

Section 1: Current Status of Health Care Insurance Coverage

1.1 Describe access to health insurance coverage

A major challenge for the government of the US Virgin Islands (USVI) is assuring access to an array of public and private health insurance plans for its citizens. As described below, access to health insurance depends upon a number of factors: place of residence, family income level, the business sector of employment; the size, industry and wage level of the firm; and the income criterion for public medical assistance. Other factors which affect access to health insurance include the geographic location of the territory, distribution of health resources, population demographics, the size of the insurance market, and general economic trends.

The Virgin Islands is an unincorporated territory of the United States (US) located 1,075 miles ESE of Miami and 90 miles E of Puerto Rico, consisting of a series of 68 islands and cays comprising an area about twice the size of Washington, D.C. Three of the islands are of economic and political importance: St. Croix (largest land mass) and St. Thomas (the capitol), separated north and south by 40 miles of deep-ocean; and the smaller island of St. John, which lies just east of St. Thomas. The remaining 65 islands and cays are mostly uninhabited. Air and sea transportation link the major islands with each other and with the US. Persons born or naturalized in the territory enjoy US citizenship and can participate in the local electoral process. A non-voting Delegate to Congress is elected; but islanders are unable to participate in US presidential elections.

There were 108,612 persons enumerated in the US Virgin Islands 2000 Census: 53,234 (49%) persons on St. Croix; 51,181 (47%) persons on St. Thomas; and 4,197 (4%) persons on St. John. Nearly 1 in 3 residents are under the age of 18. Females are 52% of the population. By race, the population is predominately Black or African American (78.3%); ethnically, 14% Hispanic, of any race.

Access to health insurance in the territory is divided among three categories of providers: a government insurance program for its workers; coverage through various entitlement programs, including local and other Federal grant programs; and private insurance that is predominantly employer-sponsored.

The US Virgin Islands government is the largest single employer in the territory and contracts for the provision of comprehensive coverage for approximately 13,000 employees and retirees on a cost-sharing basis. Employees may opt out of the program with evidence of coverage elsewhere. Government employee coverage for dependents is optional and also includes a cost-sharing requirement.

The private sector provides approximately 30,000 jobs, with the majority in the retail trade and service industries, where low wages are common. The driver of these two industries is tourism, which has been in a prolonged slump until

recently. Many of the workers in these two sectors experience typical seasonal lay-offs as part of the annual fluctuation in tourist arrivals, and thus often lose their benefits. New higher-wage companies in the fields of finance and telecommunications have entered the territory and usually offer more attractive health insurance benefits.

A recent report from the local Bureau of Labor Statistics (BLS) indicates that there are 3,243 private sector employers. Stratification by size of firm indicates that 42% of the firms only had 1 to 4 employees; 15% employed 5 to 9 individuals. Fewer than 3% of firms employed more than 100 persons; 21% reported no employees. Data from 1994 showed that 52% of employers offered health care coverage. Many commercial insurance providers in the US Virgin Islands do not offer group coverage to firms with fewer than 6 employees.

Medicaid and Medicare are the two major public programs providing coverage to residents. In 2000, Medicare beneficiaries who had both part A and Part B coverage numbered 9,111. There were 9,117 (8.4%) persons age 65 and older living in the territory, according to the 2000 Census.

In FY 2000, there were 18,385 residents eligible for the local Medicaid Medical Assistance Program (MAP). Restricted from the program are persons age 22-64 who are not disabled and who have no dependent children. A means-test criterion in MAP restricts eligibility to those whose income does not exceed \$7,500 for a family of three. In 2002, an income of \$27,476 per year places a family of 3 at 200% of poverty. Data reported in the recent Census shows that 34,931 (32.5%) residents live in poverty in the territory. This includes 14,103 children (41.7%) under the age of 18. In the last decade, the measured level of poverty in the Virgin Islands rose to 32.5% from 27.1% which means that the level of poverty in the territory is now triple that of the mainland.

1.2 Describe the current rate of uninsurance

There are two territorial surveys on insurance coverage that have associated statistical methodologies. The USVI does not participate in national insurance surveys, such as the Medical Expenditure Panel Survey (MEPS) or the Current Population Survey (CPS). Findings from the 1997 VI Consumer Expenditure Survey, conducted by the Eastern Caribbean Center at the University of the Virgin Islands, indicated that 65% (17,723) of 27,229 households had health insurance for one or more persons in the dwelling; 35% of the households had no health insurance. In the households that had health insurance, 96.4% of the coverage was through a private carrier.

The 1999 VI Behavioral Risk Factor Surveillance System (VIBRFSS), funded by the Centers for Disease Control and Prevention (CDC,) provides the only continuous trend information for estimates of uninsurance among individuals in the territory. The VIBRFS reported percentage of "no health insurance" among

individuals ranged from 37.0% in 1989 to 38.0% in 1999. The lowest estimate was 29.0%, reported in 1994. Assuming that 38% of the territory is uninsured, then the percentage of the territory that is uninsured is 40% higher than New Mexico (27.3%) and more than 2.6 times the national average of 14%. Based on the Kaiser Commission on Medicaid and the Uninsured 2000 Chartbook, New Mexico has the highest rate of uninsured citizens among the 50 states, so the territory's rate is far greater than that of any state.

1.3 Describe the characteristics of the uninsured

As is typified in other studies describing characteristics of the uninsured, similar patterns appear to prevail in the US Virgin Islands. According to the VIBRFSS data, persons without health insurance are predominately Black or Hispanic females, with less than a high school degree, heading households with dependent children; possibly working part-time, but have incomes that exceed the MAP threshold. The family has a greater likelihood of residing on St. Croix, which has a higher rate of poverty than St. Thomas. While definitive statistics are not available, it is estimated that at least 11,000 children in the territory are not covered by some form of health insurance.

A second group of persons most likely without health insurance may be either male or female of any race or ethnic group, over the age of 18, probably working in the private sector, but at a business that has 10 or fewer employees. These persons may be working less than full-time at a tourist-oriented businesses, but whose income does not support maintaining health insurance throughout the year. Young persons who enter the workforce and earn low wages may also elect not to accept health insurance, most likely due to cost-sharing requirements.

An unknown percentage of residents are underinsured for catastrophic illnesses, such as HIV/AIDS, cancer, or for prolonged disabilities that require even moderate medical expenditures. There is no local data specifying the full dimensional characteristics of the underinsured or the uninsured in any of these categories.

1.4 Describe key health issues related to access

Without health insurance, many studies show that people will delay treatment for major illnesses, put off preventive screening, or inappropriately use the hospital emergency room. Data from the 1999 VIBRFSS shows race and income differences in the utilization of preventive screening services and in the overall incidence of morbidity. While 90% of women with household incomes above \$50,000 had mammograms, only 63% of women with incomes below \$25,000 had a mammogram.

The Infant Mortality Rate (IMR) in the territory was 9.9 deaths per 1,000 live births in 1998 (US 7.2). There are differences in IMR by island: St. Croix, 11.6

deaths and St. Thomas/St. John, 8.3 deaths per 1,000 live births. Given the relationship between IMF and prenatal care, 36.2% (US 27%) of women in the territory in 1999 did not receive prenatal services in their first trimester. The primary causes of other deaths in the US Virgin Islands are: heart disease (27%), cancers (19%), and strokes (7.9%). Diabetes, the 5th leading cause of death in the territory, is associated with the level of household income, as shown in the 1999 VIBRFSS.

1.5 Describe current health delivery system

Public and private systems for health care are present in the territory, and are interactive on several levels. On the private side, 185 licensed physicians and dentists in the territory have joined together to form a Preferred Provider Organization, primarily to contract as the network for the government insurance program, as well as with several other private health insurance companies. The traditional fee-for-service private practice medical model still remains. There are no Health Maintenance Organizations (HMOs) or other Medicaid or Medicare managed care programs in the territory. Independent diagnostic radiology and laboratory services support the services of the hospitals, clinics, the dentists and the physicians. The Veterans Administration has two local primary care facilities, with additional services being provided in Puerto Rico.

There are two semi-autonomous hospitals –one on St. Croix and one on St. Thomas that form the core of the health care safety net. The hospitals provide more than 33% of the uncompensated care for inpatients and outpatients, including Emergency Room care. For patient care services not available on-island, referrals are made to facilities located primarily in Puerto Rico, or on the mainland, most often in Florida, New York, Atlanta or Washington, DC. Funding has been secured for the construction of a Cancer Center at the hospital on St. Thomas and a Cardiac Center at the hospital on St. Croix, which will reduce the necessity for off-island travel for health care.

