

**Standard Form 424 – Application for Federal
Assistance**



STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
CHARLESTON 25305

BOB WISE
GOVERNOR

April 2, 2002

Ms. Joyce G. Somsak, Director
State Planning Grants Program Office
Health Resources and Services Administration
Parklawn Building, Room 11-25
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Somsak,

I am please to submit the enclosed application from the State of West Virginia for a Health Resources and Services Administration State Planning Grant.

Access to affordable health care is a top priority of this administration. We are determined to make measurable progress in expanding health insurance for our low-income citizens. To help achieve this, one of my early actions was to form an umbrella group of State officials whose departments or agencies share in making the policies and taking the actions that shape our health care programs and systems. We have charged this health umbrella group (HUG) with the responsibility to work collaboratively, focusing the health care resources at their disposal (both federal and state) to achieve our coverage expansions.

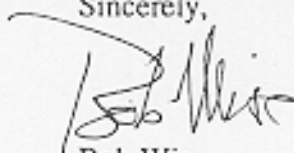
The West Virginia Health Care Authority will be the lead agency for this planning grant and will work closely with the other members of the HUG through out. As a group, they have already begun work on collecting the data that will allow their programs to better target and understand the circumstances of those who are uninsured in our State. With the help of the West Virginia Institute for Health Policy Research, the State funded the largest survey of our citizens' health insurance status ever done. The results of this 16,500 household survey are in and show that we have made great strides in covering our children – only 6.6 percent of them are uninsured. It also shows that we still have much work to do as 19.9% of our adults, most of whom work, have no health insurance. It is our intention that the State put forth the effort to cover low income working families as it has for the majority of their children. In addition, we intend to make sure that low income adults and seniors also have access to affordable health service coverage.

Ms. Joyce G. Somsak
Page 2
April 2, 2002

As a State whose citizens rank among the least healthy in our country, it is essential that we begin to take significant actions to change their health circumstances. In these times of economic stress, we recognize that our actions must be incremental and affordable within our limited public budget. But we must begin and we must have strategies to progress over time. We have shown through our children that we can be successful. We must do the same for their families and other adults. This is essential not just to improve their health status, but also to allow them the opportunity to participate fully and productively in the life of our State and its communities.

This administration is committed to a better health future for West Virginians, and a State Planning Grant will be of very real assistance as we work towards our goals. We hope you will give positive consideration to our application.

Sincerely,

A handwritten signature in black ink, appearing to read "Bob Wise". The signature is written in a cursive style with a large, sweeping initial "B".

Bob Wise
Governor

Bob Wise
Governor



Sonia D. Chambers
Chair

Paul L. Nusbaum, Secretary
West Virginia Department of
Health and Human Resources

Board Members
Sam G. Kapourales
Marilyn G. White

April 2, 2002

Ms. Joyce G. Somsak, Program Director
State Planning Grants Program Office
Health Resources and Services Administration
Parklawn Building, Room 11-25
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Somsak:

I am submitting the enclosed application for a Health Resources and Services Administration State Planning Grant as the lead agency for the State of West Virginia. The State is requesting \$1,478,602 for the purposes and activities described in the application.

One of Governor Wise's principal goals is to ensure that every one has access to affordable health care. To accomplish this task he has created an ad hoc health umbrella group (HUG) of his appointees that direct the agencies that provide, pay for and regulate health care services in the State. He has charged the group to develop the strategies that achieve his goal and to provide the leadership for implementation.

In its first year, the HUG contracted with the West Virginia Institute for Health Policy Research (Institute) to assist it with research and staffing. During this period the Group has:

- undertaken the largest survey of uninsurance and its impact ever completed for our population,
- has begun an in depth study of the health insurance market,
- is exploring options for expansions in public programs and in the development of concepts for public/private health insurance,
- is looking at ways to adopt common policies and administrative systems to reduce the provider cost burden.

As this work continues, the HUG sees this application for a HRSA State Planning Grant as an invaluable opportunity to move the Governor's vision from paper goals and strategies to reality.

The HUG has collaborated to define the goals and the activities it believes should be undertaken through the State Planning Grant project. The HUG will constitute the decision-making policy and program board for the grant, monitoring its progress, approving its products and deciding on its recommendations for implementation.

Ms. Joyce G. Somsak
April 2, 2002
Page Two

The Health Care Authority has chosen to contract with the Institute to serve as the managing partner for the grant. The Chair of the Authority and the Executive Director of the Institute will serve as co-Principle Investigators. The administration of the grant will be through a Management Team made up of the co-PI's, the Governor's HUG Coordinator, the Authority's fiscal officer and the Institute's senior leadership. This group will determine the operational strategies, plans and assignments for implementing the grant and will meet weekly with the Project Manager to ensure the grant's activities are completed effectively and on time.

The grant will also seek support and involvement from the leadership of stakeholders throughout its operation. A Health Advisory Council which will be chosen and convened as soon as the State learns of a grant award. Regular meetings of this group and work on issues through subcommittees will make sure that the grant's data collection is amplified and benefits from local and statewide expertise. In addition, one of the first tasks of the grant is to develop a public communications campaign to inform the public, develop knowledge and support for the grant activities and assume public input to the plans and programs.

West Virginia is pleased to have an opportunity to make this application. We know you will give it appropriate consideration and we also hope you will find it meets with your approval.

Sincerely,



Sonia D. Chambers
Chair

SDC/bkh

3. Table of Contents

<u>Section #</u>	<u>Item</u>	<u>Page Numbers</u>
4	Project Abstract	1-3
5	Current Status of Health Insurance Coverage	3-7
6	Earlier Efforts to Reduce the Number of Uninsured Persons	7-12
7	Requesting Preferences	12-13
8	Statement of Project Goals	13-14
9	Project Description	14-32
9 A	Detailed Project Narrative	14-26
	• Phase 1: Planning, Process	14-15
	• Phase 2: Communication Strategy	15-16
	• Phase 3: Data Collection and Analysis	17-20
	• Phase 4: Option Development	20-24
	• Phase 5: Recommendations	24-25
	• Phase 6: Final Report	26
9 B	Project Management Plan	28-32
9 C	Governance	33-37
10	Budget Plan (Placed at the front of the submission immediately after the SF424 A)	
11	Monitoring Plan and Report to the Secretary	37-38
12	Required PHS 5161-1 Forms (Federal Assurances, Check List, SF-LLL)	

4. Project Abstract

Current Status of Access to Health Insurance

In January 2001, a new administration took office in West Virginia (WV), led by Governor Robert E. Wise, Jr. From the beginning, health care was established as a major concern. The Governor's vision, clearly stated, was to provide health coverage for every citizen, beginning with those most in need: the State's children, low income working families, and low income seniors for prescription drugs and preventive care. The ultimate goal is to provide every West Virginian access to affordable health care.

Governor Wise began by convening, his appointees, who share responsibility for the State's health care policy and service programs into a Health Umbrella Group (HUG), with whom he regularly meets. HUG is charged to develop the strategies that achieve the Governor's vision and provide the leadership for their implementation. As a first step, they contracted with the West Virginia Institute for Health Policy Research (Institute) (formerly the West Virginia Center for Healthcare Policy and Research) to provide research and planning, assistance. An early HUG decision was to undertake a telephone survey of over 16,000 WV households to provide information about health insurance and the circumstances of the uninsured that would be valid at regional and county levels. This West Virginia Health Care Survey 2001 was funded jointly by the Robert Wood Johnson Foundation's State Coverage Initiatives program and the WV Health Care Authority. Its findings show that 13.8% of the State's population is uninsured, slightly less than the national rate at 14%. For children, the State can be proud of its CHIP expansion efforts that have assured the majority of our children - 94% - are insured. But there is still much work to be done. Virtually one out of every five adult West Virginians (ages 19 through 64) has no health insurance - a rate of 19.9%, and nearly a third of the State's senior population is without supplemental Medicare to help pay for prevention and prescription drugs.

Past Efforts to Expand Health Insurance

Concerned about the increasing amount of uncompensated care in the State's health care delivery system, in 1986, the Legislature created a Committee on Uncompensated Care and Medicaid Expenditures. At that time, Medicaid's standard of need for all beneficiaries was 31% of the federal poverty level (FPL). By 1990, children below age 7 were covered at 133% FPL and pregnant women and infants were covered at 150% FPL. In 1994, children's coverage was increased to 133% FPL. During this time, in 1991, the State also established a Health Care Planning Commission to look at methods to finance care for all citizens. The Commission spent eighteen months, collecting information, looking at options, and gathering, public and stakeholder input. Its report was published in December 1992, offering a series of comprehensive recommendations for reform, but its impact was quickly obscured by anticipation of health care reform legislation at the federal level.

In early 1998, the State began its CHIP program to bring Medicaid children, ages 1 to 5, to 150% FPL. In 1999, it added a non-Medicaid program for children, ages 6 to 18 to 150% FPL. In October 2000, the CHIP Policy Board expanded the program to 200 FPL%, and combined CHIP into a single non-Medicaid program. In 2001, with visible advocacy from Governor Wise's office and CHIP outreach initiatives assisted by a Robert Wood Johnson Foundation grant to the voluntary Healthy Kids Coalition, enrollment grew to over 21,000. The RWJ grant was renewed in 2002 for another 4 years.

In the private health insurance market arena, efforts were made in the late 80's to create a catastrophic health insurance program and, in 1991, to regulate cost increases in the small group insurance market. Neither of these programs proved successful. More recently, the most recent 2002 Legislature passed a bill to allow CAP grant programs to provide health insurance demonstrations for persons up to 250% FPL not otherwise eligible for public programs.

Over the past decade, the State's central revenue budget has increasingly supported care to a growing number of free clinics operating in urban communities. Since 1996, their patient numbers have grown from 17,000 to over 56,400. They receive over \$51 million in voluntary support and provide \$36 million of prescription drugs to the uninsured poor. Their legislative appropriation, begun in 1998, has grown from \$.5 million to 2.5 million.

Proposed Project Goals

This State Planning Grant (SPG) proposal has the following goals:

- A seamless public program of health care coverage for children and pregnant women up to 250% FPL, low income working parents up to 200% FPL and options for low income adults and seniors for prescription drugs and preventive care.
- Private and/or public private options for affordable, comprehensive health care insurance for small and medium size employers as well as working families and individuals with incomes above 200% FPL.
- Support for community healthcare system integration (CAP Grant programs) and the State's free clinic system to provide services to low income individuals and families not eligible for other programs.
- A climate of leadership and general public understanding that supports health insurance coverage expansion to all West Virginians.

