1. PHS 5161-1 (Rev. 7/00) – COVER PAGE

2. Table of Contents

3. Standard Form 5161-1

includes SF 424A: Budget forms
-budget plan
-federal assurances
-check lists from 5161-1
-disclosure of lobbying activity form (SF-LLL)

4. Project Abstract

5. Program narrative*
6. Appendices*

***numbered pages, count towards 45 page limit**

TABLE OF CONTENTS

Budget Plan

The budget for this Project is located at the beginning of this application, Standard Form 424 and 424A. The budget justification and narrative are provided following the 424A form. Please find below additional details for the grant application and the line item budget from SHADAC, ACHI, Center for Business & Economic Development, University of Tennessee in Knoxville (CBED), and the Center for Health Services Research at the University of Tennessee in Memphis (CHSR), proposed contractors for this grant application.

These grant funds will be managed by the Project Director, with assistance from TDCI's Fiscal Director to ensure proper expenditures. TDCI assures that grant funds will not be used to supplant other funding that is currently supporting work on these issues in Tennessee.

Expense	**Total**
Personnel Salary	$ 152,448
Project Director (1 FTE)	$ 75,000
Research Analyst (1 FTE)	$ 47,616
Administrative Services Assistant (1 FTE)	$ 29,832
Fringe (32.6%)	$ 49,590
Indirect (21.24%)*	$ 32,380
Other Expenses	$ 4,500
Equipment	$ 0
Supplies	$ 5,000
Travel	$ 15,424
In-state	$ 5,000
Out-of-state	$ 10,424
Contractual	$ 761,539
SHADAC	$ 76,142
University of Arkansas, ACHI	$ 62,726
Center for Business and Economic Research, University of Tennessee at Knoxville	$ 146,257
Center for Health Services Research, University of Tennessee at Memphis	$ 476,414
TOTAL	**$1,020,881**

*The indirect cost rate has been submitted and is pending approval from the U.S. Department of Health & Human Services.

TENNESSEE DEPARTMENT OF COMMERCE & INSURANCE

Personnel ***$152,448***
Personnel costs are calculated for the 12 month grant period.

Project Director (position to be filled) ***$75,000***
The Project director is a full-time position. The person in this position will be responsible for the oversight of Project implementation, monitoring and completion by contractors and will prepare the final reports listed under goal 7. Some of the duties of this position have been described in the Project narrative. (See Appendix A for job description).

Research Analyst (position to be filled) ***$47,616***
The proposal is for a full-time position. The person in this position will be responsible for working with the MSID data sets, other data collection processes, focus groups contractor, and other data reviews and written reports. (See Appendix A for job description)

Administrative Services Assistant (position to be filled) ***$29,832***
This is a full time position. The person in this position will provide clerical and office support to the Project Director and the Research Analyst. (See Appendix A for job description)

Fringe Benefits ***$49,590***
A fringe benefit rate of 32.6% is applied to salaries for all Project staff

Indirect ***$32,380***
An indirect rate of 21.24% is applied to salaries and benefits for all Project staff. We have submitted a Departmental Indirect Cost Rate Proposal to Mr. Bill Logan, Director of the Department of Health and Human Services Division of Cost Allocation, Mid-Atlantic Field Office. This plan was prepared and documented in accordance with OMB Circular A-87. We understand that indirect costs may not be recovered from a federal award until the indirect cost rate has been negotiated and approved by the particular Federal agency.

Other Expenses (Network fees) ***$4,500***
A network fee of $1,500 per full time employee is applied for all Project staff.

Equipment ***$0***
TDCI has sufficient equipment to provide for Project staff; no additional equipment will be needed.

Supplies ***$5,000***
General office supplies to cover expenses relating to phone charges, postage and mailing, photocopying, and other miscellaneous standard office supplies.

Travel ***$15,424***

In-state ***$ 5,000***

The Project anticipates the Project Director and Research Analyst will travel to contractor sites for monitoring, focus group sessions, and town hall meetings. Some travel may require overnight stays, depending on location of meeting and or site visit.

Out-state ***$10,424***

The SPG requires participation in quarterly meetings in Washington, D.C. during the grant period. The budget is based on all travel related expenses for two staff persons (Project Director and Research Analyst) traveling to 4, 2-day meetings plus an additional day for travel.

Airfare: $3,500; Lodging: $4,500; Ground transportation, including travel to airport, airport parking, and travel to/from hotel: $ 1200; Meals: $1,224

Detailed line item budgets and budget narratives for the proposed contractors are attached below.

TOTAL:	**$1,020,881**

STATE HEALTH ACCESS DATA ASSISTANCE CENTER (SHADAC)

BUDGET JUSTIFICATION

Technical Assistance and Support Services
Funding Agency: Tennessee Department of Commerce and Insurance (HRSA prime)
Project Period: September 1, 2004 through August 31, 2005

This document is a proposal to the University of Tennessee Center for Health Services Research from the State Health Access Data Assistance Center (SHADAC) for funding under the HRSA State Planning Grants Program to provide survey, sampling and report consultation. This is a preliminary draft; details are subject to change pending the development of a formal proposal through the University of Minnesota Office of Sponsored Projects Administration.

A. Background

Household Survey

The State of Tennessee is applying for a grant sponsored by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) State Planning Grants Program. The state will contract with the University of Tennessee in Memphis for the fielding of the Coordinated State Coverage Survey (CSCS). The CSCS is a household telephone survey designed by staff at the State Health Access Data Assistance Center (SHADAC) for estimation of health insurance coverage at the state level. Technical assistance and expert consultation will be provided by SHADAC on a contract basis. SHADAC is a technical assistance and research center located in the Division of Health Services Research and Policy, in the School of Public Health at the University of Minnesota. SHADAC provides technical assistance on data collection and interpretation related to health insurance coverage and the characteristics of the uninsured from a state perspective.

Employer Survey

To increase the state's understanding of the employer market, the State of Tennessee will contract with the University of Tennessee in Knoxville to conduct a survey of employers. SHADAC will provide technical assistance and expert consultation on the sample design, the development of the survey instrument and the analysis of the data.

B. Project Detail

The principal purpose of this survey activity is to estimate health insurance prevalence in the state of Tennessee and to describe the characteristics of the uninsured.

C. Deliverables

1) **Sample design.** SHADAC will provide expert consultation and feedback at the request of Project personnel. At the request of the University of Tennessee in Memphis, SHADAC will review and provide advice on the sample design for the household survey, including the development of sampling specifications and weighting to ensure that sampling specifications

support the Project goals. SHADAC will provide similar consultation on the sample design of the employer survey to the University of Tennessee in Knoxville.

2) **Questionnaire development.** For the household survey, the state of Tennessee has decided to use SHADAC's Coordinated State Coverage Survey instrument. SHADAC will help the staff of the University of Tennessee in Memphis craft additional questions to be added to the instrument to address Tennessee-specific issues. SHADAC will provide a copy of the Computer Assisted Telephone Interviewing (CATI) program for the survey in Sawtooth Ci3 software. Survey center staff at the University of Tennessee in Memphis will be responsible for adding new survey items to the program.

For the employer survey, SHADAC will help staff from the University of Tennessee in Knoxville design the survey instrument drawing on examples of other state employer surveys.

3) **Survey implementation.** SHADAC will work with Project staff to provide expert consultation on the administration of the CSCS instrument including the content and skip patterns. SHADAC will also provide consultation on the administration of the employer survey. We will be available for technical consultation as problems arise.

4) **Technical assistance.** SHADAC will respond to a range of technical inquiries on both the household and employer surveys and will work with Project staff to handle specific data analysis questions on a range of issues, from working with weighted data to the compilation of the final data set documentation.

PERSONNEL

Michael Davern, PhD will be the Principal Investigator for the Project. Dr. Davern will provide expert consultation on all aspects of study design and implementation, particularly on developing sampling frames, weighting schemes, and detailed analysis strategy. Dr. Davern's time is estimated at 10% for the term of the Project. Expenses are calculated on institutional base salary of $78,186 with a fringe benefit rate of 32.9% for a total of $10,394 for this Project.

Margaret Brown Good, PhD will serve as Co-Investigator for the Project. Dr. Good will provide expert consultation services on Project design, research methodology, sample design, data collection, the state data collection process, and interpretation of results. Dr. Good's time is estimated at 15% for the term of the Project. Expenses are calculated on institutional base salary of $74,169 with a fringe benefit rate of 32.9% for a total of $14,789 for this Project.

Kelli Johnson, MBA will serve as an Investigator for the Project. Ms. Johnson will be responsible for managing the staff on the Project and coordinating communication between SHADAC and Tennessee Project staff. Ms. Johnson's time is estimated at 10% for the term of the Project. Expenses are calculated on institutional base salary of $86,053 with a fringe benefit rate of 32.9% for a total of $11,439 for this Project.

Keith Onken will be the CATI programmer for the Project. Mr. Onken will provide expertise in programming the CSCS into CATI. Mr. Onken's time is estimated at 5% for the term of the

Project. Expenses are calculated on a salary of $68,908 with a fringe benefit rate of 32.8% for a total of $9,152 for this Project.

OTHER EXPENSES

Project Supplies – Project supplies including papers, CD to record data, pens, etc. Expenses are estimated usage of $15 per month.

Network Maintenance for Dr. Davern - Network Maintenance and backups will be provided by a service line within the Computer Research Center and also by Academic Computing and Distributed Services. Service to the Division Local Area Network is budgeted at $100 per month, based on percentage of effort expended, for access to a variety of software packages that range from the standard office packages to the more sophisticated statistical packages and for nightly backups to the entire machine. [$100 X .05* X 12 = $60]

Progress Meeting – Two 1-day trips, one for the household survey and one for the employer survey, for two people will be necessary for the Project. We estimate expenses at: airfare at $1,000 per person, hotel $150 per person, meals $50 per day per person, and ground transportation at $100 per person.

INDIRECT COSTS

Indirect cost. A federally negotiated off-campus indirect cost rate of 48.5%, using a modified total direct cost base, will be applied to this Project. This MTDC base excludes space rental costs, equipment, capital (A&R) expenditures, patient care, graduate student fringe benefits, and the portion of each subcontract and sub grant in excess of $25,000 per Project period.

Project Title: Tennessee Technical Assistance and Support Services
University of Minnesota
PI: Michael Davern
Period: 09/01/04-08/31/05

		09/01/04 08/31/05	TOTAL BUDGET	
EFFORT IN PERCENT				
7000 Michael Davern	Principal Investigator	10%		
7000 Margaret B. Good	Investigator	15%		
7005 Kelli Johnson	Investigator	10%		
7000 Keith Onken	CATI Programmer	10%		
SALARY				Year 1 Salary
7000 Michael Davern	Principal Investigator	7,819	7,819	78,186

7000	Margaret B. Good	Investigator	11,125	11,125	74,169
7000	Kelli Johnson	Investigator	8,605	8,605	86,053
7000	Keith Onken	CATI Programmer	6,891	6,891	68,908
TOTAL SALARY			**34,440**	**34,440**	
FRINGE					Fringe
7100	Michael Davern	Principal Investigator	2,575	2,575	32.9%
7100	Margaret B. Good	Investigator	3,664	3,664	32.9%
7100	Kelli Johnson	Investigator	2,834	2,834	32.9%
7100	Keith Onken	CATI Programmer	2,261	2,261	32.8%
TOTAL FRINGE			**11,334**	**11,334**	
TOTAL PERSONNEL			**45,774**	**45,774**	
OTHER EXPENSES					
	Network Maintenance		60	60	100.00
	Project Supplies		180	180	15.00
	FedEx		60	60	10.00
	Travel	4 trips x $1,300	5,200	5,200	1,300.00
TOTAL OTHER EXPENSES:			**5,500**	**5,500**	
DIRECT TOTAL:			**51,274**	**51,274**	
INDIRECT TOTAL:			**24,868**	**24,868**	**48.5%**
TOTAL PROJECT COSTS:			**76,142**	**76,142**	

ARKANSAS CENTER FOR HEALTH IMPROVEMENT (ACHI)

Expense	**Cost**
Personnel	22,000.00
Principal Investigator	
Data Collection Manager	
Project Coordinator	
Program Manager	
Database Administrator	
22% Fringe	
Administrative Fees	7,000.00
Travel	3,000.00
Supplies	300.00
Other Expenses	4,540.00
Remote software demonstrations services ($65 per month 12 months) Telephone Conference Calls ($1000) Microsoft SQL Server Enterprise CAL ($30) Microsoft Windows 2000 CAL ($30) New Knosys ProClarity License ($2,400) 5 Software Licenses Knosys ProClarity Maintenance Fees Hardware Depreciation ($300)	
State-Specific Dataset	15,000.00
Incorporation of a one state-specific dataset into the Multi-State Integrated Database.	
Data Cube Development ($15,000 per dataset)	
Indirect Costs (21% of total)	10,886.00
Total Costs	**62,726.00**

Budget Justification for Multi-State Integrated Database

Personnel (Multi-State Integrated Database)

Joseph W. Thompson, MD, MPH, Principal Investigator. Dr. Thompson will commit efforts related to development and implementation of the Multi-State Integrated Database. These include identification and review of database components, oversight of database development,

education and demonstration for participating states on policy applications of the integrated database, and development of the long-term database management plan.