Other participants in the health care safety net are the primary care providers. The Department of Health (DOH) provides services on all three islands that include, Maternal and Child Health and Special Needs Programs, dental services, HIV/AIDS programs, long and short-term mental health and substance abuse services. A high rate of uncompensated care, even using a sliding fee scale for payment calculations, also occurs in the DOH clinics. Direct Federal funding through CDC and HRSA programs are the major mainstays in providing funding for the Department of Health services.

There is a Federally qualified health center (FQHC) on St. Thomas and on St. Croix, each providing a comprehensive range of family health care services. Many community groups also provide direct services to the disabled, the homeless, and the HIV/AIDS populations. The government also contracts for the

management of some substance abuse, mental health and other special needs population programs. Private physicians with admitting privileges to the hospitals may also be employed part-time by the DOH or by a FQHC, or by one of the contract programs to manage patients or provide consultation.

Regardless of the setting, the territory has a shortage of health care providers, primarily in the allied professions, nursing, and in selected specialty and primary care medical practices. The University of the Virgin Islands offers both a 4- and 2-year Nursing program, but graduates often leave to take higher paying jobs elsewhere. Expensive stateside contract nurses are hired for temporary assignments to meet staffing standards. In recognition of this need, the three islands have HRSA designations as Health Professional Shortage Areas and as Medically Underserved Areas.

Section 2: Earlier Efforts To Reduce the Number of Uninsured Residents

2.1 Describe executive and legislative health reform efforts

Throughout the last two decades, the executive and legislative branches in the Virgin Islands have undertaken numerous efforts to implement reforms in the health care delivery system. Many of these reforms have focused on infrastructure autonomy issues and implementing improvements in the coordination and planning of primary care delivery systems. Health care reform in the Virgin Islands is, therefore, an on-going process that can not be separated from efforts to improve health insurance coverage.

One of the first major reform efforts was the implementation in 1994 of “The Virgin Islands Government Hospitals and Health Facilities Corporation Act”, which moved the management of the two public hospitals from the government to the partial autonomous control of a Territorial Board and two District Boards (the St. Croix District and the St. Thomas/St. John District). Legislative support for this change actually began in the mid 1980s. The Act was amended in 1999 extending fiscal autonomy by establishing a Hospital and Health Facilities Fund for the purpose of receiving, managing, and disposing of monies or property on behalf of the Virgin Islands Government Hospitals and Health Facilities Corporation.

The benefit of the change in governance has been that more timely improvements in patient care services have been made; recruitment of professionals has improved; and local control has enabled a recognition that each island has different characteristics and requires different strategies that could not as easily have been achieved solely by the central government. The hospitals still interact with the Department of Health for coordination of the safety net, and with the Office of Management and Budget for fiscal planning. Additional reforms, particularly to the Certificate of Need Law and support for hospital representation in direct negotiations with the government’s insurance carrier, are in progress in the current legislative session.

Another executive reform implemented in 2000 was to formally separate the community health centers (CHC's) (East End Health Center on St. Thomas and Fredriksted Health Center on St. Croix), funded by section 330 of the Public Health Service Act, from the management of the Department of Health. The two CHC's were re-established as non-profit corporations to meet the guidelines for Federally qualified health centers (FQHC). An 11-member board manages each CHC, with day-to-day operations overseen by an Executive Director. This reform was undertaken to enable the FQHCs to directly seek funding opportunities that support the goal of augmenting services to the medically underserved populations. Currently, the centers are seeking to expand new access points that will provide services to school-based populations and also support additional health services to the homeless, two populations traditionally under-, or uninsured.

Due to the challenges of service delivery related to separations of geography across the islands, and the knowledge that patients being seen in the hospitals are also served in many different outpatient settings that are under different management structures, a need was identified to develop integrated information systems. The FQHC, Fredriksted Health Care, Inc., coordinated with its other safety net partners to receive a 2001-planning grant from HRSA for an "Integrated Services Development Initiative". This reform will help integrate the health care safety net partner's information management systems to increase efficiency and effectiveness in providing services to the underserved population. Year one planning activities are devoted to defining needs and essential hardware and software protocols, data element definitions and operational procedures in accordance with the grant objectives. No activity being conducted under this grant will be supplanted by funding sought in the HRSA State Planning Grant.

Another initiative undertaken by the executive branch was the establishment of a HRSA funded Primary Care Office (PCO) within the Office of the Governor. While PCOs are usually found within the planning section of statewide Departments of Health, it was felt that the goals of the US Virgin Islands' office could be better served outside of that typical structure.

A critical function of the PCO at this time is to finalize a comprehensive and integrated strategic health care plan that is geared toward preventive and primary care. (Scheduled completion July 1). The Plan is part of several health care reform efforts of the executive to ensure that resources are allocated to critical health care issues in the territory. Inherent in the plan process are the quantification of need and the identification of measurable and sustainable objectives and strategies to address the gaps in community health care services. During the course of plan development that began last September, more than 14 Workshops will have been held across the territory with representatives from the public, private and non-profit sectors. The individuals in attendance are a diverse

cross-section of those who are involved in the health care system either as planners, managers, direct service providers, financial service providers, insurers, legislators, community and interfaith coalitions, other advocacy group representatives, or as consumers of services. Consultation will continue with these groups during the state planning grant process.

A second function of the PCO is to coordinate information, technical assistance and financial resources among the public and private health systems to facilitate the establishment and accomplishment of effective community-based health interventions. As this reform effort takes shape, the enhanced attention identifying and filling the gap in community health care service planning will have carryover to the issues of the uninsured. The PCO will participate in the State Planning Grant process.

2.2 Describe earlier efforts to reduce the number of uninsured

The issue of increasing levels of uncompensated care in the health care system, inadequate Medicaid funding, and identification of options to reduce the number of uninsured are inseparable in the US Virgin Islands. A graphic understanding of what was becoming a health crisis was made clearer by work done in the early 1990s.

In 1991, Mr. Larry Gage, president of the National Association of Public Hospitals and Health Systems, & Associates were engaged by the St. Croix Hospital to provide an analysis of USVI demographics and health care financial information. For the first time, the hospitals, under the initial reorganization with appointed boards, would see the true picture of relationships between utilization patterns, insurance coverage and reimbursement rates that would partially explain the reduction in hospital revenues.

No previous efforts by the US Virgin Islands to reduce the number of uninsured can be examined without an understanding of the structure and impact of the territory's Medical Assistance Program (MAP).

Federal funding for the local (and the other U.S. Territories of Puerto Rico, Guam, American Samoa, and the Northern Mariana Islands) Medicaid program, which includes coverage for children, has an annual fiscal ceiling set by Congress—\$5.59 million in 2000 and \$5.81 million in 2001—for the US Virgin Islands. The ceiling is increased relative to changes in the Medicaid component of the US consumer price index. The local Bureau of Economic Research has shown that the inflation rate in the territory is twice that of the States, making the CPI only partially informative about medical costs in the territory. In practical terms, the cost of living in the US Virgin Islands is higher than either New York or Washington, DC.

The Federal Medical Assistance Percentages (FMAP) to the States is based on a reimbursement formula (adjusted annually) that pays a higher percentage to

States with lower per capita incomes. In the US Virgin Islands, like the other territories, the 50% match formula, also set by Congress, is equal to States with the highest per capita incomes, namely New York, New Jersey, or Massachusetts. Mississippi, which in 2000 had a personal per capita income of \$20,993 - the lowest in the States but \$4,426 higher than that of the US Virgin Islands - has a FMAP of 76.6%. Nine other States with the lowest per capita incomes had a FMAP ranging from 69.9% to 76.6%. Twenty-six other States have matching rates greater than 50%.

Of all eligible recipients in the US Virgin Islands, 17,385 persons utilized approved services valued at \$12.8 million. After applying the cap, the local government had to contribute nearly \$8.1 million from its own funds, and in in-kind services. The true ratio of contribution in 2000 was, therefore, 37% Federal and 63% local. With the need for local funding as an imperative for other quality of life concerns, such as education or public safety, more than \$2.6 million in year 2000 Medicaid claims by vendors went unpaid. The accrued total of unpaid claims is over \$9 million. Funding to the territory for the State Children's Health Insurance Program (SCHIP) was initially \$279,175; this was subsequently increased to \$1.16 million in 2000. Due to the volume of unpaid medical claims for children the previous year, the program was granted a waiver to pay old bills. Increasing the enrollment of children in SCHIP, as structured, is impractical.

