APPLICATION FACE PAGE

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Budget Justification

Personnel Costs
Note: All salaries are calculated at the base rate for the first four months and then at a five percent increase for eight months to reflect merit raises that take effect January 1, 2006.

Kate Pfirman, CPA, CPFO, Director, Human Development Division, Governor's Office of Planning and Budget, will serve as Co-Principal Contact. As an employee of the State of Georgia, her time (3%) is not charged to the project. She will serve as the direct liaison with Governor Perdue's policy staff in her capacity as a member of the Governor's Advisory Committee and will be responsible for management of grant funds for the entire project. She will co-write the final report with Georgia Health Policy Center staff. Additionally, Ms. Pfirman will contribute to team meetings and conference calls.

Indirect Costs
Indirect costs for Ms. Pfirman's travel are assessed at ten percent of modified total direct costs, including a portion of Rent and Utilities and total $230.00.

Fringe Benefits
N/A

Travel
Total travel costs are calculated at $2,300.00. Out of state travel includes attendance at quarterly grantee meetings in Washington, D.C.

Equipment
None

Supplies
None

Subcontracts
Note: As with the original Grant award in FY02, the no-cost extension granted in FY03, and the Pilot Planning Grant awarded in FY04, the Governor's Office of Planning and Budget (OPB) will be the project's fiduciary home and will serve as the direct liaison to the Governor's policy team. Staff, Fellows, and subcontractors of the Georgia Health Policy Center at Georgia State University will compose the majority of the project team at the direction of OPB staff and the Governor's Advisory Committee.

Georgia Health Policy Center
Karen J. Minyard, PhD, Executive Director of Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as Co-Principal Contact (FTE 5%,

Annual Salary $153,000.00, $7,905.00), combining her academic background and knowledge of health care financing with her nationally recognized work in rural communities. Dr. Minyard will be responsible for project oversight and managing team members. She will contribute to team meetings and conference calls and contribute to quarterly meetings with the Governor's Advisory Committee. She will prepare and co-write the final report with Ms. Pfirman and Georgia Health Policy Center staff. Dr. Minyard will also be responsible for contributing her expertise to team meetings and conference calls and will carry the primary responsibility of managing Grant findings through the policy process with Ms. Pfirman.

William S. Custer, PhD, Associate Professor, Center for Health Services Research, Robinson College of Business, Georgia State University, will serve as a Project Investigator (FTE 12.5% (one academic course buy-out), Annual Salary $110,100.00, $14,221.25). Dr. Custer will be responsible for incorporating the modeling aspects of the compiled research into the experiential learning module. He will also contribute to team meetings and conference calls and contribute to quarterly meetings with the Governor's Advisory Committee.

Patricia Ketsche, PhD, Assistant Professor, Center for Health Services Research, Robinson College of Business, Georgia State University, will serve as a Project Investigator (FTE 10% (one academic course buy-out), Annual Salary $78,551.00, $8,116.94). Dr. Ketsche will be responsible for developing the experiential learning module with the project team and directing the analysis of findings. Dr. Ketsche will also contribute to team meetings and conference calls and contribute to quarterly meetings with the Governor's Advisory Committee.

Glenn M. Landers, MBA, MHA, Senior Research Associate, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as Project Coordinator (FTE 25%, Annual Salary, $84,466.80, $21,820.64). Mr. Landers will be responsible for managing the GHPC staff and consultants and contributing to the project's overall analytic design and work products. He will also prepare and contribute to the final report. He will meet with the Governor's Office of Planning and Budget on a monthly basis to provide updates of progress and will provide the staff with written status reports. Mr. Landers will attend quarterly grantee meetings in Washington, D.C. and contribute to quarterly meetings with the Governor's Advisory Committee. Mr. Landers is also responsible for convening team meetings and conference calls.

Chris Parker, MD, MPH, Research Associate, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as a Project Investigator (FTE 30%, Annual Salary $65,000.00, $20,150.00). Dr. Parker will assist with the development of the experiential learning module, contribute to the analysis of findings, and supervise Atlas.ti input and analysis.

Cindy Clark, BA, Georgia Health Policy Center Business Manager, will serve as the Georgia Health Policy Center's Project Financial Manager (FTE 5%, Annual Salary, $57,750.00, $2,983.75.) She will be responsible for the Center’s financial management, contracting, and daily operations as it relates to the project. Ms. Clark will attend all relevant meetings.

Graduate Research Assistant (GRA), The Graduate Research Assistant will be responsible for coding transcriptions into Atlas.ti. There will be one GRA working on the project working 20 hours per week for one academic semester ($2,262.91 stipend per semester, $2,262.91) The GRA will receive direct supervision from Dr. Parker and will attend all relevant team meetings.

Indirect Costs
As Georgia State University and OPB are State entities, indirect costs are assessed at a reduced rate from the federally negotiated rate (45.5%) and are computed at 10% of modified total direct costs ($15,679.09), including a portion of Workers Compensation, Unemployment Compensation, Rent, and Utilities.

Fringe Benefits
Georgia State University's fringe benefit rate is calculated at 27.15% ($19,563.86) and includes Social Security, Health Insurance, and Retirement. Fringe benefits are not assessed on Graduate Research Assistants or University contractors.

Travel
Total travel costs are calculated at $2,300.00. Out of state travel includes the attendance of a Project Coordinator at quarterly grantee meetings in Washington, D.C.

Equipment
None

Supplies
Office supplies are calculated at $1,894.66 for project related reports.

Georgia Health Policy Center Subcontracts
Georgia Health Decisions
Beverly Tyler, BA, Executive Director of Georgia Health Decisions, will serve as the Experiential Learning Module Coordinator, bringing thirteen years of experience in directing qualitative research projects to identify citizens' opinions and attitudes on health care issues. Ms. Tyler, along with her staff, will direct 30 Experiential Learning Modules across Georgia ($51,821.90). She will be responsible for refining the coverage model building exercise, working with GHPC staff to identify and recruit module participants, coordinating logistics, and facilitating the modules. Ms. Tyler will attend all relevant team meetings and conference calls.

Audio Transcription
The services of an audio transcriptionist will be necessary to transcribe the learning module proceedings at $125 per hour of tape for 30 hours; $3,750.00.

Staffing Plan and Personnel Requirements

Kate Pfirman, CPA, CPFO, Director, Human Development Division, Governor's Office of Planning and Budget, will serve as Co-Principal Contact (FTE 3%). She will serve as the direct liaison with Governor Perdue's policy staff in her capacity as a member of the Governor's Advisory Committee and will be responsible for management of grant funds for the entire project. Additionally, she will co-write the final report with Georgia Health Policy Center staff and will also contribute to team meetings and conference calls.

Ms. Pfirman is an accomplished Chief Financial and Operations executive with over fourteen years of experience in the public and private sectors. Since 2003, Ms. Pfirman has held the position of Human Development Division Director, State of Georgia, Governor's Office of Planning and Budget. Her primary roles include the development of budgets for the following departments: Community Health, Human Resources, Veteran's Services, and Workers' Compensation Board, and the analysis of legislative and policy changes for budgetary impact.

Previous to the Governor's Office of Planning and Budget, Ms. Pfirman served as the Deputy Commissioner, Chief Operating Officer, State of Georgia, Department of Human Resources. During her tenure with the Department of Human Resources, Ms. Pfirman directed and ensured the effective operation of a 2.5 billion dollar budget for social services with 20,000 employees in 159 counties. She also directed the leadership team in the management of 15 of the Division and Administrative Offices. From 1992 to 1995, Ms. Pfirman served as the Chief Accountant for the City of Macon, Georgia. Ms. Pfirman received an M.S. in Accounting from the American University, Washington, D.C, and a BA in Economics from Emory University, Atlanta, Georgia. She is a Certified Public Accountant (AICPA) and a Certified Public Finance Officer (GFOA).

Karen J. Minyard, PhD, Executive Director of the Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will again serve as Co-Principal Contact (FTE 5%), combining her academic background and knowledge of health care financing with her nationally recognized work in rural communities. Dr. Minyard will be responsible for project oversight and managing team members. She will prepare and co-write the final report with Ms. Pfirman and Georgia Health Policy Center Staff. Dr. Minyard will also be responsible for contributing her expertise in team meetings and conference calls and will carry the primary responsibility of managing Grant findings through the policy process with Ms. Pfirman.

As the Executive Director of the Georgia Health Policy Center, Dr. Minyard is charged with leading the policy, research, and technical assistance programs of the Center. The program areas are concentrated in care for the uninsured, rural health, long-term care, child well-being and health philanthropy.

She has extensive experience with the state Medicaid program, both with design of a reformed Medicaid program and external evaluation of the primary care case management program. Dr. Minyard was the Principal Investigator of a team conducting research as part of the Georgia Healthcare Coverage Project under the initial State Planning Grant awarded to the Governor's Office of the State of Georgia in July 2002 and the subsequent Pilot Planning Project grant awarded in 2004.

Dr. Minyard is also the Principal Investigator of a research project sponsored by the Commonwealth Fund that examines the experiences of five safety net initiatives that established sustainable financing streams to provide access for uninsured individuals.

Dr. Minyard is an advocate for the basic restructuring of local health care systems to focus on access to care and health status improvement. She serves as an officer on the founding board of Communities Joined in Action, a national partnership dedicated to helping communities achieve health care access and has provided numerous consultations and presentations for groups and organizations that seek to build stronger health care systems.

Dr. Minyard's research interests include the study of health care markets, the relationships among identity, image, and willingness to make strategic change in changing environments, and the role of targeted external facilitation and technical assistance in improving the clinical relevance and financial viability of local health systems. Dr. Minyard also has extensive experience directing the Networks for Rural Health Program at the Georgia Health Policy Center. Dr. Minyard received her Ph.D. in Business Administration at Georgia State University, Atlanta, Georgia. Before pursuing her Ph.D., Dr. Minyard worked in nursing and hospital administration for 15 years.

William S. Custer, PhD, Associate Professor and Director, Center for Health Services Research, Robinson College of Business, Georgia State University, will serve as a Project Investigator (FTE 12.5%). Dr. Custer will be responsible for incorporating the modeling aspects of the compiled research into the experiential learning module. He will also contribute to team meetings and conference calls and contribute to quarterly meetings with the Governor's Internal Advisory Committee.

