MONTANA

STATE PLANNING GRANT APPLICATION

A BIG SKY OPPORTUNITY TO EXPAND HEALTH INSURANCE COVERAGE

APRIL 2002

TABLE OF CONTENTS

PROJECT ABSTRACT

Montana is applying for a State Planning Grant (SPG) to secure the financial resources needed to conduct an in-depth analysis of the uninsured population and determine the most effective options for providing the uninsured access to affordable health insurance coverage.

CURRENT STATUS OF HEALTH CARE INSURANCE

Out of a total of 876,000 people in Montana, 162,000 people or 18.5% were estimated to be without insurance in 2000. The national rate of uninsurance in the same period was 14%. Montana's uninsured rate has been steadily increasing since 1995 when it was 12.7%.

EARLIER EFFORTS TO EXPAND ACCESS TO INSURANCE COVERAGE

Montana has made significant efforts to reduce the number of uninsured, develop better methods of collecting and analyzing health care information and develop options for expanding insurance coverage.

Montana began to study its health care system in 1993 when the Legislature created the Montana Health Care Authority (HCA) and charged them with developing a comprehensive statewide health care reform strategy to provide all Montanans with improved access to high quality, affordable health care. The HCA prepared a statewide universal healthcare access plan based on a single payer system and a regulated multiple payer system. Due to financial constraints and the lack of political consensus, neither plan was funded, but the focus on insurance coverage initiated a process of sequential health care reform to improve affordability and access to health insurance. Measures to improve insurance affordability and accessibility included Medicaid Managed Care, creation of purchasing pools and numerous small group insurance reforms.

The 1995 Legislature replaced the HCA with the Health Care Advisory Council (HCAC) and charged it with monitoring and evaluating incremental and market-based approaches for health care reform. The Legislature also authorized (but did not fund) the development of a Health Information Network to provide a central database of healthcare resource, cost, and quality information. The Legislature also provided state funding to support the Caring Program for Children, which is a public private partnership with Blue Cross Blue Shield of Montana to provide health benefits to low-income children without insurance.

The 1997 Legislature authorized portability insurance rights and significantly expanded the High Risk Pool. The Managed Care Network Adequacy and Quality Assurance Act was approved which provided improved access to emergency services and standards for managed care network adequacy and quality assurance.

When the HCAC was re-authorized in 1999, it prioritized efforts towards the rising number of uninsured Montanans. With assistance from the Robert Wood Johnson (RWJ) State Coverage Initiatives Project (SCI), the HCAC developed a White Paper in March 2000 titled "Strategies for Improving Access to Health Care Coverage". Expansions of CHIP and Medicaid were proposed by the Executive Branch but were not funded.

The 1999 Legislature approved funding for Montana's first Children's Health Insurance Plan (CHIP) to address the increasing problem of uninsured children in low-income families. Pursuant to a May 2000 Special Session Bill, Montana voters approved a constitutional amendment to allocate 40% of the state's tobacco settlement funds to a Tobacco Settlement Trust Fund and designate that the interest from the Trust Fund be allocated to health care and prevention programs. Legislation to implement the constitutional provision was passed in the 2001 Legislature.

The 2001 Legislature created a Joint Subcommittee on Health Care and Health Insurance to study health care and health insurance costs and develop recommendations for the 2003 Legislature to address the problems. This Legislature also provided authority for a sliding scale premium in Montana's High Risk Plan.

The State's Insurance Commissioner held a series of eight Community Roundtable Discussions on Affordable Health Care from October 2001 through January 2002 to solicit public comment on strategies to expand access to affordable health care coverage. The Insurance Commissioner will work closely with the Joint Subcommittee on Health Care and Health Insurance and the Executive Branch to present public and private sector solutions to the 2003 Legislature.

PROPOSED PROJECT

The over-all project goal is to provide access to affordable health insurance coverage to all Montana citizens. This will be accomplished through the timely completion of the following specific goals:

1) Select a Project Team and SPG Steering Committee to guide and oversee project development and implementation.

2) Collect and analyze quantitative and qualitative data that describe the characteristics of Montana's uninsured population.

3) Develop, evaluate and prioritize the most feasible options for providing access to affordable coverage and adequate benefits to all Montana citizens and develop a strategy to implement the options over a six-year period.

4) Improve the capacity and capability of Montana safety net providers to provide care to the uninsured.

5) Prepare and submit a report to the Secretary of Health and Human Services

(HHS) describing project findings by July 30, 2003.

In the past, Montana has primarily relied on data collected through federal or private efforts to describe the uninsured. The State Planning Grant will provide Montana with the financial resources needed to collect and analyze Montana-specific uninsured data and use that information to design the most viable options for expanding health insurance coverage to all Montanans over a six-year period.

LEAD AGENCY AND COLLABORATING PARTNERS

The Montana Department of Public Health and Human Services (DPHHS) will serve as the Governor-appointed lead agency to implement the SPG. The Project Liaison from DPHHS will be responsible and accountable for grant activities. The Grant Director will provide overall management of the grant. The Governor will appoint a SPG Steering Committee with broad representation from key public and private stakeholders including the Legislature, Insurance Commissioner, state universities, state agencies dealing with health and insurance, health care consumers and providers, insurance companies, private business, safety net providers, and community organizations. Montana will build on its long tradition of collaborations among state, federal and private partners to expand health insurance coverage for the uninsured.

PROJECTED RESULTS

The data collection and analysis effort will provide an in-depth understanding of the characteristics of Montana's uninsured population. The information obtained through research, surveys, focus groups, key informant interviews and public meetings will provide public and state policy makers with greater insight into the reasons why nearly one in five Montanans are uninsured. The information will then be used to provide a comprehensive framework for the development and implementation of public and private strategies tailored to meet Montana's goal of providing access to affordable health insurance coverage to all Montanans over a six-year period. Strategies to enhance the capacity and capabilities of Montana's safety net providers will be included so that basic health care services can be provided to the uninsured during and after the phase-in period. A report describing grant activities and findings will be submitted to the HHS Secretary by 7/30/03.

INTRODUCTION

While Montana is the fourth largest state in size, it ranks 44th in population. Montana's population was estimated by the United States (U.S.) Census Bureau to be 876,000 in 2000.[1] Nearly one in five of those people are without health insurance. Montana is one of only three states considered frontier states, which means there are less than six people per square mile compared to the U.S. average of 74 persons per square mile. Only 22 percent of Montana's population lives in metropolitan areas, making Montana the nation's least urbanized state. [2]

Ninety percent of Montana's population is white. Native Americans make up six percent; Hispanics two percent; and other ethnic groups make up the remaining two percent. Montana has seven Indian reservations and a migrant farm population of approximately 10,400. Montana ranks tenth in the nation for the number of people living below poverty with 41% of its citizens below 200% of the Federal Poverty Level (FPL) compared to 35% for the U.S. Montana ranks 49th in the nation for median family income ($25,682) compared to $33,154 for the U.S.[3]

The geographic and economic makeup of Montana is diverse and the relatively high number of uninsured presents unique challenges and opportunities for creating effective public and private solutions to the problem of access to health insurance. The State Planning Grant provides an excellent opportunity for the state to learn more about its uninsured population and plan the best strategy for expanding access to affordable health insurance coverage to all its citizens.

1. CURRENT STATUS OF HEALTH CARE INSURANCE

1.1 ACCESS TO INSURANCE COVERAGE AND RATES OF UNINSURANCE

In 2000, 162,000 or 18.5% of Montanans were without insurance. This is roughly one out of every five Montanans. This is higher than the national rate of 14%.[4] Montana's uninsured rate has been steadily increasing since 1995 when it was 12.7%. Of those individuals insured, approximately 64% have employer-based insurance and 36% have other private insurance.[5] Medicare provides insurance to 11% of the population and Medicaid provides insurance to 10% of the population.[6]

CHARACTERISTICS OF THE UNINSURED

Children (ages 18 and under) represent 24% of the non-elderly uninsured and adults (ages 19-64) represent 76%.[7] Males represent 52% of the non-elderly uninsured and females 48%.[8] Almost two-thirds of the uninsured (65%) live in families with income less than 200% of the FPL.[9] Sixteen percent of the White race is uninsured and 58% of the American Indian or Eskimo race is uninsured. [10] Most (70%) of the non-elderly uninsured in Montana are employed.[11]

Montana, like other small population states, has primarily relied on data

collected through federal or private efforts to describe the uninsured. The State Planning Grant (SPG) will provide Montana with financial resources to collect and analyze Montana-specific data about the uninsured and use that data to tailor strategies to meet the unique needs of our uninsured population.