The response by the MAP office to these facts has been to set low income eligibility levels (\$8,500 for family of 4), lower reimbursement rates to providers, and eliminate optional services —prosthetic devices, dentures, durable equipment, institutionalized mental health services; and place a limit on prescription drugs over \$200 and restrict the number of nursing home beds. The pernicious effect of the ceiling and minimum Federal matching is that the Virgin Islands MAP program offers far fewer optional services to the poor than the States of Alabama, Mississippi or West Virginia.

The average US Medicaid expenditure per recipient in 1998 was \$3,939; the lowest State expenditure was \$2,812 in Georgia. In the Virgin Islands, \$525 was spent per recipient overall; with \$275 spent per child; this decreased to \$235 per child in 2001. The average child recipient expenditure in the Early Periodic Screening and Diagnostic Program in the US in 1998, for example, was \$76.00; in the territory, it was \$1.20.

There are other differences in the application of Federal laws to the Virgin Islands that negatively effect the ability to provide basic services to the uninsured. Disproportionate Share Hospital (DSH) funding does not apply in the Virgin Islands, yet the hospital case load for low income patients is significant. Supplemental Security Insurance (SSI) benefits are not applicable in the territory. Persons relocating to the territory cannot transfer their benefits. A local program for the Aged, Disabled and Blind provides an average \$120 a month instead of the nearly \$500 a month possible under SSI.

As a rural area, the US Virgin Islands are faced with problems similar to other sparsely populated jurisdictions. Given that the population is dispersed over three islands, the government must triplicate health care services and facilities. In most States, with a population of 108,612 a single 200-bed hospital would suffice. Here, there are two hospitals with all of the attendant overhead and multiplied need for adequate staffing, technology and supplies. Hospital claims to MAP have increased and now account for 33% of the program expense. Paradoxically, MAP patients accounted for less than 10% of all hospital admissions on St. Thomas in 2000, which is a 3.6% decline from the previous year. Uncompensated care in the hospital, however, has grown to represent more than 1 out of every 3 patients admitted.

In 1994, anticipating changes at the Federal level for health care financing, and the need to control the upward spiral of local health care expenditures, the Governor appointed a Virgin Islands Health Care Reform Task Force (HCRTF). The mission of the group, co-chaired by the Commissioner of Health and the Lt. Governor (also the Director of Banking and Insurance in the USVI), was to identify ways to deal with the \$372 per recipient received from Medicaid in FY 1992, when the true expense locally for care counting all components was \$2799 per recipient. The HCRTF was to gather all relevant data and present options for the executive to consider.

The primary option identified during the HCRTF deliberations was the creation of a government sponsored "single payer system", in other words, a universal coverage pool financed by employers and Federal and local subsidies. Several other options were also described by the HCRTF. More than 600 people across the territory, including invited speakers ranging from the Deputy Assistant Secretary for Minority Health, Department of Human Services and the Senior White House Health Policy Advisor to the White House; and high-level health care representatives from Hawaii and Puerto Rico, participated in several conferences to discuss these options and the underlying issues.

2.3 Describe success and implementation problems of earlier efforts

Success was limited in creating coverage solutions in the hospitals to respond to the impact of the uninsured, documented by Mr. Gage. Several of the reasons for limited success were that management by the hospital boards was new and that other infrastructure needs within the health care delivery system had to be addressed first. Computers were just being adopted in most government agencies, including the hospitals and health centers and were not fully integrated for tracking and guiding management actions. In addition, successful solutions had to be territory-wide, politically palatable, and not just limited to the hospitals.

Other reasons for limited success in implementing options identified by the Health Care Reform Task Force included:

- ? Changing Federal laws would be long-term and needed an expanded political process
- ? No PPO in the VI at the time due to lack of a physician's organization.
- ? Limited number of physician providers, both primary care and specialists.
- ? Limited technological enhancements on island to provide treatment options
- ? Limited outpatient service options
- ? Insufficient actuarial information from commercial insurance providers
- ? Insufficient information on the characteristics of the uninsured
- ? Insufficient information on employers and their necessary incentives
- ? Insufficient information on uptake by individuals when insurance options are available
- ? Absence of a territorial health plan to define what preventive and primary care services were needed
- ? Absence of an on-going health policy and/or Advisory group that brought together the public, private and non-profit sectors to consider and arrive at consensus regarding feasibility and necessary parameters for implementing reform that could be politically implemented
- ? Absence of interagency data repositories and query protocols to enable complex analysis of multiple variables regarding health care utilization and insurance coverage
- ? Insufficient local funding and technical expertise to design a comprehensive system for universal access

Many operational improvements, such as computerization and the organization of a physician PPO, have occurred in the territorial health care system which addressed some of the previous limitations. Paramount to any future success in reforming the health care system is the need for statistically valid micro-specific US Virgin Islands data that is integrated from all sources upon which any coherent policy development must rest.

Section 3: Statement of Project Goals

3.1 Describe general and specific goals for the project

The overarching goal of this project is to collect data that will inform the development of realistic and broadly supported policy options designed to reduce the level of uninsured citizens in the Virgin Islands. There are four major project goals classified as follows:

- ? To develop an understanding of the health insurance status of the Virgin Islands population
 - o Determine health insurance access and coverage disparities among the various sub-populations that exist in the Virgin Islands.

- Determine the health status of Virgin Islanders as it relates to health insurance coverage and utilization of health care services.
- ? To expand our knowledge about the effectiveness of the Medical Assistance Program in providing health insurance access to the poor and near poor
 - Determine the impact of MAP coverage on health status of the population.
 - Determine the impact of MAP funding on the operation of health facilities in the territory.
 - Determine the interplay between MAP coverage and other insurance options with changes in individual and household income.
- ? To expand our knowledge of conditions in the private market that have an impact on the number of uninsured
 - Determine the characteristics of the firms that provide health insurance and the conditions which affect coverage availability and the incentives which drive willingness to provide insurance.
 - Determine why there are differentials in employee take up of coverage for themselves and their dependents when it is available.
- ? To expand our understanding of the interplay between expanded (or restricted) access to health insurance and the economic development of the territory
 - Determine the impact of expanded health insurance access programs in other US territories.
 - Determine the fiscal impact of various options on the local government.

3.2 Describe how the Territory supports the State Planning Grant program goal

The US Virgin Islands strongly endorses the goals of the State Planning Grant program to expand affordable access to health insurance for all of its citizens. The executive branch is fully committed to the project and views this program as an opportunity to accomplish a comprehensive local assessment of the issues and develop multiple insurance policy options. Further, the program is an opportunity to develop data systems which enable us to “populate” national datasets with information regarding the territories that is vital to a broader concept in the development of Federal health insurance policy for all US citizens, and not just those in the 50 States.

Section 4: Project Description

4.1 Describe how data will be collected and analyzed

The Virgin Islands has since 1989 conducted at least two types of surveys regarding health issues. One survey in 1997 by the Eastern Caribbean Center, University of the Virgin Islands, contained detailed descriptions of consumer

expenditures, in general, with a section describing health spending, in particular. The survey was conducted using standard scientific techniques to obtain a sample of the more than 20,000 households in the Virgin Islands. Interviewers visited 2,180 households that were randomly selected in the survey office and used a questionnaire to obtain detailed information on expenditures. Survey results were described in Section 1.2.

The Department of Health has been conducting a Virgin Islands Behavioral Risk Factor Surveillance System (VIBRFSS) since 1989. The VIBRFSS is an ongoing territorial computer assisted telephone interviewing survey (CATI) of the health habits of USVI residents 18 years and older supported by the Centers for Disease Control and Prevention (CDC) using a sample size of 1,500 persons. An additional module was included regarding health insurance. Survey results were described in Section 1.2.

The information that was collected in these studies is vital to understanding individual health status and provides a point-in-time profile of health insurance coverage, but there are gaps in the collected data. The State Planning Grant will enable the Virgin Islands to improve upon these efforts by addressing the gaps in the previous surveys, such as;

- ? Sample size did not include over sampling in subpopulations where people are more likely to be uninsured;
- ? Reasons why employees who have access to coverage choose not to accept it or did not cover their dependents was not included;
- ? Reasons why employers offer (do not) offer health insurance benefits and what incentives will change their choices was not included;
- ? No detailed analysis of the relationships between the type of health insurance coverage and the utilization of various health services at different facilities;
- ? No information was collected about children under age 18 and their utilization of health services as it relates to parental access to insurance;
- ? No information about health care utilization and financial coverage for persons with special needs was included.

Data collection methodologies and analyses conducted under the State Planning Grant will be structured to fill in the information gaps regarding the issues cited above for individuals and employers. The information will be used as a foundation for policy formulation.

