

Copy of the grant

April 3, 2002

Cover Letter from Lead State Agency

HRSA Grants Application Center
Attention: HAB Grants Management Office, CFDA 93.256
901 Russell Ave., Suite 450
Gaithersburg, MD 20879

Dear Sir or Madam:

As State Health Officer for the Alabama Department of Public Health, I respectfully submit Alabama's State Planning Grant proposal. The Alabama Department of Public Health, a component of state government, has been designated as the lead agency for this grant opportunity by Governor Don Siegelman.

Other agencies and organizations which will participate in this project include the directors of all relevant state agencies, the Governor's office (also representing the state's budget office), representatives from the Health Committees in the state's Senate and House of Representatives, large and small businesses, the state medical association, and advocacy groups.

At this time the principle contact for this grant is Ms. Fern Shinbaum (phone 334/206-5668, fshinbaum@adph.state.al.us). We are requesting \$833,062 for implementation of the grant.

Enclosed please find the original and two hard copies of Alabama's State Planning Grant proposal as well as a diskette containing a copy of the proposal in WordPerfect format.

Thank you for allowing Alabama to apply for this important project. Your favorable consideration would be most appreciated. If you need any additional information or have any questions, please contact Ms. Shinbaum.

Sincerely,

Donald E. Williamson, M.D.
State Health Officer

DEW/fms

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Project Abstract

Current Status of Access to Health Insurance in Alabama: According to the 1999 Urban Institute National Survey of America's Families the rates of uninsurance for both children and adults in Alabama (9% and 14% respectively) were lower than the national average (13% and 16% respectively). Lower income individuals are likelier to be uninsured. However, significant increases in access for low-income children have been achieved in recent years through the implementation of the Children's Health Insurance Program (CHIP) and increasing Medicaid reimbursement rates and provider enrollment.

Earlier Efforts to Expand Access to Health Coverage: Alabama has a relatively low rate of uninsured residents as the results of strides in expanding health care insurance access in the state through both public and private efforts. Therefore, Alabama has selected to identify itself, for this State Planning Grant, as a state with a low rate of uninsured.

Public expansions in health insurance coverage first began in the Alabama Medicaid Agency. Through waivers, mandated and optional coverage programs, Alabama Medicaid now offers coverage through 21 programs for low-income pregnant women, children, the elderly, the disabled, and for optional groups and waiver groups including services for family planning, breast and cervical cancer, and home and community based waivers. During fiscal year 2001, 717,000 Alabamians were certified as eligible for Medicaid services.

In 1998, Alabama became the first state in the nation to have an approved CHIP which serves children who are over the Medicaid eligibility levels but unable to afford private insurance. Alabama led the nation in data analysis of this population and in program planning and evaluation. As of the end of February, 2002, this program has provided comprehensive health insurance coverage to a total of 71,806 previously uninsured children.

Additionally, Alabama has a risk pool health insurance program, the Alabama Health Insurance Program (AHIP). Currently, AHIP has an enrollment of over 3,500 Alabamians and is the largest HIPAA eligible risk pool in the nation.

Privately, Blue Cross Blue Shield of Alabama has established the Alabama Child Caring Foundation (ACCF). ACCF serves children up to 235% of the Federal Poverty Level who are not eligible for Medicaid or CHIP. To date, the ACCF has served 38,500 children, and carries an enrollment between 7,500 and 8,000 children at any given time.

Proposed Project

Goals

The general goal of this project is to develop options for the state to consider to provide health insurance coverage to all uninsured residents of the state. Specific goals include:

- ◆ Determination of the size, location, and demographics of the total uninsured and unstably insured in Alabama (unstably insured refers to those residents who are at risk of losing their health insurance within the next year);

- ◆ Determination of a variety of options to expand existing health insurance programs and develop new programs to accomplish the general goal. This includes the determination of the feasibility of and prerequisites for these options; and,
- ◆ Provide a report to the Secretary of the Department of Health and Human Services (DHHS) which describes Alabama's uninsured and unstably insured populations, program expansion/development options for providing stable coverage for these groups, and partnerships necessary to implement their design.

The above goals are in complete agreement with and support the overarching SPG goal which is to encourage states to provide access to health insurance coverage to all citizens by providing them with a number of data collection, analysis, and planning strategies, along with viable coverage options to consider.

Description of the Project

◆ Data Collection and Analysis:

To determine the size, location, and demographics of the total uninsured and unstably insured in Alabama, this project will build upon earlier analytic activities within the state and the experience of those states which received SPGs in the earlier rounds of grant assistance (especially with regard to data collection methods, tools, vendor, analysis, consensus building, and time frames). The project plans to contract with the University of Minnesota, School of Public Health Survey Center and the State Health Access Data Assistance Center (SHADAC) to (1) use the validated State Coverage Survey Instrument (CSCS) which has been successfully used by previous states with SPGs, (2) conduct sample selection, (3) field the CSCS, and (4) analyze the data. Both of these entities have proven extremely helpful to previous SPGs. Further, the project plans to contract with a local research entity, Auburn University in Montgomery, to conduct and analyze data from focus groups across the state. Target populations for these focus groups will be groups such as employers, providers, etc.

◆ Coverage Options

The Alabama Department of Public Health (ADPH) CHIP unit (the grantee) has, in the past four years, successfully, used a structure for the rapid formulation (within one year) of recommendations for providing health insurance to the uninsured. In each of these instances, recommendations were made for providing health insurance to uninsured children. With the SPG, the ADPH plans to replicate this successful structure with regard to the entire population of uninsured and unstably insured in the state. This structure includes the following components:

(1) An Executive Workgroup comprised of a wide base of public and private stakeholders (See Appendix D for letters of support.) This group will review the analyses from the primary data sources (CSCS data and the focus groups) as well as secondary data from other sources (census data, etc.). This group will review recommendations presented to it by the project's subcommittees (see below).

(2) At least four Subcommittees will be formed to research and analyze various issues needing more attention. The subcommittees will be comprised of staff from the agencies/entities represented on the Executive Workgroup. It will be the task of these subcommittees to define the issues (within the scope of the subcommittee), research the issues, synthesize the information that they gather, and make recommendations for the Core

Decision Making Group and Executive Workgroup to consider. It is anticipated that four subcommittees will examine issues related to (a) description of the target population (the uninsured and unstably insured), (b) possible expansions of existing programs, (c) possible new programs, and (d) financing. Other subcommittees may be added as the information and data indicate.

(3) A Core Decision Making Group comprised of ADPH staff and key stakeholders will be responsible for the keeping both the Executive Workgroup and the subcommittees on track. In addition, this core group will assist in synthesizing the information gathered from the workgroup and relevant information gathered from the survey and focus groups to prepare the final report to the Secretary.

The project will contract with the University of Arkansas for the use of an Internet based, multi-state integrated database (MSID) to assist different groups in understanding state and substate data. In addition, opinions and consensus building in the Executive Workgroup, subcommittees, and focus groups will be aided by the use of an electronic audience response system. The Director of the ADPH, CHIP unit will provide direct oversight for the entire project.

◆ Report to the Secretary

It will be the responsibility of the SPG Project Director to organize, write, assemble, and distribute the report to the Secretary. The core decision-making group will review the report before it is finalized and the State Health Officer will ultimately approve the final report. The report will be in a format specified by the Federal program staff and will be designed to incorporate the broad range of activities planned by the Alabama SPG. The report will be based on information that was generated from the contractors, subcommittees, and the Executive Workgroup to the core decision making group.

Lead Agency and Other Partners Collaborating in the Project: The Alabama Department of Public Health (ADPH), Children's Health Insurance Program (CHIP) will be the Lead Agency and unit for this project. A broad base of partners will collaborate to achieve the project goals. Partners include representatives of all relevant state agencies, the Governor's Office (also representing the state's budget office), representatives from the Health Committees in the state's Senate and House of Representatives, large and small businesses, the state medical association, and advocacy groups.