Dr. Custer is an expert in the areas of employee benefits, health care financing, and health insurance. He has had extensive experience in conducting research projects related to the economics of health care as an economist for the American Medical Association's Health Policy Research branch. A great deal of Dr. Custer's research has examined the determinants of sources of health insurance. He has examined the effects of job characteristics, age, gender, and regulation on the numbers of uninsured in urban and rural areas. Dr. Custer has also evaluated Community in Action programs in both rural and urban areas, examining changes in patient flows, utilization, costs, and health status for the uninsured.

Dr. Custer was a key member of the team conducting research as part of the Georgia Healthcare Coverage Project under the State Planning Grant awarded to the Governor's Office of the State of Georgia in July 2002 and is currently responsible for the Study of Incidence of Uncompensated Care under the state's 2004 Pilot Planning Grant.

Dr. Custer has authored numerous articles and studies on the health care delivery system, insurance, retirement income security, and employee benefits. His research is widely disseminated in peer-reviewed publications including *Health Services Research, Health Affairs, Journal of Public Health Management and Practice,* and *Inquiry.*

Prior to joining the College in 1995, Dr. Custer ran his own research firm in Washington, D.C. Dr. Custer also has been the Director of Research at the Employee Benefit Research Institute (EBRI) in Washington, D.C., as well as serving as an economist in the Center for Health Policy Research at the American Medical Association. Dr. Custer holds a Doctorate in Economics from the University of Illinois, Champaign, Illinois.

Patricia Ketsche, PhD, Assistant Professor, Center for Health Services Research, Robinson College of Business, Georgia State University, will serve as a Project Investigator (FTE 10%). Dr. Ketsche will be responsible for developing the experiential learning module with the project team and directing the analysis of findings. Dr. Ketsche will also be responsible for co-writing the analytic portion of the final report and will contribute to team meetings, conference calls, and quarterly meetings with the Governor's Advisory Committee.

Dr. Ketsche was a key member of the team conducting research as part of the Georgia Healthcare Coverage Project under the State Planning Grant awarded to the Governor's Office of the State of Georgia in July 2002 and the 2004 Pilot Planning Grant. Dr. Ketsche contributed to the analytical oversight for all data collection activities and has been co-principal investigator on the Georgia household survey and two surveys of Georgia employers funded by the two grants.

Dr. Ketsche has conducted extensive research for various public and private organizations using the Census Bureau's Current Population Survey data, Medical Expenditure Panel Survey data, and data from the Community Tracking Study to evaluate the existing distribution of health insurance in the population and the effect of policy proposals on that coverage. Her work has generated papers that describe the link between employment and health insurance coverage. Her specialized interest and research experience relates to the issue of the uninsured locally and nationally and related policy implications for local, state, and national policymakers.

Dr. Ketsche has participated in projects relating to cost containment for Medicaid and assistance for rural health care providers by analyzing claims data and utilization patterns of various populations. She participated in an evaluation of the Georgia Department of Human Resources Mental Health, Mental Retardation and Substance Abuse program and in an early evaluation of health care quality and cost containment under Georgia Better Health Care (GBHC) for the Department of Medical Assistance, State of Georgia. She has also served as external evaluator for the Atlanta Community Access Coalition, a collaborative of providers seeking to expand access to care for the uninsured populations of Atlanta and funded through a Community Access Program grant from HRSA.

Dr. Ketsche received her Doctorate in Risk Management and Insurance from Georgia State University, Atlanta, Georgia and earned a Master of Business Administration and a Master of Health Administration from Georgia State University in 1991 and 1992 respectively.

Glenn Landers, MBA, MHA, Senior Research Associate, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as Project Coordinator (FTE 25%). Mr. Landers will be responsible for managing the GHPC staff and

consultants and contributing to the project's overall analytic design and work products. He will also prepare and contribute to the final report. He will meet with the Governor's Office of Planning and Budget on a monthly basis to provide updates of progress and will provide the staff with written status reports. Mr. Landers will attend quarterly grantee meetings in Washington, D.C. and contribute to quarterly meetings with the Governor's Internal Advisory Committee. Mr. Landers is also responsible for convening team meetings and conference calls.

Mr. Landers's areas of expertise are the uninsured and long-term care. Mr. Landers directed the team's research as part of the Georgia Healthcare Coverage Project under the initial State Planning Grant awarded to the Governor's Office of the State of Georgia in July 2002 and the state's 2004 Pilot Planning Grant.

He has worked with Georgia Health Policy Center staff in developing options for care of the uninsured in Georgia for the Department of Community Health, evaluated the strength of the health care safety net in Georgia, and recently completed a three-year evaluation of the use of primary care dollars in the state's Indigent Care Trust Fund, Georgia's Disproportionate Share Hospital program.

Mr. Landers also works on projects addressing long-term care. He recently concluded the Long-Term Care Partnership, a three-year research project that analyzed the costs and outcomes of Georgia's nursing facility program and four home and community based services programs. The project was sponsored by the Georgia Department of Community Health and the Centers for Medicare and Medicaid Services. He has also facilitated the GEORGIA Collaborative to Improve End-of-Life Care, a multifaceted research and demonstration project aimed at improving end-of-life care in Georgia. Mr. Landers's received his M.B.A and M.H.A from Georgia State University, Atlanta, Georgia.

Chris Parker, MD, MPH, Research Associate, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as a Project Investigator (FTE 30%). Dr. Parker will assist with the development of the experiential learning module, contribute to the analysis of findings, and supervise Atlas.ti analysis.

Dr. Parker joined the Georgia Health Policy Center in May 2003. During his tenure, Dr. Parker has served as a Project Manager providing technical assistance to the Central Georgia community (made up of 25 counties) as they prepared for designation as a Regional Program of Excellence (RPE) by the Georgia Cancer Coalition (GCC). He was also responsible for an assessment of the RPE Initiative throughout the state of Georgia on behalf of the GCC. Over the past nine months, Dr. Parker has worked as a member of the State Planning Grant team, assisting in the coordination of various grant activities, research, and working with stakeholder groups to build consensus around options for expanding coverage. Dr. Parker is also engaged in carrying out an examination of select community health initiatives across the nation designed to improve access for the uninsured in a project sponsored by the Commonwealth Fund.

Dr. Parker received an M.P.H degree from the Rollins School of Public Health, Emory University, Atlanta, Georgia. While there, he authored and presented papers investigating: Prescription Drug Benefits for the Medicare population, Improving Access for the Uninsured,

and the Prescription Practices of HMO Physicians. He received his medical degree from the University of the West Indies, Jamaica and worked for a number of years as a faith-based clinic physician in underserved communities.

Beverly Tyler, BA, Executive Director of Georgia Health Decisions, will serve as the Experiential Learning Module Coordinator, bringing thirteen years of experience in directing qualitative research projects to identify citizens' opinions and attitudes on health care issues. Ms. Tyler, along with her staff, will direct 30 Experiential Learning Modules across Georgia. She will be responsible for refining the coverage model building exercise, working with GHPC staff to identify and recruit module participants, coordinating logistics, and facilitating the modules. Ms. Tyler will attend all relevant team meetings and conference calls.

Ms. Tyler has been the principal investigator for more than a dozen projects that have encompassed over 250 focus groups and citizen panels, 800 community forums, and 55 conferences and workshops involving more than 35,000 citizens in all 159 Georgia counties. Ms. Tyler directed the focus group research on coverage for the uninsured with both Georgia citizens and small business owners as part of the Georgia Healthcare Coverage Project under the initial State Planning Grant awarded to the Governor's Office of the State of Georgia in July 2002 and directed the community conversations and focus groups in the current FY04 Pilot Planning Grant. Ms. Tyler received a B.A. from the University of Georgia, Athens, Georgia.

Project Abstract Summary

SPG Progam - Georgia Healthcare Coverage Project
Georgia Governor's Office of Planning and Budget – Kate Pfirman
270 Washington Street, SW, Atlanta, GA 30303
404-656-4395
Kate.Pfirman@opb.state.ga.us

Current Status of Access to Health Insurance and Previous Efforts to Expand Coverage
Georgia is home to more than 8.5 million people and, according to 2002 Georgia State Planning Grant survey data, 18 percent of the non-elderly, or 1.35 million Georgians, experienced a spell without insurance during the previous year, just over one million lacked coverage at the time of the survey, and about nine percent of the non-elderly population lacked coverage for the entire year. Tabulations from the March 2004 Current Population Survey show that the rate of non-elderly uninsured residents has increased to approximately 16 percent. As in other states, a large percentage of the uninsured are either workers or dependents of workers.

Georgia's past efforts to reduce the number of uninsured citizens have been focused on the expansion of public programs. For example, PeachCare for Kids, a Medicaid look-alike program that covers children up to 235 percent of the federal poverty level, has been very successful in enrolling eligible children. Also, Georgia is the only state to require hospitals to contribute 15 percent of their gross DSH allotment to community-based primary care programs. This requirement resulted in almost $63,000,000 in community-based primary care funding for the uninsured in FY05.

Due to limited resources resulting from an uncertain economic climate, the state has encouraged public-private partnerships in its efforts to insure the identified priority populations – working uninsured and children. The Planning Grant Team is addressing coverage for children under a State Coverage Initiative Grant in partnership with the Georgia Department of Community Health, while its current Pilot Planning Grant is addressing the creation of community-based coverage models for small businesses. Three years of State Planning Grant work has now raised the level of awareness in the legislature to the point that several bills mirroring other states' efforts to reduce the number of uninsured residents have been introduced in the current session.

Proposed Project
The state of Georgia, in collaboration with the Georgia Health Policy Center and its partners and Fellows, has worked for the past three years with SPG support to collect and analyze data that have raised public and legislative awareness of Georgia's uninsured problem. Because the health care marketplace is dynamic, the Planning Grant team understands that changes in both the numbers of uninsured residents and the degree to which employers currently offer insurance products to their employees may impact how the state addresses coverage for the uninsured.

Therefore, the Planning Grant Team has designed a five-year plan that will provide Georgia with ongoing decision-making capacity in its efforts to reduce the number of its uninsured citizens. The plan includes sequences of employer surveys, population surveys, and statewide focus groups every three years in addition to ongoing analysis, community-level coverage development, key findings dissemination, and grassroots policy development. The Team is

currently working to identify funding to support such an ongoing decision-making capacity and seeks State Planning Grant support to further its grassroots policy development efforts.