1.2 KEY HEALTH ISSUES RELATED TO ACCESS TO CARE AND UNINSURANCE

The lack of health insurance has important health and financial consequences. Many studies have documented the consequences of being uninsured and the relationship between health insurance and access to health care and medical outcomes. These effects include reduced access to care and poorer medical outcomes.[12] The uninsured are more likely to be hospitalized for conditions that could have been avoided and those with various forms of cancer are more likely to be diagnosed with late-stage cancer, which increases the cost of care.

The 1999 Survey Results from the Montana Behavioral Risk Factor Surveillance System (BRFSS) substantiates the health risks of being uninsured in Montana.

> Seventeen percent of Montana adults reported they were uninsured. Twelve percent of Montana adults reported that they could not afford to see a doctor in the past year. Thirty-six percent of Montanans reported that they had not had a routine checkup in the past year. Thirty-three percent of Montana adults reported that their physical health was not good and thirty-one percent of Montana adults reported that their mental health was not good on one or more days in the previous month.

Uncompensated Care - One of the consequences of having a high rate of uninsured is the amount of uncompensated care incurred by Montana hospitals and other health care providers. The Montana Hospital Association estimates that Montana hospitals will write off more than $100 million in charity and bad debt health care expenses for 2001. Although there are no estimates of uncompensated care for other health care providers, it is known that they are not fully compensated for some of their services. Most of the cost of this uncompensated care gets passed on to those who have health insurance coverage through higher charges, which then results in higher insurance premiums.

1.3 CURRENT HEALTH CARE DELIVERY SYSTEM

Montana is proud of the diversity of its health care delivery system. As a frontier state, Montana faces unique challenges in providing access to comprehensive primary and preventive health care. Montana has met those challenges by developing creative solutions to ensure there are adequate numbers of providers to deliver health care.

Access to Primary Care -. Montana is considered an innovator in providing rural health care by the development of the Medical Assistance Facility (MAF) concept and the use of Rural Telemedicine networks to increase access to primary and specialty care. MAFs were predecessors to Critical Access Hospitals, which have

allowed Montana hospitals in 24 communities to remain open and serve patients.

According to the 1999 Health Resources and Services Administration (HRSA) State Profiles, Montana currently has about 74 active primary care physicians per 100,000 people, which is below the estimated average of 92 in the US. To help supplement the health care workforce, physician assistants, nurse practitioners and registered nurses (RNs) are available. There are about 15 physician assistants and 771 RNs per 100,000 people compared to the US average of 10 and 798 respectively. Montana has a strong safety net of community health clinics and hospitals for providing care to the low-income uninsured. The health care safety net is described on page 21.

Variations in Coverage - Montana has fewer insurers serving the individual and group markets than most other states, which results in less competition on the price of premiums. Only six percent of the population is enrolled in a managed care plan offered by one of only two companies.[13] The largest three insurers held 65% of the group market and 46% of the individual market. Blue Cross Blue Shield of Montana (BCBSMT) is the dominant insurer in the state. In 2000, they represented 44% of the accident and health premiums written. The next closest competitor represented only 5% of the market.[14] BCBSMT is currently the only carrier providing indemnity coverage for Montana's CHIP Program. In June 2001, BCBSMT initiated **BlueCare**; a new insurance program for the low-income uninsured that was made possible by a statewide coalition of physicians and hospitals offering discounted rates to reduce premiums.

Employer Based Insurance - Employer based coverage is the foundation of health insurance in Montana as well as the rest of the country. Reasons contributing to Montana's high rate of uninsurance are the prevalence of small businesses, large numbers of part-time workers and low wages. Thirty-four percent of Montana's workforce (compared with 19% nationally) is employed by businesses with 20 or fewer employees.[15] Only 43% of all Montana's private sector firms offer employer-sponsored insurance to their employees. Of the firms with fewer than 10 employees, only 30% offer health insurance.[16]

Government-Sponsored Insurance – The following government programs provide health insurance coverage to low-income persons regardless of their pre-existing conditions. Montana has made significant strides in recent years to expand public insurance programs.

- Medicaid – Medicaid is available to anyone who qualifies for Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) for the aged, blind and disabled, children in foster care and the Medically Needy. The income levels for Medicaid eligibility vary depending on the person's age and eligibility category.

- Children's Health Insurance Plan (CHIP) – CHIP is available to children age birth to 18) in families with income less than 150% FPL. There is no resource test.

- Mental Health Services Plan (MHSP) – MHSP is available to persons diagnosed with serious mental illness and emotional disturbances whose income is less than 150% FPL.

Montana Comprehensive Health Association (MCHA) - The 1985 Legislature Montana established the MCHA to provide access to health insurance coverage for Montana residents who are either medically uninsurable or cannot obtain insurance as a standard risk. The program is supported by participant premiums and assessments on insurers. The MCHA Association Plan is the traditional High-Risk Plan and is available to Montana residents who have been rejected or offered a restrictive rider by two insurers within the last six months or have certain specified major illnesses. Enrollment in the MCHA Association Plan has grown from 46 in 1988 to 961 in 2001. The MCHA Portability Plan is available to Montana residents leaving insured or self-insured creditable group coverage. Enrollment in the MCHA Portability Plan has grown from 105 in 1997 to 1370 in 2001.[17]

1.4 OTHER STATE AND NATIONAL ACTIVITIES

The state of Montana considers itself very fortunate to benefit from national organizations like HRSA, the Robert Wood Johnson Foundation's (RWJ) State Coverage Initiative (SCI) Program and the State Health Access and Data Assistance Center (SHADAC). Montana is participating in SHADAC's Joint Data Collection Consortium to facilitate the collection and analysis of uninsured data using the expertise of SHADAC staff and the lessons learned from the twenty other state grantees. Montana will also participate in the HRSA SPG Multi-State Integrated Data Base to enhance the state's capacity to make data-driven policy decisions and inform policy makers about health insurance options. The availability of these and other state and national resources have been and will continue to be extremely helpful in providing technical assistance in data collection and analysis and identifying potential strategies and policies to expand coverage for the uninsured.

2. EARLIER EFFORTS TO REDUCE THE NUMBER OF UNINSURED

2.1 STATE AND EXECUTIVE EFFORTS

Health care reform is not at all new to Montana. Significant bi-partisan efforts dating back to the early 1990's have been made to reduce the number of uninsured, develop better methods of collecting and analyzing health care information and develop options for expanding insurance coverage. The following is a list of the more recent executive and biennial legislative efforts to address and reduce the number of uninsured residents.

- The 1993 Legislature created the **Montana Health Care Authority (HCA)** and charged them with developing a comprehensive statewide health care reform strategy to provide all Montanans with improved access to high quality, affordable health care.[18] The HCA was required to submit a single payer plan and a regulated multiple-payer system. It submitted those plans to the Governor and the Legislature and added a third alternative, which was a market-based, sequential health care reform package. There was significant opportunity for public input into the plans in the form of public meetings and surveys. Due to financial constraints and lack of political consensus, neither plan was funded, but the focus on insurance coverage initiated a process of sequential health care reform. Measures to improve insurance affordability and accessibility included Medicaid Managed Care, creation of purchasing pools and numerous small group insurance reforms.

- In 1995, the Legislature replaced the Health Care Authority with the **Health Care Advisory Council (HCAC)** and charged them with monitoring and evaluating incremental and market-based approaches for health care reform. The Council produced a report to the 1997 Legislature that recommended some of the following strategies for reducing the number of uninsured.[19]

- The 1995 Legislature directed the development of a **Health Information Network** to provide a central database of healthcare resource, cost, and quality information to increase access, promote cost containment and improve quality of care. It also authorized the development of a **Health Care Consumer Report Card** to assist health care consumers in making health care decisions. Both of these products were presented to the 1997 Legislature but were not funded due to financial constraints, lack of political consensus and privacy concerns.

- The 1995 Legislature authorized the formation of **group purchasing cooperatives.** Only one purchasing pool has been formed and it currently covers only large employers. The purchasing pool concept has not had as large an impact as anticipated primarily due to the limited number of insurance carriers to offer coverage, limited managed

care penetration and limited competition in Montana's health care market place.

- The 1995 Legislature recognized the special problem of uninsured children and provided state funding for the **Caring Program for Children**, which is a public/private partnership with Blue Cross Blue Shield of Montana targeting low-income uninsured children. The Caring Program has provided health care services to more than 3000 children since it started and was serving almost 700 children in April 2002.[20]

- The 1995 Legislature authorized state funding to create the **Mental Health Access Program**, which provided statewide managed mental health services to low-income individuals with serious mental illness and emotional disturbances who were not eligible for Medicaid. The program served an average of 2294 persons on July 2001.[21]

- The 1997 Legislature passed the **Managed Care Network Adequacy and Quality Assurance Act**, which put Montana ahead of most states in protecting the rights of individuals enrolled in managed care plans. It improved access to emergency services and set standards for network adequacy and quality assurance.