Shirley Tyson, Program Manager. Ms. Tyson will manage the oversight of the Project. Her duties will include developing training and support protocols and structuring Project timelines and tasks.

Data Collection Manager. The Data Collection Manager's responsibilities include assessment of newly available data from multiple states and principal responsibility for coordinating activities with the State Health Access Data Assistance Center (SHADAC).

Mary Richardson, Project Coordinator. Ms. Richardson will facilitate coordination across SPG component activities including the participation of multiple states in this component, monitor timelines and deliverables, and ensure optimal execution of integrated database activities undertaken by the SPG Project team.

Database Administrator. An administrator will maintain database tables and modify or create datasets.

Kevin W. Ryan, JD,MA, SPG Project Director. Mr. Ryan has primary administrative and supervisory responsibility for the Arkansas HRSA State Planning Grant and SPG Supplements which support the Multi-state Integrated Database.

Cathy Shipley, Business Manager. Ms. Shipley will provide administrative support in regards to contract and/or grants management to facilitate the administration of the Project. She will monitor and oversee the mandated guidelines for completion of the proposed Project.

Administration Support. This person or persons will provide administrative and clerical support to the Project.

Fringe Benefits.
A fringe benefit rate of 22% is applied to salaries for all SPG staff, which is the average rate for employees paid from the existing SPG grant.

Travel (Multi-State Integrated Database)
The Project anticipates one on-site users training conference related to a SPG grantee meeting (1-2 day training session for 5 AR staff). Total cost $3000 per training conference.

Supplies (Multi-State Integrated Database)
General office supply costs of $300 will cover expenses long distance telephone charges, postage and mailing, photocopying, and other miscellaneous standard office supplies.

Contractual (Multi-State Integrated Database)
David Higginson, ACMA, Consultant. Mr. Higginson is Chief Information Technology Officer at Arkansas Children's Hospital (ACH), the 6th largest pediatric hospital in the United States. He has extensive experience in developing integrated computer systems. His accomplishments include leading a 5-person team that designed, developed, and implemented 123 computer systems at ACH, resulting in cost savings and revenue generation in excess of $2 million. Examples of systems implemented include web based workflow management, 500 GB Data Repository, and Grant Management. Mr. Higginson is recognized as a leader in the field of Electronic Research Administration and currently licenses research systems to more than 20 universities and research organizations nationwide. He has spoken at numerous conferences on the topics of system design, implementing change, and managing process improvement.

He has served as the lead external consultant on the Arkansas SPG Project. In addition to his support, Mr. Higginson will select and oversee other database programming consultants to accomplish the goals of the Project. As consultant to the development of the Multi-State Integrated Database, he will use his skills for the following.

Maintain the Knosys ProClarity Enterprize Server
For each dataset from the participating SPG state, he will:

Transform Data per provided data dictionaries
Load data to Microsoft SQL Server and construct data tables, views, and stored procedures
Construct data cubes in Microsoft Analysis Services
Construct initial data views in Knosys ProClarity Briefing Books
He will also participate in developing and overseeing security procedures by following Steering Committee Guidelines to establish security on data tables in Microsoft SQL Server, on data cubes in Microsoft Analysis Services, and on data views in Knosys ProClarity Enterprise Server.

Indirect Costs (Multi-State Integrated Database)
Using a modified direct cost base, ACHI uses the UAMS negotiated rate for program grants and/or contracts of 21%.

Deliverables

Access to password protected Internet based multi-state database (at the initial grantee meeting conducted for 5th Round funded states – anticipated to occur 30 days post award).
Training (initiate 30 days post award), available upon scheduling and coordination with the Arkansas MSID staff.
Ongoing support (initiated by 30 days post award) through business hours via a help-line, web-based and telephonic tracking.
Incorporation of one State specific survey data set to be scheduled with Arkansas staff, delivery and completion is based on the availability of the state-specific data by the participating state and the scheduling and coordination with the Arkansas MSID staff. Activities must be completed by the end of the grant period.

CENTER FOR BUSINESS AND ECONOMIC DEVELOPMENT, UNIVERSITY OF TENNESSEE IN KNOXVILLE (CBED)

Budget Justification

Expense	
Personnel	$ 96,280
Principal Investigator	
Research Professor	
Research Associates (3)	
28% Fringe	
Administrative Fees	$ 4,000
Communication	$ 2,800
Printing/Duplicating	$ 1,200
Travel	$ 400
Supplies	$ 1,500
Other Expenses	$ 25,000
Data	$ 5,000
Focus Groups	$ 20,000
Indirect Costs (15% of total)	$ 19,077
Total Costs	$146,257

Personnel

Dr. Bill Fox, Principal Investigator Dr. Fox will supervise the data collection and analysis performed by CBED, which includes a review of existing employer data; the collection of new employer data through focus groups and/or surveys; review of existing insurance company (market participant) data; and collection of new market participant data in conjunction with TDCI.

Dr. Bruce Behn will provide support on the analysis of the insurance company data, and preparation of the market analysis report.

Vickie Cunningham will serve on the survey design team and development of the database structure for data analysis for employer surveys.

Joan Snoderly will serve as Project coordinator, and work on all aspects of the Project for CBED.

Angela Thacker will provide statistical consultation and database management on employer survey, as well as existing databases.

Fringe The CBED fringe benefit rate of 28% is applied to all salaries of individuals working on the Project.

Administrative Printing and copying costs were estimated at $1,200 for the employer survey, focus groups, and market participant survey and research. Telephone, fax, postal and express mail services, to be utilized in all aspects of CBED's Project duties, were estimated at $2,800.

Travel CBED is requesting funds to cover in-state trips to Nashville and other parts of the state to conduct the employer focus groups and attend various Project meetings. No out-of-state travel is anticipated.

Supplies Survey materials for the employer survey are estimated at $1,000. An additional $500 in miscellaneous supplies was included to cover standard office supplies, including computer toner and data storage.

Other Expenses CBED will subcontract with a vendor to conduct the employer focus groups and has estimated this cost to be $20,000. In addition, $5,000 was included for the purchase of an employer dataset, which may be necessary for the employer surveys.

Indirect Costs CBED has previously negotiated a 15% rate of indirect costs for all state contracts.

CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF TENNESSEE IN MEMPHIS (CHSR)

Budget Justification

Expense	**Cost**
Personnel	$ 149,240
David Mirvis, MD Teresa Waters, PhD Cyril Chang, PhD Bryan Williams, PhD Michal Tamuz, PhD Research Analyst	
33.79 % Fringe	
Travel	$ 20,433
Supplies	$ 1,200
Other Expenses	
Survey Research Lab	$ 240,000
Computer/software for RA	$ 1,600
Long Distance	$ 1,800
Total Direct Costs	$ 414,273
Indirect Costs (@ 15 %)	$ 62,140
Total Costs	**$ 476,414**

Budget Justification

Personnel
(Personnel costs are calculated for the 12-month period 9/1/04 – 8/31/05)

David M. Mirvis, M.D. will serve as Principle Investigator for the CHSR portion of this Project and will commit efforts to establishing guiding principles for the Project, monthly health insurance workgroup meetings, subcommittee work, reviewing existing household survey data , options to cover the uninsured, modifying the CSCS (survey) for Tennessee, conducting focus

groups with health care providers, reviewing reports developed by the working groups, developing a list of preferred options, assisting with stakeholder meetings, and the preparation of reports to the General Assembly and HRSA. Dr. Mirvis is the Director of the Center for Health Services Research, and has a long and distinguished career in medicine, health administration, and health policy. He has published extensively on national, state, and local health policy and currently serves as Program Director for the Health Policy Program in CHSR's Health Administration Ph.D. program.

Teresa M. Waters, PhD will serve as a Co-Investigator for the CHSR portion of this Project and will commit efforts to establishing guiding principles for the Project, monthly health insurance workgroup meetings, subcommittee work, reviewing existing household survey data, options to cover the uninsured, modifying the CSCS (survey) for Tennessee, conducting focus groups with health care providers, reviewing reports developed by the working groups, developing a list of preferred options, assisting with stakeholder meetings, and the preparation of reports to the General Assembly and HRSA. Dr. Waters is a Ph.D.-trained health economist with extensive experience managing and analyzing large databases, including the Current Population Survey, the Medical Expenditure Panel Survey, and the Behavioral Risk Factor Surveillance Survey. She has also worked extensively with health care claims data and hospital discharge datasets. Her research has focused heavily on Medicaid and uninsured populations and the providers who serve them. She currently serves as the Associate Director for Research in CHSR's Center for Health Services Research and is on the faculty in Preventive Medicine and Health Services Administration.

Cyril F. Chang, Ph.D. will serve as a Co-Investigator for the CHSR portion of this Project and will commit efforts to establishing guiding principles for the Project, monthly health insurance workgroup meetings, subcommittee work, reviewing existing household survey data and options to cover the uninsured, modifying the CSCS (survey) for Tennessee, conducting focus groups with health care providers, reviewing reports developed by the working groups, developing a list of preferred options, assisting with stakeholder meetings, and the preparation of reports to the General Assembly and HRSA. Dr. Chang is a Professor of Economics at the University of Memphis and currently serves as the Director of the Methodist LeBonheur Center of Healthcare Economics in the Fogelman College of Business and Economics at the University of Memphis. Dr. Chang's research has focused heavily on the financial health of Tennessee hospitals and the impact of financing and policy changes on the TennCare population and the providers who serve them. He has worked extensively with Tennessee's Joint Annual Report (TNJAR) data on Tennessee hospitals as well as financial data from health care providers and programs.

Bryan Williams, PhD will serve as a Co-Investigator for the CHSR portion of this Project and will assume prime responsibility for conducting the household survey. In addition, Dr. Williams will assist in establishing guiding principles for the Project, participate in monthly meetings of the health insurance workgroup, modify the CSCS (survey) for Tennessee, provide household data (and documentation) to MSID, and assist in the preparation of reports for the General Assembly and HRSA. Dr. Williams has a Ph.D. in Psychometrics from Pennsylvania State University and is currently an Associate Professor in the Department of Preventive Medicine at CHSR and Director of PROBE, CHSR's survey research lab. Dr. Williams has extensive survey

research experience, founding and managing research labs at CHSR and at the University of Arizona during the past 10 years.

Michal Tamuz, PhD will serve as a Co-Investigator for the CHSR portion of this Project and will assume prime responsibility for conducting the focus groups and analyzing the qualitative data. She will also assist in the preparation reports to the General Assembly and HRSA. Dr. Tamuz is a Ph.D.-trained sociologist with a strong expertise in the area of qualitative research. She has conducted numerous qualitative studies of health care providers and organizations and is currently the Principle Investigator of two federally funded studies examining communication among health care providers and related organizational changes.

Research Analyst – The research analyst will assist Project co-investigators in the management of the databases associated with the Project, including the existing household and employer data sets and the household survey data and in conducting data analyses.

Fringe Benefits – The CHSR fringe benefit rate of 33.79 % is applied to all salaries of individuals working on this Project.

Travel

We are requesting funds to cover the cost trips including trips to Nashville for establishing guiding principles, trips associated with provider focus groups, trips associated with the stakeholder meetings, trips to Nashville associated with the development and preparation of the reports to the General Assembly and HRSA, and trips to Knoxville to collaborate with staff of the UT-CBED. In addition, we are requesting funds to cover the cost of automobile travel in Western Tennessee for focus groups in that area.

Supplies

General office supply costs of $100 per month ($1,200) total will cover the costs of postage, printing, copying, and other miscellaneous standard office supplies, including computer toner and data storage.