The Team proposes to incorporate all that it has learned though its data collection and Pilot Planning activities into an experiential learning module that will be used with 30 (small business/local government) community groups around Georgia. Through the experience, the participants will be more knowledgeable about the uninsured in Georgia in general and the trade-offs involved in covering the uninsured. Additionally, as part of the experience, participants will design a mock health insurance plan given limited resources. The deliberations of those exercises will be recorded and coded into Atlas.ti software to analyze common themes and to create a broader depth of understanding as to the trade-offs individuals are willing to consider in covering all of Georgia's citizens. Those findings will be synthesized for legislative, county commission, and other stakeholder audiences so that the state will understand how it might further support the efforts of local communities in expanding coverage for the uninsured.

Lead Agency

The Governor's Office of Planning and Budget is submitting this application for $175,000 in support from HRSA. The Governor's Advisory Committee will provide policy oversight for the project. This committee is chaired by the Health Policy Advisor to Governor Perdue and includes the Director of Health and Human Services from the Governor's Office of Planning and Budget, the Commissioner of the Department of Community Health, the state's Medicaid Director, the State Public Health Director, the Director of Life and Health/Managed Care Division of the State Insurance Commissioner's Office, the Director of Georgia's SCHIP program, and members of the Planning Grant Team from Georgia State University's Georgia Health Policy Center and Center for Health Services Research.

As previously established throughout Georgia's involvement in the State Planning Grant Program, at least one representative each from the Governor's Advisory Committee and Georgia Health Policy Center staff will continue to participate in quarterly grantee meetings in the Washington D.C. area. Staff from the Governor's Office of Planning and Budget will continue to be responsible that all reporting requirements are in a format and timeframe as directed by the Program Officer. Office of Planning and Budget and Georgia Health Policy Center staff will both continue to cooperate in the preparation of consolidated national reports. Staff from the Georgia Health Policy Center will continue to act as a resource to other grantee and non-grantee states.

Projected Results

No amount of data collection alone will address the issue of the uninsured unless stakeholders are prepared to hear the data's messages. The culture around how the state and its citizens manage the uninsured and work to reduce their numbers, we believe, can begin to change only when all that has been learned and experienced over three years of State Planning Grant research is packaged and presented in a manner that begins to change how community leaders, employers, and citizens view the problem. The project's result, we believe, will be the creation of new partnerships that further reduce the number of Georgia's uninsured citizens.

Program Narrative

Current Status of Health Insurance Coverage

Georgia is home to more than 8.5 million people. The FY02 SPG Population Survey revealed that about 13 percent of the population under age 65, or about 1 million people in Georgia age 64 and younger, were currently uninsured at the time of the survey in fall 2002. Sixty-eight percent of non-elderly Georgians had employer-sponsored or individual private coverage, and 21 percent had some type of public coverage, such as Medicaid, Medicare, or PeachCare. The 2002 survey also showed that 16 percent of all Georgians, or 18 percent of the non-elderly, experienced a spell without insurance during the previous year, and about nine percent of the non-elderly population lacked coverage for the entire year. Thus, about half of those experiencing a gap in coverage were chronically uninsured.

In order to provide the most up-to-date estimates of the number of uninsured Georgians, the Planning Grant Team has tabulated March 2004 Current Population Survey (CPS)[1] data to contrast with data collected from the FY02 SPG activities. Statements referring to those tabulations are identified throughout this section in italics.

Tabulations of March 2004 CPS data show that 16 percent of the Georgia population overall, and 18 percent of the non-elderly population are currently uninsured. The number of Georgians without health insurance increased by over 23 percent in the first few years of this decade, increasing from 1.13 million in 2000 to almost 1.4 million in 2003. The growth of employment-based coverage failed to match population growth of the first three years of the decade. Consequently, while the number of Georgians with employment-based coverage did not change, the percentage of Georgians with employment-based coverage fell from 71 percent to 66 percent. A soft economy and falling incomes also led to increased reliance on public coverage, particularly Medicaid, over the first three years of this decade. In Georgia Medicaid coverage grew by over 23 percent.

According to the FY02 SPG Population Survey, children (0 to 18) made up 27 percent of the state's non-elderly population but only 14 percent of the State's uninsured population. Children are more likely to be covered than any other non-elderly group, with just six percent of Georgia's children lacking coverage. The low number of uninsured children was most likely due to the success of Georgia's S-CHIP program, PeachCare for Kids. On the other hand, almost one-third of Georgians between the ages of 18 and 24 had experienced some lapse in coverage during the previous 12 months, and about one-quarter was uninsured at any given point in time. By comparison, the percentage of Georgians between the ages of 55 and 64 who have had either a lapse in coverage (15 percent) or were uninsured at any point in time (13 percent) was substantially lower.

Young men (ages 18 to 24) were much more likely to be chronically uninsured than females (23 versus ten percent). Women, as they approach retirement age (ages 55 to 64), were significantly

[1] Because of large standard errors inherent in CPS data, CPS tabulation results are not directly comparable to data collected through the HRSA State Planning Grant; however, they do provide a general indication of the direction rates of insurance coverage are moving in Georgia.

more likely to experience a lapse in coverage (20 versus ten percent) or to be chronically uninsured than men (ten versus five percent). For many women, coverage is linked to the employment status of a spouse. Divorce or early widowhood may leave these women without insurance benefits. Men and women who are married or living in a family with a married primary wage earner are the most likely to be covered. Those who are single or living with a partner are the most likely to be uninsured.

The more recent tabulations of the March 2004 CPS show that 15 percent of males under age 18 and 13 percent of females under 18 are currently uninsured. Rates increase to 22 percent for men and 33 percent for women in the 18 to 24 age group. Rates then increase to 26 percent for men and decrease to 19 percent for women in the 25 to 44 age group, and finally fall to 12 percent of men and 14 percent of women in the 45 to 64 age group.

The likelihood of experiencing a gap in coverage decreases as family income increases. However, a substantial number of the uninsured in Georgia are not low-income. Per the FY02 SPG Population Survey, twenty-two percent of the uninsured lived in families with incomes at or above 300 percent of the federal poverty level (FPL), or $55,200 for a family of four. Fifty-six percent of the uninsured had incomes between 100 percent and 300 percent of the FPL. Individuals living in families with incomes below the poverty level comprised about 12.5 percent of the non-elderly population but 22.5 percent of uninsured Georgians.

March 2004 CPS data show that 51 percent of Georgia's uninsured residents have family incomes at or below 200 percent of FPL. Eighteen percent of the uninsured have family incomes between 200 and 399 percent of FPL, and seven percent of Georgia's uninsured residents have family incomes at or above 400 percent FPL.

Despite the low income of many of Georgia's uninsured residents, only 22 percent of the currently uninsured reported in FY02 being previously enrolled in some type of public coverage. Of those who reported being eligible for a public program but declining to enroll, 55 percent reported they were opposed to public coverage or the stigma attached to public programs. Ninety percent of the currently uninsured reported that they would enroll in a public program if eligible, and 95 percent reported they would enroll in a public program if they were eligible and would incur no expense associated with enrollment.

According to the FY02 SPG Population Survey, of those Georgians without health insurance, at least 68 percent worked or were the dependent of someone who works. However, those working fewer than 30 hours per week and their dependents were more than twice as likely as other Georgians to be uninsured, experience a spell without coverage, or be chronically uninsured. Among those who worked or were in a family headed by someone who worked in a permanent position, less than ten percent were currently uninsured. However, among those working or in a family headed by those who worked in non-permanent employment, the rate increased to 41 percent for temporary and 34 percent for seasonal employment.

March 2004 CPS data tabulations show that 69 percent of Georgia's uninsured residents work full-time all year or are the dependent of someone who works. However, thirty-one percent of part-time workers are uninsured, and 15 percent of full-time workers are uninsured.

Insurance coverage is also related to the size of the firm in which an individual works. Twenty-five percent of those who worked for, or were the dependent of someone who works for, firms with between two and ten employees - and 29 percent of those in single person firms - were uninsured according to the FY02 SPG Population Survey. Almost one out of three individuals without coverage was employed by firms with fewer than 25 employees or had a primary wage earner working in such a firm.

The 2004 March CPS tabulations demonstrate that the rates have shifted somewhat. Thirty-three percent of workers in firms with ten or fewer employees are now uninsured. Thirty percent of workers (or dependents of workers) in firms with between ten and 24 workers are uninsured, and even ten percent of workers in firms with 1000 employees or more are uninsured.

African American, and especially Hispanic, Georgians are more likely than white non-Hispanics to be uninsured at any given time or to experience any spell without coverage. While African American and white non-Hispanic Georgians have similar rates of being chronically uninsured, Hispanics are almost twice as likely as either of these groups to be uninsured for the entire year. Our FY02 findings suggest that minorities are not enrolling in public programs and private plans at the same rates as non-minorities.

Rates of insurance coverage vary across the state. A large percent of the population in rural areas, especially south rural Georgia, is uninsured; 17 percent of Georgians living outside urban areas in the southern half of the state and 16 percent of north rural Georgians were uninsured in FY02 as compared with 11 percent uninsured in all urban areas and only ten percent in metropolitan Atlanta, where half the state's population resides. In some rural regions, the likelihood of being uninsured is over 20 percent.

From Georgia's 2002 Household Survey, we know the uninsured are more likely to report their health status as fair or poor (17 percent vs. ten percent) and less likely to report their health status as excellent or very good (52 percent vs. 63 percent). They are less likely to receive preventive care and more likely to be sicker than the insured. They are almost four times more likely to not have had a routine checkup in the past two years (37 percent vs. ten percent), three times more likely to have never had a routine checkup at all, and more likely to have missed six or more days of work or school in the past year (23 percent vs. ten percent).

The uninsured are also half as likely to have seen a doctor in the last six months and more likely to have had an emergency room visit in the last 12 months. And, in general, the uninsured feel less confident about their ability to obtain health care than those with coverage. They are 7.5 times more likely to strongly disagree with a statement that they are able to get the health care they need. They are also much less likely to have a usual source of care than the insured population (58 percent vs. 90 percent). These numbers become even more important when one considers that in 2003, the United Health Foundation ranked Georgia thirteenth in deaths from heart disease, seventh in infant mortality, thirtieth in deaths from cancer, and eighth in premature deaths overall.

Georgia's Current Delivery System

The State of Georgia's population and geography contribute to a complex health care marketplace that consists of a mix of 152 public and private hospitals, 323 nursing facilities, large and small health insurers, four schools of medicine, several schools of nursing and allied health, and a wide variety of consumers, all of which either directly or indirectly impact the number of uninsured in Georgia.