Proposed Project Activities

During the past year, in addition to the Survey, the HUG has been working, with the Institute and consultants on tasks related to small group and individual health insurance solutions. These include: (1) assessment of the State's health insurance markets; (2) review of other state models and mechanisms for insurance expansion; (2) analysis of the Public Employees Insurance Agency's (PEIA) small agency program to assess its feasibility as a small business risk pool- (4) a "roundtable" to educate business and labor leaders about health insurance issues-, and (5) identification of program savings that can be used to increase coverage funding. These efforts have moved the State significantly forward in its understanding of health insurance in the State and in the identification of issues where further information is needed. The SPG will build upon this work as follows:

- Creation of a Health Advisory Council (HAC) to provide advice and counsel and serve as a mechanism for communication to and from the stakeholder groups for SPG activities;
- Exploration of the State's private market capacity to adopt new private or public/private health insurance options for small business employers and individuals;
- Exploration of options and costs to expand health insurance coverage to small business employers, their employees and individual purchasers, including a buy-in to the PEIA small agency risk pool;
- Development of health insurance benefit standards for covered services and cost sharing, for the State's public program and public/private health insurance options;

- Development of a HIFA waiver to cover low income adults and seniors not otherwise eligible for the State's public program;
- Strategy for the integration of the existing, public programs into a single operating organization;
- Development of communication strategies that:
 - *Promote public awareness of the importance of health coverage and access*
 - *for our citizens and the economic well being of our communities; and*
 - *Develop support for a single public program and changes to expand small business and individual health insurance.*
 - *Give a new identity and image to the State's public program and ensure all eligible children and adults are fully aware of its benefits and how to enroll.*
- Preparation of a report of the SPG activities, findings and recommendations for the Secretary of the Department of Health and Human Services.

Lead Agency

The lead agency for this grant will be the West Virginia Health Care Authority (Authority), whose responsibilities include state health planning. The WV Institute for Health Policy Research will be the "managing" partner for the purposes of this grant, and the member agencies of the HUG (Department of Health and Human Resources and its Bureaus for Public Health, Children, Youth and Families, and Behavioral Health, Health Care Authority, Bureau of Senior Services, Public Employees Insurance Agency, Children's Health Insurance Program, Governor's Cabinet on Children and Families, Insurance Commission and Bureau of Employment Programs) will serve as the decision-making, body for policy and program choices and directions.

Proposed Project Results

Successfully undertaking these activities will leave the State poised to begin implementation of the health coverage goals of this Administration, beginning, with

- implementation of communications strategies that ensure eligible individuals are made aware of and enrolled in the existing public programs and create a broad base of support for the incremental program and legislative changes required for access to affordable health insurance;
- Implementation of a strategy, for incremental public program expansions to populations most in need, e.g. eligible children, low income working families, and prescription drug and preventive care coverage for low income seniors with the plans and a timetable for a single public program;
- Implementation of insurance mechanism(s) that will create options for affordable private or public/private insurance programs for small group employers and employees and other individuals or self employed workers; and
- A final report to the Secretary of the Department of Health and Human Services.

5. Current Status of Health Insurance Coverage

WV has the benefit of data from two recent health insurance surveys to guide its work on the state-planning grant. Insurance coverage for West Virginians under age 65 was the subject of a statewide survey done for a report to the Legislature in January 2001. The Legislative Survey suggested great variation in insurance by geographical area, but the sample size did not support definitive regional or local analysis. Thus a second survey, of nearly 16,500 households, the West Virginia Health Care Survey, 2001 was commissioned to collect these data. This study constitutes a significant head start

on the data collection activities typically included in a state planning effort. The data are used here to describe the uninsured population in WV.

Status of Access to Health Insurance Coverage in WV

Rate of Uninsurance. On any given day, 16.2% of West Virginians ages 0-64 (248,765 persons) are uninsured. About 13% are uninsured throughout the year and another 10% are uninsured for part of the year. When individuals of all ages are considered, the uninsurance rate on any given day is 13.8%, which is slightly lower than the 14.0% rate for the country as a whole, as determined by the Current Population Survey.

Kinds of Coverage. Sixty-two percent of the non-elderly WV population ages 0-64 have employer-based coverage, either from a public or private employer or union; 13.9% of the population is on Medicaid or CHIP; 5.0% pay directly for coverage in the individual market or for COBRA; 1.7% are on Medicare; and 1.4% have some "other" source of coverage.

Characteristics of WV's Uninsured

Age. Of some 248,765 non-elderly West Virginians uninsured on any particular day, 11.4% are children ages 0-18 with the overwhelming majority, 88.6%, adults ages 19-64. The children without insurance represent 6.6% of their age group, while 19.9% of adults ages 19-64 are uninsured. Since covering uninsured children has been a focus of public policy, it is perhaps not surprising that the rate of uninsurance in this group falls well below that for adults. Yet it is this latter group that, by virtue of its size alone, presents the much greater challenge for public policy.

Non-Elderly Uninsured Population in WV on Any Given Day by Age, 2001

	% of Age Group Uninsured	#Uninsured
All persons 0-64	16.2	248,765
Children 0-18	6.6	28,372
Adults 19-64	19.9	220,393

About 4.4% (about 18,500 children) are uninsured throughout the year and about 10 percent (41,100) are uninsured for part of the year. Among adults ages 19-64, 16.8% are uninsured throughout the year (183,600) and about 10.2% are uninsured for part of the year (112,200). Persons who are consistently uninsured will require different strategies than persons who are temporarily uninsured.

The likelihood of being, uninsured during, childhood depends significantly on age. While 1.7% of infants under age 1 are uninsured, 7.7% of teenagers ages 12-18 are uninsured. Among persons ages 19-64, young adults ages 19-25 are the most likely to be uninsured, 26.3% of this age group. The early or pre-retirees ages 55-64 are the least likely to be uninsured, 11.2% of this age group.

Gender. The likelihood of being, uninsured does not vary significantly by gender.

Race/Ethnicity. There is no difference among the races in the likelihood of being uninsured.

Geography. The likelihood of being uninsured does vary by geographic region. The Public Health Regions in the southwest (Region II) and west central parts (Region V) of the State have the highest

proportions of uninsured children. The proportion of uninsured children also varies widely by county. While seven counties have more than 11% of their children uninsured, in nine counties fewer than 4% of the children are uninsured. The proportion of uninsured adults ages 19-64 ranges from a low of 14.3% in Public Health Region VI in the northern panhandle to a high of 25.3% in Public Health Region IV in the eastern mountains. These data suggest the importance of localized approaches to both outreach and coverage options.

Income. In all WV counties, most of the uninsured children (81% or almost 23,000 children) are in households with incomes under 250% FPL. Children in households with incomes over 175% FPL are the least likely to be uninsured (4.2% of the total), while those between 134 and 175% FPL are the most likely to be uninsured (11.4%). Because of Medicaid eligibility limits, the youngest and poorest children are most likely to have coverage and as a low income child gets older, the risk of being uninsured increases. Large proportions of adults in the lowest income bracket (under \$10,000) and the next lowest bracket (\$10,000 - \$19,999) are uninsured, 39.7% and 39.0% respectively. Even at the \$20,000-\$29,999 level, the rate of uninsurance is a hefty 29.6%. While these data suggest that many of these persons may be already eligible for public programs or reachable through expansions, they also suggest that in the absence of some kind of subsidy these persons will not be able to buy coverage on their own.

Employment Status. Of uninsured adults 19-64, 60.5% are workers with 46.2% employed by others and 14.3% self-employed. Also included among uninsured adults are students, homemakers, retirees, disabled, and unemployed persons. Among the uninsured workers, 69.4% are employed permanently and the rest have temporary or seasonal employment. The largest proportion of uninsured workers (13.8%) is in the restaurant or food service industry followed by 11.5% in construction and home repair. Many uninsured workers are employed full-time with 23.3% working more than 40 hours a week and 49.0% working 31-40 hours a week.

Key Health Issues Related to Access to Care and Uninsurance

Major Health Problems. Health status indices for many chronic diseases are less favorable for WV than those for the country as a whole. These include heart disease, cancer (particularly lung and prostate), chronic obstructive pulmonary disease, diabetes, and cerebrovascular disease. Improved access to health services afforded by health insurance, particularly among the adult population, would be expected to improve the health status of the WV population significantly.

Use of Services by the Uninsured. Children who do not have health insurance are more likely not to have a regular source of health care than children with health insurance (26% compared to 6%). More uninsured children (15%) report being unable to get needed care than do insured children (2%); with cost being the most important factor. Uninsured children are less likely to have medications prescribed than insured children and when they are prescribed, somewhat less likely than insured children to have them filled. When utilization of care over a six-month period is compared, insured children (75% of the total) are more likely to visit a health care provider than uninsured children (51%). Comparisons of health care utilization by insured and uninsured adults show similar patterns.

WV's Current Delivery System

Managed Care Penetration. Health Maintenance Organization (HMO) penetration at 11% is very low in WV compared to the 28% penetration for the U.S. Only three BA10s are active in WV. Very few counties have Medicare HMO plans available, and participation is low. One factor working,

against full risk, HMO managed care is the mountainous geography with low population density and few providers, which does not support risk contracting. Through a 1915(b) waiver, however, almost half of Medicaid participants are enrolled in managed care through one of the IB40 choices (17.6%) or through enrollment in the primary care case management (PCCM) program (33.8%).

Access to Primary Care. WV is the second most rural state in the nation, with all or part of 47 of its 55 counties designated as medically underserved areas. In this environment, access to care even with insurance can be difficult. Throughout WV, critical access and other small community hospitals, federally qualified health centers and rural health clinics, public health departments, and free clinics constitute the fabric of the health care system providing access to care for underserved rural populations and the urban poor. The amount of care provided in these settings is tremendous. For example, since 1996 the patient load of the free clinics has increased from 17,000 patients to over 56,400. These clinics alone account for over \$51 million in free care annually.

Variations in Health Insurance Coverage

Public Programs

Medicaid. The overall participation rate in WV Medicaid for persons under age 65 is 13.9%. Of adults ages 19-64, 7.5% (83,200 persons) are covered by Medicaid. The rate of participation in Medicaid for children ages 0-18 is 26.0%, or 111,700 children. These differential rates reflect the more generous income eligibility levels that are in effect for children. Moreover, children who are above the Medicaid limits may join the WV Children's Health Insurance Program (CHIP). No recourse is currently available for adults who exceed the stringent Medicaid standard of need (31% FPL). These include parents of covered children, the dually eligible, and the medically needy, all target populations for consideration during the project.

WV Children's Health Insurance Program. WV CHIP was enacted July 1, 1998 and implemented in three phases. Effective November 1, 2000, the income eligibility was raised from 150 to 200% FPL and eligibility was extended to infants. CHIP enrollment is now over 21,000 children. The preponderance of children in CHIP, 71%, are in families with incomes at or below 150% FPL; 29% of the children have family incomes between 151% and 200% FPL. Seventeen percent of CHIP participants are ages 0-5; 49% are ages 6-12- and 35%, ages 13-18. While participation in CHIP has grown significantly, there are still children who are potentially eligible but not enrolled. Survey data from parents of potentially eligible children indicate that not knowing about the program, reported by 31%, is a frequent reason for non-enrollment. Nineteen percent do not think their child qualifies and small proportions think it is too difficult to enroll (5%) or they do not want a government program (3%). The parents of 20% of the children potentially eligible for Medicaid say they are unaware of the program.

Other Insurance

Individual Market. Eight insurers underwrite in the individual market with the largest insuring 55% of the market. Carriers selling in this market may medically underwrite and risk rate premiums. This being the case it is not surprising that cost is one of the most frequent reasons for lack of insurance. Very few West Virginians purchase coverage on their own.

