THE UNITED STATES VIRGIN ISLANDS
ACCESS MONITORING REVIEW PLAN

2016

DIVISION OF MEDICAL ASSISTANCE
DEPARTMENT OF HUMAN SERVICES

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Overview

- The United States Virgin Islands (USVI) Medicaid program provides healthcare coverage for low-income individuals, including children, pregnant women, and individuals with disabilities, elderly, parents and other adults. The USVI Department of Human Services (DHS) is the single state agency that administers the Medicaid program within the territory. As of July 31, 2016, the USVI Medicaid program provided coverage to approximately 22,767 enrolled beneficiaries.

- The USVI comprises three separate inhabited islands (St. Thomas, St. Croix, and St. John) with a total population of 110,000. With two acute care hospitals, two federally qualified health centers (FQHCs), and additional enrolled private providers throughout the Territory, there are numerous options for Medicaid beneficiaries to receive healthcare.

- The Medicaid program in the USVI is exempt from the freedom choice provisions at section 1915(b) of the Social Security Act. All Medicaid beneficiaries are required to first seek primary care from one of the two FQHCs (Frederiksted Health Care Center – St. Croix, East End Health Care Center – St. Thomas), or one of the public health clinics owned and operated by the Department of Health (DOH). A system of care coordination is in place where individual beneficiaries are assigned to one of the primary care sites. Primary care providers at these sites are empowered to create care referrals in the Medicaid Management Information System (MMIS) to allow beneficiaries to access Medicaid enrolled private providers for specialty care. Services at the two on-island hospitals do not require referrals.

- There are many services such as organ transplants and Psychiatric Residential Treatment Facilities (PRTFs) which are not available on-island. The care coordinators at the DOH clinics and the FQHCs cannot authorize off-island travel or medical services. Only the special services unit in the Medicaid program is authorized to make these off-island referrals.

- The USVI measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.

- In accordance with 42 CFR 447.203, the USVI developed an access review monitoring plan for the following service categories provided under a fee-for-service (FFS) arrangement:

    - Primary care services
    - Physician specialist services
    - Behavioral health services
    - Pre- and post-natal obstetric services, including labor and delivery
    - Home health services

- The plan describes data that will be used to measure access to care for beneficiaries in FFS. The plan considers: the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are fully met.

- The plan was developed during the months of January – September 2016 and posted on the state Medicaid agency's website from May 15, 2016 – June 15, 2016 to allow for public inspection and feedback.
- Analysis of the data and information contained in this report show that USVI Medicaid beneficiaries have access to healthcare that is similar to that of the general population in the USVI.
- There are metrics requested for this report that were not available for this initial draft, such as the identification of births, prenatal and post-partum services within the overall utilization of obstetric services. We do have a plan to supplement this draft with additional data prior to the end of the calendar year.

Health Care in the United States Virgin Islands: A Brief History

The USVI first came under the administration of the United States of America as a result of foreign policy concerns about the potential annexation of Denmark by Germany during the First World War. The United States purchased the islands from Denmark for $25 million and placed them under the control of the United States Navy, reflecting the concern at the time about the expansion of submarine warfare in the Atlantic.[i] At the time, there was only the most rudimentary system of health and social services provided by the sugar planters under Danish administration.[ii]

The Navy established the first rudimentary government public health clinics on the islands to provide care to the sailors and the local residents who worked as stevedores and contractors. [iii]

Dissatisfaction with the administration of health and human services for the civilian population by the Navy led the Federal Government to reconsider the role of the Navy in administering local government in the islands. Residents of the USVI received recognition as citizens of the United States in 1927, the same year that members of Native American tribes received such status.[iv] In 1931, administration of the USVI (including the incipient public health system) was transferred to the Department of the Interior – Office of Insular Affairs (DOI/OIA).

There are parallels in the territories to the situation of Native Americans where responsibility for administering and coordinating federal policy was moved from the War Department to the DOI, Office of Insular Affairs (OIA). In both cases, administration of federal policy regarding the health and social welfare was gradually and imperfectly shifted from a branch of the military to a reconstituted DOI/OIA.[v] The key difference between the situation of Native Americans, and that of the Virgin Islanders and other populations administered under the OIA, is that no specific trust responsibility for the delivery of health care was ever acknowledged on their behalf by the United States Government. Finally, under the Organic Act of 1936 the Virgin Islands achieved self-government as a United States Territory[vi].

The USVI DOH evolved as a public health delivery system that included both preventive and direct care services for all of the citizens of the USVI. Health care was provided by a system of clinics and hospitals throughout the islands. The foundations of that system still exist today. In 1994 a separate Health and Hospitals Corporation (the Corporation) was created through legislation to manage the health care delivery system.[vii] That Corporation today administers the two hospitals in the USVI that were formerly part of the DOH prior to the enactment of the 1994 legislation – Roy L. Schneider Hospital (St. Thomas) and Juan Luis Hospital (St. Croix).

As part of that same legislation, the ownership of two of the larger Health Department clinics was transferred to community boards on St Thomas and St Croix who today oversee operations of these clinics as FQHCs.

Poverty in the United States Virgin Islands

In 2009, 32.5% of the 110,000 individuals who were residents of the USVI were living in poverty. At that point in time, the poverty rate in the USVI was approximately three times the rate on the mainland.[viii]

Despite the very high percentage of the population living in poverty, the enrollment in the Medicaid program, as a vehicle to provide health care coverage, has historically been very low. The reason for this low level of enrollment, including parents and children who could have been categorically eligible, as well as single adults who were not categorically eligible before the passage of the Affordable Care Act (ACA), is largely explained by the low federal Medicaid funding cap and the low Federal Medical Assistance Percentage (FMAP) which severely limits the ability of the USVI to leverage Federal health care funding using their available local health care funding. Instead, the USVI must pay for any Medicaid and other health care expenditures beyond the available federal funding using all local funding to try and meet the needs of its population.

Medicaid is just one piece of the health care delivery system for the poor. Prior to the recent incremental expansion, Medicaid's role was largely limited to providing services for only those individuals with the lowest household incomes that would qualify them for cash assistance. Out of a total population of 110,000, only recently has Medicaid enrollment exceeded 10% of the total population in a territory where 30-40% of the residents live below the poverty level.[ix] It is the publicly funded system that has traditionally provided care for all the rest, including parents and single adults.

Medicaid in the United States Virgin Islands

In 1965 Title XIX of the Social Security Act was passed to create the Medicaid program. In the USVI and in the other territories, the program operates differently than it does in the states on the mainland.

The Territory Medicaid program is exempt from the freedom of choice requirement. This allows the program to require that Medicaid members must first seek care from the clinics and hospitals that receive direct appropriations from the Territorial government. This restriction was put in place to contain costs.

Unlike the situation in the states where the amount of available federal Medicaid revenue is not limited by calendar year, federal funding is limited in the territories to an annual allotment. This limits the amount of federal funding provided to the territories regardless of the actual amount of Medicaid expenditures that are incurred. This was modified somewhat under the ACA where the USVI was provided a potential of an additional $298.7 million in federal Medicaid funding which is available until expended or through the end of 2019 (whichever comes first).

The Territory receives a designated a specific FMAP which is currently 55% and which cannot change without specific Congressional action. This FMAP is arbitrarily set by Congress without any reference to the statutory FMAP formula applicable to the states which varies annually and accounts for the per capita income available in each state and the District of Columbia to fund Medicaid. If that statutory FMAP formula for the states and the District of Columbia, was used to compute the FMAP for the USVI, it would be at, or near, the statutory maximum (currently 83 percent) given the low per capita income in the islands.