Other Expenses

Survey Research Lab – We are requesting $240,000 to cover the costs of conducting the survey. Based on surveys of similar length and composition, we estimate the cost of conducting the telephone survey to be $60 per completed survey. Based on discussions with SHADAC about observations needed to construct reliable estimates at the MSA and regional level as well as oversampling over minorities and low income households, our goal sample size (completed questionnaires) will be 4,000.

Computer/software for Research Analyst – Since we plan to hire a new person to serve as research analyst for this Project, we are requesting funds to purchase a desktop computer capable of conducting statistical analyses for this person.

Long distance – We are requesting $150 per month to cover the costs of long distance calls and teleconferences with the Tennessee DCI, UT Knoxville, SHADAC, ACHI, and HRSA.

Indirect Costs

Indirect costs are assessed at 15 % of modified total direct costs, which is the rate negotiated between the University of Tennessee for state contracts.

PROJECT ABSTRACT SUMMARY

State Planning Grants Program
Tennessee Department of Commerce & Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243
(615) 741-6007
kristin.coile@state.tn.us

Current Status of Access to Health Insurance in Tennessee
Over 600,000 Tennesseans do not have access to health insurance. This 2002 figure represents approximately 10.8% of the state's population, compared to the national uninsurance rate of 15.2%. The lead agency for this State Planning Grant application, the Tennessee Department of Commerce & Insurance (TDCI) receives thousands of calls a year from Tennesseans asking for help in obtaining access to health insurance. The problem, however, goes beyond access. Insurance premiums and the share of insurance costs borne by employees are skyrocketing, leaving many citizens and businesses unable to renew their policies. As an example, rates for individual health policies in Tennessee increased by more than 34% in 2003. Thus, addressing both access and affordability of health care coverage are the primary goals of this Project.

Although Tennessee has fared better than the national average in terms of health coverage, its citizens are among the least-healthy in the country. Tennessee ranked 46th in overall quality of health by the United Health Foundation in 2003 due to high rates of cardiovascular disease, diabetes, cancers, obesity, and tobacco use. Tennessee is also a relatively poor state, with 39% of its households below 200% of the federal poverty level. Without access to affordable health insurance coverage, the health needs of our state cannot be met.

Earlier Efforts to Expand Access
The TennCare program, a Medicaid waiver expansion program instituted in 1994, now provides health insurance coverage through managed care organizations to 1.3 million individuals. In addition to Medicaid eligibles, the program provides insurance to 260,000 uninsured or uninsurable individuals who otherwise would not be eligible for Medicaid. Through TennCare, Tennessee covers more uninsured or uninsurable citizens than any other state in the nation. But, like every other Medicaid expansion program in the country, new limitations on federal matching funds and scarce state resources have necessitated massive changes to TennCare in order to keep it financially viable. Governor Phil Bredesen, a former healthcare executive, has chosen to enact significant reforms rather than eliminating coverage for this uninsurable group.

Project Goals
This grant proposal outlines the data collection needed to properly identify Tennessee's uninsured, and to develop policy options to provide affordable coverage to all uninsured individuals in the state. Due to budgetary constraints, this proposal will focus on initiatives outside of the TennCare program. The Project has seven specific goals: (1) establishing the Project Management Team and guiding principles for the Project; (2) convening the Health Insurance Workgroup; (3) reviewing existing data from households, employers, and health insurance market participants; (4) collecting and analyzing new data from households, health

care providers, employers, and market participants; (5) developing a menu of options to provide access to affordable health insurance or coverage for all Tennesseans; (6) conducting public review of the preferred options; and (7) preparing final reports summarizing the Project's work.

Project Description

This grant application represents the first step in a coordinated data collection effort targeted at the uninsured in Tennessee. The Project will utilize the experts at the State Health Access Database Assistance Center (SHADAC) to refine and update household survey information. We will contract with local health experts at the Center for Health Services Research at the University of Tennessee in Memphis (CHSR) to conduct this study. CHSR will tap into the Multi-State Integrated Database (MSID) maintained by the Arkansas Center for Health Improvement as part of its efforts, and any information gained through our survey will be downloaded into the MSID. CHSR will also conduct focus groups with health care providers to better determine the real health needs of the uninsured.

Employer data will be collected and analyzed by another local expert – the Center for Business and Economic Development at the University of Tennessee in Knoxville (CBED) - with the assistance of SHADAC. CBED will assist TDCI in evaluating the condition of the health insurance market in Tennessee. Rate trends, competitive factors and financial condition of the insurers and other entities providing health coverage will be evaluated.

The Health Insurance Workgroup (HIW) will analyze the data, review policy options and devise a list of preferred options, utilizing the input of stakeholders, including private industry. A statewide outreach effort will be launched over the summer of 2005 to receive public input. Final reports summarizing the Project will be prepared at the conclusion of the grant year.

Lead Agency & Organizational Structure

The Tennessee Department of Commerce & Insurance has been designated by Governor Bredesen as the lead agency for this Project. The HIW will serve as the primary structure overseeing the Project and developing policy options. HIW will be comprised of representatives from multiple agencies of state government: Tennessee Commission on Children & Youth; Department of Commerce & Insurance; Department of Health; Department of Labor & Workforce Development; Department of Mental Health and Developmental Disabilities; Mental Retardation Division, Department of Finance & Administration; and TennCare Bureau, Department of Finance & Administration. The Project will hire a Project Director, a Research Analyst, and an Administrative Services Assistant. The Project Management Team (TDCI and Project staff) will monitor the Project's progress.

Comment [c1]:

Comment [c2]:

Projected Results

At the end of the year, the State will better understand the issues related to health insurance coverage, and will have identified policy options whose goal is to make health coverage available and affordable to all Tennesseans. We will develop a multi-year strategic plan aimed at implementing the preferred options after undergoing a thorough public review process, and receiving continuous input from policymakers and the private sector. Tennessee has demonstrated its commitment to serve the uninsured through TennCare and will continue that commitment through this SPG grant process.

PROGRAM NARRATIVE

I. Current State of Health Insurance Coverage

A. The TennCare Program

Tennessee is continuing its historic commitment to providing health care coverage to its citizens. In 1994, Tennessee adopted the unprecedented TennCare program which sought to provide coverage not only to its Medicaid population, but also to its uninsured and uninsurable populations through cost savings achieved through managed care. It was, and remains, the most ambitious Medicaid expansion initiative in the U.S. Tennessee was approved by the Health Care Financing Administration (forerunner to the current Center for Medicaid and Medicare Services (CMS)) for a five-year demonstration project to provide benefits through managed care organizations. The program began on January 1, 1994 and currently serves 1.3 million poor, disabled, and uninsured Tennesseans. Of this figure, approximately 260,000 comprise TennCare's "expansion population" who are uninsured or uninsurable and would otherwise not be eligible for Medicaid. Enrollment in TennCare has been closed to the adult expansion population since 1995. Because of TennCare's expanded coverage, Tennessee repealed its Catastrophic Health Insurance Plan, a small high risk pool program that offered coverage to "uninsurables" and that charged very high premiums. A summary of the history of TennCare is described in further detail below on page 8, but was included here to highlight the importance of TennCare to the determination of who is uninsured in this state.

B. Who are the Uninsured in Tennessee?

Although there are several databases which have collected information on the uninsured nationwide, there is no single comprehensive analysis detailing who is uninsured and why in Tennessee. The following is a summary of the various information sources that this grant proposal seeks to review and build upon.

(1) Current Population Survey (CPS)

According to the 2002 Current Population Survey (CPS), a monthly survey of 50,000 households nationwide conducted by the Census Bureau for the Bureau of Labor Statistics, the percent of Tennesseans without health insurance is 10.8%, compared to the national average of 15.2%. Using the latest census data, 10.8% of Tennessee's population represents 614,443 individuals. Over the past three years, the percent of individuals without health insurance has ranged from 10.3% to 11.5% as reflected in Table 1, but has stayed below the national average. The Bureau of Labor Statistics reports that the sample size for this survey is approximately 600 households a year in Tennessee.

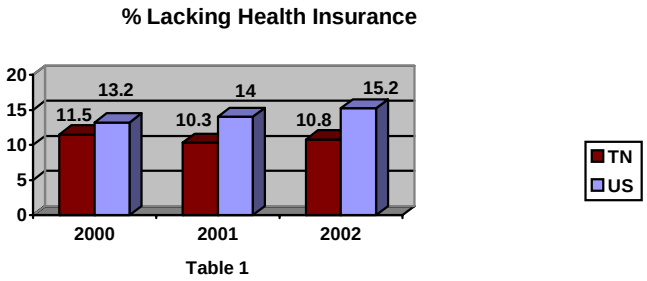

Table 1

The Center for Health Services Research (CHSR), located in the University of Tennessee in Memphis, analyzed the CPS March supplement data, which contained questions on health insurance status, for 2001. This analysis demonstrated that the highest percent of the uninsured in Tennessee are among young adults aged 19-24 (30%) and the Hispanic population (50%). The data also reflected that the level of insurance declined as income, education, and time of employment declined. In terms of income, those individuals falling within 125 – 149% of the federal poverty level had the highest rates of uninsurance at 22.7%. However, in terms of sheer volume, the majority of the uninsured in Tennessee were white U.S. citizens, with full-time jobs, a high school education, incomes over 150% of the federal poverty level, and between the ages of 25 and 44 years old.

(2) Behavioral Risk Factor Surveillance System (BRFSS)

Tennessee data under the Behavioral Risk Factor Surveillance System (BRFSS), a nationwide survey of adults administered by the Centers for Disease Control and Prevention, also shows levels of uninsurance slightly below the national average.[1] According to the BRFSS, approximately 12.6% of Tennessee's adult population lack health insurance. Over the past three years, the state's adult rate of uninsurance has fluctuated, as reflected in Table 2, from a high of 12.9% in 2002 to a low of 10.7% in 2001.[2]

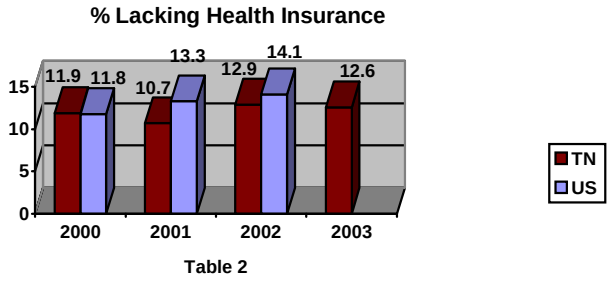

Table 2

[1] The national uninsured average was approximately 14.1% according to BRFSS in 2002. Although we were able to obtain the 2003 Tennessee BRFSS data, the national 2003 data is not yet available.

[2] Prior to the initiation of TennCare, Tennessee had an uninsured rate of 17.3% in 1992.

Of the adult population surveyed through BRFSS, the 18-34 age group has consistently been the group with the highest rate of uninsurance, with 20% lacking health insurance in 2002. These figures are similar to the CPS analysis.

In terms of geographic location, the Memphis Metropolitan Statistical Area (MSA), which includes portions of Arkansas and Mississippi, also had a slightly higher average of adults without health insurance than the state average. According to BRFSS 2002 data, 14.9% of adults in the Memphis MSA lacked health insurance. For the Tennessee portion of the MSA – Shelby County – the rate was also high at 14.5%. Shelby County is the largest county in the state with a population of 897,472, and also has the highest percent of minorities with 53% reporting as some race other than white in the 2000 Census. The Nashville/Davidson County/Murfreesboro MSA average was 12.3% without health insurance.

(3) Other Household Surveys

Household surveys conducted by the Center for Business and Economic Development (CBED), housed at the University of Tennessee in Knoxville, shows different, and much lower, levels of uninsured. Notably, these surveys included 5,000 responses to telephone calls (compared to the much smaller samples from CPS and BRFSS). The questions may vary from survey to survey which likely accounts for the discrepancies; the CBED survey based a respondent's classification on the individual's insurance status at the time of the call, not whether the individual had been uninsured at anytime during the previous year. Nonetheless, these figures show a much lower level of uninsurance in the state. See Table 3 for a summary of these figures.

TABLE 3

	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
State total	452,232	298,653	303,785	333,268	319,079	335,612	387,584	372,776	353,736	348,753
Percent	8.9	5.7	5.8	6.3	6.1	6.2	7.2	6.5	6.2	6.07

The discrepancies between the national statistics and the figures collected by CBED will be reviewed and reconciled through this grant process.