While it is known that Georgians receive health care reimbursement from the public, private, and charitable sectors, Georgia has lacked data on the impact of fluctuations in each of these reimbursement mechanisms and the true costs of the uninsured, overall. Georgia has yet to define the contributions of each sector to the costs of caring for the uninsured; however, work is underway with 2004 SPG Pilot Planning funding to answer those questions through a study of the incidence of uncompensated care.

Georgia currently has 152 acute care hospitals, many of which – especially in Georgia's many rural areas – are at risk of closure due to losses from indigent and charity care. In January 2005, Southwest Hospital and Medical Center in metro Atlanta closed due to a delay in receipt of federal Disproportionate Share Hospital (DSH) dollars. These hospitals survive in a primarily discounted fee for service environment, especially outside metropolitan Atlanta.

In 2003, the Insurance Commissioner's office reported 243 companies offering guaranteed renewable individual policies. Of that number, only one was a traditional HMO. The Insurance Commissioner also reported 280 companies offering group policies, of which ten were traditional HMOs. The Kaiser Family Foundation reports that in 2003, Georgia's HMO penetration rate was 14.2 percent and that 86 percent of Medicaid enrollees were in managed care.

According to the Georgia Department of Community Health,[2] more than 60 percent of hospital stays were covered by government payments in FY03, and more than $800,000,000 dollars is spent each year on indigent and charity care. According to the Kaiser Family Foundation, Georgia had 219 physicians per 100,000 population in 2003 compared with a national average of 281. Georgia also had 65 nurses per 10,000 population compared with 78 per 10,000 nationally and two physician assistants per 10,000 population – the same as the national average.

Between September 2002 and February 2003, the National Center for Primary Care (NCPC) at Morehouse School of Medicine assessed the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia. To be counted as part of the primary health care safety net, a health center or health care professional must provide the full range of services typically provided in a family physician's office. The NCPC determined that Georgia has a current need of almost three million primary care visits for the uninsured but provides only 772,947 visits through currently available safety net providers. The NCPC also reported that roughly 266,533 uninsured persons, or one-quarter of Georgia's currently uninsured population and one-third of Georgia's chronically uninsured, are being served by existing safety net providers.

[2] http://www.communityhealth.state.ga.us/

The Health Resources and Services Administration's Bureau of Primary Health Care funds 19 Community Health Center organizations in Georgia, comprising a total of 81 primary care delivery sites. Georgia's state and county health departments offer many categorical services (family planning, immunizations, etc.) to uninsured and other underserved Georgians, but some also offer more comprehensive primary care services. Public hospitals offer primary care in outpatient clinics and neighborhood satellites. Georgia's hospitals also provide outpatient indigent or charity care and reported spending roughly $1 billion dollars in un-reimbursed costs for hospitalization or uninsured patients in 2002.

Hospitals that treat a disproportionate number of Medicaid and other indigent patients qualify to receive federal Disproportionate Share Hospital (DSH) payments through the Medicaid program. The Indigent Care Trust Fund represents the largest component of DSH payments. Fifteen percent of the state's Indigent Care Trust Fund dollars are explicitly awarded to Georgia hospitals specifically for "primary care" programs. A 2003 analysis of the primary care requirement of Georgia's DSH hospitals by the Georgia Health Policy Center (GHPC) revealed that of the approximately $62,000,000 in primary care services delivered, about 40 percent was allocated to hospital-specific projects, 30 percent was allocated to prescription drug assistance, 14 percent was allocated to local public health departments, and 16 percent was allocated to rural health system development and various screening programs.

Some charitable organizations operate full or part-time clinics, often with volunteer physicians and nurses. These clinics are essential in providing services to specific immigrant groups or other underserved populations. Georgia's physicians and other health care professionals working in private practice often care for uninsured or other underserved patients, but typically cannot offer up-front discounted charges or sliding fees for the services they provide.

In several Georgia counties, coalitions of community-based organizations and/or health care providers have banded together to provide more structured mechanisms for providing primary health care to the uninsured. Since 1999, the GHPC and the Office of Rural Health Services, with funding from Georgia's Department of Community Health, have provided technical support for the development of rural health networks. These networks have demonstrated tremendous success in bringing together key stakeholders to achieve coordination of services to patients in need. Through the inclusion of private practitioners, they may expand clinical delivery sites. However, they have also demonstrated that their impact will be limited if they do not have the ability to expand capacity in terms of high volume patient care for low-income and uninsured patients.

Georgia Medicaid has embarked on a plan that has the potential to dramatically shift the way in which services are delivered to Medicaid recipients, and in turn, the population as a whole. The state has issued a Request for Proposals to effectively shift the financing of Medicaid services to at-risk Care Management Organizations for the low-income adult and child, PeachCare for Kids, Right from the Start, and Refugee populations. The department's intention is to have two CMOs in each of six regions around the state. The plan will be implemented incrementally beginning in January 2006 with two regions. Additional regions will be added throughout 2006. While it is too soon to tell the impact such a system might have on the state's uninsured residents, members of the Planning Grant Team have been in conversation with providers, state officials, and other

stakeholders in an advisory capacity to keep the needs of the uninsured and community health organizations at the forefront of discussions.

Georgia's Examination of National Activities

Georgia has begun examining multiple options employed at the national level and by other states for reducing the number of uninsured citizens, spurred on by the activities of the Georgia Healthcare Coverage Project. Health Savings Accounts (HSAs), proposed under the 2003 Medicare Modernization Act, are seen as a complement to the current activities underway with the 2004 Pilot Planning grant. In fact, HSAs are being considered as part of three communities' plans for a three-share like coverage model[3] under Georgia's current Pilot Planning Project.

The Georgia Legislature has also introduced legislation in its current session that mirrors efforts of other states:

HB 83: The "Small Business Employee Choice of Benefits Health Insurance Plan Act" would allow small employers to offer plans that do not include state required mandates. The expectation is that employers not previously in the group insurance market and their employees would gain access to insurance they would not otherwise be offered.

HB 166: The "Health Share Volunteers in Medicine Act" would exempt volunteer providers from liability in their treatment of indigent clients. The state, instead, would take on this responsibility

SB 102: The "Group Accident/Sickness Insurance Act" would allow the marketing of "association plans" within the state.

SB 218: This bill would create a financing mechanism for Georgia's High Risk Pool through an industry assessment on health insurance plans. This would allow Georgia to join the 32 other states that have funded High Risk Pools.

Additionally, the Georgia Health Policy Center, in partnership with the Georgia Department of Community Health, is evaluating Georgia's opportunities to extend benefits to the parents of PeachCare recipients and premium support of private coverage through a Robert Wood Johnson State Coverage Initiatives grant.

Earlier Efforts to Reduce the Number of Uninsured Georgians

Georgia's past efforts to reduce the number of uninsured citizens have been focused on the use of public programs and funding. However, the state has recently encouraged private and local-level responsibility for the uninsured (due to the state's limits financial capacity under current economic constraints) and the consideration of coordinated statewide efforts to expand coverage and reduce costs, and those efforts have been supported by a key finding of Planning Grant activities in 2002 and 2003 - a common desire for shared responsibility that enhances the current employment based system.

[3] Three-share models were originally created by the Muskegon Community Health Project in Muskegon Michigan. The concept creates insurance-like products supported by the employer, the employee, and, usually, a public source of funds.

Medicaid and PeachCare

Medicaid has played a critical role in past attempts to reduce the number of uninsured Georgians. Between 1980 and1989, these efforts consisted of the initiation of 30 enhancements or expansions of the Medicaid program, extending insurance coverage to many previously uninsured residents. Federal Medicaid expansions in the late 1980's and early 1990s were also responsible for large increases in enrollment of children. From 1990 to 1999, 26 additional enhancements or expansions to the Medicaid program were implemented.

In 1990, Georgia established the Indigent Care Trust Fund (ICTF) with federal DSH dollars to expand Medicaid eligibility and services; support rural and other health care providers that serve the medically indigent; and fund primary health care programs for medically indigent Georgians. Georgia is the only state that requires hospitals to contribute 15 percent of their gross DSH allotment to community-based primary care. This requirement was challenged in FY04 in an effort to reduce primary care expenditures to the hospitals' net allotments - effectively cutting primary care funding in half. Governor Perdue ultimately required the maintenance of the existing effort - preserving more than $63,000,000 in community-based primary care funding in FY04.

As with other states, Georgia is currently in talks with the Center for Medicare and Medicaid Services as to the manner in which it distribute DSH allotments to participating hospitals. The primary question revolves around funds that Georgia Medicaid holds back from the hospitals in order to enhance or expand other departmental programs, such as PeachCare. The current dilemma is targeted for resolution by the end of the current fiscal year, and the state legislature has created a plan for replacing those funds should they not be made available through DSH.

In November 1995, the Department of Medical Assistance (then Georgia's Medicaid Administrator) was charged with examining state Medicaid reform. That study, entitled "Directions for Change: Recommendations for Medicaid Reform in Georgia," was prepared by the Georgia Coalition for Health and the Georgia Health Policy Center and financed in part by the Robert W. Woodruff Foundation. The study resulted in a recommendation that disabled individuals who work should have the opportunity to buy-into Medicaid. Mechanisms for funding such an expansion (not exclusive to the disabled community) are still being examined in a larger context of planning for uninsured residents.

During the mid-1990's, two efforts were undertaken in an attempt to reduce Medicaid costs and allow for Medicaid expansion. These efforts were Georgia Better Health Care, a primary care case management program still in use today (and responsible for the reported high percentage of Medicaid managed care in Georgia), and a capitated managed care program that was not able to gain traction beyond the Atlanta metro area and is not currently in operation. Medicaid remains one of the top three expenditures of the Georgia budget.

In March 1998, the Georgia State Legislature approved an SCHIP program, PeachCare for Kids, which has been very successful in enrolling eligible children. PeachCare is a Medicaid look-alike program that covers children up to 235 percent of the federal poverty level. Enrollment has far exceeded state predictions, with over 178,000 children currently enrolled. In the current

legislative session, a late payment lock-out provision instituted in July 2004 has been rescinded, and eligibility remains at 235 percent FPL.

Insurance Market Reforms and Market Developments

In the late 1980's, Georgia passed into law a risk pool mechanism. However, due to uncertain costs, the risk pool remains unfunded. Efforts by the insurance industry to create legislation in the 2004 legislative session to assess one dollar per policy per month on all health insurance policies in the state in order to fund the risk pool did not gain traction due to overall state budget concerns and the time spent on closing a $65,000,000 budget gap. However, the process did begin to raise the level of awareness, and the measure has been reintroduced in the current session with better prospects for passage.