- The 1999 Legislature approved funding for Montana's first **Children's Health Insurance Plan (CHIP)** to address the increasing problem of low-income uninsured children. The CHIP Program has been very successful, and met enrollment targets in the first year of operation. The CHIP Program made an impact on reducing the number of uninsured children in the state. Since October 1999, coverage has been provided to over 25,000 children. As of 2/27/02, 9350 children were enrolled and 482 children were on a waiting list.[22]

- The HCAC was re-authorized in 1999 and the Council chose to prioritize their efforts towards the rising number of uninsured Montanans. The Department of Public Health and Human Services (DPHHS), in conjunction with the HCAC, requested technical assistance from the State Coverage Initiatives (SCI) Program funded by RWJ. The SCI staff prepared a report based on research and findings from their January 2000 site visit to the state. As a result of SCI assistance, the HCAC directed the development of a **White Paper titled "Strategies for Improving Access to Health Care Coverage".**[23] The white paper was widely distributed and a public meeting was held in March 2000 to solicit feedback on the strategies from the health care community and the public. There was strong support for most of the proposals and several of the strategies were later proposed as budget and legislative issues. Expansion of CHIP and Medicaid were proposed by the Executive but were not funded. The White Paper continues to serve as a useful tool to educate the public and elected officials about the uninsured in Montana and to generate public discussion around the issue of the

uninsured.

- Pursuant to a May 2000 Special Session Bill, Montana voters approved a constitutional amendment to allocate 40% of the state's tobacco settlement funds to a Tobacco Settlement Trust Fund and designate that the interest from the Trust Fund be allocated to health care and prevention programs. Legislation to implement the constitutional provision was passed in the 2001 Legislature.

- During 2000, DPHHS implemented several public/private programs to address the rising number of Montanans who were eligible for publicly funded insurance programs but were not enrolled. Eligibility workers were out-stationed in Community Health Centers and outreach money was provided to community agencies to increase enrollment in CHIP and Medicaid. **Administrative simplifications** were made including a streamlined universal application form for children's health insurance programs. DPHHS also participated in a public/private partnership with other state and local organizations to implement an **RWJ Covering Kids Grant** to identify and enroll eligible children in health insurance programs. Awareness of public programs remains a key issue that will be addressed in strategies developed under the State Planning Grant.

- The 2001 Legislature **expanded Medicaid** to cover comprehensive health benefits for women screened for breast or cervical cancer through the federal screening program. Forty-four women have been served since July 1, 2002.[24]

- The 2001 Legislature passed Senate Joint Resolution Number 22 (SJR 22) to create a **Joint Subcommittee on Health Care and Health Insurance** to study the issue of health care and health insurance costs and develop recommendations for the 2003 Legislature that address identified problems. Central among the concerns were the rising cost of health care and health insurance and the higher than average rate of uninsurance. The Subcommittee has met four times since it was created and has developed a draft paper outlining options for reducing the number of uninsured and controlling the cost of health care. The 2001 Legislature passed two bills affecting the **Montana Comprehensive Health Association (MCHA)**. The first bill provided the authority for the MCHA to set up a sliding scale premium for MCHA eligible persons with income less than 150% of the FPL. Through the efforts of the Insurance Commissioner and Montana's Congressional Delegation, $1.25 million in federal funding from HHS was approved to implement a demonstration project. The second bill required the Insurance Commissioner's office to set up a study committee to recommend a new financing system for MCHA. This effort has begun and the outcome is considered critically important to ensuring the long-term financial stability of the program and the affordability of premiums.

- Montana's Insurance Commissioner held a series of

eight **Community Roundtable Discussions on Affordable Health Care Coverage** from October 2001 through January 2002. The purpose of the Roundtable Discussions was to solicit public comment on strategies to expand access to affordable health care. Almost 400 people attended the roundtables and an additional 76 responded to questionnaires to measure the level of support for specific policy solutions. There was consensus there is a significant problem accessing affordable health care and health insurance coverage. Several potential strategies for dealing with the problem were identified. Montana participants were encouraged to continue the discussions at the local level and communicate with their elected representatives on problems and potential solutions. The findings were summarized in a report that was provided to Montana's Congressional Delegation, the Governor and the Legislative Sub-Committee studying Health Care and Health Insurance.[25] The Insurance Commissioner will work closely with the Joint Subcommittee on Health Care and Health Insurance and the Executive Branch to present public and private sector solutions to the 2003 Legislature.

2.2 SUCCESSES AND IMPLEMENTATION CHALLENGES

Montana is proud of the successes of its many efforts to increase access to health insurance coverage and is committed to build on that track record. Many of the details about successes and implementation challenges are described above. While not all efforts have been approved by the Legislature, this was not because of lack of vision, good ideas, or the amount of energy and time expended by all those in the public and private sector who were involved. Lack of funding and lack of political consensus have been the primary obstacles.

Montana, like so many other states, is experiencing the harsh realities of budget shortfalls as a result of a slowing down of the national and state economy. The limitations on spending and new revenue sources create tremendous pressures on the state budget. In past, and certainly future legislative sessions, significant resources to address the problem of the uninsured have competed with other highly visible priority areas, including funding for education, the corrections system, economic development, and emergency appropriations to deal with fires and drought. Recent events including disaster preparation, a slow-down in tourism and the increasing cost of the Medicaid Program will add to the financial pressures on the state budget.

The Insurance Commissioner, the Joint Subcommittee on Health Care and Health Insurance and other groups continue to explore new revenue sources to deal with the problem of the uninsured. Options being discussed include an increase in tobacco taxes and the use of interest from the Tobacco Settlement Trust Fund.

Other implementation challenges include the lack of a comprehensive statewide health information system to provide current data about health care costs, utilization and trends. Having such a system would assist policy makers to evaluate the effectiveness of current and past system reforms and model the cost and

impact of future reforms. Legislation to fund a Health Information Network has been introduced in the past two sessions but legislation has not passed largely due to concerns over the cost and privacy protections.

The State Planning Grant is an opportunity to continue focusing on the benefits of a Health Information Network and other strategies to reduce the uninsured. Once policy makers see the true extent of the uninsured problem and the impact it is having on the economy, more resources may be made available to address public and private solutions to the problem.

The barriers to providing access to insurance coverage are not insurmountable. Public opinion polls continue to demonstrate that health care is a priority issue for Montanans because health care costs and insurance premiums continue to increase. More people are losing their jobs and their health insurance coverage. Implementation of the State Planning Grant will help to keep the uninsured issue high on the public policy agenda.

2.3 HOW PLAN WILL SUPPORT EARLIER EFFORTS OR CREATE NEW INITIATIVES

The SPG will provide Montana with an excellent opportunity to build on earlier efforts to increase access to health insurance. Information collected during earlier analyses by the HCA, HCAC, Insurance Commissioner Roundtables and Joint Sub-Committee on Health Care and Health Insurance and the planned Governor's Health Summit will be carefully reviewed and serve as a foundation for making informed decisions about expanding health insurance coverage. The SPG will enable data-driven policy decisions to be made and will inform policy makers about new initiatives to expand access to affordable to health insurance.

REQUEST FOR PREFERENCE

Montana is specifically requesting the preference because of the potential that exists to significantly reduce the state's relatively high rate of uninsured.

Montana has demonstrated its commitment to reduce the uninsured through its past and current health care reform efforts. There have been several statewide efforts to reduce the uninsured; however, finding adequate financial resources to fund the proposals has been difficult given Montana's economy. Montana, like other states, has felt the effects of the economic down turn and is finding it increasingly more difficult to find resources among the many competing needs. Now more than ever, Montana desperately needs the additional financial resources to truly understand its uninsured problem and obtain public and private participation and consensus on potential solutions. The SPG will allow research to be conducted to design a strategy to provide more Montanans with health insurance and help convince policy makers and the tax-paying public of the financial, health and social consequences of having nearly one in five Montanans without insurance. A comprehensive and accurate statewide survey will describe the seriousness of the problem among the hard working single adults and families, small businesses, Native Americans and others who lack health insurance. This accurate Montana-based information can help to dispel many of the current misconceptions about the uninsured and generate public support for effective solutions.

The window of opportunity for action is now. As evidenced by the present bipartisan commitment of the Governor, Executive Branch, Legislature and the Insurance Commissioner, Montana is poised to take necessary actions to reduce its uninsured population. The Governor, in her State of the State address, indicated that health care is a priority and has announced plans to sponsor a Health Care Summit in May. The Joint Sub-Committee on Health Care and Health Insurance has been meeting for the past year to address and make recommendations on health insurance issues. Montana's Insurance Commissioner has just completed eight Community Roundtable Discussions seeking public comments on ways policymakers can improve access to affordable health care.

Montana's SPG will provide other rural and frontier states with a non-traditional model for health care delivery and improved access to health insurance coverage. With such diverse characteristics as the highest percentage of people living in rural areas, a high percentage of Native Americans and a low penetration of managed care, Montana could serve as a laboratory for testing strategies that might work in other states with similar demographics. The Grant combined with the momentum of current bipartisan health care reform efforts will make a significant difference for Montanans who need affordable health insurance.

