial enrollment since most of these centers already serve as the connection point to care for the uninsured. By using the existing usual sources of care for the uninsured as enrollment points (CHCs, free clinics, rural health clinics, rural hospitals) and by using out-stationed outreach and enrollment coordinators, the program is intended to maximize enrollment for eligible participants. By also using these same sources and through the education and outreach efforts contemplated in the plan, the program also seeks through the linkage of uninsured with a community-based medical home (in concert with the on-going-educational efforts of the provider community by the West Virginia Health Improvement Institute) to assist those uninsured that are currently “medically homeless” and to connect them to coverage (within program resources).

Agencies/individuals responsible for completing project tasks and methods for managing progress and delays; private and public collaborators, contractors, and/or supporters to be involved in the program and process for decision-making in implementing the proposed program: The lead agency, WVDHHR will be responsible for overall management of the project. The lead agency, under the direction of the Office of the Secretary, will designate a project Steering Committee consisting of representatives of the collaborating organizations, including the OIC, the Medicaid program, the West Virginia Health Improvement Institute, the Health Care Authority and WVHIN, the West Virginia Telehealth Alliance, the Office of Technology and Chief Technology Officer, GO HELP (and others as appropriate). Contractors will be retained as needed to complete the tasks contemplated in the project plan to complement the resources within the organizations of the collaborating public and private participants. Contractors will be selected and retained based upon experience and qualifications relative to the assigned tasks and scope of work for which they are being sought to provide services as part of the project implementation. Representatives of participating health insurance carriers may be utilized by the OIC to assist in the formation and operation of the health insurance exchange segment of WV CONNECT. The Project Team shall assist in administering the program, while the Steering Committee shall provide strategic guidance on program implementation.

Each participating organization will designate a project coordinator that will be responsible to the Steering Committee for assuring that the project tasks and assignments

under the Workplan are completed in a timely fashion in accordance with the project budget. The Steering Committee will make recommendations for the resolution of any project delays or impasses that may arise, and these issues will be coordinated with GO HELP as contemplated by statute, but the final resolution lies with the lead agency (with respect to all issues pertaining to administration of the SHAP grant and use of grant funds) and the Office of the Secretary of WVDHHR. The Secretary may resolve such issues in consultation with the Governor to assure consistency in the administration of the program with the Governor's strategic vision for health care policy. The lead agency will also be responsible for preparation and submission of all progress and other reports due for the grant in a timely fashion. The WVDHHR office of Grants Management, which works closely with HRSA on a number of grants to the State, will oversee preparation and submission of all required reports and will administer all audit and supervisory responsibilities in accounting for grant fund disbursement. WVDHHR will also work closely with HRSA staff to comply with audit requirements of the Office of Management and Budget (OMB) Circular A-133, submit Payment Management System Quarterly Reports, submit a Financial Status Report (FSR) within 90 days of the end of the grant period, and submit all required reports to HRSA and HRSA contractors in a timely fashion, following the prescribed HRSA formats. The lead agency may use the resources of the Steering Committee and/or one or more contractors, including the West Virginia Health Improvement Institute and the evaluation team retained to perform the evaluation of the program, to assist in the preparation and submission of the required reports.

Strategies to enhance the utility of the HRSA-funded program and to produce information to share with other States, e.g. implementation guidelines, program materials, and software, as applicable: The WV CONNECT program intends to operate in totally transparent fashion and to make all information (other than personal protected health information) available for replication and use by others wishing to leverage the HRSA investment to support similar expansion efforts in other states. The project intends to build technology solutions using public domain or open-source solutions that can be easily replication and transferred to other States (consistent with the extensive utilization of public-domain and open source HIT solutions as part of the State's EHR/HIE technology infrastructure). It is contemplated that the websites and portals can be easily replicated by other States (or hosted as part of a multi-state collaboration).and that tools used to support enrollment, outreach, education and provider network development will be posted for other States to use. The State also intends to develop materials and contribute white-papers and tools to any national compendium of coverage expansion resources. It is also anticipated that the Insurance Commissioner, Medicaid Commissioner and other public officials will have opportunity to make presentations to their respective national organizations on the West Virginia efforts and lessons learned from implementation of WV CONNECT.

Relationship of project to the goals of the Healthy People 2010 initiative: *Healthy People 2010* represents a comprehensive set of disease prevention and health promotion objectives set as a national priority with two overarching goals: 1. Increase quality and years of healthy life 2. Eliminate health disparities. The health improvement aspects of the coverage expansion project is consistent with both of these

primary goals through focused prevention efforts and patient self management of chronic conditions and use of medical homes to eliminate health disparities. WV CONNECT project goals are consistent and supportive of the Healthy People 2010 initiative at both the federal and state level.

Cultural and linguistic issues: Nationally, racial or ethnic minorities are disproportionately impacted by access to health insurance. At the national level, of the 45.7 uninsured Americans, over half are a racial or ethnic minority. In designing WV CONNECT, cultural issues are less significant since West Virginia has a very homogeneous population compared to the overall population of the United States:

Population Distribution by Race/Ethnicity, (2006-2007)				
	WV		US	
	#	%	#	%
White	1,706,090	95%	196,128,710	66%
Black	57,120	3%	36,259,720	12%
Hispanic	7,460	0%	45,949,210	15%
Other	31,240	2%	19,877,720	7%
Total	1,801,920	100%	298,215,360	100%

West Virginia’s population is 94.6 percent Caucasian, 3.2 percent African-American , 0.5 percent Asian, 0.2 percent American Indian or Alaska native, and 0.2 percent other ethnicity. About 0.7 percent of the population is of Hispanic/Latino origin. Provision will be made in the enrollment, education and outreach materials, including the development of web-based tools, to include translated versions of the materials and to make translation services available for communication within the program for individuals for whom English is not a native language.