4.1.1. Population information

Since persons of color and low-income status are considered at risk for negative health outcomes, the entire population of the US Virgin Islands is the target of the project. Through application of statistically correct sampling methodologies, representative households and individuals will be included in the sample. Two data collection methods will be used to obtain information on health insurance status, health status and service utilization from residents in the household.

Formal Household Survey. Statistical data from a representative sample of households in the US Virgin Islands can be obtained by two primary methods: by an interviewer with a survey instrument, or by telephone. Due to the limitation on time to complete this survey in a timely fashion, and because of the greater cost associated with door-to-door interviewing, the telephone method is more desirable.

The population to be sampled for this part of the survey—the core Computer Assisted Telephone Interviewing (CATI) survey—includes qualifying residents of the US Virgin Islands who are living in households that are served by personal telephones. According to the 2000 VI Census of Population and Housing, 92 percent of the occupied housing units had telephones. The level of telephone penetration is equivalent to that of Kansas, New Mexico, Georgia, West Virginia, Texas, and South Carolina. It is higher than that of Florida, Alabama and Mississippi. The plan for sampling Dwelling Units (DUs) and individual respondents from the core CATI survey will yield a probability sample that is representative of this large segment of the U.S. Virgin Islands population. The core CATI survey requires identification of eligible DUs—non-business personal households—and sampling of designated respondents from within a sample of designated DUs.

Method Of Random Digit Dialing

The CATI survey will make use of conventional sampling methods with random digit dialing (RDD) procedures in order to select a probability sample of DUs and a probability sample of individual respondents for this survey. There are two kinds of sampling frames used for telephone surveys. One consists of the names and numbers listed in telephone directories, and the other is the set of all possible numbers within existing telephone exchanges. The use of the latter is known as RDD. RDD is generally preferred because directories do not contain unlisted telephone numbers, and are not up-to-date. The proposed sample-selection method for RDD is known as the Waksberg-Mitofsky method, and proceeds as follows: obtain from the local telephone company—Innovative Telephone in the Virgin Islands—a recent list of all existing prefix numbers within the Territory. There is only one telephone area code—340—for the US Virgin Islands. To a prefix, one adds all possible choices for the next two digits, and prepares a list of all the possible first five digits of the seven-digit telephone numbers which are thus treated as Primary Sampling Units (PSUs). [In the

states where there is more than one area code, a PSU consists of the first 8 digits of the 10 digits in telephone numbers].

A random selection is made up of the PSU and the next two digits. The number is then dialed. If the dialed number is that of a residential address, the PSU is retained in the sample. Additional last-two digits are selected at random and dialed within the same group, until a set number, k , of residential telephones is reached. Interviews are attempted both at the initial number and additional k numbers. If the original number called was not a residence, the PSU is rejected. This process is repeated until a pre-designated number of PSUs, m , is chosen. The total sample size is $m(k + 1)$. The values of m and k are chosen to satisfy the criteria for an optimum sample design.

Sample Design And Size: CATI

It is desirable to have both Territory-wide and island-wide estimates. For this reason, it is necessary to oversample on St John because of the relatively small population on that island compared to those on St Croix and St Thomas. Moreover, because one-third of the population of the US Virgin Islands is foreign-born, the occurrence of health insurance in homes may vary widely by ethnicity. This suggests the need to obtain estimates of smaller ethnic groups within islands, thereby necessitating larger island sample sizes to accommodate estimates with smaller margins of error.

Plans for Respondent Selection at the Dwelling Unit Level

In order to achieve a targeted goal of 1,600 completed interviews for the core CATI survey, ECC will sample about 2,900 eligible Dwelling Units (DU), making adjustments for non-response and non-contact.

Recruitment at the level of the individual eligible DU, with successful completion of the steps that lead to sampling of an individual designated respondent, will seek a minimum response rate of 70 percent of the designated DUs that are sampled for this core CATI survey. In situations where contact is not made with a designated DU, the survey staff will be thoroughly instructed against the selection of an arbitrary substitute DU. And when a DU is appropriately selected, field staff will also be expressly directed by senior research staff that only probability sampling procedures can be utilized to select a respondent within the DU. Given the manner in which survey response rates must be calculated, one of the most effective ways to achieve an adequate survey response rate is to minimize non-response at the level of the designated DU. *At least 10 callbacks will be made to the DU in order to select the designated respondent.*

In those circumstances in which a respondent in the DU hesitates to provide information that is needed for sampling of a designated respondent, one or more calls-back to the DU by an experienced senior member of the field work staff will be attempted in order to persuade the respondent to provide the requested

information. The use of experienced staff skilled in communication of this kind is necessary to differentiate the delicate balance that exists between effective persuasion and badgering, in that the former is within the bounds of ethical procedures for research with human subjects, whereas the latter is not.

Plans for the Selection of Individual Designated Respondents

Designated respondents for this core CATI survey will be adult Virgin Islands residents who are 18 years or older, and who have been resident in the US Virgin Islands for at least one month at the time of sampling the DU. For the core CATI survey, only one designated adult respondent will be selected per DU, yielding a probability of selection that varies proportionally to the number of eligible adults within the DU. Designated respondents will be selected by conventional probability sampling methods.

Within each of the designated DUs, a designated individual respondent will be selected using the *next-birthday* method and recruited for the survey. Procedures in the sampling process will be designed to enumerate the entire household, relationships among the members, and garner specific information regarding children in the household. In many instances, the adult designated respondent will not be present in the household at the time of sampling among household members, and a minimum of *10 callbacks* to the designated respondent (DR) will be made in order to schedule the CATI interview, and to achieve successful completion of that interview in a timely manner. Callbacks will be equally distributed over days of the work week and disproportionately more on the weekends and over time of day (a.m. vs. p.m.). At least two-thirds of the calls will be made in the evenings and on weekends. When appropriate, variation in the sample selection probabilities will be specified in order to achieve coverage of sub-regions—on each of the three main islands and the major Census sub-districts or aggregates thereof. The target for the response rate will be 72 percent and will be calculated using the CASRO formula (Council of American Survey Research Organizations, 1982).

The plan for respondent selection will attend to ethical procedures for recruiting the designated respondents and maintaining information about them and their DUs in a manner that protects confidentiality of the survey data and precludes unwarranted invasion of privacy. Identifying information about individual designated respondents and how to contact them in the future will be maintained in order to provide for: (a) call-backs to the DU as discussed in the prior paragraph; (b) the possibility that the DR shows hesitation or uncertainty in participating, and should be called back at a later time by an experienced member of the fieldwork staff (discussed below); (c) verification callbacks for routine auditing and assurance procedures put in place to maintain a high quality of survey data and to reduce survey error. The Center will follow specified procedures for protecting confidentiality, including detailed procedures for: (a) encoding and decoding individual identifiers; and (b) maintaining separate confidential data files.

As discussed in relation to the selection of designated DUs, there also will be a specific policy and procedures for circumstances in which the DR hesitates to give informed consent, with provisions for one or more call-backs to the DR by an experienced senior member of the fieldwork staff with expertise in the persuasion of difficult-to-recruit respondents. Here also, the Center will be sensitive to the differences between effective persuasion methods and badgering of designated respondents. Once the study's disclosure statement has been read to a DR, a DR who is rated as *hesitant* may be called back by a member of the persuasion staff. However, DRs who have heard the disclosure statement and who qualify as *hard refusals* will not be called back.

Responsibility for Data Collection and Analysis

The household survey will be conducted by the Eastern Caribbean Center (ECC) located at the University of the Virgin Islands (UVI). The ECC, together with its antecedent Caribbean Research Institute, has been involved in demographic and socioeconomic research in the US Virgin Islands since 1978. It has conducted area probability surveys of households, CATI/CAPI random digit dialing surveys, surveys of businesses and employees, as well as surveys of institutional records. ECC's primary collaborator on Territorial surveys since 1995 has been the International Programs Center of the US Bureau of the Census, and it has also worked jointly with Johns Hopkins University in a prior health survey. ECC will be responsible for implementation of the procedures necessary to receive approval for human subject research through the University's Institutional Review Board.

Acting as technical consultants to ECC for the household survey will be the State Health Access Data Assistance Center (SHADAC). 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 focuses exclusively on providing technical assistance on data collection and interpretation related to health insurance coverage and the characteristics of the uninsured from a state perspective.

The Survey Instrument

The Virgin Islands project will use The Coordinated State Coverage Survey (CSCS), a household telephone survey developed by the staff at (SHADAC). The tool is designed for estimation of health insurance coverage at the state level. Any modifications that are necessary for use of the tool in the territory will be part of the consultative process. CSCS is modeled after the state household survey used to monitor the uninsured for the state of Minnesota since 1990. The survey instrument is programmed using Computer Assisted Telephone Interviewing (CATI) software and the survey tool, CATI. Currently a version of the survey is being administered in Colorado, Connecticut, West Virginia and Minnesota. The CSCS instrument is designed to save survey time and resources by providing a

high quality survey instrument, CATI programming and the accompanying survey documentation.