PEIA (Public Employees Insurance Agency.) PEIA covers employees of state, county, and local governments, boards of education, state higher education and their dependents, a total of 11.4% of the population. This program is currently used to administer WV CHIP, which uses the same

benchmark coverage. The potential for expanding PEIA to provide affordable coverage for the uninsured will be explored during, the planning, project.

Gaps in Knowledge about Coverage and How Grant Activities Will Bridge Gaps

Geographical Differences in Uninsured Rates. WV is a state characterized by tremendous diversity. There are two standard metropolitan statistical areas, but only one first class city. The state's geography is primarily small cities, towns, and rural areas with profound cultural and economic differences among, regions with some dominated by coal, others by steel and others with economies based on tourism or farming. Data from the Legislative Survey suggested great variation in uninsurance by Geographical area but the sample size did not support definitive regional or local analysis. To address this need, the West Virginia Health Care Survey 2001 was commissioned to obtain data to allow small area analysis. These data will be available to support the planning project.

Employer-based Coverage, Uninsured Workers. In 1998, 53% of the private sector businesses in WV offered health insurance to their workers, a rate just slightly below the national average of 55%. Preliminary data indicate that employment trends in WV are towards smaller employers that increasingly hire part time and/or low wage workers. The literature on employer based insurance points to these types of employers being, least likely to offer employee health insurance. Given that a significant proportion, 60.5 %, of uninsured West Virginians is employed, including 14.3% who are self-employed, it is imperative that the potential for employer-based coverage be thoroughly explored during the SPG. A major data collection effort will be made to determine the extent of employment-based coverage in WV by region, the characteristics of businesses that do not offer coverage compared to those that do and the characteristics of the coverage offered. Other states' employer surveys will be reviewed in preparing the survey instrument. Once the universe is better understood, key informant interviews and focus groups will be used to probe attitudes toward health insurance and to build support among, employers for the uninsured initiative.

6. Earlier Efforts to Reduce the Number of Uninsured Residents

For the last two decades, WV has wrestled with the problems of providing affordable access to health care for its citizens.

Legislative Efforts to Develop and Implement Health Care Reforms

Medicaid Expansions

In 1986, the Legislature created a "permanent" interim Legislative Committee on Uncompensated Care and Medicaid Expenditures. The Committee's work included not only recommending expansions exceeding the federal requirements, but finding the revenue sources to fund them. When the Committee began its work, the State's Medicaid standard of need for all beneficiaries was 3 1 % FPL.

By 1990, all children below age 7 were covered at 133% FPL and pregnant women and infants were covered at 150% FPL. In 1994, all children's coverage was increased to 133% FPL by legislation, which included a phase-in schedule to move to 200%. The implementation of that Medicaid phase-in was superseded by passage of the federal Children's Health Insurance Program. Current income eligibility levels are shown below.

Population	% of FPL
Pregnant women	150
Infants under 1	150
Children 1-5	133
Children 6-18	133
Supplemental Security Income	74
Medically Needy/Individual or Couple	31

The overall participation rate in WV Medicaid for persons under age 65 is 13.9%. Among adults ages 19-64, 7.5% are covered by Medicaid. The rate of participation in Medicaid for children ages 0-18 is 26.0%. These rates by age group exceed the national participation rates for 1997-99, which were 6% for adults and 20% for children. Despite the poor economic status of WV relative to almost every other state, it has succeeded in providing essential health coverage to a substantial proportion of its needy residents.

Health Care Planning Commission

As the Medicaid effort was going on, the Legislature in 1991, at the request of the Governor, established a Health Care Planning Commission to look at health care services delivery and methods to finance care for all citizens. The Commission spent 18 months, collecting information, looking at options, and gathering public and stakeholder input. Its report was published in December 1992 and was a comprehensive outline of recommendations for change. The impact of this ambitious report however, was quickly obscured by anticipation of legislation at the federal level.

Support for "Safety Net" Providers

In addition to expanding health care coverage to WV citizens, over the past decade, the State's general revenue budget has increasingly supported care provided at a growing number of free clinics operating in urban communities. Since 1996, the patients seen at these clinics have grown from 17,000 to over 56,400. These clinics receive over \$51 million in voluntary support and provide \$36 million of prescription drugs to the uninsured poor. State funding has grown from \$.5 million in 1998 to \$2.5 million in 2001.

WV Children's Health Insurance Program

WV CHIP was enacted July 1, 1998 and was implemented in three phases. WV has followed a policy of incremental expansion, broadening the eligibility criteria to offer the program to more and more children. Phase I of the WV CHIP program consisted of a Medicaid expansion for children ages 1-5 from 133% FPL to 150% FPL. Phase II introduced a private insurance model with an income eligibility limit of 150 % FPL for all children. In 2000, the entire program was placed under the Public Employees Insurance Agency (PEIA) administration and uses an expanded version of the PEIA benefit offerings. It also uses the PEIA fee-for-service delivery system with the preferred network expanded to include school-based clinics and other "safety net" providers that are typically used by low income children.

Effective November 1, 2000, the income eligibility was raised from 150 to 200% FPL for all children ages 0-18. There is a cost-sharing requirement for participants with incomes between 150% and 200% FPL. During Federal Fiscal Year 2001 (10/00 through 9/01) a total of 11,485

children were added to CHIP, an increase of 53% from the previous fiscal year. WV ranked 13 out of 51 programs for the percentage increase in enrollment. As of late 2001, CHIP enrollment exceeded 21,000, experiencing a net increase of about 2,000 children per quarter.

CHIP outreach initiatives have been greatly assisted by a Robert Wood Johnson Foundation grant made to voluntary non-profit group, Healthy Kids Coalition and substantive inroads have been made in enrolling uninsured children. This grant was renewed in 2002 for another 4 years.

Insurance Market Reform

While the Legislature has been successful in extending health coverage and health care access through public programs, legislation has not played a key role in the health insurance market. Efforts were made in the late 80's and early 90's to create a catastrophic health insurance program in the private market and to regulate cost increases in the small group market; however, neither of these programs proved successful.

While WV has extended COBRA to employees of companies of less than 20 employees, the impression is that most persons who leave their jobs do not use the COBRA option because of the cost. Less than 1% of the population at any time has COBRA coverage. WV has adopted the federal fall back position for the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) small group and individual health insurance provisions. While federally eligible individuals are guaranteed the right to buy individual health coverage from any insurance company selling such plans in WV, they may be charged premiums based on health status, age or other factors. As a result, portability insurance carries very high premiums and participation is negligible.

As will be discussed below, considerable analytic work is underway to identify approaches for reforming the small group and individual markets, which appear to be failing. Currently, a small employer buying a group health plan enjoys modified community rating. This means that while the employer cannot be charged a premium based on the health status of the workers, premiums are rated for other demographic factors such as employee age or industry.

Finally, in the recent 2002 legislative session, a bill was passed to allow local health entities to provide health insurance for persons up to 250% FPL and not eligible for other state or federal coverage through pilot demonstration Community Access Programs (CAP).

Efforts of the Executive Branch

Health Umbrella Group

The current Governor, Robert E. Wise, Jr. in office since January 2001 has focused on the issue of uninsurance in the State particularly as it affects children and low income working families and underinsurance of low income Medicare beneficiaries. His vision for the State is to provide all West Virginians access to affordable health care, understanding that the only feasible strategy with the current economic circumstances of WV is incremental.

Early in his administration, the Governor convened the Health Umbrella Group (HUG), comprised of his appointees who share responsibility for the State's health care services provision, payment and/or regulation. The HUG is charged with developing the short and long term strategies that will fulfill the Governor's vision and with providing the leadership for their implementation. Its agenda is to include (1) incremental public program expansions, starting with populations most in need, etc., low

income children, their families, pregnant women and the frail elderly; (2) the information and models necessary to create workable options for affordable private or public/private insurance pro-rams for small group employers and employees and other individual low income workers; and (3) community health care collaborations that can enhance stable safety net delivery and health care for those not otherwise served.

HUG is currently overseeing a number of data collections, analytic and coalition-building activities related to the uninsured which will provide a foundation for the work to be undertaken through the SPG. These efforts are funded by the State and by the State Coverage Initiatives program of the Robert Wood Johnson Foundation. These activities include:

- An analysis of the individual and small group insurance market in WV and market reform efforts elsewhere to identify strategies suitable to WV, including the feasibility of using the PEIA small agency risk pool to expand health insurance coverage in the individual, small group, and non-ERISA large group markets.
- An analysis to identify the potential for savings in public programs in order to redirect the funds toward coverage expansion.
- Creation of a business roundtable to explore attitudes toward health insurance as a precursor to private-public partnerships. The purpose of the roundtable is to increase the understanding of the importance of health insurance coverage to WV's economic development and the benefits that would be derived from providing an affordable, quality insurance product(s) to the State's citizens, businesses and other purchasers of coverage and the options that exist for such coverage.
- A major household survey, the West Virginia Health Care Survey 2001 to obtain small area data on the uninsured and their characteristics in order to prioritize target population and geographic areas and identify appropriate intervention strategies. This study has been completed and constitutes a jump-start on the data collection component of the state planning process.
- HUG's work will be continued through the proposed planning grant, with HUG acting as the key decision-maker in the development of WV's plan to cover the uninsured.

Other Efforts

Four Community Access Pro.-ram (CAP) grants have been awarded to organizations that are targeting an estimated 104,000 uninsured persons in 22 out of 55 WV counties. CAPs will be breaking new ground in developing minimum benefit packages for people in their communities as well as in offering unique coverage packages to local business. Their experience as well as the input from their communities will be helpful in designing an affordable benefit package for all of WV. The Legislature has just enacted legislation to support the work of the CAP programs by excluding their coverage from insurance regulations thus giving them the leeway to create affordable products without regard to mandated benefits or other requirements.

While there may be creditability issues with coverages that are not up to benchmark, the benefit designs, consumer and employer reactions to them, and the level of business and community interest generated will carry important lessons for the SPG activities.

Most importantly, the CAPs will be providing some level of coverage to previously uninsured persons. Even with the extension of public programs and the development of new initiatives in the small group and individual markets some persons may fall through the cracks and remain uninsured. These may include:

- Those who choose not to participate in public program's
- Those who are in categories not eligible for public coverage in the near future
- Persons not eligible for public programs and who do not value insurance or who do not think it is affordable
- People who are temporarily uninsured due to job loss but not income eligible for a public program

Concerned with the underinsurance of many Medicare beneficiaries with respect to their prescription drug, needs, WV launched the Golden Mountaineer Card in 2001, which entitles seniors to pharmacy discounts at the point of sale. Remediating the underinsurance of this group continues to be a high priority.

Successes

At this time 14% of the WV population is receiving health insurance coverage through Medicaid, compared to 10% nationally. Twenty-six percent of WV children, about 112,000, are covered by Medicaid. An additional 4.4 % of WV children are covered by CHIP. Aggressive outreach to CHIP eligible has brought that enrollment to more than 21,000 children. Ninety-three percent of WV children are now covered by health insurance, a significant accomplishment resulting from the commitment of political and community leaders. The WV Healthy Kids Coalition has had dramatic success in helping, to expand CHIP enrollment. They will be invited to participate in the SPG effort and will provide expert assistance in planning, the outreach and marketing aspects of all options considered for implementation.