Although racial minorities do not make up a significant segment of the overall population in West Virginia, there are significant concentrations of minority populations within the state – for example 21.6% of the state’s 57,323 Black Americans reside in just two West Virginia counties: Raleigh and McDowell. The Health Policy Institute studies demonstrate that there are significant health disparity issues that should be addressed as part of the WV CONNECT implementation plan. For example, according to the Healthcare Survey results:

For Black Children (Ages 0-18) in Raleigh and McDowell counties:

They were much more likely than other children to have Medicaid (57.5% versus 39.8%), but less likely to have CHIP (2.5% versus 4.9%); they are more likely to insured (4.5% of Black American children were uninsured, compared to 10.4% of other children in these counties); they are more likely to live in low-income situations (24.9% lived in households with incomes less than \$10,000, compared to 15.5% of other children); and they were more likely to have been diagnosed with a chronic health condition or disability (19.8% versus 14.1%).

For Black Adults (Ages 19-64) in these counties:

They were less likely to have a usual healthcare provider (82.1% versus 88.3%); more likely to list a hospital emergency room (5.5% versus 1.8%) and a community health center or free clinic (25.4% versus 20.5%) as their usual site of care; lived in households with lower incomes: 25.3% had incomes below \$10,000 (compared to 13.2%) and 65.9% had incomes below 200% of the federal poverty level (compared to 48.7%); were more likely to be uninsured (23.6% versus 18.5%); and more likely than other adults to mention, “could not get an appointment” (14.4% versus 0.7%), “transportation” (3.6% versus 0%), and “provider not open when available” (2.6% versus 1.4%), as reasons for not receiving care.

These results are instructive in taking into account cultural issues in the design and implementation of the WV CONNECT program. It is the intent of the WVDHHR Office of the Secretary to include representatives of the Minority Health programs within WVDHHR in the Steering Committee activities and to work with advocacy and outreach groups during the implementation process to assure that cultural issues are appropriately addressed for the project.

Commitment to serving, and experience with culture and literacy levels of, the specific target population: In addition to the steps previously outlined, the health care organizations to be utilized in the community-based medical home network have a long history of providing service to medically underserved and chronically-ill residents. The health centers, free clinics and rural clinics have traditionally served as the usual source of care for many of these uninsured individuals and include community outreach to integrate faith-based and other community resources into the local continuum of care. The community health centers that are to serve as the anchors for this network of care have social and outreach workers and other trained professionals to address specific behavioral and economic issues, such as patient assistance programs to help with individuals who can't afford medications or those with health literacy issues. Because most staff members of these community-based health care organizations reside in the communities served, there is a more personalized sensitivity to addressing these cultural and literacy (including health literacy) issues (and barriers to care) in an appropriate and compassionate fashion.

All of the staff providing education and outreach and servicing those utilizing WV CONNECT will be trained in cultural and literacy sensitivity and will be given access to resources for those needing communication or translation assistance (it is anticipated that these services will be contracted through one or more of the State's institutions of higher education). Options will also be provided for those that are visually or hearing impaired in all of the WV CONNECT portals and customer interaction tools.

Sustainability of the program at the end of the five year grant period: As duly noted throughout this narrative, the WV CONNECT project and implementation plan uses a phased approach that builds the infrastructure and enrollment in the program in a gradual fashion over the initial five years of the SHAP grant. The SHAP grant funds will be used in concert with the matching appropriations, contributions and participant fees to build the infrastructure and launch the program. The majority of the SHAP funds will be used

for premium assistance during the initial launch and ramp-up of the program. As coverage is expanded on a national level, funds that are currently being spent to sustain uninsured through grants can be redirected into the WV CONNECT program. It is also contemplated that fees for use of the health information exchange will increase if coverage becomes mandatory at the federal level and as the WV CONNECT program demonstrates value and benefit to those using the service.

As efficiencies are recognized through health system improvements through HIT investments and medical home transformation, the cost savings to the State (in PEIA and Medicaid (related to the State's share)) can be reinvested to sustain the program. Lessened inappropriate use of ER facilities, reduced costs for avoidable hospitalizations and avoided complications for preventable complications of chronic conditions will not only support the WV CONNECT effort after the SHAP grant funds are exhausted, but these enhancements will also make health care more affordable and protect the coverage availability for those that currently have health insurance. By using the health insurance exchange to assist individuals and small businesses to access health care coverage options in a more organized and cost-effective fashion, it is anticipated that coverage rates can be maintained or improved and jobs can be preserved (since benefit costs continue to escalate under the current system and become a significant portion of overall employment costs – particularly for older workers that may be eligible for post-retirement coverage that must be included in financial reporting of OPEB (other post-employment benefit costs) for financial disclosure reporting purposes.