(4) Employer-Sponsored Health Insurance

The Center for Health Science also reviewed the Medical Expenditures Panel – Insurance Component (MEPS-IC), a national survey conducted by the Agency for Healthcare Research & Quality which targets households, businesses and governments, to analyze the levels of employer-sponsored health insurance in Tennessee. In 2001, over 58% of private-sector firms offered health insurance benefits to their employees in Tennessee. These benefits generally followed the size of employers: over 96% of employers with 50 or more employees offered health coverage benefits, while only 41% of firms with fewer than 50 employees offered such benefits. Nearly 90% of Tennesseans working in the private sector work for firms who offer these benefits. However, only 20.2% of part-time workers are generally eligible for the benefits, compared to 85.8% of full-time workers. Thus, the analysis found that the size of the company,

and the employee's status of full-time v. part-time were large factors in determining whether an employee would be eligible for and receive health insurance coverage.

C. The Health Insurance Marketplace in Tennessee

Individuals access health care through a variety of options. An individual may have access to a group plan offered at work through a traditional health insurance company, health maintenance organization (HMO) or BlueCross BlueShield of Tennessee (BCBST)[3]. An individual may work for a company that has a self-insured plan authorized under ERISA which is administered by a health insurance company or BCBST. An individual may have coverage through an individual policy purchased from a health insurance carrier, or the individual may belong to a trade or other association that provides health benefits to its members. Only a fraction of these plans – the traditional health insurance company or HMO plans – are regulated and documented by state government. More data is needed to determine the full range of health care plans offered in Tennessee.

(1) State Regulated Plans

The majority of the regulated plans are sold through 12 licensed insurance companies or HMOs. Eight of these companies are domiciled in Tennessee. The dominant market force, however, is BlueCross BlueShield of Tennessee (BCBST), which wrote over 7 times the amount of premiums compared to its nearest competitor.[4] These entities offer literally dozens of plan options including Preferred Provider Organizations (PPO), POS (Point of Service), and HMO group plans, and individual plans.

Tennessee's Small Group Employer Plans and Small Employer Health Reinsurance Pool laws, enacted in 1992, provide access to health benefits to employees of small employers defined as employers with less then 25 employees in the previous year. These laws set caps on premiums and rate increases, and require participating insurers to offer a basic and standard plan in an effort to help small business afford coverage. The plans offered must also be "guaranteed issue and renewable" upon satisfaction of application requirements and premium payments and cannot exclude pre-existing conditions. Insurers are allowed to cede the risks from these plans into a reinsurance pool, which many have done. Unfortunately, many small employers still cannot afford the coverage provided, even at a minimal level.

(2) Self-Insured & Other Plans

The Tennessee Chamber of Commerce & Industry, a statewide association of more than 1,000 businesses, conducted a recent survey and found that of its members who provide health benefits, 48% were self-insured, compared with 52% who provided commercial health insurance. Although no clear data currently exists on the self-insured plans in Tennessee which may be

[3] Technically BCBST is a not-for-profit hospital and medical service corporation, not an insurance carrier. Legislation passed in 2003, however, provides authority to TDCI to regulate BCBST as it regulates other health insurance carriers.

[4] BCBST had approximately $1,445,737,834 in premiums in 2002. The next highest level of premiums was issued by HealthSpring, Inc., a licensed health maintenance organization, which had $197,751,013 in premiums in 2002.

administered by regulated entities, TDCI has informally collected such information from BCBST. According to 2003 data, BCBST covers 660,000 Tennesseans through its insured policies and approximately 980,000 individuals through self-insured plans that it administers for various entities. As an example, through a non-profit organization, Tennessee Rural Health (TRH), Tennessee's Farm Bureau Federation has developed a health coverage plan for individuals that is administered by BCBST. This plan covers close to 160,000 individuals. Since this program is not subject to HIPAA or state mandated benefits laws, the plan is often times affordable, but fails to cover pre-existing conditions. Under state law, this plan is not defined as insurance and TRH is not regulated by TDCI.

Unregulated out-of-state associations are also writing health insurance in Tennessee. State law cannot reach these groups and therefore many times TDCI receives complaints from policyholders such as service industry workers who lost coverage when these associations canceled their group policy. TDCI would like to gather more information on these associations in order to determine if and how these entities could be regulated to protect the interests of policyholders. Overall, in order to get a true picture of health care coverage in the state, more data on the self-insured population and the various plans offered by unregulated entities is needed.

(3) Affordability

In addition to looking at access to insurance, TDCI is greatly concerned with affordability. As the insurance regulator in the State, TDCI has seen the rapid increase of health insurance rates over the past five years. As demonstrated in Table 4 below, *individual* policies, which are becoming more popular due to employers' inability to afford group plans, have seen tremendous rate increases. Most small and large group rates are not filed with the Department.

TABLE 4

YEAR	RATE INCREASE
2003	34.44%
2002	29.73%
2001	27.56%
2000	28.1%
1999	23.7%

While most carriers had an average increase in individual health insurance plan rates in 2003 of just over 34% (including BCBST), BCBST also returned over $67 million to its insured policyholders in Tennessee in October 2003. Other states, such as Pennsylvania, are analyzing the large reserves of its Blues' plans to determine whether such reserves could be utilized for subsidizing the uninsured in the state. Tennessee may wish to explore its options in conducting a review of the reserves of its carriers, in accordance with current statutory requirements.

D. Health Issues Related to Uninsurance

This proposal seeks to obtain additional data from the uninsured related to their key health issues. In terms of existing data, a 2001 TennCare study reviewed the health care benefits obtained when an uninsured person gains access to health insurance coverage. The study, sponsored by the Health Care Financing Administration (HCFA), revealed that TennCare expansion enrollees fared better than their uninsured counterparts in receiving continuity of care. Ninety-two percent (92%) of the TennCare expansion enrollees had a usual place of care, compared with 71% of the uninsured. Also, over 69% visited the same health care provider at the usual place of care, compared with 55% of the uninsured. The uninsured population was twice as likely than the TennCare expansion enrollees to not see a health care provider when needed (63.8% v. 33.6%). Close to 75% of women enrollees received pap smears, compared to 50% of the uninsured; 75% of children received well-child visits compared with 55% of uninsured children. Thus, this study reveals that when access to health insurance coverage is provided, a state can improve the health and well-being of its citizens.[5]

E. Tennessee's Health Care Delivery System

(1) The Providers

Tennessee has a population of 5.7 million. Twenty-five percent of these people live in non-metropolitan areas that are difficult to incorporate with sufficient healthcare facilities. Tennessee has 123 primary Health Professional Shortage Area (HPSA) designations in the state (38 geographic, 27 low-income population, and 58 facility designations) with three more pending approval. Sixty-six percent of Tennessee counties (63 of the 95 counties) have either whole or partial county Primary Care HPSA designations. These areas also see a lack of specialty care facilities, pharmacies, and other integral healthcare services. There are more cases of preventable diseases and high rates of uninsurance in these areas. Overall, the health care delivery system faces many challenges in serving the citizens of this state.

As of May 2004, Tennessee had 161 licensed non-federal hospitals. Seventy-six of these hospitals (approximately 42.7%) are non-profit hospitals. Fifty-one (51) are for-profit hospitals (approximately 31.7%); and 34 are state or locally run hospitals (31.7%). Tennessee currently has 4.4 hospital beds for every 1000 people.

In addition to these state licensed facilities, Tennessee has a total of 22 federally qualified health centers (FQHCs) located at 83 sites across the state. As often the sole provider of sliding fee scale services, Tennessee's FQHCs serve a disproportionate share of the uninsured. The health centers see an estimated 60,000 uninsured users (and 90,200 TennCare users) annually. Nationally, 40% of the patients seen by community health centers are uninsured. For Tennessee, 31% of the community health centers users are uninsured.

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[5] Statistics cited herein were discussed in the *Health Affairs* January/February 2001 edition: "Covering the Uninsured Through TennCare: Does It Make A Difference?"

Over the next five years, Tennessee health centers plan to serve an additional 106,995 individuals with the full range of primary care services. Examples of these proposed services include:

- Expanding into 23 new communities and serving an estimated 79,330 new users;
- Expanding into primary dental and behavioral health services through existing health centers in an effort to reach 40,215 users (an estimated 9,349 users will be new users of health center services); and
- Serving an additional 59,317 uninsured users.

The Nashville/Middle Tennessee area is also widely known as the national hub of the health care industry. Health care companies located in the middle Tennessee area include: American Healthways, AmSurg, Community Health Systems, HCA Inc., LifePoint Hospitals, Renal Care Group, and many others. In 2002, nineteen (19) of these companies were publicly traded and had a combined revenue of close to $35 billion. These companies control over 2,300 sites and facilities nationwide, and either own or manage over half of all investor-owned hospitals in the country.

(2) Tennessee's Health

Tennessee is a relatively "sick" state. In 2003, the United Health Foundation ranked Tennessee 46th in terms of quality of health, due in large part to a high risk of heart disease, cancer, infant mortality rates and smoking prevalence. The study did note on the positive side our relatively low level of uninsured and support for public health care.

A recent study on the well-being of children ranked Tennessee 43rd in the nation. Although the 2004 Kids Count Data Book found that Tennessee was below the national average in four areas, it had improved on six indicators, including child health measures and the child death rate. The study noted that the percentage of Tennessee's children without health insurance was 7% compared to the national average of 12%. The study acknowledged that TennCare was an example of good public policy that contributed to the improvement in the child death rate. These reports reflect the importance of health insurance to the overall well-being of both adults and children in this state.

(3) Impact of the Uninsured on the Health Care System

The health care system is clearly affected by the uninsured, who often use emergency rooms to obtain primary care and lack the preventative care that could curtail more serious illnesses. One measure of the volume of uninsured care that health care providers and facilities are currently absorbing is the amount of charity and medically indigent care.[6] These amounts are included on the Joint Annual Report filings that are required of all short-term, non-federal hospitals. Table 5 reveals the amount of uncompensated care hospitals have absorbed over the past five years.

[6] "Charity care" is defined in the Joint Annual Report glossary as services provided by a hospital to the medically needy for which they do not expect payment due to insufficient assets or income; "medically indigent" care includes those individuals who may not be low income but who have inadequate resources or income to pay medical bills. Department of Health, Division of Health Statistics, Joint Annual Reports 1998 – 2002.

Comprehensive data for other types of health care facilities or professionals was not readily available.

TABLE 5

YEAR	CHARITY CARE	MEDICALLY INDIGENT CARE	TOTAL UNCOMPENSATED CARE	% OF TOTAL REVENUES
1998	$236,716,880	$27,403,274	$264,120,154	4%
1999	$222,835,221	$24,815,782	$247,651,003	3%
2000	$166,024,923	$91,181,040	$257,205,963	3%
2001	$176,717,744	$85,871,018	$262,588,762	3%
2002	$208,304,489	$106,348,621	$314,653,110	3%

While these figures may appear low in comparison to total revenues of the hospitals, it is striking to note that each year, the amount of uncompensated care exceeds the dollar amount of health insurance premiums written by health insurance carriers, except BlueCross BlueShield of Tennessee.

F. Other State and National Activities to Reduce the Uninsured

Over the past several years, due to budgetary constraints, the primary focus on helping the uninsured in Tennessee was the effort to reform and thereby preserve the TennCare program. Governor Bredesen, a former HMO executive, ran on this promise and has delivered by authoring significant TennCare legislative reforms that became law on May 28, 2004. These reforms preserve the eligibility of the 260,000 uninsured and uninsurables on TennCare, and instead deal primarily with limitations on benefits, co-pays and anti-fraud measures. While these reforms are being implemented, now is the time for Tennessee to look beyond its TennCare population to the 600,000 individuals without any health coverage so that we can build upon the successes of other states accomplished through the SPG program.

TDCI has followed the battle over association health plans (AHPs), tort reform and health savings accounts on the national level. We have also attended state risk pool conferences, and researched other state initiatives through this SPG planning process, as well as the State Coverage Initiatives process funded by the Robert Wood Johnson Foundation. Tennessee hopes to compile all of this research, and identify which options will best fit its unique population.