Implementation Problems

Lack of Financial Resources. Since expansions of federal programs require matching funds, there is always an issue as to where the funds will come from, particularly in WV, a state with poor economic indices and a limited public coffer. Finding and earmarking funds for program expansion requires public support and consensus building in the political sphere. A major goal of the state planning process will be to develop broad public support for the planning recommendations.

Lack of Technical Expertise in Conducting Effective Outreach. The main obstacle to CHIP enrollment during its early implementation was ineffective outreach. This was addressed and, through an intense community-based effort, CHIP enrollment has grown considerably. WV learned that promotion and outreach must be local, involving providers, churches, and other community figures, and sensitive to the culture and mores of the population. Yet, while the expansion has been impressive, the program has been more effective at reaching young children than adolescents and teens, and they are still to be targeted. The CHIP outreach experience, both in what it has and has not accomplished, offers valuable lessons for other public program expansions and any public-private partnerships that may be formed as a result of the SPG.

Lack of Consensus Regarding the Expansion of Public Program. The public programs bear the burden of the public's image of them, and past experience has shown that these perceptions and

attitudes must be addressed early in the planning process. Given WV's strained economic circumstances, policy makers are hesitant to discuss expansion of public programs. In addition, there is little history of involvement by the WV business community in health care issues.

A major challenge will be to shape public opinion in order to gain the support needed for public program expansion and for public-private approaches to affordable health care coverage for small firms and for those who need to buy insurance in the individual market. The HUG has already begun to address this need by conducting a roundtable on health insurance issues for business and labor leaders. Critical to the state planning effort will be a public information campaign directed at promoting public awareness of the need for health insurance and the benefits of such coverage for the health and well-being of the citizenry and the economic wellbeing of the community.

7. Requesting Preferences

Although WV has a relatively high rate of uninsurance, the State has been focused on lowering the percentage of uninsured for several years. Longitudinal data from the Current Population Survey indicate that the rate of uninsured in WV has declined over the past three years, from 15.7% to 14.3% (1998 to 2000). The CPS figure for 2000 is slightly higher than the uninsurance rate of 13.8% at the end of 2001, as reported by the West Virginia Healthcare Survey 2001, which suggests further improvement.

WV has placed much emphasis on making sure that children are covered. The 2001 Survey found that 6.6% of children were uninsured compared to 19.9% of the non-elderly adult population. WV has incrementally broadened coverage through its publicly financed programs by raising the standard of need, especially for pregnant women and children. It is now time to address and rectify the issue of uninsurance for other adults.

The advent of the CHIP provided WV with an opportunity to further assure that children are covered by health insurance. In 2000 WV raised the income eligibility standard to 200% FPL, Children are guaranteed 12 months of coverage. WV employs an aggressive outreach program for the CHIP and has been very successful in achieving participation, particularly of young children.

Decision-makers in WV are committed to reducing the number of uninsured West Virginians. They are focused on increased access to care and increased avenues for coverage of care. Access is being facilitated through government support of free clinics operating in urban areas. Coverage is being expanded through the Medicaid and CHIP programs. Most recently, the Legislature passed a bill to allow the demonstration of benefit programs for small employers through a pilot of the CAP concept of community-based provider services and exempted them from insurance regulations and statutes. The ultimate goal is to provide all West Virginians with affordable health care.

The current efforts are positive but it is recognized that more is needed. In particular, low income parents of Medicaid and CHIP children, families not eligible for public programs, other low income workers and adults, and frail elderly need affordable coverage. Many of these people are working, but uninsured. As a means of addressing lack of coverage, the Governor has convened the Health Umbrella Group (HUG). The HUG has already begun the work of collecting data and building a

coalition to work together to find solutions. A State Coverage Initiatives planning grant from the Robert Wood Johnson Foundation is being used along with State dollars to fund the effort to date. A HRSA SPG will help WV to more quickly perform the needed work that must be done before the coverage goals can be achieved.

The work has begun; a broad community commitment has been made. The time is right to address the problem of uninsurance in WV. For these reasons, we request that preference be given to this application for a SPG.

8. Statement of Project Goals

The overall mission of the WV planning effort is to ensure that every resident has access to affordable health insurance. The project's work is directed at four major goals.

Goal 1: Creation of a seamless public program of health care coverage for children and pregnant women up to 250%FPL, low income working parents up to 200% FPL and low income adults, and seniors for prescription drugs and preventive care.

Various avenues for extending coverage in the public program to additional populations will be explored, including a HIFA demonstration waiver. Working parents under 200% FPL may be covered through public program expansions or through their employers via a public private partnership. A seamless program will facilitate enrollment and reduce costs through streamlined administrative functions

Goal 2: Development of private or public-private options for affordable, comprehensive health care insurance for small and medium size employers as well as working families and individuals with incomes above 200% FPL.

The major data collection efforts of the project will focus on documenting the characteristics of firms in the small and medium group markets and the attitudes of these employers toward employee health insurance. An analysis of the WV small group and individual health insurance markets has already been funded through the HUG and will feed into the development of innovative coverage options for these markets.

Goal 3: Support for community healthcare system integration (CAP Grant program) and the State's free clinic system to provide services to low income individuals and families not eligible for other program.

Even with the extension of public programs and the development of new initiatives in the small group and individual markets, some persons may remain uninsured. These will include:

- Those who choose not to participate in public programs
- Those who are in categories not eligible for public coverage in the near future
- Persons not eligible for public programs and who do not value insurance or who do not think it is affordable
- People who are temporarily uninsured due to job loss but not income eligible for a public program

Safety net providers, including the CAP programs, will continue to be important in providing access to health services for these populations.

Goal 4: A climate of leadership and general public understanding that supports health insurance coverage expansion through public and private program that offer affordable health care coverage to all West Virginians.

Broad public support will be needed to implement the initiatives that will be identified through the planning grant process. Recommendations will require new legislation, redirection of state health care spending, financial commitments from businesses, and support by the public who in most cases will have to pay a share. Activities during the planning year will focus on developing this broad support by involving the various stakeholders in the planning process through the Health Advisory Council, an aggressive public information and education campaign and town meetings focused on SPG findings and recommendations.

9. Project Description

A. Detailed Project Narrative

Phase 1: Planning Process

Major Task: Create a multi-faceted Health Advisory Council

The first step in the planning process will be to create a multi-faceted Health Advisory Council (HAC or Council) to provide advice, representation, and a mechanism for communication and input from the various stakeholders groups. The Council will be involved in the review of data, the analysis of options, and priority setting and will serve in an advisory capacity to the decision making body for the project, the Governor's Health Umbrella Group (HUG). The Council will be subdivided into committees that will be given specific charges by the HUG. An initial schedule of meetings will be set, and staff support will be assigned. The HUG assisted by the Institute will also layout a process for the subcommittee deliberations and for reports to the HAC and HUG. The relationship between the HUG and the HAC is discussed fully below under "Governance."

The members of the HUG, assisted by staff, will identify approximately 60-75 persons from throughout WV who might be appropriate for inclusion on the Council. These persons will then be invited to participate, and 40-60 will be asked to commit to meeting, regularly (about once a month during the course of the planning year). Since a substantial commitment of time will be required, stipends will be offered to secure participation.

Participation in the HAC will be enlisted from both the public and private sectors. Business representatives may include insurance, major business and industry, labor, chambers of commerce, farm bureau/extension services, economic and community development agencies. Representatives of community organizations with an interest in health will also be included; for example, county and city leadership, local media, not-for-profit civic and voluntary organizations (libraries, foundations, United Way, and Lions Clubs), social service organizations, and religious organizations. Provider participants may include rural and community hospitals, the four Community Access Pro-rams funded in WV, community clinics and mental health centers, and medical, nursing and other health

professionals. Particularly important will be ensuring that the interests of the uninsured are represented among, the Council members.

Review of the other SPG processes has shown that such an advisory council can be effective in securing, broad participation. For example, the insurance industry must be involved in the process if market mechanisms will be relied on to deliver affordable coverage to those not eligible for subsidies. A subcommittee structure is proven to be effective in accomplishing a great number of tasks in a limited time,

Action Steps

- Identify individuals for inclusion in the Health Advisory Council
- Secure their interest and commitment
- Develop a stipend structure and meeting schedule
- Identify the appropriate subcommittee structure
- Assign staff support to the subcommittees
- Structure the deliberation/decision-making process

Anticipated Results

This task will result in an assemblage of 40-60 diverse individuals who, as the HAC, will serve in an advisory capacity to develop approaches for expanding health insurance coverage in WV.

Agencies/Individuals Responsible for Completion

The HUG, assisted by staff, will determine the most appropriate committee structure. The Institute will assign staff to provide research and analytic support to these committees. Assisted by the Institute, the HUG will lay out a deliberation and decision-making, structure that will provide for full consideration of the input provided by the committees and the HAC a whole and will include regular reports to the HUG.

Processes for Collaboration

Membership in the HAC will be drawn from many sectors of WV. Suggestions for experts to participate in subcommittee efforts will be solicited from the individuals tapped for HAC participation, which will further ensure broad representation.

Timetable

Activities involved with setting up the HAC will require two months at the outset of the project.

Phase 2: Communication Strategy/Public Information Campaign

Major Task: Lay out a communication strategy, including a public information campaign, to build support for the outcome of the planning process.

Cognizant of the fact that new approaches to providing, coverage to the uninsured will require broad support, the project will strive to create this climate of support through an orchestrated communication strategy that will involve a public information campaign to be conducted during the second half of the planning, year. The coal of the campaign will be to improve the general public's understanding of and commitment to the importance of health insurance for supporting community health care systems, access to care and the quality of life enjoyed by WV residents, and community

economic development. The communication strategy will also include regular legislative briefings on the activities of the project as well as briefings to the HAC.

The data from the WV Healthcare Survey 2001 indicate that most people value health insurance for their families (95% of the respondents think it is "very important") and 91% of the respondents think it is "very important" that all West Virginians have access to coverage. While this suggests that public sentiment will be sympathetic to the work of the SPG, it will be very important to keep the public apprised of the proceedings to encourage their participation in the debate and to secure their financial commitment for the necessary public funding.

Action Steps

Contract with a public relations consultant to provide expertise for this task

- Review relevant data from the 2001 Survey and conduct key informant interviews to identify the elements of an effective public relations campaign
- Create a detailed communication plan, identifying the audiences, media, timetable, and costs
- Develop materials to conduct outreach and provide information to the public
- Disseminate regular reports about the uninsured, the availability of coverage, and access options to the general public and target audiences
- Conduct briefings for the Legislature at the beginning of the project and at key points during the project

Anticipated Results

The completion of this task will result in a communication strategy to be implemented in the second half of the planning, year and directed at a variety of audiences including the general public, the Legislature, and the stakeholder community.