In the mid-1990s, when many states were undertaking major insurance market reforms, Georgia undertook a series of smaller, but still important, reforms. In 1995, the General Assembly passed a law that limits insurers' ability to deny coverage in the small group market based on pre-existing conditions. Also in 1995, Blue Cross Blue Shield of Georgia began the process of conversion to for-profit status. In response to the conversion, a group of non-profits filed suit and won an 80 million dollar judgment for the public's interest in the conversion. In 1996, the federal HIPAA law was passed, requiring guaranteed issue, renewal, and portability in the group market. Based on the status of the state's insurance market, Georgia chose to implement a HIPAA alternative mechanism rather than guaranteed issue in the individual market. The alternative mechanism provides a combination of conversion and risk assignment for individuals who have exhausted all continuation coverage available to them.

In the late 1990's, a law providing for Health Plan Purchasing Cooperatives was passed. However, for a variety of reasons, cooperative purchasing has yet to gain traction in Georgia. A major milestone was achieved in 1999 when the Patient Protection Act was signed into law. While the Patient Protection Act does not provide insurance to the uninsured, it provides a bill of rights for Georgians enrolled in managed care and greatly reduces under-insurance for managed care clients receiving emergency medical attention.

The late 1990s were also marked by the increasing adoption of mandates by the General Assembly. Two mandates were passed in 1998 - HB 1565, which requires insurers to provide coverage for annual Chlamydia screenings, and SB603, which mandates coverage for routine costs associated with clinical trial programs for children who have cancer. Two mandated offerings were also passed in 1998 - HB1086 mandates osteoporosis testing, and SB 55 requires the provision of diabetes treatment, education, and supplies. A mental health parity bill requiring employers with two to 50 employees to offer a minimum mental health benefit with the same annual and lifetime cap for mental illness as for other illnesses was also passed. In 2002, a bill to eliminate mandates in the small group market was introduced for the purpose of reducing the cost of health insurance to small employers and, thus, reducing the number of uninsured Georgians; however, the bill did not pass. As mentioned above, HB 83, a bill also addressing mandates, is currently under consideration in the state legislature.

In the private sector, Kaiser Permanente offers the Bridge Program in the Atlanta metro area. The Bridge Program is designed for individuals and families up to 250 percent of poverty and

provides subsidized insurance for up to two years. Because the program is subsidized through Kaiser's community endowment, the program is capped at 2,000 participants. Kaiser Permanente is also working with the current Pilot Planning project to design a group product for small business that incorporates input from metro Atlanta small employers and employees.

Progress on SPG Program Funded Activities

The State of Georgia was funded under the 2002 Planning Grant Program and the 2004 program with a Pilot Planning grant. The Georgia Healthcare Coverage Project, created initially to perform the work under the 2002 grant, has assembled support from a variety of sources to address the many dimensions of access for the uninsured. With funding from State Coverage Initiatives and in partnership with the Georgia Department of Community Health, the Project is examining extending access to the parents of PeachCare recipients. With funding from the Georgia Healthcare Foundation, the project has developed a micro-simulation model for evaluating the impact of multiple changes in eligibility or participation requirements for Medicaid and PeachCare on affected health consumers. With funding from the Commonwealth Fund, the project has examined community efforts nationwide to expand coverage through non-traditional plans.

The activities completed with FY02 and FY04 State Planning Grant support include:

- The establishment of a Political Body to Recommend Strategies to Address the Uninsured. This committee is chaired by Abel Ortiz, Health Policy Advisor to Governor Perdue, and includes the Director of Health and Human Services from the Governor's Office of Planning and Budget, the Commissioner of the Department of Community Health, the State Public Health Director, the Director of Life and Health/Managed Care Division of the State Insurance Commissioner's Office, the Director of Georgia's SCHIP program, and members of the Planning Grant Team from Georgia State University's Georgia Health Policy Center and Center for Health Services Research.

- The creation of a Georgia-specific dataset on the uninsured. The State has never before had the opportunity to compare rates of uninsured residents and employer sponsored health care coverage by region, nor has the state ever had the opportunity to look at self-reported health status by state service delivery. To do this, the team simultaneously collected data from multiple sources to comprehensively research the availability of health insurance, employee health benefits, Georgians' health care values and attitudes and their opinions on the accessibility and affordability of health insurance, and the attitudes and opinions of key Georgia decision-makers. This endeavor included the following data collection activities:

    - ***Georgia Household Health Insurance Survey*** **-** The University of Minnesota's School of Public Health Survey Research Center conducted a telephone survey of more than 10,000 Georgia households between October 2002 and February 2003. The survey enabled the modeling of the number of uninsured in Georgia by location, income, and the characteristics of the population that vary with insurance status. Topics covered in the survey included health insurance status, access to health insurance, type of coverage, health status and access to care, use

of services, and demographic characteristics of respondents. The survey, by its design, collected information about the health insurance status of each individual in the household as well as detailed information about a randomly selected target individual in each household. In keeping with HRSA's desire to share SPG products with other states, the Georgia survey was used by the state of Alabama in its data collection activities.

- ***Georgia Employer Health Benefits Survey*** - A health benefits survey that collected information from over 1,400 establishments in Georgia (20 percent response rate) was performed by Georgia State University between October 2002 and January 2003. This survey gathered information about the characteristics of the work force and the benefits available to employees. The survey sample was drawn from ES202 Firm-level Employment and Address Data, collected by the Georgia Department of Labor and compiled from the Tax and Wage Report, which is filed quarterly by each Georgia employer covered by unemployment insurance legislation. The Georgia team has consulted with Virginia and Hawaii in modeling their SPG employer surveys after Georgia's. Furthermore, Drs. Custer and Ketsche have shared the lessons learned from the employer survey with a Bureau of Labor Statistics sponsored coalition of states interested in design of a coordinated state benefits survey for administration by Departments of Labor in the respective states. Additionally, Dr. Ketsche presented results from Georgia's survey at the 2004 Academy Health Annual Research Meeting and has a paper based on the results forthcoming in *Medical Care Research and Review*.

- ***Georgians on Health Insurance Focus Groups*** - Between September 2002 and December 2002, 21 focus groups (total participation of about 250 individuals) were convened to measure Georgian's attitudes and opinions regarding the development of a plan for providing affordable insurance coverage for all Georgians. The focus groups were conducted using a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System.

- ***Attitudes of Small Georgia Employers on Health Insurance***
  Between February 2003 and April 2003, five focus groups with Georgia's independent small employers (total participation of about 50 individuals) were conducted in the employers' communities. Small employers are those defined as having between two and 50 employees. Because there was no methodology similar to the PRIZM system for employers, the five focus groups were conducted in, and the small employers recruited from, five geographically separate and economically distinct counties in Georgia. During February and March 2004, an additional four focus groups were held with small business owners who did not offer health insurance, so as to better understand the barriers that they face in providing coverage for employees.

- ***Georgia Key Decision Maker Interviews*** - Interviews with 22 key Georgia decision-makers were completed to understand the attitudes and opinions of key

leadership in Georgia about health insurance, the uninsured, and access to care. Individuals were selected from the following five groups: consumers, employees in the executive branch of state government, insurers, legislators, and providers. Criteria for selection included current position, prior experience, and influence on health care related decisions in Georgia.

- ***Assessment of Georgia's Primary Care Safety Net*** - The National Center for Primary Care at Morehouse College conducted an assessment of the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia between September 2002 and February 2003. The purpose of the assessment was to identify affordable primary care services available to an undifferentiated patient, rather than isolated categorical programs offering individual services such as mammography or family planning.

- ***Community Listening Sessions*** - Four listening sessions for community leaders (total participation of about 60 individuals) were conducted by Grant staff in locations selected for their geographic and cultural diversity and their relative rankings of aggregate economic strength. Participants were drawn from representatives of the business and economic development communities, health care providers, insurers and underwriters, philanthropies, community-based organizations, and elected officials. The purpose of the listening sessions was to gauge opinions about the impact of the uninsured at the local level and attitudes about health care reform options.

The data collection process also included the evaluation of information from secondary sources, including information from the Current Population Survey (CPS), the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), the Behavioral Risk Factor Surveillance Survey (BRFSS), County Business Patterns (CBP), and policy and opinion papers from a variety of sources.

Additional 2002/2003 activities included:

- ***Data Analysis and Presentation*** - With the analysis of the data completed, there have been many opportunities for incorporating the information from those analyses into the public domain to inform decision makers and build consensus. Core messages associated with the research findings were made available in two formats - fact sheets produced in an easy-to-read format supplemented by more detailed reports for those desiring more technical information. Consideration was given to promoting messages that would be understandable to elected officials, key stakeholder groups, researchers, and the general public.

Specific accomplishments in the use of the data include:

- Development of a project website allowing access to the most up to date information coming out of the Planning Grant activities;

- Ongoing responses to multiple requests by local organizations for detailed technical assistance in creating community-based solutions. The public was encouraged to request and use the findings for planning local initiatives that will help improve access to health insurance;
- Many requests for small area estimates have been received, and localized data from the household survey have been used, particularly for the purpose of applying for grant funding, the establishment of Community Health Centers, or other federal grants. As a result, Project Staff and the Division of Public Health in the Department of Human Resources are working together to make the data available to the public via the Internet on that agency's OASIS system;
- Participation in the Arkansas Multi-State Integrated Database System; and,
- Presentation of results at the 2004 Academy Health Annual Research Meeting and forthcoming publication of results in *Medical Care Research and Review*.

- ***Fact Sheets and Reports*** **-** Fact sheets were distributed at statewide presentations, provided to and discussed with Legislators, sent electronically to an extensive mailing list of stakeholders, and posted on the grant website. These include:

  - 13 fact sheets outlining the findings of the household population survey statewide and for each of the 12 sub-state service delivery regions;
  - One report on the methodology of the research conducted under the grant;
  - One report on the results of the employer survey;
  - One report on the results of the citizen focus groups;
  - Two reports on the results of the employer focus groups; and,
  - One report on the results of statewide coverage modeling.

- ***Additional Reports and Data*** **-** Detailed reports of the findings of the employer survey, the focus groups, and the community listening sessions have been distributed through public presentations, the Grant's website, and via e-mail lists. County-by-county estimates of the uninsured have been produced and posted on the grant website. Finally, several PowerPoint presentations outlining the work of the grant and key research findings have been posted on the grant web site.