3. PROJECT GOALS

3.1 PROJECT GOALS

The over-all goal of the State Planning Grant Project is to provide access to affordable health insurance coverage to all citizens in Montana. This will be accomplished through the timely completion of the following specific goals:

1) Select a Project Team and a Governor-appointed Steering Committee to guide and oversee project development and implementation. The Project Team will be comprised of the DPHHS Project Liaison, Grant Director and leaders from three work teams established to deal with Data, Coverage Options and Safety Net issues.

2) Collect and analyze quantitative and qualitative data that describe the characteristics of Montana's uninsured population.

3) Develop, evaluate and prioritize the most feasible options for providing access to affordable coverage and adequate benefits to all Montana citizens and develop a plan to implement the options over a six-year period.

4) Improve the capacity and capability of Montana safety net providers to provide care to the uninsured.

5) Prepare and submit a report to the Secretary of HHS describing project findings by July 30, 2003.

3.2 HOW GOALS SUPPORT SPG GOAL

Montana's goals directly support the SPG Goal of encouraging states to provide access to affordable health insurance to all citizens. The grant will provide the financial resources needed to assure an in-depth understanding of Montana's uninsured population, to explore options and strategies for improving access to insurance coverage and to better inform the general public and state policy makers of the complex nature of the problem and potential solutions and implementation strategies. Armed with data, best practices and realistic options, Montana can then develop and implement specific strategies to provide all Montanans with access to affordable health insurance coverage over a six-year period.

4. PROJECT DESCRIPTION

4.1 DATA COLLECTION AND ANALYSIS

It is extremely important for Montana to collect state specific data that more accurately and completely describes the characteristics of the uninsured population. Having more accurate and comprehensive quantitative and qualitative data about Montana's uninsured population will enhance informed decision-making and increase the confidence of policy makers and the general public in the strategies proposed to increase health insurance coverage.

Previous data collection efforts have focused on national census data, which have provided a general overview of insurance coverage in Montana. Using only national data has certain limitations. The state sample size used by the US Census Bureau is small and there is a significant lag time in getting the results. The Census data also does not estimate different rates of health insurance coverage across various demographic, socio-economic and occupational categories. For example, it has been necessary in the past to estimate county rates of uninsurance from the state average rate of uninsurance. This approach masks the much higher rates of uninsurance found among low-income families, Native Americans, and certain occupations, as well as those living in the more rural areas of the state.

The Grant Director, in consultation with DPHHS, will select a multidisciplinary Project Team to assist in completing data collection and analysis activities. The Project Team will consist of the Grant Director, DPHHS Liaison and leaders from work teams established for Data, Coverage Options and the Safety Net. The Project Team and work team members will be responsible to assist in analyzing data, presenting information and recommending policy options to the Steering Committee.

Membership on the work teams will include key public and private stakeholders, including legislators, the Insurance Commissioner's office, state agency experts, health care consumers, health care professionals, business leaders, insurance representatives, university staff and community leaders. Attention will be paid to selecting work team members who have been active in previous planning and advocacy related to increasing health insurance coverage.

The Data Work Team will provide guidance and report progress to the Steering Committee on issues related to the collection and analysis of qualitative and quantitative data that describes the uninsured in Montana. The Coverage Work Team will assist in examining and recommending policy options to provide insurance coverage to the uninsured. The Safety Net Work Team will develop recommendations to improve the capacity and capability of the Safety Net to provide care to the uninsured.

Montana will contract with the **University of Montana's (UM)**

Bureau of Business and Economic Research to collect data on the uninsured. The Bureau is the research department within the University that has monitored Montana's economic and business conditions for more than 40 years.

Montana will contract with **SHADAC** at the University of Minnesota for technical assistance and expertise through the Joint Data Collection Consortium (JDCC). SHADAC will provide technical assistance in survey design, data analysis, coverage options and preparation of the final report. Montana will also use the free technical assistance provided by the Academy for Health Services Research and Health Policy SCI Program to assist in identifying potential coverage options and potential funding for small planning grants and larger scale demonstration projects.

Montana will also participate in the SPG **Multi-state Integrated Database (MSID)** managed by the Arkansas Center for Health Improvement (UAMS). Participation in this project will allow the state access to a web-based software program that will provide state-specific national data including the BRFSS, the Current Population Survey and the County Business Pattern Census. The MSID will also incorporate two additional datasets that will likely be the household and employer survey information collected by UM. Access to such a comprehensive database will improve Montana's grant planning process, and enhance and inform policy makers about coverage options.

One of the first data collection and analysis actions will be the review of existing federal and state data sources to determine what is already known about the uninsured and identify information gaps. The review of federal data sources will include but will not be limited to the Current Population Survey (CPS), Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), BRFSS, Survey of Income and Program Participation (SIPP), MEPS Household Component, National Health Insurance Survey (NHIS), State and Local Area Integrated Telephone Survey (SLAITS), National Survey of American Families (NSAF) and the Community Tracking Study (CTS). The review of state data sources of data will include but not be limited to past surveys and administrative data from the Medicaid and CHIP program as well as administrative data from the State Insurance Commissioner, State Departments of Labor and Commerce and Blue Cross Blue Shield of Montana.

Montana will use the **Coordinated State Coverage Survey Instrument (CSCS)** as the survey instrument. The CSCS has been revised and tested to confirm its validity and ability to measure insurance coverage, especially among low-income populations. Use of this validated instrument should reduce project administrative costs and increase survey credibility by building on existing and tested survey tools and data collection protocols. SHADAC's expertise with the CSCS will also facilitate more timely and in-depth technical assistance and allow for cross-state comparisons. UM will work with SHADAC to add modules to the CSCS to ensure that Montana-specific information is collected and analyzed. The survey will be designed to provide information that is not already known from existing sources.

UM will have the primary responsibility to collect information from Montana

households and employers about the uninsured. UM will administer a statewide telephone **Household Survey** to 2000 households that include members who are uninsured and/or who are at risk of losing insurance. While the primary focus of the data collection will be on those currently uninsured, information also needs to be collected about those at risk of losing their current coverage because of losing access to insurance or being unable to pay for it.

The household survey will be designed to provide broad-based information on the different rates of insurance across various dimensions such as state geography, income, race, and occupation. The survey will provide information on the reasons why a person or family is not insured and ask for suggestions on types of programs or policies that would help the uninsured obtain and keep health insurance coverage. Particular attention will be paid to ensure that households without telephones are represented in the survey. Estimates of the uninsured will be developed for selected regions of the state. The regions will be selected to ensure that each region has a sample size large enough to draw valid statistical conclusions and has similarities in demographics, population, employment, and makeup of the health care market.

In addition to the household survey, UM will administer a **Business Survey** to 500 firms to solicit information from employers concerning the factors that affect their decision to offer health insurance coverage and what they think should be done to increase available insurance coverage. Understanding why so many Montana businesses do not offer insurance and finding out what employers think should be done about it is a critical part of this grant.

Policy options that expand employer-based coverage will be a major part of Montana's strategy to increase health insurance coverage. Strategies to help employees access coverage offered by employers and strategies to help employers offer coverage to their employees will have a significant impact on the insurance rate. Special emphasis will be paid to Montana's small businesses because they are less likely to provide insurance and most likely to be influenced by health insurance premium increases.

UM will design and conduct a series of six **focus groups** to provide a better understanding of why so many Montanans are uninsured and what strategies they recommend for increasing health insurance coverage. The purpose of the focus groups will be to obtain insight and information into attitudes about health coverage and why certain groups have higher rates of uninsurance. Focus groups will include special populations such as Native Americans, farmers and ranchers, the self-employed and low-income families who have more difficulty accessing health insurance.

UM will design and conduct **key informant interviews** with 15-20 persons having special knowledge and experience in working with the uninsured. In-depth interviews will be conducted with such key informants as small business owners, health care providers, insurance companies and insurance agents and consumer advocates. Their insights into the challenges faced in offering insurance

coverage will prove very helpful in designing policy options for Montana's unique circumstances.

After the data collection activities are completed, UM will analyze the data, compare it to other data sets and literature and prepare a **report of findings** detailing the characteristics of Montana's uninsured. The report will include an analysis of the regional variations among the uninsured. UM will present the report of their findings at a SPG Steering Committee meeting.

4.2 HOW ANALYTIC EFFORTS SUPPORT DEVELOPMENT OF OPTIONS

The results of UM's data collection and analysis as well as the results of previous data collection efforts will be analyzed and used to provide a data-driven picture of who the uninsured are and why they are without health insurance coverage. SHADAC will assist in the data analysis efforts by providing technical assistance in the development of a detailed analysis strategy and plan and monitoring the data collection process. SHADAC will also work with the Grant Director and Coverage Team to analyze the data and develop a list of preliminary policy options for providing access to affordable insurance for uninsured Montanans. The preliminary public and private policy options will be presented to the Steering Committee for their review and approval.