Even with the establishment of the Medicaid program in the USVI, the services provided by the clinics and hospitals that receive direct funding from the government continue to provide primary care, hospital, behavioral health, and emergency services throughout the islands. These services are available to all island residents, regardless of their ability to pay (USVI Code Title 19, Chapter II, Section 16). This was acknowledged by the Federal Government in their approval of the USVI as an Expansion State in April, 2014. The relative size of the investment in direct funding has limited the size of the appropriations available to support the local share (45%) of Medicaid expenditures. As a result, the USVI has continued to rely to a large extent on publicly funded service delivery system while limiting the size of the Medicaid program.

An FQHC Example

East End Medical Center (EEMC) is an FQHC located on St. Thomas. EEMC receives a direct appropriation each year from the Territorial Senate. The appropriation is intended to ensure the delivery of care to the large volume of patients who are classified as “self-pay”. EEMC also routinely bills Medicaid, Medicare and commercial insurance.

An analysis of the relative volume visits, charges ad payments received by payer category is illustrative of the vital role that non-Medicaid, locally-funded care plays in the USVI (see table below).

East End Medical Center: 10/1/2010 through 9/30/2011

Payer Type	Patients	Percent	Visits	Percent	Charges	Ins. Paid	Patient Paid	Balance
Commercial	712	18%	1,871	17%	$262,936	$114,577	$ 45,512	$102,847
Medicaid	1,079	27%	3,634	32%	$445,931	$302,009	$ 1,186	$142,737
Medicare	208	5%	856	7%	$ 49,925	$ 45,925	$ 5,730	($2,286)
Self-Pay	1,962	50%	4,810	44%	$522,628	$ 0	$220,510	$302,118
Total	3,463		11,171		$1,280,866	$462,513	$272,939	$545,416

In the federal fiscal year, the uninsured/self-pay service population accounted for 50% of the patients and 44% of the visits at East End. Medicaid by contrast was represented by less than one-third of the patients and approximately one-third of the patient visits. In the absence of the appropriation available to East End and the other public clinics, the large uninsured population, including parents and single adults, would have no recourse. This is an example of how the publicly funded health care system traditionally ***wrapped around but did not replace*** the Medicaid program as the primary funding vehicle for indigent health care.

Medicaid Expansion

While the 1994 legislation that established the Hospitals Corporation guarantees access to health care for all USVI residents regardless of their ability to pay, it at best provided for episodic care to

meet urgent and emergency care needs. Under this system continuity of care is more a matter of chance than policy. The type of structured financial criteria, medical eligibility, and coordination of care that only a program like Medicaid can provide is lacking in the public health system.

Beginning in 2013, DHS embarked on an ambitious Medicaid expansion program supported by the additional $378 million in federal funding that became available as the result of the decision by the Territory not to pursue the establishment of a Health Exchange under the Affordable Care Act. (See chart below). The Medicaid program now provides coverage to 30,000 beneficiaries including:

- Categorically Eligible pregnant women, parents, children and childless adults with household incomes up to 75% of the FPL, no asset test.

- Categorically Eligible Aged, Blind and Disabled (ABD) with household incomes up to 100% FPL, $1,500 asset test for a household of one, $100 for each additional household member.

- Medically Needy ABDs, pregnant women, parents, children with incomes up to $5,500 and a $1,500 asset test.

Chart 1: Medicaid (MAP) Expansion Under DHS						
		1st Expansion	2nd Expansion	3rd Expansion	Outreach: Expansion III(a)	4th Expansion
MAP Covered Group	**Original Maximum Allowable Annual Income**	**Increase Income Limits for Pregnant Women and Children Aug 1, 2013**	**Outreach to Add eligible but unenrolled people July 2014**	**Increase Maximum Annual income for covered groups, add Foster Children 18-26 yrs. February 1, 2015**	**Outreach to Add eligible but unenrolled people Mar 2015**	**Add New covered Group - Childless Adults at 133% of VI poverty Level June 2015**
Children	$5,500 HoH + $1,000 for each covered family member	Increased to $6,500 for HoH + S1,000 for each covered family member	$6,500 for HoH + $1,000 for each covered family member; Notices sent to household that meet the income criteria identified based on SNAP data	Increase to 75% of FPL: $8,753 + $3,045 for each covered family member; Gross Income (MAGI) Methodology	Notices will be sent to household that meet the Expansion III income criteria identified based on SNAP data	75% of FPL: $8,753 + $3,045 for each covered family member
Parents	$5,500 HoH + $1,000 for each covered family member	$5,500 HoH + $1,000 for each covered family member	$6,500 for HoH + $1,000 for each covered family member; Notices sent to household that meet the income criteria identified based on SNAP data	Increase to 75% of FPL: $8,753 + $3,045 for each covered family member; Gross Income (MAGI) Methodology	Notices will be sent to household that meet the Expansion III income criteria identified based on SNAP data	75% of FPL: $8,753 + $3,045 for each covered family member
Pregnant Women	$5,500 HoH + $1,000 for each covered family member	Increased to $6,500 for HoH + S1,000 for each covered family member	$6,500 for HoH + $1,000 for each covered family member; Notices sent to household that meet the income criteria	Increase to 75% of FPL: $8,753 + $3,045 for each covered family member; Gross Income (MAGI) Methodology	Notices will be sent to household that meet the Expansion III income criteria identified based on SNAP data	75% of FPL: $8,753 + $3,045 for each covered family member

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			identified based on SNAP data			
People with Disabilities	$5,500 HoH + $1,000 for each covered family member	$5,500 HoH + $1,000 for each covered family member	$5,500 HoH + $1,000 for each covered family member	Increase to 100% of FPL: $11,670 for HoH + $4,060 for each covered family member; Net Income with Additional Disregard to 100% FPL	No Outreach scheduled at this time	100% of FPL: $11,670 for HoH + $4,060 for each covered family member
Senior Citizens	$5,500 HoH + $1,000 for each covered family member	$5,500 HoH + $1,000 for each covered family member	$5,500 HoH + $1,000 for each covered family member	Increase to 100% of FPL: $11,670 for HoH + $4,060 for each covered family member; Net Income with Additional Disregard to 100% FPL	No Outreach scheduled at this time	100% of FPL: $11,670 for HoH + $4,060 for each covered family member

Chart 1: Medicaid (MAP) Expansion Under DHS						
		1st Expansion	**2nd Expansion**	**3rd Expansion**	**Outreach: Expansion III(a)**	**4th Expansion**
MAP Covered Group	**Original Maximum Allowable Annual Income**	**Increase Income Limits for Pregnant Women and Children Aug 1, 2013**	**Outreach to Add eligible but unenrolled people July 2014**	**Increase Maximum Annual income for covered groups, add Foster Children 18-26 yrs. February 1, 2015**	**Outreach to Add eligible but unenrolled people Mar 2015**	**Add New covered Group - Childless Adults at 133% of VI poverty Level June 2015**
Former Foster Children	Not a covered group	Not a covered group	Not a covered group	Added With No Income Limits		Added With No Income Limits
Childless Adults	Not a covered group	Not a covered group	Not a covered group	Not a covered group		Added at 133% of VI Poverty Level
Women with Breast or Cervical Cancer	No Income or Asset Test	Not a covered group	Implemented 7/14			
Estimated Total Covered	**approximately 9-10,000**	**Increase 3,000 Medicaid Total - 11,300**	**Increase 4,700 Medicaid Total 16,000**	**Increase 2/28/15 1,317 *Total expected 4,650 *Expected Medicaid Total 20,000**	**Outreach Letters sent to 1,000 additional potential Medicaid members**	***Expected increase 5,000 to 15,000 *Medicaid Total to surpass 30,000**

The Table below shows the enrollment total by eligibility category as of July 1, 2016.

Physician Access and the Health and Hospitals Corporation

As the USVI makes the transition from what was historically a public health delivery system to combined government and private insurance marketplace, there are still residual elements of the public health model that play an important part in access to health care.