Agencies/Individuals Responsible for Completion

The development and implementation of the communication strategy including the public relations campaign will be the responsibility of the Institute's Director of Community Programs. Expert assistance will be sought from a consultant who will aid in conducting the research and designing the campaign, prepare the information pieces, and arrange for their placement.

Processes for Collaboration

While the development of the communication strategy will be the responsibility of the Institute, the proposed plan will be reviewed by the HUG. As such, all relevant State agencies will have the opportunity to provide input to this activity. The HAC will also be invited to offer suggestions particularly with respect to the most effective ways for reaching, the general public in their communities.

Timetable

The communication plan and public information campaign will be developed during the first six months and implemented throughout the rest of the project.

Phase 3: Data Collection and Analysis

Major Task: Review and synthesize existing data sets and collect new quantitative and qualitative data on employer-based coverage

Review and Synthesis of Existing Data

The synthesis of existing data will provide a context for the collection of new data. Considerable information is available on the characteristics of the uninsured population from the WV Healthcare Survey 2001. This survey will continue to be analyzed as part of the SPG. While this survey will yield some insight into uninsured workers, additional data collection is needed on employer-based insurance in WV, National data sources will be synthesized prior to undertaking new data collection in this area.

West Virginia Specific-Surveys

Legislative Survey 2000. A small statewide survey of 800 households was undertaken in the closing months of 2000 to furnish a report to the Legislature on the number of uninsured in WV and their characteristics. Of special interest were the regional differences in health insurance coverage, from 8.5% in the northern panhandle to 27.5% in the east central counties, differences that did not appear to correlate with either employer-based coverage or public program coverage. While the survey suggested wide variation, the sample size did not support definitive local or regional analysis. The results provided the impetus for another much larger survey, the West Virginia Health Care Survey 2001, which provides a wealth of data on the uninsured and their characteristics.

West Virginia Healthcare Survey 2001. The West Virginia Healthcare Survey 2001, conducted by telephone during November and December 2001 surveyed approximately 290 households in each of 55 WV counties, 16,500 in all, regarding, health insurance, health status, and use of the health care system. The Institute conducted the survey under a contract with the HUG.

Households were chosen at random, and one adult in each household was interviewed. This was the person who identified him or herself as the most knowledgeable about the health insurance of all household members. Prior to analysis, the data were weighted for the probability of selecting each household, and then adjusted so that the age and sex distribution of each county matched the 2000 Census. The data were then adjusted to account for households without telephone service.

A complete profile of uninsured individuals can be developed from the data which include income, age, gender, family composition, health status, employment status, availability of private availability of public coverage, race/ethnicity, geography, and duration of uninsurance. Analyses can be performed at the regional and county levels and will be further enriched by drawing on the state and county level data available from the 2000 Census. It is not anticipated that any significant new data collection will be needed on the General uninsured population. With this survey data already in hand, WV greatly reduces the data collection effort typically required for an SPG and accelerates the planning process. The two reports, already produced from this survey, will be reviewed by the HUG and the HAC at the outset of the planning process.

National Data Sources

The main shortcoming of national data sources is that the samples for WV are not large enough to generate reliable estimates, and estimates are generally not available below the state level.

Nonetheless, these data will be reviewed for the guidance they can provide for new data collection primarily in the area of employer-based insurance. These data sets include the Current Population Survey, the Medical Expenditure Panel Survey-Insurance Component, and the Behavioral Risk Factor Surveillance System (BRFSS). The project will utilize the technical assistance available from the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

In addition, WV's project will be supported by the SPG Multi-State Integrated Database (MSID) managed by the Arkansas Center for Health Improvement. The MSID provides access to a web based software program (ProClarity Knosys) that enables enhanced utilization of state-specific national data including the Behavioral Risk Factor Surveillance Survey (CDC), the Current Population Survey (Bureau of Labor Statistics), and the County Business Pattern Census (U.S. Census Bureau). There will also be the opportunity to incorporate up to two state-specific datasets into the database. The MSID takes advantage of technology to link data for timely and clear responses to queries and, as such, is a useful tool for presenting complicated data sets in formats that are easily understood by policy makers and the general public. It will be utilized for all legislative briefings and presentations during the project.

New Data Collection on Employer-Based Coverage

The "employed uninsured," representing almost two-thirds of all uninsured persons, are the largest subpopulation among, the uninsured in WV. The State wishes to understand better the characteristics of employers that do and do not provide health insurance coverage as well as the nature of the coverage that is provided in order to assess the potential for working through employers to decrease the number of uninsured. It also wishes to understand the attitudes of employers toward health insurance in order to assess the potential for public-private partnerships.

First, all available data on employer-based coverage and uninsured workers in WV from national and state data sources will be drawn together in a white paper to provide a backdrop for new data collection. This synthesis will also review national trends and examine WV in the national context, identifying issues that may be specific to WV and that need follow-up through new data collection. Certain information on uninsured workers will be available from the WV Healthcare Survey 2001.

A major statewide survey of employers will be undertaken in order to identify the characteristics of employers that do and do not provide coverage in WV. Data collected will include firm size, industry, employee income levels, full time versus part time workforce, and geographic location. For businesses that do provide coverage, information will be collected on benefit structure and employee cost. In addition to descriptive data, attitudinal information related to health insurance (views on employer/employee contributions, public programs, role of insurance in employee retention) will be collected to gain insights for the development of new approaches to coverage, including public private partnerships. Survey instruments used by other states involved in an SPG will be reviewed. A stratified sample will be identified to include large and small employers, the self-employed, urban and rural employers and a variety of industries. One thousands employers will be surveyed.

Analysis of the WV insurance market

While a major thrust of the planning effort will be on developing employer-based options for uninsured workers, it is also important to develop alternative strategies for reaching individuals and their families, apart from their jobs. Indeed, such strategies are vital for those who have no prospects

of job-related insurance. An analysis of the individual market is already underway as part of a broader study on the potential for health insurance market reform in WV.

The State has hired a consultant to analyze the individual, small group, and large group (non ERISA) market in WV, including insurers participating; the type, costs and benefit packages available; take up rates; the legal and regulatory framework; implementation of HIPAA provisions; and the impact of State beneficiary protections on the cost and availability of products. The consultant will also examine these insurance markets in other states to identify mechanisms that might be successful in WV and analyze several specific options for insurance market reform. The report will be completed before the planning grant begins and will not be part of the planning, grant. This effort is being overseen by the Institute.

Action Steps

- Continue the analysis of the data collected in the West Virginia Health Care Survey 2001
- Contract with Multi-State Integrated Database project
- Review available national databases
- Synthesize the data and identify gaps in the knowledge of the uninsured particularly with respect to the employed uninsured and employer-based coverage
- Hire the consultant to assist with survey development and to conduct the survey
- Conduct a literature review including survey instruments used by other state planning grantees for employer surveys
- Develop and field-test the survey instrument.
- Determine and select the sample
- Field the survey
- Compile and analyze survey data and prepare report

Anticipated Results

A synthesis of available data will be available to the HUG and HAC for identifying target uninsured populations. Gaps in the data will be identified as a prelude to additional data collection. As a result of the employer-based survey, a compendium of information will be available on employer-based coverage in WV that can be used to target uninsured workers for special initiatives.

Agencies/Individuals Responsible for Completion

The Institute, with the assistance of a consultant, will continue to analyze the data from the West Virginia Health Care Survey 2001. The Institute has initiated and will manage the contract with the Arkansas Center for Health Improvement for the HRSA SPG Multi-State Integrated Database. The Institute will also have primary responsibility for the new data collection related to employer-based coverage. Institute staff will conduct the background literature review and data synthesis and will work with the consultant to develop the instrument for the employer survey. The consultant will contribute to the design of the survey instrument, field test the instrument, conduct the survey, compile and analyze the data and, with the collaboration of the Institute, write the report.

Process for Collaboration

The synthesis of the data will be presented to the HUG and HAC for their review and use in identifying uninsured populations for targeting. Members of both groups will have an opportunity to pose questions and to request special data runs. The HAC and HUG will also have an opportunity to raise questions for inclusion in the employer-based survey. The draft survey instrument will also be

reviewed by the HUG and the appropriate subcommittees of the HAC, in order to obtain input from business, labor and representatives of uninsured workers.

Timetable

The entire data collection and analysis effort will span five months. Review of the available data will be done during Month I of the project. The consultant for the employer-based survey will be identified and contracted during Months I and 2; the survey instrument, developed and field tested and the sample, selected in Month 3; and the survey, conducted in Month 4. Initial data analysis and a report to HUG and the HAC will be completed by Month 5 of the project.

Phase 4: Option Development

Major Task: Develop strategies for creating one seamless public program, including approaches for expanding public health insurance programs and providing affordable health insurance to workers, their families, and persons in the individual market

HUG has embarked on its chance to expand health insurance coverage to all West Virginians with a high level of activity and has already identified a number of options for in-depth investigation. Analysis of some of these options has already begun. Additional options will be identified during the planning process. Key to the option development effort is assessing the suitability of the option to the WV political, economic, and social environment. Analysis of the option will involve a full impact and feasibility assessment including the description and number in the target population, cost and source of funds, integration with existing programs, "crowd out", eligibility and enrollment, health care delivery system used, outreach and marketing, and other factors; in other words all the "nuts and bolts" of how the option would work. We will also consider the capacity of the existing system to support an increased demand for services. The small area data from the West Virginia Healthcare Survey 2001 will be used to address area specific needs for outreach and product development. Full advantage will be taken of the opportunity to benefit from the experiences in other states by consulting with them in person or by telephone.

Creation of a Single, Seamless Public Program

The SPG will plan for the integration of the existing administrative structures for Medicaid and CHIP into a single organization. The "desirability" analysis will consider the impact on outreach, ease of participation for beneficiaries and health care providers, effect on quality outcomes and health status, improvements in system efficiency, and costs. For example, it may be possible to offset some of the costs of expanded coverage through streamlined administration. Another issue to be considered is the public's perception of the program including the issue of stigma. The feasibility analysis will involve visiting other states where a unified program is being, contemplated or has been achieved and developing the plan and timetable for the transition. The HAC and the HUG will review the plan to be followed in the analysis, and thus will have the opportunity to raise issues for exploration that are of concern to the constituencies they represent. A consultant under the direction of the Institute will perform the analysis and Authority staff will contribute to the financial component.

Expansion of Eligibility for Public Programs

While WV has made considerable inroads in providing health insurance to its children with 93% covered, a significant proportion of adults ages 19-64 (20% of the total) are uninsured. The SPG will be used to investigate the feasibility and desirability of extending public coverage to low income

working parents under 200% FPL and low-income adults under 200% FPL using Medicaid and SCHIP resources through a Health Insurance Flexibility and Accountability (HIFA) demonstration waiver. Consideration will also be given to extending the income limits to 250% FPL for pregnant women and children, and including seniors who need coverage for prescription drugs and preventive care.

The impact on the number of uninsured persons and financial projections, including the cost to the State of WV, potential sources for funds, the impact on uncompensated care and administrative expenses will be considered. Financial projections will be developed and sustainable revenue sources identified. The potential for premium assistance programs for private group health plans will also be considered. Other states will be consulted regarding their experiences in designing and implementing these expansions as well as the impact of these waivers on the level of uninsurance. A consultant under the direction of the Institute will perform the analysis of a potential HIFA waiver and prepare a written report and recommendations. The developmental work will include discussions with the Center for Medicare and Medicaid (CMS) staff.