The implementation plan and budget project declining reliance on SHAP grant funds over the project period and a clear path to financial sustainability once the grant funds have been exhausted. The financing of WV CONNECT after the project period for the grant is reflected in the projected budget set forth in the budget narrative attached.

EVALUATION PLAN:

Description of the indicators to be measured and how they will be captured systematically to demonstrate the value provided by the HRSA grant to the overall implementation of the State's health care coverage expansion program: Evaluation design: In accordance with the grant guidance, the WV CONNECT project has identified a balanced set of performance indicators (process and outcome) that will be used to evaluate the effectiveness of the project and its implementation. These include: 1. Purchase of health insurance by previously uninsured through WV CONNECT; 2. Increased access to primary health care services for previously uninsured that utilize WV CONNECT to secure coverage; 3. Number of individuals that use WV CONNECT to assist with a health insurance purchasing decision or for information about health insurance coverage options; 4. Lead time between contact with WV CONNECT and enrollment in health coverage; 5. Response time for inquiries from customers of WV CONNECT; and 6. Percentage of implementation activities for the project accomplished on-time and on-budget. The evaluation process will also measure and document the extent to which having information more readily available through WV CONNECT influences coverage for those that are eligible to participate and the extent to which the

premium assistance program was a determining factor for those engaging coverage through the Prepaid Clinic/Wrap-around product.

For each of the project components (exchange, medical home and premium assistance and clinical portal), a cost-benefit analysis will be completed during each year of the project period to determine the value of the SHAP grant funds in successfully implementing and managing the project and the contribution of those funds to the strategic objectives of the project.

Methods: The research will be conducted on a prospective basis through extraction and analysis of data from the sources described below. The evaluation team may also use outside data to evaluate impact of the program on coverage rates and health care utilization, such as hospitalizations, emergency room utilization, specialty care and overall medication cost to determine the cost-benefit of access to health care services afforded through the program. The effectiveness of certain training and education programs for staff and contractors of WV CONNECT will be evaluated through assessment tools and evaluation studies.

The evaluation will assess the transition process to coverage and the individual learning process (and barriers) to connecting uninsured individuals to coverage and a community-based medical home. The evaluation will also examine the degree to which use of the various technology tools contributed to project objectives and any weaknesses that need to be addressed through technology enhancements or process changes.

Data collection and analysis: Data will be gathered from Web-based tools will include counters to determine the frequencies of use by prospective purchasers of insurance to the exchange and other WV CONNECT portals. Clinical information to establish baseline and key clinical indicators of primary prevention services (based upon appropriate evidence-based outcome measures from HRSA and other sources) will be integrated into the clinical portal to be established as part of the project. Where necessary to establish baseline or comparative information, data may be gathered by audit or review of paper or electronic records of the program based upon statistically-valid sampling techniques. The WVHII will coordinate much of the clinical aspect of the evaluation. Information about price sensitivity and demographics of those using the exchange and WV CONNECT tools will be gathered from registration information and from customer service staff assigned to the project. Information concerning the impact of WV CONNECT on the take-up of coverage and access to primary care will also be gathered by surveying customers and providers participating in the provider network. Time studies may also be employed if necessary to establish time and/or cost savings associated with use of technology tools to administer the project. One or more data analysts may be used on a contract basis to help evaluate the data gathered as part of the evaluation process.

Data will be analyzed for those purchasing coverage through the exchange and those that participate in the Prepaid Clinic/Wrap-around program. Program staff will also be surveyed to determine effectiveness of outreach and education efforts, to determine barriers, particularly those that are cultural or lingual, that impede the effectiveness of the

program. Surveys will also be conducted of uninsured at CHCs and other participating health care organizations, or of those that frequently use a non-provider network source (such as a hospital ER) to determine the reasons for non-enrollment in the Prepaid Clinic/Wrap-around program or non-use of the WV CONNECT resources.

Rationale to support the proposed process evaluation plan to assess implementation and completion of key tasks and project milestones during the 5 year HRSA-funded project period: Evaluation and program monitoring will be integral parts of the WV CONNECT implementation process. Data collection and evaluation will permit project managers and participants to determine the extent to which project goals and objectives are met in a timely fashion and the contribution of project activities to increased access to and actual purchase of health insurance coverage. Using the resources of the various participants together with data from the OIC and other state and national reporting services, the project leaders will be able to quantitatively describe and compare statewide health care coverage characteristics pre- and post-implementation. Using data collected from the health insurance exchange and clinical portal will also permit evaluation of the effectiveness of outreach and education on coverage expansion and access to health care services through expanded coverage on the health status of those who have been uninsured. Data collected from the multiple sources participating in the project will permit project managers to continuously monitor and evaluate the results of its efforts to increase health care coverage over time, as well as monitoring progress toward accomplishing the key project-related Healthy People 2010 goals, with the following objectives in mind:

- Increase the proportion of persons with health insurance.
- Increase the proportion of persons who have a medical home as a specific source of on-going care.
- Reduce the proportion of individuals that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

Continuous program monitoring is needed to ensure the project is managed properly, is on track, is within budget, and is mitigating project risks. WVDHHR, as the lead agency, will be responsible for the overall direction of grant activities. The grant will be carefully monitored to ensure that project activities are implemented according to the project plan and expected outcomes are attained. Accurate assessments, measurements, and ongoing evaluation of project results are critical to the project's success.