II. Description of Earlier Efforts to Reduce the Number of Uninsured

A. TennCare

As described earlier, Tennessee's efforts to reduce its uninsured have had their greatest recent success through the TennCare program, which began in 1994. On July 1, 1995 TennCare reached 90% of its target capacity and closed enrollment in the uninsured category. On April 1, 1997 children under the age of 18 who did not have access to insurance through a parent or

guardian were allowed to enroll in the uninsured category. TennCare provided coverage for people who had lost access to COBRA and who did not have access to other insurance plans; people who were Medicaid-eligible or who are determined uninsurable by an insurance company for medical reasons; or children under age 19 whose individual family incomes were below 200% of the federal poverty level. In December 1998, TennCare was approved for a three-year waiver extension. On July 1, 2002 the federal government agreed to another five-year agreement with Tennessee that separated TennCare into three sections: TennCare Medicaid, TennCare Standard, and TennCare Assist. As proposed, TennCare Medicaid would provide coverage to those persons eligible for Medicaid; TennCare Standard would provide health coverage with certain benefit limitations, premium payments, and co-pay amounts to those persons who were uninsured as a result of a medical condition, and had no other access to insurance or health benefits, and met certain income limitations; and TennCare Assist would provide financial assistance to persons who were insurable but, based on income information, could not afford the coverage sought. As a result of litigation and state budgetary issues, implementation of these reforms has been stalled.

Currently, TennCare provides health benefits through managed care organizations to the traditional Medicaid population, children in state custody, children under the age of 19 whose family incomes are below 200% of the federal poverty level, the uninsured/uninsurable population that remains from TennCare's early implementation, and prescription drug coverage to persons who are dually eligible for Medicaid and Medicare. Uninsurable persons may qualify only if determined to be medically needy and if they meet Medicaid's income limitations. TennCare is not currently available to uninsurable persons on a basis of availability of insurance alone.

Responding to cost growth in the TennCare Program, Governor Phil Bredesen proposed a broad based TennCare Reform initiative earlier this year. This proposal, which became law in May 2004, seeks to check TennCare's budgetary growth while continuing to make benefits available to the widest population possible. Without those changes, the budget growth for TennCare was projected by the McKinsey Group to take almost 90% of every new dollar in Tennessee's Treasury for the next 4 years. Governor Bredesen proposed to do the following:

1. Enact benefit limitations with differing levels of coverage for various classes of enrollees.
2. Seek to place coverage limitations and co-pays in the non-Medicaid population.
3. Develop coordinated disease management and treatment systems.
4. Institute a dedicated fraud investigative unit for sources of fraud beyond just provider fraud.

Governor Bredesen's proposals were approved overwhelmingly by Tennessee's General Assembly and became effective May 28, 2004. The detailed waiver amendment is being prepared for CMS' approval. These reforms are designed specifically to preserve coverage to the TennCare expansion population.

B. Successes and Problems of Earlier Efforts

Approximately 20% of the total number of people enrolled in TennCare would not be eligible for coverage under the traditional limits of Medicaid. TennCare has been successful in providing health insurance to 260,000 Tennesseans who otherwise would not have access to affordable coverage. Tennessee covers more of its uninsured than any other state through TennCare, and Governor Bredesen is committed to preserving that broad coverage at a time when many other states are pushing thousands of people from their Medicaid programs. In fact, the state with the largest high risk pool, Minnesota, covers only 30,000 individuals. Many other states with high risk pools are only able to cover a fraction of their population. Thus, Tennessee's commitment to the uninsured, which has continued and is evidenced through the priorities of Governor Bredesen, cannot be overstated.

TennCare's implementation problems have included the financial collapse of several managed care organizations (MCOs), a steady exodus of doctors – particularly medical specialists – from the program, challenges via federal court lawsuits, and severe budget constraints. Without significant restructuring of TennCare, by 2008, 91% of every new state budget dollar will be going to fund TennCare. TennCare expenditures make up 33% of the 2004 state budget.

As a result of budgetary limitations, TennCare has been closed since 1995 to those who have become "uninsurable" due to accident or illness. In an effort to determine the need to re-create its catastrophic health insurance plan or other plans that might potentially increase access to health benefits, a bill was passed this year encouraging insurers to develop plans for catastrophic illness that require inpatient hospital care, subject to approval by TDCI. Legislation was also passed to require the state's joint legislative Fiscal Review Committee to review future mandated benefits and to review existing mandated benefits if feasible within existing budget limitations. Legislation passed in 2002 authorized TDCI to survey individuals who have left TennCare due to ineligibility, in an effort to determine whether they have been able to access health coverage in the commercial market. TDCI has received state approval of the survey document and is in the process of hiring a vendor to conduct the survey.

If successful in receiving this grant, Tennessee will be better equipped to build on its earlier commitment to provide insurance to all Tennesseans, which began with TennCare back in 1994. Right now, however, the data is not there to help us understand who is uninsured or uninsurable and why. Only once we have narrowed down and properly defined this group can we craft appropriate solutions for coverage.

III. Project Goals

A. Seven Project Goals

As demonstrated through TennCare and its recent reforms, health care coverage is a top priority for Tennessee. Although Tennessee's uninsured rate is below the national average, skyrocketing health care costs and rate increases will likely cause the number of uninsured to increase over the next several years.

Tennessee proposes the following seven goals to help achieve health insurance coverage for all Tennesseans.

1. Establish a Project Management Team (PMT) and define the guiding principles for the Project.
2. Convene the Health Insurance Workgroup (HIW).
3. Review existing data on:
   a. The uninsured in Tennessee;
   b. The types of health coverage plans offered by employers in-state; and
   c. The financial condition of the existing market participants.
4. Collect new data through household surveys, employer surveys and focus groups, market participant surveys, and health care provider focus groups.
5. Develop a menu of options to provide access to affordable health insurance for all Tennesseans.
6. Conduct a public review of a list of preferred options.
7. Prepare final reports summarizing the outcomes of earlier research.

The above stated goals support the SPG Program goal of "encouraging States to provide access to affordable health insurance coverage to all citizens." Since 1994, Tennessee has committed itself to providing such coverage. By allowing the state to review and gather new data, we will be better suited to develop the appropriate tools to provide affordable coverage statewide. TDCI proposes to focus on the private market and the 614,443 individuals who currently do not have access in this proposal. To this end, we think that the household and employer surveys will be key in better defining who has insurance and from what source. We also need to understand which employers are providing benefits, and what level of contributions are required from employees. TDCI is aware that many employers are dropping coverage due to increasing rates, but we have not seen data pinpointing which employers are dropping coverage, if their coverage is self-insured or insured, and what options they believe would allow them to continue coverage (i.e. would a "bare bones" plan encourage them to continue these benefits, or would their employees rather have comprehensive coverage with different levels of co-pays and deductibles). TDCI is also aware that the public is not always appropriately informed of their rights to secure insurance under COBRA or HIPAA, and thus may miss the 63-day window and become uninsurable merely due to their gap in insurance coverage.

B. Project Relationship to Healthy People 2010

The Project goals also correspond with the goals and objectives of Healthy People 2010. By providing health care coverage to all uninsured, the health of individuals will be improved, thus meeting the goal of increasing life expectancy and quality of life. Right now, access to health care varies widely generally based on income level, education, and employment status. By providing coverage to all uninsured, the Project will meet the second goal of eliminating health disparities because everyone, regardless of status, will now have access to health care. By understanding the health needs of the uninsured and devising programs to provide health care coverage, we will also meet the primary and first objective of Healthy People 2010 which is access to quality health services. As demonstrated in the *Health Affairs* TennCare article cited

earlier, once people obtain health care coverage (traditional insurance policy or self-insured plan), their continuity of care improves. Providing coverage to all uninsured also specifically meets one of the leading health indicators of Healthy People – access to quality health care. Once the health needs of the uninsured are properly identified, additional health indicators and objectives of Healthy People will likely be met, although we are unable to adequately identify those objectives until the data collection and analysis is completed.

IV. Project Description

A. Data Collection

TDCI proposes to review and collect data from four different groups: households; employers; health care providers; and health care coverage entities such as insurance companies or associations (referred to herein as market participants).

(1) Household Surveys

This Project proposes to review the existing household surveys (CPS and BRFSS) and to compile a revised survey instrument that will give us a true picture of the uninsured in Tennessee. The Project plans to contract with Arkansas in order to utilize the Multi-State Integrated Database (MSID) for a review of existing data. Both the Project Director and the Research Analyst will be trained on this database and will work closely with the vendor, Center for Health Services Research (CHSR) at the University of Tennessee in Memphis to access and query this database as part of the review of existing information. A more detailed narrative of this portion of the Project is contained in Appendix B. Budgetary line items are further described in the budget narrative beginning on page A-1. Tennessee understands that payment will be made directly to the Arkansas Center for Health Improvement (ACHI) if this grant is awarded.

For the collection of new household data, TDCI proposes to utilize the Center for Health Services Research at the University of Tennessee in Memphis (CHSR), in conjunction with the State Health Access Data Assistance Center (SHADAC). CHSR staff has already conducted initial analyses on the uninsured in this state, and worked with SHADAC on other projects. As demonstrated in the narrative below and the biographical sketches in Appendix A, the staff at CHSR are truly the leading health experts in this state and the region. Building on examples of previous state successes, CHSR will work closely with SHADAC to prepare a modified Comprehensive State Coverage Survey (CSCS) tailored to meet the unique needs of this state. CHSR will conduct the survey and consult with SHADAC as needed on sample size and related issues. The revised CSCS survey will also, for the first time, focus on the health needs of the uninsured. TDCI defers to the expertise of the vendor as to the scope of the survey but will ensure that the survey focuses on the uninsured (outside of TennCare expansion population), and that the sample is statistically valid and representative of the three grand divisions of the state (referred to as Middle, East and West Tennessee) and conducted in such a way that statistically relevant comparisons can be made between rural and urban populations. CHSR will utilize the expertise of SHADAC as needed in preparation of the reports summarizing the data.

In addition, CHSR is currently involved in a consortium of academic, business and government groups focusing on the health of the Lower Mississippi Delta. As part of that project, CHSR and other consortium members will be collecting data through focus group and surveys in an effort to assess the value of "health as an economic engine" in the Delta region, which includes Memphis, the area in Tennessee with the highest rate of uninsurance. Other members in the consortium, which is funded in part by grants from the Agency for Healthcare Research and Quality, Department of Health and Human Services, include the Methodist-LeBonheur Center for Health Economics at the University of Memphis and the Department of International and Population Health at Harvard University School of Public Health. This data, in conjunction with the data sought under this Project, will further enhance the state's understanding of the health needs of the uninsured.

(2) Employer Data

Employer data currently exists through the Medical Expenditure Panel Study – Insurance Component (MEPS-IC). This information has not been analyzed on an ongoing basis. The Project, thru its vendor the Center for Business and Economic Development at the University of Tennessee in Knoxville (CBED), will first look at the MEPS-IC existing data and determine what data gaps exist and what information is needed to paint an accurate picture of what health benefits are offered by employers, to which groups of employees, and at what cost to those employees.

Over ten years ago, the Tennessee Department of Labor & Workforce Development (then named the Department of Employment Security), performed a statewide survey of employers that asked respondents for information on health insurance. No recent survey has been performed since that time, and the prior data has been viewed as highly unreliable. Recognizing, however, that employer surveys are extremely difficult to perform, TDCI proposes to work with its local experts from CBED to determine whether a written survey, focus groups or a combination thereof would best accomplish the task of obtaining relevant data from employers on health benefits. CBED will design the appropriate tools for securing this information and also ensure that the tool reflects the range of businesses across the state by industry type, size and geographic location. CBED will consult with SHADAC as needed on the employer survey/focus groups. CBED is a highly regarded institution and has worked with state policymakers on a wide range of issues including the TennCare program, state tax structure and welfare policy. For additional information on the key personnel from CBED who will be involved in the Project, see Appendix A.

(3) Market Participants

The third prong of the proposed data collection, which Tennessee believes has not been replicated in earlier SPG grants, centers on the financial status of the health insurance market. The goal of this Project is not only to provide access to insurance, which admittedly exists in many states if you have sufficient resources. The goal is to provide <u>affordable</u> access to health coverage or insurance to everyone. Thus, a review of the companies who currently provide insurance or other health care coverage, the rates they charge, and their financial health is essential to this Project. TDCI proposes to use the Rhode Island annual report "The Health of

RI's Health Insurers" as a model for the deliverable related to this action step. TDCI, with the assistance of CBED, will first review the existing data and prepare a summary of such data, and identify key data gaps. From this report, TDCI and CBED will develop a survey or other tool to access additional data as needed from the market participants and develop a report summarizing the findings.