Improved Outreach

Owing to a concerted outreach effort involving the State program office, "grass roots" organizations, and the Healthy Kids Coalition, CHIP enrollment in FY 2001 increased 53 percent over the previous year with the addition of 11,485 children to the pro-ram. Techniques that were successful for CHIP will be identified so that they can be applied to Medicaid as well as to any future public program expansions. The HUG will seek to become experts at the art of reaching eligible populations so that as new options for covering the uninsured are developed they can be successfully delivered to the target populations.

While the overall CHIP results have been laudable, older children have not been reached as successfully. The rate of uninsurance for children ages 12-18 is 7.7% compared to 1.7% for infants and 4.8% for preschoolers ages 1-5. Parents of 31% of potentially CHIP eligible children say their children are not enrolled because they are unaware of the program. Parents of 20% of the Medicaid eligible children who are not enrolled say they are ignorant of the program.

The planning project will undertake two activities to improve outreach efforts for public programs. First, the data from the West Virginia Healthcare Survey 2001 will be reviewed to better understand the issue of non-enrollment by eligible persons. SPG funds will then be used to interview key informants and conduct focus groups with the parents of eligible but uninsured to identify the characteristics of what would be a successful public outreach campaign in WV. Institute staff will perform these research activities.

Employer-Based Approaches to Affordable Coverage for Workers and Their Families

An estimated 44% of the uninsured WV population is employed full-time and another 17% are part-time or seasonal workers. Fourteen percent of uninsured workers are self-employed. Because many workers are low income, it is envisioned that some kind of premium subsidy program either through the employer or directly to the worker may be needed. The major data collection effort of Phase 3 will seek to understand the characteristics of firms that do not provide health insurance particularly those whose workforces are predominantly full-time. These data will be used to profile employers who might be good candidates for public-private partnerships. These characteristics might include proportion of full-time workers, industry, competitiveness of industry, average length of employee tenure, size of company, and reason for not providing health insurance.

WV will strive to benefit from experience of other states by undertaking a literature review and analysis of best practices to identify options for employer-based coverage, that are either privately sponsored or the result of private public partnerships. Each approach will be assessed for its applicability to WV. A major next step will be to collect qualitative data through key informant interviews in order to identify key industries or locations for the partnership and to "test the waters" on the possible options. Financial projections will then be developed for the models and sustainable sources of revenue, identified. Once this work is completed, the options will be presented to the Authority, HAC, and HUG for preliminary acceptance. Focus groups will then be conducted with business owners to test their willingness to support the proposed public-private partnership, including their response to various price points and benefit packages. Focus groups will also be conducted with uninsured workers to explore their attitudes towards contributing to health insurance, their preferred approach (employer-based coverage or other). These focus groups will also test a benefit design. (See below). A complete feasibility analysis of the options examined, including a tentative implementation plan, will be presented to the HUG and Authority.

Institute staff and a consultant will prepare the synthesis of best practices, interview the key informants, conduct the focus groups, and prepare the analysis of the options with the participation of Authority financial staff. Creation of the employer-based approach will include input from business (via interviews and focus groups) and uninsured workers (via focus groups).

This work will take three months and will result in an analysis of employer-based approaches, possibly with public subsidies.

New Approaches to Risk Pooling

The HUG has already employed a consultant to analyze the feasibility of extending the PEIA small agency risk pool to other small employers. This work will be complete before the planning grant begins. The results of this analysis will be available for review by the HUG. As with other options, consideration must be given to the acceptability of the solution to various stakeholders, for example, in this case other state employees who might be concerned about the effects on their own health insurance costs. Fiscal projections will be undertaken to understand the program benefits for a small agency risk pool in terms of administration, beneficiaries' costs, stabilization, and other factors, including protections to eliminate negative impact on current beneficiaries.

Affordable benefit packages

Expanded public programs, public private partnerships, and market products all require a benefit package that is affordable yet consistent with benchmark coverages. A major issue in designing a benefit plan is keeping it affordable to persons with limited incomes who have many other demands on their incomes. Certain benchmark products may simply be too costly for this market. Minimum standard benefits while intended to be protective of the health of the citizenry may also add to costs. The challenge will be to provide a benefit package that will protect in the case of catastrophic expenses but at the same time support access to regular care so that chronic conditions are followed and preventive services, received.

The target populations' perceptions of what is affordable and the value they place on insurance coverage are very important factors that will determine the success of any initiative. Insights into uninsured workers' attitudes towards health insurance (their willingness to contribute, their desire for

coverage, etc.) will be explored through focus groups. In addition, cost-sharing, affordable premium levels, and benefit design preferences are other issues to explore with the target populations. Should it be determined that benchmark coverage is not perceived as affordable or valued by the population in a particular income stratum, alternative solutions will need to be identified.

The Institute staff and a consultant will develop the tentative benefit plan with several variations, price the package, and conduct focus groups with uninsured workers, other uninsured persons, and business owners to assess their reaction to the benefits, what they value and do not value, how much they would be willing to pay and for what benefits, their overall attitudes toward health insurance and the value they place on it among other competing needs. The results of this activity will be an affordable benefit design that meets the needs of the uninsured population and reflects their values with respect to the coverage provided.

Individual Purchasers

A major deterrent to the purchase of individual coverage in WV is the absence of community rated pools. While there is requirements for Guaranteed renew ability, insurers may medically underwrite and risk adjust premiums. As a result, certain people will be uninsurable or will be offered insurance at rates that are completely unaffordable. Persons who have recourse to portability coverage find extremely hi-h rates since there is no control on premiums. There will always be people at higher income levels who will not be within the radar for public programs or public/private partnerships. Yet many of these people are uninsured and must be enabled to buy what they would consider affordable coverage. Relative to other goods and services, health insurance is very expensive in WV and consumes a larger proportion of income than it does in many more prosperous states, The analysis of insurance market reform will look at other states that have community rating, requirements and the effect on the levels of insurance and participation of insurers in those states. This report will be finished prior to the SPG and will be available for consideration by the HUG and HAC.

Support for the Community Access Programs (CAP) and Safety Net Providers

Aware that even with the extension of public programs and-the development of new initiatives the small group and individual markets, some persons may-remain uninsured, the SPG activities will also assess the contribution from CAPs and safety net providers in providing, services to vulnerable uninsured persons.

Underinsured Populations

It is possible that the benchmark coverage developed by the SPG process will exceed the coverage available to many insured persons who, when compared to the standard, become underinsured. For example, if prescription drugs were part of the benchmark coverage, persons on Medicare who did not have drug, coverage would become underinsured. In addition, there are other groups already identified as being underinsured; some 7% of insured WV children, 28,200 in number, and 8% of insured adults, 79,600 persons, who have only a catastrophic or hospital cash plan and thus do not have the support for regular primary care.

Action Steps

- Identify options to accomplish a seamless public program which may include expansions, new benefit designs, waivers, public private partnerships and other approaches
- Conduct key informant interviews to pre-test possible approaches

- Conduct a desirability and feasibility analysis of each option including a thorough financial assessment
- Review the options with the Authority, HUG and the HAC to identify potential approaches
- Conduct focus groups with employers and potential enrollees
- Prepare a report incorporating the analyses and focus group results

Option Development: Anticipated Results

This phase of the project will yield outlines of viable options for possible implementation.

Agencies/Individuals Responsible for Completion

Identification of options to be explored will be determined by the Institute, the HUG and the HAC with the assistance of the consultant. The analyses will be done by the Institute staff, the consultant, and the Authority financial analysts.

Process for Collaboration

The HAC, which will be broadly representative of a multitude of stakeholders, will be involved in the initial selection of options for analysis and the selection of options for focus group testing. Employers, uninsured workers and other uninsured persons will have a chance to provide input through key informant interviews and/or focus groups.

Option Development: Timetable

Work on Option Development will begin in Month 3 and be completed by Month 10 in order to allow two months for final deliberations and recommendations.

Phase 5: Recommendations

Major Task: Select options for implementation

The Institute staff with the help of a consultant will review all of the HAC and HUG deliberations, the data collected, the focus group and other research results, and the option analyses to prepare a draft report for the Authority, HUG, RAC, and the Governor. Based on the review and discussion of this material, the HUG will propose a plan for expanding health insurance coverage in WV. This will include one or more options with a timetable for implementation. All recommendations will have been assessed for their cost impact the capability of the system to support the approach, and the effectiveness of the approach in making affordable health insurance coverage available to as many West Virginians as possible. Options may be selected for specific target populations taking, into consideration such unique circumstances as Geographic location or employment setting.

A briefing, will be held for the Legislature, and public input will be sought on these draft recommendations through town meetings in each of WV's eight Public Health Service Regions. Project staff will set up the public town meetings, which will be keynoted by the Governor when feasible and led by members of the HUG. Authority and Institute staff will also assist in facilitating the discussions. The meetings will be set up with the assistance of community leader's from the business, labor, consumer, and health care sectors, whose role it will be to assure attendance by the affected public. The process of seeking public input and completing the final report will take seven weeks. The feedback from the town meetings will be discussed by the HUG with priorities for implementation assigned and a feasible timetable for implementation adopted and incorporated into

the final recommendations. These recommendations will then be presented to the Governor and Legislature.

Throughout the planning process, the Institute will carry out a communication plan to increase public awareness of the need to expand health insurance and improve health care access for all West Virginians. This will provide a basis for broad support of the SPG recommendations. The active participation in the entire process by the HUG and the HAC comprised of representatives from the business sector, community organizations, and the health care delivery system will further assure that the recommendations are acceptable and represent a consensus on which to move forward.

Actions Steps

- Prepare report to reflect all planning, activities up to the results of the options analyses
- Select the options to be used to expand health insurance coverage to all West Virginians
- Conduct legislative briefing
- Set up town meetings in consultation with community leaders, health care providers, and the business community
- Present draft recommendations at town meetings
- Revise recommendations to reflect public input as appropriate
- Approve and prioritize recommendations
- Present recommendations and timetable to the Governor of WV and WV Legislature

Anticipated Results

Final recommendations that will be used to expand health insurance coverage to all West Virginians and a time table for implementation.

Agencies/Individuals Responsible for Completion

All staff work to support the development of the final recommendations will be performed by the Institute and the Authority, with the assistance of a consultant. Town meetings will be set up by staff and will feature a keynote address by the Governor, when feasible. Following input from the public, the HUG will decide on the final recommendations for presentation to the Governor and the Legislature. The HUG Chairperson, the Authority Chair, and the Institute Executive Director will present the recommendations to the Governor and Legislature.

Processes for Collaboration

A multitude of stakeholders from throughout WV will have the opportunity to provide feedback on the draft recommendations during a series of town meetings to be held in all of the Public Health Service Regions of the State.

Time Table

The recommendations will be finalized during Month 11 and 12 of the project.