Anticipated results and timelines for each project activity are identified in the Workplan. The impact of the project will be determined by actual outcomes (contrasted with anticipated results). The evaluation team will assess the degree to which:

- Project activities are accomplished as outlined in the Workplan;
- Project objectives are accomplished within established timeline and in accordance with the project budget;
- Project outcomes meet or exceed expected outcomes;
- Contractor performance expectations are met;
- Data collection and analysis is conducted to permit appropriate meaningful assessment of the degree to which project goals and objectives have been met (and in the

event of shortcomings, the reasons, barriers and opportunities for solutions to address these shortcomings);

- Surveys and evaluation mechanisms are in place to evaluate specific program components and the overall project plan.

The monitoring process will identify and provide a mechanism to report any activities that are behind or ahead, any unexpected delays, or any issues or problems that were encountered in accomplishing the activities. The process will include an evaluation of problem solutions and implications for future activities.

Post-grant evaluation of the program's impact after the project period, including responsiveness to meeting the needs of the uninsured and to responsiveness to making the changes needed: The evaluation process will be ongoing and will continue to address the effectiveness of the project after the grant period ends. It is anticipated that the project team will make periodic reports of the progress of the project to key stakeholders, including the Governor, the Legislature and interested parties such as advocacy and public interest groups supporting expansion of coverage. The GO HELP legislation provides another avenue of on-going support and evaluation of the project, post-implementation and after the grant project period. The impact of this initiative and the responsiveness to the needs of the uninsured will be constantly evaluated by State leaders annually during the Legislative session since the project is intended to have a significant impact on future health care costs and access to care (positively impacting State costs associated with lack of access to health insurance).

WORK PLAN:

The Workplan is attached in Attachment 3 and the activities and actions steps are detailed in the Workplan. The Workplan also includes a timeline and responsible staff for the phases of the project. A chart reflecting the organization of the project team is attached as Attachment 7.

Project Governance: Governor Joe Manchin will provide political leadership and support to the continuation of WV CONNECT to increase access to health care coverage and to assure that implementation of the program is consistent with state health policy and budget priorities. The Governor has designated the West Virginia Department of Health and Human Resources (WVDHHR) as the lead agency to act on behalf of the State and to administer the HRSA SHAP grant if awarded. As the largest agency in West Virginia state government, WVDHHR has a wealth of resources to support the objectives of the project. As noted in preceding sections of the narrative, WVDHHR administers a number of programs that benefit and touch the uninsured and there is a significant connection for many low-income working families to DHHR services. It is only natural for DHHR and Secretary Martha Walker to oversee this initiative. DHHR and the Office of the Insurance Commissioner have a long tradition of collaboration on key health initiatives and Secretary Walker and Commissioner Cline has a long-established working relationship from prior service together in State government and Legislative roles. Each of the agencies has highly skilled and experienced staff upon which to draw to fulfill the needs of the project. In addition, both agencies have excellent

working relationships with other State agencies and outside parties, such as the insurance companies and health care providers that are essential components of the project plan. The Secretary of DHHR and the Commissioner of Insurance have signed an interagency memorandum, expressing the general understanding of the agencies relative to the collaboration anticipated in the project plan and this agreement will be expanded prior to implementation to include all of the terms and condition associated with the HRSA grant funds, if awarded. See Attachment 6.

As the lead agency for this project, DHHR will maintain overall direction and responsibility for the project. The agency provides the ideal, supportive environment to lead this project, since it includes the HRSA-funded Division of Primary Care, whose mission is to increase access to primary care services, as well as a well-versed grants management section that administers a number of HRSA- and CMS-funded federal grants.

The DHHR project liaison will be Gerald Roueche, Assistant to Secretary Walker. Mr. Roueche will be accountable to Secretary Walker and responsible for coordinating the interaction between DHHR and OIC, with Bill Kenny, Deputy Commissioner of OIC, who reports directly to Commissioner Cline. Tara Buckner, CFO of DHHR will serve as the grants manager and she and her staff in DHHR Grants Management will oversee financial administration of the grant. Nancy Maleček, Insurance Market Analyst in the Research and Executive Division of the OIC will serve as overall project coordinator to assist the Project Team with various coordination activities and will oversee data collection and analysis, actuarial studies, and policy analysis work. The project contemplates use of contractors, including the West Virginia Health Improvement Institute and the West Virginia Telehealth Alliance, the West Virginia Health Policy Research Institute to perform certain project functions as contractors and/or sub-recipients.

The proposed budget and detailed justification for the project are included in the grant application. The budget is reasonable for the project and supports the project management plan and program goals. Budget and fiscal staff from the lead agency, DHHR will provide technical assistance and oversight to the grant director. DHHR will maintain a financial management system that operates in accordance with existing state and federal laws and regulations. The system will provide complete and accurate funds control and will have adequate internal controls to ensure that project funds are being properly expended and accounted for, and comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Timely and efficient access to financial information about the grant will be provided upon request.

Periodic Reports on the outcomes and lessons learned from program activities to HRSA. As noted elsewhere in the project narrative, the project team will submit periodic progress reports on the implementation of the project and post on the WV CONNECT website, tools and materials that would assist other States in implementing a similar program. The project team will also compile, from project staff, consultants and external sources such as participating carriers, customers and health care providers in the

provider network, a series of lessons learned, best practices and real life stories to reflect the impact of the program on the uninsured (with appropriate safeguards for the privacy of personal information and the appropriate consents to use real stories).

