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THE INSULAR AREAS MEDICAID CLIFF

OVERSIGHT HEARING

BEFORE THE

COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

Thursday, May 23, 2019

Serial No. 116–18

Printed for the use of the Committee on Natural Resources

Available via the World Wide Web: http://www.govinfo.gov
or
Committee address: http://naturalresources.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE
36–525 PDF WASHINGTON : 2019

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OVERSIGHT HEARING ON THE INSULAR AREAS MEDICAID CLIFF

Thursday, May 23, 2019
U.S. House of Representatives
Committee on Natural Resources
Washington, DC

The Committee met, pursuant to notice, at 10:06 a.m., in room 1324, Longworth House Office Building, Hon. Gregorio Sablan [Vice Chairman of the Committee] presiding.

Present: Representatives Grijalva, Sablan, Lowenthal, Cox, Van Drew, Cunningham, Soto, Horsford, Tonko, Radewagen, González-Colón, and Hern.

Also present: Representative Plaskett.

Vice Chair SABLAN. Good morning. The Committee will now come to order.

The Committee is meeting today to hear testimony on the impact of the end of Medicaid funding for the insular areas under the Affordable Care Act, also known as the insular areas Medicaid cliff.

Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman and the Ranking Member. Therefore, I ask unanimous consent that all other Members' opening statements be made part of the hearing record if they are submitted to the Clerk by 5 p.m. today.

I ask unanimous consent that the gentlewoman from the U.S. Virgin Islands, Ms. Plaskett, be allowed to sit on the dais and question the witnesses.

Hearing no objection, so ordered.

STATEMENT OF THE HON. GREGORIO KILILI SABLAN, A DELEGATE IN CONGRESS FROM THE TERRITORY OF THE NORTHERN MARIANA ISLANDS

Vice Chair SABLAN. Good morning again, everyone.

The Mariana Islands, which I represent, and the four other U.S. insular areas all face a Medicaid cliff at the end of this year. Supplemental funding for the Medicaid programs in our areas included in the Patient Protection and Affordable Care Act, or "Obamacare" as we like to call it, expires this year.

And I can just recall as if it was only yesterday when Pedro Pierluisi and I enlisted the help of the congressional Hispanic Caucus and met with the President on this issue, and the Senator from New Jersey joined us. And I think from that meeting we were able to get this money, because we were not included in the Affordable Care Act under the reconciliation budget process.

But loss of that funding puts healthcare delivery at risk, not just for Medicaid recipients in our islands, but for the population at large. Today's hearing is meant to shine a light on that imminent crisis.

I want to thank the directors of the insular areas Medicaid programs for being here as witnesses. Your programs are already short of cash, so the cost of coming to Washington was not taken lightly, but I think that we could have no better spokespeople to describe how truly dire the situation is. I hope we will be able to learn from you what the loss of Medicaid funds will mean to the people you serve—real people, our people, who simply have no other means of getting basic health care.

Also invited to testify today is the Chief Executive Officer of the Commonwealth Healthcare Corporation, Ms. Esther Muna runs the one and only hospital in the Marianas, and that hospital depends on Medicaid for over one-quarter of its revenue.

I hope Ms. Muna will be able to tell us what the loss of Medicaid funding will mean to the hospital's ability to deliver services and how that will impact not only Medicaid patients, but all her patients. I think Ms. Muna's description of how the hospital depends on Medicaid revenue will help us understand how losing Medicaid revenues will hurt healthcare providers in private practice as well.

So, we are all working from a common set of facts, let me quickly review the situation. In the states and the District of Columbia, Medicaid is an entitlement program. To the extent there is a need for services and to the extent a state can provide local matching funds, Federal Medicaid funds are always available.

In the five insular areas, this is not the case. Up until 2011, we each received a fixed block grant. That block grant, I am sorry to say, is unrelated to the needs of each of our areas. It seems to have been set rather arbitrarily decades ago. And the local match to access that block grant was set in law at 50/50. And 50/50 is the same matching rate as the wealthiest states, while states as poor as the insular areas only match at a rate of 24 local/76 Federal.

Obamacare provided some relief—an extra $7.3 billion in temporary Medicaid funding and a permanent change to the match to 45 local/55 Federal. But the Obamacare money is no longer available after this year, and all the insular areas will revert to their block grants.

Using 2018 data for American Samoa, that means going from $20 million in Federal funding to $12 million; for Guam, from $56 million to $18 million; for the Marianas, from $25 million to $7 million; for the U.S. Virgin Islands, from $70 million to $18 million; and for Puerto Rico, from $2.3 billion to just $360 million. We cannot suffer cuts like that and continue to deliver services.

The path forward is unclear. Certainly, more money is needed, and an equitable matching rate. But there is also the need for each of the insular areas to build capacity to deliver care. Because, ultimately, the goal is not just to have the same funding as states. What we want is medical care for those who need it in the insular areas to be every bit as good as medical care in the states.

I look forward to hearing from the witnesses for their advice and experience.

Last, I want to report that one of the meetings we arranged for the directors to add value to their time in Washington has paid off. Some of you already knew this prior to coming here. But you met yesterday with staff from the Senate Finance Committee and the

House Energy and Commerce Committee. We also arranged for you to meet with administration officials of CMS, the Centers for Medicare and Medicaid Services.

You asked them at that meeting to allow for Obamacare Section 1323 money to be used in Fiscal Year 2020 before you use the Section 1108 annual block grant. I received word last night that CMS has decided to do what you asked. That will make more money available that otherwise would have been lost.

So, if we are able to do nothing else, your trip here was rewarded. I would like to say that we will get something else done here. But I certainly do believe that your trip here and today's hearing will have positive results.

[The prepared statement of Vice Chair Sablan follows:]

PREPARED STATEMENT OF THE HON. GREGORIO KILILI SABLAN, A DELEGATE IN CONGRESS FROM THE TERRITORY OF THE NORTHERN MARIANA ISLANDS

Good morning. The Mariana Islands, which I represent, and the four other U.S. insular areas all face a "Medicaid cliff" at the end of this year. Supplemental funding for the Medicaid programs in our areas, included in the Patient Protection and Affordable Care Act—or Obamacare as we like to call it—expires this year.

Loss of that funding puts healthcare delivery at risk—not just for Medicaid recipients in our islands, but for the population at large. Today's hearing is meant to shine a light on that imminent disaster.

I want to thank the directors of each of the insular areas Medicaid programs for being here today as witnesses. Your programs are already short of cash, so the cost of coming to Washington was not taken lightly, but I think that we could have no better spokespeople to describe how truly dire the situation is. I hope we will be able to learn from you what the loss of Medicaid funds will mean to the people you serve—real people, who simply have no other means of getting basic health care.

Also, invited to testify today is the Chief Executive Officer of the Marianas Health Care Corporation. Ms. Esther Muna runs the one and only hospital in the Marianas. That hospital depends on Medicaid for over one-quarter of its revenue.

I hope Ms. Muna will be able to tell us what the loss of Medicaid funding will mean to the hospital's ability to deliver services, and how that will impact not only Medicaid patients, but all patients. I think Ms. Muna's description of how the hospital depends on Medicaid revenue will help us understand how Medicaid revenues will affect healthcare providers in private practice, as well.

So, we are all working from a common set of facts, let me quickly review the situation. In the states and the District of Columbia, Medicaid is an entitlement program. To the extent there is a need for services and to the extent a state can provide local matching funds, Federal Medicaid funds are always available.

In the five insular areas this is not the case. Up until 2011 we each received a block grant. That block grant, I am sorry to say, is unrelated to the need in each of our areas. It seems to have been set rather arbitrarily, decades ago. And the local match to access that block grant was set in law at 50–50. That is the same matching rate as the wealthiest states. While states as poor as the insular areas only match at a rate of 24–76.

Obamacare provided some relief: an extra $7.3 billion in temporary Medicaid funding and a permanent change in the FMAP to 55–45. But the Obamacare money is no longer available after this year. And all the insular areas will revert to their block grants.

For American Samoa, this means going from $20 million in Federal funding to $12 million. For Guam, from $56 million to $18 million. For the Marianas, from $25 million to $7 million. For the Virgin Islands from $70 million to $18 million. And for Puerto Rico, from $2.3 billion to just $360 million. You cannot suffer cuts like that and continue to deliver services.

The path forward is unclear. Certainly, more money is needed and an equitable matching rate. But there is also the need for each of the insular areas to build capacity. Because ultimately the goal is not just to have the same funding as states. What we want is medical care for those who need it in the insular areas to be every bit as good as medical care in the states.

I look forward to hearing from the witnesses for their advice and experience.

Vice Chair SABLAN. I now recognize my colleague, the gentlelady from the Puerto Rico, for an opening statement.

STATEMENT OF THE HON. JENNIFFER GONZÁLEZ-COLÓN, RESIDENT COMMISSIONER OF THE COMMONWEALTH OF PUERTO RICO

Miss GONZÁLEZ-COLÓN. Thank you, Vice Chairman.

I really appreciate this hearing taking place. I want to thank you all for being here today to discuss one of the most important and critical issues currently affecting all the U.S. territories: the impending expiration of the additional Medicaid funds granted by the Affordable Care Act and the instability of our healthcare infrastructure.

In 2017, 1.6 million Americans living in the territories were enrolled in Medicaid. That breaks down to 79 percent of the population of American Samoa, 21 percent of the population of Guam, 33 percent of the population of the Northern Mariana Islands, 47 percent of the population of Puerto Rico, and 16 percent of the population of the U.S. Virgin Islands. The national average enrollment for the states and the District of Columbia was 21 percent.

During the same year, the Medicaid program spent an average of $1,800 a year per territory enrollee. In contrast, the national average, excluding the territories, was more than $7,000 per enrollee.

Medicaid in the territories is subject to a statutory Federal Matching Percentage, what we call "FMAP." The FMAP for the states varies annually relative to each state's per capita income. The FMAP for the territories, however, is completely different. We are permanently capped by law to 55 percent. If the formula used to determine the FMAP for the states were applied to Puerto Rico, the Federal Government's matching share would be increasing up to 83 percent, the program maximum.

For the 50 states and the District of Columbia, Medicaid provides a guarantee of Federal matching payments with no pre-set limit. And this is the main difference between the treatment to the territories and the rest of the states. However, annual Federal funding for Medicaid in the territories is subject to this statutory cap. Once a territory exhausts its capped Federal funds, it will no longer receive Federal financial support for its Medicaid program during that fiscal year.

In 2011, the Affordable Care Act granted the territories an additional $8.25 billion in Federal funds for their Medicaid programs in lieu of establishing a health insurance marketplace. The additional funding for each territory ranged from $109.2 million for the Northern Marianas to $6.3 billion for Puerto Rico and was available to be drawn down between July 2011 and September 2019.

Since 2011, Federal Medicaid spending in Puerto Rico has exceeded the statutory cap by using the funds available under the Affordable Care Act. These funds were depleted in February of last year.

During the last Congress, the 115th Congress, President Trump acted to avert this crisis in Puerto Rico's Medicaid program, with a temporary increase of the Federal cap to $296 million for Fiscal Year 2018–2019 in the Consolidated Appropriations Act of 2017. Moreover, as a result of the state of emergency caused by

Hurricanes Irma and Maria in 2017, we again increased the Federal cap to $4.8 billion, for the first time with 100 percent Federal cost share through Fiscal Year 2019, to keep Puerto Rico's Medicaid program operational. All these additional sources of Federal funding for Puerto Rico's Medicaid program will expire in September of this year.

For my island, the Medicaid cap set by statute for Fiscal Year 2020 will be approximately $375 million, with no additional source of Federal funding available. This means that Puerto Rico will exhaust its Federal Medicaid allotment in the first 3 months of Fiscal Year 2020 and will bear the expense in excess of 85 percent of the Federal program, placing additional pressure on sparse territory resources. And I know this is going to be happening in all territories as well.

Each territory is affected by this inequitable treatment in healthcare funding in their own way. However, all of the Medicaid programs, as currently conceived, are unsustainable. This underfunding contributes to larger systemic problems, including lower provider reimbursement rates and provider shortages.

To correct these challenges, I have introduced H.R. 2306, the Puerto Rico Medicaid Act, which seeks to strengthen the Medicaid program on the island by increasing the cap and removing the statutory FMAP limitation.

I am also an original co-sponsor of H.R. 1354, the Territories Health Equity Act, legislation introduced by Congresswoman Plaskett of the Virgin Islands that attempts to fix this problem for all five territories.

Both bills are currently under the jurisdiction of the Energy and Commerce Committee, and I will continue to work with my fellow delegates and the members of that committee to advocate for the advancement of those bills.

I trust that today's testimonies will help my colleagues understand the urgent need for action. If we fail to act with the expediency that the situation requires, the provision of health care in all territories will be severely affected, with far-reaching repercussion for the rest of our Nation.

Although I recognize that this is not the committee with jurisdiction, I would like to thank Vice Chairman Sablan and members of this Committee for this important hearing. Having the witnesses testify and be on the record on the impacts of the Medicaid cliff will undoubtedly help us as we continue working for a long-term solution on this issue.

Thank you, Chairman.

[The prepared statement of Ms. González-Colón follows:]

PREPARED STATEMENT OF THE HON. JENNIFFER GONZÁLEZ-COLÓN, RESIDENT COMMISSIONER OF THE COMMONWEALTH OF PUERTO RICO

Good morning, everyone. I thank you all for being here today to discuss one of the most critical issues currently affecting all of the U.S. territories: the impending expiration of the additional Medicaid funds granted by the Affordable Care Act and the accompanying instability of our healthcare infrastructure.

In 2017, 1.6 million Americans living in the territories were enrolled in Medicaid. That breaks down to 79 percent of the population of American Samoa, 21 percent of the population of Guam, 33 percent of the population of the Northern Mariana Islands, 47 percent of the population of Puerto Rico, and 16 percent of the

population of the U.S. Virgin Islands. The national average enrollment for the states and the District of Columbia was 21 percent.

During that same year, the Medicaid program spent an average of $1,866 a year per territory enrollee. In contrast, the national average (excluding the territories) was $7,654 per year per enrollee.

Medicaid in the territories is subject to a statutory Federal Matching Percentage (FMAP). The FMAP for the states varies annually relative to each state's per capita income. The FMAP for the territories, however, is permanently set by law at 55 percent. If the formula used to determine the FMAP for the states were applied to Puerto Rico, the Federal Government's matching share would increase to the 83 percent program maximum.

For the 50 states and DC, Medicaid provides a guarantee of Federal matching payments with no pre-set limit. However, annual Federal funding for Medicaid in the territories is subject to a statutory cap. Once a territory exhausts its capped Federal funds, it no longer receives Federal financial support for its Medicaid program during that fiscal year.

In 2011, the Affordable Care Act granted the territories an additional $8.25 billion in Federal funds for their Medicaid programs *in lieu* of establishing a health insurance marketplace. The additional funding for each territory ranged from $109.2 million for the Northern Mariana Islands to $6.325 billion for Puerto Rico and was available to be drawn down between July 2011 and September 2019.

Since 2011, Federal Medicaid spending in Puerto Rico has exceeded the statutory cap by using the funds available under the Affordable Care Act. These funds were depleted by February 2018.

Last Congress, we acted to avert a crisis in Puerto Rico's Medicaid Program with a temporary increase in the Federal cap of $296 million for FY 2018–2019 in the Consolidated Appropriations Act of 2017. Moreover, as a result of the state of emergency caused by Hurricanes Irma and Maria in 2017, we again increased the Federal cap to $4.8 billion with 100 percent FMAP through FY 2019r to keep Puerto Rico's Medicaid program operational. All these additional sources of Federal funding for Puerto Rico's Medicaid program will expire by September 30, 2019.

For Puerto Rico, the Medicaid cap set by statute for FY 2020 will be approximately $375 million, with no additional source of Federal funding available. This means that Puerto Rico will exhaust its Federal Medicaid allotment in the first 3 months of FY 2020, and will bear the expense in excess of 85 percent of the Federal program, placing additional pressure on sparse territory resources.

Each territory is affected by this inequitable treatment in healthcare funding in their own way. However, all of our Medicaid programs—as currently conceived—are unsustainable. This underfunding contributes to larger systemic problems, including lower provider reimbursement rates and provider shortages.

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Although I recognize that this is not the committee of jurisdiction, I would like to thank Vice Chairman Sablan and members of this Committee for this important hearing. Having the witnesses testify and be on the record on the impacts of the Medicaid Cliff will undoubtedly help us as we continue working on a long-term solution for this issue.

Thank you.

Vice Chair SABLAN. I thank the gentlelady for her opening statement.

I now recognize the Chairman of the Full Committee, Chairman Grijalva.

Mr. GRIJALVA. Thank you very much. No opening statement, Mr. Chairman. Just to thank you for organizing a meeting. I think it

is an excellent panel, and I am here to learn something on which direction legislatively we are going to go in terms of dealing with this issue.

So, thank you very much, Mr. Chairman. I appreciate it.

I was just commenting to Mr. Lowenthal here that when you are Chairman of a Full Committee, Mr. Sablan, you are always a little conscious, whether people say it or not, of a possible coup, where your power is removed and you are thrown off the chair. And having said that, Mr. Sablan, of all the people, Mr. Sablan, I just can't believe it, you know?

With that, I yield back.

Vice Chair SABLAN. Thank you. I am going to have to analyze those comments, but I think he meant well.

And I would now like to introduce our witnesses.

Ms. Esther Lizama Muna, who is the Chief Executive Officer of the Commonwealth of the Northern Mariana Islands Healthcare Corporation. Ms. Muna, again, runs our only hospital in the Marianas, whose revenue is about one-quarter, if not more, of the—comes from Medicaid patients.

Ms. Helen Castro Sablan, who is the Director of the Commonwealth of the Northern Mariana Islands State Medicaid Agency.

Welcome to the two of you.

I am going to go ahead and also acknowledge Ms. Theresa Arcangel, who is the Chief Administrator of the Guam Division of Public Welfare, which runs the Medicaid program.

And I would like to ask Mrs. Radewagen to introduce her witness.

Mrs. RADEWAGEN. Thank you, Mr. Chairman.

Our Medicaid Director and CEO is Chief Tofoitaufa Sandra King Young. She came into the position of CEO and Director of Medicaid, and she has been there for most of the time that the ACA funds have been there. She has been working very hard on it, and I want to welcome her and her delegation to town.

Vice Chair SABLAN. Thank you.

I will now recognize the Ranking Member for introduction of her witness.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Sablan.

I would love to introduce Ms. Angie Avila. She is Executive Director of the Puerto Rico State Health Insurance Administration.

Actually, we held a panel yesterday, and she is the one providing the data related to our healthcare system in coordination with the Secretary of Health in Puerto Rico, Mr. Rodriguez.

Vice Chair SABLAN. All right.

And I recognize Ms. Plaskett to introduce the witness from the U.S. Virgin Islands.

Ms. PLASKETT. Thank you, Mr. Chairman. It is an honor and a pleasure to be here under your leadership.

Mr. Grijalva, I would have you note that I called the leadership of this subcommittee for Mr. Sablan, so please be careful.

This is a really important issue, and I am really grateful to have Ms. Michael Rhymer-Browne, who is the Assistant Commissioner of the U.S. Virgin Islands Department of Human Services, which does tremendous work and is managing this issue as well.

I do note that the governor has his chief of staff here, as well as other members of the administration, because we recognize, and our governor, Governor Albert Bryan, recognizes what a tremendously important issue and the need for this funding is to the people of the Virgin Islands.

Thank you.

Vice Chair SABLAN. Thank you, everyone.

And, again, witnesses are welcome.

Under Committee Rules, oral statements are limited to 5 minutes, but your entire statement will appear in the hearing record. The light in front of you will turn yellow when there is 1 minute left and then red when your time is expired.

I like to keep a time frame. We may, if necessary, do two rounds of questioning. But, at the moment, we will start with Ms. Esther Muna, please.

STATEMENT OF ESTHER L. MUNA, CHIEF EXECUTIVE OFFICER, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS HEALTHCARE CORPORATION

Ms. MUNA. Chairman Grijalva, Ranking Member Bishop, Vice Chairman Sablan, and distinguished Committee members, thank you for the opportunity to appear before you today.

As Chief Executive Officer, I oversee the work of the Commonwealth Healthcare Corporation, known as CHCC. CHCC is responsible for CNMI's sole hospital, dialysis services, mental health or public health services, and several outpatient clinics on Saipan, Tinian, and Rota.

As one born and raised on Saipan, I relied on our healthcare services long before I became responsible for them. I have seen how being in a remote location poses a host of challenges for our population.

For example, in the 1990s, a baby with a congenital heart disease had to take a total of 8 hours in flight time to receive care, costing $1 million accumulated in a year.

Several residents that are my neighbors, my relatives, and my friends are unable to return home to the CNMI because we do not have an oncologist on-island to manage their complex cancer treatment.

A gentleman with a neurological injury waited for days before being transported off-island because the cheapest and safest way for him to receive treatment for his injury was at a hospital in the Philippines and, like many U.S. citizens, did not own a U.S. passport. Patients with complex medical issues like this gentleman are often flown to Guam, Hawaii, the Philippines, and Taiwan in order to receive care.

In addition to these challenges of access to care, delivering health services in a remote island is more costly, with the high cost of shipping, and we are competing with U.S. hospitals for the same work force. Fifteen years ago, with only the capped and inadequate Medicaid funding and the CNMI undergoing a major economic crisis due to several global and U.S. Federal policy shifts, the hospital struggled to stock medical supplies and recruit healthcare workers.

The 2007 CMS survey revealed many problems. With no funding improvements, paydays were missed, and doctors and nurses left

the island. In September 2012, CMS issued a termination notice to our hospital. It was clear that without adequate funding the CHCC could not sustain lifesaving services, much less the healthcare needs of our residents.

The $100 million available to the CNMI through supplemental Medicaid funding in 2011 gave us the chance to deliver a little more than basic healthcare services that our people deserve. Prior to 2011, we were receiving the leftover crumbs of the capped funding since the insufficient Medicaid funding was desperately needed and was utilized to save the lives that were going off-island.

With the supplemental Medicaid funding, the CHCC accepted a payment methodology that allowed the hospital to be paid at 55 cents of its $1 cost because the CNMI government's declining economy could not afford to make the match of the 45 cents. It wasn't the most ideal funding; however, if it were not for that boost in Medicaid funding that supplemented that statutory cap, we may have lost our hospital, and I wouldn't be here before you today.

Thanks to the steady Medicaid reimbursements, my team has brought the hospital operations to the highest level that it has ever been. With increased revenue, we have implemented an electronic health record system, a quality assurance unit, outpatient pharmacy, telemedicine services, and added specialty services such as podiatry, ENT, orthopedic surgery, and, as of this month, oncology.

We have tripled our medical staff, with clinic visits nearly doubling since 2013. We have cut our readmission rate in half, far below the national average. We did this by maximizing efficiency and innovation to maintain U.S. hospital standards in our remote rural environment.

During two of the worst storms in U.S. history, we ensured uninterrupted patient services while bringing medical attention directly to the villages that were hit hard by the storms.