Phase 6: Final Report to the Secretary

Major Task: Prepare final report to the Secretary of the U.S. Department of Health and Human Services

At the conclusion of the planning, process, a final report will be prepared for presentation to the Secretary of the U.S. Department of Health and Human Services. The report will summarize the SPG activities, findings and deliberations, and set forth the plan for significantly reducing the number of uninsured persons in WV. The uninsured population, expansion options, the needed partnerships, and the implementation timetable will be described.

Action Steps

- Prepare draft report
- Review draft report
- Prepare final report

Anticipated results

A final report that documents the activities conducted during, the planning process and presents the recommendations for reducing, the rate of uninsurance in WV.

Process for Collaboration

The HUG will review, comment, and approve the final report and recommend its submission to the Governor for his transmittal to the Secretary.

Agencies/ Persons Responsible for Completion

A consultant under the direction of the Institute will write the draft and final version of the report for submission to the Secretary.

Timetable

The final report will be completed at the end of the project.

9 B. Project Management Matrix

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
<i>Phase 1: Planning Process</i>				
Legislative leadership briefing	Upon notification of the grant award	Authority and Institute	An assemblage of interested, diverse individuals to serve in an advisory capacity in developing methods to eliminate or reduce the lack of insurance in West Virginia	Dissemination of information
Create a multi-faceted Health Advisory Council(HAC)	7-1-01 to 7-31-02	Authority and HUG	Participation by all stakeholders in the HAC including persons currently uninsured	A member list and defined charge to the group
Establish stipends to assure adequate representation of all desired groups in the HAC	7-1-02 to 7-31-02	Authority and HUG	Subcommittees peopled by individuals capable and willing to undertake an intensive study of their topic area	Adequate diversity and participation by the desired group of individuals
Create subcommittees to focus on particular areas for research and data collection	8-1-02 to 8-31-02	Authority and HUG	Adequate staff to support the work of the subcommittees and the HAC	A list of subcommittees and an initial schedule of the meeting dates
Assign staff support to the subcommittees	8-1-02 to 8-31-02	Authority and the Institute	A process in place to perform the work and to report the progress to the HAC and the HUG	Named staff for the subcommittees
Establish the structure for the subcommittee deliberation and decision-making process, including reporting back to the HAC and HUG on a regular basis	8-1-02 to 8-31-02	Authority and the Institute		An established process and ongoing reports to the oversight entities

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
<i>Phase 2: Communication Strategy/Public Information Campaign</i>				
Contract with a public relations consultant	7-1-02 to 9-15-02	Institute	A contract	The preparation and dissemination of communication messages
Conduct an in-depth review of the 2001 survey re: communication issues	9-16-02 to 9-30-02	Institute and consultant	Identification of the key communication issues	Information to be used in the preparation of a public information campaign
Conduct key informant interviews	9-16-02 to 9-30-02	Institute and consultant	Identification of the key elements of an effective public relations campaign	Information to be used in the preparation of a public information campaign
Create a detailed communication plan	10-1-02 to 10-31-02	Institute and consultant	Identification of the audiences, media, timetable and costs	A communication plan
Develop materials to conduct outreach and provide information to the public	11-1-02 to 12-31-02 and following adoption of the desired program options	Institute and consultant	Multiple and diverse materials to use in both a general information campaign and in targeted outreach	Effective tools to use in a communication effort
Ongoing dissemination of information about the uninsured and the availability of the coverage and access options	1-1-03 to 6-30-03	Institute and consultant	An ongoing outreach and communication campaign	General and targeted messages to the public

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
<i>Phase 3: Data Collection and analysis</i>				
Review the results of the existing health care survey	7-1-02 to 9-15-02	Institute	Background data and identification of gaps in the knowledge of coverage and access in West Virginia	Analysis of data
Contract with the Multi-State Integrated Database project	7-1-02 to 7-31-02	Institute and consultant	Access to national data and creation of WV specific database	Data availability
Review available national data sources	7-1-02 to 7-31-02	Institute and consultant	Background data and identification of gaps in the knowledge of coverage and access in West Virginia	Analysis of data
Contract with a consultant to assist in the development and conduct of an employer survey	7-1-02 to 8-31-02	Institute	Contract with a knowledgeable consultant	Effectuated contract
Develop a tool for a statewide survey of employers	9-1-02 to 9-15-02	Institute and consultant	Survey tool	Tool sufficient to determine the characteristics of WV employers regarding health insurance
Field test the employer survey tool	9-16-02 to 9-30-02	Consultant	A complete, easy to understand survey tool	Changes to the tool if gaps or areas of misunderstanding are identified
Determine and select the sample	9-16-02 to 9-30-02	Institute and consultant	A stratified sample allowing a survey of large and small employers, self-employed individuals, urban and rural employers	A completed array of employers to be surveyed
Field the survey	10-1-02 to 11-1-02	Institute and consultant	Completed surveys for the specified goal(50%)	Completed surveys

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
Compile and analyze the survey data	11-1-02 to 11-15-02	Institute and consultant	Analysis of the data	Data
Prepare a report with the results of the survey and recommendations	11-16-02 to 11-30-02	Institute and consultant	Completed report provided to all parties	A report with recommendations
Complete the analysis of the WV insurance market already underway	Report to be completed prior to 7-1-02. Results will be used during SPG	Institute, Consultant and Authority	Completes report	Completed report
Legislative leadership briefing	12-1-02 to 12-31-02	Institute, HUG, Consultant and Authority	Informed legislature	Information dissemination

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
<i>Phase 4: Option Development</i>				
Development of options to accomplish a seamless public program based on literature review, research of other state programs, fiscal analysis and data collection	9-1-02 to 1-31-03	Project Manager with Institute, consultant and HUG	Several program options including expanding existing programs and developing new programs such as benefit package design, waivers, state plan amendment, an incremental timeline for implementation and others	Outlines of potentially viable programs
Conduct key informant interviews	9-1-02 to 10-31-02	Institute and consultant	Information on program features that are essential for feasible approaches	Information to use in the development options
Determine the price for each of the proposed options	2-1-03 to 2-28-03	Consultant and Authority financial staff	Price tag for each of the proposed option	Review of the numbers used to establish the price tag

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
Review options with the Authority, HAC and the HUG to eliminate those deemed unaffordable	3-1-03 to 3-15-03	Institute with consultant	Feasible program options	Outline of potentially viable programs
Conduct focus groups with potential enrollees and employers	3-16-03 to 4-15-03	Institute with consultant	An understanding of the options most attractive to persons seeking insurance and employers	Public input into the program options
Prepare a report on the focus group findings	4-16-03 to 4-30-03	Institute with consultant	A report of the focus group findings	Report

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
<i>Phase 5: Recommendations</i>				
Review all of the research, data collected, program options and focus group findings	5-1-03 to 5-15-03	Institute with consultant	Review of all relevant materials	Summary of data findings
Prepare a report for the Governor, Authority, HAC and HUG	5-15-03 to 5-31-03	Institute with consultant	Report with finding	Report
Recommendations for one or more programs to address coverage for the uninsured including a timetable for implementation	6-1-03	HUG	Recommendations for a program to address uninsurance in West Virginia	Recommendations
Legislative leadership briefing	6-2-03	Institute, HUG, Consultant and Authority	Informed legislature	Information dissemination
Public discussion of the HAC and HUG recommendations	6-3-03 to 6-15-03	Institute, HUG, Consultant and Authority	Town meetings in each of the eight health service regions	Public input into the final program design

Task Identifier	Timetable	Responsible Party	Anticipated Results	Evaluation/Measurements
Revision of the recommendations based upon public input	6-16-03	HUG	Final recommendation	Recommendations
Presentation of the recommendations to Governor and Legislature	6-20-03	HUG, Authority, consultant	Approval of the recommendations	Discussion and approval or changes to the recommendations

<i>Phase 6: Final Report</i>				
Preparation of the final report to the Secretary	6-21-03 to 7-15-03	Institute and consultant	First draft of final report	Report draft containing all elements of the SPG tasks
Review of the final report	7-15-03 to 7-20-03	Authority, HAC and HUG	Comments on the draft	Report reviewed
Prepare and submit the final report to the Secretary	7-20-03 to 7-31-03	Institute with consultant	Complete final report	Technical review of the report by the Secretary

9 C. Governance

The Governor of WV is fully committed to expanding health insurance coverage to all West Virginians and has appointed the WV Health Care Authority (Authority), the state planning agency, as the lead organization for the project. Because it has a relatively small staff with an already full set of responsibilities, the Authority has chosen to contract with the Institute to serve as the "managing partner" for the SPG, with the Chair of the Authority and the Executive Director of the Institute acting, as co Principle Investigators.

The Authority and the Institute will work closely with the Health Umbrella Group, set up by Governor Wise in 2001 to address the issue of the uninsured in WV. With high-level participation from the executive levels of all state agencies involved in health care, HUG is charged with planning an incremental approach to health insurance coverage of all West Virginians. The Institute provides staff support to the Health Umbrella Group and has directed their various data collection efforts on the uninsured, including the West Virginia Healthcare Survey 2001. The Chair of the Authority is a member of the HUG.

The Authority, the Institute and the HUG will be assisted in their work by a Health Advisory Council (HAC) that will be broadly representative of all stakeholders to the project. The HAC's role will be advisory. The grant will be administered by a project management team described below under "Project Management".

Role of Lead Organization in Coordinating the Project

The Authority is an autonomous agency within the Department of Health and Human Resources with statutory responsibility for a variety of health planning, regulatory and data activities. With broad responsibility for the state of the health care system in WV, the Authority is unencumbered by a narrow programmatic perspective. An experienced leader of a number of interagency efforts for state government, the Authority is well suited to provide policy direction to an effort that will brine, together multiple constituencies for a single purpose. The Authority will contract with the Institute as a "managing, partner". The Institute is a not-for-profit component of West Virginia University's Robert C. Byrd Health Sciences Center and is part of the Office of the Vice President. The staff at the Institute has established track records in health services research and analysis.

The Executive Director of the Institute will be responsible for the administrative oversight of the SPG, assisted by the Institute's leadership and the Project Manager, In this role, she will be responsible for the smooth and timely progress of the tasks being undertaken, the resolution of problems and barriers which may arise, the timeliness and effectiveness of contracting, hiring and other operating functions, as well as the timeliness and quality of all products produced and activities undertaken by the SPG.

The Authority will provide the Budget Officer who will be responsible for overseeing expenditures and ensuring accountability and who, as the Contract Officer, will assure the timely and complete communication required by the Health Resources and Services Administration.

The Institute's Research Director will be responsible for all research activities, working with assistance from the Senior Research Associate and the consultants, and for managing the timely completion of this work.

The Institute's Director of Community Programs will be responsible for working with the communications consultant and the staff specialist to manage the strategies developed for the public awareness campaign and their implementation, and to develop the SPG partnership with the Healthy Kids Coalition and their community-based Family Resource Networks so that they can be part of and help to inform the consultant's work on program outreach models for the State's public programs.

The Senior Research Associate at the Institute will be responsible for overseeing and facilitating the work of the HAC and its subcommittees, with the support of staff from the Institute, Authority and the various appropriate state agencies.