Information from all the previously mentioned reform efforts will be considered when developing policy options. This information when combined with the information collected through household and employer surveys, focus groups, key informant interviews will provide a comprehensive view of the uninsured and help policy makers better understand the problems of the uninsured. In the past, lack of complete data and limited analysis of the data may have led some policy-makers to arrive at wrong conclusions about strategies to address the uninsured. For example, there is a common misperception that most of the uninsured are unemployed and some choose not to have insurance. The facts are that most of the uninsured are working and do not have insurance because it is either too expensive or it is not offered on the job. Having a comprehensive data set may help to dispel some of the myths about Montana's uninsured.

Proper analysis of the quantitative and qualitative information collected during this project will help to build a solid foundation for developing the best public and private sector strategy for covering the uninsured and provide a plan for implementing and funding the strategy. Improving the completeness and accuracy of data regarding the uninsured will boost the confidence of policy makers and increase the support of the public and private sector in participating in the planning process and becoming part of the solution.

4.3 HOW OPTIONS WILL BE DEVELOPED

Montana recognizes there is no single option to expand coverage to all of Montana's uninsured. A solution that works well in an urban county may not be as effective as a solution designed for a more rural county. Benefit design can

significantly influence program enrollment, so much time and effort will be put in evaluating and prioritizing which policy options Montana should consider to increase health insurance coverage. Multiple options that integrate public and private, traditional and non-traditional and combination approaches will have to recognize the need for collaboration and shared responsibilities among the employee, employer and state and federal government. Because of financial and political realities, the most feasible options will have to be phased in over a six-year period making it important to target which groups should receive the highest priority for coverage.

One of the first steps in developing options will be the review of existing state and federal coverage policies and the review of existing reports that have identified options for increasing coverage. These include strategies and policy options identified in the RWJ State Coverage Initiatives Report, the Montana Health Information Network Report, the Health Care Advisory Council's White Paper, the Insurance Commissioner's Health Care Community Roundtables and the Joint Sub-Committee on Health Care and Health Insurance Report. All of these excellent and informative products will be carefully reviewed and evaluated in light of the data that was collected through the surveys, focus groups and key informant interviews.

The first meeting of the SPG Steering Committee will include a presentation by the Grant Director of the overall project strategy and timelines for the grant process. SHADAC will provide background information about current state and federal efforts to expand insurance coverage and potential funding sources. Information about federal waivers including the Health Insurance Flexibility and Accountability (HIFA) 1115 Demonstration Proposal will be part of the presentation.

SHADAC will work with the Grant Director and Coverage Team to identify and study coverage options used in other states. From this comprehensive review, a list of preliminary policy options to increase health insurance coverage will be developed. The policy options identified will be based on information collected from research of current state and federal efforts and findings from the project's data collection efforts. Implementation strategies for each policy option and simulation models to estimate the costs of the options will be developed and presented to the Steering Committee

The Steering Committee will review and approve guiding principles and criteria against which policy options will be analyzed and prioritized. Guiding principles will help educate the Steering Committee members, set expectations and facilitate group discussions. Criteria for analyzing and rating the options would include, but not be limited to, the following items:

- Effectiveness at achieving desired outcomes;

- Costs to implement and methods to contain costs;

- Identifiable funding sources including the potential for federal match;
- Estimated number of persons covered;
- Political acceptability;
- Ability to measure quality and access;
- Operational feasibility and administrative costs.

All of the policy options will be evaluated according to their ability to meet the desired program goal of providing access to affordable and adequate health insurance coverage to all Montana citizens. Access will be defined as the opportunity to purchase health insurance coverage or participate in a program that provides adequate benefits at an affordable cost. Adequacy of benefits will be determined by comparing the plan to the scope of benefits offered under the Federal Employees Health Benefit Plan, Medicaid, State Employees Benefit Plan or other similar quality benchmarks. Affordability will be defined through a method of cost sharing based on the individual's income level and applying a sliding scale related to income or by other cost sharing methods such as an out-of-pocket limit.

4.4 DECISION MAKING PROCESS

The Governor has designated the Montana Department of Public Health and Human Services (DPHHS) to serve as the lead agency to maintain overall direction and responsibility for project activities. The DPHHS Project Liaison (Maggie Bullock) will be accountable and responsible for the overall project. DPHHS will contract with a Grant Director (Kelly Moorse) to manage and direct project activities and make recommendations to the DPHHS Project Liaison and the SPG Steering Committee. The Governor-appointed Steering Committee will include key public and private stakeholders who will provide strategic guidance and oversight to project activities. The Steering Committee will provide final policy recommendations in a report to DPHHS, the Governor, the Insurance Commissioner and the Legislature.

After data on Montana's uninsured has been collected and analyzed, the Steering Committee will be fully briefed by UM and SHADAC on the results of the data analysis and the list of preliminary policy options. After the Steering Committee approves the list of preliminary policy options, they will evaluate and prioritize the options using the approved guiding principles and criteria described in Section 4.3.

An independent meeting facilitator will work with the Steering Committee to review and approve the policy options to be included in a draft Insurance Coverage Plan. The draft Insurance Coverage Plan will describe the approved policy options and how they will be implemented over a six-year period to provide health insurance coverage to all Montanans.

Once the Steering Committee approves the draft Insurance Coverage Plan, it

will be presented for public review and comment as described in Section 4.5. Comments from public review will be incorporated into a final Insurance Coverage Plan. The final Insurance Coverage plan will provide the basis for preparing the final SPG report to the HHS Secretary. The final Insurance Coverage Plan will be presented to the Governor, Insurance Commissioner, the Legislature and all other interested parties.

Safety Net Providers

One of the project goals is to enhance the capacity and capability of Montana's safety net providers to provide care to the uninsured. Since Montana will be implementing policy options to provide health insurance coverage to all Montanans over a six-year period, it is critical to ensure that the safety net system stays strong during and after the phase-in period. The safety net system will need to continue to provide the uninsured with basic health care services and outreach and referral to insurance programs. While the grant goal is to provide insurance coverage to all Montanans, it must be recognized there will always be some individuals who continue to need safety net services because they may choose not to participate in health insurance programs despite their eligibility and access to coverage.

Montana is very fortunate to have such an excellent network of safety net providers who share a common mission of delivering health care to persons experiencing barriers to accessing health care. The health care safety net provides health care to a significant number of Montanans who are both insured and uninsured. The clinics offer health services to low-income uninsured individuals on a sliding scale but do not refuse services to anyone based on inability to pay.

Montana's safety net includes seven Community Health Centers operating in 9 counties, one Migrant Health Center with seasonal sites across the state, one Healthcare for the Homeless Program, five Urban Indian Clinics, 15 National Health Service Corps Clinic sites, 33 Rural Health Clinics, 56 Local Health Departments and other providers committed to serving the underserved.

During 2001, the Montana Primary Care Association estimated that 41,609 Montanans received services at federally funded Community/Migrant Health Centers. Of those, 26,473 or 64% were uninsured. Also during 2001, Tribal Indian providers served 69,231 residents and Health Care for the Homeless Clinics served 1,939 individuals. National Health Service Corps providers served 28,537 individuals. These sites provide comprehensive, preventive and primary health care, which may include dental and mental health services. There are currently 28 Critical Access Hospitals that provided a broad range of services to over 15,000 persons in 2000.

Montana's safety net providers, advocates and state and federal officials have worked diligently to sustain and strengthen the safety net. As plans are developed and implemented to provide access to health insurance to all Montanans, it is critical to have the input and participation of the providers who are currently treating most of the uninsured. In addition to the strong role safety net

providers will play on the Steering Committee and Work Teams, there are additional activities planned under the grant to enhance their overall capacity to serve additional patients.

Key stakeholders in the safety net community will to be selected to serve on the Safety Net Work Team. The Safety Net Work Team will provide technical assistance and guidance to the Steering Committee on safety net issues. The Safety Net Work Team will identify existing safety net coverage areas and gaps in coverage to include an assessment of current capacity and financial viability.

The Safety Net Work Team will develop a preliminary list of recommendations to strengthen the safety net's capacity and capability. Recommendations would include the best methods of supporting the current and future provision of safety net services. Examples of recommendations that might be included would be improved data systems and information sharing, mechanisms to assure adequate and consistent funding, educational programs to promote the utilization of safety net resources, and improved outreach programs to reach individuals who are eligible for other public and private programs but are not enrolled.

The recommendations from the Safety Net Work Team will be presented to the SPG Steering Committee for consideration with other policy options. Recommendations approved by the Steering Committee will become part of the overall Insurance Coverage Plan and process to increase health insurance coverage.