(4) Health Care Providers

Although we know that the uninsured are accessing health care, we do not know the full impacts to the health care system, or the primary health care services they are accessing. To solicit this information, the Project proposes to conduct focus groups with health care providers across the three grand divisions of the state in both rural and urban areas. These focus groups will discuss and review what the real needs of the uninsured are, and how these needs are or are not being handled today. CHSR will work closely with the Department of Health to identify the type and location of health care providers who should be consulted in these focus groups. A final report will be prepared by CHSR summarizing the results.

B. Coverage Options

TDCI proposes to look at a wide menu of options, including but not limited to:

i. the need to develop alternative risk pools;
ii. changes in rate regulation;
iii. changes in state mandated benefits;
iv. review and use of reserves from regulated entities to subsidize the uninsured;
v. tax incentives for employers to provide coverage;
vi. tax incentives for individuals to carry coverage;
vii. cost containment; and
viii. relief for health care institutions currently absorbing uncompensated care.

Due to pending TennCare's tight budgetary constraints, the focus of this grant will be on options outside of the state Medicaid program.

C. Project Management Plan – see attached

PROJECT MANAGEMENT PLAN

TASK #1: ESTABLISH PROJECT MANAGEMENT TEAM AND GUIDING PRINCIPLES FOR PROJECT					
✓		*Timetable*	*Responsible Agency or Person*	*Anticipated Results*	*Evaluation /Measurement*
	Action Step #1: Establish Project Management Team (Project Director, Research Analyst, Administrative Services Assistant and TDCI employees)	Summer, 2004	TDCI	Commissioner of TDCI to identify appropriate personnel to work with Project Director	Membership to be filled prior to September 1, 2004
	Action Step #2: Hire Project Director, Research Analyst, and Administrative Services Assistant	September-October, 2004	PMT	Identify and interview qualified candidates	Positions to be filled by October 1, 2004
	Action Step #3: Establish guiding principles for Project	September-October, 2004	PMT	Guiding principles to be focus of first PMT meeting	Written document
	Action Step #4: Establish regular biweekly meeting schedule	September, 2004	PMT	PD to prepare weekly agendas, monitor progress of Project	Meeting schedule to be published on website; 1st meeting to be held by 9/15/04
TASK #2: CONVENE HEALTH INSURANCE WORKGROUP					
	Action Step #1: Designate appropriate individuals from TDCI, TDOH, TCCY, TLWFD, TMHDD, MR, TC to serve on HIW	September 15, 2004	PMT	PMT to work with each Commissioners to appoint appropriate individuals	Membership to be finalized by September 15, 2004
	Action Step #2: Establish regular	October 1, 2004	Project Director	Project Director to prepare	Schedule to be published on

	monthly meeting schedule			monthly agendas	website; 1st meeting to be held by 10/1/04
	Action Step #3: Divide into subcommittees (to include industry and stakeholder representatives)	November 15, 2004	HIW	HIW to discuss and establish subcommittees at first meeting	Subcommittees to set up meeting schedule and written goals
	Action Step #4: Develop and implement public outreach plan	Plan to be developed by December 15, 2004; ongoing efforts	HIW and PMT to develop; PD to lead public outreach efforts	HIW and PMT members to attend various public forums and town hall meetings	Periodic updates from HIW to post on website
TASK #3: REVIEW EXISTING DATA DOCUMENTING TENNESSEE'S UNINSURED, THE VARIOUS TYPES OF HEALTH INSURANCE CURRENTLY OFFERED IN THE STATE, AND THE FINANCIAL CONDITION OF THE EXISTING MARKET PARTICIPANTS					
	Action Step #1: Contract with UT-CHSR to review existing household survey data by tapping into Arkansas Multi-State Integrated Database (MSID)	November 15, 2004	CHSR	CHSR and PMT to designate individuals to be trained for access to MSID; CHSR to review existing data, and identify data gaps for future survey	Summary report to be prepared by CHSR for PMT and HIW review
	Action Step #2: Contract with UT - CBED to review existing employer survey data (including MEPS-IC)	November 15, 2004	CBED	CBED to review existing data, and identify data gaps	Summary report to be prepared by CBED for PMT and HIW review
	Action Step #3: Prepare report summarizing the top market participants and their financial health	October 15, 2004	TDCI/CBED	TDCI/CBED to review existing data, and identify data gaps	Summary report to be prepared by TDCI and CBED for PMT and HIW review

	Action Step #4: Development of summary of options selected by other states to cover uninsured	April 15, 2005	PD w/ PMT and assistance as needed from CHSR/CBED	PD to select options based from other states, based upon information obtained from surveys	PD to prepare summary of options for coverage
TASK #4: COLLECT NEW DATA ON THE UNINSURED, THE TYPES OF HEALTH COVERAGE OFFERED BY EMPLOYERS, THE FINANCIAL CONDITION OF MARKET PARTICIPANTS, AND IMPACTS TO HEALTH CARE SYSTEM					
	Action Step #1: Contract with SHADAC and UT-CHSR to modify CSCS for Tennessee	December 1, 2004	SHADAC and CHSR	Questions to be added/deleted from existing CSCS	Modified CSCS instrument
	Action Step #2: Conduct modified household CSCS survey	February 15, 2004	CHSR w/ assistance from SHADAC	Telephone surveys	Written report summarizing findings (with assistance from SHADAC)
	Action Step #3: Develop and conduct revised employer based survey and/or focus groups	March 15, 2005	CBED w/ assistance from SHADAC	Written employer surveys, and/or focus groups	Prepare written report summarizing all types of employer-sponsored health insurance coverage currently in TN
	Action Step #4: Develop and conduct revised market participant survey	Surveys conducted November-December, 2004; final report by February 15, 2004	TDCI/CBED	Written market participant survey	Written report on the various types of health insurance coverage in TN, the health of these providers, and other financial trends (rates, reserves, profits, etc.)
	Action Step #5: Hold focus groups with health care providers	Completed by March 15, 2004	CHSR	Focus groups to be held at various	Summary presentation of findings to PMT

				locations throughout 3 regions of TN	and HIW
	Action Step #6: Provide household survey data to Multi-State Integrated Database	Upon completion	CHSR	Download data	CHSR to transmit data to ACHI for inclusion in national database
TASK #5: DEVELOP MENU OF OPTIONS TO PROVIDE ACCESS TO AFFORDABLE HEALTH INSURANCE OR COVERAGE FOR ALL TENNESSEANS					
	Action Step #1: HIW to review reports on surveys and focus group findings	April 1, 2005	HIW	PMT to provide reports, seek assistance from CBED and CHSR as needed	Review at April meeting
	Action Step #2: HIW to review policy options summary from PD	May 1, 2005	HIW	PMT to provide summaries	Review of May meeting
	Action Step #3: HIW to develop list of Preferred Options	June 1, 2005	HIW	PD to provide summary of options	Discussion at June meeting; PD to prepare summary document of Preferred Options
TASK #6: PUBLIC REVIEW OF PREFERRED OPTIONS					
	Action Step #1: Launch statewide media efforts	Summer, 2005	PD	Print, video and radio coverage	Development of PSAs, print and video news coverage
	Action Step #2: Statewide town hall meetings	Summer, 2005	PD	PD to hold meetings in 3 grand divisions with public to solicit comments on options	Summary of comments from meetings to be posted on website
	Action Step #3: Meetings with key stakeholders	Summer, 2005	PD	PMT meetings with identified stakeholder	Summary of comments from stakeholders to

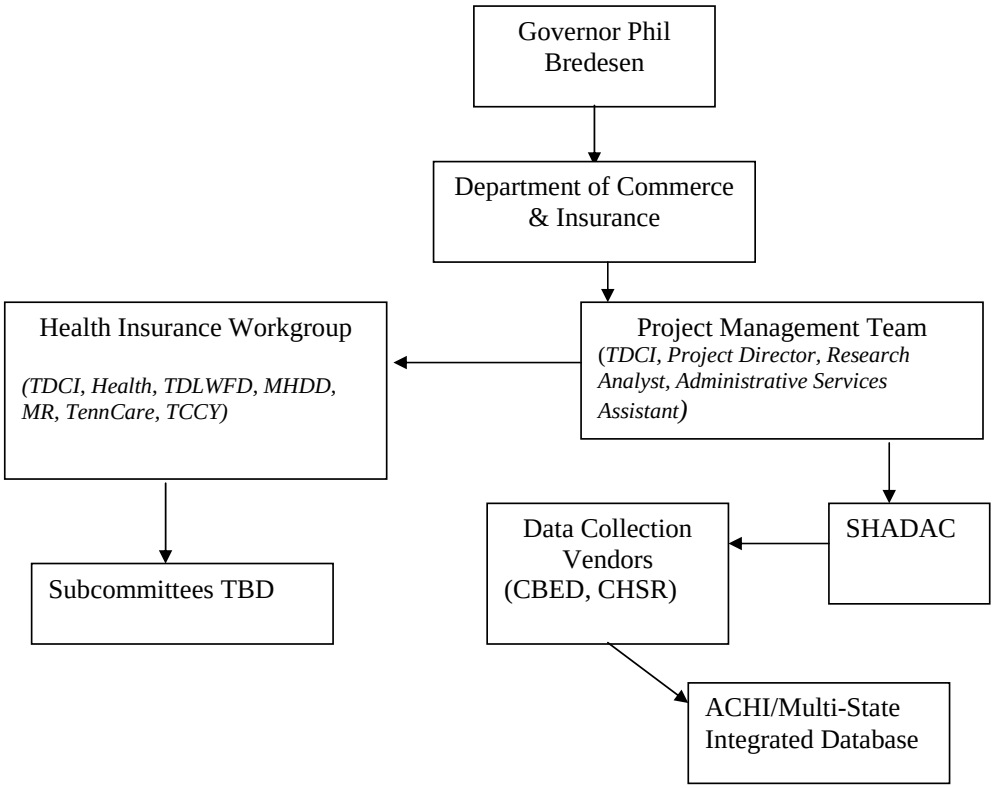
				groups – seek assistance from CBED, CHSR as needed	be posted on website
	Action Step #4: Meetings with state officials	Summer, 2005	PMT	PMT to meet with officials, discuss any needed legislation	Summary of discussions, recommendations from officials to be posted on website
TASK #7: PREPARATION OF FINAL REPORTS					
	Action Step #1: Preparation of report to General Assembly (required under PC 675)	March 15, 2005	PD/PMT	Interim report on progress as of 3/15/05	Written report to be prepared for General Assembly, published on website
	Action Step #2: Development of multi-year Strategic Plan for providing access to affordable health insurance to all Tennesseans	August 15, 2005	PMT	PD to serve as primary author with oversight from PMT	Final written strategic plan to be published on website and circulated to stakeholders
	Action Step #3: Preparation of final HRSA report	30 days after grant cycle	PD w/ assistance from SHADAC	PD to serve as primary author with oversight from PMT	Final written report to be published on website

LEGEND:

CBED	Center for Business and Economic Development, University of Tennessee in Knoxville
CHSR	Center for Health Services Research, University of Tennessee in Memphis
TDCI	Tennessee Department of Commerce & Insurance
TDOH	Tennessee Department of Health
HIW	Health Insurance Workgroup
TLWFD	Tennessee Department of Labor & Workforce Development
TMHDD	Tennessee Department of Mental Health and Developmental Disabilities
TMRD	Mental Retardation Division, Tennessee Department of Finance & Administration
PD	Project Director
PMT	Project Management Team
RA	Research Analyst
TC	TennCare Bureau, Tennessee Department of Finance & Administration
TCCY	Tennessee Commission on Children and Youth

D. Governance

TDCI is the lead agency for this proposal and will house the Project Director, Research Analyst and Administrative Support staff for this Project. The Project Director will be responsible for the day-to-day management of the Project and will work with the Project Management Team on a daily basis to track the progress of the seven goals of the Project. The following chart represents the overall governing structure of the proposal:



For a detailed description of Project Personnel please see Appendix A.

TDCI is ready to launch this Project as soon as a decision is made by HRSA to approve this application. TDCI has proposed forming the Project Management Team and identifying candidates for the Project Director over the summer of 2004, so that the Project will be able to embark immediately upon receipt of the grant funds. Due to its status as a state agency, TDCI's contracts with outside sources will be subject to the state procurement process. TDCI believes that due to the need to access experts in the field and work within the grant timeframe that it will be able to receive approval to execute sole source, non-competitively bid contracts with CBED, CHSR, ACHI and SHADAC. Tennessee has proposed contributing its data to the Multi-State Integrated Database and any other appropriate national database. Tennessee is committed to work with the Federal Project staff and other State Planning Grant Program grantees as requested.