The reliable monthly reimbursements from Medicaid protected CHCC's cash-flow and enabled our staff to do their jobs. We took full advantage of the opportunity presented to us in 2011 to stabilize our healthcare system.

So, on the heels of Typhoons Yutu and Mangkhut, we face another crisis. Our Medicaid program is unable to sustain the needs of our healthcare system. Earlier this year, the program exhausted the Federal funds made available in 2011. A return to the low statutory cap on Federal contributions and the low fixed Federal share endangers the very existence of our healthcare system, threatens to further erode our economy, and puts at risk the health and well-being of our people.

Help us maintain our progress and avoid a return to those dark days. Stabilize our Medicaid funding, and provide equity to the U.S. citizens in the CNMI.

Thank you.

[The prepared statement of Ms. Muna follows:]

PREPARED STATEMENT OF ESTHER L. MUNA, CHIEF EXECUTIVE OFFICER, COMMONWEALTH HEALTHCARE CORPORATION, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Chairman Grijalva, Vice Chairman Sablan, and distinguished Committee members, thank you for the opportunity to appear before you today to discuss an issue of significant importance to the Commonwealth of the Northern Mariana Islands (CNMI). On the heels of Super Typhoon Yutu, which devastated the CNMI

economy and its people, we face another crisis—our Medicaid program is unable to sustain its operations with the low statutory cap on Federal contributions.[1] Low Federal contributions, coupled with the exhaustion of PPACA funds this year, creates a fiscal cliff for our Medicaid program. This fiscal cliff threatens to unweave our substantial improvements over the past 10 years in the delivery of health care, further erode our economy, and threaten the health and well-being of our people.

CNMI MEDICAID FINANCING

The framework for Medicaid financing in the CNMI resembles that of the fifty states: the cost of the program (up to a point) is shared between the Federal Government and the Territory and the Federal Government pays a fixed percentage of CNMI Medicaid costs. For CNMI, that fixed percentage is 55 percent. However, unlike the 50 states, the Federal Government pays a *fixed* percentage of the CNMI Medicaid costs within a *fixed* amount of Federal funding. Should CNMI Medicaid expenditures exceed the territory's Federal Medicaid cap, the CNMI becomes responsible for 100 percent of Medicaid costs going forward.

Moreover, the CNMI receive a relatively low fixed percentage, which is known as the Federal Medical Assistance Percentage or FMAP.[1]

The FMAP rate for the CNMI is, and has been, lower than most of the 50 states. The formula by which FMAP is calculated for the 50 states is based on the average per capita income for each state relative to the national average. Thus, the poorer the state, the higher the FMAP is for that jurisdiction in a given year. However, due to statutory restrictions on Medicaid financing for the CNMI, the FMAP we receive is not based on per capita income of residents; subsequently, the territories' FMAP does not reflect the financial need of the CNMI in the same way as the states' financial need is reflected, and the FMAP rate for our territory remains largely stagnant.

Thus, the CNMI is at a disadvantage in their Medicaid financings in two ways: (1) a low FMAP requires a territory to contribute more local funds than a state is required to provide in order to run a Medicaid program; and (2) a cap on Federal Medicaid contributions stifles the overall ability of CNMI Medicaid to function.

CNMI BACKGROUND

In 1975, voters of the Northern Mariana Islands chose to enter into a covenant that established the political union between the Northern Mariana Islands and the United States. The Covenant recognizes U.S. sovereignty but limits, in some respects, applicability of Federal law. The Covenant established that the, "United States will assist the Government of the Northern Marianas to achieve a progressively higher standard of living for its people as part of the American economic community and to develop the economic resources needed to meet the financial responsibilities of local self-government."[2]

From 2004 to 2007, the CNMI lost one-third of its economy.[3] This economic downfall was due largely to several concomitant U.S. Federal and global policy shifts, including the lifting of quotas on garment exports to the United States,[4] the imposition of the Federal minimum wage,[5] and implementation of Federal immigration authority in the territory.[6] Figure 1 demonstrates the severity of this economic spiral.

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[1] Section 1108 of the Social Security Act.

[2] 48 U.S.C. § 1801 Article VII Section 701.

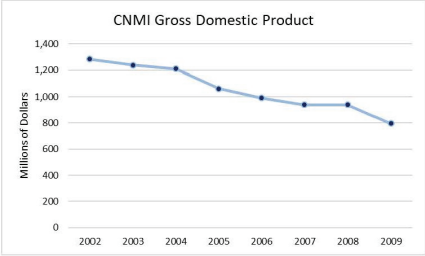
[3] "Economic Impact of Federal Laws on The Commonwealth of The Northern Mariana Islands." October 2008. Malcolm D. McPhee & Associates and Dick Conway. https://marianaslabor.net/news/economic_impact.pdf.

[4] The 1994 Uruguay Round Agreement on Textiles and Clothing called for the World Trade Organization (WTO) members to eliminate quotas on textiles and clothing by January 2005. This meant the CNMI garment industry could no longer compete with cheap labor in countries such as China, Bangladesh, and the Philippines. (Source: Northern Mariana Islands Business Law Handbook: Strategic Information and Laws. International Business Publications, 2013.)

[5] On May 25, 2007, Congress enacted Public Law 110–28, increasing the minimum wage in the CNMI by fifty cents per hour. The act further increased the CNMI minimum wage by fifty cents per year until parity with the U.S. minimum wage was reached.

[6] On May 8, 2008, the president signed P.L. 110–229 applying the U.S. immigration law to the CNMI.

Figure 1—CNMI Gross Domestic Product 2002–2009



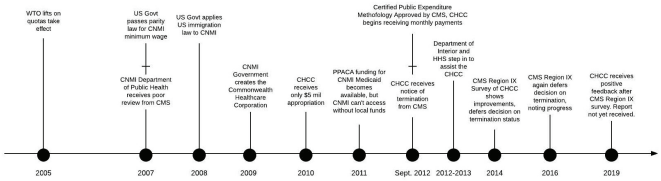
Source: Bureau of Economic Analysis, U.S. Department of Commerce, Released October 17, 2018

THE INCEPTION OF THE COMMONWEALTH HEALTHCARE CORPORATION (CHCC)

In 1978, the CNMI Department of Public Health was formed under the executive branch of government. Over the next 30 years it came to operate the sole territory hospital and emergency department, several outpatient clinics, a dialysis unit, ancillary services, behavioral health services, and all public health functions. In 2007, in the thick of the CNMI's economic collapse, the Department of Public Health began experiencing financial shortfalls due to reduced government revenues, and struggled to stock adequate medical supplies, and recruit healthcare workers. At the CMS Region IX visit in 2007, surveyors identified many problems with the delivery of health care at the hospital, and cited several cases where harm and injury to patients was found to be imminent if immediate corrective actions were not implemented.

In FY 2009, the CNMI government appropriated roughly $31 million of local government resources (about 20 percent of the total budgetary resources identified for appropriation that year) to the CNMI Department of Public Health. In January 2009, to conserve stagnant public funding improve efficiency, the CNMI government reformed its Department of Public Health into an autonomous government corporation, the Commonwealth Healthcare Corporation (CHCC).[7] The CHCC took over operations of the sole hospital, primary care services, dialysis services, disease surveillance, substance abuse, mental health, and all public health services. In 2010, in the face of dwindling revenues, the CNMI government slashed the budget for public health and healthcare service delivery. Only $5 million was appropriated to the newly established CHCC, and even this was not made available all at once.[8] For an operation that normally received a local government appropriation of $30–$40 million annually, with only $5 million for the newly established CHCC, it became known as the "baby born with no blanket." Figure 2 below demonstrates the series of events which have significantly impacted the delivery of health care in the CNMI.

Figure 2—Factors Affecting the CNMI Public Healthcare System 2005–2019



[7] CNMI Public Law 16–51.

[8] Special to the Saipan Tribune by former CHCC CEO Juan Nekai Babauta. August 7, 2018. https://www.saipantribune.com/index.php/the-struggles-of-chcc/.

Several more visits were made by CMS surveyors, and it was clear that due to inadequate funding, the CHCC, was not meeting medical care standards, and was not meeting the needs of CNMI residents.

In July 2011, the Federal Government awarded a total of $7.3 billion in additional funds available across all five territory Medicaid programs under the Patient Protection and Affordable Care Act (PPACA), including an additional $100.1 million for the CNMI[9] from July 2011–September 2019. This meant the CNMI Medicaid program could receive an average of $11 million of Federal funds beyond its statutory cap every year until the funds were scheduled to expire in September 2019. With the statutory Federal cap for the CNMI Medicaid program typically around $6 to $7 million each year, these additional funds created an unprecedented opportunity to make improvements to delivery of healthcare services in the CNMI. This extra funding opportunity meant that the CHCC could rely on receiving reimbursement for seeing a higher volume of patients, and could expand services sustainably with improved financing streams through Medicaid. However, the local government still needed to come up with a local match of roughly $10 million each year to take full advantage of this opportunity and turn around the CNMI's failing system. In FY 2012, on the heels of deep economic recession, roughly $2.7 million was appropriated from local funds to cover the expenses of the CNMI Medicaid program, which meant the CNMI Medicaid Agency didn't have enough local funds to draw down the Federal contribution in full. This meant the Medicaid Agency was not able to fulfill its obligations to the CHCC *and* to private medical providers, so payments to private providers were prioritized.

CHCC and the CNMI Medicaid program proposed a Certified Public Expenditure reimbursement methodology to CMS, otherwise known as CPE. The CPE methodology meant that the CHCC's expenditures, as a public entity, would contribute to the local government's match. This meant that although the CHCC would not receive a 100 percent reimbursement on claims submitted to Medicaid, it would at least receive the Federal share of the reimbursement at 55 percent. The CPE methodology is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider (e.g., public hospital), incurs an expenditure eligible for Federal Financial Participation (FFP) under the state's approved Medicaid state plan. The governmental entity (CHCC) certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service. The CPE methodology was approved by CMS in 2012; the Federal match that the CPE permitted improved financial stressors at CHCC almost immediately.

However, the same month this new funding methodology was implemented, in September 2012, CMS issued a notice of termination to the CHCC for not meeting the standards of care required as conditions of participation in the Medicare. This meant the CHCC was at serious risk of losing all Medicaid and Medicare funding.

The 2012 notice of termination prompted the Department of the Interior and the U.S. Department of Health & Human Services to deploy several U.S.P.H.S. Commissioned Corps Personnel with expertise in internal medicine, pharmacy, pediatric medicine, laboratory services and nursing to assist the hospital in complying with the standards of care.

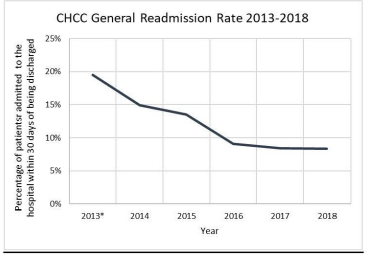
The Federal reimbursement opportunities available due to the newly established CPE methodology coupled with support received from HHS in response to the CHCC's notice of termination from CMS, enabled the CHCC to make the corrections necessary to meet the standards of care required as conditions of participation by CMS regulations. A 2014 CMS survey found numerous improvements; and another survey which took place just a few months ago demonstrated maintenance of these corrections and even further advancement.

[9] Section 2005 of the Patient Protection and Affordable Care Act.

EXCEEDING EXPECTATIONS

In 2008, the CNMI Department of Public Health generated roughly $15 million in revenue.[10] In 2018, the CHCC generated nearly four times that amount at $56 million. Since 2011, we've implemented an electronic health records system, a quality assurance unit, an outpatient pharmacy, sustainable telemedicine services, have tripled our medical staff, added specialty services such as podiatry, ENT, orthopedic surgery, and, as of this month, oncology. We have maintained the only CLIA-certified laboratory in the territory, and renovated our inpatient pharmacy to be compliant with new compounding standards more than a year ahead of schedule.[11] Clinic visits have nearly doubled since 2013, and earlier this year, clinic hours were expanded to accommodate a greater volume of patients. We have improved patient care outcomes and significantly reduced hospital readmission rates by developing a discharge planning process which includes the unpaid caregivers of patients (See Figure 3). During this same period, we weathered two of the worst storms in U.S. history,[12] avoiding any interruption to our inpatient and emergency departments, and getting other services such as dialysis, primary care up and running within 48 hours of each storm. Beyond maintaining services through these disasters, the CHCC was also able to provide medical outreach, disease surveillance of local shelters, and conduct post-disaster rapid community health assessments. Providing these services was possible because of the reliable monthly reimbursements from Medicaid which protected the CHCC's cashflow.

Figure 3—CHCC Readmission Improvement



***Data is only available for October through December 2013**
Source: CHCC Corporate Quality and Performance Management (CQPM)

DEPENDENCE ON MEDICAID FUNDS

In FY 2018, Medicaid reimbursements made up almost one-half (49 percent) of all third-party payer reimbursements to the CHCC and about 30 percent of CHCC's total revenues (about $17.3 million). This high proportion exists even though the CHCC only receives a 55 percent reimbursement[13] from Medicaid, and is not eligible for supplemental Medicaid payments, such as Disproportionate Share Hospital (DSH) payments or Critical Access Hospital designation on the remote islands because of its location in a U.S. territory.[14] Furthermore, because the CHCC is located in a U.S. territory, the CHCC's hospital is not eligible for other programs designed to assist rural hospitals serving low-income populations, such as the Medicare EHR

[10] "Finance: Public Health Generates only $15M Annually." August 13, 2008. Marianas Variety. http://www.mvariety.com/cnmi/cnmi-news/local/9257-finance-public-health-generates-only-15m-annually-.

[11] USP 797 and USP 800 are updated standards for the compounding intravenous drugs. The deadline to meet these standards.

[12] Typhoon Soudelor in August 2015 was a Category 4 typhoon, while typhoon Yutu in October 2018 was classified as a Category 5 super typhoon.

[13] CHCC services, including outpatient pharmacy, dental clinic, Tinian Health Center, and Rota Health Center are billed outside of the CPE methodology and reimbursed at the regular Medicaid Assistance Program. The 55 percent reimbursement represents the Federal share of the CNMI Medicaid program funding.

[14] Section 1886(d) of the Social Security defines eligible hospitals as being located in one of the 50 states or District of Columbia.

incentive program, and the 340B drug discount program.[15] As the sole hospital service provider, the CHCC provides 100 percent of on-island inpatient and emergency care to CNMI Medicaid beneficiaries, and provides far more outpatient visits to Medicaid beneficiaries than any other provider in the CNMI.

Therefore, the operation of the CHCC is highly dependent on Medicaid's ability to pay for services, especially given that 28 percent of the CNMI population relies on Medicaid[16] to access healthcare services, approximately 34 percent of the total population were uninsured in 2010,[17] and an estimated 46 percent of CNMI adults didn't have any form of health insurance coverage in 2016.[18]

Fifty-two percent of CNMI residents, it must be noted, live on incomes at or below the Federal Poverty Level,[19] and the median household income for CNMI families was less than half of the U.S. Nationwide median household income in 2010. Despite the high poverty rate, many CNMI residents don't qualify for Medicaid coverage because they do not hold the necessary permanent resident status to be eligible.[12]

Employer-sponsored insurance is not a requirement for any class of employee in the CNMI, and individual health insurance plans are not available from private insurance companies operating in the CNMI.[20]

IMPACT OF ADDITIONAL ACA FUNDING ON CMNI AND CHCC

We are deeply grateful that Congress took the steps to provide additional resources to the CMNI Medicaid program through the ACA. This funding has been critical to expand services on the island such as enabled to expanding services, establish new ones such as ENT, podiatry, orthopedic surgery, and oncology, reducing patient readmissions, and increasing access to primary care. Outpatient visits at the CHCC's Saipan clinics have steadily increased by more than 50 percent in just 3 years from 2013 to 2017 (See Figure 5). Earlier this year, the adult clinic hours needed to be expanded to evenings and Saturdays to accommodate the growing patient demand. In 2018 alone, the adult clinic added psychiatry, podiatry and otolaryngologist services, further improving access to on-island care, but also increasing the number of patient visits.

The additional ACA funding for the territories expires at the end of September 2019. If no action is taken by U.S. Congress to cushion the free fall from the Medicaid fiscal cliff for the CNMI, the CHCC would not be able to continue to sustain the range of services from inpatient care, primary care, dialysis, behavioral health services, laboratory, pharmacy, and many public health services that it makes available to *all CNMI residents* today. This would impact all health services as personnel at the CHCC may need to be drastically cut, leaving residents to either forego the care they need, or seek care off-island, possibly becoming Medicaid beneficiaries of other states or territories such as Guam. For most island residents, off-island care is not a viable option due to the cost of travel and services.

Figure 4 demonstrates how thoroughly the CNMI has utilized Section 2005 Patient Protection and Affordable Care Act (PPACA) funds. A return to the Federal statutory cap would not cover even half of what is needed to deliver the healthcare services needed by our population.

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[15] Although several public health programs in the CNMI are able to use the 340B drug discount program tied to their grant funding, the CNMI hospital and its outpatient clinics are not eligible because of the territories' exclusion from Section 1886 of the Social Security Act. In April 2019, Governor Torres requested assistance from Secretary Alex Azar to consider including rural health systems of the territories in designations such as sole community hospital and disproportionate share hospital. This request letter is attached to this testimony.

[16] CNMI Medicaid Program Enrollment Data 2018.

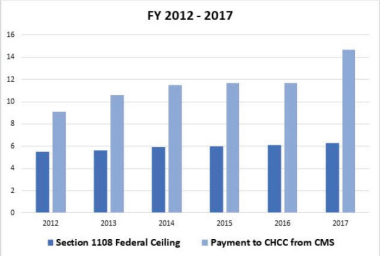
[17] 2010 Census.

[18] 2016 CNMI Non-Communicable Disease and Risk Factor Hybrid Survey.

[19] 2010 Census.

[20] The majority of the Patient Protection and Affordable Care Act health insurance market reforms and health insurance mandates do not apply to the CNMI as a U.S. territory.

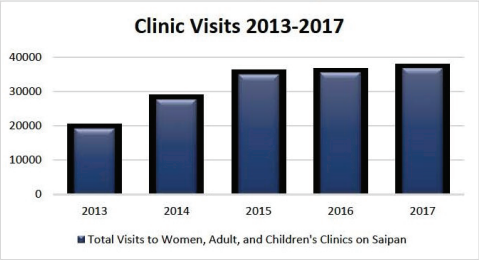
Figure 4—CMS Payments to CHCC Compared with Section 1108 Cap on Federal Funds to the CNMI Medicaid Program



Section 1108 Federal Ceiling Amounts taken from "Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands" March 2019 document published by MACPAC found here https://wwwmacpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Commonwealth-of-the-Northern-Mariana-Islands.pdf. Data on payment to CHCC from CMS is from CHCC Financial Records.

Earlier this month, our Medicaid program announced that it had exhausted all Federal and local funds for the program amid deep CNMI government budget cuts.[21] As a result, the CNMI Medicaid program has chosen to divert Medicaid beneficiaries to the CHCC for all outpatient care in order to maximize the savings for the local government through the CPE methodology. This means that the maximum amount of Medicaid funding will be channeled to the CHCC, the only public healthcare services and safety net provider. Although this will help the CHCC to maintain its operations, as Figure 4 demonstrates, even this strategy will not keep the CHCC operating at the level it is today, much less keep moving us forward.

Figure 5—Outpatient Clinic Visits at CHCC Facility on Saipan



Source: CHCC Resource and Patient Management System (RPMS).

Super Typhoon Yutu, which tore through the CNMI in October 2018, brought the CNMI's tourism industry to a stand-still for several months, and devastated many local businesses and residents. Two deaths were attributed to typhoon Yutu, and although fortunately there were no major disease outbreaks, many residents found it difficult to maintain their regimens for chronic disease care during the recovery months after the disaster. The CNMI government is in no position to make up the significant financing shortfall caused by the depletion of Section 2005 funds. U.S. Congress must act to increase or eliminate the CNMI's Section 1108 cap on Federal contributions.

[21] "Starting June 1, NMI Medicaid will no longer reimburse private health providers" May 16, 2019. Lori Lyn C. Lirio. http://www.mvariety.com/cnmi/cnmi-news/local/112741-starting-june-1-nmi-medicaid-will-no-longer-reimburse-private-health-providers.

Without continued additional Federal support of the CNMI Medicaid program, services will be eliminated, and doctors and nurses will once again leave the island thereby threatening our CMS accreditation. In order to remain compliant with CMS, ensuring patient safety and quality services while maintaining the ongoing operations of the sole hospital service on the island, we would need to make the hard decision to prioritize urgent care needs at the expense of preventive and primary care services.

Although the CHCC offers a sliding fee discount for patients who live on low incomes and don't have health insurance, this program is unfunded, and is primarily a means to reduce barriers to care. The CHCC provided roughly $18 million uncompensated care to uninsured patients in the FY 2018, and about $4 million in charity care under the sliding fee discount program. If the CNMI Medicaid program is unable to pay for services for the Medicaid beneficiaries, then, the CHCC, as the safety-net provider, will bear an even larger burden of uncompensated and charity care, making operations even more difficult to sustain. This will affect any resident of CNMI who requires any form of healthcare services, not only Medicaid beneficiaries. An investment in the CNMI Medicaid program is an investment in the CNMI economy.

LOOKING FORWARD

The CHCC has many plans for further improvements to our healthcare system, but without greater certainty that Medicaid will be able to reimburse for services, these plans may need to be put on hold. Our plans for future enhancements include:

- Expanding telemedicine services, including, but not limited to, telepharmacy and teledentistry on the smaller islands of Tinian and Rota.
- Improving care efficiency by adopting the Patient-Centered Medical Home models at our outpatient clinics.
- Transforming our clinics on the islands of Tinian and Rota into Federally-Qualified Health Centers (FQHCs).
- Constructing a new 40,000+ sq. ft. outpatient facility to accommodate a greater range of services and higher patient capacity, including an outpatient chemotherapy center, and Skilled Nursing Facility.
- Expanding the sole hospital, which was built in 1986 to accommodate a population of fewer than 20,000 people. Today, the CNMI population is nearly three times this size, but the hospital has undergone very little renovation. These plans include expanding the emergency and radiology departments to more than double their current size, and expanding other units of the hospital such as the operating room, laboratory, labor and delivery ward, and intensive care units.
- Investing in photo-voltaic energy generation to improve self-sufficiency and mitigate interruption to hospital services by storm damage to the CNMI's electricity infrastructure.
- Building the first ever comprehensive cancer center in the CNMI.
- Investing in local students who pursue medicine, nursing, pharmacy, and behavioral and public health to build a strong and diverse healthcare work force. We are committed to bringing health workers back home, but we need a financially stable health system to do that.
- Bringing value-based services using population health models and eliminate fee for service models that are paid by volume.
- Working with Medicaid to identify cost-saving opportunities to control costs in the program.
- Offering sustainable and innovative healthcare services in the CNMI.

QUESTIONS SUBMITTED FOR THE RECORD TO MS. ESTHER L. MUNA, CHIEF EXECUTIVE OFFICER, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS HEALTHCARE CORPORATION

Questions Submitted by Rep. Sablan

Question 1. If Congress finally treats the territories equitably and provides uncapped funding with Federal match determined in the same was as states, what would the Commonwealth of the Northern Mariana Islands do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?