4.5 COLLABORATION PROCESS

Montana has a long and rich history of collaboration. Montana expects to build on that tradition of collaboration among public and private partners for expanding health insurance coverage. One of the major ways that will occur will be to involve the public and key stakeholders through out the state planning grant process. The stakeholders will include those in government and in the business, health care, consumer and provider community who have been interested and participated in past and current efforts to expand access to affordable health care. The Steering Committee will include these and other key stakeholders from the public and private sector. Members of the Steering Committee will be carefully selected to provide a balance of different viewpoints and expertise on health insurance.

Montana's formal process for collaboration on the grant will begin even before the notification of SPG awards. In May 2002, Governor Martz will host a statewide Health Care Summit to solicit input on ways to improve access to health insurance coverage. Information about the State Planning Grant goals and data on the uninsured will be presented at the Governor's Summit.

Public education will be a crucial and ongoing part of the grant process. The Steering Committee will play a key role in conducting a public-education campaign to include statewide public meetings and other public education strategies. The public meetings will provide an opportunity for experts, public and private stakeholders and others to learn and provide input on the options being considered by the Steering Committee to expand access to insurance coverage. **M**ontana's

Educational **T**elecommunications **Net**work, METNET, will be used for public meetings to maximize public participation. METNET allows for two-way interactive meetings in 13 sites across the state.

In addition, the Grant Director, with assistance from the Project Team and Steering Committee, will make presentations to other key groups including Legislative leadership, Chambers of Commerce, Professional Associations, local elected officials, Native Americans, consumer groups and other community and advocacy organizations.

DPHHS will work closely with the Insurance Commissioner's Office and other executive branch agencies including the Departments of Commerce, Labor and Industry and Administration who have a stake in or can provide resources to deal with the issue.

Because the Legislature must provide statutory authority and funding for any major health reform initiative, their ongoing involvement is essential. Legislators will serve on the Steering Committee. DPHHS has already made two presentations about SPG plans to the Joint Subcommittee on Health Care and Health Insurance. The Grant Director will continue to make regular status presentations to this committee and all other pertinent legislative interim committees. While the project will not be completed prior to the 2003 legislative session, a full legislative briefing will be conducted during the session. In addition to keeping the Executive and Legislative Branch of government informed and involved, formal communication will also take place with the private sector including business, the health care provider community, consumer groups and others.

Methods of communication will include public meetings, statewide media coverage, news releases and newsletters prepared and distributed on a regular basis. A special website devoted to the State Planning Grant will be developed to include information about grant progress, dates of meetings, meeting minutes and other special events and significant findings developed throughout the grant process. Links to websites of DPHHS, the Governor, the official state site, HRSA and others will be established to inform interested parties of related health reform efforts. At the outset of the project, the Department's Communication Officer and the Governor's Communication Director will assist the Grant Director in developing a comprehensive communications strategy.

4.6 REPORT TO SECRETARY

Montana is committed to providing a report to the Secretary of Health and Human Services (HHS) that describes the results of the State Planning Grant Project by July 30, 2003. The report will describe Montana's uninsured population and the options and strategy for expanding insurance coverage. Montana will contract with SHADAC for assistance in preparing the final report. Prior to beginning preparations for the final report, the Grant Director will review the HHS report format and work with SHADAC to develop a report outline based on the prescribed format. The Grant Director and SHADAC will conduct a through review of other state grantee interim and final reports to determine best

practices for presenting the required information. SHADAC, with assistance from the Project Team, will prepare a draft report and distribute it the SPG Steering Committee and Work Teams for review and approval. After the changes resulting from the review of the draft report are incorporated, a final report will be prepared and mailed before the deadline.

4.7 PROJECT NARRATIVE AND PROJECT MANAGEMENT PLAN

TASK 1: Establish a State Planning Grant Project Team and Steering Committee				
	TIME TABLE	**RESPONSIBLE AGENCY OR PERSON**	**ANTICIPATED RESULTS**	**EVALUATION MEASUREMENT**
ACTION STEP 1 Contract with Grant Director (Kelly Moorse)	7/1/02	DPHHS Liaison (Maggie Bullock)	Signed contract	Review of contract performance by DPHHS Liaison
ACTION STEP 2 Appoint SPG Steering Committee.	8/01/02	Governor	Formal appointment of members	Balanced and representative membership of key stakeholders and state government
ACTION STEP 3 Establish the SPG Project Team and work team members.	8/01/02	Grant Director and DPHHS Project Liaison	Appointment of Project Team and work team members	Balanced and representative membership of key stakeholders and state government
ACTION STEP 4 Develop meeting schedule and conduct meetings	8/02 – 6/03	Grant Director	At least bi-monthly meetings with the first meeting scheduled for 8/02	Full attendance and participation (80%) at meetings

ACTION STEP 5 Develop communication strategy and SPG website.	8/02	Grant Director/Governor and DPHHS Communication Directors	Communication Strategy and signed contract for a website	Approval of Steering Committee and positive user evaluations of the website
TASK 2: Collect and analyze data that describes the characteristics of Montana's uninsured population.				
	TIME TABLE	**RESPONSIBLE AGENCY OR PERSON**	**ANTICIPATED RESULTS**	**EVALUATION MEASUREMENT**
ACTION STEP 1 Develop and sign contract with UM for data collection and analysis.	7/15/02	DPHHS Project Liaison and Grant Director	Signed contract	Review of contract performance standards by Grant Director
ACTION STEP 2 Develop and sign contract with UAMS to participate in the Multi-State Integrated Data Base. (MSDI)	7/15/02	DPHHS Project Liaison and Grant Director	Signed contract	Review of contract performance standards by Grant Director
ACTION STEP 3 Provide Montana specific data to MSDI.	8/02	UAMS and DPHHS contact (Pete Feigly)	Montana specific data included in MSDI	Successful completion of contract performance standards
ACTION STEP 4 Review all data currently available.	8/02	Grant Director, UM and Data Team	Access to State and Federal data	Approval of selected data resources
ACTION STEP 5 Modify the CSCS for Montana use.	8/02	Dr. Seninger and SHADAC	Montana specific survey	Ability to measure insurance coverage in Montana

ACTION STEP 6 Conduct statewide telephone survey of Montana households.	7/02 – 12/02	Dr. Steve Seninger, UM	Completed surveys	Successful completion of contract performance standards
ACTION STEP 7 Develop and conduct a survey tool for Montana employers.	7/02 – 12/02	Dr. Steve Seninger, UM	Completed surveys	Successful completion of contract standards
ACTION STEP 8 Develop and conduct focus groups.	9/02 – 12/02	Dr. Steve Seninger, UM	Completed focus groups	Successful completion of contract performance standards
ACTION STEP 9 Develop and Conduct Key Informant interviews	10/02-12/02	Dr. Steve Seninger, UM	Completed key interviews	Successful completion of contract performance standards
ACTION STEP 10 Prepare report of findings from data collection surveys, focus groups and key informant interviews.	1/03	Dr. Steve Seninger, UM	Report of findings	Successful completion of contract performance standards

Task 3: Develop the most feasible options for providing access to affordable health insurance coverage for all Montanans over a six-year period.				
	TIME TABLE	**RESPONSIBLE AGENCY OR PERSON**	**ANTICIPATED RESULTS**	**EVALUATION MEASUREMENT**
ACTION STEP 1 Develop and sign contract with SHADAC for coverage option analysis/development and report preparation.	7/02	DPHHS Project Liaison and Grant Director	Signed contract	Review of contract performance standards by Grant Director

ACTION STEP 2 Research existing state and federal coverage policies.	7/02	Grant Director, SHADAC and Coverage Team	Access to state and federal policies	Approval of selected policies
ACTION STEP 3 Evaluate previous work on policy options and program design.	7/02	Grant Director, SHADAC and Coverage Team	Access to previous health reform documents	Approval of selected documents
ACTION STEP 4 Present overall project strategy, timelines and Best Practices to Steering Committee.	8/02	Grant Director and SHADAC	Comprehensive and accurate presentation	Positive evaluation of presentation
ACTION STEP 5 Develop draft guiding principles and criteria for evaluating and prioritizing policy options.	8/02	Grant Director SHADAC and Coverage Team	Draft guiding principles and evaluation criteria	Steering Committee approval of draft guiding principles and evaluation criteria
ACTION STEP 6 Evaluate cost and coverage impacts of options for expanding coverage.	12/02	Grant Director, SHADAC and Coverage Team	Full cost and impact evaluation of feasible options	Evaluation meets pre-established criteria
ACTION STEP 7 Develop preliminary policy options	12/02	Grant Director, SHADAC and Coverage Team	List of preliminary policy options	Preliminary options meet pre-established criteria