Perhaps the most notable of these is the role in the Medicaid program played by the clinics operated by DOH and the FQHCs. As a United States territory, the USVI is exempt from the freedom of choice requirements at section 1915(b) of the Social Security Act. As a cost containment measure, the Medicaid program requires that beneficiaries must first seek care from one of the six DOH clinics or the two FQHCs before a referral can be provided to a private provider. The result is that all or nearly all primary care is provided to Medicaid patients at the clinics.

There is also an analogous relationship for access to specialty and obstetrical care provided in the hospitals. The hospitals are part of the Health and Hospitals Corporation which receives direct appropriations from the government to cover the costs of uncompensated care. In addition, the hospitals and their attending physicians participate in a unique relationship with the government where, as part of the subsidy that the hospitals receive for uncompensated care, the attending physicians receive coverage for malpractice insurance and are eligible to participate in government retirement benefits. This additional compensation, above and beyond their hospital salaries or any reimbursement from Medicaid, Medicare, or private insurers, was intended as way to attract and retain medical professionals.

In exchange for these benefits, the physicians on staff at the hospitals are required to provide coverage for services in the emergency room, in the maternity wards, or in the surgical units. They are, in effect, a pool of rotating specialists who attend cases in the hospitals for those patients, Medicaid and uninsured, who are not admitted by their own attending physician. This unique relationship is a key strategy employed by the Territory to ensure that all residents are able to access emergency, maternity, and surgical care.

This arrangement was undoubtedly necessary prior to the expansion of the Medicaid program. Today, as Medicaid approaches cove rage of 20% of the population in the islands, it is possible to think of alternative models to insure patient access, including the recruitment of additional providers to serve the Medicaid and Medicare population strictly on an FFS basis. The Territory receives no federal match under the Medicaid program for the subsidies that are provided to the physicians as a quid pro quo for services provided in an inpatient setting. Many Medicaid eligible pregnant women receive their prenatal care from a provider at one of the clinics who hold only a limited medical license that does not include admitting privileges at one of the two hospitals. When that woman comes to the hospital to deliver her baby, the attending physician or nurse midwife may be someone she has had no prior contact with. When she is discharged from the hospital after the birth, her relationship with the community provider at the clinic will hopefully resume.

Care Coordination

As noted earlier, the USVI Medicaid program is exempt from the requirement that clients must have freedom of choice of their medical providers. Medicaid patients must first seek care at one of the six clinics operated by the DOH and one of the two FQHCs – East End medical center on St. Thomas and Frederiksted Health Center on St. Croix.

The issue of access to specialty care beyond the care that can be provided at the clinics has been a challenge in the past. Providers who work at the clinics often operate under a restricted medical license that does not include admitting privileges at the hospitals. Historically authorizations to see private providers could only be approved by the Special Services unit in the Medical Assistance program (Medicaid). These authorizations could take weeks to obtain and patients were forced to forgo treatment pending their approval.

However, under an innovative Care Coordination system implemented in 2014, Medicaid patients are able to select a DOH clinic or an FQHC in their District (St. Thomas, St. John, or St. Croix) as the coordinator of their care. Once the clinic is selected, the primary care provider at that clinic is able to make referrals to Medicaid private providers outside the clinic without having to receive additional authorization from the Special Services unit at DHS. This has greatly reduced the waiting time for authorizations and has increased access to private providers. It also has the effect of placing the primary care provider at the clinics at the center of coordinated care for the Medicaid patient. Primary care providers have proven to be effective advocates for their patients in obtaining necessary medical care.

HIT in the United States Virgin Islands

In January 2014 the USVI received approval from the Centers for Medicare & Medicaid Services (CMS) for an update to the original Implementation Advanced Planning Document (IAPD) to fund Health Information Technology (HIT) in the territory. The update provided for a total of $691,280 between 2013 and 2016 to assist providers in acquiring the ability to exchange Electronic Health Records (EHRs) that satisfy the conditions for meaningful use.

In the circumstances described above with reference to pregnant women, a functioning EHR exchange between the hospital, the clinic and the attending physician would be an important tool to ensure that patient records were accessible and supported continuity of care.

Unfortunately, the application for funding for EHRs and their deployment has been slow to develop in the public delivery system. While both hospitals have received their subsidies to support EHRs, the DOH clinics and the FQHCs have been slow to apply for the implement a similar technology. Part of the problem has been the requirement that individual providers who meet the Medicaid specialty and volume criteria described in 42CFR:495 must be the ones who apply and receive the HIT subsidies, not the clinics, themselves. The salaried clinic providers must seek the subsidies on behalf of the clinics and then turn the funds over to their employers to purchase the EHR systems. While the hospitals have been successful in negotiating these arrangements, the clinics have been much slower to implement this purchasing strategy.

As a result, the USVI continues to pursue an effective reciprocal electronic system for the exchange of clinical information between the hospitals and the public clinics. DHS is working with Mercer and Molina Healthcare to resolve these issues and will present their strategy to move the issue forward in the next update to the IAPD.

Fees and Access: A Comparison of the Medicaid Program and Private Insurers

With the inauguration of the MMIS in 2013, the USVI Medicaid program was required to make public fees schedules for physician, dental, and other covered services. Prior to the implementation of the MMIS, many provider services outside those provided in the clinics were based on individual negotiations. However, with the introduction of a mechanized claims processing system, the

Territory needed to make consistent fees a priority and the make them available on the MMIS website (www.usvimmis.com).

Based on prior practice with clinic services, the department adopted the Medicare fee schedule for all Medicare covered services. The territory currently reimburses providers 100% of the Medicare allowed amount. For services that Medicare does not cover, such as Dental, the Territory still conducts individual provider negotiations to ensure patient access.

There is only one significant private insurer in the USVI as a basis for comparison. CIGNA provides coverage to territorial employees and retirees. CIGNAs fees average 50% higher than the Medicare allowable amounts for medical services and up to 100% higher than Medicare for surgical procedures.

At first glance this fee discrepancy would seem to point to a potential access problem for the beneficiaries of the Medicaid program. However, it is important to consider three of the remaining attributes of the public health delivery system noted above and the role that they play in Medicaid patient access:

1. Primary Care is almost entirely delivered by DOH clinics and the FQHCs.

2. These same clinics are authorized to provide referrals to specialty services without additional approval by DHS and can act as facilitators for patient appointments.