Community Participation in Focus Groups. While not as rigorous as data derived from a statistical sample, important information for policies that must have broad community acceptance is often better gleaned in the Virgin Islands through informal but recognized community structures. The population in the territory that has often been dependent upon Federal programs for basic services, and who may not have experiences with managed care concepts or with the health insurance market, yet who are the most familiar with the real workings of the health delivery system may be reluctant to participate in formal survey research without sufficient education of what is involved.

To address these concerns and provide another facet of insight into the data collection process, the Virgin Islands proposes to conduct focus groups with stakeholders to obtain information from them on how they manage to navigate health care services, pay for services and what they think about those services. A lead community group on each island will assist, with the aid of a professional facilitator in the organization of the focus groups and in the collection of the information. Structure for the guided focus group survey tool will be designed with the assistance of SHADAC and ECC.

The purposes of the community focus group meetings are two-fold:

- ? Provide education about the formal process, should the participant be randomly selected for the telephone survey;
- ? Build community sense of ownership in the development of health insurance options by incorporating their concerns and expectations in advance.

Other information that can be obtained informally from the focus groups include the difficulties experienced by individuals in acquiring private insurance, enrolling in public programs and what happens to family support when insurance is either lost or can not be acquired. Print and radio media will be used as marketing materials in advance of these meetings to also bring attention and build consensus.

Community of St. Thomas and St. John. On St. Thomas, The Community Foundation of the Virgin Islands (CFVI) has been the lead agency for preparation of the annual USVI KIDS COUNT Survey (KCS). The KCS, a project of the Annie E. Casey Foundation, is a national and state-by-state effort to track the health, educational, physical, social and economic status of children both in the US and internationally. The USVI KCS project is a product of a partnership involving the CFVI, the University of the Virgin Islands, the Departments of Education, Human Services, Health and Police. While the Annie E. Casey Foundation KIDS

COUNT project has been operational nationally for many years, it has provided separate funding for data collection in the territory only since 1995. The Virgin Islands data is not incorporated into their databank.

Given their experience in this process, the CFVI has agreed to assist the State Planning Grant Project by organizing focus group meetings with the St. Thomas and St. John communities. The project anticipates three meetings on St. Thomas and one meeting on St. John in the early stages of the project and follow-up meetings when options are being considered. An experienced facilitator will guide each of the meetings.

Community on St. Croix. The strongest community leadership on St. Croix for social issue discussions is the St. Croix Interfaith Coalition (SCIC), representing over 100 faith organizations. In the last four years, the SCIC has become involved in providing home care services to HIV/AIDS patients through a grant it received from CDC. The SCIC has also received funding to conduct education and outreach activities regarding HIV/AIDS with its members and other community groups. As in many small communities that are predominantly of color, attendance at faith institutions is very high and important social messages are often shared with the congregants by the faith leader.

The Community Foundation of St. Croix (CFSC) also has an active social presence and serves as the fiduciary agent for many Federally funded health programs. The CFSC also is the lead agency for the recruitment and assignment of AmeriCorps/VISTA volunteers in the US Virgin Islands who often work at health-related agencies.

Both of these organizations serve similar yet different community constituents on St. Croix who will be important to reach in the data collection process, as well as in the policy development phase. The same facilitator working with the St. Thomas groups will also conduct three meetings on St. Croix, with the addition of a single pre-planning meeting with the faith leaders. Follow-up meetings will also be held to consider insurance options. As in St. Thomas, media outlets will be used to market the process.

4.1.2 Employer Information

There is very little information in the Virgin Islands about the characteristics of firms that offer or do not offer health insurance benefits. The government is the largest employer with accessible health insurance coverage, but from a research and policy perspective not as much as could be derived from this source has been studied. If there is much to be understood about the government worker's plan, then the knowledge about the private sector, with respect to the provision of health insurance is limited. Beyond publicly accessible registration as a licensed business with the appropriate government agencies, our knowledge about the insurance choices of individuals who are self-employed is essentially zero.

The Virgin Islands State Planning Grant program proposes to collect data about employers and the factors that influence the decision to provide affordable health insurance. Statistical information of the type of business, employment sizes, types of positions and wage level are generally available from the Employer's Quarterly Wage and Salary Report submitted by the business to the Bureau of Labor Statistics (not required if Self-employed). Basic licensing information is also available from the Department of Licensing and Consumer Affairs. Compliance with the quarterly reporting requirement though high, is variable; and not all operating businesses are legally licensed.

Limitations of sample survey

Under more normal conditions where the time for data collection is less limiting, the appropriate approach to the determination of health uninsurance rates data from employers would have been to conduct a survey among a probability sample of employers. However, two primary reasons argue against this method. First, a reliable sampling frame of current employers in the Virgin Islands is not readily available or reliable. Second, the experience of previous attempts, though not related to health care, is that employers in the Virgin Islands are notoriously difficult to interview because their response rate to written questions has been traditionally very low, and in-person interviews consume inordinate amounts of call-back time that often do not result in completed survey instruments. For these reasons, it appears that the traditional survey method would not be the most productive, and the preferred approach is the focus group interview.

Data Plan for Focus Groups

The method of data gathering that will be used by the Virgin Islands is to organize focus groups of employers on all three islands. By its very nature, this qualitative research tool for data gathering is subjective. The basic approach is to select a number of employers from organizations with particular characteristics—of size in the number of employees and of industry type—and engage them in extensive discussion on the issue of health insurance of their employees. Certain business ownership in different sector types is also more representative of one ethnic or racial group than another. Selection of which business to include in the focus groups will also take this factor into account so that as close to a representative a sample of the business community will be obtained.

The data plan will include arranging three focus groups of employers on St Croix, three focus groups on St Thomas and one focus group on St John. Each island group will consist of 10 participants. While interviews will not be as formal as in the case of an administered questionnaire, there will be a common core of questions to which responses will be sought. Their collective perceptions will be fashioned into basic dimensions that will help to inform the broader issue of why some ethnic groups and some industrial types have lower health insurance levels than other traditional groups in the Territory. Follow-up meetings with employers will also be held at the sage of consideration of options. Some of the qualitative

areas of interest that will be explored with the employers in the focus groups will include:

Employers Offering Coverage	Employers Not Offering Coverage
Level of contribution	Reasons for not offering coverage
Participation required or optional	How is employee sick time handled
Structure of dependent coverage	Will purchasing alliances for group coverage influence decision to purchase plan
Factors influencing choice of plan	Will subsidies to employer or employee influence decision to offer a plan
Factors that would lead to change in plan	Other alternatives that influence actions
Have any changes been made in plans & why or contemplate a change this year	Has coverage been offered previously and why not now

The Chamber of Commerce on each island has agreed to assist the data collection consultants in arranging the focus groups. They will also lend their support by providing business forums to build constituents understanding for the overall goals of the State Planning Grant process.

The Eastern Caribbean Center and The University of Minnesota State Health Data Access Center will be the consultants who have overall responsibility for the design and implementation of the Employer Focus groups data collection and analysis. Tools for the focus groups will be developed by the consultants drawing upon work that has already been done by States such as Massachusetts, Alaska, Idaho, New Hampshire and Minnesota. Selected employers may be carved out, providing a large enough sample is available, for receipt of a more detailed written survey at the option of the design consultants. The facilitator who will be working with the community groups will also assist with the employer focus groups and business forums.

4.1.3 Other Available Data

In order to make fully informed policy decisions, particularly regarding financial resources needed to provide a comprehensive range of preventive, primary or treatment services, other data beyond household or employer studies must be analyzed as part of the State Planning grant process. Identifying methods to extract data maintained by these other sources, whether qualitative or quantitative, will be part of the data collection activities. The other sources identified below, will be contacted for information relevant to the grant objectives in support of the Project Management Team's commitment to seek out avenues for effective collaboration.

Utilization Data From Government's Insurance Carrier.

Cigna Healthcare of Florida is the insurance carrier for the more than 13,000 employees and retirees of the Virgin Islands government and its authorities and instrumentalities. Analysis of the quarterly experience and utilization data reports (only since October 2001) that are produced as part of the contracted services with Cigna (other reports are at an extra fee) will be included. Information may also be available from the previous carrier, Blue Cross/Blue Shield.