Answer. With reliable, full reimbursement, the Commonwealth Healthcare Corporation (CHCC) could expand the availability of services on island even further than it has since the ACA funding became available in 2011. Currently, the CHCC only receives a 55 percent reimbursement for services rendered to Medicaid beneficiaries. While this reimbursement has been regular, reliable, and essential for the cashflow of the CHCC, full and dependable reimbursement from CNMI Medicaid would enable to CHCC to pursue new healthcare services. Most of the CHCC's insured patients are covered by Medicaid, so Medicaid reimbursement is essential to assure sustainability of any new service. The assurance of Medicaid reimbursement for new and expanded lines of healthcare services means that these services would also be available to patients who are uninsured or insured through other third parties.

With the security of equitable Medicaid funding, the CNMI healthcare system could make available a more robust suite of healthcare services on our islands for Medicaid beneficiaries. This would serve the additional benefit to our community as an investment in our economy and healthcare workforce.

1a. With the additional Federal funding, what specific investments could you make to improve eligibility and benefits over time?

Answer. Because this question refers to Medicaid eligibility and benefits, please refer to the CNMI Medicaid Agency's response for the answer to this question.

Question 2. What improvements in your healthcare infrastructure would be needed?

Answer. The Commonwealth Healthcare Corporation (CHCC) has many plans for further improvements to our healthcare system, but without greater certainty that Medicaid will be able to reimburse for services, these plans may need to be put on hold. Our plans for future enhancements include:

- Expanding telemedicine services, including, but not limited to, telepharmacy and teledentistry on the smaller islands of Tinian and Rota.
- Improving care efficiency by adopting the Patient-Centered Medical Home models at our outpatient clinics.
- Transforming our clinics on the islands of Tinian and Rota into Federally-Qualified Health Centers (FQHCs).
- Constructing a new 40,000+ sq. ft. outpatient facility to accommodate a greater range of services and higher patient capacity, including an outpatient chemotherapy center, and Skilled Nursing Facility.
- Expanding the sole hospital, which was built in 1986 to accommodate a population of fewer than 20,000 people. Today, the CNMI population is nearly three times this size, but the hospital has undergone very little renovation. These plans include expanding the emergency and radiology departments to more than double their current size, and expanding other units of the hospital such as the operating room, laboratory, labor and delivery ward, and intensive care units.
- Investing in photo-voltaic energy generation to improve self-sufficiency and mitigate interruption to hospital services by storm damage to the CNMI's electricity infrastructure.
- Building the first ever comprehensive cancer center in the CNMI.
- Investing in local students who pursue medicine, nursing, pharmacy, and behavioral and public health to build a strong and diverse healthcare workforce. We are committed to bringing health workers back home, but we need a financially stable health system to do that.
- Bringing value-based services using population health models and eliminate fee for service models that are paid by volume.
- Working with Medicaid to identify cost-saving opportunities to control costs in the program.
- Offering sustainable and innovative healthcare services in the CNMI.
- Technical assistance to implement systems for utilization review. For example assessing use of brand name vs. generic pharmaceuticals for Medicaid beneficiaries.

2a. Would dedicated up-front funding be needed to make those changes?

Answer. MMIS and Utilization review technical assistance and systems. As this speaks to Medicaid program infrastructure, please refer to the CNMI Medicaid Agency's response for the answer to this question.

Question 3. Would provider payments have to be increased and to what extent?

Answer. Please refer to the CNMI Medicaid Agency's response for the answer to this question.

Question 4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could the Commonwealth of the Northern Mariana Islands make to ensure residents get high quality health care in other ways that meets their needs?

Answer. Please refer to the CNMI Medicaid Agency's response for the answer to this question.

Question 5. Overall, what do you see as the necessary steps to better ensure access to quality, comprehensive care for the Commonwealth of the Northern Mariana Islands residents and what would be a reasonable timeline to reach such a goal?

Answer. The operation of the Commonwealth Healthcare Corporation (CHCC) is highly dependent on Medicaid's ability to pay for services, especially given that 28 percent of the population relies on Medicaid to access healthcare services and about 46 percent of CNMI *adults don't have any form of health insurance coverage*.[1] Fifty-two percent of CNMI residents, it must be noted, live on incomes at or below the Federal Poverty Level,[2] and the median household income for CNMI families was less than half of the U.S. Nationwide median household income in 2010.[3] Despite the high poverty rate, many CNMI residents don't qualify for Medicaid coverage because they do not hold the necessary permanent resident status to be eligible. As of 2010, 43 percent (23,184) of all CNMI residents were non-U.S. citizens, with fewer than one-fifth of them holding the immigration status necessary to be eligible for CNMI Medicaid assistance. Employer-sponsored insurance is not a requirement for any class of employee in the CNMI, and individual health insurance plans are not available from private insurance companies operating in the CNMI. A major step to improving access to quality, comprehensive care for CNMI residents is to improve reimbursement mechanisms for services. Equitable financing for the CNMI Medicaid program would bring the CNMI closer to the reimbursements that are needed to sustain its healthcare system. Other steps must be taken at the local CNMI level to reduce the rate of the non-Medicaid eligible uninsured population and assist low income residents to pay for health care.

Question 6. What will you have to cut if you go off the cliff?

Answer. Please refer to the CNMI Medicaid Agency's response for the answer to this question.

Question 7. What will be the impact on individuals and the healthcare delivery system in the territory, when Obamacare funding ends this year?

Answer. If no action is taken to cushion the free fall from the Medicaid fiscal cliff for the CNMI, the CHCC would not be able to continue to sustain the range of services that it makes available to all CNMI residents today. This would impact all health services as personnel at the CHCC may need to be drastically cut, leaving residents to either forego the care they need, or seek care off-island, possibly becoming Medicaid beneficiaries of other states or territories such as Guam. For most island residents, off-island care is not a viable option due to the cost of travel and services.

The healthcare system problems of 2011/2012 will reoccur, where services would need to be eliminated and doctors and nurses leave island. In order to consistently ensure patient safety and services quality, CHCC will need to make the hard decision to cut back on essential services and refer off-island.

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[1] 2016 CNMI Non-Communicable Disease and Risk Factor Hybrid Survey.
[2] 2010 U.S. Census.
[3] 2010 U.S. Census.

Although the CHCC offers a sliding fee discount for patients who live on low incomes and don't have health insurance, this program is unfunded, and is primarily a means to reduce barriers to care. The CHCC incurred roughly $18 mil of uncompensated care from uninsured patients in the FY 2018, and about $7 mil in charity care under the sliding fee discount program.

If CNMI Medicaid is unable to pay for services for the Medicaid beneficiaries, then, the CHCC, as a safety-net provider of care, will bear an even larger burden of uncompensated and charity care, making operations even more difficult to continue, thereby affecting the whole population requiring any form of healthcare services.

Vice Chair SABLAN. Wow. Perfect timing, Ms. Muna. Thank you for that.

We are trying to get our witnesses' testimony, because some Members will need to run to vote.

Ms. Sablan, you are recognized for 5 minutes.

STATEMENT OF HELEN C. SABLAN, DIRECTOR, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS STATE MEDICAID AGENCY

Ms. HELEN SABLAN. Honorable Chairman Grijalva, Ranking Member Bishop, Vice Chairman Sablan, members of the Committee on Natural Resources, thank you so very much for holding a hearing on the insular areas Medicaid fiscal cliff and for providing the Commonwealth of the Northern Mariana Islands the opportunity to present information on what the fiscal cliff means for the U.S. citizens of the CNMI.

We recognize that we are the smallest of the U.S. territories in terms of population and geographic size. Nevertheless, the CNMI and its U.S. citizens value their U.S. citizenship and the Medicaid program.

The CNMI Medicaid lives under Section 1108 budget caps that are totally inadequate. The ACA recognized the problem and temporarily adjusted the budget caps. The Federal Medical Assistance Percentages (FMAP) was also adjusted to 55/45 percent when calculations give the CNMI income would be higher than almost all states. What does that mean for the CNMI today and tomorrow?

In Fiscal Year 2018, the CNMI Medicaid program expended over $53 million to provide care for the 15,138 eligible Medicaid populations. Today, the number of enrolled Medicaid beneficiaries has increased to 16,206 following the two typhoons in 2018, including the Category 5 Super-Typhoon Yutu.

In March 2019, the CNMI Medicaid program completely exhausted its Medicaid program funding, including the final amounts made available through ACA. The CNMI is not at the fiscal cliff, but it is in free-fall.

For Fiscal Year 2020, Region 9 has informed us that our allotment will be $6.85 million for MAP and $11.2 million for CHIP. This is not much of a change in the cap and means that the shortfall between the actual Medicaid expenditures for Fiscal Year 2018 and the CMS Fiscal Year 2019 allotment will be around $50 million when the accounts payable for 2018 and Fiscal Year 2019 are accumulated.

The median income for a family of four, based on data provided by the U.S. Census in 2010, shows that the CNMI family earned

$19,958 in the same year that the average U.S. family earned $61,564. If we step back for a minute and think about just this basic information, we can clearly understand why so many residents in the CNMI rely on Medicaid for health care or are uninsured. The more than 16,206 individuals in the Medicaid program constitute 46 percent of the U.S. citizens in the CNMI.

The CNMI government, the Medicaid program and its beneficiaries, and the CNMI health system is in a dire situation following the end of additional funding provided under the ACA and the devastating impacts of Typhoon Mangkhut and Super-Typhoon Yutu in 2018. I am here to plead the U.S. Congress to provide Medicaid disaster assistance and to address the inequities in the Medicaid program for the territories.

I have worked in the CNMI Medicaid program since 1986, over 32 years ago. In all these years, I have never been more emotionally affected than I have in the past year. We are currently in the process of severely curtailing services, limiting choice of providers in the program, and are making decisions knowing full well the adverse short- and long-term consequences our decisions will have. I am frightened and saddened at each step in our undertaking because I understand the effects on our people and our health system.

While we are doing our very best to determine what might be intellectually characterized as the so-called "best interests" given the "limited resources"—decisions regarding what services should be continued, what should be curtailed or dropped, and what providers can be paid, are and will continue to be made.

It is very hard to explain to those that come to our office asking whether the health services that they are receiving will be cut. It is very hard to listen to their stories. What should we do with the patient that has been in an off-island hospital in another state that may be dying? Should we now inform the patient and parents that we are sorry but we will no longer pay for any of their medical bills? It is impossible for me not to see the faces of the people behind the numbers and impact that each decision made will have.

In summary, the CNMI is in a desperate and dire situation, and the U.S. citizens in these islands deserve equity in health care. As such, we are humbly pleading for the U.S. Congress to please help to treat this equitably and, if I may humbly ask, quickly.

Thank you once more for taking the time to hear this issue.

[The prepared statement of Ms. Helen Sablan follows:]

PREPARED STATEMENT OF HELEN SABLAN, MEDICAID DIRECTOR, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Honorable Chairman Grijalva, Ranking Member Bishop, and members of the U.S. House of Representatives Committee on Natural Resources: Thank you so very much for holding a hearing on the Insular Areas Medicaid Fiscal Cliff and for providing the Commonwealth of the Northern Mariana Islands (CNMI) the opportunity to present information on what the "Fiscal Cliff" means for the U.S. citizens of the CNMI.

We recognize that we are the smallest of the U.S. territories in terms of population and geographic size. While World War II has long past and memory and knowledge of the Americans that died on Saipan or remembrance of the Enola Gay, the bomber that dropped the nuclear bomb on Japan, flew from the island of Tinian in the CNMI, may have faded, we believe the CNMI remains a location of strategic value in the Asia-Pacific region. Our citizenry appreciates becoming a U.S. territory

in 1978 and a participant in the Medicaid program since 1979. The CNMI and its U.S. citizens value their U.S. citizenship and the Medicaid program.

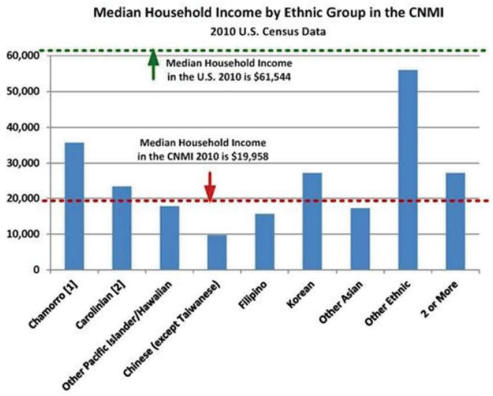
The purpose of this testimony is to provide the facts and challenges of the CNMI Medicaid program and the impacts the Medicaid Fiscal Cliff will have on the U.S. citizens in the territory. There is already so much information on the Medicaid program by U.S. government agencies and non-profit organizations, as well as expertise within the Congress and congressional offices, that I will not try to be duplicative of what this Committee and Congress already knows. At the same time, I will present some data to highlight important considerations.

BASIC INFORMATION

The Medicaid and CHIP programs in the CNMI today have about 15,136 U.S. citizens enrolled in the programs. The number of U.S. citizens in the territory are about 33,273 or 61 percent of the total population of 54,546 in the CNMI. Medicaid and CHIP provides critical healthcare services for about 46 percent of the total U.S. citizens in the CNMI today.

In 2010, the U.S. Census provided data on the per-family median income in the United States. Figure 1 shows that the median income for a family of four in the CNMI was $19,958, in comparison to the median family income of $61,544 for the United States. Figure 1 also shows the income disparities among the ethnic groups in the CNMI. The income disparities among the indigenous Chamorros, Carolinians, and "Other," principally Caucasian populations, when compared to the Asian populations are even more stark but important to note since they are principally non-U.S. and because of their income levels, constitute the vast majority of the uninsured population in the CNMI.

Figure 1—Median Household Income in the CNMI from the CNMI State Innovation Model Plan



As a result of the low-income levels and the high cost of health insurance in the CNMI, there should be no surprise that 46 percent of the eligible U.S. citizens in the CNMI are enrolled in the Medicaid program. In 2016, the uninsured rate was estimated to be 34 percent of adults. The 20 percent of the population that do have private health insurance include the government employees which account for about 10 percent of the population.

THE MEDICAID FISCAL CLIFF

The CNMI Medicaid program is not approaching the Medicaid Cliff. Today, the CNMI Medicaid program has *fallen off the cliff and is currently in freefall*. The CNMI, in FY 2019, has expended all Medical Assistance and ACA funding, although there remains some funding for CHIP that are expected to be fully expended by the end of FY 2019.

Table 1 shows that in FY 2018, the CNMI Medicaid program expended over $53 million dollars. Additionally, as shown in Table 1, there is an Accounts Payables estimate of $18 million dollars remaining at the end of FY 2018.

Table 1 further shows that in the current fiscal year, FY 2019, the Section 1108 budget cap amounts, CHIP funding, and the balance of the ACA increases that have

been fully expended will result in an estimated shortfall for FY 2019 of around $42 million. This will result in another carry-over of Accounts Payables. The Accounts Payable amounts will depend on how much additional debt is incurred from services that cannot be reduced or eliminated and whether there is any relief through Medicaid Disaster Assistance for the current FY 2019.

For FY 2020, the CMS has informed the CNMI of the MAP and CHIP amounts. Based on the formula for the CAPs, the amounts will remain around $19 million. Again, assuming no Medicaid Disaster Assistance or lifting of the Section 1108 caps in Title XIX, the shortfall will be over $42 million, higher than the $36 million estimated by CMS needed for Medicaid Disaster Assistance. This is largely due to the Accounts Payables that are not reflected in the CNMI government financial accounting system.

Table 1—Summary of Fiscal Year Expenditures and Fiscal Year Shortfall Given the End of Additional Funding under the ACA

Fiscal Year and Expenditures	In Millions
FY 2018 Total Medicaid Expenditures in FY 2018	$53.11
FY 2018 Accounts Payables - Unbooked (Incurred But Not Reported (IBNR))	$18.31
Total FY 2018 Medicaid Expenditures and Accounts Payables	**$71.42**
FY 2019 Medicaid Section 1108 Budget CAP	$6.17
FY 2019 CHIP Program Budget	$11.20
FY 2019 Remainder of ACA Section 2005 CNMI Allocation	$2.56
FY 2019 CMS Reconciliation for Previous Years	$4.27
FY 2019 CNMI Legislative Appropriations for Match	$4.64
Total Federal and CNMI Medicaid Funds for 2019	**$28.84**
FY 2019 Projected Shortfall Given 2018 Expenditures and APs or Disaster Assistance Needed Based on 2018 Actual Expenditures and Unbooked IBNR	$42.58
CMS Estimated Shortfall of $36M for Disaster Assistance Provided to U.S. House	$36.00
Shortfall even with proposed $36 Million for Disaster Assistance. Note: This does not include any AP that is accumulating since last drawdown of MAP and ACA.	$6.58

THE PEOPLE BEHIND THE NUMBERS

There are many reports of agencies of U.S. government and non-profit corporations that collectively describe the situation of the Medicaid and CHIP programs in the CNMI and other U.S. territories. These include publications from the Medicaid and CHIP Payment and Access Commission (MACPAC), Kaiser Family Foundation (KFF), U.S. Government Accountability Office (GAO), and many others. We believe that these organizations collectively provide very useful information and data on the situation with the Medicaid programs in the U.S. territories. However, please, let us not forget the people behind the numbers.

As Judge Gladys Kessler in the *Salazar v. District of Columbia* precedential Medicaid case once stated:

> ". . . *let there be no forgetting the real people* to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children, AIDS patients unable to get treatment, elderly persons suffering from chronic conditions like diabetes and heart disease who require constant monitoring and medical attention. Behind every "fact" found herein *is a human face and the reality of being poor in the richest nation on earth*." [1]

IMPACTS ON THE U.S. CITIZENS IN THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

I have worked in the CNMI Medicaid Program since 1986, over 32 years ago. In 1998, I served as the Acting Medicaid Administrator and since 2000, as the Medicaid Administrator/Director for the CNMI Government. In all these years, I have never been more emotionally affected than I have been in the past year.

With the end of the additional funding provided under the Affordable Care Act, the inequitable Section 1108 budget caps under Title XIX, the inequitable FMAP, the chronic lack of local funding, the added financial challenges created by Typhoons Mangkut and Yutu, some of the very highest rates of Medicaid and uninsured in the United States, and the many other challenges of distance, time, and costly air travel, I have had to lead an organization that is planning and executing Medicaid

[1] https://www.courtlistener.com/opinion/2468509/salazar-v-district-of-columbia/.

program cuts that will have both short- and long-term harsh and life-threatening impacts on our U.S. citizen beneficiaries.

The CNMI Medicaid Program is in the process of *severely curtailing services, limiting choice of providers in the program*, and are making decisions knowing full well the adverse short- and long-term consequences this will have on the U.S. citizens in the CNMI. It has been a very emotional and difficult time for our office to plan and implement decisions because we recognize and understand the impacts that this will have on the health of some of the most-needy people in the United States.

I am frightened and saddened at each step in our undertaking because I understand the effects on our people and our health system. While we are doing our very best to determine what might be intellectually characterized as the so-called "best interests" given the "limited resources"—decisions regarding what services should be continued, what should be curtailed or dropped, and what providers can be paid, are and will continue to be made. We very clearly understand the consequences to each decision on the health of the people that we serve and I am frightened for the short- and long-term impacts that will occur.

It is even more of an emotional toll because in our small territory, we know many people that are Medicaid beneficiaries. We have relatives and friends through extended familial or community connections that are Medicaid beneficiaries. It is unavoidable that we, the Medicaid program, not see them at the grocery store, at churches, or the checkout clerk or the restaurant server, the laborer fixing roads, and everywhere else in the community. It is difficult not to know, as I see them, that decisions we are making in the Medicaid program are directly affecting their access to health care and the impacts that very lack of care will have on them, if not immediately, then, very certainly over the long-run.

It is very hard to explain to those that come to our office asking whether the health services that they are receiving will be cut. It is very hard to listen to their stories. What should we do with the patient that has been in an off-island hospital in another state that may be dying? Should we now inform the patient and parents that we are sorry, but we will no longer pay for any of their medical bills? It is impossible for me, not to see the faces of the people behind the numbers and the impacts that each decision made will have.

NOTICE TO BENEFICIARIES AND PROVIDERS

The CNMI Medicaid Program informed Medicaid Beneficiaries this month that they must seek primary care services only from the Commonwealth Healthcare Corporation (CHCC). We have also informed private providers that effective June 1, there will be no reimbursements from the Medicaid program. The notification was provided in accordance with the CNMI Medicaid State Plan.

Since August 2018, when the public became informed of the Medicaid Cliff, our small Medicaid office has been busy fielding many questions from both our beneficiaries and private providers. Today, our response is that we cannot pay the providers what we simply do not have in funding. Even now, at the same time that we are initiating further restrictions in the program, we are fully aware that the CNMI Government is already accumulating additional debt and that the Accounts Payables for the Medicaid program is growing.

Further, while we are struggling with eliminating or reducing services, we have had to forewarn our private providers, including the CHCC, that we will not be able to pay our accumulating debts until we are provided funding again. We are, and continue to be, fully aware that the CNMI is still trying to financially recover from Typhoon Mangkut and Super Typhoon Yutu, a Category 5 that ripped through the center of the CNMI islands and that territory general funds are not available. The reason is that even our office has been forewarned that austerity may affect our Medicaid staff as well.

How can we get national attention to the plight of the CNMI, the small territory located only 140 miles from the Territory of Guam where there is the U.S. Navy and U.S. Air Force? And will people hear us?

IMPACTS ON THE CNMI GOVERNMENT AND THE SAFETY NET HEALTH SYSTEM

The U.S. Government Accountability Office (GAO), about 2 months ago, had a teleconference with the CNMI Government and the Medicaid program. Specifically, they asked questions and requested information and insight into the impacts of the Medicaid Fiscal Cliff and its impacts on the general fiscal conditions of the CNMI government especially following the typhoons.

We explained how we have reached the point, where, without Medicaid Disaster Assistance or a lifting of the Section 1108 Caps and an adjustment to the FMAP,

the Medicaid program will add to the further debt burden of the CNMI until the CNMI Medicaid program is able to cut all services including off-island care, dental services, and even drugs, unless we don't even pay the CHCC for the amounts that the CMS has determined are appropriate to pay under the Certified Public Expenditure methodology. We have been praying for Medicaid Disaster Assistance funding and for the U.S. Government to lift the Section 1108 budget caps and let the FMAP be based on the same formula as other states.

This is what the CNMI Medicaid program is doing today to our U.S. citizens. This is what I will have to continue to do when I return home.

IMPACTS ON THE COMMONWEALTH HEALTHCARE CORPORATION

The CNMI Medicaid program is also very cognizant and worried with the impact the shortfalls will have on the health system of the CNMI. The CNMI has a unique public corporation that provides hospital, clinical, and public health services. It is a safety-net health system and has also been doing its best given its own challenges. Due to the chronic financial shortfalls and when the CNMI government austerity program reduced work hours for all government employees by 20 percent for 2 years, the Medicaid program, in 2012, proposed use of the Certified Public Expenditures (CPE) payment methodology because the CNMI Government simply did not have funds to provide the matching amounts. Unfortunately, this also means that the full Medicaid reimbursement has not been provided to the CHCC since the program took effect.