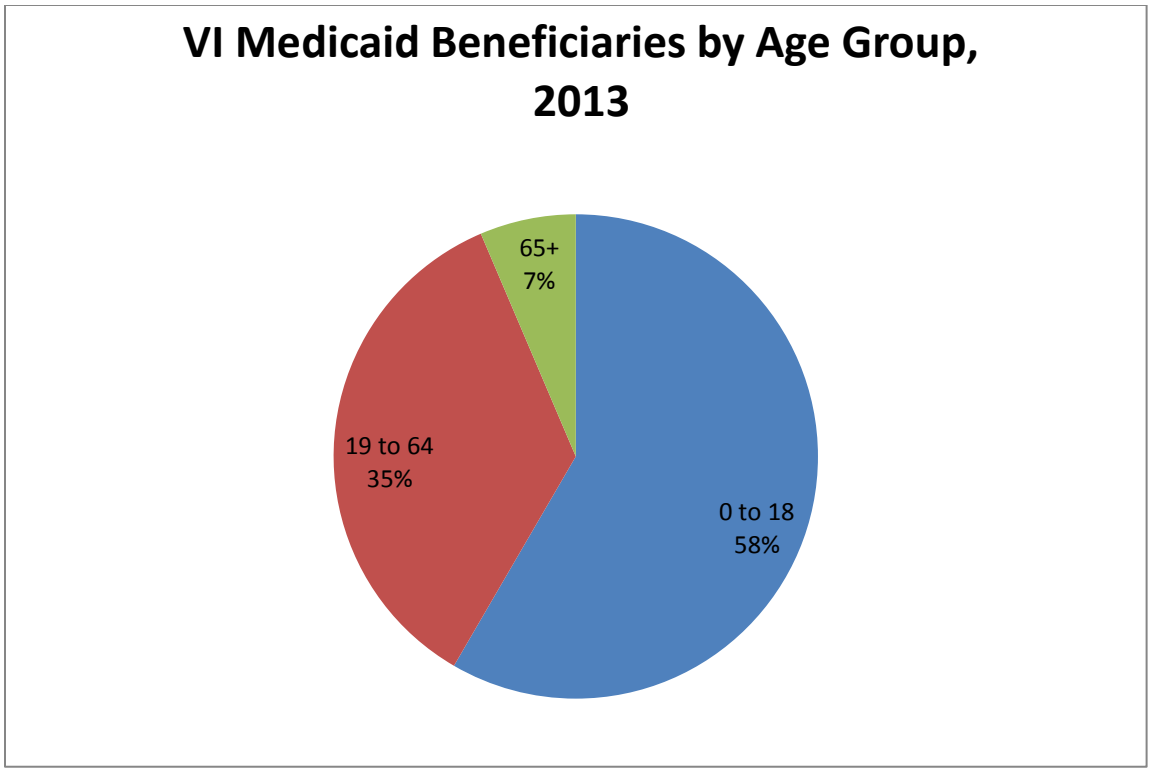
3. Under the agreement with the Health and Hospitals Corporation, private practice physicians who have admitting privileges at the two hospitals are required to attend at emergencies, birth and deliveries, surgeries, and diagnostic testing that occur in the hospitals. This provides a safeguard for Medicaid and uninsured patients to receive access to necessary medical care, including medical specialties.

Access Concerns Raised by Beneficiaries

The USVI operates a beneficiary call center as part of the MMIS as a way to engage beneficiaries and assist them with their needs. Each beneficiary's Medicaid card includes the toll-free number for the call center along with information about how to seek assistance if they have difficulty finding a provider or scheduling an appointment. The call center operates daily from 8am – 8pm and utilizes a messaging service after hours. Calls into the call center are logged detailing the issues raised and the resolution. On a bi-weekly basis, a report is produced detailing the number of calls, the issues raised and the resolution of the issue, including the timeliness.

The majority of calls in which the beneficiary requests assistance with locating a provider are resolved immediately by call center staff. These calls are tracked and repeat callers seeking assistance in locating the same type of provider are flagged as this might indicate a potential access issue.