- ***Public Forums*** **-** A series of public forums was begun with the launch of Cover the Uninsured Week 2003 to share the findings supported by the Grant and to encourage public discussion. Each Public Forum was widely advertised directly to stakeholders and legislators, as well as the public through print, radio, and television media. The Forums were effective methods of building interest and support for the work of the Grant among stakeholders, legislators, and the public. The findings of the data analysis, and their implications for Georgia, were the subject of thoughtful reporting in well-circulated media outlets (Atlanta Metro, Macon, Augusta, Savannah, and Albany) across the state.

- ***Modeling*** **-** Using Georgia specific data, the Planning Grant Team has engaged in modeling local and national coverage proposals to gauge their impact and costs. In an effort to address the emerging themes of access for the working uninsured and access for

uninsured children, the Health Care Coverage Project modeled three options - Health Savings Accounts, Tax Credits, and High Risk Pools. The results of this modeling exercise were released in March 2004.

- ***Consensus building activities and the provision of technical assistance to key stakeholder groups include:***

    - **August 2003 -** The National Association of Counties (NACo) and the National Conference of State Legislators (NCSL) partnered with the Georgia Health Policy Center and the Association County Commissioners of Georgia to host a meeting to examine the issue of the uninsured in Georgia. The organizations together hosted the two-day event in Atlanta. There were nearly 100 participants, including: state legislators, county chairs and commissioners, district health officers, health network directors, conference faculty, representatives from NCSL, and representatives from Kaiser Permanente.

      The data from the State Planning Grant provided the information around which the participants became engaged in attempting to craft solutions to the problem of covering the uninsured. At the end of two days, the group determined that the working uninsured and uninsured children should be the two focus areas going forward. This imparted significant momentum to the process and quickened the formation of a House-appointed task force to further investigate those two priorities.

    - **October - December 2003 -** The House Task Force on Health Insurance Options for Small Businesses and the Working Uninsured, created by the Georgia General Assembly, was a direct result of the August event. This bipartisan Task Force, chaired by Representative Pat Gardner, was provided with information and technical assistance from the Planning Grant Team. During this time, the committee built further consensus by engaging the participation of the Georgia Association of Health Underwriters in their deliberations as they considered options for expanding coverage. A report to the House, outlining the recommendations of the committee, was produced by the Planning Grant Team.

    - **December 2003 -** The Atlanta Regional Health Forum, a multi-disciplinary group (public, private, governmental, corporate, legal, education, business, managed care, community-at-large, etc.) and the Georgia Health Policy Center co-sponsored a meeting of small business executives from the Atlanta region to discuss the data and options coming out of State Planning Grant activities during the year. Vondie Woodbury, of Access Health in Muskegon Michigan, also briefed the group on public/private partnerships. The group was then led through a participatory exercise to arrive at options they individually would be willing to consider.

- **April 2004 -** The Health Care Subcommittee of the Georgia Rural Development Council has been charged by Governor Perdue with the responsibility of making recommendations to the Council on four specific health issues affecting rural communities: tort reform, the working uninsured, the state of rural hospitals, and the role of communities in rural health care and coverage. The group solicited the technical assistance of the Georgia Health Policy Center using the findings from the State Planning Grant to inform their discussions.

- **May 2004 -** Organizers of Cover the Uninsured Week 2004 activities in Augusta and Savannah and the Annual meeting of Covering Kids and Families in Macon each included presentations by the Georgia Health Policy Center using the findings from the State Planning Grant in forums designed to build support for public policy that will foster expansion of coverage.

- **May 2004 -** Given the growing consensus around targeting strategies for the expansion of coverage to the working uninsured, the State Planning Grant Team organized a three-hour pilot discussion with ten business leaders in Albany Georgia. The discussion provided insight to the level of business support for the concept of public/private approaches to the problem of the working uninsured, as well as the potential of approaches to be embraced by larger employers.

The 2002/2003 Planning Grant activities concluded with the submission of a final report to HRSA. Because those activities were directed primarily at data collection and public and legislative awareness, there has not yet been a direct opportunity to reduce the numbers of uninsured citizens through Planning Grant activities; however, the work of the grant has provided opportunities for the Planning Grant Team to educate legislators in their work around the state budget and its potential impact on the uninsured. Specifically, the Planning Grant Team believes the work completed under the grant disseminated directly to legislative audiences, has contributed to halting the further erosion of public programs, particularly around PeachCare.

2004 Pilot Planning Grant Activities
Georgia's Pilot Planning Grant is composed of three components:

1. An updated employer insurance survey.
2. A study of incidence of uncompensated care.
3. Four community-based coverage models created by four diverse Georgia communities.

Employer Survey: The employer survey has been fielded and is in the final stages of analysis. Almost 2,000 Georgia employers responded to the survey. Findings will be presented at the March 30, 2005 site visit and all-community meeting. In addition to assisting the four pilot communities with the design of their coverage products (pilot communities were over-sampled in the survey), the survey's findings will be presented in a final report and issue brief to legislators and other stakeholders.

Study of Incidence of Uncompensated Care: The Study of Incidence of Uncompensated Care, in addition to estimating the total health care utilization of uninsured Georgians, estimating the effect of uncompensated care on provider charges, and examining the incidence of charges by type of insurance, will create a model of cost incidence that will be used by the four pilot communities in the development of their coverage plans. For example, the pilot communities will be able to estimate the effect of new provider revenue gained through the coverage plan versus the losses previously sustained through care of the uninsured. Such information will be used to recruit providers into the four coverage plans. Demand estimate output is on track for completion in April 2005 with further analyses completed in May 2005.

Coverage Model Pilot Planning: Four community-based coverage models, designed to increase small employer coverage participation, are being created in Atlanta, Dalton, Macon, and Brunswick, Georgia. The communities have formed their governing boards, considered various coverage models, held their first community conversations, gained the support of employers and providers, and determined the models they will pursue. Three communities are creating variations of the 3-share model. One is tailoring the model to include large as well as small employers and using an existing primary care clinic as the plan members' medical home. The Atlanta group is working with Kaiser Permanente to create a new product that is affordable for small businesses and their employees. All four communities will continue to gain feedback through focus groups with community members, and the remainder of the grant period will be spent conducting market analyses and determining benefit design, plan pricing, and utilization rates.

According to Academy Health, the progress made by Georgia's four pilot planning communities has served as a model for other HRSA Pilot Planning grantees in their work with community-based coverage models.

As discussed earlier, the Georgia Health Policy Center is responsible for the completion of project tasks under the direction of the Governor's Office of Planning and Budget and Governor Perdue's Planning Grant Advisory Committee. For that reason, the Georgia Health Policy Center is under a deliverable-based contract with the Office of Planning and Budget. Deliverables yet to be billed include those for the study of incidence of uncompensated care, the focus groups with both employers and community members, the coverage designs, and the final report. Total funds to meet these deliverables are $242,812.88.

Statement of Project Goals

The state of Georgia, in collaboration with the Georgia Health Policy Center and its partners and Fellows, has worked for the past three years with SPG support to collect and analyze data that have begun to raise public and legislative awareness of Georgia's uninsured problem. Because the health care marketplace is dynamic and the economy uncertain, the Planning Grant team understands that changes in both the numbers of uninsured residents and the degree to which employers currently offer insurance products to their employees may impact how the state addresses coverage for the uninsured.

Therefore, the Planning Grant Team has designed a five-year plan that will provide Georgia with ongoing decision-making capacity in its efforts to reduce the number of its uninsured citizens. The plan includes sequences of employer surveys, population surveys, and statewide focus groups every three years in addition to ongoing analysis, community-based public-private coverage development, key findings dissemination, and grassroots policy development. The Team is currently working with the State to identify resources to support such ongoing decision-making capacity and seeks State Planning Grant support at this time to further its grassroots policy development efforts begun with FY02 and FY04 Planning Grant support.

The Team proposes to incorporate all that it has learned though its data collection and Pilot Planning activities into an experiential learning module that will be used with 30 (small business/local government) community groups around Georgia. Through the experience, the participants will be more knowledgeable about the uninsured in Georgia and the trade-offs involved in covering the uninsured. Additionally, as part of the experience, the participants will design a mock health insurance plan given limited resources. The deliberations of those exercises will be recorded and coded into Atlas.ti software to analyze common themes and to create a broader depth of understanding as to the trade-offs individuals are willing to consider in covering all of Georgia's citizens through public-private coverage partnerships. Those findings will be synthesized for legislative, county commission, and other stakeholder audiences so that the state will understand how it might further support the efforts of local communities in expanding coverage for the uninsured.

The specific goals related to this effort are to:

1. Design an experiential learning module that incorporates the findings of past SPG work.
2. Design an assessment tool that measures participants' knowledge level before and after participation with the module.
3. Conduct 30 experiential learning modules with community groups that include local business and government participants.
4. Analyze the proceedings of 30 experiential learning modules with Atlas.ti software.
5. Disseminate the analylyzed findings to the 2006 Legislative Biennial, the annual meeting of Georgia County Commissioners, and other stakeholder venues.

Project Description

The State of Georgia, working in a continually changing economic and political climate, acknowledges that the growing problem of Georgians without health insurance cannot be addressed with the resources of one Planning Grant. Therefore, the Planning Grant Team has designed a five-year plan that will provide Georgia with ongoing decision-making capacity in its efforts to reduce the number of its uninsured citizens (Figure 1). The plan includes sequences of employer surveys, population surveys, and statewide focus groups every three years in addition to ongoing data analysis, community-level coverage development, key findings dissemination, and grassroots policy development. The Team is currently working with the State to identify resources to support such ongoing decision-making capacity and seeks State Planning Grant support to further its grassroots policy development efforts begun with FY02 and FY04 support.

Figure 1: Five-Year Decision-Making Infrastructure Components

Data Collection	Knowledge Building	Knowledge Transfer	Policy Development
• Population Survey • Employer Survey • Focus Groups	• Analysis • Modeling • Experiential Learning • Best Practice Dissemination	• Reports • Issue Briefs • Targeted Briefings • Legislative Hearings	• Consensus Building • Community-driven Coverage Solutions • Legislative Advisement

Because of a difficult economic environment, Georgia is focused on preserving existing public services, building a Medicaid managed care system that strengthens the statewide safety net, and supporting the creation of community-based public-private coverage partnerships through regulatory, administrative, or legislative means, where possible. The state firmly believes in the power of community to make a lasting difference in the number of uninsured Georgians. In order to mobilize the power of community, the state requests Limited Competition Planning Grant support to work more broadly within the state at community-level grassroots policy development by sharing the findings of three years of work on the uninsured and eliciting from those communities the next phase of policy direction.