The CPE was proposed to the Centers for Medicare and Medicaid Services (CMS) as the only way that the Medicaid program could provide Federal Medicaid funding because of the public expenditures by the CHCC. The CMS calculates the amounts based on its annual analysis of the Medicare Cost Reports submitted by the CHCC and conducts audits to reconcile these amounts.

Under the CPE methodology, the monthly payment for the CHCC, again, as determined by the CMS, is currently $1.64 million per month or $16.34 million per year. I point this out because the Medicaid MAP for 2019, based on the Section 1108 budgetary caps, the CNMI Medicaid program will barely compensate the CHCC public corporation for an amount that the *CMS determines should be paid*. This means that all other expenses and services would need to be curtailed, including radiology services (because we have no radiologist on island), cancer care treatment, off-island surgeries that cannot be performed at the CHCC, and many others. The list is endless and dooms the U.S. citizens in the CNMI to substandard or no care.

There are further consequences. Not only will the CHCC not be reimbursed even the full estimated Federal-local share of Medicaid services. What are we to do?

AVERTING THE MEDICAID CLIFF

The CNMI Medicaid program believes that the U.S. House of Representatives clearly understands the major sources of the challenges and the recent questions sent by the U.S. Senate Committee on Natural Resources strongly suggests an understanding of the very serious nature of the Medicaid Cliff.

There are three major policy proposals that will provide the level of assistance that is needed. First, the CNMI Medicaid Program requests Medicaid Disaster Assistance in the amounts minimally described as needed by the CMS. Second, the CNMI Medicaid Program strongly supports the lifting of the Section 1108 caps and allow the standard methodology to apply to the U.S. territories for the Medicaid Federal Medical Assistance Percentages (FMAP). Passage of the proposed H.R. 1354, the Territories Health Equity Act of 2019, would provide equitable treatment for one of the most important U.S. programs that affects the U.S. territories and the U.S. citizens of the Commonwealth of the Northern Mariana Islands (CNMI)—Medicaid.

SUMMARY

The CNMI is in a desperate and dire situation; and, the U.S. citizens in the Northern Mariana Islands deserve equity in health care. As such, we are humbly pleading for the U.S. Congress to please help to treat the U.S. citizens of the U.S. Commonwealth of the Northern Mariana Islands equitably, and if I may humbly ask, quickly.

Thank you once more for taking the time to hear this issue.

QUESTIONS SUBMITTED FOR THE RECORD TO HELEN SABLAN, DIRECTOR, COMMONWEALTH OF THE NORTHERN MARINAS ISLANDS STATE MEDICAL AGENCY

Questions Submitted by Rep. Sablan

Question 1. If Congress finally treats the territories equitably and provides uncapped funding with Federal match determined in the same was as states, what would the Commonwealth of the Northern Mariana Islands do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?

1a. With the additional Federal funding, what specific investments could you make to improve eligibility and benefits over time?

Answer. The CNMI Medicaid program, today, provides the statutory and regulatory required mandatory Medicaid services. Additionally, the CNMI Medicaid program, today, provides many optional services, including, but not limited to, prescription drugs (all states provide this option), dental services for adults; physical therapy; prosthetic devices; eyeglasses; medical supplies; and other services. The optional Medicaid services were made possible because of the additional funding available through Patient Protection and Affordable Care Act (ACA).

For FY 2019, the Medicaid Disaster Assistance passed by Congress provides temporary relief to continue the services until September 30, 2019 for the CNMI Medicaid program, and the CNMI greatly appreciates this assistance. The lifting of the Section 1108 caps or a second year of Medicaid Disaster Assistance is not provided for Fiscal Year (FY), then, the CNMI Medicaid program will not be able to fully provide the mandatory services for the full duration of the 2020 Fiscal Year *and* both mandatory and optional services that are currently being provided will be eliminated or curtailed.

Should equitable funding as the states be provided, then, the amount of the optional services comparable to what the states provide will be substantially improved. Specifically, the CNMI Medicaid program would assess the optional services permitted under the program. We would assess what other states have done and assess the optional services on the basis of need, feasibility, benefit-cost, effectiveness/cost and other criteria.

The adjustment to the FMAP and the commitment of territorial funding are essential to planning optional services include diagnostic, screening, preventive, and rehabilitative services, respiratory care services, home and community-based services, and other services provided by other states. The CNMI will also be in a position to evaluate managed care service delivery options and the use of Medicaid waivers and other Medicaid program service options to improve care and health of the Medicaid population, and to lessen the cost of health care. We would also work closely with the policy makers that would need to appropriate the CNMI matching funds on the value of the proposed optional services.

With respect to eligibility, the CNMI and the CMS implemented a 1902(j) waiver that enables the maximum participation in the Medicaid Program.

Question 2. What improvements in your healthcare infrastructure would be needed?

2a. Would dedicated up-front funding be needed to make those changes?

Answer. The CNMI needs improvements in the clinical, financial, and technology infrastructure. The following is a brief discussion of the needed improvements.

Health Care Services Infrastructure—The clinical and public health infrastructure in the CNMI has significantly improved since the Commonwealth Healthcare Corporation was established as a public corporation in 2011 and the additional Medicaid funding became available through the ACA. There are more clinicians and healthcare services that are currently provided and the quality of services has continuously improved. Still, despite the substantial progress, there are many clinical services that are not currently provided in the CNMI at this time because of the Section 1108 caps, the inequitable FMAP, and the high rates of uninsured in the CNMI. The small size of the territory, the lack of specialists, and the uncertainties of Medicaid program fiscal cliff have been barriers to improving the overall healthcare services infrastructure in the CNMI. The CNMI Medicaid program is studying the Medicaid services to determine what are the high priority areas where services and other infrastructure can be effectively provided within the territory. Given the small size of territory, there will be continued reliance on specialized healthcare providers and services that are outside of the CNMI.

Financial Infrastructure—In terms of the financial infrastructure to support the health system, the two main problems remain the Medicaid caps and FMAP, and the high uninsured rate resulting from the repeal of the CNMI Employer Responsibility law for immigrant laborers in 2013. The amount of charity and sliding fee supported care results in additional millions of losses in revenue for the CHCC, the safety net provider in the CNMI. Again, the limited financial infrastructure for health care will be the limited financial structure will be devastated especially since the funds provided under the Section 1108 caps of $6.85 in FY 2020 is not even sufficient to cover the CPE amounts determined by CMS for the CHCC.

The capped amount of $6.85 million and the CHIP amount of $11.2 million and current proposed CNMI appropriation for Medicaid of $5 million are around $48 million short of the 2018 Medicaid expenditures of $53 million and the Incurred But Not Booked Accounts Payable of $18 million. The 16,206 current Medicaid beneficiaries will become uninsured in the CNMI second quarter of FY 2020 without the equitable treatment as states. Finally, it is important to note that the estimated amounts provided by the CMS to Congress of the $36 million amount needed for FY 2019 Disaster Assistance did not include the IBNR Accounts Payables and was based on two quarters of available ACA funding that was exhausted in March 2019. CNMI respectfully requests that in addition to lifting the Section 1108 caps and adjustment of the FMAP, that an additional year of 100 percent Federal funding be provided based on Medicaid Disaster Assistance.

Health Information Technology Infrastructure—The Health Information Technology for Economic and Clinical Health (HITECH) Act was instrumental in helping the nation to establish a Health Information Technology (HIT) infrastructure by incentivizing the use of Electronic Health Records (EHR) systems and providing funding for Health Information Exchange (HIE), and public health information system interfaces. Unfortunately, the CNMI, today, remains behind the states.

In part, the reason is that the small size of the territory has resulted in a different inequity. For example, it should be clearly noted that the CNMI received only $800,000 to plan, design, and implement a Health Information Exchange (HIE). The amount was obviously insufficient. According to the Office of the National Coordinator for Health Information Technology (ONC), the three Pacific territories received the equivalent of a small state. As a result, none of the Pacific Territories had a functioning HIE. Efforts were made to reach out to other states. However, all efforts were rebuffed.

Further, under the HITECH, the CNMI CHCC hospital did not qualify for both the Medicare EHR incentive funding because of a quirk in the law, despite the CHCC's role as a Medicare provider. The HITECH Act failed to mention the territories for the Medicare EHR incentive. As a result, the CHCC was unable to use the full incentive provided to all other state hospitals that provide Medicare services. CHCC was only eligible for the Medicaid EHR Incentive.

In the CNMI, the HIT infrastructure to improve clinical care, patient safety, public health and the like, remains a challenge. Even the CHCC health system has not been able to meet the Promoting Interoperability Standards of the CMS to receive the formerly "Stage 2" of Meaningful Use incentives; and *no private providers* in the CNMI have met the standards as well. Of course, this means that the use of HIT and HIE to improve clinical care, undertake care coordination, submit data for public health disease surveillance, and conduct studies on the population health of Medicaid beneficiaries is not equal to the infrastructure of other states. Still, despite these facts, the CNMI Medicaid continues to work with all provider to make progress in all of these areas. There is some health data exchange that use Direct Secure Messaging to comply with both ONC and the Health Insurance Portability and Accountability Act (HIPAA), as amended by the HITECH Act.

Medicaid Enterprise Systems (MES)/Medicaid Management Information System (MMIS) Administrative Information Infrastructure—The CNMI has planned meetings with the CMS to initiate the planning and implementation of an MMIS claims processing both to improve administrative efficiency, eliminate errors with claims, conduct ongoing fraud analysis, and to achieve the national objectives of submitting data to the CMS Transformed Medicaid Statistical Information System (T-MSIS). CNMI has received initial planning funds from the CMS to initiate a Medicaid claims data warehouse that is absolutely integral to enable data analysis to improve care quality; conduct service utilization and cost studies; improve care services and coordination; detect waste/fraud and abuse; and identify opportunities to lessen the cost of health care.

Federal funding is available for these program activities and the CNMI Medicaid program will seek the both Federal funding and the local matching funds to move

forward with the information technology infrastructure for MES/MMIS and a Medicaid claims and clinical data warehouse. As such, the CNMI Medicaid program is not seeking any "special" treatment to fund the MES/MMIS/Health Information Technology activities. The CNMI is only requesting equity with the funding and FMAP as provided to other states for the Medicaid Assistance program.

The CNMI Government will need to find the match, as all other states have done, for the full MES/MMIS and data warehouse activities so that data can be submitted to the CMS T-MSIS data systems and to enable an effective Medicaid Fraud Control Unit to function with the continuous monitoring of Medicaid claims. Nonetheless, with equitable funding and FMAP, then, the CNMI would need to prioritize local funding.

Question 3. Would provider payments have to be increased and to what extent?

Answer. The provider payments would have to be increased since almost all our providers are paid using Medicare reimbursement. We should use the Medicare reimbursement times 20 percent at least. Some of the providers are not willing to treat our patients because of the low reimbursement. For example, the Guam Memorial Hospital Authority (GMHA) has not been accepting our patients since 2011 because of the low reimbursement; and, because of the Section 1108 caps, we are unable to develop waiver and other programs that can facilitating our desire to improve care, improving quality, improve population health, and lessen costs for the Medicaid program and beneficiaries. However, no provider payment adjustments can be contemplated without equity in the caps and FMAP.

Question 4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could the Commonwealth of the Northern Mariana Islands make to ensure residents get high quality health care in other ways that meets their needs?

Answer. The CNMI Medicaid program is constantly assessing ways to improve benefits and at the same time ways to lessen Medicaid expenses. We want to have a fully functional program that is able to efficiently process Medicaid claims, have a Medicaid data warehouse that would enable our program to analyze the cost and quality of care and determine the high-costs areas and areas where we might use waivers and other Medicaid programs to improve care and lessen costs. We believe that there are many program changes that we might be able to accomplish but are unable to do so of the Section 1108 caps, FMAP, and CNMI general funds for a match.

Question 5. Overall, what do you see as the necessary steps to better ensure access to quality, comprehensive care for the Commonwealth of the Northern Mariana Islands residents and what would be a reasonable timeline to reach such a goal?

Answer. The following are some of the steps that will be taken should the caps be lifted and the Federal Matching Assistance Percentage (FMAP) be adjusted to be the same as states or substantially. The CNMI will: (a) continue the review of the Medicaid program to determine optional services and evaluate the other optional services for inclusion; (b) assess the quality of services; (c) analyze alternatives to lessen the cost of care; (d) plan and implement a full Medicaid Enterprise System services; and evaluate the use of Medicaid program options. Just as important, the CNMI Medicaid program, just as one example, will immediately initiate planning to implement waiver programs as a diabetes care/management/education program under Section 1115(c) or Section 1915(i). Diabetes is a major problem in the CNMI and has long-term consequences for Medicaid costs, comorbidities, and debilitating problems such as renal, vision, cardiovascular and others. The program design will be based on the many evidenced-based studies that have shown the efficacy of diabetes self-management and patient education and care coordinated followup. The program will be closely coordinated with public health education for the general public and schools and a public awareness campaign organized with the Commonwealth Healthcare Corporation (CHCC).

The CNMI Medicaid program believes that such a program will achieve the objectives of improving care, care coordination, population health, and lessen the costs over a period of time. This would be coordinated with the CHCC, a unique public corporation, that has both clinical and public health functional responsibilities. Due to its unique public corporation structure, the CHCC is well positioned to implement a multi-faceted program intervention that would, as suggested in evidenced-based literature, result in long-term reductions in diabetes and lessen debilitating and costly diseases such as Chronic Kidney Disease, cardiovascular problems, vision, and the many well-understood comorbidities.

The anticipated reductions from diabetes alone, will lessen the cost of care and serves as only one example of how the CNMI would move forward with implementing programs that not only improve the health of beneficiaries but lessen healthcare costs at the same time. This will take time. However, the CNMI Medicaid program is fully committed to continuously improving the program for Medicaid beneficiaries.

Waiver programs could not be implemented today because of the gap between the Medicaid funding, as a result of the Section 1108 caps, where the Medicaid program struggled to meet the healthcare financing of the current program.

The CNMI has already initiated a plan to establish a Medicaid Claims Data Warehouse to provide the data needed to evaluate the cost of services, the quality of care, and the population health conditions that are driving healthcare expenditures. The reasonable timeline to reach such a goal is about 3 years because of the limited resources.

Question 6. What will you have to cut if you go off the cliff?

Answer. The CNMI Medicaid program was not approaching the cliff but fell off the cliff at the end of March 2019 when ALL Federal MAP and ACA increases were exhausted, including even the Section 1323 funding provided to CNMI because it did not elect to establish a Health Insurance Exchange. Now that H.R. 2157 is signed into law, the mandatory and optional services provided will be continued until September 30, 2019. At that time, we will again fall off the cliff within the first quarter given that the capped MAP will not even cover the cost of Medicaid Federal share amounts due to CHCC as determined by CMS. So, to be clear, it is not what we will have to cut to preserve the program, the CNMI will not be able to maintain even the mandatory services for the year.

The CNMI has initiated consultation with the CMS Region IX. The purpose of the consultations is to ensure that when services are cut, the program remains even though the Federal and local funding will have been exhausted. The situation is that dire. There is no exaggeration since all government and non-government agencies recognize the gap caused by the Section 1108 MAP caps and the FMAP.

Another option could be to have the CNMI Government continue to incur Accounts Payables that could lead to severe financial problems for the territory, Medicaid providers dropping out of the program, and even more severe consequences given the financial situation of the CNMI government following Typhoons Mangkhut and Yutu.

Question 7. What will be the impact on individuals and the healthcare delivery system in the territory, when Obamacare funding ends this year?

Answer. The health care of the 16,206 U.S. citizens and Medicaid Beneficiaries will be very severely affected in both the short and long run. Medicaid Beneficiaries that need tertiary cancer care or surgeries and other services that public acute Commonwealth Health Center hospital is unable to provide may need to finance it themselves or use the CNMI citizen benefits if eligible or forego getting the care that they need. If we use the full amount of the Medicaid MAP and CHIP allotment under the caps to pay the public CHCC, then, the CNMI Medicaid program will not be able to pay all other "on-island" or "off-island" Medicaid providers. The CHCC does not have a radiologist on staff, does not provide advanced cancer care treatment, does not have a gastroenterologist, and unable to perform many surgeries.

Questions Submitted by Rep. González-Colón

Question 1. How will the overall healthcare system and the non-Medicaid population in the Northern Mariana Islands be affected if Medicaid funding is not increased for FY 2020?

Answer. The impacts on the overall healthcare system will be clearly devastating for the non-Medicaid populations if the Medicaid funding is not increased for FY 2020.

The main provider of care is the Commonwealth Healthcare Corporation (CHCC), a unique public corporation that was constituted in late 2011. The CHCC is responsible for the sole acute care hospital in the territory; adult, children, family, dental, dialysis clinics on the CHCC campus on Saipan; and clinics on the two remotely populated main islands of Rota and Tinian. The CHCC also has statutory responsibilities for all public health program functions that are operated by state and/or county governments throughout the United States, including a behavioral health program. The unique public corporation is the safety net provider in the CNMI.

There are also several private clinics, a Section 330 Community Health Center, a second renal dialysis clinic, several dental clinics, and a private laboratory. There

is no on-island radiologist or gastroenterologist or cancer treatment center, to name only a few of the medical services that are not provided in the CNMI. Medicaid Beneficiaries that need those services must see "off-island" healthcare providers in Guam, Philippines, Hawaii, and the U.S. mainland.

If a second year of Medicaid Disaster Assistance is not provided or the Section 1108 caps are not eliminated, then, the CHCC will need to survive on a portion of the $6.85 million of total Medical Assistance funding under the caps. This amount, even if all funds were provided to the CHCC, will not even meet the Federal amounts the CMS has determined should be provided to the CHCC as the Federal share under the Certified Public Expenditure (CPE) methodology. The current CPE amount as determined by the CMS is $1.5 million or $18 million a year based on the CHCC Medicare Cost Reports. So, loss will be $12 million to the CHCC if you assume that all funding is provided to the CHCC. When you include the fact that the CHCC treats the uninsured and provides a sliding fee for indigent patients at a loss of $19 million a year, the impact will be devastating to the CHCC and to health system of the CNMI.

It is critical to understand again that the CHCC includes an acute care hospital that does not cover all types of specialties. As a result, the use of "off-island" providers is unavoidable. Further, even with lifting the Section 1108 caps, there will need to be significant reliance on Providers that are outside of the CNMI since the territory would not have the patient volume to support the specialist within the territory. The CHCC renal dialysis center has been rated highly by the annual CMS conducted surveys. Nonetheless, the CHCC does not have sufficient dialysis stations and must rely on the second dialysis center to meet the number of dialysis patients in the CNMI.

Finally, it should be noted that following the CHCC lost five physicians and a significant number of nurses when the CHCC was unable to make payroll due to the financial conditions at the birth of the CHCC. History will repeat itself without lifting the caps and adjusting the FMAP.

Question 2. Currently, the Social Security Act provides for capped Medicaid funding for the territories. For FY 2017, the cap in the Northern Mariana Islands was $6.34 million. How much did the Medicaid program benefits actually cost?

Answer. As shown in Table 1, below, the actual Medicaid expenditures for FY 2018 was $53.11 Million. With an additional Incurred But Not Booked (IBNR) Accounts Payable of $18 Million, the FY 2018 total was $71.42 Million.

Table 1

Summary of FY 2018 Expenditures and FY 2020 Shortfall Given the End of Additional Funding under the ACA

Fiscal Year and Expenditures	In Millions
FY 2018 Total Medicaid Expenditures in FY 2018	$53.11
FY 2018 Accounts Payables - Unbooked (Incurred But Not Reported (IBNR))	$18.31
Total FY 2018 Medicaid Expenditures and Accounts Payables	**$71.42**
FY 2019 Medicaid Section 1108 Budget CAP	$6.48
FY 2019 CHIP Program Budget	$11.20
FY 2019 Remainder of ACA Section 2005 CNMI Allocation	$2.56
FY 2019 CMS Reconciliation for Previous Years	$4.27
FY 2019 CNMI Legislative Appropriations for Match	$4.64
Total Federal and CNMI Medicaid Funds for 2019	**$29.15**
FY 2019 Projected Shortfall Given 2018 Expenditures and APs or Disaster Assistance Needed Based on 2018 Actual Expenditures and Unbooked IBNR	$42.27
CMS Estimated Shortfall of $36M for Disaster Assistance Provided to U.S. House	$36.00
Shortfall even with proposed $36 Million for Disaster Assistance. Note: This does not include any AP that is accumulating since last drawdown of MAP and ACA.	$6.27

For FY 2020, the CMS has informed the CNMI of the MAP and CHIP amounts. Based on the formula for the CAPs, the amounts will remain around $19 million. Again, assuming no Medicaid Disaster Assistance or lifting of the Section 1108 caps in Title XIX for FY 2020, the shortfall will be over $42 million, higher than the $36 million estimated by CMS needed for Medicaid Disaster Assistance. This is largely

due to the Accounts Payables that are not reflected in the CNMI government financial accounting system.

For the current FY 2019, the CNMI completely exhausted its $6.48 million in the Section 1108 Cap as well as the last of the ACA funding, including the Section 1323 funding since the CNMI did not elect to implement a Health Insurance Exchange.

For FY 2020, the CMS informed the CNMI Medicaid program that the allocation would be $6.85 million for the Medical Assistance Program and $11.20 for the Children's Health Insurance Program. The gap between the FY 2020 allocation and the 2018 Medicaid expenditures, including Accounts Payables, is about $42.27 Million. Again, this staggering amount for the CNMI does not include the 2019 Accounts Payable IBNR that is currently accruing.

Question 3. Could you please provide the Committee actual examples of how the current statutory FMAP of 55 percent affects the provision of health care in the Northern Mariana Islands?

Answer. The following are two very specific examples of how the FMAP affects the provision of health care in the CNMI Medicaid program. At the same time, please keep in mind that without the lifting of the Medicaid Section 1108 caps, the total amount required will not even be available.

First, the Statutory FMAP of 55–45 percent affects the provision of health care is illustrated by two facts. Fact 1—the CNMI Legislature has never appropriated sufficient general fund appropriations to match the Federal expenditures at the 55–45 percent level. This helps to explain the IBNR Accounts Payables of $18 million. The IBNR AP amount is for private providers.

If the CNMI did not implement the Certified Public Expenditure (CPE) payment methodology that uses the public expenditures of the Commonwealth Healthcare Corporation, a public corporation, as the CNMI match for both inpatient and outpatient services, then, the *CNMI would NOT have been able to even expend the amounts provided by the ACA* and the optional services would have had to be severely curtain.

Fortunately, the CNMI Medicaid program elected in 2012 to implement the CPE methodology. The Federal share based on the CPE payment methodology is calculated by the Centers for Medicare and Medicaid Services (CMS) each year. As a result of the use of the CPE methodology, the CNMI was able to expend the much-needed amounts provided under the ACA for the CHCC; and, as the CHCC testified, was instrumental in helping the CHCC to make improvements. Unfortunately, at the same time, the use of the CPE essentially means that the CHCC did not receive the 45 percent in the local match. Nonetheless, the CHCC health system has made substantial improvements over the years due to the increased amount under the ACA.