Characteristics of the Medicaid Population: 2013-2015


VI Medicaid Beneficiaries by Age Group, 2013
65+ 7%
19 to 64 35%
0 to 18 58%

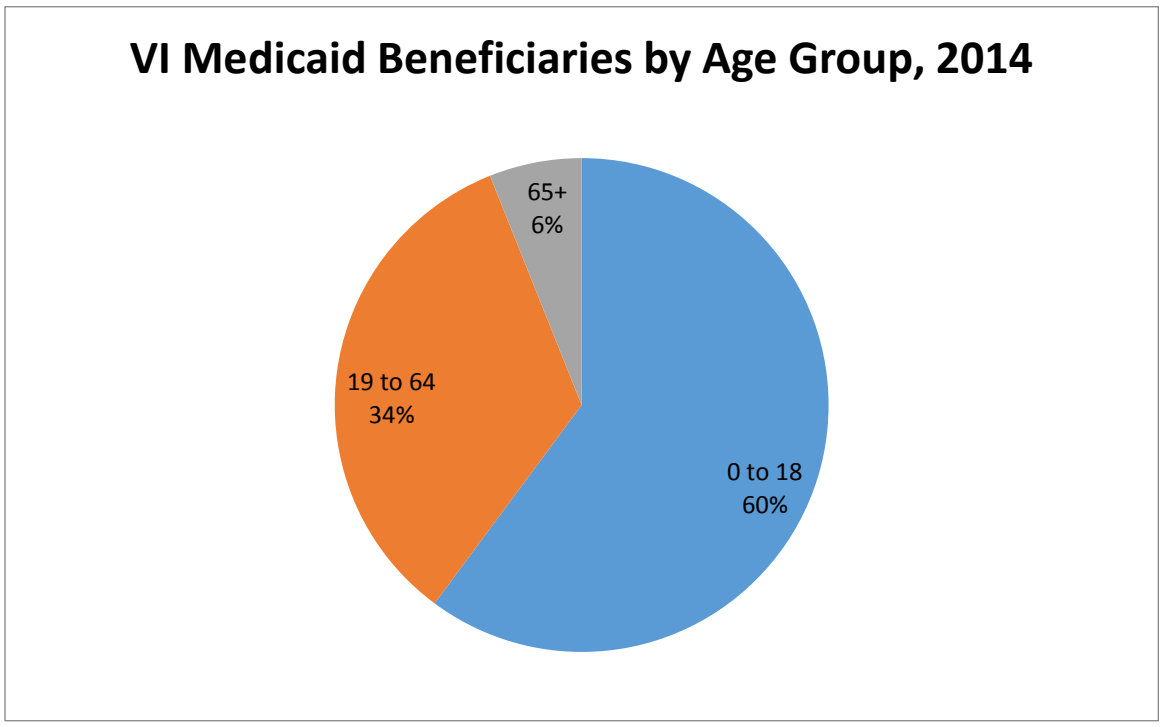
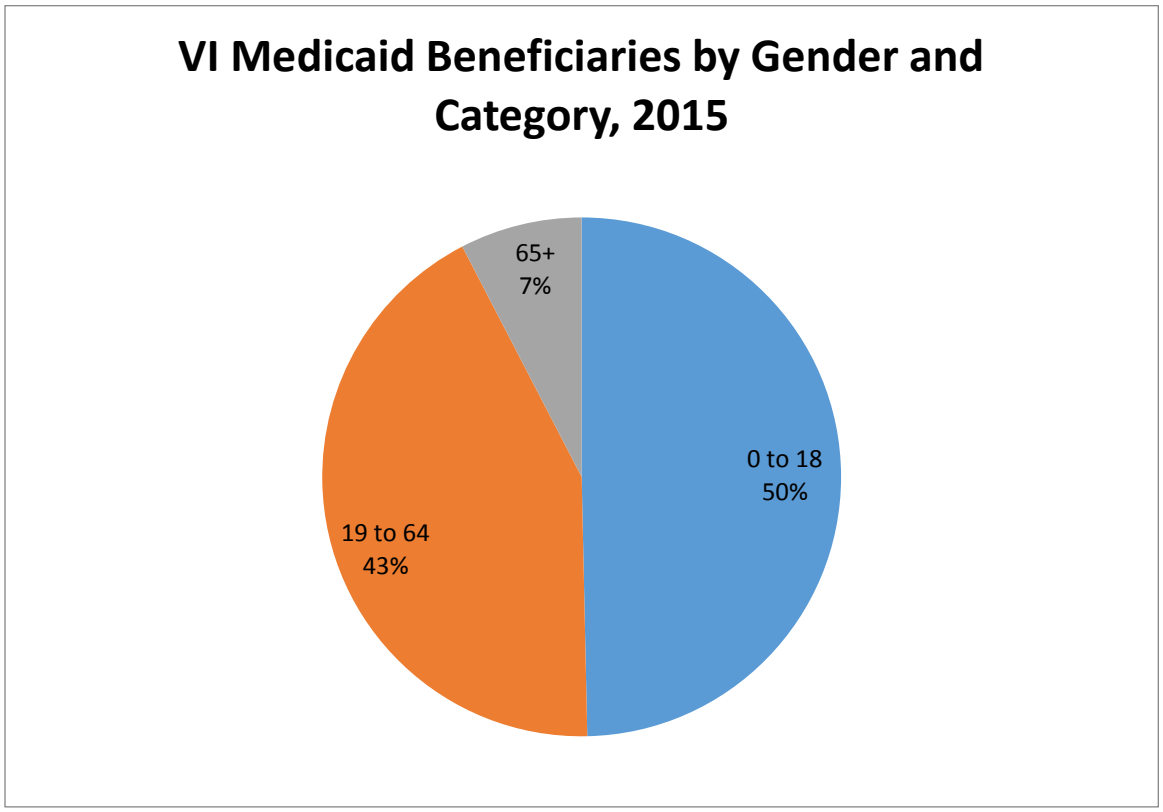
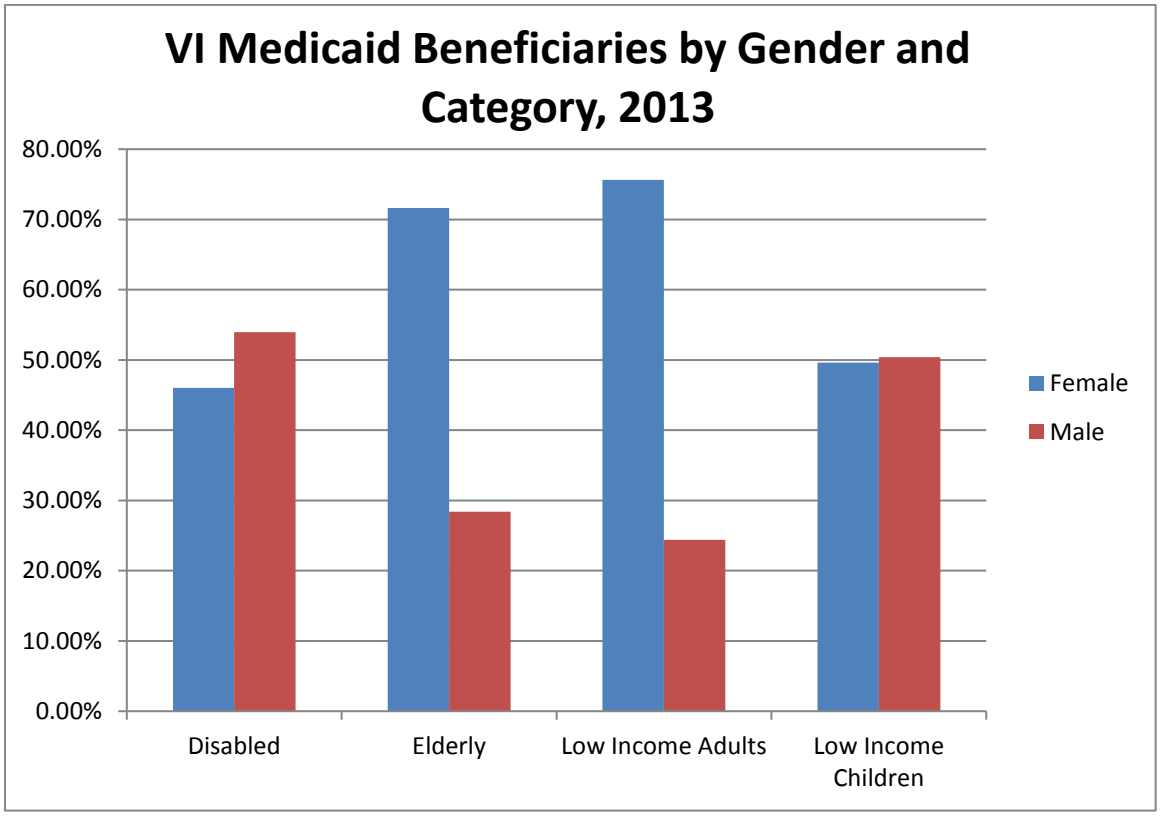
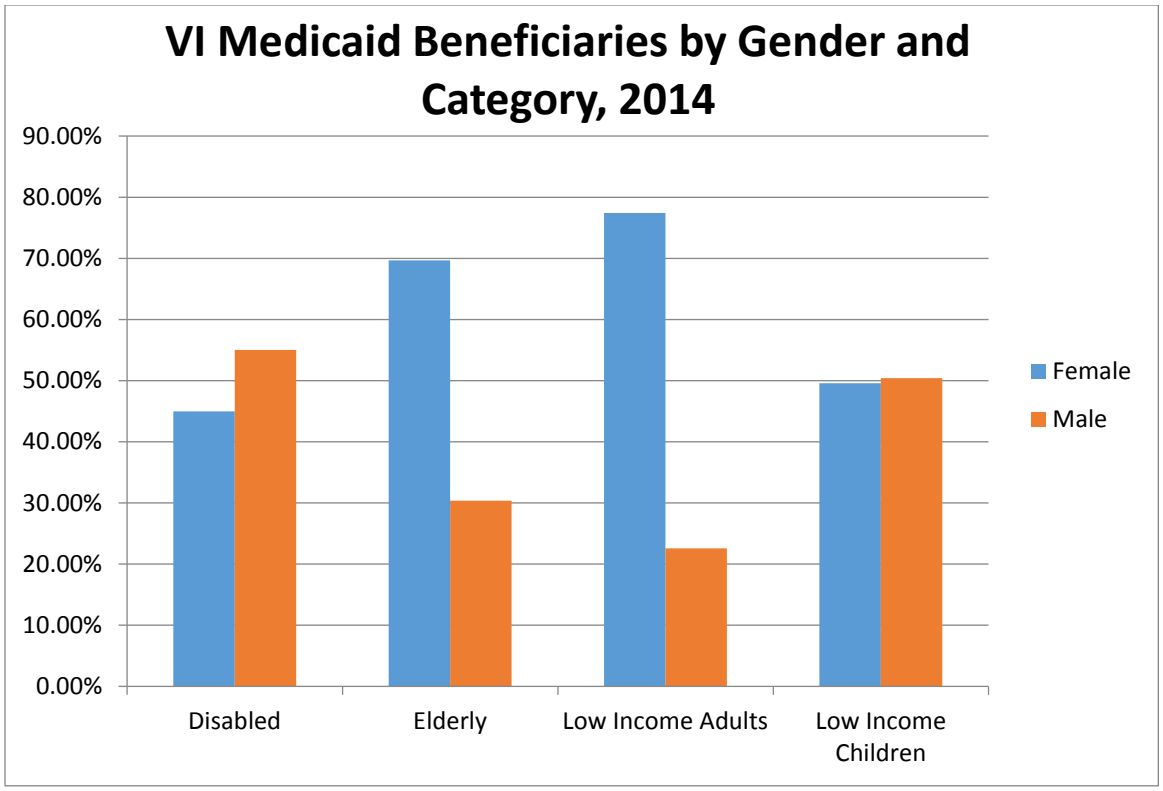
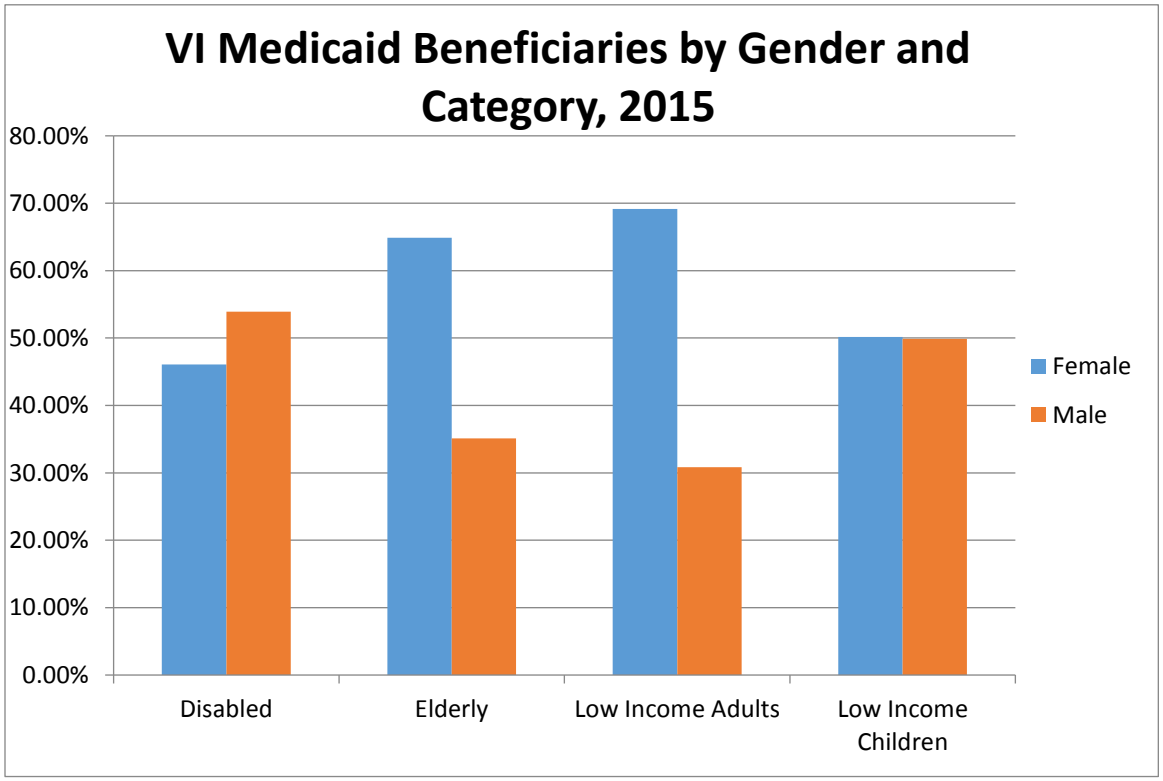