RESOLUTION OF CHALLENGES

Discuss challenges that are likely to be encountered in implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.

The WV CONNECT project is bold, ambitious and innovative. The project planning team, consisting of representatives of DHHR, OIC, WVTA and WVHII, along with consultations of HPRI, recognizes that implementing an expanded coverage initiative in the midst of an economic recession and significant national health care reform is a daunting endeavor and will require great coordination and collaboration. Despite the planning and preparation for this undertaking, there will be unintended consequences and unforeseen obstacles. Some organizations and groups may express opposition by urging delay as a path to avoid the impact of the project on current business arrangements. The participants recognize that for the more than 140,000 working West Virginians without health insurance, the status quo is not an option and the parties will use a collaborative decision making process, as outlined in other sections of this narrative, to resolve delays, address unforeseen circumstances, respond to changes in market conditions or in available health care resources to accomplish the project objectives.

It is the job of the project leaders to set reasonably high expectations for the long term with the understanding that there will be a series of short-term challenges and to encourage constructive suggestions from the participants to work through these challenges. The DHHR and OIC will provide strategic guidance and leadership to keep the focus on expanding access to coverage and to achieve intended health improvement for the uninsured. Project participants will be encouraged to express opinions openly, to treat other participants with respect and to operate in an open, collaborative, transparent fashion. Project teams will be reminded and expected to stay focused on the aim of the project, but not to lose the possible in search of the perfect implementation plan.

The project will also create economies of scale from activities other than the HIT innovation; for example, integration will result in collaborative clinical protocol development, shared training resources and centralized information technology staff. Most importantly the HIT innovations described in this narrative will improve patient health outcomes and support population-based health improvement using the community-oriented primary care delivery model.

EVALUATION AND TECHNICAL SUPPORT CAPACITY:

Experience, skills, and knowledge of key project staff to conduct the proposed program, including previous work of a similar nature: Each of the project staff members that have been or will be assigned to the project has sufficient prior experience and skills to meet the objectives of the WV CONNECT Workplan. The background and

experience of the key leadership team members is included in Attachment 5. The executive leadership of DHHR and OIC has experience in working collaboratively on major projects such as this one. Page limitations preclude a detailed listing of the experience and job descriptions of each of the participants in the project. The staff of the OIC has been involved in a number of coverage expansion projects as outlined in the narrative and has extensive experience in bringing new insurance products to the market. The OIC staff has just completed the conversion of the State's workers' compensation system from being state-run to the private market and the experiences of that transition will serve the needs of this project. Likewise, the staff within DHHR (and the Medicaid program) has overseen the transition of the Medicaid program to include personal responsibility and use of medical homes to drive health improvement. The GO HELP office will also provide assistance once it becomes staffed and operational in the fall of this year. The external parties such as the West Virginia Health Improvement Institute and WVTA have experienced staff and consultants that will facilitate the timely completion of tasks that are contemplated to be assigned to them by the project team.

Readiness to initiate project: The lead organizations have assigned staff and have the resources to commence the project upon award of the requested grant. Much of the planning and preparation has been done in response to prior legislative initiatives and the efforts leading up to passage of the GO HELP legislation during the most recent session. Staff of OIC and DHHR has each reviewed national proposals and funding alternatives under ARRA and pending national health reform legislation.

Information technology (IT) capabilities of program staff/consultants with regard to system installation (if required of a new program), system maintenance, and staff training. Each agency has sufficient IT resources to accommodate the technology aspects of the project plan. As noted in the narrative, the OIC and DHHR will coordinate technology aspects of the plan with the Office of Technology and the CTO for the State to assure consistency with overall technology strategic plans and to avoid duplication or conflict among systems and technology solutions. The project plan contemplates using consultants and contractors to complement the technical resources of OIC and DHHR. The project plan will also be coordinated with the HIT and HIE initiatives of Medicaid, the WVHIN and the Health Care Authority as contemplated in the GO HELP legislation.

ORGANIZATIONAL INFORMATION

Commitment of collective resources of project participants: The parties to the WV CONNECT project have a history of collaboration in support of efforts to expand coverage for the uninsured. The parties have committed resources in support of the project as outlined in the grant application. The parties have a successful track record of collaboration that supports the anticipated success of the project. The commitment of resources is reflected in the project budget and in the history of service to the uninsured by the safety net providers that will be the hub of the WV CONNECT provider community. The project will benefit from similar health improvement efforts and will leverage the significant investments in HIT and expanded medical capacity made available through the ARRA and the health improvement infrastructure created through Medicaid transformation and the West Virginia Health Improvement Institute.

Description of key organizations involved in the program, including the State applicant entity. As noted throughout this narrative, the WV CONNECT project is a multifaceted undertaking that involves the collaboration of a diverse group of stakeholder. The project is governed by the strategic vision of **Governor Joe Manchin**, who has designated the **WVDHHR, Office of the Secretary** (under the direction of Cabinet Secretary **Martha Walker**) as the applicant for this grant and as the lead agency on this project. The Office of the Secretary will serve as the coordinating agency for the contemplated public-private collaboration of a number of parties (whose contributions to the project and roles and responsibilities have been outlined throughout the project narrative), including the following key organizations:

The West Virginia Office of the Insurance Commissioner (OIC) (under the direction of Commissioner **Jane Cline**) is the agency responsible of overseeing the insurance industry in West Virginia, including regulation of the health insurance companies doing business within the state. The Insurance Commissioner's Office also coordinates consumer protection and education related to insurance matters and data collection and evaluation with other state agencies such as DHHR and organizations such as the WVHII and the WVHIN.