Information From Government Agencies

Banking and Insurance. This office under the direction of the Lt. Governor is responsible for setting the guidelines for the entrance of health insurance providers into the local market. Certificates of Authority for Life and Health Insurance on file in 2001 show 94 firms are listed. The application for admission into the territory should contain coverage plan information. If it is missing, the firms will be contacted to complete file.

Office of Management and Budget. This local government office maintains historical budget information by prime and sub accounts of monies allocated to health care functions. These records will be analyzed for funding allocations to health-related activities, as part of the project's relational database construction effort.

Hospitals, Department of Health and FQHCs. Preliminary health service utilization data, expense and revenue data has been provided by these facilities. Additional information on operation of programs is available. Data and insights from the Vital Statistics and Health Planning Units will be included in the analysis.

Medicaid and Medicare. A comprehensive statistical analysis will be made of all data maintained by these two agencies regarding utilization, reimbursement rates, payments, and certification procedures. Cross-checking will be done for dependent coverage in the government insurance database.

Department of Human Services. The Department manages the Head Start program, two long-term care facilities, the juvenile detention center, and makes arrangements for physicals and diagnostic screening of children. It also sub-contracts the management of a residential foster care facility for children who are abused or neglected and need special services for medical or developmental disorders that could be Medicaid eligible.

Department of Education. The Department manages the school health system of nurses and also is responsible for implementation of the Youth Behavioral Risk Surveillance System with the University of the Virgin Islands, funded by CDC. The school system is also responsible for paying for interventions for children who have special learning needs complicated by medical problems, and could be

eligible for Medicaid services. Off-island care is paid by the Government for services not available on-island. These services may be Medicaid eligible.

Other Agencies. The Housing Authority provides Medicaid eligible services to elderly residents who are able to live in independent housing. The Bureau of Corrections is responsible for the medical and psychological care of the detainees in the jails on St. Thomas and St. Croix, and for those who are incarcerated in the prison on St. Croix.

University Affiliated Program. The University of the Virgin Islands has funding for the operation of the VI University Affiliated Program that provides training for persons and families who need assisted living interventions. In most States, these services are eligible for Medicaid funding.

Federal Programs. The Veteran's Administration provides primary and urgent care for approximately 1,600 veterans on island. More expanded services are provided in Puerto Rico. The Federal Bureau of Corrections contracts the management of a substance abuse/halfway house program on St. Croix. It also pays the local Bureau of Corrections for any Federal inmates housed, including medical services rendered, in the local jail or prison.

Non-Profit Agencies. There are several non-profit agencies who manage the medical needs of clients whose service requirements might qualify for Medicaid payments. There are other active community groups in the territory who advocate on behalf of expanded Medicaid coverage to children and to other vulnerable populations, such as the disabled. The Virgin Islands Medicaid Task Force formed in 1999 represents 28 community groups.

For Profit Providers. Home Health Care agencies on St. Thomas and St. Croix and the Sea View Nursing and Rehabilitation Facility on St. Thomas provide services that are eligible for Medicaid funding.

External Data Sources. Any available Virgin Islands health care utilization or financial information that may be held at the Centers for Medicaid and Medicare Services, the National Center for Health Statistics, Health Resources and Services Administration, and the Agency for Healthcare Research and Quality will be identified and incorporated.

4.1.4 Data Synthesis

In order to create a realistic picture of the current coverage status and develop viable insurance strategies, quantitative and qualitative data from the household surveys, employer and community focus groups along with information from any of the sources cited above must be tracked and linked together. Grant funded consultant(s) will be used to organize and analyze sub-parts of the collected information so that either statistical or economic relationships can be determined.

Consultant services under the State Planning Grant will be also be used to build a data repository that is accessible to the project management staff and can be used to build complex queries for the development of policy options. Compatibility issues of the different data formats from multiple sources will be addressed by the database management consultant. Only summary data disaggregated as necessary for proper analysis and interpretation will be made available to the Advisory Committee and other procedures put in place to protect privacy and security of the information.

4.2 Describe use of data to develop coverage options or design programs

Data that are collected from employers, individuals, focus groups and input from the Advisory Council, as well as from all other collaborative sources identified above will be used to develop coverage options or design programs that provide health insurance coverage to the under-, and uninsured residents of the territory. For any plan to be viable, it should be based upon expanding Federal, local, and private partnerships. The data collection process will identify the current range of benefits offered at each size of firm and the average and median cost of premiums for the employer and the employee. Apparent price elasticities of demand for insurance in the general community, that takes into account varying levels of co-payments and deductibles will be analyzed from the collected data. On the employer side of the equation, tolerance levels for premiums and the cost of program administration will be evaluated. Given that the Virgin Islands represent a small market to commercial insurers, historic and expected loss ratios for different segments of the public must be determined from the data, as part of the assessment. Contract support from research economists and statisticians will be utilized in this part of the analysis.

Previous work by the Health Care Reform Task Force will be drawn upon in the development of coverage options. The background material for options considered at that time will be updated by new data developed in the grant process. One option that previously drew a lot of attention was the creation of a single payer scenario whereby the Virgin Islands government (through a managing entity) would deposit into a restricted treasury;

- ? all employer and individual premium payments
- ? all Medicare and Medicaid payments
- ? all other Federal payments and subsidies for health services in the territory, including Workmen's Compensation
- ? local "excise" taxes earmarked to finance the program.

Critical questions that will be examined after the data collection is complete in order to develop models that meet the goal for reducing the number of uninsured include:

- ? Who are the target groups who require insurance coverage

- ? How will the options be phased-in and are their different options for different groups
- ? Using the Federal Employees Health Benefit Plan as the benchmark, how will other choices for expanded levels of coverage be handled
- ? Will catastrophic coverage be available
- ? Can individuals with better coverage opt out of the program
- ? Is participation of employers and individuals mandatory; Can services be given outside of the VI network
- ? How will data be collected, quality and accessibility monitored; who will perform audits
- ? How will the system be financed, premiums collected; what is the expected impact on the local treasury related to each model
- ? What type of cost-sharing must be included in each model
- ? What management system must be in place to handle the program options and what is the administrative cost for each
- ? What health services must be accessible on-island to make the options viable
- ? Will there be changes in the Medical Assistance Program/SCHIP; are funding changes at the Federal level necessary
- ? How is participation maximized in existing private/federal insurance programs

The Project Management Team and the Advisory Committee will review the data collection and data integration at each step of the process and then use the information to answer these, and other questions. The outcome at each point of the data collection and analysis process will be the development of a range of model options for increasing health insurance coverage that will attain greater specificity during the project period as more information is incorporated. Defining the options and the necessary evaluation parameters for analyzing each option requires detailed knowledge of the insurance industry, the interplay between private insurance, Medicare and Medicaid, and an understanding of the complexities of developing and administering health programs outside of the 50 States.

Guidance and direction in this part of the project will be the responsibility of Lewis Consulting, LLC, a partnership of consultants who have extensive expertise in this arena. The partnership has a depth of understanding of federal health care financing programs tempered with substantial knowledge and appreciation of the complexities in administering these programs in unique jurisdictions such as the Virgin Islands. They also bring a well-informed knowledge of what did or did not work in the health care reform efforts implemented in Puerto Rico or in the other territories. Other economists and financial modeling consultants will be utilized, as needed, in this part of the work with the Lewis partnership under the leadership of the Bureau of Economic Research.

The rapid changes and contractions that have occurred in the insurance industry since September 11th have had carryover effects in the Virgin Islands. Identifying and testing models of insurance coverage in a period of economic recovery will require the Management Team and its consultants to include in the analysis

varying levels of fiscal growth, both locally and nationally, as option simulations are conducted.

4.3 Describe decision-making and collaboration for proposing recommendations

The development of coverage options is based upon the data collected and synthesized from the household survey, employer and community focus groups, and inclusion of information gained from other statistical data reports, meetings with industry representatives, various community and advocacy groups, health professionals, consultants and other interested parties. The State Planning Advisory Committee (see Governance Section 5.3) and the Project Management Team will work diligently to ensure that as much information as possible from as many sources as possible are, considered and incorporated into the decision making process.

The decision making process in a project of this type must be transparent and organized in order to keep moving forward, given the restrictions of the planning period. As the data is collected, analyzed, linked to previous information and entered into a repository, it will be reported and discussed with the Advisory Committee and the other participating parties.

The process of formulating strategies from the data also involves maintaining effective collaboration with other community groups, executive agencies, the health legislative committee, the Tax Study Commission, the VI Primary Care Office, and with the health care Safety Net partners –the Department of Health, the Hospitals and the Federally Qualified Community Health Centers. Their expertise in validating data and in assisting in the formulation of realistic options will be included in the process during the focus groups meetings, Advisory Committee Working group meetings, and at special meetings specifically identified for that purpose.