VI Medicaid Beneficiaries by Age Group, 2014
65+ 6%
19 to 64 34%
0 to 18 60%

Figure #3 shows the number of beneficiary calls identifying an access issue from 2012 – 2015.

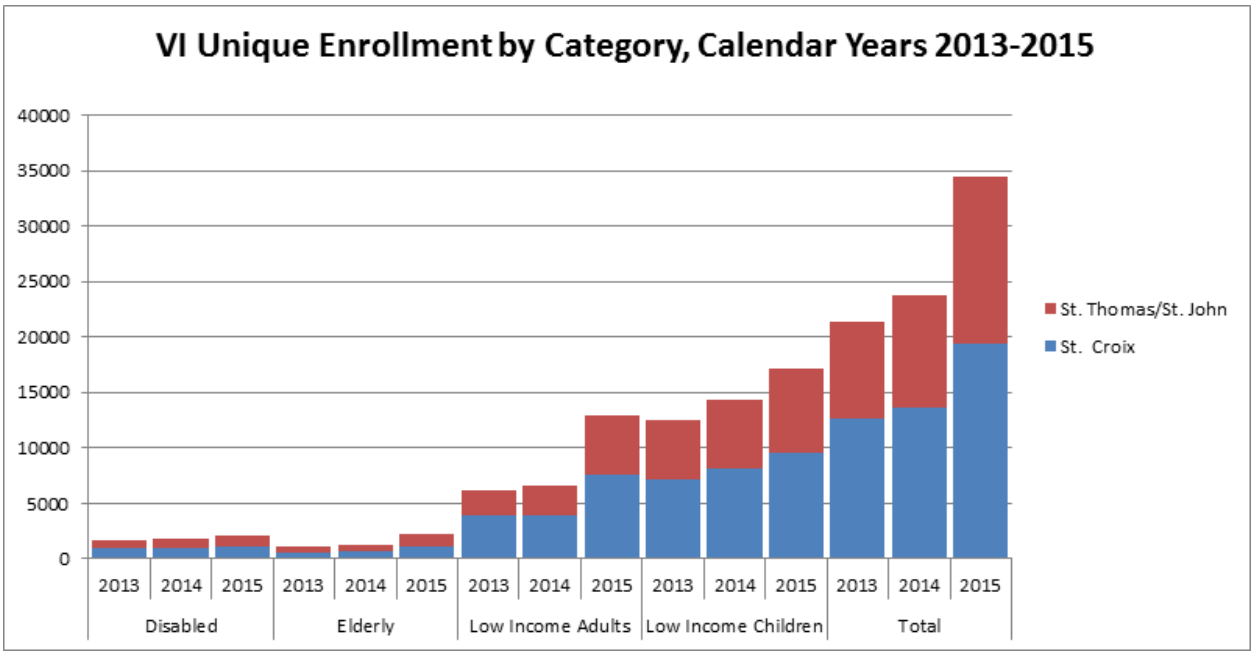





VI Medicaid Beneficiaries by Gender and Category, 2014
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Disabled
Elderly
Low Income Adults
Low Income Children
Female
Male


VI Medicaid Beneficiaries by Gender and Category, 2015
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Disabled
Elderly
Low Income Adults
Low Income Children
Female
Male

Medicaid Eligibility Growth by Category:2013 to 2015



Medicaid Eligibility: 2013 to 2015

2013					
Category	**Age**	**Gender**	**St. Thomas**	**St. Croix**	**Total**
Disabled Adults	19 to 64	M	316	430	746
Disabled Adults	19 to 64	F	252	339	591
Disabled Adults	65+	M	37	82	119
Disabled Adults	65+	F	48	99	147
Elderly		M	142	164	306
Elderly		F	360	412	772
Low Income Adults	19 to 64	M	507	1,002	1,509
Low Income Adults	19 to 64	F	1,735	2,959	4,694
Low Income Adults	65+	M	5	6	11
Low Income Adults	65+	F	10	9	19
Low Income Children	0 to 18	M	2,665	3,637	6,302
Low Income Children	0 to 18	F	2,659	3,548	6,207
Total			8,736	12,687	21,423

2014					
Category	**Age**	**Gender**	**St. Thomas**	**St. Croix**	**Total**
Disabled Adults	19 to 64	M	366	502	868
Disabled Adults	19 to 64	F	296	380	676
Disabled Adults	65+	M	40	54	94
Disabled Adults	65+	F	45	65	110
Elderly		M	174	189	363
Elderly		F	407	426	833
Low Income Adults	19 to 64	M	519	946	1,465
Low Income Adults	19 to 64	F	2,025	3,013	5,038
Low Income Adults	65+	M	6	7	13
Low Income Adults	65+	F	19	10	29
Low Income Children	0 to 18	M	3,148	4,075	7,223
Low Income Children	0 to 18	F	3,068	4,036	7,104
Total			10,113	13,703	23,816

2015					
Category	**Age**	**Gender**	**St. Thomas**	**St. Croix**	**Total**
Disabled Adults	19 to 64	M	454	593	1,047
Disabled Adults	19 to 64	F	414	452	866
Disabled Adults	65+	M	38	47	85
Disabled Adults	65+	F	46	56	102
Elderly		M	410	381	791
Elderly		F	761	700	1,461
Low Income Adults	19 to 64	M	1,626	2,313	3,939
Low Income Adults	19 to 64	F	3,621	5,247	8,868
Low Income Adults	65+	M	32	35	67
Low Income Adults	65+	F	56	59	115
Low Income Children	0 to 18	M	3,780	4,747	8,527
Low Income Children	0 to 18	F	3,787	4,789	8,576
					-
Total			15,025	19,419	34,444