West Virginia Bureau of Medical Services (BMS or Medicaid) (under the direction of Commissioner **Marsha Morris**) is an agency within WVDHHR responsible for administering the Federal/State Medicaid program to assure access to appropriate, medically necessary, and quality health care services for all Medicaid beneficiaries.

West Virginia Public Employees Insurance Agency (PEIA) (under the direction of Executive Director **Ted Cheatham**) is the largest insurer of public employees in the state of West Virginia and provides coverage to approximately 212,000 residents of the state (this coverage includes active and retired public employees and their dependents).

The West Virginia Office of Technology (WVOT), under the Department of Administration, and its Chief Technology Officer, **Kyle Schafer**, is responsible for developing an organized approach to information resource management for the State while providing technical assistance to state entities in the design and management of information systems.

The West Virginia Health Care Authority (WVHCA) (under the direction of Chairperson **Sonia Chambers**) provides regulatory oversight and cost-containment authority over certain health care organizations and provider and administers the State's Certificate of Need program, WVHCA also collects and disseminates financial data on health care facilities, including hospitals, nursing homes, home health agencies, hospice agencies, behavioral health centers and ambulatory surgical centers and provides administrative support for the WVHIN.

The West Virginia Health Information Network (WVHIN) (under the direction of Executive Director **Sallie Milam**) was established in 2006 to promote the design,

implementation, operation and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information in the state while ensuring the privacy and security of patient health care information. It is a public-private partnership operating as a quasi-governmental entity created by statute, focused on health information exchange.

Mountain State Blue Cross & Blue Shield (MSBCBS) is the state's largest private insurer (and an affiliate of Highmark, a BCBS plan headquartered in Pennsylvania) and provides or administers coverage to more than 400,000 individuals in West Virginia.

The **West Virginia Health Improvement Institute (WVHII)** (under the direction of **Roger Chaufournier**, interim Executive Director) is a West Virginia non-profit corporation representing a multi-party collaboration of state agencies, public and private insurers, professional healthcare organizations representing physicians, community health centers, hospitals, behavioral health providers, dietitians, academic healthcare (including the state's three medical schools) and ancillary service providers, business (through the West Virginia Chamber of Commerce), labor (through the West Virginia AFL-CIO), consumers (such as AARP and the Bureau of Senior Programs) and advocates (such as West Virginians for Affordable Health Care). The West Virginia Health Improvement Institute was initially chartered as part of the West Virginia Medicaid Redesign and Transformation initiative, but is also being co-sponsored by the West Virginia Public Employees Insurance Agency and Mountain State Blue Cross & Blue Shield in recognition of the alignment of common interests in health promotion and improvement by these agencies.

West Virginia Telehealth Alliance (WVTA) (under the direction of Chairman **Larry Malone**) is a West Virginia non-profit corporation dedicated to advancing telehealth use and capabilities throughout the state. Participants in the WVTA include hospitals, rural health care centers, academic health care facilities (WVU, Marshall, CAMC and W.Va. School of Osteopathic Medicine), community mental health centers, local health departments, senior groups, consumers as well as AFL-CIO and the West Virginia Chamber of Commerce, and major telecommunications companies. WVTA is one of 69 programs from across the U.S. that has been selected to participate in the FCC's Rural Health Pilot program. The objectives of the WVTA include the following:

- Aid in the dissemination of relevant information, training, and technical assistance to healthcare organizations and providers to assist them with the adoption, deployment and utilization of new and emerging telehealth technologies for patient treatment and care coordination;
- Increase use of distance learning in public health and medical care; and
- Facilitate access to training for healthcare workers, medical professionals, and patient education in rural and medically underserved areas.

Governor's Office of Health Enhancement and Lifestyle Planning (GO HELP) (when formed) is charged with, among other things, the duty of initiating strategies that will result in greater access to health care, assure greater quality of care and result in reduced cost for health care delivery services to the citizens of West Virginia.