Data analysis, therefore, must be fluid and dynamic to take into account new information as it is processed and then used to inform and test conclusions about previous information. The results of a dynamic process of data analysis will inexorably lead to a range of possible options that must be evaluated for legal, financial, political and community acceptability. The range of options must be measurable to test their relative ability to accomplish the intended goal of the project. Not all options may be targeted to the same group, but the cumulative effect of the complementary set of options should be to reduce the level of uninsured residents in the territory. In addition to the specific insurance-related options, other recommendations may be made that highlight programmatic infrastructure and data management issues in the health care delivery system. Increasing access to health insurance alone without addressing capacity to provide health care would be an incomplete solution.

The Bureau of Economic Research will be the lead in guiding and supervising the development of policy recommendations that will be considered by the Advisory

Committee. The Bureau is the major provider of technical assistance in the territory in the areas of economic development planning and financing. The Bureau has extensive experience in leading analyses of this type and is the liaison between the US Economic Development Administration and the Comprehensive Economic Development Strategy Committee (CEDS). The CEDS is comprised of public- and private sector decision-makers versed in the area of socio-economic development. The Governor appoints the members of the board.

A project management system will be implemented that tracks action items and responsible parties. A data repository, query mechanisms, and Intranet will be constructed so that the Team and the Advisory Committee can access the status of the work at all times, be updated on key decisions, and perform strategy simulations. JDJ Associates, Inc., will be engaged as the project and database managers.

Other members of the Governor's Policy Development staff will also participate in the development process and assist in insuring cooperation from other executive agencies. Consensus policy recommendations on the range of options that would be effective in reducing the level of uninsured in the territory will be made to the Governor for review and consideration prior to inclusion in the final report to the Secretary. The final report will include the relevant research, analytical methodologies and recommended policies.

4.4 Describe the process for preparing report to the Secretary

The Principal Investigator will coordinate the preparation of the final report with other members of the Project Management Team. The report to the Secretary will be made 30-days after the end of the one-year grant period. The report will include a summary of the variables which were taken into consideration in designing feasible options which will best expand access to affordable health insurance coverage to the uninsured residents of the territory.

The report will summarize the quantitative and qualitative data collection methodologies, identify the key findings, and define the characteristics of the uninsured within the Virgin Islands. It will also include a description of the analytical tools employed in evaluating the findings and developing recommendations.

A discussion of the factors which influence the structure and quality of the health care delivery system in the Virgin Islands will also be provided. Within that discussion will be an analysis of the effect of federal programs on the level of uninsured residents and the types of care they receive.

4.5 Provide detailed project narrative and project management matrix

The project matrix shown below identifies the key tasks, the projected timetable, the responsible party, anticipated results and the method of evaluating the performance of that task. The four goals of the project described in Section 3.1 are expanded into major tasks for clarity in the overall concept of the project. Points of collaboration described in Section 4.1.3 are included under the column of “Responsible Party”.

<i>Grant Planning Preparation</i>				
<i>Action Steps</i>	<i>Timetable</i>	<i>Responsible Agency or person</i>	<i>Anticipated results</i>	<i>Evaluation/Measurement</i>
Recruit Major Project staff and consultants and project manager	Prior to grant award	Management Team	Staff will be hired as soon as the award is announced	Qualified staff hired in a timely fashion
Preliminary planning meetings with SPG Advisory Committee	Prior to grant award	Management Team	Advisory Committee given background on grant and role in project	Advisory Committee members will represent executive agencies, private, nonprofit sectors, advocacy groups and consumers
<i>Task 1: Establish Project Management Procedures & Advisory Committee</i>				
Action Step 1: Hire staff / consultants; arrange travel for first meeting	July 15	Management Team	ECC and SHADAC & JDJ engagement scope of work complete	Hiring process completed and all documents processed; payment schedule agreed to
Action Step 2: Formal invitation from Governor to join Advisory Committee (AC)	July 15	Governor, Deputy Chief Principal Investigator	Set orientation Meeting, outline expectations	Acceptances; materials for first meeting prepared; Intranet setup
Action Step 3: Press Conference by Governor to announce project and expected results	July 30	Governor, Deputy Chief Principal Investigator (PI)	Will highlight the process and need to cooperate with this important study; education of community leaders	Press conference is held and news story archived; briefing with key community, legislative, executive leaders completed
Action Step 4: Set up Management Team (PM Team) procedures	July 15	PI Proj. Manager (PM) PM Team	Set PM Team schedule Review procedures	Minutes of meeting and baseline schedule distributed

Action Step 5: Attend training workshops SHADAC & HRSA	July 22-23; others as scheduled	PM Team	Understand survey procedures and review use CATI tool; grant review	Ability to use CATI tool; understand HRSA grant issues
Action Step 6: Database Manager meet with PMT and review needs & schedule& start survey of data	July 25	PI, PM Team	PM Team will understand how data repository will function and the steps required to implement	Record Feedback on data repository and use SQL tools
Action Step 7: Meeting with AC; establish procedures, schedule and Workgroups	Aug 1	PI, PM, PM Team	Review goals and objectives of the grant and make assignments for Workgroups; establish monthly meeting schedule	Detail schedule distributed, minutes of meeting show action items
Task 2: Collection of household data				
Action Step 1: Review sampling plan and CATI tool; pre-test as needed; finalize	Jul 15-30	PM ECC/SHADAC (Survey Consultants)	Interim descriptive report of the tool	Final document and code books approved by Management Team
Action Step 2: Hiring and training of CATI staff	July 15-30	Survey Consultants	Training of staff	Staff demonstrate ability to conduct survey with CATI tool
Action Step 3: Field CATI household Survey in 2,900 homes sample	Sep-Dec	Survey Consultants	Data usable for determining characteristics uninsured	Continuous quality control of survey forms; clean, review, accept results; average
Action Step 4: Data Analysis and interim progress report;	Oct, Nov, Dec '02; Jan, Feb '03-final	Survey Consultants	Interim written progress reports. Final report of data determining characteristics uninsured	Achieve completed surveys to meet expectations; results can be interpreted; trend information presented
Action Step 5: Final report with detailed analysis; present to Advisory Committee	Feb 03	PI, PM PM Team Survey Consultants	Development of uninsured estimates at island and territory level; special finding on sub-groups	Final report with details of insurance coverage; pertinent highlights. Enter into data repository

Action Step 6: Review procedures and training for community focus groups; produce tool; hold focus groups	Aug-Sept	PI & PM Survey Consultants Mtg. Facilitator Foundations Interfaith Coalition.	3 focus groups on St. Thomas; 3 on St. Croix; 1 on St. John; identify any response trends	Document feedback from participants, Moderators compare notes; summary of what was said; interim report
Action Step 7: Integrate data from survey with focus group data	Sept 02 And Jan-03	Database Manager	Update website that report is there and can be used to formulate questions	Identify any trends from demographic or other data in repository
Task 3: Establish Data Repository & Initiate Special Studies				
Action Step 1: Develop intranet and SQL procedures; training PM Team	Aug	P Manger Database manager (DBM) PM Team	Have data network established; passwords assigned; training manual for PM Team	Demonstrate proficiency in accessing intranet; demonstrate can construct complex queries
Action Step 2: Identify locations where health demographic, or utilization or financial info kept; start extraction; report preliminary results	Jul-Oct	PM PM Team DBM	Schedule meetings with partners to review data identification and extraction procedures; privacy issues addressed	Meeting notes; participating agencies providing access; information can be cleaned, extracted and entered as field test; reports generated
Action Step 3: Identify what can be gathered from Medicaid and Medicare; extract & clean; set schedule for analysis	Oct-Nov	DBM PM Team Dep. Health, M-caid/care; Uni. Illinois Statisticians.	DBM able to set up repository to begin to enable complex queries on for information PM Team needs to develop options	Progress reports on extraction & entry; preliminary report from Un Illinois on findings
Action Step 4: Review website/ Intranet; security and training for all	Sep	DBM PM Team	Procedures to manage data from consultants, groups and track process	No QC issues in use of Intranet to receive email, meeting notices, get data; remote monitor security
Task 4: Collection employer information on insurance provided				
Action Step 1: Review Depts. Labor and Licensing for registration files	Sept	Survey Consultants Department Labor	Will have compatible documents that are the universe of	Focus group selected that are representative of the businesses; over sample for attendance of those in

to use as sampling frame to select participants for focus groups		Department Licensing	employers; stratify by size/industry	smaller size group
Action Step 2: Develop focus group tool and training on use with facilitator; field meetings	Sept-Oct	Survey Consultants Mtg. Facilitator Chamber Com.	3 meetings St. Thomas 3 meetings St. Croix 1 meeting St. John	Able to extrapolate qualitative characteristics of firms that have no plan; interim report;
Action Step 3: Summary report of methods and results; review with employer Working group	Oct-Nov	Consultants PM Team	Get sufficient participation in focus groups in order to make inferential analysis	Coded Information entered into repository Identification of incentives needed for insurance to be offered