Projected Results: Data collection and analyses will be accomplished by February 28, 2003. Recommendations regarding options for covering all the uninsured residents in Alabama will be accomplished by June 30, 2003. A report containing the findings of the project will be produced and submitted to the Secretary of DHHS by July 30, 2003.

Current Status of Health Insurance

Alabamians have access to health insurance most often through their employer. According to the Kaiser Family Foundation, 78% of households in Alabama with at least one full-time worker have some type of group or employer sponsored health insurance coverage. In fact, Alabama ranks eighth in the nation in terms of the percent of employers offering some sort of group health insurance plan to their employees (64% as compared to a national average of 58%). Larger employers (greater than 50 employees) are more likely than small employers to offer such coverage (97% as compared to 52%). However, despite this impressive record in employer sponsored insurance coverage, Alabama ranks 24th in the nation in terms of the uninsured.

Approximately 12.7% of all Alabamians lack health insurance. Through surveys such as the Census Bureau's Current Population Survey and the Urban Institute's National Survey of America's Families (NSAF), legislators, state staff members and health care advocates have gained valuable insight into the number of uninsured in the state and been able to influence policy decisions regarding health insurance coverage. For children in particular, there has been a very positive impact. The 1997 National Survey of America's Families is used as the baseline estimate of the uninsured in the state. When the 1999 survey was released, Alabama showed marked improvement in the rate of uninsured children. From 1997 to 1999, the rate of children in Alabama without health insurance decreased from 14.6% to approximately 8.6%. Over the same time frame, the rate of non-elderly adults in Alabama without insurance decreased from 17.5% to 14.4%. These aggregate data provide a snapshot of the uninsured in Alabama. However, though these data are limited in specificity, they do provide a baseline from which to measure success.

In order to gain some insight into the uninsured in Alabama, we have turned to data from the 1999 National Survey of America's Families. This survey analyzes age, gender, race, family structure, family work status and income of the uninsured in Alabama. These data provide the best analytical look at the uninsured in the state.

In general, uninsured non-elderly adults were more likely to be under the age of 34 (19% compared to 11.5%). Children essentially showed no differences between those aged ten and younger and older children up to age 18 (8.5% and 8.8% respectively). There are striking differences between racial groups as well. When we look at the state population as a whole, Hispanic persons are more likely to be uninsured than persons in other racial categories. Thirty-eight and one half percent of all Hispanics in Alabama are uninsured compared to 10.9% of white non-Hispanics and 16.3% of black non-Hispanics persons. This disparity is magnified when you look specifically at non-elderly adults. Approximately 45.4% of Hispanic non-elderly adults are uninsured compared to 12.4% of white non-elderly adults and 19.4% of black non-Hispanic non-elderly adults. Children have higher rates of insurance coverage in Alabama. However, there is still evidence of racial disparity. Approximately 23.3% of Hispanic children in the state lack health insurance compared to 7% of white, non-Hispanic children, and 11% black, non-Hispanic children.

The data of family structure illuminates differences between married and non-married adults and between parents and childless adults. Single adults with children lacking health insurance is reported at 35.2% as compared to 11.6% of married adult parents. There is also a difference between single and married childless adults. Single childless are over two times as likely to lack insurance as married childless adults (17.4% and 8.2% respectively). In addition, children living in single or no parent family structures are more likely to be uninsured than their counterparts in two parent households. In fact 11.5% of children in single parent households lack health insurance as compared to 6.8% of children in two parent households. As may be evident from the state's high rate of employer-sponsored health insurance, work status is a good indicator of health insurance status. Over one-fifth of non-working adults report having no health insurance and 19% of adults with only part-time employment lack health insurance as well. But probably the strongest indicator of health insurance coverage is family or household income. Twenty-seven and one half percent of all Alabamians aged 0-64 living at or below the federal poverty level (FPL) are uninsured. While the likelihood of being without insurance decreases as income increases, there are still many families at higher income levels struggling to find affordable health insurance that is available to them. In fact, 19.5% of those earning between 100 and 200% of the FPL are uninsured and 13.1% of those earning between 200 and 399% FPL are also uninsured. Even at incomes above 400% FPL 4% of persons remain uninsured in Alabama. The rates of insurance coverage are higher for children at all income levels, but it is still stratified along income ranges. Due to the success of the Medicaid program and the SCHIP program, many more low income children have been able to be covered. The proportion of children in families earning less than 100% FPL who lack insurance has decreased from 27.1% in 1997 to 14.6% in 1999. This decrease is reflected in children in families earning between 100% and 200% FPL as well. In this group, the percent of children lacking health insurance had decreased from 18.3% in 1997 to 13.6% in 1999.

Despite these successes, there are still many issues related to the uninsured in Alabama that must be addressed. As mentioned above, the decrease in the rate of uninsured children is most likely the result of an increase in coverage under Medicaid and SCHIP. The increase in insurance rates for non-elderly adults is most prominent when you look at non-elderly adults living in households earning under 200% of the federal poverty level. These adults reported increases in other private coverage rather than with an employer. Teasing out what other health insurance means for these adults and determining its availability to low-income families in the state is just one area that this grant can greatly impact. In addition, the geographic distribution of uninsured in the state is not available from the current data. Nor is there any information available regarding the unstably insured. Unstably insured is defined as those persons that are currently covered under health insurance but who feel that there is a strong likelihood that their insurance will end within the next twelve months. This grant will enable the state to understand not only who the uninsured are in Alabama, but also where they are and what options are available to them and their employers for increasing access to the private insurance market. Also, because we recognize that access to care is more than access to insurance, the SPG will provide valuable data for policy makers and health care professionals for an increased understanding of how health insurance

access may impact health indicators such as infant mortality, immunization rates and deaths due to heart disease, cancer and stroke.

The SPG will also allow for a better understanding of the health care delivery system in the state and help identify areas for improvement. Alabama is a very rural state, with 31% of the population living in non-metropolitan areas as defined by the Census Bureau Current Population Survey. Nationally only 19% of households are in non-metropolitan areas. The managed care penetration rate is very low (7% as compared to 28% nationally) and the current health care delivery system is predominantly structured in a discounted fee-for-service environment. A large segment of the health care delivery infrastructure is administered by the state and other public entities such as federally qualified health centers (FQHCs). Thirty-nine percent of hospitals are administered by the state or local governments compared to 24% nationally. Conversely, 24% of the hospitals are for-profit institutions as compared to 15% of hospitals nationally.

Income levels and availability of health care services are lower in Alabama than the national average. Forty-one percent of Alabamians live in families earning less than 200% of the Federal Poverty Level. These factors and others allow for most of Alabama to be designated as a Medically Underserved Area (MUA) and Health Professional Shortage Area (HPSA). Roughly 3.1 million Alabamians are considered medically underserved by the National Association of Community Health Centers. This need is met through both public and private facilities throughout the state. There are 15 Health Center HPSA grantees in Alabama, and while the number of hospital beds per thousand residents is slightly above the national average (3.7 compared to 3.0), there are 68 fewer non-federal physicians per 100,000 citizens and 11 fewer nurses per 10,000 citizens than the national averages for these indicators. Utilization of services is also higher than national averages in relation to admissions and emergency room visits. Both of these indicators show that Alabama utilization rates are over 20% higher than the national averages when calculated per one-thousand persons. High utilization patterns coupled with a lack of health insurance coverage may mean increased levels of preventable disease. The SPG would allow Alabama to extract data from the uninsured to answer questions regarding their access to care. The 1999 NSAF began to examine these questions and shows that, notwithstanding differences in insurance status, 5.7% of children and 13.4% of all non-elderly adults do not have a usual source of health care and of those that did indicate a usual source of care, 2.7% of children and 4.9% of adults indicated the emergency room was that usual source of care. Unmet need was also addressed in the survey and 10.3% of children and 19.8% of adults indicated that they had some degree of unmet need for medical care, dental care or prescription drugs. In addition, 7.2% of children and 7.5% of adults reported that they were not satisfied with the quality of care they received. The SPG will allow further analysis of these important issues through focus groups of consumers and providers.