A second example of how the FMAP is a barrier is with payments to private providers. The CNMI government has not appropriated sufficient funds based on the inequitable FMAP requirements of a 45 percent CNMI share. As described above, this led the CNMI to use the CPE methodology for payments to the CHCC. But, for the other providers, the inability of the CNMI government to fund the 45 percent share of the artificial FMAP has resulted in Incurred But Not Reported (IBNR) Accounts Payables of $18 million at the end of FY 2018.

The CNMI Medicaid program, as with all other states and territories, absolutely must match the Federal funds that are provided for Medicaid program based on the FMAP. However, since the CNMI Government has not been able to appropriate the full matching requirements needed, the CNMI Medicaid program must defer payments to Private Providers because of the inability of the CNMI to provide a 45 percent match. This results in the IBNR Accounts Payables. The same problem has occurred in other territories.

If both the Section 1108 and FMAP inequities are corrected, then, the CNMI would be able to pay the non-CHCC providers in a far more timely manner since payments to private providers must be deferred until matching funds are available. This has led many Medicaid providers, especially specialist off-island providers, to stop providing services for the CNMI Medicaid population.

Vice Chair SABLAN. Thank you. Another perfect-timing witness. Thank you very much, Ms. Sablan.

At this time, I would like to recognize Ms. Theresa Arcangel for her 5 minutes, please.

STATEMENT OF THERESA ARCANGEL, CHIEF ADMINISTRATOR, GUAM DIVISION OF PUBLIC WELFARE

Ms. ARCANGEL. Hafa adai, Mr. Chairman and Ranking Minority Member. For the record, my name is Maria Theresa Arcangel, Chief Administrator for the Division of Public Welfare, Guam Department of Public Health and Social Services. I oversee Medicaid administration.

I am here with Ms. Linda DeNorcey, director of the department. On behalf of Governor Leon Guerrero and the people of Guam, we thank you for inviting us to testify regarding Guam Medicaid financial issues.

The cost of providing health care in Guam is quite high due to its geographic location and the lack of tertiary centers and other healthcare professionals. Some medical providers refuse to accept Medicaid patients due to delayed payments. This further increases the medical cost because recipients are forced to seek treatment at the hospital emergency room.

Additionally, the cost of drugs is more expensive in Guam compared to the U.S. mainland because there are only five to six wholesalers that ship drugs to Guam in comparison to the hundreds of companies available here. These vendors may tend to impose a higher price due to lack of competition. The shipping costs and the risk of stocking drugs that have limited shelf life also contribute to this high cost.

Guam has been burdened for years by U.S. treaty obligations with the Compact of Freely Associated States, which allows unrestricted immigration. These immigrants have contributed to the changes in Guam's demographics. In Fiscal Year 2017, Guam estimated that nearly $147 million was spent on education, public safety, health care, and social services for these migrants. Of that amount, $38.5 million was for health care and welfare services.

Guam's economy is heavily dependent on the tourism industry and U.S. military spending. The influx of COFA migrants created an additional hardship on Guam's economy. As a result, the government is unable to guarantee the availability of local matching funds to draw down the Federal grant awards.

Guam administers Medicaid under Federal regulations that are different from the 50 states and the District of Columbia. Guam Medicaid's Federal Medical Assistance Percentage is fixed at 55 percent. In addition, the Federal Medicaid funding to Guam is subject to an annual funding cap, which is $17.97 million for this fiscal year, unlike the states and DC that are open-ended.

Furthermore, beginning in 2014, the Federal Government funded the states that implemented the ACA Medicaid expansion for childless adults at 100 percent of the coverage costs for the first 3 years. This is not applicable in Guam.

Instead, Section 2005 of ACA provided Guam with $268 million, which partly alleviated the financial shortfall not only of our Medicaid program but also of Guam's locally funded medical assistance program, where most of the COFA citizens qualify. This funding allowed Guam to shift the cost of COFA migrants' emergency services to Medicaid. But the 45 percent required local match provides hardship in fully expanding the program to cover more

uninsured population. Unfortunately, Guam would not be able to expend all the ACA funding, which will expire this fiscal year.

If ACA is not extended or replaced, the Guam Medicaid could be forced to decrease its income guidelines and terminate some of its program eligibles. This will further increase the uninsured population in Guam.

The U.S. territories receive fewer Federal dollars for low-income healthcare programs than the U.S. states due to long-standing regulations. There should be no disparity on the Medicaid funding distribution. The low-income U.S. citizens in Guam and other U.S. territories are no different from the U.S. citizens in the mainland, and so their healthcare benefits and needs should not be viewed or treated differently.

Hence, Guam proposes to remove the expiration date of funding appropriation under Sections 2005 and 1323 of ACA until it is fully expanded, remove the Medicaid cap, and increase the FMAP of Guam and the other U.S. territories.

We applaud the Committee for this oversight and for taking the necessary steps to evaluate the needs of Guam and the other territories. Thank you for the opportunity to speak regarding this important issue.

[The prepared statement of Ms. Arcangel follows:]

PREPARED STATEMENT OF MS. MARIA THERESA ARCANGEL, CHIEF HUMAN SERVICE PROGRAM ADMINISTRATOR, DIVISION OF PUBLIC WELFARE-GUAM

Hafa adai, Mr. Chairman and Ranking Minority Member, my name is Maria Theresa Arcangel, Chief Human Service Program Administrator for the Division of Public Welfare, Guam Department of Public Health and Social Services that oversees the administration of Medicaid. I am here with Ms. Linda Unpingco DeNorcey, Director of the Department.

On behalf of Governor Leon Guerrero and the people of Guam, we thank you for inviting us to testify before the Committee on Natural Resources on the matter of Medicaid and the cliff Guam faces if there is no meaningful action taken by the Congress before the expiration of ACA Medicaid Funding on September 30, 2019 and more broadly how Medicaid is applied to Guam as well as other U.S. territories.

My testimony will cover the Medicaid issues in several contexts: (1) access to healthcare services, (2) the cost of health care and high cost of medications, (3) immigration of the Compact of Freely Associated States citizens, (4) Guam financial instability, (5) the limited time to fully utilize funding appropriated under Section 2005 and Section 1323 of the Affordable Care Act, and (6) the disparity on the Medicaid Program funding distribution of the U.S. Territories in comparison to the U.S. states given Guam Medicaid's Federal Medical Assistance Percentage (FMAP) rate of 55 percent and Guam's annual Medicaid Federal capped funding.

As you know, Guam became a U.S. territory in 1950; the island is 210 square miles, located approximately 5,800 miles west of San Francisco, and has an estimated population of 170,000. It is the largest island in the western Pacific and is a part of Marianas Archipelago, which includes the Commonwealth of the Northern Mariana Islands.

Guam's proximity to Asia (3–4 hours by air) makes it the most strategically important U.S. location in the Pacific for defense and for U.S. force projection.

Moreover, as the U.S. regional hub in the Pacific, a healthy visitor industry which eclipses more than 1.5 million visitors annually and the primary destination for migrating FAS citizens, the risk of communicable and infectious disease outbreaks (i.e., Tuberculosis, Hepatitis, Influenza, etc.) is heightened.

Like many stateside rural areas, Guam suffers from a shortage of primary care physicians, specialists, dentists, and psychiatrists. Health Resources and Services Administration (HRSA) has qualified Guam as both a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA). The shortage of health professionals is primarily attributed to the difficulty in recruiting providers due to Guam's remote island setting, small scale, and territorial status (i.e., not linked to any larger state entity), the physician salary not comparable to U.S. rate, and the

high cost of malpractice insurance on Guam. Clearly, with an estimated population of 170,000 individuals, there remains a shortage of primary care physicians, which is felt most especially among the Medicaid, Medically Indigent, and the uninsured patients who struggle finding a provider and a permanent "medical home" since providers on island refuse to accept Medicaid patients due to delayed Medicaid payments. Thus, clients are forced to seek treatment at the hospital emergency room, which is more costly.

Other than the shortage of providers, there are gaps in tertiary care services (there are no tertiary care facilities on Guam as in the United States), off-island referral services, and inpatient care services. Additionally, there are instances when off-island hospitals/doctors refuse to accept Guam's Medicaid referrals due to untimely reimbursements. Thus, the difficulty of accessing health care (facilities and specialists) increases patients' physical and emotional stress, reducing the likelihood of seeking medical care, and so they forego medical care until their condition worsens that they have to be hospitalized.

Given the above factors, the cost of providing health care on Guam is quite high because of its unique geographic location, limited number of primary care physicians, specialists, and allied-health professionals, and the lack of tertiary care facilities.

Similarly, the cost of drugs is more expensive in Guam as compared to the U.S. mainland due to limited choices of pharmaceutical wholesalers and distributors (only 5 or 6) that can ship drugs and medical devices to Guam effectively as compared to hundreds of companies available to the U.S. mainland. These vendors may tend to take advantage of this lack of competition by imposing a higher price on medications. Other factors contributing to the high cost of pharmaceuticals is the shipping cost and the stocking of drugs with a limited shelf life. Thus, pharmaceutical services rank as the second highest Medicaid expenditure on Guam.

The migration of FAS immigrants is allowed under the Compact of Free Association (COFA) signed between the U.S. Federal Government and former U.S. associated Pacific Islands. This U.S. treaty obligation allows unrestricted migration of FAS citizens (often ill individuals) from the Federated States of Micronesia (FSM) (Pohnpei, Yap, Kosrae, Chuuk), the Republic of Marshall Islands, and the Republic of Palau to the United States and its Territories (Guam, Commonwealth of the Northern Mariana Islands, and America Samoa).

According to the U.S. Census Bureau, in 2013, there were 17,170 compact migrants on Guam. Guam is an attractive place due to the availability of health and social services programs. These immigrants have contributed to the changes in Guam's demographics and have adversely impacted the financial well-being of Guam. In 2017, Guam estimates that nearly $147 million dollars was spent on education, public safety, health care, and social services. Of this amount, $38.5 million was spent on health care and welfare services for this population while living on Guam. Moreover, of the $110.8 million (Federal and local) spent by the Guam Medicaid Program in Fiscal Year 2018, $29 million, or 27 percent of the total expenditures were spent for FAS population healthcare needs. Thus, there is no equitable reciprocal healthcare services payment from the Federal Government for the FAS population.

Furthermore, Guam's economy is heavily dependent on the tourism industry and U.S. military spending. The influx of Compact Impact of Free Association created an additional hardship on Guam's economy. As a result, the government is unable to guarantee the availability of local matching funds to drawdown the Federal grant awards to pay the medical providers timely for the services rendered to program recipients.

Prior to the supplemental funding of $268 million brought about by Section 2005 of the ACA, Guam Medicaid always expends its annual Federal capped funding before each fiscal year ends. The ACA provides significant benefits and important health insurance reforms. However, the limited application of its provisions to the U.S. territories, its insufficient funding allocation of Federal funds to implement Health Insurance Exchange, and the Medicaid Program Expansion significantly limits Guam's opportunity to implement new healthcare innovations and provide coverage to the Guam's uninsured population. Because of the ACA's limitations in funding and the exemption of some of its most important provisions to the insular territories, Guam has decided that the health insurance exchange would not be beneficial to implement.

Additionally, there are some disparities in the law that affects the U.S. Territories. Beginning in 2014, the Federal Government funded the states that implemented the ACA Medicaid Expansion provision for childless adults at 100 percent of the coverage costs of newly eligible individuals for the first 3 years; and phased down gradually to a permanent rate in 2020 at 90 percent FMAP. However,

this is not applicable in Guam. Even though ACA increased the Territories FMAP by 5 percent, this is not enough to alleviate the local budget shortfall.

The ACA funding of $268 million partly alleviated the financial shortfall not only of Medicaid, but also of Guam's locally funded medical assistance program called Medically Indigent Program, where most of the COFAS citizens qualify. The additional funding provided by Section 2005 of ACA allowed Guam to shift the cost of COFAS emergency services to Medicaid. Though Guam obtained some additional funding of $268 million as a separate ACA provision to help alleviate its Medicaid funding shortfall, the 45 percent required local match provides hardship in fully expanding the program and utilizing the $268 million. Unfortunately, Guam would be unable to expend all the aforementioned ACA funding, which will expire in September 30, 2019.

The U.S. territories administer their Medicaid Program under Federal regulations that are different from those applicable to the fifty (50) states and the District of Columbia. The U.S. territories' Federal matching rate is fixed in statute, unlike the statutory formula for U.S. states. For instance, Guam Medicaid's Federal Medical Assistance Percentage (FMAP) rate is 55 percent, the same as the other U.S. territories. However, the FMAP for the 50 states and DC varies by state's per capita income, which ranges from 50 percent to 83 percent. In addition, the Medicaid programs in the U.S. territories are subject to annual Federal capped funding, unlike the states and DC that are open-ended. Guam's regular Medicaid funding for FY 2019 is $17.97 million dollars (administration and medical services payments), which increases yearly based on Medical Consumers Price Index. However, the $17.97 million dollars may not even be enough to last for one quarter of a fiscal year based on the trend of Guam's Medicaid program expenditures, which increases annually.

Guam Medicaid's expenditure increased by 323 percent over the past decade (from $26,185,419 in FY 2009 to $110,876,286 in FY 2018) due to an increase in utilization, cost of medical treatment, new medical technology or mode of treatment, and the increasing cost of drugs. If ACA funding is not extended or replaced, the Guam Medicaid Program could be forced to decrease its income guideline and terminate more than 50 percent of its current eligible individuals. This will further increase the rate of the estimated uninsured population, which was 24.8 percent (adults 18 years and above) of Guam population in 2017 (2017 Guam Behavioral Risk Factor Surveillance Survey). Guam's residents who cannot afford the needed health care will delay getting care at an early stage of their illness until they are forced to go to the hospital emergency room. This will aggravate the operational and financial issues of the only government hospital even more, which continues to struggle because of EMTALA (Emergency Medical Treatment and Labor Act). This will continue to heighten the financial problem of Guam.

Additionally, Guam and other territories received fewer Federal dollars for low-income healthcare program than the U.S. states due to long-standing regulations. According to Guam Department of Labor, the 2010 Guam's per capita income was $12,864, which is lower than any of the U.S. states per capita income including Mississippi (one of the lowest per capita income in the United States). Mississippi's FMAP rate ranges between 73.05 to 84.86 from FY 2010 to FY 2019 (Kaiser Family Foundation FMAP Rate Listing) as compared to Guam Medicaid's FMAP rate of 55 percent and a funding cap. Thus, there is a huge disparity on the Medicaid Program funding distribution of Guam including the U.S. Territories in comparison to the U.S. states. Those differences on Medicaid rules contribute to the economic destabilization of Guam.

Hence, **Guam proposes to remove the expiration date of funding appropriation under Section 2005 and Section 1323 of ACA until the funding is fully expended; remove the Medicaid cap; and increase the FMAP of Guam and the other U.S. territories**. The low-income U.S. citizens in Guam and other U.S. territories are no different from the U.S. citizens in the mainland and so their healthcare benefits and needs should neither be viewed, nor treated any differently.

We applaud the Committee on Natural Resources for this oversight hearing and for taking the necessary steps to evaluate the needs of Guam, and we hope that the Committee will develop a solution to assist Guam's U.S. citizens.

Thank you for the opportunity to provide Guam's written and oral testimonies on this important issue during the "Insular Areas Medicaid Cliff" hearing.

Medicaid Program Expenditure

Fiscal Year	Total No. of Medicaid Eligibles	Total No. of FAS Eligibles Under Medicaid	Percentage of FAS Under Medicaid	Total Medicaid Expenditure	Total Expenditure FAS MIP-ER Services Charge to Medicaid	Total FAS Expenditure Under Medicaid	Overall FAS Expenditure Under Medicaid	FAS Expenditure Percentage
2009	31,246	5,290	17%	$ 26,185,419	$ -	$ 3,878,669	$ 3,878,669	15%
2010	33,604	5,845	17%	$ 37,508,337	$ -	$ 5,110,716	$ 5,110,716	14%
2011	35,702	6,349	18%	$ 37,076,067	$ -	$ 4,666,994	$ 4,666,994	13%
2012	40,422	7,411	18%	$ 57,127,802	$ 3,039,911.88	$ 4,365,300	$ 7,405,212	13%
2013	43,955	8,247	19%	$ 73,499,383	$ 5,473,192.62	$ 7,220,452	$ 12,693,645	17%
2014	44,892	8,505	19%	$ 86,846,732	$ 5,605,949.24	$ 8,353,934	$ 13,959,883	16%
2015	44,381	8,715	20%	$ 81,596,426	$ 7,394,801.67	$ 7,309,464	$ 14,704,265	18%
2016	43,948	8,944	20%	$ 95,382,705	$ 6,848,039.77	$ 10,385,839	$ 17,233,878	18%
2017	43,749	8,906	20%	$ 108,609,905	$ 11,506,550.63	$ 14,103,896	$ 25,610,447	24%
2018	43,853	8,940	20%	$ 110,876,286	$ 14,450,645.36	$ 15,063,821	$ 29,514,467	27%

Note: Medicaid Number of Eligibles -Unduplicated count for the entire fiscal year.

QUESTIONS SUBMITTED FOR THE RECORD TO MS. THERESA ARCANGEL, CHIEF ADMINISTRATOR, DIVISION OF PUBLIC WELFARE, GUAM

Questions Submitted by Rep. Sablan

Question 1. If Congress finally treats the territories equitably and provides uncapped funding with Federal match determined in the same was as states, what would Guam do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?

Answer. The Guam Medicaid Program will conduct a survey to analyze medical providers practices and perceptions to determine the reasons for not participating under the program.

Conduct a study to determine if Managed Care is more beneficial for Guam Medicaid Program.

Encourage program participation by conducting an island-wide medical provider comprehensive informational outreach/conference or training.

Structure the Medicaid Program payment methodology to a capitated (prepaid) model.

Provide Medicaid incentives to providers if Medicaid patients seen is equal or more than 10 percent of their practice.

1a. With the additional Federal funding, what specific investments could you make to improve eligibility and benefits over time?

Answer. Guam Medicaid Program is in need of dramatic technology transformation. Currently, due to shortage of staff eligibility application processing is untimely, and influx of clients' inquiries on benefits and applications' follow-up is tremendous. Guam Medicaid program is going to leverage the use of digital technology to submit program application and inform or assist existing clients and new applicants regarding eligibility requirements, application status, scheduled appointments, etc. Thereby, improving client accessibility and customer service, streamlining application processing for a timelier receipt of benefits.

Though there is a separate funding for MMIS (90/10), we would like to add that we plan to enhance our existing customized automated system (PHPRO) to meet the MITA (Medicaid Information Technology Architecture) requirements for a certified MMIS (Medicaid Management Information System) and to be able to comply with TMSIS (Transformed Medicaid Statistical Information System). The local funding that we can save from increasing the Guam FMAP can be utilized as the 10 percent local funding match to enhance our current system.

Question 2. What improvements in your healthcare infrastructure would be needed?

2a. Would dedicated up-front funding be needed to make those changes?

Answer. There is a need for a tertiary care facility and a hospital-based outpatient clinic facility to properly manage patients' condition and reduce hospital admissions. The only Government of Guam hospital is not well-equipped to treat critical patients. Due to TEFRA regulation the hospital Medicare and Medicaid reimbursement is very low to support and sustain the facility operation.

A dedicated up-front funding is needed to physically improve the facility that will make care accessible with trained staff and healthcare professionals. Additionally, funding is needed to procure new modernized medical equipment, medications, and other supplies.

Question 3. Would provider payments have to be increased and to what extent?

Answer. The healthcare cost in Guam is higher compared to the U.S. mainland because of its geographic location, lack of tertiary facilities, and the limited number of healthcare professionals including specialists. An increase in provider payments would be beneficial in order to attract more provider participation and at the same time attract providers from the U.S. mainland to come and stay in Guam. If CMS or the regulation will allow through a state plan amendment to increase the provider reimbursement beyond the Medicare Upper Payment Limit (UPL) up to 120 percent to 150 percent depending on providers specialty that would be helpful to ensure that our recipients have a medical home.

Question 4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could Guam make to ensure residents get high quality health care in other ways that meets their needs?

Answer. No, provided funding is available.

Question 5. Overall, what do you see as the necessary steps to better ensure access to quality, comprehensive care for Guam residents and what would be a reasonable timeline to reach such a goal?

Answer. Steps to ensure access to quality comprehensive care for Guam residents include: recruitment and retention of more physicians and specialists from the U.S. mainland; increasing Medicaid provider participation; and creating an alternative payment models for a more coordinated primary care approach.

Timeline would be 5 to 6 years (depending on the recruitment and retention of physicians, specialists, and other healthcare professionals).

Question 6. What will you have to cut if you go off the cliff?

Answer. Medicaid would be forced to terminate 50 percent or more than 23,000 eligibles and remove some of the optional benefits such as dental services, some prescription drugs, clinic services, optometry services and eyeglasses, etc.

Question 7. What will be the impact on individuals and the healthcare delivery system in the territory, when Obamacare funding ends this year?

Answer. Currently, there are around 43,000 to 44,000 eligibles under Medicaid program. If Obamacare funding to the U.S. territories is not extended or replaced, Guam would be forced to reduced its current Guam Medicaid Poverty Level income guideline, which is 30 percent to 31 percent below the Federal Poverty Level for 48 contiguous states and DC, to terminate 50 percent or more than 23,000 of its current eligibles. This will further increase the estimated 24.8 percent uninsured population in Guam. The two hospitals (Government and private) in Guam will be inundated with a lot of self-pay patients because the facilities would not be able to refuse any patient that present to their door due to EMTALA and would eventually suffer huge losses and may end up filing bankruptcy.

Questions Submitted by Rep. González-Colón

Question 1. You testified that Guam will be unable to spent the ACA funds before they are set to expire. Why is that? In addition to extending their expiration date, what would Congress need to do to help Guam spend these funds in healthcare services to its residents?

Answer. Due to Guam's limited financial resources, the Government is unable to guarantee the 45 percent required local matching funds to drawdown the Federal grant awards. Additionally, although Guam Medicaid expanded the program to include the childless adults to reduce the uninsured population, which was 24.8 percent of Guam population in 2017, the income guideline was reduced by 30 percent to 31 percent (based on household size) from the existing 100 percent Federal Poverty Level for the entire Medicaid population except the program for Old Age Assistance and Assistance to Permanently and Totally Disabled individuals because of the required 45 percent local match.

Congress needs to increase the FMAP to 100 percent and extend the expiration date of ACA Section 2005 and Section 1323 to help Guam spend all the funds and provide quality healthcare services to the disadvantage population in Guam.

Question 2. How will the overall healthcare system and the non-Medicaid population in Guam be affected if Medicaid funding is not increased for FY 2020?