V. Grant Monitoring Plan and Report to the Department

Tennessee has developed a detailed Project Management Plan that contains 7 goals and 28 action steps designed to meet the 12-month timetable for this grant award. This Project Management Plan will drive all aspects of the Project, including the meeting agendas and task assignments for the PMT and HIW. The PMT will monitor the progress on attaining these seven goals and evaluate how the Project is functioning at least on a monthly basis. If the Project Director feels a given task may not be accomplished by a certain deadline, immediate assistance will be brought in by TDCI.

The final goal is the preparation of three reports. First, an initial report must be made to the Tennessee General Assembly on the study required under Public Chapter 675 by March 15, 2004.[7] TDCI has already contacted the sponsor of this legislation, Senator Mark Norris of Memphis, who has acknowledged that additional data and reports will be made at the end of the grant period and that any report on March 15, 2005 may be interim, with the date subject to change if necessary during the next legislative session. The second report is the development of a multi-year strategic plan that will include a timetable for implementing the preferred options. The last report is the final report to HRSA. Tennessee will follow the revised guidelines for this report and submit the report as required by HRSA. The Project Director will pull together the necessary data for the HRSA report and consult with SHADAC as needed. Tennessee remains committed to participating in the SPG effort and will provide any additional data requested to HRSA or other entities as needed. Tennessee will also comply with all administrative requirements outlined in 45 CFR Part 92, as appropriate.

VI. Decision-making Process

Tennessee proposes that the HIW, which will be making the final recommendations along with the PMT, work on a consensus building model. As the list of preferred options is developed, the

[7] Public Chapter 675 requires TDCI to study the feasibility of implementing risk pools, and why individuals are unable to obtain insurance in the commercial market. PC 675 was a bipartisan effort and was signed by Governor Bredesen on May 18, 2004.

Project Director will embark on a statewide tour to provide the public and state and local officials with the options identified to best address the problem of the uninsured in Tennessee.

Public and private support will be needed to implement any options identified by the Project Management Team. To this end, the PMT will work closely with the private sector – particularly the health insurance carriers, the health care providers, and employers who will be involved with the Project through the surveys and focus groups. Private groups will be included in the HIW subcommittee process, the data collection, and the public outreach efforts. The Project will also coordinate very closely with state officials, including the Governor's Policy Office and legislative leadership.

VII. Public Outreach

A comprehensive public outreach plan will be developed by the PMT and HIW by December 15, 2004. The Project Director will be in charge of overseeing the implementation of this plan. The Project Director and Research Analyst will immediately design a website and provide daily updates of Project activities. Once the coverage options are defined, the Project Director will bring the options to venues across the state to solicit public comments. This plan will include public town hall meetings across the state, and meetings with key stakeholder groups to discuss the preferred options. Members of the HIW will also discuss the Project and preferred options with their respective regulated and advocacy groups throughout the grant year. A comprehensive media strategy will be devised to inform and educate the public on health insurance issues and proposed solutions. Further details of the plan are to be fleshed out by the Project Management Team and Health Insurance Workgroup, with leadership provided by the Project Director.

APPENDIX A

Project Management Team

Tennessee Department of Commerce & Insurance - TDCI

Commissioner Paula A. Flowers

Commissioner Flowers will provide leadership to the entire Project and report directly to the Governor. Commissioner Flowers was appointed in December, 2002, and has focused on consumer education and awareness at the Department by re-vitalizing the Division of Consumer Affairs, overhauling the department's information systems, and expanding regulatory information available to the public. Commissioner Flowers is responsible for supervising the 600+ employees at the Department, housed within the six divisions including the Insurance Division; the Division of Consumer Affairs; Division of Fire Prevention; Securities; Regulatory Boards (which houses over 20 professional regulatory boards); and TennCare Oversight. Prior to her appointment as Commissioner, Ms. Flowers was a partner and co-founder of the law firm of Farmer & Luna, PLLC in Nashville, Tennessee, where she specialized in insurance, TennCare and litigation issues. Commissioner Flowers holds a bachelors degree in civil engineering from Tennessee Technological University; a masters in civil engineering from McNeese State University, Lake Charles, Louisiana; and a J.D. from the University of Tennessee.

Kristin Coile – Assistant to the Commissioner/Legislative Liaison

Ms. Coile is an attorney who will be the primary contact within TDCI for the Project, and will work closely with the Project Director. Ms. Coile works on policy initiatives in the Commissioner's office, is the representative of the Department before the Tennessee General Assembly, and coordinates closely with the Governor's Legislative and Policy Offices. Ms. Coile will report directly to Commissioner Flowers. Prior to her work at the Department, Ms. Coile was an associate attorney in private practice in a large Nashville-based law firm specializing in regulatory issues. She holds a B.A. from the University of North Carolina-Chapel Hill; a J.D. from the Marshall-Wythe School of Law, College of William & Mary; and an M.S.L. – Masters of Studies in Environmental Law - from Vermont Law School.

Project Director (PD) (To be filled)

Job Description: TDCI proposes to create a temporary full-time state employee position for the Project Director to be housed in TDCI's Nashville office. This position will be executive service and will terminate when the grant period terminates. The Project Director (PD) will be responsible for overseeing the day-to-day activities of the SPG grant program and will report to the Project Management Team. The Project Management Team will begin a search for the PD immediately upon filing of this application.

Five years of professional experience in public policy, administration, health care or related health services will be required. Management skills and the ability to lead a publicly funded, statewide initiative will be key criteria for filling this position. Post-graduate degrees in health services or public policy will be preferred.

Research Analyst (RA) (To be filled)
Job Description: TDCI proposes to provide create a temporary full-time Research Analyst (RA) position, to be housed in TDCI's Nashville office. This position will be executive service and will terminate when the grant period terminates. The RA will assist the vendors in data collection and compilation, conduct any needed data collection for the Project Director, PMT and HIW, and report directly to the Project Director. The RA will also be trained on the Multi-State Integrated Database (MSID), and will be available to train individuals within TDCI for use of the MSID.

Three years of professional experience in conducting research and analyzing statistical data will be required. Degree from an accredited four-year college or university also required, with preference given to specialization in health policy.

Administrative Services Assistant (ASA) (To be filled)
Job Description: TDCI will create a temporary full-time state employee position for the Administrative Services Assistant (ASA). This position will be executive service, and will involve both administrative duties and occasional research to assist the Project Director, Research Analyst and Project Management Team. The ASA will be housed in TDCI's Nashville office and will report directly to the Project Director. The ASA will provide daily assistance to the Project Director and coordinate agendas and meetings of the PMT and HIW.

Three to five years prior administrative, clerical experience required. Degree from an accredited four-year college or university preferred. Prior research experience or work on large, publicly funded statewide initiatives a plus. Organizational and computer skills will be a high priority for this position.

Contractors

Center for Health Services Research – University of Tennessee, Memphis (CHSR)
David M. Mirvis, MD TDCI will contract with CHSR to perform data collection and analysis. This contract will be non-competitive and based upon the specialized expertise of the Center, and therefore subject to approval by the Department of Finance & Administration. Dr. Mirvis is the Director of the Center for Health Services Research at CHSR, an intercollegiate center to promote health services and policy research and education, and has a long and distinguished career in medicine, health administration, and health policy. He has published extensively on national, state, and local health policy and currently serves as Program Director for the Health Policy Program in CHSR's Health Administration Ph.D. program. Dr. Mirvis also serves as Executive Director of the Tennessee State Forums Partnership, one of eight members of the Robert Wood Johnson Foundation's State Forum Partnership Program, which develops health-related public policy through a nonpartisan analysis, education and dialogue organized through forums on critical state and regional health care topics.

Dr. Mirvis received his M.D. from the Albert Einstein College of Medicine, Yeshiva University. He completed his residency in internal medicine and a fellowship in cardiology at the University of Tennessee, Memphis. He was a research fellow in cardiovascular physiology at the National

Institutes of Health and has completed continuing professional education courses in leadership and health policy at Harvard University, School of Public Health and John F. Kennedy School of Government.

Teresa Waters Dr. Waters is a Ph.D.-trained health economist with extensive experience managing and analyzing large databases, including the Current Population Survey, the Medical Expenditure Panel Survey, and the Behavioral Risk Factor Surveillance Survey. She has also worked extensively with health care claims data and hospital discharge datasets. Her research has focused heavily on Medicaid and uninsured populations and the providers who serve them. She currently serves as the Associate Director for Research in CHSR's Center for Health Services Research and is on the faculty in Preventive Medicine and Health Services Administration.

Cyril Chang is a Suzanne Downs Palmer Professor in Economics at the Fogelman College of Business and Economics, The University of Memphis where he is also the Director of the Methodist LeBonheur Center for Healthcare Economics. In addition to his primary appointment at The University of Memphis, he holds graduate faculty appointments in two departments at the University of Tennessee Health Science Center, the Department of Preventive Medicine, College of Medicine, and the Department of Community Nursing, College of Nursing. Cyril Chang received his MA in Economics from Memphis State University in 1972 and Ph.D. in Economics from the University of Virginia in 1979. He has written a nursing economics book that won the 2001 American Journal of Nursing Book of the Year Award and published over 100 book chapters and journal articles in health economics, economics of education, and nonprofit organizations. He has received many research grants, chaired or served on 15 Ph.D. dissertation committees, and provided consulting service to health care institutions and funded research projects. His current research focuses on: (1) evaluation of TennCare as a state-initiated health care reform, (2) cost effectiveness of health intervention strategies, and (3) the economics of health prevention.

Bryan Williams Dr. Williams has a Ph.D. in Psychometrics from Pennsylvania State University and is currently an Associate Professor in the Department of Preventive Medicine at CHSR and Director of PROBE, CHSR's survey research lab. Dr. Williams has extensive survey research experience, founding and managing research labs at CHSR and at the University of Arizona during the past 10 years.

Michael Tamuz, PhD Dr. Tamuz is a Ph.D.-trained sociologist with a strong expertise in the area of qualitative research. She has conducted numerous qualitative studies of health care providers and organizations and is currently the Principle Investigator of two federally funded studies examining communication among health care providers and related organizational changes.

State Health Access Data Assistance Center (SHADAC)

*Michael Davern***,** PhD will be the Principal Investigator for the Project. Dr. Davern applies his expertise in federal population surveys to help states translate and use national population survey data for state health policy work. Prior to joining the Center, Dr. Davern worked as a statistician for the United States Census Bureau. During his time at the Census, he conducted evaluations of the methodologies and estimation techniques used in the Census Current Population Survey, the

American Community Survey, and the Survey of Income and Program Participation. Dr. Davern's research interests include social research methodology, quantitative analysis, social networks, economic sociology, labor markets and social stratification. Dr. Davern will provide expert consultation on all aspects of study design and implementation, particularly on developing sampling frames, weighting schemes, and detailed analysis strategy.

*Margaret Brown Good***,** PhD will serve as an Investigator for the Project. Dr. Good's research focuses on disadvantaged populations' access to health care and health insurance. Before coming to SHADAC, Dr. Good was an Assistant Professor in the Department of Public Policy at the University of Maryland, Baltimore County (UMBC) where she taught courses on the Politics of Health, Health Care Issues among Disadvantaged Populations, and a Practicum in Health Services Research. Prior to her graduate training, she worked in the Government and Social Policy Group of a survey research firm in Princeton, New Jersey where she spent three years working on a national evaluation of the impact of the Job Opportunities and Basic Skills (JOBS) program on families receiving welfare. Dr. Good will provide expert consultation services on Project design, research methodology, sample design, data collection, and interpretation of results.

Kelli Johnson, MBA will serve as an Investigator for the Project. Ms. Johnson has over 15 years of experience working in the state health policy arena and has an in-depth knowledge of government structures and political processes. As the Minnesota Deputy Commissioner of Health, Ms. Johnson coordinated health policy activities with the Governor's office, the Minnesota State Legislature, governmental organizations, and the larger Minnesota community. Past experience also includes work for the Minnesota House of Representatives where she participated in the analysis and development of health care legislation and monitored the progress of initiatives through the legislative process. Ms. Johnson will be responsible for managing the staff on the Project and coordinating communication between SHADAC and Tennessee Project staff.

Keith Onken will provide CATI programming assistance on the Project. Mr. Onken is the Director of Programming and Data Management at the Division of Health Services Research Survey Center at the University of Minnesota. Mr. Onken has extensive experience in survey methods, initially trained at the SESRC at Washington State University and later worked for the Institute for Social Research at the University of Michigan prior to taking a position here at the University of Minnesota. Mr. Onken will provide expertise in programming the CSCS into Computer Assisted Telephone Interviewing (CATI.)