Description of Earlier Efforts to Reduce the Number of Uninsured

A. Efforts of State Government

The state has implemented three (3) programs aimed at reducing the number of uninsured residents by increasing access to health insurance coverage. All three of these programs have the support of the legislature and governor. All three have legislative authority and funding appropriated by the state legislature and approved by the governor. Specific governmental support for these programs is detailed under each of the following three subheadings.

Medicaid

The first of these programs was the Medicaid Program, which began in 1970. Since its beginnings, the state has made significant expansions in Medicaid coverage in both mandatory and optional coverage areas. Medicaid now offers coverage through 21 programs for low-income pregnant women, children, the elderly, the disabled, and for optional groups and waiver groups including services for family planning, breast and cervical cancer, and home and community based waivers. During fiscal year 2001 717,000 Alabamians were certified as eligible for Medicaid services.

Additionally, the Medicaid Agency has worked diligently to improve access to its programs and by making the application process as family-friendly as possible. One hundred thirty-five enrollment workers are outstationed across the state in health care provider settings so that applicants can apply for Medicaid at the same time as a health care visit. During this fiscal quarter, Medicaid staff will also be placed in state's State Children's Health Insurance Program (CHIP) enrollment unit in order to facilitate enrollment of children who are below CHIP income levels. Medicaid staff also train non-Medicaid employees in the interview and enrollment processes to facilitate entry into its programs.

The Medicaid Agency has partnered with other state agencies in special grant projects which seek to reduce the number of uninsured in the state. Most recently these have included, a Robert Wood Johnson Foundation (RWJF) grant, Supporting Families After Welfare Reform (diagnosis grant and submission of a follow-up implementation grant), another RWJF grant, Covering Alabama Kids, in which Medicaid is piloting several enrollment simplification/streamlining processes, a Smile Alabama dental health grant (another RWJF grant) which sought to increase the number of dentists participating in the program, as well as several privately and governmentally funded evaluation projects.

Challenges which the Alabama Medicaid Agency has faced center around marginal funding for the agency's programs and stigma sometimes associated with being an enrollee in the program. While the funding issue seems to be a continual problem, the stigma issue seems to be decreasing as the programs become more well known and as the number of providers participating in these programs increases.

It should also be noted that the Alabama Medicaid Commissioner is appointed by the

Governor of the state and has his full support.

State Children's Health Insurance Program (CHIP)

Alabama was the first state in the nation to gain approval for and implement CHIP. Alabama's CHIP began implementation on February 2, 1998. As of the end of February, 2002, this program has provided comprehensive health insurance coverage to a total of 71,806 previously uninsured children. The Alabama Department of Public Health (ADPH), the proposed grantee for this State Planning Grant (SPG), is the lead agency for CHIP in Alabama.

CHIP is comprised of two (2) components: a Medicaid expansion and a stand alone private-model program, known as ALL Kids. Both of these components were conceived and assisted in development by two governmentally initiated groups. The Children's Health Insurance Program Commission, a two-year decision-making body, was legislatively mandated to develop and advise Alabama's CHIP. The Governor's Task Force on Children's Health Insurance, a one-year advisory group, was appointed by the state's executive branch to develop recommendations for decreasing the number of uninsured children in the state by increasing access to health insurance through both CHIP and Medicaid Programs. Both the CHIP Commission and the Governor's Task Force on Children's Health Insurance were structured as statewide bodies which represented a wide variety of private and public interests. These groups were comprised of state agency directors as well as consumer advocates, health care providers, and health insurance industry leaders. It was with the help and support of these groups that Alabama has become a nationally recognized leader in reducing the number of uninsured children.

It is upon the structure of the above successful models of broad-based group support that Alabama's SPG proposal is based.

Alabama Health Insurance Program (AHIP)

The Alabama Health Insurance Plan (AHIP) was created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is a HIPAA eligible only risk pool. AHIP is designed for people who have exhausted coverage through a former group plan and have no other health care coverage available. Like the above programs, AHIP enrollment has grown each month since its inception. Currently, AHIP has an enrollment of over 3,500 Alabamians and is the largest HIPAA eligible risk pool in the nation.

B. Private Efforts

In addition to the governmental programs above, a privately managed program, the Alabama Child Caring Foundation (ACCF), has been established by Blue Cross and Blue Shield of Alabama to assist in covering uninsured children in the state. The ACCF was established in 1987 to provide medical coverage for physician office visits and hospital outpatient services for children who were not eligible for governmental programs. With the advent of SOBRA Medicaid and CHIP, the ACCF adjusted its income eligibility criteria and maintained its mission to insure uninsured children. To date, the ACCF has

served 38,500 children, and carries an enrollment between 7,500 and 8,000 children at any given time. Although it was anticipated that with the introduction of CHIP in 1998, the number of children enrolled in ACCF would decrease, this has not been the case. In fact, the opposite has occurred. The increase is due to the fact that the ACCF serves Hispanic children who are ineligible for governmental assistance, and state and public school employees who are barred from participation in CHIP/ALL Kids, and other uninsured children in families with incomes between 200% and 235% of Federal Poverty Level. ACCF also benefits from CHIP outreach efforts, as those determined to be ineligible for Medicaid or CHIP/ALL Kids are referred to ACCF.

The ACCF is funded by charitable contributions which attract dollar-for-dollar matching donations from Blue Cross. While similar programs in other states either discontinued or downsized as CHIP was established and the economic downturn occurred, the ACCF has successfully adapted and flourished.

C. Specific Efforts to Develop and Implement Health Care Reforms

While the above programs represent the major efforts to develop and implement health care reforms in the state, it should be noted that these programs are very dynamic and responsive to changes in population demographics, economic changes in the state, and consumer feedback. Below is a list of a few recent program initiatives which were made in response to population changes and feedback.

- ◆ CHIP/ALL Kids, SOBRA Medicaid (a program for children and pregnant women), and ACCF all use a common application form
- ◆ CHIP/ALL Kids and Medicaid use a joint renewal form
- ◆ CHIP/ALL Kids has eliminated all eligibility verification requirements except that required by CMS for alien status.
- ◆ SOBRA Medicaid is piloting the elimination of several eligibility verification requirements
- ◆ Medicaid has outstationed eligibility workers in health care provider settings
- ◆ CHIP/ALL Kids and ACCF use a totally mail-in process for enrollment
- ◆ CHIP/ALL Kids has eliminated waiting-time barriers to enrollment for specific populations

D. Successes and Implementation Problems

Alabama is motivated to improve the health status of its citizens. This motivation has provided the initiative behind combined efforts. The delinking of Medicaid from welfare provided the stimulus for the de-stigmatization of Medicaid as a welfare program. Initiatives by Medicaid to enhance its Medicaid Management Information System has resulted in more timely payments to providers. Medicaid increased physician rates making it more attractive for physicians to participate in the program. Medicaid embarked upon a dental initiative fueled by a Robert Wood Johnson grant that, to date, has resulted in an additional 140 dentists being enrolled in the Medicaid program. With the implementation of CHIP, Medicaid and CHIP partnered to form a synergistic approach to outreach and education. Since the implementation of CHIP, enrollment into

Medicaid, CHIP and the Blue Cross Blue Shield Alabama Child Caring foundation has significantly increased. A joint application serves all three programs. Predicated on the only baseline data available at the time (1997 National Survey of America's Families), in the past four years, Alabama has been able to reduce the number of uninsured children from 173,012 to approximately 60,000 - 80,000. The same efforts and motivation that Alabama has applied to children could be focused on other uninsured populations in the state.