Answer. If Medicaid Funding is not increased, Guam Medicaid would be forced to terminate 50 percent or more than 23,000 of its eligibles by reducing the income guideline, which will further increase the uninsured population in Guam, or remove some of the optional services such as prescription and dental services. Guam's residents including the non-Medicaid population (COFAS) who cannot afford the needed health care will delay getting care at an early stage of their illness until they are forced to go to the hospital emergency room. This will further aggravate the operational and financial issues of the only government hospital even more, which is already struggling because of EMTALA (Emergency Medical Treatment and Labor Act). More providers will refuse to accept Medicaid patients and so the two Guam Federally Qualified Health Centers (Northern and Southern Region Community Health Centers) with limited healthcare practitioners will be inundated with patients. This will continue to heighten the financial problem of Guam.

Question 3. Currently, the Social Security Act provides for capped Medicaid funding for the U.S. Territories. For FY 2017, the cap in Guam was $17.02 million. How much did the Medicaid program benefits actually cost?

Answer. Guam Medicaid Program is a 100 percent fee-for-service delivery system. All mandatory and most of the optional services are covered. The income guideline is below the 100 percent of the Federal Poverty Level (FPL) and so there are no deductibles, nor co-payments except for minimal co-pays for childless adults.

In FY 2017, Guam Medicaid paid out $108.6 million dollars to medical providers for services rendered to 43,749 program eligibles. The FY 2017 total IBNR (Incurred But Not Reported) expenditure was $19.2 million dollars. The yearly expenditure is controlled by the budget appropriation and Guam's revenue.

Question 4. Could you please provide the Committee actual examples of how the current statutory FMAP of 55 percent affects the provision of health care in Guam?

Answer. The required 45 percent local match is a financial barrier to the provision of quality healthcare services on Guam. The Guam Department of Administration reimburses the providers based on cash-flow. The providers have to wait 2 to 4 months or more depending on the revenue to receive payments for medical services rendered. As a result, providers on- and off-island refuse to accept Medicaid patients. Thus, patients requiring treatment on island are forced to seek treatment at the hospital emergency room. Additionally, patients that need to be transported to an off-island facility (services unavailable on island) have to wait until the off-island provider receives payment and also agrees to accept them. Meanwhile, the patient's condition worsens because the needed immediate treatment is unavailable. Thus, with a debilitating medical condition, this translates to an even higher healthcare cost.

Furthermore, Guam Medicaid program's lack of prompt payment and its low reimbursement rate have cascading effects on Guam's only Government hospital in that GMH is unable to pay vendors timely for medication, laboratory supplies, facilities and maintenance, etc. Without the financial resources, the Government hospital cannot improve its facility and services, which in turn affects the quality of patient care.

Vice Chair SABLAN. Wow. Thank you, Ms. Arcangel. Perfect timing again. I appreciate your coming here and testifying.

I would like to now recognize Ms. Michal Rhymer-Browne.

Did I get that right, Ms. Browne?

Ms. RHYMER-BROWNE. "Michal."

Vice Chair SABLAN. All right. You are recognized for 5 minutes.

STATEMENT OF MICHAL RHYMER-BROWNE, ASSISTANT COMMISSIONER, U.S. VIRGIN ISLANDS DEPARTMENT OF HUMAN SERVICES

Ms. RHYMER-BROWNE. Chairman Sablan, Ranking Member Bishop, and members of the Committee, thank you for the opportunity to provide testimony on the significant impacts to our healthcare system and the people of the U.S. Virgin Islands in light

of the impending Medicaid fiscal funding cliff, which will impact us beginning October 2019.

I am Michal Rhymer-Browne, Assistant Commissioner of the Virgin Islands Department of Human Services, and I have direct oversight of the Medicaid division. Accompanying me today is Mr. Gary Smith, our Virgin Islands Medicaid Director.

I must also thank Kimberley Causey-Gomez, Commissioner Designee of the VI Department of Human Services, who has extended to us her complete support as we prepared to come to this important Committee meeting today.

On behalf of the Honorable Governor Albert Bryan, Jr., and the more than 100,000 American citizens living in the U.S. Virgin Islands, we bring you greetings and, as we say in the Virgin Islands, a pleasant good morning.

As a people, we want to convey our heartfelt gratitude, appreciation, and thanks for the concern and the support that you and your colleagues in Congress have provided as we continue to recover from the unprecedented damages caused by Hurricanes Irma and Maria, two Category 5 hurricanes which ravaged the Virgin Islands in September 2017.

We are a resilient people, but my testimony today is truly intended to actualize the empathy. I appear before you today to request your continued urgent support to address the critical Federal and local funding crisis we are facing in our healthcare system.

On September 30, 2019, by that date, we are currently projecting we will have fully expended the additional $142.5 million in Federal medical funding provided under the BBA.

Members, with no exaggeration, the Congress, together with the Administration, must act by September 30, 2019, to avert catastrophic damage to our healthcare system. At that point, the Federal Medicaid matching rate will revert back to the statutorily mandated 55 percent matching rate for most of our Medicaid program and the Federal Medicaid funding cap of approximately $18.8 million.

This is not sustainable given the current state of our Medicaid program. If the Virgin Islands only receives the statutory cap amount of $18.7 million at the 55 percent rate, that funding is projected to only cover 26 percent of the Federal funding needed during the fiscal year.

We believe that there needs to be a permanent statutory fix that addresses the unfair and disparate treatment all territories face in their Medicaid programs along the lines of H.R. 1354, the Territories Health Equity Act, introduced on February 25, 2019, by our Delegate, Stacey Plaskett.

We are requesting that Congress and the Administration work with us to support the following 5-year Medicaid funding request.

We are requesting a 100 percent Federal Medicaid matching rate be extended to the U.S. Virgin Islands for 2 additional Federal fiscal years. And we are currently projecting that at least $251.5 million in additional Federal Medicaid funding be provided during this period, as was done in the BBA 2018.

Second, we are requesting at least an additional $377 million in Federal Medicaid funding based upon our current projection, in lieu of our annual Medicaid cap, be provided to the U.S. Virgin Islands.

Unless the Congress and the Administration act to support the two requests I have outlined above before September 30, 2019, we will be faced with potentially catastrophic damage to our Medicaid program and our healthcare system, to include having to remove upwards of 15,000 individuals from our Medicaid program who still need healthcare services and having to deny men, women, and, children and infants who need to be transferred to the U.S. mainland for care.

We want to thank you for the opportunity for being here today, and we strongly urge that we are considered for additional funding going forth in the next fiscal years.

Thank you very much.

[The prepared statement of Ms. Rhymer-Browne follows:]

PREPARED STATEMENT OF MICHAL RHYMER-BROWNE, ASSISTANT COMMISSIONER, U.S. VIRGIN ISLANDS DEPARTMENT OF HUMAN SERVICES

Chairman Grijalva, Ranking Member Bishop, and members of the Committee: Thank you for the opportunity to provide testimony on the significant impacts to our healthcare system and the people of the U.S. Virgin Islands, in light of the impending Medicaid fiscal funding cliff which will impact us beginning October 2019. I am Michal Rhymer-Browne, Assistant Commissioner of the Virgin Islands Department of Human Services, and I have direct oversight of the Medicaid Division. Accompanying me today is Mr. Gary Smith, our Virgin Islands Medicaid Director. I must also thank Kimberley Causey-Gomez, Commissioner Designee of the V.I. Department of Human Services, who has extended to us her complete support as we prepared to come to this important committee meeting today.

On behalf of the Honorable Governor Albert Bryan, Jr. and the more than 100,000 American citizens living in the U.S. Virgin Islands, we bring you greetings, and as we say in the Virgin Islands, "a pleasant good morning." As a people, we want to convey our heartfelt gratitude, appreciation, and thanks for the concern and the support that you and your colleagues in Congress have provided as we continue to recover from the unprecedented damage caused by Hurricanes Irma and Maria—two Category 5 Hurricanes, which ravaged the Virgin Islands in September 2017. We are a resilient people, but my testimony today is truly intended to actualize the empathy.

I appear before you today to request your continued urgent support to address the critical Federal and local funding crisis we are facing in our healthcare system on September 30, 2019. By that date we are currently projecting we will have fully expended the additional $142.5 million in Federal Medicaid funding provided under the Bipartisan Budget Act of 2018 (BBA) and the 100 percent Federal matching rate will expire. Along with this, we are projecting we will lose access to the nearly $158.9 million in remaining Federal funding provided under the Affordable Care Act (ACA). It is only through this additional Federal funding and the 100 percent matching rate that we have been able to sustain our healthcare system during these trying times.

Members, with no exaggeration, the Congress, together with the Administration, must act by September 30, 2019, to avert catastrophic damage to our healthcare system, if left on its current course. At that point, the Federal Medicaid matching rate will revert back to the statutorily mandated 55 percent matching rate for most of our Medicaid program and the Federal Medicaid funding cap of approximately $18.8 million. This is not sustainable, given the current state of our Medicaid program. If the Virgin Islands only receives the statutory cap amount of $18.7 million at the 55 percent matching rate, that funding is projected to only cover 26 percent (barely one-quarter) of the Federal funding needed during the fiscal year for the Medicaid expenditures supported by that cap. This is the Medicaid "fiscal cliff" that we have been warning about for some time. Once the cap is exhausted, the Virgin Islands would have to fully make up the deficit in Federal Medicaid funding, as it has in the past, and pay for its Medicaid services with 100 percent local funding. That local funding is not available, and our citizens will not be able to receive the essential health care they need, and our already fragile healthcare

infrastructure would be further destabilized, and its recovery would be further delayed.

We believe that there needs to be a permanent statutory fix that addresses the unfair and disparate treatment all Territories face in their Medicaid programs along the lines of H.R. 1354, "The Territories Health Equity Act," introduced on February 25, 2019, by our Delegate Stacey Plaskett. However, we understand from various informal discussions with congressional and Administration staff that such a permanent fix may not be possible at this time. Therefore, I am requesting that the Congress and the Administration work with us to support the following 5-year (Fiscal Years 2020–2024) Medicaid funding request:

1. 100 percent Federal Medicaid matching rate be extended to the U.S. Virgin Islands for two additional Federal fiscal years (October 1, 2019 through September 30, 2021) and we are currently projecting that at least $238 million in additional Federal Medicaid funding be provided during this period, as was done in the BBA 2018. This assumes that other Federal requirements and funding under the Medicaid program remain in place during this period.
2. At least an additional $377 million in Federal Medicaid funding based upon our current projections, in lieu of our annual Medicaid cap, be provided to the U.S. Virgin Islands at an 83 percent Federal matching rate for three additional Federal fiscal years (October 1, 2021 through September 30, 2024). This assumes that other Federal matching requirements and funding under the Medicaid program remain in place during this period for areas such as CHIP allotments, MMIS, Eligibility and Enrollment, and Medicare Part D Co-insurance and deductibles.

As we reiterated in previous meetings with the Administration, and in testimony before Congress, healthcare funding in the Virgin Islands was under great stress even before the two hurricanes. Under Medicaid, an arbitrarily low Federal matching rate (FMAP) and a correspondingly high local matching requirement added to the limited capped Federal funding have imposed severe and unsustainable financial demands on the Territory. We have had to contribute a vastly disproportionate share of our own limited local funding for our Medicaid Program compared to that of the states.

We are particularly grateful for the additional Federal funding provided under the ACA and the temporary disaster-related waiver of the local match and additional Federal funding provided through the BBA 2018. These actions have allowed us to more than double our Medicaid program to over 27,000 individuals from approximately 12,000 individuals since 2012, increase total expenditures under our Medicaid program to over $120.5 million, provide much needed healthcare services to our people, and allowed our Medicaid program to continue to operate during these trying times.

However, unless the Congress and the Administration act to support the two requests I have outlined above before September 30, 2019, the U.S. Virgin Islands will be faced with potentially catastrophic damage to our Medicaid program and our healthcare system as detailed below:

- The U.S. Virgin Islands will have to remove upwards of 15,000 individuals from our Medicaid program who still need healthcare services.
- We will not be able to continue the outreach to the community to bring into the Medicaid program those 15,000 to 20,000 additional Virgin Islanders who we believe are eligible for the program currently but not yet enrolled.
- The U.S. Virgin Islands will have to pay for any needed healthcare services with all local funds that are not available in our budget at this time.
- We will face further delays in rebuilding our hospitals and clinics and other healthcare infrastructure as funds will have to be diverted to pay for needed ongoing day-to-day healthcare services.
- The U.S. Virgin Islands will have to continue to evacuate even more patients to the mainland, at even further costs to us, which we are unable to support with local funding as delays in the rebuilding of our healthcare infrastructure continue.
- We will be faced with losing more and more of our medical providers if we are unable to pay and retain them. This will be compounded by our inability to attract new medical professionals willing to come and work in the islands when we are facing such a critical financial crisis in our healthcare system and they are concerned with whether they will be able to be paid.

- We will not be able to expand much needed long-term care support services to our elderly and disabled population—our most fragile population—as we have no certified nursing homes in the U.S. Virgin Islands and such care has to be provided mainly in the community.
- Finally, the U.S. Virgin Islands is facing a mental health and behavioral health crisis as declared by Governor Albert Bryan, Jr. in March 2019 as a result of the lack of providers and facilities to address the demand for these services in the territory, and we will not have access to needed Federal funds to help address these critical issues.

We are also keenly aware that with the added Federal support being provided by our Federal partners comes additional responsibility on our part to utilize and oversee that support in an efficient and effective manner and with full accountability. Toward that end, the U.S. Virgin Islands has moved forth with purposeful actions, and we are implementing various activities, as outlined below which will ensure that this accountability continues:

- We implemented the first ever Territory Medicaid Management Information System (MMIS) in 2013.
- The U.S. Virgin Islands implemented a Medicaid MAGI compliant online Medicaid eligibility system in July 2017, called the Virgin Island Benefit Eligibility System (VIBES). This system will be expanded beginning later this year to complete integration with our other Federal programs like SNAP and TANF.
- We implemented a Medicaid Fraud Control Unit (MFCU) in 2018.
- The U.S. Virgin Islands also implemented the Transformed Medicaid Statistical Information System (TMSIS) with CMS through our Medicaid Management Information System (MMIS) in 2018 to ensure detailed statistical and financial reporting be provided to the Centers for Medicare & Medicaid Services (CMS).
- We will shortly be completing cost report audit reconciliations for our two hospitals and two Federally Qualified Health Centers (FQHCs) to bring those audits and reconciliations current.
- The U.S. Virgin Islands will shortly begin the audit and reconciliation process for our Department of Health Clinics.
- We recently completed the CMS Medicaid Program Integrity (PI) Review.
- We also executed a memorandum of understanding with CMS to receive technical assistance in additional Medicaid PI activities and Medicaid data analytics.
- The U.S. Virgin Islands is working with HHS to finalize an advance planning document which will provide upwards of $15 million to implement a territory wide health information exchange system.

We believe that all of these activities indicate our strong ongoing commitment to ensuring the integrity of our programs and our responsible stewardship of the Federal Medicaid funding that we receive. The U.S. Virgin Islands is also committed to the ongoing improvement of program integrity, transparency, and efficiency and the Federal funding outlined above is needed to continue these efforts and maintain our programs.

For the forgoing reasons, I strongly urge the Congress, in conjunction with the Administration, to promptly act on this matter of critical urgency to the people of the U.S. Virgin Islands. The enactment of our proposal will serve to enable us to continue to provide urgent healthcare services to our citizens while we work to rebuild our healthcare infrastructure and economic viability, and will serve to provide a temporary "fix" to the disparate arbitrary, and unfair treatment that the Territories continue to receive under the Medicaid Program.

Given the very short time remaining in this fiscal year, and the need for the U.S. Virgin Islands and other Territories to be able to reliably and predictably plan their upcoming internal Medicaid program changes and budget request, I ask that you address this issue in the next available legislative vehicle.

I appreciate the opportunity to share my views with you. We look forward to working together with you to address the immediate issue of the impending Medicaid fiscal funding cliff and we look forward to collaborating with you on achieving a permanent solution that can finally eliminate the unequal treatment of Virgin Islands and the other Territories under the Medicaid Program and provide parity for Medicaid enrollees and the full benefits of the Federal Medicaid program for our citizens and our providers.

Thank you for your consideration and attention to these urgent matters. I am honored to be here and open to answer any questions you may have, along with Gary Smith, our U.S. Virgin Islands Medicaid Director.

QUESTIONS SUBMITTED FOR THE RECORD TO MICHAL RHYMER-BROWNE, ASSISTANT COMMISSIONER, U.S. VIRGIN ISLANDS DEPARTMENT OF HUMAN SERVICES

Questions Submitted by Rep. Sablan

Question 1. If Congress finally treats the territories equitably and provides uncapped funding with Federal match determined in the same was as states, what would the U.S. Virgin Islands do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?

1a. With the additional Federal funding, what specific investments could you make to improve eligibility and benefits over time?

Answer. No response.

Question 2. What improvements in your healthcare infrastructure would be needed?

2a. Would dedicated up-front funding be needed to make those changes?

Answer. The immediate priority is to restore on-island services at least to the level available before the storms.

- We need to rebuild the two hospitals in the Virgin Islands to be able to provide the full range of on-island inpatient services and other critical care hospital services which are currently very limited and result in our having to evacuate upwards of 20 persons per month to Puerto Rico or the mainland for these critical services at a considerable extra cost to our very limited budget.
- We need to rebuild our Department of Health public clinic system which was severely impacted by the storms and has resulted in a reduced level of critical primary care for our residents.
- We are in critical need of at least two certified nursing facilities on the island. We need to repair and upgrade our current Herbert Grigg Home for the Aged on St. Croix so that it meets Federal reimbursement standards. Similarly, we need to acquire, repair, and upgrade the other Home for the Aged at Seaview so it meets Federal reimbursement standards and is operated by the Virgin Islands.
- We need to address the critical need for behavioral health treatment on the island through the development of inpatient and outpatient treatment facilities that are federally reimbursable.
- Finally, even as we work to rebuild and improve our institutional infrastructures on the islands we need to take this opportunity to emulate the approach taken by Medicaid Programs on the mainland to provide community based care for persons with disabilities and mental illnesses.
- We believe this dual approach of structural improvements and community based service improvements is necessary to ensure that our citizens have access to comprehensive care and services comparable to the mainland.

We believe that dedicated funding for these improvements is perhaps the only way to make these improvements possible as the Virgin Islands is not in a financial position to pay for and complete this on our own. Further, dedicated funding must be outside the capped Medicaid funding we need to have for providing the basic ongoing healthcare services under our Medicaid program.

Question 3. Would provider payments have to be increased and to what extent?

Answer.

- Currently, under our Medicaid program we pay our hospitals and other public providers at the full Medicaid cost of providing services to Medicaid patients. This is the maximum that can be paid to public providers.
- What we need for Congress to provide through legislation is for our hospitals to be able to receive Medicare and Medicaid disproportionate share hospital (DSH) payments for uncompensated care in our hospitals as is provided to hospitals on the mainland. Our hospitals are precisely the types of facilities that the DSH program was intended to support.

- Additionally, we need for Congress to provide through legislation that CMS be directed to work with the Virgin Islands hospitals to update the Medicare base period for our TEFRA hospital reimbursement system. The base periods for Medicare have not been updated since the early 1990s and results in artificially low Medicare reimbursements rates that do not support the cost for the services being provided to Medicare eligibles.
- With respect to community non-public providers the Virgin Islands pays those providers (including nurses) for Medicaid services at the established Medicare rates for those services. The problem with respect to those providers is that given the costs of relocating and living in the Virgin Islands it is difficult to attract providers and other specialists to work here. We would ask that the Congress provide through legislation that we be allowed to pay providers who work in the Virgin Islands a supplemental add-on to the Medicare rates that we pay to offset the additional costs here and make it attractive for providers to relocate and stay here in the Virgin Islands.

Question 4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could the U.S. Virgin Islands make to ensure residents get high quality health care in other ways that meets their needs?

Answer.

- We ask that the Congress modify Section 1902(j) of the Social Security Act to add the Virgin Islands to this provision of the law. This would allow the Secretary to waive certain aspects of Title XIX to provide the Virgin Islands with greater flexibilities in the eligibility, reimbursement, and coverage under the Medicaid program.
- As a result of the significant matching requirement (45 percent for most of our program) we have been unable to come up with the local share necessary to fully enroll all of the potentially eligible Virgin Islanders into the Medicaid Program. We estimate that there may be 15,000 to 20,000 eligibles who are not yet enrolled. Since our last expansion in early 2017 we have proceeded slowly because of the local match requirement and our financial limitations of our budget. So, treating the VI as a state for matching purposes would enable to expand our program eligibility.
- Similarly, as we move to expand our community based services and reintroduce nursing facility services and cancer treatment services on the island to meet the needs of our population we would be able to do this within our budget limitations if the matching rate were computed like the states and if the cap on our program funding was removed.

Question 5. Overall, what do you see as the necessary steps to better ensure access to quality, comprehensive care for U.S. Virgin Islands residents and what would be a reasonable timeline to reach such a goal?

Answer.

- Access to quality of care will be a significant struggle in the short term (3–5 years) because of the infrastructure issues discussed already above. Without fully functioning hospitals, dialysis, and cancer treatment facilities we are faced with providing limited services on island and having to rely on higher cost evacuation to the Puerto Rico and the Mainland for critical health services.
- Additionally, we currently do not have certified nursing facilities and those facilities (old age homes) which are currently providing care to our disabled and frail elderly were severely damaged by the hurricanes. These facilities first have to be repaired from the storm damage and they then have to be brought up to Federal code. This will require a significant investment of upfront funding before these facilities can provide quality care and receive Federal reimbursement.
- We face a shortage of specialty and other physicians and nurses to provide quality of care. We need to be able to pay these types of providers at higher rates or with some type of supplemental payment in order to be able to attract providers to relocate to the Virgin Islands and to remain here once they are here. Without being able to offer such financial advantages and incentives we will continue to face a shortage of service providers and this will continue to negatively impact our access to quality care.

- We have very limited behavioral treatment on the island as a result of the lack of providers and facilities. Building new treatment centers or converting current facilities will take time and money. Additionally, attracting service providers in this area will face all of the problems previously discussed for attracting and retaining providers.

Question 6. What will you have to cut if you go off the cliff?

Answer. Unless the Congress and the Administration act before September 30, 2019, the U.S. Virgin Islands will be faced with potentially catastrophic damage to our Medicaid program and our healthcare system as detailed below:

- The U.S. Virgin Islands will have to remove upwards of 15,000 individuals from our Medicaid program who still need healthcare services.
- We will not be able to continue the outreach to the community to bring into the Medicaid program those 15,000 to 20,000 additional Virgin Islanders who we believe are eligible for the program currently but not yet enrolled.
- The U.S. Virgin Islands will have to pay for any needed healthcare services with all local funds that are not available in our budget at this time.
- We will face further delays in rebuilding our hospitals and clinics and other healthcare infrastructure as funds will have to be diverted to pay for needed ongoing day-to-day healthcare services.
- The U.S. Virgin Islands will have to continue to evacuate even more patients to the mainland, at even further costs to us, which we are unable to support with local funding as delays in the rebuilding of our healthcare infrastructure continue. However, when we enter the new fiscal year and return to the capped Federal funding amount of $18.7 million the U.S. Virgin Islands will have to severely limit the number of transfers to the U.S. mainland hospitals of very ill and injured Medicaid members who cannot get the necessary medical care (e.g., trauma cases, selected orthopedic surgeries, cancer treatments, and services for severe cardiological issues). The U.S. Virgin Islands would simply be unable to afford the expenses associated with airlifting the patients to the mainland and paying for their medical care and rehabilitation services.
- We will be faced with losing more and more of our medical providers if we are unable to pay and retain them. This will be compounded by our inability to attract new medical professionals willing to come and work in the islands when we are facing such a critical financial crisis in our healthcare system and they are concerned with whether they will be able to be paid.
- We will not be able to expand much needed long-term care support services to our elderly and disabled population—our most fragile population—as we have no certified nursing homes in the U.S. Virgin Islands and such care has to be provided mainly in the community.