Center for Business and Economic Development – University of Tennessee, Knoxville

William Fox, Director Stokely Distinguished Professor, Director and Research Professor of the Center for Business and Economic Research and Professor of Economics—Dr. Fox received his Ph.D. from The Ohio State University. Dr. Fox has held appointments as a Visiting Scholar for the Federal Reserve Bank of Kansas City and as a Visiting Professor at the University of Hawaii. In addition, Dr. Fox has served as a consultant on finance, taxation, and economic development in a number of states and developing countries. Dr. Fox is a member of the American Economics Association and immediate past President of the National Tax Association. Dr. Fox's fields of

specialization include Public Finance and Regional and Urban Economics. He has served as a consultant on tax, finance and economic development for a number of states and developing countries and has been widely published in journals ranging from the *National Tax Journal*, *Public Finance Review*, and the *Journal of State Taxation*. He has worked closely with the state of Tennessee on wide array of projects ranging from state tax structure to welfare policies, and has appeared countless times before select committees of the Tennessee General Assembly.

Bruce Behn, Stokely Distinguished Scholar and Associate Professor of Accountancy—Dr. Behn joined the University of Tennessee faculty in 1994 after completing his doctorate at Arizona State University. He has an MBA from Arizona State University and a bachelors degree from the University of Wisconsin-Madison. Prior to obtaining his Ph.D., Dr. Behn worked for Rockwell International in Uithoorn, The Netherlands as the international financial coordinator for Allen-Bradley Europa B.V., Allen-Bradley Company as controller and financial analyst, and KPMG Peat Marwick as senior auditor. He teaches financial statement analysis and performance management in the Physician, Senior and Professional MBA programs. He also facilitates the Marketplace simulation for the Master of Accountancy Business Core. Dr. Behn has won several teaching awards including AAA's 1999 Innovation in Accounting Education Award and the 2003 TSCPA Educator of the Year. He has served as Co-editor for the Journal of International Accounting Research and Associate Editor for Issues in Accounting Education. He has published widely.

Vickie Cunningham, Research Associate—For more than 17 years has provided support utilizing sophisticated statistical and econometric techniques to analyze economic and demographic data. Administers original data collection efforts. Create relational databases for survey data. Develops survey instruments and manages survey processes. Maintains the quarterly Tennessee Econometric forecasting model and the monthly economic indicator series. Coordinates surveying functions. Serves as web manager for CBER.

Joan Snoderly, Research Associate—For over 17 years has provided support utilizing sophisticated statistical and econometric techniques to analyze economic and demographic data. Administers original data collection efforts. Develops survey instruments and manages survey processes. Maintains the State of Tennessee Employment Security Insurance forecasting model. Maintains State revenue collection database and provides analysis. Provides contract management support.

*Angela Thacker***,** Research Associate—Provides Project management support for the Tennessee Department of Human Services Families First database, working with major panel data sets involving hundreds of thousands of individuals. Provides survey sampling efforts utilizing statistical properties.

APPENDIX B

Goal of Multi-State Integrated Database

As a participating state in the State Planning Grant program funded by HRSA for grant period 2000-2001, the Arkansas State Planning Grant team found a need to have access to existing data in a time frame that was conducive to decision-making policy discussions. In order to address this challenge, the Arkansas team utilized existing technologies to develop methods for incorporating this existing data into a manageable format. The result of these efforts was the development of an Integrated Database as a data extraction tool. This Integrated Database is managed by the staff of the Arkansas Center for Health Improvement (ACHI) the health policy division of the University of Arkansas for Medical Sciences (UAMS) and the Arkansas Department of Health (ADH).

During the 2001-2002 SPG grant period, HRSA funded Arkansas to develop a Multi-State Integrated Database (MSID) in order to provide access and policy development support in utilizing three national datasets to all of the SPG grantee states. The funded activities included development of a web-based, password-protected database, the incorporation of the three national datasets for SPG grantee states (Behavioral Risk Factor Surveillance System, Current Population Survey, County Business Patterns), software licenses, training and technical support, training for states on policy development utilizing the national datasets and incorporation of state-specific surveys conducted during the each state's planning grant activities. This funding was continued by HRSA for the 2002-2003 and 2003-2004 SPG grant periods to allow ongoing access to the database for participating states.

With HRSA's support and funding the Arkansas team was able to develop a Multi-state Integrated Database to provide access to data for funded states. To accomplish this goal, several developmental steps were taken as outlined below:
-Establishment of a State Planning Grant Database Steering Committee. The primary function of this committee is to address issues associated with creating a national data source and develop Project guidelines.
-Acquisition of national data for incorporation into the Multi-state Integrated Database. Construction of the database. This process entailed purchasing the software and hardware components (SQL Server and ProClarity Knosys) to put data into the required format, development of the components to allow web-based and desktop access to datasets and establishment of a URL for web access.
-Development of security measures and password protection for users.
-Development of training protocols and completion of training sessions with participants.
-Establishment of long-term maintenance of the Multi-State Integrated Database based upon end-user needs and utility assessment.

Based upon the response of 1st, 2nd 3rd and 4th Round states, the Arkansas State Planning Grant team is offering the same services to the 5th Round of states (7/03 – 6/04). The following actions must take place to enable 5th Round states to employ the MSID as a component of their activities:

Task 1: Provide each participating state access and user support for use of the Multi-State Integrated Database
Task 2: Facilitate translation of state-specific data into the Multi-State Integrated Database
Tasks & Action Steps for Multi-State Integrated Database

Task 1: Provide access and user support for use of the Multi-State Integrated Database.

Action Step 1a: Provide access to the Multi-State Integrated Database

Three typical types of users use the Multi-State Integrated Database. One is the "author-power user" who has intimate knowledge of the data and who is constructing complicated views to develop answers to earlier or complex questions. This user level is granted authority to publish views provided for the "casual user" (viewer). A second is the "power user" who has all of the functionality of the "author-power user" but cannot publish views. The remaining is the more "casual user" who is typically starting with a previously saved view of the data, and who is then performing some rudimentary real-time changes. The former groups are best served by the desktop version of the software as it carries the full feature set; however the causal user can be overwhelmed with this software and the more guided approach of the web version is often more successful. (Make same changes as on other documents)

To implement the Multi-State Integrated Database, both solutions will be provided. The central web version requires no installation or setup at the site using the software because it will be installed, configured, and maintained at the host site - Arkansas. Users will simply navigate to a given web site, enter their username and password and will immediately be able to begin viewing data. In addition, each participating SPG state will also receive 2 licenses for the desktop software. This software will connect to the data cubes in Arkansas via the Internet and data can either be viewed or copied to the laptop for use at a later time. In both scenarios, connection to the central Multi-State Integrated Database will be via the Internet; however, when the desktop version of the software is being used, the data may be retrieved and stored for later "off-line" use (e.g. a laptop or desktop).

Regardless of the access method employed by the state, security to the data will be established at three separate points employing Microsoft Windows 2000 challenge/response technology and PKI encryption standards. At the first security checkpoint, access to the data in the Microsoft SQL server will be defined by each user at the table, view, and column level. Second, access to the data cubes will be controlled in Microsoft Analysis Services at the cube and data-element level, thus allowing one user to see different sets of variables as contrasted with another user of the same data cube. Finally, access to the data via the Internet can be controlled using the security features of the Knosys ProClarity product. Usernames and passwords will be established to allow access to the main host web site, and each user can be granted individual access to specific data cubes or data views. Each user will also receive dedicated server drive storage capability to save views they develop. Users can select to share access or not to this storage area, which they can choose to share with others or keep private. The SPG Principal Investigator for each state or a designee will be responsible for identifying who is allowed access to their state's information.

Each state will identify approved end-users and submit requests for personal user identification and account establishment to the Multi-State Integrated Database Project Team. Appropriate security precautions and password protection will be incorporated as described above. After

establishment of necessary safeguards by MSID staff, end users will be able to access the Multi-State Integrated Database through various mechanisms. By using the web-enabled version of the ProClarity software, state approved users of the data will be able to access pertinent data over the Internet utilizing a web-browser (Microsoft Explorer). In addition, at each state's option, two dedicated computers at each stated will be licensed with ProClarity software. Through these two site-licenses, the states will be able to download versions of their datasets and have local and/or portable assessments using the database.

Action Step 1b: Provide user support and training

The Arkansas SPG team will provide training and user support to all participating states via a user's conference and web-based training sessions. These conferences will be scheduled at the convenience of the participating states and the Arkansas MSID team. Individual training sessions via the web and teleconferences will also be available to any of the participating states. The Arkansas team will provide user support to all participants in regards to the application use, the web-site management and any hardware/software issues that may arise.

Task 2: Facilitate translation of state-specific data into the Integrated Database

Action Step 2a: Communicate translation process to participating states

The Arkansas SPG team Survey/Data Analyst will contact an identified state survey/analytical team member to collect information regarding the data set to be included into the database. The Arkansas analyst will instruct the state contact on the translation process in order to facilitate the data's inclusion into the database. The state will send the Arkansas team a copy of the state specific survey and codebook in order to select the variables for inclusion into the MSID. These variables must then be prepared to enter the translation process. Issues of continuous, categorical and derived variables will be addressed as well as any other possible complications or issues that arise.

Action Step 2b: Implementation of Access data form

Once all of the variables have been chosen and prepared, the Arkansas team will send an Access data form to the participating state. All pre-selected variables will be entered by the state into this form. Employment of this Access form will ensure that all formatting and variable issues have been addressed as well as to create a translation file and codebook required to continue the data translation process. After the variables have been entered into the data form, the state will generate a codebook, review the file to ensure accuracy then send the file to the Arkansas team for review. Upon their of the state submitted file approval, Arkansas MSID staff will instruct the participating state to transmit their raw data. When received, the raw data will be reviewed and compared to the translation file and codebook. After all of the quality checks have been performed the cube building process will be initiated.

Action Step 2c: Build data cubes

The Arkansas SPG team will develop the datasets to be incorporated onto the website. The raw data, with data dictionary, will be imported into the Microsoft SQL Server using Data Transformation Services. Once data loading is complete, data cubes can then be constructed in Microsoft Analysis Services. In contrast, in a more traditional data repository environment, database analysts would have to write individual data queries to view, sum, average, or manipulate data in the SQL database. However, the placement of the data in an OLAP data cube uses sophisticated algorithms and storage techniques to pre-calculate all possible iterations,

combinations, and permutations of the selected data sources and save these in an optimized pattern for data retrieval.

Each data cube can be constructed using data from one table or any combination of data tables that exist in the database. Typically one cube is constructed for each dataset, with additional cubes being constructed if smaller subsets of data are required. This approach is typical with datasets such as CPS, where the user has more than 900 data fields from which to choose.

The cube will be constructed by choosing the data elements that can be later searched upon, grouped together, or included in the columns or rows of a result set. In addition, numeric values can be selected as the data points for the cube, and these tend to be items such as number of respondents, number of children in household, or poverty level. These values can also be calculated and can include mathematical functions such as averages, mean, standard deviation, etc. Experience has shown that the data cubes are often adjusted in the early stages of development when practical use of the data suggests improvements or optimizations of the data. While the basic constructs of the cube can be achieved using a typical Microsoft "drag and drop" interface, the more complicated functionality must be built using a specialized data query language called MDX.

Once the cube design has been established, the data cubes will be generated and the resulting files saved on the Arkansas server. These data cubes may be reprocessed at any time, and a process of pre-scheduled updates can be implemented. . Regeneration of the data cubes is only necessary when data or the cube designs are changed.

The completion of the processes above will result in a number of data cubes being generated. Once this is completed, the Knoysys ProClarity software will be used to view the data and provide the user with all the functionality needed to analyze and mine their data.

Action Step 2d: *Perform data quality checks and release data to states*

Once the data cubes have been completed the Arkansas SPG team will perform data quality checks prior to releasing the data to the participating state. By executing data runs in the Multi-state Integrated Database and a statistical program using the raw data, the Arkansas team will confirm accuracy of the data in the MSID. When the quality checks have been completed, the Arkansas team will contact the state's Principal Investigator or designee to review the database and perform combined data integrity checks. Based on availability of Arkansas staff, additional training can be scheduled with states requiring assistance in use of their datasets. The same security measures will apply to the state specific data sets.