It is felt that the successful implementation of programs to insure children, has been due to four things:

- ◆ A political consensus in the state that there has been a need to decrease the number of uninsured children in the Alabama;
- ◆ Available funding;
- ◆ A high level of health insurance technical expertise available in the state (both in governmental agencies such as the State Employees Insurance Board, the Medicaid Agency, the Department of Insurance, and in private businesses such as Blue Cross Blue Shield, and UnitedHealthcare;) and
- ◆ Use of a broad-based, advisory group for researching and recommending directions to pursue. (This is the model upon which Alabama's SPG proposal is based.)

Medicaid, CHIP/ALL Kids, and ACCF have not been without areas of challenge. Medicaid has continued to face funding challenges in an era of economic decline. There is also a stigma sometimes associated with being an enrollee in the program. While the funding issue seems to be a continual problem, the stigma issue seems to be decreasing as the Medicaid programs become more well known, as provider reimbursement increases, and as the number of providers participating in these programs increases. Challenges which CHIP has faced relate to the challenge of implementation of any new program for which there is pent up demand. These challenges include: reaching hard to reach eligibles who are not yet enrolled, staying ahead of policy development needs, and staying ahead of staffing needs. These challenges have been met with enthusiasm and will continue to be successfully dealt with. The ACCF was faced with decisions regarding its role when CHIP came into being. Because of the strong but flexible leadership of the program, the great need in the state, and the great support from grassroots donations, ACCF redefined its target population and has continued to thrive.

While Alabama has been extremely successful in the area of insuring uninsured children, the state has experienced more difficulty in doing so in the adult population. Because Alabama is a relatively poor state, it is challenging to implement any health insurance program without federal matching funds. The state has also undergone an economic decline in which there have been many plant closings and job layoffs. A decline in jobs means a decline in employer sponsored health insurance. This has made the need for new or expanded health insurance programs greater than ever. However, because the state has been in a condition of economic decline, it has not been the appropriate time to propose new health insurance programs or expansions. It is important to note, however, there are indications that the economic decline is slowing. It is time to explore what options exist

for extending health insurance beyond the current level through expansions of existing programs and new endeavors built using the successes of the existing programs. In fact, Alabama's proposed SPG structure for exploring new options for covering the state's uninsured is based upon the successful structures of the legislated CHIP Commission and the Governor's Task Force on Children's Health Insurance. It is fortunate that this time for exploration coincides with the opportunity that the SPG offers.

Requesting Preferences

Alabama has a relatively low rate of uninsured residents as the result of strides in expanding health care insurance access specifically targeted at children in the state through both public and private efforts. This can be seen by examining data from pooled March 2000 and 2001 Current Population Surveys. These data show that 13% of all Alabama citizens lacked health insurance. This rate ranks Alabama 24th in terms of the number of uninsured with New Mexico at the number one rank with 24% uninsured.

This is a relatively low rate of uninsurance when compared to other states and when compared to other states in the Southeast. It is a lower rate than reported for Florida, Georgia, Mississippi and Tennessee. Therefore, Alabama's State Planning Grant has selected to identify itself, for this grant, as a state with a low rate of uninsured

Statement of Project Goals

A. General and Specific Goals

The general goal of the Alabama SPG is to develop options for the state to consider to provide health insurance coverage to all uninsured residents of the state. Specific goals include:

- ◆ Determination of the size, location, and demographics of the total uninsured and unstably insured in Alabama (unstably insured refers to those residents who are at risk of losing their health insurance within the next year);
- ◆ Determination of a variety of options to expand existing health insurance programs and develop new programs to accomplish the general goal. This includes the determination of the feasibility of and prerequisites for these options; and,
- ◆ Provide a report to the Secretary of the Department of Health and Human Services (DHHS) which describes Alabama's uninsured and unstably insured populations, program expansion/development options and the partnerships necessary to implement their design.

The above goals are in complete agreement with and support the overarching SPG goal which is to encourage states to provide access to health insurance coverage to all citizens by providing them with a number of data collection, analysis, and planning strategies, along with viable insurance expansion options to consider. The specific goals also support the federal program description which is to (1) collect and analyze data that describe the characteristics of the state's uninsured and assist in the design of approaches

to provide access to affordable coverage, (2) design options that would provide all uninsured residents with access to insurance benefits similar to state employee coverage, Federal Employees Health Benefit Plan, Medicaid or other similar quality benchmarks, through a state, federal and private partnership, and (3) prepare a report to the Secretary describing these findings.

To accomplish the above general and specific goals, Alabama plans to build upon:

- ◆ The experience of those states which received SPGs in the first and second rounds of grant assistance (especially with regard to data collection methods, tools, vendor, analysis, consensus building, and time frames).

- ◆ The two recent, successful, experiences that the state has enjoyed in using a broad-based advisory group for research and support (used in developing recommendations for the formation of CHIP and the improvement of coverage for uninsured children).

Project Description

Note: All project activities including outsourced activities, will fall under the supervision of a full time Project Director and/or a 40%-time Data Specialist. These staff will be assisted by one full-time secretary. (See Appendix A for job descriptions and qualifications.) These staff will utilize two laptop computers, three desktop computers, three desktop printers, two portable printers, and associated software purchased by grant funds.

A. Detailed Project Narrative

1. Approach to Data Collection and Analysis

The Alabama SPG will build on earlier analytic activities within the state. This application also proposes to follow the success of previously funded states by contracting with the University of Minnesota, School of Public Health, Survey Center (see Appendix B) and the University of Minnesota, State Health Access Data Assistance Center (SHADAC) (see Appendix C). The principal benefits in using this approach include cost and time savings because the University of Minnesota has specific experience in this area, a survey instrument available at no charge, quality assurance/use of a validated instrument, the potential for cross-state comparisons, the ability to add state-specific questions to the survey, and having the survey in the field faster due to the University of Minnesota's experience. Additionally, the project plans to contract with the Auburn University in Montgomery for activities and analysis related to conducting focus groups.

During the first month of the grant period, the project will either negotiate a contract with the University of Minnesota or see if it is possible for HRSA to contract directly with the University of Minnesota, on behalf of Alabama, using the funds appropriated to Alabama for these services.

The contract with the University of Minnesota School of Public Health Survey Center (hereon referred to as the Survey Center) will specifically cover (1) use of the validated State Coverage Survey Instrument (CSCS) which has been successfully used by previous states with SPGs, and (2) fielding the CSCS. The CSCS has been revised and tested over

the years to confirm its validity and ability to measure coverage, particularly among low-income populations like the Medicaid-eligible. Specifically, the contract will cover the following:

1. The first activity will be the refinement of the instrument and development of the sampling plan. These activities will start in early September 2002. The refinement of the instrument will include the following activities: wording changes in the instrument to focus specifically on Alabama issues and programs, additional items that the state of Alabama will want to add to the questionnaire (or removal of existing items). The development of the sampling plan will focus on any stratification that the state of Alabama wishes to include in the sampling plan. Once the sampling plan is specified the sample of contact information will be purchased (from commercial vendor, SSI, Genesys, etc.).
2. Once changes/additions to the instrument have been established and approved by the Project Director, these changes will be integrated into the CATI program. Once this programming is complete the instrument will be pre-tested by the core interviewing staff of the survey center. Any changes, if necessary, will be made to the instrument and CATI program. Once this is completed recruitment, hiring, and training of an interview staff for the project will be done. This group of interviewers once trained will also pre-test the survey (this process serves as both a pre-test as well as continuation of training for the interviewers). Again if problems are identified they will be documented and resolved. Following this the CATI program will be finalized and approved by Alabama.
3. Approximately 6,000 telephone interviews will be conducted. During this time the University of Minnesota survey center will provide bi-weekly disposition reports to the state of Alabama. If there are any problems encountered during the administration of the survey, the Survey Center will notify the Project Director in writing of any problems and the actions taken to correct the problems. If these problems have to do with the instrument or sampling frame and they have the potential to affect the results of the study, no action will be taken without first approval from the Project Director. In monitoring interviewers two primary methods of evaluation will be used. The primary evaluation is listening in, in which a supervisor listens to the interviews as they are conducted. Approximately 20% of interviews will be monitored. The others means of evaluation is looking at what is loosely called interview productivity. In this, interviewers will be evaluated in terms of a range of data collected from the CATI system, including: number of dialings, interview length, number of refusals, etc. interviewers who have extreme values (high number of refusals, low number of dialings per complete, etc.) will be identified and monitored closely and corrective action will be taken as necessary.
4. The final part of the study will be focused on producing the final datasets for the study. Two datasets will be used: 1) the results from the telephone interviewing for all completed cases and 2) the sample disposition file. Post data collection

processes will include data management activities for each of the datasets as well as writing the final report for the survey. This final report will include the following:

- ◆ Description of the instrument
- ◆ Description of the fielding of the study (dates in field, etc.)
- ◆ Final response and cooperation rates (using AAPOR guidelines)
- ◆ All data cleaning procedures
- ◆ Univariate frequency distributions for all items in the instrument
- ◆ A SAS dataset on a CD-ROM.

The contract with SHADAC will cover their full package of assistance for State Planning Grants which involves the following:

1. In-depth support on sample design and data collection:
 - ◆ Develop sampling frames and weighting schemes
 - ◆ Assist in the development of interviewer training materials
 - ◆ Participate in interviewer training
 - ◆ Conduct on-site visits and participate in interviewer monitoring
2. Assist in data analysis and dissemination of results
 - ◆ Develop detailed analysis strategy and plans
 - ◆ Evaluate entire data collection process
 - ◆ Synthesize research results (including cross-state comparisons if applicable)
 - ◆ Create data tabulations
 - ◆ Assist states in making their data use file
 - ◆ Compile final data set documentation
 - ◆ Write state report using state-level data collected under HRSA
 - ◆ Formulate draft policy recommendations
 - ◆ Design implementation strategies for policy recommendations

The contract with Auburn University in Montgomery will include all activities related to conducting focus groups within the state and analyzing this data. The exact target populations for these focus groups has not yet been determined. However, it is known that focus groups with employers in the state will be conducted as well as other groups such as health care providers and consumers.

(2) Develop Coverage Options and Design Programs that Provide Health Insurance Coverage to Uninsured Citizens

The ADPH CHIP unit has, in the past four years, successfully used a structure for the rapid formulation (within one year) of recommendations for providing health insurance to the uninsured. In each of these instances, a wide base of stakeholders were involved in gathering information and formulating recommendations for providing health insurance to uninsured children. With the SPG, the ADPH plans to replicate this successful structure with regard to the entire population of uninsured and unstably insured in the state. This structure includes the following components:

- ◆ Executive Workgroup comprised of a wide base of stakeholders (See Appendix D for letters of support from many of these representative agencies.)

The Workgroup will be comprised of:

- Directors or designees from relevant state agencies (including Alabama Medicaid Agency, Alabama Department of Insurance, Alabama Department of Human Resources, Alabama Department of Mental Health and Mental Retardation [the agency also over substance abuse], Alabama Department of Senior Services, Governor's office [also representing the state's budget office]);
- Representatives from the Health Committees in Alabama's Senate and House of Representatives;
- Representatives of both large and small businesses in the state as identified by the Business Council of Alabama;
- A representative from the Medical Association of the State of Alabama;
- A representative from Alabama Arise and Voices for Alabama's Children (prominent advocacy groups for low income Alabamians);
- A representative from Alabama Family Voices (a prominent advocacy group for Alabamians with special health care needs);
- A representative from one of the state universities which does research on the target population for this grant;
- The director or designee of the Alabama Hospital Association;
- The director or designee of the State Employees Insurance Board;
- A representative of Blue Cross Blue Shield of Alabama (the largest private insurer in the state);
- Director or designee of Alabama Association of Health Plans (the Alabama's HMO association)
- Appropriate representatives of the Alabama Department of Public Health including Family Health Services, Office of Primary Care and Rural Health Development, and Office of Professional and Support Services.

The Executive Workgroup will meet regularly (beginning in January, 2003 through June, 2003) and will review information gathered from survey results and focus groups. This information will include data on the uninsured and unstably insured, information on possible expansions of existing health insurance programs, and information on possible new health insurance programs. They will make recommendations for options for health insurance coverage to a core decision-making group for the final report to the Secretary of DHHS. Consensus within the Executive Workgroup will be reached by discussion,

possibly supplemented by voting. Consensus reaching will be aided by the use of an audience response system, which will allow members to register their opinions anonymously through individual electronic voting terminals. The Project Director, with assistance as needed from ADPH staff, will be responsible for ensuring that the Executive Workgroup's task is completed on time.

- ◆ Subcommittees

In order to facilitate information gathering and to ensure input from a wide base of stakeholders, it is anticipated that subcommittees (or sub workgroups) will contain membership which is both reflective of the agencies represented in the Executive Workgroup and broader in scope. Membership will be through invitation and self-selection and involve persons from the state, regional and local levels. The subcommittees will meet beginning meeting in December, 2002 through June 2003.

It is anticipated that there will be at least four subcommittees which will examine issues related to the description of the target population (the uninsured and unstably insured), possible expansions of existing programs, possible new programs, and financing. Specific subcommittees will be designed based on the data obtained in the information stages and from the discussion of the Executive Workgroup. Subcommittees may be added as the information and data gathered indicate. It will be the task of these subcommittees to define the issues within the scope of the subcommittee, research the issues, synthesize the information that they gather, and make recommendations and reports for the Executive Workgroup to consider. The subcommittees will have the ADPH and other key stakeholder staff assigned to serve as facilitators of discussions and to assist in organizing the information gathered through the committee work. Based on previous experience, it is anticipated that subcommittees will meet at least monthly (beginning in the second half of the project year) and may meet more frequently as needed.

The data subcommittee will be assisted in their research by an Internet based multi-state integrated database (MSID) procured from the University of Arkansas, Arkansas Center for Health Improvement (hereon referred to as Arkansas). The ADPH will contract with Arkansas for computer programming and training in relation to the MSID. The MSID will provide 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 (Centers for Disease Control and Prevention), the Current Population Survey (Bureau of Labor Statistics), and the County Business Pattern Census (U.S.Census Bureau). In addition, up to two state-specific datasets (e.g., household, etc.) will be incorporated into the database to optimize policy support and decision-making in the SPG. Included in the contract with Arkansas will be Internet access to the password protected database, all necessary software licensing, required training and ongoing technical support during the grant period, and state-specific support of use of the database in policy development. These services and programming will allow Alabama's SPG to use secondary state data from national databases and primary data generated through this project in a user-friendly, rapid, interrelational way. The use of this data in this way will promote presentation of the data to widespread audiences, rapid answers to interrelated questions regarding insurance coverage and population demographics.

While voting may occur within the subcommittees, there will not have to be total consensus on each decision point. However, obtaining opinions from each member of the subcommittee will be aided by the use of an audience response system which will allow members to register their opinions anonymously through individual electronic voting terminals. Information from the subcommittees and Executive Workgroup will be given

to State Health Officer who with the support of the CHIP and key ADPH staff will prepare a report to be presented to the Governor and Legislature.