Question 7. What will be the impact on individuals and the healthcare delivery system in the territory, when Obamacare funding ends this year?

Answer.

- The impact will be that a decade of progress in expanding enrollment and access to services will come to an end and things will revert to the situation prior to 2011 when the funds became available.
- All of the impacts outlined above related to the fiscal cliff will be the necessary result of reverting to Medicaid current law for the Virgin Islands—a capped program with a 55 percent matching rate.
- The stark reality for the Virgin Islands is that if we revert to the annual cap of $18.7 million in FY 2020 we will be at least $53.3 million short in the Federal funding we need for those services covered by that cap in FY 2020. We cannot make that up with local funding. That shortfall only increases in the out years as the program grows and the need for Federal matching funds increases.

Vice Chair SABLAN. Wow. Thank you. Such wonderful witnesses. I love you all.

Thank you again, Ms. Rhymer-Browne.

I would like to, at this time, recognize Ms. Sandra King Young. This is not her first appearance, she has been here before.

Ms. Young, you have 5 minutes, please.

STATEMENT OF SANDRA KING YOUNG, MEDICAID DIRECTOR, AMERICAN SAMOA GOVERNMENT

Ms. YOUNG. Good morning, Chairman Sablan, Ranking Member González-Colón, and honorable members of the Committee. I bring to you greetings from our governor, Lolo Matalasi Moliga, and our lieutenant governor, Lemanu Peleti Mauga. And thank you for this important hearing to provide information on the impact of the September expiration of the Medicaid funding for American Samoa and our sister territories.

My name is Sandra King Young, Medicaid Director for American Samoa. My written testimony submitted for the record to the Committee outlines the devastating impact of the loss of the ACA funds that American Samoa has not been able to spend and the reasons why, so I will not reiterate those points here.

At the outset, I want to point out again that, for American Samoa, Medicaid is our only health insurance plan available to the public at large. Insurance carriers have historically declined to provide health insurance to our people because we are a high-risk and very sick population with one of the highest rates of obesity and non-communicable diseases in the world.

And we are a very poor community. Without Medicaid, our people will have no health insurance coverage, and our healthcare system would face an absolute collapse and insolvency. Medicaid is our people's and our territory's lifeline for medical care services.

As we have repeatedly shared, the two biggest challenges with our Medicaid program are our government's inability to fund the local match requirement for the Medicaid program. Second, the statutory capped annual funding, or block grants, placed on the territories prohibits us from fully executing the benefits requirements under our state plan and the Social Security Act.

Because we have exhausted our local match for this fiscal year, as of today, our Medicaid agency has suspended all referrals of any new off-island patients to New Zealand. We have suspended any new patients needing wheelchairs or other durable medical equipment, including prosthetics. And we are cutting back on co-pay assistance to our Medicaid dual-eligible population.

Our hospital, however, continues to receive its Medicaid funding under the ACA because it does not need local-match dollars under its certified public expenditure payment method.

Oftentimes, when we try to explain why we need the relief from local match and why we cannot spend all of ACA Medicaid dollars, I think people nod their heads, but they don't really know what that means to a patient's life, to their family, or to our community.

The real-life stories of life-changing impact on patients because of the availability of the ACA funding justifies an increase in the territory's block grant. The devastating life-and-death outcomes that we face with the potential loss of this ACA funding without a resolution justifies an increase in the territory's Medicaid funding block grants.

Last year, I had to make a difficult decision on whether we were going to refer a child, an infant of 6 months, to New Zealand. Severely disabled, cerebral palsy. We got the quote back from New

Zealand that the child, ethically, they must accept, but prognosis, they don't think the child will survive beyond 12 months. And in that 12 months, they would have to care for the child, because we can't care for the child on-island. But the child will likely die anyway. And it would cost us a million dollars, if not more.

Our government only provided us $2 million in local match to do the off-island referral. We made a difficult decision to deny the referral of this child because we didn't have the local match. A few weeks later, the infant died.

Currently, we have two patients in New Zealand. One is a middle-aged father who was sent for neurological surgery on his back. This week, we got word that the man is severely ill and requires triple bypass heart surgery, at a cost of nearly $100,000. And I had to deny that because we don't have the local match. And just yesterday, I had to reverse my decision, because the family is devastated. And we have to deal with that now, on how we are going to make that payment when the invoice arrives in our office.

We have one patient in New Zealand, a young man with his whole life ahead of him. He had an on-the-job injury, a pile of plywood fell on his back and broke his neck. And he had to be air-ambulanced to New Zealand. And last week, New Zealand requested if he could stay 2 more months to do a sleep study to see how well he could survive if he returns home. Again, we had to deny the referral, but, again, this week, we reversed our decision because we have to deal with that. New Zealand won't discharge the patient. Ethically, they won't.

Why are we sending our patients to New Zealand? Because we have a block grant, and we can't afford the local match. We cannot afford the Medicare costs in the United States.

For Congress to fail to increase the territories' annual Medicaid block grant and to provide a more fair FMAP for the territories in light of the knowledge of the consequences and the loss of lives and potentially crippling physical and cognitive outcomes for our people because of insufficient medical funding is morally unconscionable. We need your help. Only Congress can solve these Medicaid challenges for the territories.

Thank you, Mr. Chairman and the Committee, for this opportunity, and thank you for holding this hearing.

[The prepared statement of Ms. Young follows:]

PREPARED STATEMENT OF SANDRA KING YOUNG, MEDICAID DIRECTOR, AMERICAN SAMOA

Good morning Chairman Sablan, Ranking Member Bishop, and members of the Committee. I bring to you greetings from our Governor Lolo Matalasi Moliga and our Lt. Governor Lemanu Peleti Mauga. On behalf of our government and our people, thank you for the opportunity to appear before you today to provide information on the impact of the September expiration of the Medicaid funding for American Samoa and the other territories contained in the Patient Protection and Affordable Care Act (ACA) of 2011. I'd like to recognize that today with me, is our Medicaid Finance Analyst, Mrs. Faiilagi Poufa-Faiai.

Since Governor Lolo Matalasi Moliga and Lt. Governor Lemanu Peleti Mauga came into office in January 2013, we have been very concerned about the need to address the expiration of the ACA funds. Over the past 6 years, we have consistently shared our concerns with the Administration through the Centers for Medicare and Medicaid Services as well as Congress to either extend the availability of the ACA funds or to increase the territories Medicaid block grants. Although grateful for the additional Medicaid funding provided by ACA, due to several

challenges, our government was never going to be able to expend the full $197,800,000 million made available to American Samoa within the time frame of the ACA law. At the time that Governor Lolo and Lt. Governor Lemanu began their administration in 2013, our territory had only spent $10,357,446.17 million of the ACA funds. Currently, we have a remaining balance of $152,338,473 million in our ACA Medicaid account (See Table 1. American Samoa ACA spending history).

The ability of our territory to expend the ACA funds is constrained by a number of factors. First, we cannot access the ACA funds until we first spend our regular annual block grant which is currently at $12 million a year. Our regular annual block grant is usually exhausted by the 3rd quarter of the fiscal year and only then, is our territory able to tap into the ACA funds. Our territory's historical spending of ACA funds has averaged only $5.4 million a year. Further, ACA funding can only be spent for eligible allowable Medicaid expenditures. It cannot be used for construction or renovation of hospital facilities or any other non-medical services not allowed for under the Medicaid State Plan.

Table 1. American Samoa ACA Spending History

YEAR	ACA	ACA Expenditures	
2011	4,032,265.00	3,957,205.00	75,060.00
2012	7,135,836.00	6,400,241.17	735,594.83
2013	5,000,000.00	4,321,067.67	678,932.33
2014	5,000,000.00	4,795,911.88	204,088.12
2015	6,773,371.00	6,773,371.00	-
2016	5,000,000.00	4,919,305.97	80,694.03
2017	6,230,000.00	6,047,825.78	182,174.22
2018	6,590,000.00	6,502,193.02	87,806.98
2019	6,722,000.00	1,744,405.44	4,977,594.56
TOTAL	**52,483,472.00**	**45,461,526.93**	7,021,945.07
ACA Award		181,800,000	
Marketplace insurance		16,000,000	
		197,800,000	
ACA Expenditures	2011-2019	-45,461,527	
ACA Remaining Balance		**152,338,473**	

Up until 2017, we were unable to add any new Medicaid providers because our local government did not have the local revenues to provide the local match for new providers. The government-owned hospital utilizes a certified public expenditure payment method that does not require direct cash match, but any new providers or services outside of the hospital would require direct cash match. In 2017, our government was able to provide $2 million in the Governor's special programs budget to launch new Medicaid services such as the off-island referral program to New Zealand.

Second, American Samoa's small population only incurs a certain level of expenditures per annum based on medical care services delivered by providers; and third, our government does not have enough Medicaid providers that could increase reimbursement claims. Adding new Medicaid providers to deliver services outside of the hospital can never be done unless our government can identify sources of revenues to provide Medicaid local match. Currently, the hospital receives government subsidies from the general fund to support hospital operations. Based on the hospital's annual final settled Medicare Cost Report, Medicaid is able to provide stable monthly reimbursement funds to the hospital. The new providers outside of the hospital is supported by the Governor's Special Programs budget that also comes from the government's general fund.

One oft-misunderstood facet of American Samoa's Medicaid program is our consistent inability to spend our allotted ACA funds each year. There seems to be a fundamental misunderstanding of the root causes that explain American Samoa's unspent ACA monies to date. Only the medical providers can incur "allowable

eligible" Medicaid expenses to draw down Federal Medicaid dollars—the Medicaid office does not spend the Medicaid funds. The Medicaid program also cannot advance Medicaid dollars—it is a reimbursement program wherein the medical providers must first provide services that are eligible "allowable" expenses payable under Medicaid. The Medicaid office is simply the administrating office that pays out Medicaid funds. Because of ACA funding, our government was able to significantly improve delivery of medical care services to our people with the addition of new Medicaid services and providers to the Medicaid program. The new providers have helped our territory draw a little more of the ACA funds, but it will always be limited by the availability of local matching dollars. Without more local match funds to serve more patients and add more services, spending the ACA funds will always be a challenge.

As the territory faces the looming ACA expiration deadline this September, it will again be unprepared to absorb the loss of nearly $152 million in unspent ACA funds. Absent an ACA funds extension or without an increase in the statutory cap placed on the territories, American Samoa will be forced to suspend all new Medicaid benefits. We will suspend our off-island program to New Zealand that has been a life-saving program for many of our patients who otherwise would not be alive today had it not been for the ACA funding. ACA funding has allowed us to save and improve lives by providing a direct pipeline for residents to medical services and care that is not available at the local hospital.

Consider the case of a young 30-year-old mother and nurse of five who is alive and fully functioning today after experiencing a traumatic brain hemorrhage—she is alive today because ACA funds paid for the Air Ambulance and nearly $300,000 of medical treatment costs to save her life and rehabilitate her so she can still live life to the fullest as a mother. Although no longer working as a nurse, she is fully able to care for her children and her family. ACA made a difference to residents, young and old, adults and children alike, who live on because they received off-island, life-saving medical treatment not available at our local hospital. Amputees, diabetics, orthopedic and cancer patients have benefited from our off-island referral program, gaining critical medical treatment they otherwise would not have access to. People whose lives have been transformed, living life with less pain and an overall higher quality of life—all because of ACA Medicaid funding. All of these success stories hinge on the presence of ACA monies. Viewed in this light, failure to act by Congress before the September expiration deadline would be disastrous for our people. It literally will mean the loss of lives and permanent disabilities for people who will lose access to medically necessary care. All of these new services will have to be suspended in the new fiscal year—*if there is no solution provided to increase our annual Medicaid block grant*.

This point cannot be overstated: Medicaid is the only health insurance program that is available to the general population in American Samoa, including government workers, cabinet directors and other government officials from the legislative and judicial branches. Cannery workers. Children. Working folk from the private sector and service industries. All of them rely on U.S. Medicaid. As a Medicaid Director here in the United States, I have no health insurance coverage unless I buy travel insurance. My Finance Analyst, Mrs. Faiilagi Poufa-Faiai, also sits before this Committee without health insurance coverage as an American Samoa government employee and as U.S. nationals. Why only Medicaid? Because for decades in spite of efforts by our government to recruit health insurance providers, health insurance companies refuse to serve a community that is high risk and low income.

In the worst-case scenario that Congress fails to act before September, the American Samoa Government is prepared to:

1. Suspend all new services implemented by the Lolo administration and preserve the regular annual Medicaid funding for the LBJ hospital—all funds would be exhausted in the third quarter; or
2. Support all Medicaid services, in which case Medicaid funds will be exhausted in the second quarter, then suspend all new services while the local government pursues options to continue the operations of the hospital.

Clearly, neither option is ideal. Both represent what would objectively be a devastating blow to American Samoa's healthcare delivery system and substantially harm hard-working families of American Samoa. Medicaid is the lifeline for the people of American Samoa and without additional funds in the new fiscal year, we face an unconscionable medical crisis that could have been prevented by Congress.

Given what we know, the best long-term, sustainable fixes are ones that only Congress can provide at this point and do so in ways that are sustainable and address long-term and systemic concerns. Northern Marianas, Guam, Puerto Rico,

Virgin Islands, and American Samoa—all of us since the launch of Medicaid in the territories have operated under what is essentially a block grant system of payments. Before the ACA, the territories' annual Medicaid block payments under the statutory cap were, by and large, insufficient. Moreover, in American Samoa's case, the recent increase in additional ACA monies were ostensibly negated by demographics and the local government's inability to make the required annual dollar match. In order to mitigate the loss of monies that will occur when ACA funding expires at the end of September 2019, we recommend that Congress undertake the following steps:

First, extend the ACA expiration date for ACA monies for American Samoa. It is long overdue for Congress to increase the cap on block grants to give the territories more equitable access to the benefits of the Medicaid program and to ensure essential monies are not left on the table because of the match requirements.

Second, the territories' FMAP formula must also be adjusted in order to align with that of the states. The FMAP formula for the states is based on the Federal poverty level. However, the territories are subjected to an arbitrary percentage that makes no sense, since the territories are some of the poorest jurisdictions in the Nation. The territories FMAP formula is similar to the wealthiest states in the country. If the FMAP formula were applied the same way as the states, American Samoa would have an 88 percent Federal FMAP rather than the current 55 percent. This would greatly assist American Samoa with the local match requirements which it currently cannot meet to access more ACA funds.

Finally, while adjusting the territories' FMAP formula so it aligns with the current formula in use by the states is important, it is only a partial and first step. The cap on the territories' block grants must also be raised. These two steps are complementary and must be taken in conjunction together in order for them to truly be effective in the long term. Either of those two fixes in isolation without the other simply means American Samoa's Medicaid block grant funding will be exhausted faster. In that scenario, the territory is left with having to either take out a loan or find new public revenues to offset the financial shortfall. Receiving the FMAP at 100 percent under the disaster supplemental going through Congress now would provide much needed relief to our Medicaid program that has suspended new services due to the exhaustion of the local match share.

Thank you again Mr. Chairman and the members of this Committee for this opportunity to appear before you today. We appreciate the time and attention given to the territories Medicaid issues. I would be happy to answer any questions that you may have.

QUESTIONS SUBMITTED FOR THE RECORD TO SANDRA KING YOUNG, MEDICAID DIRECTOR, AMERICAN SAMOA

Questions Submitted by Rep. Sablan

Question 1. If Congress finally treats the territories equitably and provides uncapped funding with Federal match determined in the same was as states, what would the American Samoan Government do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?

Answer. The only acute care hospital facility that serves our people is located on the island of Tutuila (the largest island). There are five community health centers, three in the outlying islands of Ta'u, Ofu and Olosega. Residents of these outlying islands must either travel by boat or airplane to access medical care services for severe illnesses or major healthcare challenges. Air travel to the Manu'a islands is sporadic given our dependence on a foreign airline to provide transportation between Tutuila and the outlying islands. The residents of these islands are considered severely underserved. It is abundantly clear that we need to improve the quality of healthcare services to these outlying islands, but the demands for improving the main acute care hospital facility on Tutuila continue to dwarf and overshadow the needs of this population. Additional Federal funding support would go a long way for us to address this inequity. As a start, American Samoa would increase service providers to expand the delivery of comprehensive healthcare services including to the outlying islands.

We will attract private healthcare providers to set up operations in American Samoa as the full actual cost of rendering healthcare services will be captured and be reimbursed. These would include Long Term Support Services, home health services, nursing facility services, rural health clinic services, plus expanded

pharmacy services, drug and tobacco cessation services and other mandatory and optional health benefits currently not being supported due to the cap and unsustainable FMAP. While this pathway is being pursued, the American Samoa Government would immediately invest in attracting Board Certified Doctors and specialists to render the same quality of service available in the United States. Moreover, the American Samoa Government will increase the diagnostic abilities of our only acute medical care facility—the Lyndon Baines Johnson Tropical Medical Center. We would invest in purchasing state-of-the-art diagnostic equipment along with ensuring that qualified Radiologists and technicians are on site to facilitate optimization of the equipment's effectiveness. Unlike CNMI, the nearest U.S. Medical Institution for medically necessary care not available on island is Hawaii and the cost of travel is cost prohibitive. The frequency of flights is twice (2) weekly, throughout the year except for an added third flight during the Christmas Holiday and summer. The remoteness of American Samoa and the limitation of only one airline and two flights a week to the United States contributes to the high cost of providing healthcare services compared to the states and some of the territories.

1a. With the additional Federal funding, what specific investments could you make to improve eligibility and benefits over time?

Answer. AS would engage in a full-scale reassessment of our presumptive eligibility program which does not do individual enrollment. This is the way our Medicaid program was set up when it was first established in 1982 under our 1902(j) Waiver. It is important to know that AS continues to support our presumptive eligibility program as it is relevant to our environment. We would continue to strengthen our collaboration with our providers to invest in the improvement of their operational and financial systems to better manage healthcare costs and provide more equitable access to services. Ultimately, we hope that with additional financial resources, our Medicaid program will be able to provide comprehensive healthcare services to our people.

Question 2. What improvements in your healthcare infrastructure would be needed?

Answer. We would need major investment in upgrading our hospital facility and major investment to build new or upgrade our existing community health clinics. In particular, a tremendous gap is the lack of diagnostic equipment that would better diagnose patients to provide more effect treatment plans for patients. The American Samoa Government has been working to elevate the quality of services and the appropriate medical environment to facilitate compliance with Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) standards demanded of all U.S. Medical facilities in the United States. In addition, the current physician and nursing shortage requires a more targeted focus on investment in our local nursing program and as well as inspiring and motivating enrollment in medical schools through the provision of scholarships.

2a. Would dedicated up-front funding be needed to make those changes?

Answer. Yes, absolutely this would be very helpful. The current effort to waive the Medicaid local match reflects the financial inability of the American Samoa Government to address not only the myriad of territorial needs but also to invest in the repair and rehabilitation of aged facilities. Up-front funding would greatly help facilitate immediate attention to mitigate our aging facilities and acquire diagnostic equipment that would help improve patient treatments.

Question 3. Would provider payments have to be increased and to what extent?

Answer. With a small number of providers and with our presumptive eligibility (PE) formula, payments to providers are simple to administer. Payments are based on our population numbers that is calculated on an annual basis and the PE can either go up or go down tied to population increase or decrease. Payment methods are provider-specific and based on actual costs from prior year Medicare Cost Reports, actual costs for off-island referral and encounter rates for the FQHC community health clinics—but they are all still based on the PE formula. I cannot comment on any increase on provider payments except to state that we do have the authority to accept or deny any increases that would make provision of services cost prohibitive for the Medicaid program.

Question 4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could American Samoa make to ensure residents get high quality health care in other ways that meets their needs?

Answer. The immediate option that AS has to provide high quality health care to meet the needs of our patients is the off-island program to New Zealand. We would like to expand this program to Hawaii or to other states in the United States, but we are unable to do this under our existing block grant and the FMAP we have. As to other ways, it would be to increase services at our local hospital, invest in diagnostic equipment, increase physician services, increase community base healthcare providers, etc.

Question 5. Overall, what do you see as the necessary steps to better ensure access to quality, comprehensive care for American Samoan residents and what would be a reasonable timeline to reach such a goal?

Answer. The U.S. Army Corps of Engineers recently completed its assessment of American Samoa's healthcare facilities under an engagement by the U.S. Department of the Interior responding to the congressional directive calling for this healthcare infrastructure assessment. This report would provide the most current information on the condition and status of American Samoa's healthcare facilities. In addition, I refer the Committee to the State Innovation Model Report that was issued by American Samoa through the Medicaid State Agency that identifies the gaps, recommendations and lays out a pathway to improve the healthcare services system in the territory. This report will be forthcoming under a separate cover. Briefly however, the necessary steps to better ensure access to quality, comprehensive care for our residents is: (1) the lifting of the Medicaid cap and adopting a fairer FMAP for the territories. Our biggest barrier to access to quality and comprehensive health care is the lack of financial resources; and (2) increasing medical care and other services providers under the Medicaid program.

Question 6. What will you have to cut if you go off the cliff?

Answer. If AS goes off the cliff with the expiration of ACA funds and without a replacement source of funding, we will have to cut all the new services and new providers approved during the Lolo administration—(1) the Off-island medical referral program to New Zealand; (2) the Department of Health Federally Qualified Health Center's community clinics; (3) the Durable Medical Equipment, Prosthetics, Orthotics and Supplies; and the Medicare Dual-Eligible Co-Pay assistance program. Our block grant can only afford to cover services for our only hospital and this is the priority of our government, to keep the hospital open.

Question 7. What will be the impact on individuals and the healthcare delivery system in the territory, when Obamacare funding ends this year?

Answer. The impact would be devastating. People would not have access to life saving services. For example, children who need rheumatic heart disease surgeries would not get them, people who need cancer treatment would not get them, any heart surgery would not be available and all other medically necessary care that are not available on island would not be accessible to our people.

Questions Submitted by Rep. Radewagen

Question 1. Given service utilization and the historical issues with generating local matching funds, what is the minimum FMAP that American Samoa's Medicaid system needs if the annual allotment is raised to $30 million?