BUDGET - WV CONNECT	Salary and Benefits	Project Period	Post-Grant Period				
Line Item Budget and Narrative	(for FTE)	2009- 2010	2010- 2011	2011- 2012	2012- 2013	2013- 2014	2014-2015
Justification, with Staffing Plan		YR 1	YR 2	YR 3	YR 4	YR 5	
PERSONNEL							
WVDHHR							
DHHR							
New positions - Service Coordinator (4) (100%)	160,000	160,000	160,000	160,000	160,000	160,000	160,000
The four new positions will coordinate enrollment through the One-Stop portal to screen for eligibility fo other services for those using the exchange							
Public Health/Division of Primary Care							
Coordination - Nell Phillips (20%)	9,290	9,290	9,290	9,290	9,290	9,290	9,290
Nell Phillips in the Division of Primary Care will coordinate use of the safety net providers as part of the project							
OFFICES OF THE INSURANCE COMMISSIONER							
Proj. Coord. - Nancy Malecek (100%)	55,008	55,008	55,008	55,008	55,008	55,008	55,008
Proj. Liaison - Bill Kenny (20%)	19,327	19,327	19,327	19,327	19,327	19,327	19,327
Legal/Regulatory - Tim Murphy (20%)	14,050	14,050	14,050	14,050	14,050	14,050	14,050
The designated members of the OIC will be providing executive leadership on the project as part of the Project Team							
HEALTH INSURANCE EXCHANGE							
Administration (new positions)							
Exec director (100%)	90,450	90,450	90,450	90,450	90,450	90,450	90,450
Financial officer (100%)	74,925	74,925	74,925	74,925	74,925	74,925	74,925
Assoc director for content (100%)	70,875	70,875	70,875	70,875	70,875	70,875	70,875
Insurance Counselors (6) (100%)	234,900	234,900	234,900	234,900	234,900	234,900	234,900
This administrative structure is new and these positions are necessary to oversee the functions of the Exchange							

	2009- 2010	2010- 2011	2011- 2012	2012- 2013	2013- 2014	2014-2015
EQUIPMENT						
Servers/software (6)	250,000				30,000	
Storage device (1)	250,000					
The Equipment listed is to provide the infrastructure to host the technical platform for the exchange and other web applications described in the application. The system will need to be updated within 5 years under the product life cycle projection.						
CONTRACTUAL						
Contract services to be procured						
Consulting contract w/ behavioral economists	25,000	10,000	10,000	10,000	10,000	10,000
Marketing contract	200,000	200,000	200,000	200,000	200,000	200,000
Contract services - Survey update	30,000		30,000		40,000	
Project reports and publications	20,000	20,000	20,000	20,000	50,000	50,000
The foregoing are the projected costs for the necessary contractual services to implement the project plan, including developing pricing, marketing the exchange and benefit program, updating the prior Healthcare Surveys and producing annual reports for distribution. These costs are based upon prior experience and prevailing rates for these types of services.						
PROGRAM COSTS -						
Payments to Providers/Carriers for covered services	7,687,665	14,962,080	14,962,080	21,351,600	21,351,600	21,351,600
The foregoing are the projected costs of providing benefits and purchasing the wrap-around products as outlined in the narrative.						
EVALUATION						
Evaluation design	14,250	6,250	6,250	6,250	14,250	
Evaluation & consulting contract	20,000	20,000	20,000	20,000	20,000	
Data Analyst	30,000	30,000	30,000	30,000	30,000	

	2009- 2010	2010- 2011	2011- 2012	2012- 2013	2013- 2014	2014-2015
The foregoing are the projected costs for the conducting the Evaluation of the program outlined in the narrative. To assure independence and objectivity, these are contracted services rather than staff positions. These costs are based upon prior experience and prevailing rates for these types of services.						
CLINICAL PORTAL						
Contractual Services -						
Design and Maintenance	200,000	50,000	50,000	50,000	50,000	50,000
The project plan contemplates the establishment of a clinical portal to facilitate gathering of clinical data to aid in evaluation and facilitate HIE and PHRs - cost represents launch and annual updating of hosted service						
ONE STOP BENEFIT PORTAL						
Contractual Services to be procured	300,000	60,000	60,000	60,000	60,000	60,000
The project plan contemplates the establishment of a one-stop portal to link WV CONNECT and other public services, including the oral health referral network						
MEDICAL HOME CLINICAL NETWORK DEVELOPMENT						
Contractual Services -						
West Virg Health Imp Inst						
Network Org and Mgmt	350,000	250,000	250,000	250,000	250,000	250,000
Technical Assistance to Medical Homes	350,000	250,000	250,000	250,000	250,000	250,000
The project contemplates using the WVHII to help organize the provider network and to provide technical assistance to medical homes to serve as enrollment and service centers						
VIRTUAL EXTENSION NETWORK - VIDEO PORTAL						
Contractual Services -						
West Virg Telehealth Alliance	350,000	200,000	200,000	200,000	200,000	200,000
The project plan contemplates using the WVTA to establish and manage the virtual extension network to facilitate outreach and education with participating sites						
SOFTWARE LICENSE FEES	50,000	50,000	50,000	50,000	50,000	50,000
The software licenses are for operating systems and third-party products used with the IT platform.						
TOTAL PROJECT COSTS	11,906,071	17,989,902	18,078,119	24,437,639	24,545,639	24,409,389
SOURCES OF PROJECT REVENUE						
HRSA SHAP grant proceeds	6,343,900	8,852,930	6,255,031	7,871,579	7,559,679	
State Match - OIC	800,000	800,000	900,000	900,000	900,000	1,150,000
State Match - DHHR	800,000	800,000	900,000	1,200,000	1,500,000	1,500,000
In-kind and other match	50,000	75,000	125,000	225,000	300,000	725,000
Program Income applied						
Health exchange fees	20,000	76,500	325,280	580,500	625,400	840,960
Premiums/fees -covered parties	3,892,171	7,385,472	9,572,808	13,660,560	13,660,560	20,193,429
Other program revenue						
Total Project Revenue	11,906,071	17,989,902	18,078,119	24,437,639	24,545,639	24,409,389

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	HRSA SHAP Grant - Attachment	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Letter to USDHHS re HRSA-09-	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	HRSA SHAP grant workplan.pdf	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	HRSA SHAP grant Attachment 4	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	HRSA SHAP Grant Application	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	HRSA -- Interagency Memorand	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	HRSA SHAP grant org chart.pd	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Interagency Memorandum of Collaboration

This Interagency Memorandum of Collaboration is made as of this 1st day of June, 2009 by and between the West Virginia Department of Health and Human Resources, Office of the Secretary (Martha Y. Walker) and the Offices of the Insurance Commissioner (Jane L. Cline).