Grassroots policy development will be achieved through an experiential learning module with 30 Georgia community groups, an interactive health insurance policy development exercise with those groups, and a synthesis of the deliberations of those groups participating in the module to identify common concerns, needs, questions, and recommendations regarding the development of community-based public-private coverage partnerships. Those findings will be disseminated to key stakeholder audiences to encourage the alignment of state administrative, regulatory, and legislative efforts with community efforts. The key tasks that compose this effort are described below.

Experiential Learning Module Design and Insurance Plan Exercise Refinement

Findings from FY02 Planning Grant activities have been shared with multiple audiences across Georgia; however, these findings have not been shared widely in a focused, deliberate manner intended to support and encourage community-based public-private coverage partnerships since the state moved in this policy direction with its FY04 Pilot Planning Grant.

In order to support and encourage broader development of these partnerships across Georgia, the Planning Grant Team will develop an experiential learning module throughout the fall of 2005 (September through December) that incorporates the findings of all previous Planning Grant activities to date. The module will include findings from:

- The 2002 Georgia Household Survey
- March 2005 CPS Estimates of Uninsured Georgians
- The 2002 and 2004 Georgia Employer Surveys
- 2002 Focus Groups with Georgians and Small Employers
- The Assessment of Georgia's Safety Net
- Modeling High-Risk Pools, Health Savings Accounts, and Tax Credits
- The Experiences of Four Georgia Communities Designing Public-Private Coverage Partnerships with FY04 Pilot Planning support

The module's design will be led by Dr. Minyard with assistance from Drs. Custer, Ketsche, and Parker, and Mr. Landers and Ms. Tyler. The design process will first identify key findings from the activities listed above throughout September and October 2005. The finished module will be piloted with the Governor's Advisory Group in December 2005, and any refinements based on that pilot will be made to the module. As a result of the design process, the experiential learning module will be ready for use with Georgia communities in January 2006.

The second component of the experiential learning module is the insurance plan design exercise, which Georgia Health Decisions has used to engage local communities in dialogue. In 1997, working with the Georgia Coalition for Health to define a standard benefits package for health insurance, Georgia Health Decisions undertook a process of qualitative research and community forums. Participants who attended the community forums were given a list of health care services and asked to reach agreement on which services, if any, should be available to all Georgians. Following that discussion, participants were then given the same list of services with relative costs of providing health insurance for a family for one month. With a defined budget, participants were requested to decide which services they would include in coverage that should be available for most Georgians. Conclusions reached by 3,345 Georgians in 170 community forums were combined with the findings of the qualitative research to define the standard benefits package.

Georgia Health Decisions, under the direction of Beverly Tyler, will have lead responsibility for the refinement of the exercise described above. The Planning Grant Team will assist Ms. Tyler throughout October and November 2005 in identifying and incorporating national and state models of public-private coverage partnerships into the refinement of the insurance plan building exercise to focus participants on options that can be accomplished at the community level. This exercise will also be piloted with the Governor's Advisory Group in December 2005, and any revisions to the exercise will be made in order to have the complete module ready for January 2006 implementation. Any materials necessary for use with the module will be produced by Georgia Health Policy Center staff in November and December 2005. As a result of the design process, this component of the experiential learning module and all materials will be ready for use with Georgia communities in January 2006.

Assessment Tool Design

While the primary purpose of the experiential learning module is to transfer knowledge that forms the basis of evidence-based decision-making and encourages the development of community-based public-private coverage partnerships, a secondary purpose is to raise the level of knowledge at the community level of the problem and challenges presented by uninsured Georgians. In order to assess whether or not this objective is achieved, the Planning Grant Team will design an assessment tool to measure the degree to which community group members have raised their levels of knowledge. The assessment tool will be administered at the start and end of the experiential learning module.

The tool's design will be led by Dr. Minyard with assistance from Drs. Custer, Ketsche, and Parker, and Mr. Landers. The design process will take place throughout September and October 2005 and will focus on key knowledge areas around the uninsured in Georgia. The completed assessment tool will be piloted with the Governor's Advisory Group in December 2005, and any refinements based on that experience will be made to the tool. As a result of the design process, the assessment tool will be ready for use with Georgia communities in January 2006.

Experiential Learning Module Activity

From January to June 2006, Georgia Health Decisions, led by Beverly Tyler and assisted by the Planning Grant Team, will work with 30 Georgia Communities to work through the two-part experiential learning module. Throughout November and December 2005, Georgia Health Decisions staff will work with the Georgia Chamber of Commerce, the Association County Commissioners of Georgia, the Department of Community Affairs, and the Georgia Rural Development Council to identify communities, business leaders, and local government officials who are willing and eager to participate in the module. Georgia Health Decisions will also work through November and December to coordinate logistics and scheduling to maximize participation from key business and local government leaders.

The experiential learning module itself will be brought to 30 Georgia communities between January and June 2006. Georgia Health Decisions will have lead responsibility for conducting the modules with the assistance of at least one member of the Planning Grant Team. Since it's inception in 1991, Georgia Health Decisions has developed and conducted community forums across Georgia to engage average citizens in discussions about health care issues. These community forums have several objectives, including:

- Educating participants about the issues to be discussed
- Stimulating community discussion about health care issues
- Engaging participants in thinking beyond the current system
- Identifying community values and priorities

To achieve these objectives, Georgia Health Decisions has developed a process that goes beyond the typical "town hall meeting" format. Instead of an open microphone for public comment, these community forums enable community members to talk to each other about important policy issues in a structured format. To achieve this dialogue, discussion modules are developed for each community forum initiative. The discussion modules frame the issue to be discussed in a manner that most Georgians can understand and relate to, provide discussion questions, and

require groups to reach consensus on a course of action to be taken. Information is collected at each community forum as to the decisions reached by the discussion groups so that common themes can be identified. For purposes of the current experiential learning module, community conversations will be audio recorded to facilitate analysis.

The Planning Grant Team anticipates that at the end of each of the 30 experiential learning modules, local community groups will:

1.) Gain a greater depth of understanding about uninsured Georgians and the impact that the lack of health insurance has on health care financing overall and the direct effect it has on the local health care delivery system;
2.) Learn of national and state community-based public-private coverage options and the roles communities and the state can play to facilitate those partnerships;
3.) Understand the trade-offs involved in the creation of an insurance plan with limited resources and the role the state and local governments might play in the removal of barriers to the creation of those plans.

Findings Analysis

In order to synthesize key findings from community group deliberations, identify common themes, and develop a greater depth of understanding of what local communities are willing to contribute toward the broader development of community-based public-private coverage partnerships, audio tapes of the 30 experiential learning modules will be transcribed as they are created between January and June 2006 by Georgia Health Decisions and Georgia Health Policy Center staffs.

As audio tapes are transcribed, Dr. Parker will supervise the coding of module transcriptions into Atlas.ti, a software package designed for the qualitative analysis of large bodies of textual, graphical, audio and video data. Throughout July 2006, the Planning Grant Team will review Atlas.ti output for common themes and contextual threads common to the 30 communities visited. For example, the output might indicate that a common theme among communities is the need for the state to remove certain health insurance regulatory barriers in order for them to develop their own community-based public-private partnerships. As a result of the analysis process, the Planning Grant Team will produce a report of findings that synthesizes those common themes with recommendations for the state to take action in support of community-based coverage initiatives.

Findings Dissemination and Policy Development

The final project task, with the exception of the preparation of the report to the Secretary, will be the dissemination of findings and support for policy development at the state level. As the Planning Grant Team has experienced in its past and current SPG work, ad hoc opportunities for dissemination will arise beyond the timeframe of the project, and a continued close relationship with Governor Perdue's Health Policy Advisors will foster additional opportunities for policy advisement and development; but, the Team has identified two important venues at which the findings from this work have the potential to create great impact.

The first targeted venue is the 2006 Association County Commissioners of Georgia Fall Policy Conference in September. This venue will afford the Planning Grant Team the opportunity to describe the work of the grant and impart the willingness of local business and government leaders to support public-private coverage partnerships in an effort to enable counties to understand the role they might play with the state in supporting such partnerships.

The second venue is the Georgia General Assembly Legislative Biennial for new and returning state legislators in December 2006. The Biennial is held every two years to educate legislators as to issues critical to the functioning of the state and those that are likely to arise during the upcoming legislative session. In the past, the Georgia Health Policy Center has been asked to share material on the role and costs of public coverage. This session would be modeled after the Georgia Health Care Access Forum held as part of Georgia's Planning Grant activities in August 2003 with the support of the National Association of Counties and the National Conference of State Legislatures. At the conclusion of the session, legislators will be more knowledgeable about Georgia's uninsured problem in general and the roles they might play in supporting public-private coverage partnerships through legislative or other means.

Georgia Health Policy Center staff will take the lead on dissemination and policy development activities and will respond to every opportunity that builds on public-private coverage partnership development. While both activities described above are scheduled to take place beyond the timeframe of the grant, the Planning Grant Team is committed to its five-year plan of decision-making capacity development around Georgia's uninsured and will pursue both activities without regard to the grant's end date. The Planning Grant Team will also pursue opportunities for dissemination at national meetings such as the Academy Health Annual Research Meeting.

Report to the Secretary

As previously established throughout Georgia's involvement in the State Planning Grant Program, at least one representative each from the Governor's Advisory Committee and Georgia Health Policy Center staff will continue to participate in quarterly grantee meetings in the Washington D.C. area. Staff from the Governor's Office of Planning and Budget will continue to be responsible that all reporting requirements are in a format and timeframe as directed by the Program Officer. Office of Planning and Budget and Georgia Health Policy Center staff will both continue to cooperate in the preparation of consolidated national reports. Staff from the Georgia Health Policy Center will continue to act as a resource to other grantee and non-grantee states.