◆ Focus Groups

ADPH plans to contract for Auburn University of Montgomery (AUM) to assist in gathering data and other information through extensive use of focus groups. The focus groups will be held in different regions of the state and using open ended questions and the _audience response system_ obtain information from consumers, health care providers, business communities and other stakeholders on the nature of the uninsured in the state while assessing for attitudes and support of a variety of options. Again, the _audience response system_ will be used to ensure that every participant of the focus group will be able to register his/her opinion and that the discussions are not dominated by persons with dissenting opinions. Staff will also use the information compiled in the data base by the University of Arkansas to answer questions that come up during the focus groups and _drill down_ information so that participants have detailed information on which to focus their opinions and the discussion.

◆ Core Decision Making Group

See the following section.

(3) Decision Making

The Director of the CHIP unit within the ADPH will provide direct oversight for this project. A core decision making group of ADPH staff and key stakeholders will assist in keeping both the Executive Workgroup and any subcommittees on track and assist grant staff and the State Health Officer in developing the final report to be presented to the Secretary of DHHS.

The Project Director will keep this group informed of data analysis performed as a part of this project. Based on previously used models, the core group will have between five and twelve members who have participated in the Executive Workgroups and subcommittee discussions and include the State Health Officer, the Staff Assistant to the State Health Officer, the ADPH Administrative Officer, a representative from the ADPH Legal staff, the SPG Project Director, and others. Key persons from the subcommittees will serve on the core group. The State Health Officer will participate in and consider all discussion within this core group but it will be he who has the final authority with regard to decisions issued from this group. This core group will meet at least monthly (beginning when the Executive Workgroup begins to meet) and may meet more often as needed. The core group will assist in synthesizing the data obtained from the Executive Workgroup, the subcommittees, and relevant information gathered from the survey and focus groups.

(4) Preparation of Report to the Secretary

It will be the responsibility of the SPG Project Director to organize, write, assemble, and distribute the report to the Secretary. The core decision-making group will review the report before it is finalized and the State Health Officer will ultimately approve the final report. The report will be in a format specified by the Federal program staff and will be

designed to incorporate the broad range of activities planned by the Alabama SPG. The report will be based on information that was generated from the contractors and subcommittees through the Executive Workgroup to the core decision making group.

Work on the report will start at the beginning of the third quarter of the grant period (January, 2003) when the Executive Workgroup and subcommittees begin to meet. An outline will be developed at the onset (in January) and sections completed as information and recommendations are forthcoming. The report will be finalized during the final month of the grant. The report will be submitted to the Secretary within 30 days after the end of the grant period. The ADPH pledges to participate in the federal program's aggregate reporting efforts and it is willing to provide available data requested by the Secretary.

B. Project Management Plan

The management plan is detailed in the matrix on the following pages.

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
Task 1: Staff the project & complete contractual arrangements				
Action Step 1-1: Identify/hire project staff (Project Director, Data Specialist, Secretary) (These staff may be drawn from currently employed ADPH staff)	Time of grant award notice - 7/1/02	CHIP Director	Suitable candidates will be identified and state personnel system appropriately utilized	All 3 positions are to be filled on 7/1/02
Action Step 1-2: Develop contracts with the University of Minnesota School of Public Health, Survey Center, the University of Minnesota State, Health Access Data Assistance Center Survey Center, SHADAC, Auburn University at Montgomery, and the University of Arkansas, Arkansas Center for Health Improvement	7/1-7/15/02	SPG Project Director	Mutual agreement between ADPH and contractors on contracts	Written contracts covering items set forth in section 9A above
Action Step 1-3: Execute the contracts in #1 above through the contracting agencies and the AL contracting review system	7/15-8/31/02	ADPH CHIP Administrator and SPG Project Director	Contracts signed by all necessary parties	Contracts signed by all necessary parties are on file in the ADPH

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
<p>Task 2: Identify and describe the target population for this project (Alabama_s uninsured and unstably insured).* Subtask 2-1 Utilize the CSCS household telephone survey tool and the data analysis and consultation services of SHADAC Subtask 2-2 Utilize the SPG Internet based, Multi-State Inegrated Database (MSID). Subtask 2-3 Utilize focus groups.</p> <p>(*Some of the action steps may be conducted while the contracts are being processed.)</p>				
<p>Subtask 2-1 Utilize the CSCS household telephone survey tool and the data analysis and consultaiton services of SHADAC.</p>				

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
Action Step 2-1-1: Refine telephone survey instrument, sample plan, and purchase sample.	9/1-15/02	SPG Project Director utilizing Univ. of Minn. Survey Center and SHADAC	Telephone survey instrument and sample plan are finalized.	Telephone survey instrument and sample plan are on file in the ADPH. Sample is on file at the U of MN Survey Center.
Action Step 2-1-2: Hire and train interviewers and pre-test household survey instrument, and finalize CATI programming	9/16-30/02	SPG Project Director utilizing Univ. of Minn. Survey Center and SHADAC	Interviewers are employed and trained and CATI programming is complete	Interviewers are employed and trained and CATI programming is complete
Action Step 2-1-3: Conduct field study and monitor field procedures	10/1/02-1/31/03	SPG Project Director utilizing Univ. of Minn. Survey Center and SHADAC	Survey is properly conducted	Data is collected for dataset
Actions Step 2-1-4: Produce final datasets, conduct post data collection	2/1-15/03	SPG Project Director	A dataset and sample disposition file are	The data provided is able to be used to

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
management activities		utilizing Univ. of Minn. Survey Center and SHADAC	constructed that AL can use for analytic purposes.	know and understand the distribution of size & demographics of the uninsured and unstably insured
Action Step 2-1-5: Data analysis	2/15-28/03	Project Director utilizing SHADAC	Analysis strategy & plans are reviewed & approved by all responsible agencies, analysis describes the characteristics of uninsured & insured AL residents at the state and county levels, the barriers to insurance, & the concerns of the unstably insured.	Data analyses are done error free, interpretations do not outstrip what the statistical models can support, & results are conveyed in an easily digestible manner. Internal quality review will be undertaken whereby, for example, separate analysis attempt to generate the same results.
Action Step 2-1-6 Report writing	3/1-15/03	Project Director utilizing SHADAC	Delivery of 2 primary reports: 1) a summary report on survey methodology; 2) a report that identifies	Reports identify real policy options. Study results are presented in a clear and defensible manner.

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
			policy recommendations & strategies for implementation	
Subtask 2-2 Utilize the SPG Internet based, Multi-State Inegrated Database (MSID)				
Action Step 2-2-1: Gain access to password protected MSID (via Arkansas contract)	At first grantee meeting	SPG Project Director	All relevant parties will know how to access the database	Relevant parties have access the database
Action Step 2-2-2: Receive training on the MSID (via Arkansas contract)	7/15-9/15/02	SPG Project Director, Data Specialist	SPG Project Director & Data Specialist will have an in-depth knowledge of the MSID	SPG Project Director & Data Specialist are able to use the MSID unassisted and be able to train others on its use.
Action Step 2-2-3: Receive ongoing support from Arkansas for the MSID (via Arkansas contract)	7/15/02-6/30/03	SPG Project Director, Data Specialist	SPG Project Director & Data Specialist will promptly receive technical assistance from Arkansas as	SPG Project Director & Data Specialist are able to use the MSID unassisted and be able to train others on its