TASK 4: DETERMINE COVERAGE OPTIONS TO COVER ALL MONTANANS OVER A SIX-YEAR PERIOD.				
	TIME TABLE	**RESPONSIBLE AGENCY OR PERSON**	**ANTICIPATED RESULTS**	**EVALUATION MEASUREMENT**

ACTION STEP 1 Present findings from data collection and analysis and preliminary policy options to Steering Committee.	1/03	Grant Director, UM, SHADAC and meeting facilitator	Comprehensive and accurate presentation	Positive evaluation of presentation
ACTION STEP 2 Obtain Steering Committee approval of preliminary policy options.	1/03	Grant Director with assistance of meeting facilitator	Steering Committee approval of policy options	Positive evaluation of process
ACTION STEP 3 Evaluate and prioritize policy options using approved guiding principles and criteria.	2/03	Steering Committee	List of prioritized policy options	Options meet approved criteria and positive evaluations of process
ACTION STEP 4 Obtain Steering Committee approval of options to include in draft Insurance Coverage Plan.	3/03	Grant Director with assistance of meeting facilitator	Steering Committee approval of options to include in draft Insurance Coverage Plan	Full participation (80%) and positive evaluation of process
ACTION STEP 5 Prepare draft Insurance Coverage Plan.	4/03	Grant Director, SHADAC and Coverage Team	Draft Insurance Coverage plan	Plan meets contract standards and expectations of Steering Committee
ACTION STEP 6 Present draft Insurance Coverage Plan for public review and comment**.**	5/03	Grant Director and selected members of Steering Committee and Project Team	Assessment of public perception and support for options	Positive evaluations from public presentations

ACTION STEP 7 Develop final Insurance Coverage Plan to implement policy options over a six-year period.	6/03	Grant Director, SHADAC and Coverage Team	Final Insurance Coverage Plan	Steering Committee approval of final plan and positive evaluation of process

TASK 5: Improve capacity and capability of Montana safety net providers to provide care for the uninsured				
	TIME TABLE	**RESPONSIBLE AGENCY OR PERSON**	**ANTICIPATED RESULTS**	**EVALUATION MEASUREMENT**
ACTION STEP 1 Identify key stakeholders to serve on Safety Net Team.	9/02	Grant Director and Director of Montana Primary Care Association (MPCA)	Formal appointment of members	Balanced and representative membership of key stakeholders
ACTION STEP 2 Identify existing coverage and gaps and options to strengthen safety net.	10/02 – 11/02	Safety Net Team with assistance of MPCA and independent meeting facilitator	Report of safety net coverage, gaps and options	Full attendance and participation (80%) at meetings
ACTION STEP 3 Evaluate and prioritize safety net policy options.	12/02	Grant Director and Safety Net Team	List of priority policy options	Options meet approved criteria and positive evaluations of process
ACTION STEP 4 Present preliminary findings to Steering Committee.	1/03	Safety Net Team	Comprehensive and accurate presentation	Positive evaluation of presentation

ACTION STEP 5 Incorporate approved safety net policy options into draft Insurance Coverage Plan.	3/03	Steering Committee and Safety Net Team	Approved list of safety net policy options to include in Insurance Coverage Plan	Positive evaluations of process

TASK 6: Prepare and submit a final report to HHS describing project findings by July 30, 2003.				
	TIME TABLE	**RESPONSIBLE AGENCY OR PERSON**	**ANTICIPATED RESULTS**	**EVALUATION MEASUREMENT**
ACTION STEP 1 Review the HHS report format report	10/02	Grant Director	Access to report format and	Approval of report format
ACTION STEP 2 Develop interim and final report outline based on the HHS format	11/02	Grant Director and SHADAC	Report outline in approved format	Approval of report outline
ACTION STEP 3 Conduct review of other state grantee interim and final reports.	12/02	Grant Director and SHADAC	Access to other reports	Identification and approval of best practices
ACTION STEP 4 Submit interim report.	01/03	Grant Director and SHADAC	Interim report mailed by deadline	HRSA approval of report
ACTION STEP 4 Prepare draft report and submit to Steering Committee and Work Teams for review and approval.	6/03	SHADAC and Grant Director	Draft final report	Approval of Final report by Steering Committee
ACTION STEP 5 Incorporate changes to draft and prepare final Report.	7/01/03	Grant Director	Final Report	Incorporation of comments

ACTION STEP 6 Submit final Report.	7/30/03	Grant Director	Final report mailed before deadline.	HRSA approval of report

4.8 ORGANIZATIONAL STRUCTURE AND GOVERANCE

Governor Judy Martz will provide political leadership and support to the project. She has designated the Montana Department of Public Health and Human Services (DPHHS) as the lead agency to maintain overall direction and responsibility for the project. As an umbrella agency, DPHHS is responsible for the administration of statewide health and human services. DPHHS has a long history of leadership in providing services including Medicaid, CHIP, Public Health, Human Services, Mental Health and Substance Abuse, Aging, Developmental Services, and Child Support Enforcement. DPHHS has staffed and been a member of previous Health Care Advisory Councils and has been a leader in tracking and researching health reform efforts at the state and national level.

The **DPHHS Project Liaison** (Maggie Bullock) will be accountable and responsible for the overall project. She will manage and oversee the contract with the Grant Director (Kelly Moorse). The **Grant Director** will manage and direct project activities, and make recommendations to the DPHHS Project Liaison and the SPG Steering Committee. The Grant Director will manage subcontracts with UM, SHADAC and UAMS.

DPHHS will work closely with the Insurance Commissioner's Office and other state agencies including the Departments of Commerce, Labor and Industry and Administration who have a stake or can provide resources to deal with the issue.

The Governor will appoint a **SPG Steering Committee** with broad representation from key public and private stakeholders including the Legislature, the Insurance Commissioner, state universities, state agencies dealing with health and insurance, health care consumers and providers, insurance companies, private business, safety net providers, local government, tribal government and community organizations. The Governor's Health Policy Advisor will play a key role by identifying needs for involvement of other Executive Branch staff and reporting to the Governor on the progress of project activities and major issues. The Chairperson of the Steering Committee will be from DPHHS and the Co-Chairperson will be a representative from the private sector. This will demonstrate the partnership that will be required between the public and private sector to deal with issues involving the uninsured.

Representation on the Steering Committee will attempt to balance geography, race, and gender and the interests of consumers, providers, employers and government. This balance is important to obtain different perspectives on increasing access to insurance coverage and to reflect the political realities of the challenges that will be confronted in reaching consensus on coverage options.

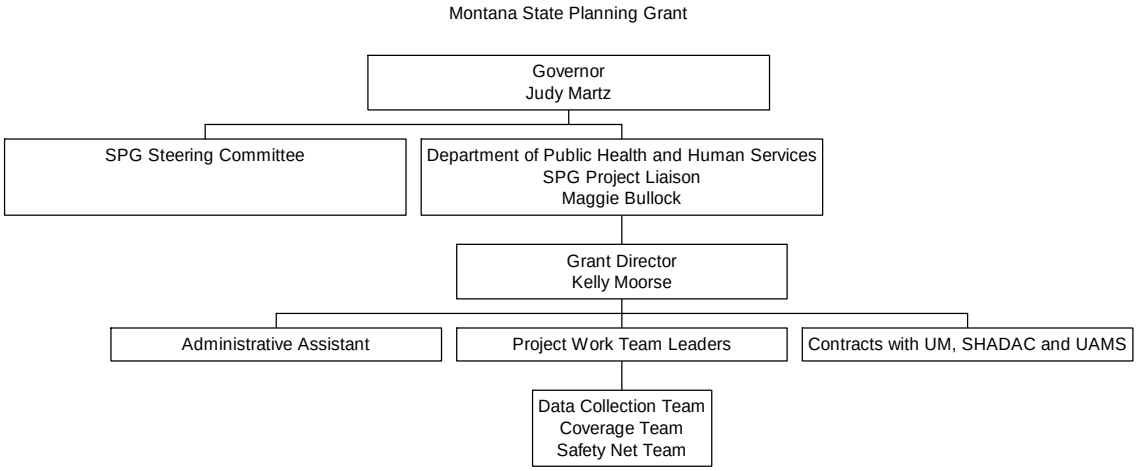
The Steering Committee will meet at least bi-monthly to provide strategic

guidance and oversight to project activities. The Steering Committee will consider all the data collected on the uninsured and develop a strategic Insurance Coverage Plan to provide adequate and affordable health insurance to all Montanans over a six-year period. The Steering Committee will provide prepare final policy recommendations to DPHHS, the Governor, the Insurance Commissioner and the Legislature. Steering Committee members will volunteer their time but will be reimbursed for travel-related expenses.