Project Management Plan

Task 1: Comprehensive Oversight Activities

	Timetable	Responsible Agency or Individual	Anticipated Results	Measurement
Quarterly Meeting with Governor's State Planning Grant Advisory Committee	September and December 2005, March and June 2006	Governor's Advisory Committee, Office of Planning and Budget (OPB), Georgia Health Policy Center (GHPC), Center for Health Services Research (CHSR)	Guidance on planned activities	Meeting held and feedback/guidance incorporated into project
Monthly Project Team Meeting	September 2005 – August 2006	OPB, GHPC, CHSR	Tasks and schedules reviewed and adjusted, if necessary	11 monthly meetings completed

Task 2: Design Experiential Learning Module

	Timetable	Responsible Agency	Result	Measurement
Identify Key Findings from 2002 – 2004 SPG Activities	September – October 2005	GHPC, CHSR	Key findings Identified	Key findings included in educational component
Condense Key Findings into One Learning Session	September – October 2005	GHPC, CHSR	Educational component designed	Educational component completed
Identify National, State, and Local Coverage Options to be Included in Insurance Plan Exercise	October – November 2005	GHPC, CHSR	National, state, and local coverage options are included in insurance plan exercise	Coverage options are representative of national, state, and local efforts
Refine Insurance Plan Building Exercise	November – December 2005	GHPC, CHSR, GHD	Insurance Plan exercise is refined	Insurance plan exercise ready for use
Produce Experiential Learning Module Materials	November – December 2005	GHPC, CHSR, GHD	Materials produced	Number of learning module materials
Pilot Experiential Learning Module with Governor's Advisory Committee	December 2005	GHPC, CHSR, GHD, OPB	Governor's Advisory Committee experiences experiential learning module	Exercise design completed
Refine Experiential Learning Module	December 2005	GHPC, CHSR, GHD	Experiential learning module is refined based on experience with Governor's Advisory Group	Experiential learning module is complete

Task 3: Design Participant Assessment Tool

	Timetable	Responsible Agency	Result	Measurement
Determine Coverage Knowledge Baseline Questions	September – October 2005	GHPC, CHSR	Baseline questions determined	Short list of baseline questions

Pilot Participant Assessment Tool with Governor's Advisory Committee	December 2005	GHPC, CHSR, GHD	Governor's Advisory Committee completes pre- and post-assessment	Assessment completed
Refine Assessment Tool	December 2005	GHPC, CHSR, GHD	Assessment tool is refined based on experience with Governor's Advisory Group	Assessment tool is completed
Task 4: Conduct 30 Experiential Learning Modules				
	Timetable	**Responsible Agency**	**Result**	**Measurement**
Identify and Recruit Participants	November – December 2005	GHD	30 local business and government groups agree to participate	Local business and government leaders attend experiential module
Coordinate Schedule and Meeting Logistics	November – December 2005	GHD	Facilities are confirmed for all modules	Experiential learning modules are conducted
Facilitate and Record Experiential Learning Modules	January – June 2006	GHD	Insights from local business and government leaders are provided for further coverage partnership development	30 experiential learning modules are completed
Task 5: Analyze Experiential Learning Module Findings				
	Timetable	**Responsible Agency**	**Result**	**Measurement**
Transcribe All Learning Module Findings	January – July 2006	GHPC, GHD	All findings are transcribed	Written record of learning module sessions is produced
Code all Findings Into Atlas.ti	January – July 2006	GHPC	Transcriptions are coded	Complete Atlas.ti file
Analyze Findings and Common Themes	June – July 2006	GHPC, CHSR	Findings are analyzed	Common themes are identified
Prepare Report	July 2006	GHPC	Completed report synthesizing 30 experiential learning sessions	Report ready for distribution
Disseminate Report	July 2006	GHPC	Report widely distributed	Report distributed statewide

Task 6: Disseminate Experiential Learning Module Findings				
	Timetable	**Responsible Agency**	**Result**	**Measurement**
2006 Legislative Biennial	December 2006	GHPC, CHSR	Experiential learning module findings are presented to legislative audiences	Presentation Completed
2006 Georgia County Commissioners Annual Meeting	August 2006	GHPC, CHSR	Experiential learning module findings are presented to county commissioner audiences	Presentation Completed
Ad Hoc Presentations	July – December 2006	GHPC, CHSR	Findings are presented to stakeholder audiences as requested	Presentation Completed
Task 7: Final Report				
	Timetable	**Responsible Agency**	**Result**	**Measurement**
Prepare Draft Report	August 2006	OPB, GHPC, CHSR	Draft report to the Secretary completed	Draft reviewed by all team members
Prepare Final Report	September 2006	OPB, GHPC	Final report to the Secretary completed	Final report completed
Submit Final Report	September 2006	OPB	Final report forwarded to Secretary	Receipt of report by HRSA

OPB: Governor's Office of Planning and Budget
GHPC: Georgia Health Policy Center
CHSR: Center for Health Services Research
GHD: Georgia Health Decisions

Governance

Structure

The Governor's Office of Planning and Budget will continue to be the proposed project's administrative home, and staff from that office will meet monthly with key project staff from the Georgia Health Policy Center to be updated on project activities and assure that the project's direction continues to be aligned with the State's budgetary and policy priorities. The Office will also be the direct liaison with the Governor's policy staff for input and guidance as the project proceeds.

The Governor's Limited Competition Planning Grant Advisory Committee will provide direction and input to the Project Team and its activities and provide insight from the perspective of each state department. Formal meetings will occur monthly, but input will be sought additionally on an as-needed basis. Members of the Governor's Limited Competition Planning Grant Advisory Committee include:

- Abel Ortiz: Health Policy Advisor to Governor Perdue

- Kate Pfirman: Director, Human Development Division, Governor's Office of Planning and Budget
- Tim Burgess: Commissioner, Georgia Department of Community Health
- Dr. Stuart Brown: Acting State Public Health Director
- Mark Trail: Chief, Georgia Department of Medical Assistance
- Fran Ellington: Georgia Department of Medical Assistance
- Rebecca Kellenberg: State PeachCare (SCHIP) Director
- Carol Clark: Director, Life and Health/Managed Care Division, Office of the Commissioner, Insurance and Safety Fire

Continuation Limited Competition Grant Personnel

Kate Pfirman, CPA, CPFO, Director, Human Development Division, Governor's Office of Planning and Budget, will serve as Co-Principal Contact (FTE 3%).

Karen J. Minyard, PhD, Executive Director, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as Co-Principal Contact (FTE 5%.)

William S. Custer, PhD, Associate Professor, Center for Health Services Research, Robinson College of Business, Georgia State University, will serve as a Project Investigator (FTE 12.5% - one academic course buy-out.)

Patricia Ketsche, PhD, Assistant Professor, Center for Health Services Research, Robinson College of Business, Georgia State University, will serve as a Project Investigator (FTE 10% - (one academic course buy-out.)

Glenn M. Landers, MBA, MHA, Senior Research Associate, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will serve as Project Coordinator (FTE 25%.)

Chris Parker, MD, MPH, Research Associate, Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, will contribute to experiential learning module development and assist in conducting and analyzing the modules (FTE 30%.)

Cindy Clark, Georgia Health Policy Center Business Manager, will serve as the Georgia Health Policy Center's Project Financial Manager (FTE 5%.)

Georgia Health Decisions, under the leadership of **Beverly Tyler**, will serve as the Experiential Learning Module Coordinator (Subcontract).

Grant Monitoring Plan and Report to the Department
In an effort to further Georgia's grassroots policy development around options for addressing the uninsured and to contribute to an overall five-year plan that builds a decision-making

infrastructure for the uninsured in Georgia, the purposes of Georgia's Limited Competition Planning Grant are threefold: (1) to design and implement with 30 communities an experiential learning module that increases the understanding of local business and government leaders as to the tradeoffs and decisions involved in covering the uninsured; (2) to synthesize the findings of those modules and identify common themes; (3) to disseminate those findings to state leaders in an effort to maximize the state's relevant and sustained contributions to local public/private coverage partnerships.

The work of Georgia's Limited Competition Planning Grant will be evaluated quantitatively and qualitatively. The quantitative evaluation will include the following measures:

(1) The ultimate measure of success of the Georgia's Limited Competition Planning Grant is the number of individuals who gain health care coverage because of the grant activities. Since the intent of this grant is to plan for rather than implement coverage programs, the potential number of individuals gaining health care coverage from the project will be estimated.
(2) The Project Management Plan on pages 42 - 44 details the project activities, timetable, responsible agency or individual, anticipated results, and measurements. The project manager will monitor results and communicate to the project team and the Governor's Limited Competition Planning Grant Advisory Committee. Regular monitoring and broad knowledge of project goals and progress will create the opportunity for the project team, Governor's Office, and Governor's Limited Competition Planning Grant Advisory Committee to make quick adjustments because of unexpected obstacles.

The qualitative measures of Georgia's State Planning Grant will include:

(1) The Governor's Limited Competition Planning Grant Advisory Committee will have an evaluative component built into each meeting in which members will be asked to assess progress toward the three purposes discussed above (design and implement an experiential learning module, synthesize findings, disseminate findings).
(2) Monthly project team meetings will contain an evaluative component. Members will be asked to assess progress toward the three key goals. Results will be presented to the Governor's Advisory Group.

GHPC staff will prepare regular written progress reports to OPB, and GHPC staff will meet in person with OPB staff each month to review project activities and progress. Progress will be measured against the timelines contained within this application. OPB, in its role as a department within the Governor's Office, will have direct access to the Governor's policy staff and will confer with them as required, in addition to the quarterly meeting of the Governor's Limited Competition Planning Grant Advisory Committee.

This relationship has been productive in fostering ties between the Planning Grant Team and the Governor's Health Policy Staff. Throughout 2004 and 2005, the Governor Perdue's policy staff has regularly called on the Planning Grant Team to offer advisement on proposed legislation regarding high risk pools, health insurance mandates, and the impact of proposed Medicaid

managed care on the state's safety net. Partly due to the resources provided through the State Planning Grant process, the use of evidence based research in health policy decisions has risen to a level not previously seen in Georgia.

As has been the case in FY02, FY03, and FY04, OPB will complete the required quarterly financial reports. The Georgia Health Policy Center will be responsible for quarterly progress reports submitted to HRSA. The final report to the Department will be completed in consort with OPB and GHPC staffs in the specified format by the required deadline. Drafts of the report will be prepared in August, allowing time for the Governor's Limited Competition Planning Grant Advisory Committee to review and comment. A final draft will be prepared in September and delivered to HRSA. OPB and GHPC staffs have enjoyed the working relationship developed with SPG staff over the past three years and are committed to continuing that relationship, including any ad hoc requests the Department may have of the Project Team.

Appendix A

Letters of Agreement and Support