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
			needed.	use.
Action Step 2-2-4: Receive Alabama-specific data available in the Behavior Risk Factor Surveillance System survey (BRFSS) usable within the MSID. (via Arkansas contract)	During 8/02	SPG Data Specialist	Arkansas will send the SPG Data Specialist Alabama-specific BRFSS data within the framework of the MSID	SPG Data Specialist is able to utilize Alabama-specific BRFSS data via the MSID.
Action Step 2-2-5: Receive Alabama-specific data available in the Current Population Survey (CPS) usable within the MSID. (via Arkansas contract)	During 8/02	SPG Data Specialist	Arkansas will send the SPG Data Specialist Alabama-specific CPS data within the framework of the MSID	SPG Data Specialist is able to utilize Alabama-specific CPS data via the MSID.
Action Step 2-2-6: Receive Alabama-specific data available in the County Business Patterns (CBP) usable within the MSID. (via Arkansas contract)	During 8/02	SPG Data Specialist	Arkansas will send the SPG Data Specialist Alabama-specific CBP data within the framework of the MSID	SPG Data Specialist is able to utilize Alabama-specific CBP data via the MSID.
Action Step 2-2-7: Receive Alabama-specific data from primary data collection surveys (up to 2 surveys)	To be scheduled with	SPG Data Specialist	Arkansas will send the SPG Data Specialist Alabama-specific data	SPG Data Specialist is able to utilize Alabama-specific data

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
	Arkansas (9/02 - 4/03)		(from up to 2 primary data collection surveys) within the framework of the MSID.	(from up to 2 primary data collection surveys) via the MSID.
Subtask 2-3 Focus Groups				
Action Step 2-3-1: Select focus group target populations	8/1-15/03	SPG Project Director	Focus group populations will be identified	List of focus group target populations and number of groups to be conducted will be developed
Action Step 2-3-2: Develop focus group interview topic lists	8/16-31/02	SPG Project Director utilizing the AUM contract	Lists of pertinent topics for focus group discussions will be developed	Lists of topics for focus group discussions will be developed
Action Step 2-3-3: Make local arrangements for conducting focus groups.	9/1-15/02	SPG Project Director utilizing the AUM contract	Local arrangements for conducting focus groups will be made.	Local arrangements for conducting focus groups will be made and a list on file in the project office.
Action Step 2-3-4:	9/16-30/02	SPG Project Director utilizing the AUM	Individuals are contacted to attend	Focus group attendees agree to attend

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
Contact individuals for focus groups		contract	focus groups	agree to attend
Actions Step 2-3-5: Conduct focus groups	10/1-15/02	SPG Project Director utilizing the AUM contract	Focus groups are conducted	Notes and transcriptions from focus groups are on file in the ADPH
Action Step 2-3-6: Analyze data collect from the focus groups	10/16- 31/02	SPG Project Director utilizing the AUM contract	Data will be analyzed	Ananalysis of data are on file in the ADPH
Action Step 2-3-7: Report writing	11/1- 15/02	SPG Project Director utilizing the AUM contract	Delivery of a report which details the methodology of the focus group surveys and synthesis of the data.	Report is on file in the ADPH.
Task 3: Identify options for covering the state_s uninsured and stabilizing the unstably insured				
Action Step 3-1: Convene meetings of the Executive Workgroup	1/03- 6/03	SPG Project Director	This workgroup will review data and consider and advise on health insurance options and make any necessary requests to	List of options (and their prerequisites) for covering the uninsured and stabilizing insurance for the unstably insured will

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
			the Project Director for additional research/ information.	be on file in the ADPH.
Action Step 3-2: Identify subcommittee members through invitation and self-selection.	1/2- 31/03	SPG Project Director	Audience members attending the 1 st Executive Workgroup meeting will self-select a subcommittee and other individuals will be invited by members of the Executive Workgroup and the Project Director.	All subcommittees will have a membership list containing the names of at least 8- 10 members.
Action Step 3-3: Convene subcommittee meetings to review data, research the feasibility and prerequisites for health insurance options, provide information for the Executive Workgroup to consider	2/1- 6/30/03	SPG Project Director	Data on the target population will be reviewed. The feasibility and prerequisites for health insurance options will be researched for the Executive Workgroup to consider.	Minutes/notes from subcommittee meetings will be on file in the ADPH.

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
Action Step 3-4: Convene core decision-maker meetings for the purposes of keeping both the Executive Workgroup and the subcommittees on track, making final decisions on the recommendations presented from the Executive Workgroup and contained in the final report to the Secretary of DHHS.	11/1-7/28/03	SPG Project Director	Progress of the Executive Workgroup and the subcommittees will be reviewed and decisions on recommendations will be made.	Notes from the core decision- making group will be on file in the ADPH.
Task 4: Provide a report to the Secretary describing findings by July 30, 2003				
Action Step 4-1: Outline the content for the report to the Secretary	4/1- 30/03	SPG Project Director	An outline for the content of the report, describing the organization of the project, data collection and analysis, and list of options for insuring the uninsured and stabilizing the unstably insured in Alabama, will be developed	An outline of the content will be on file in the ADPH.
Action Step 4-2: Write the content of the report	5/1/03-7/14/03	SPG Project Director	The content of the report, describing the organization of the project, data collection	Drafts of the report will be on file in the ADPH.

Tasks & Action Steps	Time table	Responsible Agency/ Person	Anticipated Results	Evaluation/ Measurement
			and analysis, and list of options for insuring the uninsured and stabilizing the unstably insured in Alabama, will be developed	
Action Step 4-3: All appropriate entities review the report.	7/15- 25/03	SPG Project Director	All relevant individuals/ agencies will approve the report	A list of entities who have reviewed and approved the report will be on file in the ADPH.
Action Step 4-4: Revise report into final copy	7/16- 7/28/03	SPG Project Director	The report will be revised to meet relevant individuals_ and agencies_ review	A copy of the final report will be on file in the ADPH
Action Step 4-4: Submit report to the Secretary of DHHS	7/29/03	SPG Project Director	The Secretary of DHHS will receive the final report by the deadline of 7/30/03.	The Secretary of DHHS will have the final report by the deadline of 7/30/03.

C. Governance

As stated above, all project activities, including contracted, outsourced activities, will fall under the supervision of a half-time Project Director and/or a 40%-time Data Specialist. These staff will be assisted by one full-time secretary. (See Appendix A for job descriptions and qualifications.)

Structure

The ADPH will serve as the lead agency for this project. The SPG will contract with the Survey Center and SHADAC for data collection from telephone surveys and analysis. The SPG will also contract with Arkansas for use of the MSID. These data and analyses together with information from the focus groups conducted by the Auburn University in Montgomery, will inform the discussion of the subcommittees. As stated previously, the subcommittees will review data, research insurance options, and make recommendations to the core decision making group and the Executive Workgroup. The Executive Workgroup will be made of a wide base of stakeholders who will review information from the subcommittees and the focus groups. The core decision making group will review information from the subcommittees, review the workgroup's recommendations, and make the final recommendations for the report to the Secretary of DHHS. Final decisions with regard to the report to the Secretary of DHHS will be within the purview of the State Health Officer. However, the State Health Officer will make decisions based up discussions and points of consensus within the focus groups, subcommittees, the workgroup, and the core decision making group. Thus the opinions and concerns of partnering individuals and agencies which are represented in the Executive Workgroup and in the subcommittees will be recognized. The compositions of the Main Workgroup, subcommittees, and the core decision-making group are described in section A (2) above. As stated in the descriptions and compositions of these groups, relevant agencies, the legislature, and key groups (public and private) will have ample representation and participation within the project.

Project Personnel

In addition to those personnel employed by this grant's contractors, the grant will be staffed by three employees: full-time project director, 40% time data specialist, full-time secretary. Job descriptions and qualifications may be found in Appendix A. Staff have not yet been identified for these positions. Therefore, no biographical sketches are available. The job descriptions in Appendix A indicate how the qualifications and experience of the key personnel fit with their responsibilities for this project.

Budget Plan

The budget plan can be found at the beginning of this appli;

Budget Plan

A. Management of Grant Funds

Grant funds will be managed by the Project Director with oversight from the ADPH CHIP Director and the ADPH Financial Services unit. All contracts will be subject to the state's contractual review processes.

B. Line Item Description

The line item description can be found at the beginning of this proposal between the Standard Form 424A- Budget Information - Non-Construction Budget

C. Assurance

The ADPH assures that grant funds will not be used to supplant other funding that is currently supporting this work in Alabama.