The parties to this Memorandum of Collaboration wish to pursue an undertaking to expand access to health insurance coverage for uninsured West Virginians, particularly those that are working and yet do not have health insurance coverage, and the parties wish to mutually pursue funding for this undertaking through a HRSA State Health Access Program (SHAP) grant (HRSA-09-226) (the "Grant") and the parties have collectively engaged in a number of initiatives to address the plight of the uninsured, particularly the working uninsured, and this initiative is consistent with Governor Manchin's Strategic Vision and Action Plan issued in 2007 and he has issued a letter in support of the project as part of the application process. Accordingly, the parties agree to the following:

1. WVDHHR, at the request of and by designation of the Governor, will act as the lead agency for this project. DHHR will maintain overall direction and responsibility for the project. The nature of the project and the roles and responsibilities of the parties are set forth in the Project Narrative and accompanying documents that comprise the SHAP grant application.
2. The DHHR project liaison will be Gerald Roueche, Assistant to Secretary Walker. Mr. Roueche will be accountable to Secretary Walker and responsible for coordinating the interaction between DHHR and OIC, with Bill Kenny, Deputy Commissioner of OIC, who reports directly to Commissioner Cline. Tara Buckner, CFO of DHHR, will serve as the grants manager and she and her staff in DHHR Grants Management will oversee financial administration of the grant. Nancy Maleček, Insurance Market Analyst in the Research and Executive Division of the OIC, will serve as overall project coordinator to assist the Project Team with various coordination activities and will oversee data collection and analysis, actuarial studies, and policy analysis work. The project contemplates use of contractors, including the West Virginia Health Improvement Institute and the West Virginia Telehealth Alliance, the West Virginia Health Policy Research Institute to perform certain project functions as contractors and/or sub-recipients. The Secretary and the Commissioner shall jointly designate members of the Project Team from within State Government resources and appropriate external consultants and contractors. The Project Team shall assist in administering the program, while the Steering Committee shall provide strategic guidance on program implementation.
3. The Office of the Secretary, as the applicant for the grant, will designate a project Steering Committee consisting of representatives of the collaborating organizations, including the OIC, the Medicaid program, the West Virginia Health Improvement Institute, the Health Care Authority and WVHIN, the West Virginia Telehealth Alliance, the Office of Technology and Chief Technology Officer, GO HELP (and others as appropriate). Contractors will be retained as needed to complete the tasks contemplated in the project plan to complement the resources within the organizations of the collaborating public and

private participants. Contractors will be selected and retained based upon experience and qualifications relative to the assigned tasks and scope of work for which they are being sought to provide services as part of the project implementation. Representatives of participating health insurance carriers may be utilized by the OIC to assist in the formation and operation of the health insurance exchange segment of WV CONNECT.

4. Each participating organization serving on the Steering Committee will designate a Project Coordinator who will be responsible to the Steering Committee and Project Team for assuring that the project tasks and assignments under the Workplan are completed in a timely fashion in accordance with the project budget. The Steering Committee will make recommendations for the resolution of any project delays or impasses that may arise, and these issues will be coordinated with GO HELP as contemplated by statute, but the final resolution lies with WVDHHR, as the lead agency with respect to all issues pertaining to administration of the SHAP grant and use of grant funds, and the Office of the Secretary of WVDHHR. The Secretary may resolve such issues in consultation with the Governor to assure consistency in the administration of the program with the Governor's strategic vision for health care policy.

5. The lead agency will also be responsible for preparation and timely submission of all progress and other reports due for the grant. The WVDHHR Office of Grants Management, which works closely with HRSA on a number of grants to the State, will oversee preparation and submission of all required reports and will administer all audit and supervisory responsibilities in accounting for grant fund disbursement. WVDHHR will also work closely with HRSA staff to comply with audit requirements of the Office of Management and Budget (OMB) Circular A-133, submit Payment Management System Quarterly Reports, submit a Financial Status Report (FSR) within 90 days of the end of the grant period, and submit all required reports to HRSA and HRSA contractors in a timely fashion, following the prescribed HRSA formats. The lead agency may use the resources of the Steering Committee and/or one or more contractors, including the West Virginia Health Improvement Institute and the evaluation team retained to perform the evaluation of the program, to assist in the preparation and submission of the required reports.

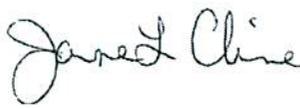
6. The parties may amend this Memorandum at any time and may enter modify or supersede this arrangement as necessary for purposes of completing the project and administering the Grant, if awarded.

The parties have caused this Memorandum of Collaboration to be executed as of the date first written above.

West Virginia Department of
Health and Human Resources

Offices of the Insurance Commissioner

By: _____
Cabinet Secretary

By:  _____
Commissioner