Composition and Decision-Making Structure

All decision-making authority related to the SPG will reside in the Health Umbrella Group. The HUG will be aided in their work by the Health Advisory Council, comprised of stakeholders drawn from business and labor, community and provider organizations, and consumers who will provide advice and analysis and serve as a vehicle for communication between the project and the stakeholder communities. The HAC will carry out its work through a subcommittee structure with staff support.

At the outset of the planning year, the Authority and HUG will specify a formal structure for deliberations and decision-making, which will take into full consideration the recommendations of the HAC. The process for informal and formal communication between the HAC and the HUG will be charted during the first month of the project.

The co-chairs from the Authority and the Institute will manage the process for decision-making which will include weekly meetings of senior project staff, regular monthly and special meetings of the HUG, interim meeting, staff assignments, monthly meetings and reports by the HUG with the Governor, as well as regular meetings with the Health Advisory Council (HAC) and the leadership of the Legislature. The co-chairs will also manage the HUG approved structure, subcommittee assignments and work reporting mechanisms of the HAC, and will act as spokespersons for the -rant and its undertakings.

Participation of State Agencies, the Legislature, and Other Key Public & Private Groups

All relevant state agencies will be involved in the process either through membership in the HUG or the HAC. The legislature will receive regular briefings on the proceedings of the grant activities. The planning, effort will represent the formal collaboration of business, the health care provider community, consumer groups and researchers. All key constituencies will be involved in the process through their inclusion in the HAC.

Health Umbrella Group. The membership of the Health Umbrella Group includes the executives of all WV State health agencies-the Secretaries of Health and Human Resources and Employment Programs; the Directors of the Public Employees Insurance Agency, the Children's Health Insurance Program, and the Governor's Cabinet on Children and Families; the Commissioners of the Bureau for Children and Families, the Bureau of Medical Services, the Insurance Commission, and the Bureau of Senior Services; and the Chair of the Health Care Authority. The members of HUG have a long history of collaboration and have worked effectively with each other on earlier task forces. To carry out the work of the proposed planning grant, the HUG composition will be expanded to include representation from the Governor's Office of Technology, and the executive offices of Tax and Revenue and the Budget.

Since its formation, the HUG has initiated a number of data collection efforts on the uninsured including, the recently completed statewide household survey, West Virginia Healthcare Survey 2001. It also provided the impetus for the analytic work on reform of the small group market, which is currently underway by Health Management Associates. Recognizing the need for more coalition building with the private sector particularly employers, the HUG will participate in a business roundtable in Fall 2002 to examine health and health insurance issues in WV. The HUG has embraced its mission to expand health insurance coverage energetically- the momentum already created gives a significant jump-start to the proposed planning, effort that will build on the foundation already in place. The HUG has received funding, for its work from the State Coverage Initiative of the Robert Wood Johnson Foundation with the Institute as the grantee.

Health Advisory Council The HUG will be assisted in its work by the Health Advisory Council (HAC), which will be created with broad representation from the private and public sectors and will include representatives from business and labor, WV communities, health care delivery, consumers, and politics. Approximately 40-60 persons will comprise the council. The Council will use a subcommittee structure of approximately 8-10 persons per subcommittee to carry out its work. These subcommittees will be identified during the second month of the project. Possibilities for subcommittees include "public program expansion", "employment-based initiatives" and "insurance market reform". Each subcommittee will be co-chaired by a member of HUG and a Council member.

Project Management

The administration of the grant will be through a management team made up of the Chair of the Authority and the Executive Director of the Institute as co-chairs, the Governor's HUG coordinator, the Authority fiscal officer, and the Institute's senior leadership which includes the Research Director, the Director of Community Programs, and the Senior Research Associate. This group will determine the strategies and assignments for implementing the SPG, and will meet weekly with the Project Manager to assure these strategies and assignments are on schedule.

Accounting Process

The Authority's will provide a Budget Officer for the SPG with responsibility for overseeing expenditures and ensuring accountability. A separate account will be established for the project and it will be subject to a special audit to assure that funds are being, expended appropriately. All consultant agreements will be with the Authority and will be contracted in compliance with state guidelines.

Qualifications and Experience of Key Project Personnel

Health Care Authority

Chair. Sonia D. Chambers, as Chair of the Authority, is responsible for oversight of all of the Authority's statutory duties including hospital rate review, certificate of need, health planning, data and public information, and the rural health system program. A seasoned health policymaker, Ms. Chambers has served as a Special Assistant for Coordinated Health Purchasing at the WV Public Employees Insurance Agency, Policy Director for former WV Governor Gaston Caperton, Deputy Commissioner for Administration and Finance for the WV Department of Health and Human Resources, and Legislative Director for U.S. Congressman Bob Wise. Her broad experience in national and state health policy and her executive level administrative experience highly quality her

as co-leader for this critical state planning, effort. Ms. Chambers earned a Bachelors at Davidson College.

Institute for Health Policy Research

Executive Director. Sally K. Richardson, Executive Director of the Institute has an exceptional record in the health policy arena in WV and nationally. The Institute, under her leadership since its inception in 1999, plays a central role in health services research and policy development in WV and also carries out projects of national significance. Ms. Richardson came to the Institute from the Health Care Financing Administration (HCFA), where she served as Director of HCFA's Center for Medicaid and State Operations. Ms. Richardson served as HCFA's Deputy Administrator for a year, and for three years as the head of the Medicaid Bureau. Ms. Richardson has held numerous positions in WV, including Director of the Public Employees Insurance Agency (PEIA), Deputy Director of WV's Department of Health, and Chair of the WV Health Care Cost Review Authority. Ms. Richardson holds an A.B. degree from Vassar College, an honorary Doctor of Laws from the University of Charleston, and serves on the adjunct faculty of the WVU's School of Medicine. Ms. Richardson's experience with the health care system in WV and the uninsured issue, combined with her intimate understanding of the Medicaid program, as well as other federal programs, make her ideally suited to lead this project.

Research Director. Raymond L. Goldsteen, research director, has an established track record in health services research and teaching,. He came to the Institute from Clemson University, where he held the position of Associate Professor in the Department of Public Health Sciences. He has held academic appointments at St. Louis University, Wichita State University, University of Illinois, the Medical University of South Carolina, Albert Einstein College of Medicine, and Lehman College of the City University of New York. He also served with the U.S. Public Health Service commissioned Corps. Dr. Goldsteen holds a Dr.P.H. from Columbia University, an M.A. from Brown University and a B.A. from Columbia University. Dr. Goldsteen's understanding of healthcare policy issues, particularly health care financing, combined with his work on universal access to care make him well qualified to be the chief researcher on this project.

Senior Research Associate. W. Donald Weston, MD is a senior level professional with extensive experience in health services research and analysis, administration, and clinical medicine. He also serves as the Vice Chancellor for Health Sciences, University System of WV. He has held a multitude of administrative, academic, and consulting appointments and has published on such topics as health profession education in WV, the relationship between academic medical centers and HMOs, and restructuring the U.S. health care system. His wide experience and depth of knowledge makes him ideally suited to contribute to the various research and analytic activities to be conducted for the SPG. Dr. Weston received his MD from the University of Southern California. His postgraduate training included Pediatrics, Adolescent Medicine, and Psychiatry. He received a Masters of Science in Management from the Sloan School of Management at the Massachusetts Institute of Technology. He also holds an honorary Doctor of Science degree from Northern Michigan University.

Director of Community Relations. Gail Bellamy, Director of Community Relations at the Institute since January 2002, has enjoyed a rich career in community health, academia, and health policy. She holds academic positions as Associate Director in the WVU Health Science Center Eastern Division

and as Associate Professor in the Department of Health Policy and Management in the School of Public Health at Texas A&M University. She is currently providing project coordination support for the Pediatric Preventive Oral Health Project and is the staff coordinator for the West Virginia Oral Health Policy Task Force. She is also overseeing the Transportation for Health Project funded through the WV Southern Rural Health Access Project and the Robert Wood Johnson Foundation. Previously, she served as director of community research and program development for Scott and White Memorial Hospital. Her areas of research interest and expertise cover both policy and programmatic factors affecting access to care for rural and underserved populations. She holds a Bachelors degree from UCLA, a Masters from Pepperdine University, and a Ph.D. in Public Health from the Johns Hopkins University.

Project Manager. This is a new position that will be added to the Institute staff. A senior level health professional will be recruited to oversee all project activities and to assure that grant objectives are met. The project manager will have the combination of planning, research, and analytic skills needed to provide direction to a complex and ambitious planning process. He/she will also have the interactive and communication skills necessary to relate effectively to multiple constituencies, including the legislature and the executive branch of the WV government.

11. Monitoring Plan and Report to the Secretary

Plan for Self Evaluation and Monitoring Progress

The Project Management Team, comprised of the Chair of the Authority, the Executive Director of the Institute, the HUG coordinator, the Authority fiscal officer, and Institute senior staff will oversee the completion of all activities required to attain the goals of the project.

The Project Manager, who will report to the Executive Director of the Institute, will be responsible for managing the project and overseeing the progress on the grant on a day-to-day basis. Using the Project Management Matrix (49 B), the Manager will assure that all project activities are completed and the expected results are attained on the designated time schedule. Attainment of these results will be an indication that the work is progressing, as desired. The Project Manager will meet weekly with the Project Management Team to discuss progress.

Each agreement with an external consultant will also have its own work plan, deliverables, and timeliness. Additionally, the HUG, HAC, and subcommittees of the HAC will each develop its own work plan to support the completion of its charge. Day-to-day monitoring of these activities will also be the province of the Project Manager, under the direction of the Project Management Team. Should it appear that an activity would not be completed on schedule, the Authority is committed to assigning additional staff or contracting for additional assistance so that the activity is fully supported.

The Project Management Team, with the assistance of the Project Manager, will also monitor process concerns, which may include

- Is the diversity of the stakeholder input sufficient?
- Are the uninsured sufficiently represented in the research methods?
- Are new ideas for public private partnerships developing support?
- Has the general public become more aware of the project and its activities?
- Is legislative interest being sustained over time?

Indicators to assess process concerns will be determined by the Project Management Team and reported monthly to the HUG.

While completion of SPG activities and the process for completion are important, the project will ultimately measure its success by the expected outcome from the process; namely, the reduction in the level of uninsurance in WV. Accepting that the current data on the general and age specific uninsurance rates are correct, objectives for reducing these rates in year 1, 2, and 3 post-planning grant will form part of the final report.

Capacity to Participate in and Contribute to a National Program Report

The WV project team is fully prepared to participate in and contribute to the national program report. As outlined above, the principal product of the planning process will be a final report, which lays out a plan for extending affordable health insurance coverage to all West Virginians.

As WV expects to benefit from the experiences of other state planning grantees, we also wish to share the WV experience so that other states may draw lessons for their own environments. The project team from the Authority and the Institute will be available to travel to national meetings to collaborate and share information with our colleagues from other states. The researchers at the Institute are experienced in cooperating with fellow researchers at other academic institutions and in leading health policy initiatives at the local and national level.

WV's final report will be prepared in the specified format and key data elements will be provided as requested. We would also be pleased to participate in the development of the format as necessary and to respond to specific data requests from the Secretary.