Task 5: Quality Assurance for process

Action Step 1: Monthly Review of consultant reports; update calendar for next month/quarter	Every month start Sept	PM Team DBM Consultants	Project staff will be able to identify and resolve gaps in analysis or data collection	Missing information identified; resolution procedures clarified
Action Step 2: Financial reports reviewed and PM schedule reviewed	Every month start Sept	PI PM Team Project Accountant	Federal reporting as required is occurring; draw down reports, bal. Left in sub accounts	Fiscal reporting is accurate Variances are resolved
Action Step 3: Analyze work of Advisory Committee, set special meeting for presentations of consultants	On-going	PI PM Team Consultants as required	Intent is to generate collaborative of information & identification of what is important	Sign in sheets track participation; work proceeding according to schedule
Action Step 4: Midpoint analysis of progress	Nov	PI PM Team	Make adjustments as required to get back on schedule	Review of what is in data repository; measurable variance to schedule not more than 2 weeks,

Task 6: Conduct study of relationship health status & coverage

Action Step 1: Review data entered from the partner locations; determine SQL questions	Dec	DBM PM Team	Develop initial policy options for improving the health system; predict how presence of insurance would affect	DBM reports Statistician reports
Action Step 2: Review Medicaid & Medicare statistical report from Un. Illinois; CDC preliminary results BRFSS 2000	Dec-Jan	DBM PM Team Statisticians Medicaid staff	Identification of trends and analysis of utilization and health status relationships	Quantitative and qualitative results that can interpret impact of current system on health status
Action Step 3: Meeting Working Group of Advisory Committee on results	Jan '03	PI PM Team Medicaid Task Force	Develop strategy based on information for policy actions	Participation by key leaders; informed discussion of real needs and effect of absence of coverage
Action Step 4: identification data gaps from Action Step 3	Jan '03	PM Team Lewis Group	Identification additional questions to answer; revisit report	Updated report and data Updated strategies
Action Step 5: identification of sub-population groups where further information is needed; structure tool to acquire	Feb '03	DBM Survey Consultants	Definition of sub-populations and reasons additional queries needed	Update data; revised query and or survey or focus tool fielded
Action Step 6: Review furthers study results with full Advisory Committee;	Feb '03	PI PM Team	Advisory Committee receive monthly reports regarding the progress of the consultants and their findings, as well as a copy of issues needing further study	Review of Intranet for accessing uploaded reports

Action Step 7: Receive Final report on population household survey	Feb '03	Survey Consultants PM Team	Development of uninsured estimates for whole population; inferences to be drawn from findings	Report entered into data repository; query the report with other findings from Medicaid & Medicare analysis
Task 7: Development of Coverage Options				
Action Step 1: Review files Bank. & Ins. Verify company still active; complete listing benefits offered	Sep -Nov	Lewis Group	Where data is missing or incomplete, contact firm to complete; provide interim report	Enter listing in data repository
Action Step 2: Identify parameters and how will measure on range of options	Oct -Nov	Lewis Group PM Team	Report on how will analyze each option; what data will be needed	Determine if query can locate data; exception report if not found –direct to source
Action Step 3: Integrate information from Population survey and initial employer focus group into range of options that will address	Nov -Dec	Lewis Group DBM PM Team	Evaluation of existing employer-sponsored programs, types of programs	Report of evaluation made; further directions to study
Action Step 4: Actuarial analysis of population based on results in Step 3 and Step 1; special data runs from Cigna request	Dec-Feb '03	Lewis Group Consultant GESG (gov't managers of insurance) Other agencies	Evaluation of degree to which commercial insurers will cover expanded pool; do model simulations	Determination of expected loss ratios for various insurance coverage proposals; simulations tax & premium analysis
Action Step 5: Briefing of Advisory Committee and key community on interim report from step 4	Mar '03	Lewis Group Consultant PM Team	Integrate major findings with all other activities from other consultants to develop criteria for final selection of coverage strategies	Document responses from Advisory Committee and next steps, if further analysis is needed
Action Step 6: Second round focus groups with community&	Mar '03	Mtg. Facilitator Lewis Group PM Team	Responses from community to be incorporated into final plan	Document participation and responses; update as needed. Integrate into repository; note any

Employers for reaction to preliminary types of coverage that could work in the territory				changes from initial round
Task 8: Finalization of Coverage Options				
Action Step 1: 1st Draft coverage strategies; review with Governor's staff	Apr '03	PI PM Team Lewis Group	Integrate all findings from various components of the study	Measure degree to which uninsured level will reduce with each option; what system changes must be in place; update as needed
Action Step 2: Updated draft to Advisory Committee for review and action	May '03	PM Team	Final report will be prepared, approved by Advisory Committee	Final inclusion of any other additional data or summary conclusions
Task 9: Final Report to the Secretary				
Action Step 1: Review required structure of final report/ Draft final report for reviews with PM Team, Advisory Committee; coverage strategies; review with Governor's staff	May – June '03	PI PM Team	Fulfill grant requirement for the report summarizing data methods, key findings; recommended strategies & adequacy of strategies to reduce coverage	Input from team members on data included; update report as required
Action Step 2: Preparation of final report to Secretary	June-July '03	PM Team and Consultants	Final report approved by the Adv. Committee & Governor	Final report submitted to Secretary

4.6 Describe governance structure and key personnel

4.6.1. Governance Structure and Key Project Personnel

The planning grant will have an organizational structure that has delegated authority from the Governor, can provide oversight of the project, and can ensure collaboration among the critical players. The Bureau of Economic Research (BER) will be the designated agency responsible for the overall direction of the grant activities. The BER is a major provider of technical assistance in the areas of economic development planning, financing, special project management, grant writing and management, general economic analyses and information

management. The Director of BER will be the Principal Investigator for the project. The budget provides for a Project Manager and Database Manager, support staff for each office, and research economists or statisticians, as required. Professional contracting for administrative or analytical services is a typical and effective working prerogative of the Bureau, given the need to maintain the Governor's Executive Order of a hiring freeze and the nature of the work to be performed. The administrative and primary research staff for the project will be located in offices of the Bureau in St. Thomas and in leased space on St. Croix.

The Virgin Islands government has established accounting procedures for tracking and reporting federal grant revenues and expenditures. There are specific procedures in place to fast-track professional service contracts, control and monitor payments, and provide internal/external actions to maintain checks and balances. Staff of the BER will be responsible for all federal reporting and fiscal accounting of the project. The BER has successfully managed more than 27 different grants totaling over \$2 million in its direct accounts, and provided technical assistance in the management of over \$4.0 million in grant funds received by other agencies.

A State Planning Grant Advisory Committee (SPGAC), chaired by the Principal Investigator, will formally be appointed by the Governor upon notification of grant award. Thirty individuals, who have indicated their willingness to participate in the project, have diverse backgrounds and represent a cross section of the community in the private, public and non-profit sectors. Two preliminary planning meetings have been held in preparation for the grant. The SPGAC will meet monthly. Working groups within the SPGAC will consider specific issues of strategy development that include: concerns related to employer sponsored coverage; delivering health care services to immigrant populations; health care for special needs populations; establishing portable insurance for temporary workers; relationship of insurance coverage to health status; providing primary mental health care services; establishing a data repository and populating national datasets. Written reports at specified intervals will be made summarizing the progress of the Working groups and the consultants. A listing of the expected members of the Advisory Committee is included in the Appendix.

The Principal Investigator will be supported by a Project Manager who is responsible for the day-to-day activities being performed by the consultants and facilitate the activities of the SPGAC, as described in the project matrix. The Project Manager will also supervise the work of the Database Manager to assure that the intranet is updated, track progress in implementing the data repository, that all data queries are addressed, consultant and Advisory Committee Working group schedules are maintained, and all reports prepared and distributed. A Management Team consisting of the Governor's Health Policy Liaison, the Principal Investigator, the Project Manager, the Data Survey Consultant (ECC/SHADAC), the Policy Options Consultant (Lewis, et.al.), will meet weekly

to review progress, either in person or by web/teleconference to review schedules, resolve issues and track progress.