Claims Activity: 2013 to 2015

Claim Summary	2013	2014	2015
Total Inpatient Hospital	936	3,606	2,588
Total Outpatient Hospital	8,497	33,081	24,627
Total Primary Care	11,494	31,152	14,902
Total Obstetrical Care	6,755	16,069	8,150
Total Dental Services	4,295	9,587	6,844
Total Specialist Services	6,152	35,189	23,150
Total Behavioral Health	632	108	276
Total Long Term Care	244	2,793	1,149
Other (DME, Transportation, Physical Therapy, etc.)	721	2,286	2,535
Home Health	-	-	11
Total Claims	39,726	133,871	84,232

Medicaid Enrolled Providers: 2013 to 2015

Enrolled Providers	2013	2014	2015
Inpatient Hospitals	2	2	2
Outpatient Hospitals	2	2	2
FQHCs	2	2	2
LTC	1	1	1
Home Health	1	1	1
Primary Care	49	55	56
OBGYN/Nurse Midwives	11	12	18
Dental	11	11	13
Behavioral	7	8	9
Specialists	99	121	133
Other (Lab, Pharmacy, Vision, DME, NEMT, etc.)	35	37	37
Total	220	252	274

Beneficiary Perceptions of Access to Care

The USVI does not currently collect the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. In the future DHS intends to deploy the survey through the hospitals, operated by the Health and Hospitals Corporation, the clinics operated by DOH, and the two FQHCs.

What do the Data Tell Us So Far?

The USVI Medicaid program has made a successful transition from a "closed" provider network where care was largely delivered through a public health model to an "open" Medicaid program where care delivery is shared between the remaining public clinics and the increasing roster of enrolled private providers. The key to this transition has been the implementation of the MMIS in 2013.

The Medicaid eligible and enrolled beneficiary population has increased dramatically since the days of the carefully circumscribed population and eligibility requirements in 2009, when only 9,000 members were eligible at any given time. The factors contributing this growth include:

1. The development of non-cash eligibility categories for children, parents, pregnant women and the Aged, Blind and Disabled in the years between 2012 and 2014. Prior to this time the USVI Medicaid program had not fully separated Medicaid eligibility from cash assistance.

2. The federal recognition of the two eligibility systems (VIMS - Medicaid, and CARIBS -SNAP and Cash Assistance) as two complimentary single state agency pathways to eligibility under a 1914€ waiver from CMS. This allowed DHS to use SNAP data to facilitate Medicaid eligibility applications.

3. The introduction of innovative strategies to encourage enrollment such as Express Lane Eligibility, Mail-In applications, and Hospital Presumptive Eligibility.

4. The additional federal financial resources that became available as a result of the Affordable Care Act and successful Certified Public Expenditure (CPE) claims for hospital services and Retro-Claiming for other publicly financed health care that was previously paid for with 100% local funds.

5. The expansion to cover childless adults in 2015 and the CMS approval of the Alternative Benefit Plan.

6. See the Expansion charts on pages 6, 7 and 8 for details.

There was a dramatic surge in claims submitted to the MMIS from 2013 to 2014. While there was a modest growth in the eligible population and the number of Medicaid enrolled providers, neither factor can account for such a dramatic increase in services.

We can point to two major factors that contributed to this surge.

1. With the implementation of the MMIS in 2013, it undoubtedly too some time for providers to become familiar with the new system of reimbursement. Prior to the implementation of a fully automated claims system it often took weeks, if not months for providers to be paid. With the MMIS that time was cut to a matter of days. As providers became more aware of the advantages of the new system their participation increased accordingly.

2. The USVI experienced some of the phenomena known as "pent up demand". With medical services much more readily available, many lingering and often ignored issues such as dental services were the subject of increased utilization.

We know that the increased utilization went well beyond dental. At the same time that the DHS was aggressively seeking to expand the Medicaid population, DHS took steps to loosen the restrictions on referrals to private providers that may have artificially limited utilization. Prior to the implementation of the MMIS, all requests for referrals to private providers needed to be approved by the medical staff at DHS. In 2014, DHS implemented a new Care Coordination model where Medicaid clients selected or were assigned to a primary care site – either an FQHC (East End Medical Center-St. Thomas and Frederiksted Health Center-St. Croix), or one of the clinics operated by DOH. Upon the initial approval by DHS, each primary care site was now able to establish a patient referral for services from a private provider and was allowed to add additional services to that referral in the MMIS. As a result, access to specialist providers increased dramatically – from 6,152 claims in 2013 to 35,189 claims in 2014.

Just as the USVI experienced explosive growth in claims activity between 2013 and 2014, between 2014 and 2015 claims activity fell dramatically, from 133,871 claims to 84,232 claims. The reasons for this are not totally understood.

It seems counter-intuitive that that the surge in claims occurred during a period of modest growth in client enrollment between 2013 (21,423) and 2014 (23,816). In contract between 2014 and 2015 Medicaid eligibility soared from 23,816 to 34,444, and increase of 45%.

What can account for the dramatic decline in provider claims while eligibility was increasing substantially?

There are at least three potential hypotheses, both of which have significant implications for the future of the Medicaid program in the USVI.

1. The surge in claims activity in 2014 was a one-time phenomenon, reflecting the opening of a broader provider network and increased provider activity incentivized by awareness of prompt payment. Pent-up demand also contributed to increased utilization.

2. The drop-off in claims activity in 2015 is curious. I am tempted to posit that claim lag may be skewing the results. However, we are now (September, 2016) 9 months beyond the end of the 2015 calendar year. It is unlikely that claim lag alone could make such a large contribution to decreased claim activity.

3. The competing explanation is that access and utilization have now resumed “normalized” levels after the heady days of eligibility expansion, technology innovations HIT, and the provider-friendly MMIS. The suspicion is that after many years of a tightly controlled public delivery model, access may become a little too loose and providers may have taken advantage.

Conclusions and Recommendations

You will note that in this iteration of the Access Report there are statistics that we have so far been unable to provide, such as the number or prenatal and post-partum visits provided during the period of global obstetrical care. We are not even certain that we can identify the number of Medicaid births in each of the three years that are the subject of this report, although we are pursuing that number with the USVI DOH. We expect to able to provide much more granular analysis of the utilization data in a subsequent draft of this report. Our intention was to provide at least some high level analysis to meet the October 1 deadline.

In terms of the strengths and successes of the USVI Medicaid program, we can take pride in the expansion of the eligible population, which now comprises fully one third of the total population of the Territory. Given the persistent poverty that effects the population in the islands, this coverage is much more in line with the needs of the population than it has even been before. We can expect that coverage to increase in the future.

The Territory can also point to the achievements in health technology, including the implementation of the first CMS-certified MMIS in a United States territory. The Territory is now well on its way towards replacing the legacy VIMS and CARIBS eligibility systems with a comprehensive, integrated human service eligibility system (the VIBES Project) which is funded with a 90% federal match under an approved IAPD and schedule for implementation in 2017.

And yet, there are serious questions that still must be addressed.

1. The reporting capacity of the MMIS is still an under-utilized management tool. Management staff at DHS have not fully taken advantage of the Service Utilization and Reporting System (SURS) and the online query features to monitor utilization and provider behavior. In the absence of a more focused, data-driven approach management will not be able to respond nimbly to requests for data from local government or our federal partners.

2. This lack of a focused approach to reporting also leaves open the potential for provider abuse, and even outright fraud. The Territory is currently in discussions about the establishment of a Medicaid Fraud and Abuse Unit working in concert with the Office of the Attorney General. However, those efforts will continue to be seriously compromised without a more robust data initiative.