Monitoring Plan and Report to the Secretary

A. Monitoring Plan

The Project Director and Data Specialist will conduct ongoing monitoring of the tasks listed in the matrix. Special attention will be paid to the activities which are outsourced through contracts. Each contractor will submit at least bi-weekly progress reports to the Project Director. The Project Director and/or the Data Specialist will communicate with each contractor at least weekly throughout the contract time period. In addition, the Project Director will formally monitor each of the actions steps listed in the matrix at the end of each of the time frames listed for the action steps. This formal monitoring will compare actual progress with what has been listed in the _anticipated results_ and _measurement/evaluation_ sections in the matrix. The Project Director and the Data Specialist will report actions taken and progress made at each monthly staff meeting of the Children's Health Insurance Program.

Progress reports will also be given to the Executive Workgroup and core decision making group at each of their meetings.

B. Report to the Secretary

The Project Director will prepare and submit a written report for the Secretary of DHHS. The format of the report will be in accordance with that specified by the federal program staff and will be designed to incorporate the broad range of activities conducted in this grant. The ADPH agrees to participate in the federal program office's effort to aggregate information to describe the uninsured and unstably insured nationally and to make a feasible, comprehensive list of options which states may adopt to appropriately cover these groups. The ADPH willingly agrees to provide the Secretary and the federal program any available data from this project.

Project Director
Job Description

Responsibilities:

The Project Director will be responsible for supervising all project staff with regard to their work in this project. The Project Director will receive direct supervision from the Director of the Children's Health Insurance Program.

This is responsible administrative work in planning, coordinating, and directing a statewide health services project. This employee is responsible for a combination of complex administrative functions to include personnel, accounting and budget, management methods, procurement, office, public information training, and other support services. This employee will assist management in developing administrative policies. The Project Director will develop recommendations for administrative policies and management procedures.

Specifically with regard to the SPG, the Project Director will supervise the contracts, coordinate the workflow of the Workgroup, subcommittees, and core decision making group. The Project Coordinator will also have the responsibility for writing and submitting the final report to the Secretary of DHHS.

Qualifications

Bachelors degree in any field and two years of administrative experience in the health field including one year of supervisory experience. The Project Director must exhibit a high degree of organizational skills and be self-directed.

Data Specialist
Job Description

Responsibilities

This is professional and technical research work involving the investigation of various public health issues and problems. This employee will assist and conduct research studies involving multiple types of public health data.

Specifically in relation to this project, the Data Specialist will give work assignments to contractual entities engaged in the collection, preparation and analysis of health data. Provide specific oversight for the focus group process including working with the entity analyzing the qualitative data for presentations. This employee will receive training in the an Internet based multi-state integrated database (MSID) procured from the University of Arkansas, be able to train others on this system, analyze data collected by the survey center, and supervise and review the work products contracted for with SHADAC. The Data Specialist will handle responsible research assignments unassisted and in an independent manner. The Data Specialists work with regard to this project will be evaluated by the Project Director.

Qualifications

Bachelors degree in science, social science, public or business administration, health, or a closely related field, preferably supplemented by a Master's degree in the specialized area, plus two years of experience in analyzing health related data using statistical or data management techniques.

Secretary
Job Description

Responsibilities

This employee will perform a variety of clerical duties. These duties will include filing, sorting mail, typing documents, proofreading documents, making copies, greeting and directing the public, taking telephone messages, posting records, simple calculations, scheduling meetings, and taking meeting minutes.

Qualifications

This employee must meet the qualifications for the Alabama Merit System classification of Administrative Support Assistant I.

INFORMATION ON THE UNIVERSITY OF MINNESOTA, SCHOOL OF PUBLIC HEALTH, SURVEY CENTER

1 Organizational Experience

As part of the Institute of Health Services Research we have developed a data collection center. The purpose of the data collection center is to assure professional, non-bias interviewing for faculty research projects and health care policy research being conducted either outside the University or in conjunction with the University. Our data collection center would be an ideal setting to complete the Blueprint Project. To conduct these types of interviews with the volume of interviews you need an organization that has had experience, in both national research projects and experience with the different populations being interviewed. Our organization has a proven track record of delivering high quality interviewing, expert training, professional supervision and an expertise in both in-person and telephone interviewing. We have had experience in large projects that require a quick turn around and projects that require tracking individuals over a period of time. On every project we have been involved in during the past sixteen years we have been able to reach a 90% response rate for 90% of projects we have completed. That response rate along, with the quality of work and our experience in data collection make us an excellent choice for this project.

Experience: In the past sixteen years our data collection center has successfully been involved with over fifty research projects, completing around one hundred thousand interviews, with a response rate of 90% or higher. This is a proven track record for quality and excellence in data collection. Although we pride ourselves on individualizing each project, we take to each project our success from past or similar projects.

SIMILAR PROJECTS

The **Andersen School Project** was completed in three phases. The first phase was to obtain a health screening form from every child in the Andersen school complex and three neighboring schools. These schools are located in a low- income area in Minneapolis. If the child did not return their health form, an interviewer would telephone and obtain information from a guardian. If there was no telephone, the interviewer went in person to obtain the information. Phase one was completed with 507 families with a response rate of 96%. Phase two was to obtain screening information about possible asthma or asthma related illnesses from every child. The same method was chosen first the child turned in the form to their teacher and than our interviewers followed up on all non-respondents. Between telephoning and in person our interviews talked with 179 families with a response rate of 98%. Phase three was to interview families that had children that indicated either asthma or asthma related illnesses on the screening form. We completed 482 interviews by telephone and in person with a response rate of 90%.

Our experience with telephone interviews ranges from consumers, physicians, administrators, to frail or vulnerable adults and children. We recently completed a project for the **Department of Employee Relations with the State of Minnesota**. We interviewed 18,000 employees and their families. Our response rate, of course is in the mid nineties. What is remarkable about our success in this project is we only had a two- week lead-time to pretest, hire, and train interviewers. The project was completed in three months.

In 1996 we began a long relation with the **Health Access Project**. We completed 9,000 telephone household interviews in ten weeks, with a response rate of 97%. In 1999 the survey center completed 10,000 random telephone calls to individuals in Minnesota to complete four cells to determine health insurance status with a 90% response rate. We had two additional samples for Ramsey County and Hennepin County. We completed this project once again in 2001. In 2001, we had a RDD sample of 60,000 households, of that we completed 27,357 surveys. Throughout our sixteen years as a data collection center, we have completed thousands of interviews, which we considered to be vulnerable, interviews with family members who are doing intensive care giving, interviews with individuals who have been hospitalized, interviews with families whose children have survived childhood cancer, interviews with frail elderly in nursing homes, and of course large RDD telephone interviews.

Finally, we are currently conducting the **SHAPE II** survey for Hennepin county and the City of Minneapolis. The SHAPE survey is a general population survey (list based frame), in which we will complete 9500 interviews with residents of Hennepin county regarding a wide range of personal and public health as well as public health service issues. The interview is ½ hour in length and the survey will be administered using five different languages: English, Spanish, Hmong, Vietnamese, and Somali. The sampling frame that has been developed in conjunction with Hennepin County stratified to include the diverse cultures in the twin cities.

State Health Access Data Assistance Center (SHADAC)

The State Health Access Data Assistance Center (SHADAC) is a technical assistance and research center located at the University of Minnesota. SHADAC focuses exclusively on accessing and interpreting data about health insurance coverage from a state perspective. Led by principal Investigator Lynn A. Blewett and Co-Principal Investigator Kathleen Call, SHADAC is staffed by a unique combination of researchers in health care access, survey design experts, and professionals with state health policy experience. We work with states to help them bridge the gap between researchers and policy makers by translating data into the real world of state health policy.