The DPHHS Project Liaison and Grant Director will select **work teams** on Data**,** Coverage Options and the Safety Net. Attention will be paid to selecting work team members who have been active in previous planning and advocacy on issues relating health insurance coverage for the uninsured. Work teams will be responsible to assist the Grant Director and the contractors (UM and SHADAC) in researching and analyzing uninsured data, and presenting and recommending policy options to the Steering Committee. Each of the work teams will select a Work Team Leader to be part of the Project Team. Work team members will advise the Steering Committee and attend Steering Committee meetings but will not be official Steering Committee members. Work team members will volunteer their time but will be reimbursed for travel-related expenses.

The multidisciplinary **Project Team** will include the DPHHS Project Liaison, the Grant Director and Work Team leaders. The Project Team will report progress and findings to the SPG Steering Committee and coordinate the work of work teams and contractors to ensure ongoing coordination and communication.

The **Data Team** will assist in collecting and analyzing the qualitative and quantitative data describing Montana's uninsured. The **Coverage Team** will assist in examining and recommending policy options to provide insurance coverage to the uninsured. The **Safety Net Team** will develop recommendations to improve the capacity and capability of the Safety Net to provide care to the uninsured.



4.9 KEY PROJECT STAFF

Key Project Staff will include **Maggie Bullock** as the Project Liaison for the

Department of Public Health and Human Services. As the DPHHS Project Liaison, she will be accountable and responsible for the overall project. As the current Administrator of the Health Policy and Services Division, Ms. Bullock is responsible for the administration of the statewide Medicaid, CHIP and Public Health Programs. Ms. Bullock has 33 years experience providing leadership in private and public human services. Twenty- seven of those years include working directly with or in community based organizations in programmatic and administrative capacities. She has also served in teaching, advisory and consultative capacities to universities, colleges, other public and private organizations and Boards of Directors of community-based organizations. Ms. Bullock will devote approximately 10 % of her time to the project.

Ms. Bullock will contract with **Kelly Moorse** to serve as Grant Director. Ms. Moorse will manage and direct project activities and make recommendations to the DPHHS Project Liaison and the SPG Steering Committee She will be responsible for ensuring communication and collaboration with DPHHS, other state agencies, contractors, the SPG Steering Committee, Work Team members and other critical players in the public and private sector. She will work with the Steering Committee and SPG Project Team to ensure that grant activities are accomplished on a timely basis within budget. The Grant Director will also oversee the work of a contracted Administrative Assistant.

Kelly Moorse has over 27 years experience in health care and project management. Her most recent positions include Operations Director and Associate Executive Director of Magellan Behavioral Health Care where she was responsible for the management of the statewide Managed Mental Health Contract, which covered over 70,000 lives. She is considered an excellent manager of both people and projects and is known for her results oriented management, organizational skills, problem solving approach and ability to handle multiple, diverse projects simultaneously. She has established positive working relationships with Montana providers and consumers throughout her long professional career. She has a Bachelor's Degree in Education and a Master's Degree in Theology and Communication. Her knowledge and experience in health care at the state and federal level and her proven skills in project management, public speaking, program planning, government relations, public policy development, program evaluation, contract and financial management makes her extremely qualified for the Grant Director position. Ms. Moorse and the contracted Administrative Assistant will devote 100% of their time to the project.

Dr. Steve F. Seninger is the project's Principal Investigator from **University of Montana-Missoula.** He is the Director of Economic Analysis for the Bureau of Business and Economic Research and a professor in the Department of Management at the University. As a PhD economist, he has research and teaching experience at several major universities and is currently in charge of the Bureau's Health Care Industry Research Program, which examines health care markets and the cost of health care. He directs Montana's KIDS COUNT program, a statewide effort to track and monitor the well being of Montana's children. His published research covers a wide range of subjects, including health care, economic development, and public policy issues. He has consulted and advised numerous

government agencies and private corporations. Dr. Seninger will devote 66% of his time to the project.

Timothy J. Beebe, Ph.D., is the project's Principal Investigator from SHADAC. As a Senior Research Associate at **SHADAC,** he has more than ten years of experience in health care policy and survey research. He recently served as the Division Manager for Health Care Research at the Minnesota Department of Human Services, the state's Medicaid agency. He is skilled in data analysis, experienced in the development and implementation of research protocols, and knowledgeable about the design and validation of survey research and clinical screening instruments. Mr. Beebe will devote 15% of his time to the project.

5. BUDGET AND ACCOUNTING PROCESS

The proposed budget and detailed justification and a description of the budget and accounting process is located after Standard Form 424A in the application. The budget is reasonable for the project and supports the project management plan and program goals.

6. MONITORING PLAN AND REPORT TO SECRETARY

6.1 MONITORING PROCESS

Monitoring and evaluation will be an integral part of the State Planning Grant process. Program monitoring is needed to ensure the project is managed properly, is on track, is within budget and is mitigating project risks. DPHHS, as the SPG lead agency, will be responsible for the overall direction of grant activities. The grant will be carefully monitored by the DPHHS Project Liaison and the Grant Director to ensure that grant activities are implemented according to the project plan and expected outcomes. Accurate assessments, measurements and ongoing evaluation of project results are critical to the project's success.

Anticipated results and timelines for each project activity have been identified in the project management matrix. To determine how successful the overall project is being implemented, it will be necessary to compare actual outcomes to anticipated results. Outcome measures to determine success will include the following:

- Grant activities are accomplished as outlined in the project management matrix;
- Grant activities are accomplished within established timelines;
- Grant activities are accomplished within budget;
- Grant accomplishments compare to expected outcomes;

- Contractor performance expectations are met;
- Baseline data collection is completed;
- Surveys and evaluation mechanisms are in place to evaluate specific program components and the overall plan.

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

Minutes will be taken at every meeting to document action items and responsible individuals. Meeting participants will complete evaluations after each Steering Committee meeting and other appropriate meetings to identify follow-up issues and ways to improve future meetings.

There will be regular meetings and conference calls between the Grant Director and the Project Team to assess progress and identify compliance issues. Weekly calls between the Grant Director, Project Team and contractors will be conducted to assess progress and compliance with contract expectations. Contractors will also be required to provide monthly written status reports to DPHHS, the Grant Director and the SPG Steering Committee and others as required. The status reports will identify current status of worked performed, interim findings, estimated completion times can be for each project task, and difficulties or special problems so remedies can be developed as soon as possible.

6.2 REPORT TO SECRETARY

Montana is committed to providing a report to the Secretary of Health and Human Services (HHS) that describes the results of the State Planning Grant Project by July 30, 2003. Montana will provide the data in the format specified by Federal Program staff. Montana will also provide an interim report that is due January 1, 2003. The final report will identify the results of the data collection activities, including the characteristics of Montana's uninsured. It will also include an analysis of strategies for providing the uninsured with access to health insurance coverage and the state, federal and private partnerships that will be required to implement the strategies. Montana is committed to working with HRSA staff and other SPG grantees to prepare the report to the Secretary of HHS and contribute to the national report. Participating in the national report is essential for Montana and other states to learn about best practices in providing access to insurance coverage.

ENDNOTES

[1] US Census Bureau, March 2001 Current Population Survey (CPS) using November 2001 correction

[2] Kaiser Family Foundation Website www.statehealthfacts.kff.org

[3] Kaiser Family Foundation Website www.statehealthfacts.kff.org

[4] US Census Bureau, March 2001 CPS using November 2001 weighting correction

[5] US Census Bureau, March 2001 CPS using November 2001 weighting correction

[6] Kaiser Family Foundation Website www.statehealthfacts.kff.org Sources: Urban Institute and Kaiser Commission estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys.

[7] Kaiser Family Foundation Website www.statehealthfacts.kff.org

[8] Kaiser Family Foundation Website www.statehealthfacts.kff.org

[9] CPS 2000 (Represents calendar year 1999)

[10] CPS 2000 (Represents calendar year 1999)

[11] CPS 2000 (Represents calendar year 1999)

[12] No Health Insurance? It's Enough to Make you Sick – Scientific Research Linking the Lack of Health Coverage to Poor Health, by the American College of Physicians-American Society of Internal Medicine,

[13] Insurance Commissioner

[14] Calendar year 2000 information from the Insurance Commissioner's Office

[15] Small Business Administration, www.sba.gov

[16] MEPS Insurance Component Tables (Health Insurance Cost Study)- 1996-1999

[17] MCHA Presentation to Legislative Subcommittee on Health Care and Health Insurance

[18] *A Market–Based Sequential Health Care Reform Plan for Montana.* HCA Report,December 1994.

[19] Health Care Advisory Council Report to Governor Racicot and the 1997 Legislature, October 1996

[20] BCBSMT

[21] DPHHS Addictive and Mental Disease Division

[22] DPHHS CHIP Program

[23]*Strategies for Improving Access to Health Care Coverage* can be found at www.dphhs.state.mt.us/hpsd/index.htm

[24] DPHHS Health Policy and Services Division

[25] A Report on Health Care Roundtable Community Discussions, Montana Insurance Commissioner John Morrison is available at www.discoveringmontana.com/sao