3. Over the past seven years the USVI has been fortunate to receive enhanced federal funding under the American Recovery Act (ARA), the ACA, numerous Advanced Planning Documents (APDs), CPEs, Retro-Claiming, etc. However, for the program to be sustainable with the growth in the eligible population there are significant budget challenges ahead. The leaders in the Territory will need to make difficult choices between increasing the appropriation for the local Medicaid share of expenses (45%) and the direct appropriations that now go the hospitals and the clinics. If the territory desires a more modern and open Medicaid program, it will need to decide how to fund it in the long term.

4. Long Term Care is looming as the next area of challenge. In 2016 the only previously certified skilled nursing facility in the territory (Seaview) lost its certification by CMS due to deficiencies in management and care delivery. That means that there is currently no Medicaid enrolled long term care provider, other than the one home health agency located on St. Thomas. At the same time, the population of the islands is aging, as younger islanders seek their fortune on the mainland and the old remain behind.

DHS is currently conducting an inventory of the services that it provides through the Adult Services division to determine which of those services could potentially qualify for Medicaid reimbursement. The goal of this initiative is to develop the locally-funded services that are provided to the elderly and the disabled citizens of the USVI as the foundation for a community-based system of care with Medicaid support. The options under consideration include State Plan Amendments for Personal Care Attendant services, a Community First Choice Option, and federal claiming for contracted medical and nursing services provided in group homes and supported apartments.

Attachment A – Response to CMS Questions

Question 1: Did the territory provide coverage to parents and childless adults up to at least 100% of the applicable poverty line, as of March 23, 2010?

Answer:

Medicaid eligibility for parents in the United States Virgin Islands (USVI) Medicaid program as of March 23, 2010 was limited to the categorical income and asset levels described in Supplement 1 to Attachment 2.6-A, page 1 of the approved State Plan. There was no specific coverage for single adults in effect as of that date. However, separate and apart from the Medicaid program, the USVI has historically been providing comprehensive health care coverage to individuals in the islands, including parents, childless adults and others, no matter what their income level. The commitment that the Territory will provide health care services to its citizens regardless of their ability to pay (or their eligibility status with Medicaid), was affirmed with the passage of USVI Code Title XIX, Part 2, Chapter 16, Subsection 277(a):

"No resident of the Virgin Islands shall be denied medical care because of financial inability to pay the cost thereof".

The 1994 legislation that established the Health and Hospitals Corporation re-affirmed the right to health care for the resident of the USVI and went on to mandate that:

1. Health care is to be provided to all residents.[1]

2. The Corporation shall demonstrate fiscal responsibility and efficient management of a territorial health system.[1]

3. The Corporation shall establish a schedule of fees for all services.[1]

4. All fees collected will be deposited into "The Health Revolving Fund" to further support the provision of services to residents.[1]

5. No resident will be denied care because of their inability to pay the established fees.[1]

6. The Corporation shall improve quality of care, reduce morbidity and mortality and establish standards for performance.[1]

7. In conjunction with the Corporation, the USVI DOH is charged with maintaining a schedule of fees for the medical care receives direct funding to provide.[1] Medical care is define broadly as including "medical, surgical, dental, and nursing services, and other remedial services recognized by law, in the home, office, hospital, clinic, and any other suitable place.[1]

Thus, since 1994 the USVI has been offering comprehensive health care coverage to individuals in the islands, including parents, childless adults and others, no matter what their income level. This satisfies the fundamental threshold criterion in the CMS expansion State/Territory analysis.

In June, 2015, Medicaid formally extended coverage to childless adults with household incomes up to 75% of the federal poverty level. Medicaid now provides coverage to all citizen residents with household incomes up to 75% of the federal level without an asset test, including children, pregnant

women, parents and childless adults. The Aged, Blind, and Disabled group is covered up to 100% of the federal poverty level with a $1,500 asset test.

Question 2: With regard to the coverage provided as of March 23, 2010:

a) What was the upper income level of coverage for parents as of March 23, 2010?

Answer:

As described above, there was no income level for parents as of March 23, 2010. However, in June 2015 Medicaid coverage

b) What was the upper income level for coverage of childless adults as of March 23, 2010?

Answer:

There is no upper income level on coverage of childless adults in the USVI as coverage is provided to everyone regardless of income level. In 2014 Medicaid coverage was extended to parents with household incomes up to 75% of the federal poverty level (see Chart 1)

c) If coverage was provided through a section 1115 demonstration, please provide the demonstration's name and project number; if through a state-only program, please identify the state-only program.

Answer:

The USVI has no Section 1115 waivers. The previous USVI "State-Only" program operates as the Health and Hospitals Corporation under USVI Code Title XIX, Part 2, Chapter 16. See Chart 1 for the Medicaid coverage provided and the effective dates of the coverage.

d) Was this coverage based on the federal poverty line or on a local poverty line specified in an approved state plan?

Answer:

The USVI is exempt from the federal poverty level established by the Office of Management and Budget. Instead, the Territory retains the authority to establish its own level of poverty. The Territory poverty level is equal to 75% of the federal poverty level. This standard is applied without an asset test to all Medicaid coverage groups with the exception of the ABDs and the Medically Needy without an asset test (see Chart 1).

Question 3: Was this coverage offered on a territory-wide basis?

Answer:

Yes

- Publicly funded hospitals are located on St. Croix (Juan Luis) and St. Thomas (Roy Schneider)
- FQHCs are located on St. Croix (Frederiksted) and St. Thomas (East End)
- DOH clinics are located on St. Croix, St. Thomas, and St. John

Question 4: What was the scope of coverage provided to these populations?

Answer:

As of the date of enactment of the ACA, publicly funded services included and went well beyond inpatient hospital services. Services provided through the hospitals, FQHCs and DOH Clinics include:

- Primary care
- Dental care
- Behavioral health
- Family Planning
- Birth and Delivery
- Emergency Services
- Emergency medical transportation (ambulance)

a. Did the coverage include inpatient hospital services?

Answer:

Yes, see the answers to Questions 3 and 4 (above)

The tradition of publicly funded health care services for the population on the USVI goes back to the earliest days of American jurisdiction and was in place well before the date of enactment of the ACA. Publicly funded health care services:

- Are offered on a territory-wide basis;
- Are not dependent on access to employer coverage, contribution, or employment; and
- Are not limited to premium assistance, hospital only benefits, a high-deductible plan, or a health opportunity account.

b. Was the coverage dependent on access to employer coverage, employer contribution, or employment?

Answer:

No. Services funded by direct appropriations to the hospitals, FQHCs, and DOH clinics are available to all residents of the USVI, regardless of employment status

c. Was the coverage limited to:

i. Premium assistance?
ii. Hospital-only benefits?
iii. A deductible plan?
iv. A health opportunity account?

Answer:

No

[i] A History of the Virgin Islands of the United States, Isaac Dookhan, Canoe press, 1974
[ii] For the Health of the Enslaved: Slaves, Medicine, and Power in the Danish West Indies, Niklas Jensen, Museum Tusculanum Press, 2011
[iii] US Navy Archives – www.history.navy.mil
[iv] America's Virgin Islands: A History of Human Rights and Wrongs, William W. Boyer, Carolina Academic Press, 2008
[v] Ibid
[vi] PL 74-749, 48 Stat 1907, enacted June 22, 1936
[vii] United States Virgin Islands Code, Title 19, Part II, Chapter 16 – Government Hospitals and Health Facilities Corporation
[viii] US Virgin Islands Bureau of Economic Research, 2009
[ix] USVI DHS 2013
[ix]Ibid -section 240(i) – General Provisions
[ix] Ibid - section 242 (e)
[ix] Ibid – General provisions, Section 244(e)
[ix] Ibid- section 275
[ix] Ibid - Section 277
[ix] Ibid - Section 248(k)(4)
[ix] Ibid – section 272 (a)
[ix] Ibid – section 217