Answer. American Samoa would like to need the maximum FMAP that it is eligible for under the standard poverty formula used by the states to determine their FMAP. Currently, the American Samoa government can only put up $2 million for local match. It would be unable to come up with the match for the additional $13–$10 million we are requesting. AS thus requests an initial FMAP of 90/10 for the next 2 years, to increase to 85/15 in year 3 and 4 and then to 80 percent in year 5.

Question 2. The Senate version of the disaster relief bill in addition to temporarily increasing American Samoa's FMAP to 100 percent from January 1–September 30 for FY 2019, requires American Samoa to submit a plan on how the territory will collect and report reliable data to the Transformed Medicaid Statistical Information System (T-MSIS). American Samoa is currently exempt from many data reporting requirements. If passed, what is the projected cost of implementing such a system.

Answer. American Samoa does not have a T-MSIS system because that would not make sense for American Samoa whose annual cap is $12 million. A traditional T-MSIS system is estimated to cost over $20 million and even a smaller version would not be financially feasible for American Samoa. The Medicaid agency keeps internal data on expenditures and patient utilization and is able to report this data to CMS.

Question 3. American Samoa's Medicaid program covers 14 of the 17 mandatory benefits and some optional benefits. What is the projected cost and time frame it would take for American Samoa to become 100 percent compliant?

Answer. I cannot comment on this time frame because we would need to do a full-scale evaluation and cost-benefit analysis together with CMS to plan this out. The territory's existing work force, education pipeline to train new medical providers, local and Federal regulations would all need to be reviewed to come up with the projected cost and time frame for full compliance. It is not possible for AS to be compliant under the current capped funding and heavy FMAP requirement.

Question 4. In the 2016 GAO report on Medicaid in the Territories, American Samoan Health Officials stated they planned to use some of the new ACA funds to expand services. Please explain in detail what these new services are and what suspending them may mean for American Samoans.

Answer. The new services added during Governor Lolo Matalasi Moliga and Lt. Governor Lemanu Peleti Mauga's administration are the (1) Off-island medical referral program to New Zealand, (2) the Department of Health Federally Qualified Health Center's community clinics, (3) the Durable Medical Equipment, Prosthetics, Orthotics and Supplies, and (4) the Medicare Dual-Eligible Co-Pay assistance program. Suspending all the four services would put people's lives at risk of permanent disability or worse, loss of life. Our people would not have access to medically necessary care that is not available on island.

Question 5. GAO reported they "found little assurance that territory Medicaid funds are protected from fraud, waste, and abuse"—A discussion area that will be discussed as the Congress debates a greater Territorial Medicaid solution. Could you please tell us about the current efforts and its successes?

Answer. In American Samoa, there has only been one Medicaid provider until 2017. CMS in 2011, put in place the certified public expenditure payment method for the hospital significantly reducing any risk of fraud, waste and abuse. Now with the four new services added since 2017, CMS continues to work closely with our Medicaid office to improve policies and procedures to implement tight controls and checks on all approvals for expenditures of Medicaid funds. AS Medicaid is working with the CMS Program Integrity Contractor Qlarant to improve and implement program integrity procedures in all Medicaid activities. It is not feasible to establish a full scale Medicaid control fraud unit for American Samoa because it would cost disproportionately more than what AS actually receives in a block grant.

Question 6. The Federally Qualified Health Centers (FQHCs) do not operate on the certified public expenditure method. Relative to LBJ Hospital, how much spending do FQHCs account for annually?

Answer. The FQHC just became a Medicaid provider in 2017. They utilize an encounter rate payment method and incurred $1,128,741.95 in Federal funds and $711,424.67 in local funds in FY 2018. Medicaid anticipates transitioning the FQHC to the CPE payment method once they have a couple of years of audited financial statements available.

Question 7. States currently do not have capped Federal Medicaid contributions and they have FMAP based on the average per capita income for each state relative to the national average. You mentioned in your testimony that given a lifting of the cap and a better FMAP, American Samoa would be able to attract more providers, but there are states that still struggle to attract providers despite not having these same statutory burdens. How exactly would removing the Federal cap and raising the FMAP, allow American Samoa to attract providers?

Answer. We would be able to have the financial resources to hire board certified doctors to serve in the LBJ hospital. We would also be able to encourage the development of the private sector healthcare providers with the availability of more Medicaid funding and lessening the burden on the FMAP. Because the local match must come from the government, the FMAP is key to expanding the private sector healthcare providers. No matter how much Federal Medicaid funds we receive, drawing these funds down are subject to the local match. Without the local match, we cannot draw Federal funds and this is when we suspend all services.

7a. Would you raise reimbursement rates?

Answer. Only in so much as cost of living increases because reimbursement rates for American Samoa are based on actual costs and on the CMS Medicare Fee Schedule.

Question 8. Would raising the FMAP and the Federal cap allow American Samoa to attract private insurers?

Answer. Highly unlikely, because Medicaid is essentially the universal healthcare provider for American Samoa. The majority of the population that fall within the poverty line threshold for the presumptive eligibility program in American Samoa is covered under Medicaid. The high poverty rates, high risk population and unsustainability of local revenues to cover private insurance premiums and deductibles would continue to be a great deterrent to the attraction of private insurers.

Question 9. Has there been any efforts to investigate or adopt a Kaiser Health Care model—the creation of an internal non-profit insurance plan managed by the facility that delivers care—for LBJ hospital?

Answer. That is a question best addressed to the LBJ hospital. Medicaid does not have the authority to investigate or adopt the creation of an internal non-profit insurance plan to be managed by the facility that delivers care for LBJ hospital. Medicaid did however, engage Kaiser Permanente at the beginning of the Lolo administration, regarding off-island services using their facilities in Hawaii. Kaiser was not prepared at the time to engage AS in that area without an identifiable and guaranteed source of long-term local funding from the American Samoa Government.

Question 10. What behavioral health services and or programs designed to address top public health priorities such as obesity and hypertension, if any, are currently covered under American Samoa's Medicaid program?

Answer. All behavioral health services are covered under the AS State Plan—the challenge is not having sufficient numbers of behavioral health providers to provide these services and not having sufficient financial resources to support these services—due to the capped funding and unsustainable local match.

Questions Submitted by Rep. González-Colón

Question 1. American Samoa will end this fiscal year with an unused balance of $153 million in ACA funds. You have explained to us the reasons for this balance but, from your testimony, extending the expiration date on these funds will not get you very far.

Answer. It will not get us far because we cannot come up with sufficient local match.

1a. What are the most important restrictions for the use of these funds that Congress must change in order for American Samoa to effectively use them to improve the provision of health care to its residents.

Answer. In terms of the $153 million, the President recently signed the Disaster Supplemental bill that gives AS 100 percent FMAP through September 30, 2019. Our territory would not be able to expend these funds by that date. It would be ideal if AS is allowed to use these funds past September 2019 until fully expended using a less burdensome FMAP or to be to obligate these funds for services delivered by this deadline. In addition, it would be helpful for AS if these funds were made available for infrastructure improvement and work force development. Currently, it is allowable only for medical care, but the major gaps in our healthcare system that impacts the delivery of quality medical care, deal with inadequate work force, poor facilities and lack of medical diagnostic equipment that could better diagnose our patients in order to better provide proper clinical response and prompt treatment strategies.

Question 2. How will the overall healthcare system and the non-Medicaid population in American Samoa be affected if Medicaid funding is not increased for FY 2020?

Answer. Overall, it would be devastating as we would have to cut back on the new services the territory implemented. As for the non-Medicaid population which is nominal, they would not be affected as they are not eligible for Medicaid and they pay out-of-pocket for medical services. However, the term non-Medicaid population is not generally used because all residents in American Samoa are presumptively covered under the Medicaid program. Because of the cap on AS Medicaid funding and the burdensome FMAP rate, healthcare services are limited to the extent of funding available.

Question 3. Currently, the Social Security Act provides for capped Medicaid funding for the territories. For FY 2017, the cap in American Samoa was $11.51 million. How much did the Medicaid program benefits actually cost?

Answer. Based on actuals contained in the Medicare Cost Report for allowable Medicaid costs for the hospital and expenditures from the private providers we have, program benefits cost approximately $17 million in Federal Medicaid funds only. Because we are only 2 years into our new services, this number is expected to increase based on the increase in patient utilization patterns as a result of increased public outreach on the availability of these new services.

Question 4. Could you please provide the Committee actual examples of how the current statutory FMAP of 55 percent affects the provision of health care in American Samoa?

Answer. The 55 percent FMAP greatly limits our territory's ability to provide comprehensive healthcare services to our people. Basically, it limits the provision of mandatory and optional services that the Medicaid program can provide under the Medicaid State Plan. The LBJ Tropical Medical Center receives locally generated revenues to provide medical care services and uses a certified public expenditure method that provides predictable funding and does not require actual cash match. The issue for the hospital is the capped funding which is not enough to cover the hospital's service for the year. Further, there are many services that are not available at the hospital for any number of reasons—no equipment, no physician specialists, no diagnostic equipment, etc. The Medicaid program to address this gap added new services which do require actual local cash match. Because the FMAP is so high comparable to the wealthy states in the United States, the territory which generates very limited local revenues, is unable to provide any substantial local dollars for the local match. The Medicaid program only receives $2 million in local match dollars a year for the off-island referral program. When this is exhausted in the second quarter, we suspend all reimbursements to providers and effectively suspend services.

Vice Chair SABLAN. Thank you very much for that, Ms. Young. Ms. Avila from Puerto Rico, you are recognized for 5 minutes.

STATEMENT OF ANGELA AVILA, EXECUTIVE DIRECTOR, PUERTO RICO STATE HEALTH INSURANCE ADMINISTRATION

Ms. AVILA. Thank you. Good morning, Mr. Chairman, Ranking Member González, and members of this Committee. Thank you for the opportunity to testify today on Puerto Rico's impending Medicaid cliff. I am honored to be here on behalf of the government of Puerto Rico and to be at the witness table with friends and colleagues from the other territories.

Puerto Rico's Medicaid program serves some of our Nation's most vulnerable citizens. We serve approximately 425,000 children and 305,000 elderly and disabled. We provide care to 1.5 million individuals out of a population of 3.2 million U.S. citizens.

Yet, Federal healthcare funding for Puerto Rico has been insufficient for generations. Puerto Rico's Medicaid system has been chronically underfunded due to the historical low Federal Medical Assistance Percentage, known as FMAP, and correspondingly high local matching requirement and the cap on Federal funding.

Currently, we are operating under increased Medicaid funding and a temporary 100 percent FMAP, which we received in the aftermath of Hurricane Maria, the worst natural disaster in our nation's history.

However, this supplemental funding will expire on September 30, 2019. If no action is taken for Fiscal Year 2020, the FMAP will

revert back to the statutorily mandated 55 percent FMAP, up to the Federal Medicaid funding cap of approximately $380 million.

This level of Federal funding is not sustainable, as it will only cover 19 percent of the Federal funding needed during Fiscal Year 2020 and will last approximately 3 months. Once this funding is exhausted, Puerto Rico would have to fully fund the deficit, as it has in the past, and pay for its Medicaid services with 100 percent local funding. Given the island's current financial situation, local funding is not available.

Unless Congress acts, we will be faced with potentially catastrophic damage to our Medicaid program and our healthcare system. We will be forced to potentially remove any services that are not required under the Medicaid rules, such as pharmacy coverage and dental coverage. We will have to end coverage for the current population who receive health care with local funds.

We will face further delays in much-needed improvements to our hospitals, clinics, and other healthcare providers. We will continue to lose more of our medical providers because we will not be able to ensure reasonable reimbursement. We will face a mental health crisis as individuals and families continue to struggle to have their most basic needs met.

Earlier this month, Governor Rossello submitted Puerto Rico's official Medicaid ask to Congress: $15.1 billion in funding at an 83 percent FMAP for 5 years. This funding would provide Puerto Rico with certainty in the short term while we work together on a sustainable, long-term funding mechanism.

As part of the Governor's request, we have identified critical sustainability measures needed to further stabilize and improve the healthcare system in Puerto Rico as a whole, which include: keeping physicians within the system to avoid critical shortages, provide lifesaving hep C drugs, provide Medicaid Part B premium coverage, and adjust the Puerto Rico poverty level to increase fairness in Medicaid eligibility.

The Medicaid cliff that Puerto Rico is facing is an emergency that must be dealt with swiftly and smartly. I love my island. It is my home. And I am committed to working with Congress to create a Medicaid program that all of us can be proud of and that provides the necessary care to the 1.5 million U.S. citizens who rely on it.

Thank you for your attention on these urgent matters. I welcome any questions you may have. Thank you.

[The prepared statement of Ms. Avila follows:]

PREPARED STATEMENT OF ANGELA AVILA, EXECUTIVE DIRECTOR, PUERTO RICO STATE HEALTH INSURANCE ADMINISTRATION

Chairman Grijalva, Ranking Member Bishop, and Members of the Committee: Thank you for the opportunity to testify today on Puerto Rico's impending Medicaid cliff and the significant and detrimental impact this funding cliff will have on the people of Puerto Rico and our healthcare system if Congress fails to act. I am honored to be here on behalf of the Government of Puerto Rico and to be joined at the witness table with my friends and colleagues from the other territories. We are united in our need for sustained Federal funding for Medicaid so that we can provide adequate health care to our people.

I appear before you today to request Congress' continued and expedient support to remedy the Medicaid funding crisis Puerto Rico is facing. On September 30, 2019, the increased Medicaid funding and the temporary 100 percent Federal Medical

Assistance Percentage (FMAP) we received in the aftermath of Hurricane Maria—the worst natural disaster in our Nation's history—will expire. It is only through this additional Federal funding and the 100 percent FMAP that we have been able to sustain our healthcare system.

Without this temporary funding provided in the Bipartisan Budget Act for Puerto Rico's Medicaid system, Medicaid beneficiaries in Puerto Rico would have been forced to forgo care, would have suffered needlessly and in many cases, would have died prematurely. These people include some of the most vulnerable citizens of the United States of America. We serve approximately 425,000 children, 305,000 elderly and disabled individuals, and more than 17,000 pregnant women at any given time. We provide care to 1.5 million individuals through our Medicaid program—out of a population of 3.2 million U.S. citizens—who may be suffering from mental and physical illnesses, often both and, all of whom are financially destitute. Without a more permanent and sustainable funding solution, we will be unable to complete the planning necessary to stabilize the system and improve health outcomes for our citizens.

Congress must act before September 30, 2019, to avert catastrophic damage to our healthcare system and the health and well-being of the people of Puerto Rico. If no action is taken for Fiscal Year 2020, the FMAP will revert back to the statutorily mandated 55 percent FMAP (established in 1968) for most of our Medicaid program, up to the Federal Medicaid funding cap of approximately $380 million. This level of Federal support for Puerto Rico's Medicaid program is not sustainable as that funding is projected to only cover 19 percent of the Federal funding needed during Fiscal Year 2020 for the Medicaid expenditures supported by that capped Federal allotment. If Puerto Rico only receives its statutory cap of $380 million at the fixed FMAP of 55 percent for FY 2020, Federal funding of Puerto Rico's Medicaid will only last 3 months. These simple and stark numbers represent the Medicaid "fiscal cliff" that we have been talking about for some time. Unless Congress acts on the Government of Puerto Rico's request before September 30, 2019, we will be faced with potentially catastrophic damage to our Medicaid program and our healthcare system:

- We will have to conduct a review of all current benefits and potentially remove any services that are not required under Medicaid rules, such as Pharmacy coverage and Dental coverage.
- We will have to abandon all plans to modify the Puerto Rico Poverty Level to add uninsured individuals presenting at hospitals to receive uncompensated care.
- We may have to end coverage for the current population who receives health care with local funds.
- We will have to pay for any needed Medicaid healthcare services with all local funds that are not available in our budget at this time.
- We will face further delays in much needed improvements to our hospitals, clinics, and other healthcare infrastructure as funds will have to be diverted to current Medicaid obligations.
- We will continue to lose more of our medical providers because we will not be able to ensure reasonable reimbursement to retain this critical work force. Our healthcare work force shortage is compounded by our inability to attract new medical professionals to Puerto Rico due to concerns of financial instability and is especially problematic with specialty providers needed to treat expensive and prevalent health conditions.
- Finally, we will face a mental health crisis as individuals and families continue to struggle to have their most basic needs met, particularly in the aftermath of Hurricane Maria which provoked a 20 percent increase in suicide rates.

Due to the disproportionately low level of Federal Medicaid funding historically available to Puerto Rico, we have been forced to limit Medicaid eligibility to income levels well below the Federal poverty level used by the states. For example, Puerto Rico covers individuals with income up to 138 percent of the Puerto Rico poverty level, which is $11,736 annually for a family of four or approximately 46 percent of the Federal poverty level for a family of the same size in 2019 on the mainland.

Once the cap is exhausted, Puerto Rico would have to fully fund the deficit in Federal Medicaid funding, as it has in the past, and pay for its Medicaid services with 100 percent local funding. Given the island's current financial situation, local funding is not available. Come October, if Congress fails to act, nearly 1.5 million U.S. citizens may lose the essential health care they need, our already fragile

healthcare infrastructure would be further destabilized, and the island's recovery would be further delayed.

I would like to take a moment to clear up a misconception that seems to be all-to-common when it comes to Puerto Rico. Puerto Rico has not mismanaged any funds in administering its Medicaid program, in fact, we have made extraordinary efforts and worked tirelessly to provide the best care for our citizens with the fewest resources. For FY 2020, for example, Puerto Rico's projected total spend per full year equivalent, including Federal and state funds, is estimated to be lower than the Federal spending in any of the states. We are aware that additional and sustained Federal support comes with additional responsibility on our part to ensure that the Medicaid program is efficient, effective, and accountable. Toward that end, we have already taken several actions outlined below:

- We implemented a fully functioning Medicaid Management Information System (MMIS).
- We implemented a Medicaid Fraud Control Unit (MFCU).
- We enhanced our most recent Managed Care Organization (MCO) Contracts with additional requirements, including financial conditions, related to encounter data, program integrity activities, achieving improved health outcomes, and one of the highest Medical Loss Ratios in the Nation.

We believe that all of these activities, in addition to our complete responsiveness to the Financial Oversight Management Board (FOMB) created by Congress under the Puerto Rico Oversight Management and Economic Stability Act (PROMESA), P.L. 114–187, indicate the island's ongoing commitment to ensuring the integrity of our programs and our responsible stewardship of the Federal Medicaid funding that we receive.

Earlier this month, the Governor of Puerto Rico, the Honorable Ricardo Rosselló submitted Puerto Rico's official Medicaid ask to Congress—$15.1 billion in funding at an 83 percent FMAP for 5 years in order to prevent the collapse of the healthcare system in Puerto Rico.[1] This funding would provide the island with certainty in the short term while Congress works with us to determine a sustainable, long-term funding mechanism that eliminates the inequity in funding and allows us to meet the healthcare needs of our most vulnerable residents. As part of the Governor's request, we have identified critical sustainability measures needed to further stabilize and improve the healthcare system in Puerto Rico as a whole:

- **Keep physicians within the system to avoid critical shortages**—The number of registered physicians has decreased due in part to low reimbursement rates and lack of infrastructure. This is especially problematic with key specialty physicians. We are working on a strategy to ensure dollars earmarked for increased provider reimbursement reach providers under managed care, whether the provider is an individual practitioner or part of a larger group practice.
- **Provide life-saving Hepatitis-C drugs**—Unlike in the mainland's Medicaid system, currently, Puerto Rico's Medicaid system does not cover the drugs that cure the Hepatitis-C virus and there are an estimated 14,000 Puerto Ricans with the disease. While the short-term cost of proving this benefit is high, significant savings can be realized by investing in the long-term health of our members and avoiding costly treatment options in the future.
- **Prevent collapse of hospital system due to losses**—According to the latest Centers for Medicare and Medicaid Services (CMS) cost reports, over 50 percent of Puerto Rico's hospitals reported losses. Because Medicaid covers over half of the population of the island and has the lowest reimbursement rates for hospitals, our funding status jeopardizes the hospitals' ability to operate and reinvest in infrastructure. Additional funds are needed to compensate hospitals for losses attributable to Medicaid.
- **Provide Medicare Part B Premium coverage**—Coverage of Part B premiums has the potential to help approximately 282,000 Medicaid and Medicare dual eligibles that pay Medicare Part B premium out-of-pocket or opted not to enroll in Medicare Part B due to the cost. In most cases, this is a deduction from each individuals Social Security check, which for most recipients is their sole source of income. Since premiums can be as high as

[1] This assumes that other Federal matching requirements and funding under the Medicaid program remain in place during this period for areas such as CHIP allotments, MMIS, Eligibility and Enrollment, and Medicare Part D co-insurance and deductibles.

$135.50 per month, some elderly residents must choose between food, rent and health care. This is a choice no U.S. citizen should be forced to make.

- **Adjust the Puerto Rico Poverty Level to increase fairness in Medicaid eligibility**—Due to the low level of Federal Medicaid funding, Puerto Rico uses its own poverty level as the basis for determining eligibility. As I mentioned earlier, the Puerto Rico Poverty Level is less than 50 percent of the Federal Poverty Level used by other states. As a result, a significant percentage of vulnerable families and individuals in Puerto Rico lack healthcare coverage. Currently, Puerto Rico covers approximately 120,000 of these individuals directly with local funds. As local dollars may not consistently be available to cover these individuals, they may have no choice but to move to the mainland in search of adequate healthcare coverage.

As we have stated in previous meetings with the Administration, and in testimony before Congress and recently, the Medicaid and CHIP Payment and Access Commission (MACPAC), Federal healthcare funding in Puerto Rico has been insufficient for generations. Under Medicaid, the historically low FMAP, a correspondingly high local matching requirement, and the cap on Federal funding have imposed severe and unsustainable financial demands on Puerto Rico.

The Medicaid cliff that Puerto Rico is facing is an emergency that must be dealt with swiftly and smartly. As this Committee knows, the Government of Puerto Rico is currently in the midst of working with the Oversight Board to obtain approval of our revised Fiscal Plan and our FY 2020–2021 state budget, all of which must happen by June 30, 2019. Given the very limited time available for approval, we ask that you address this issue in the next available legislative vehicle. Our proposal will allow us to continue to provide urgent healthcare services to our citizens while we work to rebuild our healthcare infrastructure and economic viability and will serve to provide a temporary "fix" to the disparate, arbitrary, and insufficient treatment that Puerto Rico continues to receive under the Medicaid Program.

I am grateful for the opportunity to share these facts with you and thank you for allowing me to testify before this Committee on this critically important issue. I love my island—it is my home, and I am committed to working with Congress to create a Medicaid system that all of us can be proud of and that provides the necessary care to the 1.5 million U.S. citizens who rely on it. We look forward to working together to address the immediate issue of the impending Medicaid fiscal funding cliff and we look forward to finding a solution that can eliminate the unequal treatment for Puerto Rico, provide parity for Medicaid enrollees and the full benefits of the Federal Medicaid program for our citizens and our providers once and for all. Thank you for your consideration and attention to these urgent matters. I am honored to be heard and open to answer any questions you may have.

QUESTIONS SUBMITTED FOR THE RECORD TO ANGELA AVILA, EXECUTIVE DIRECTOR, PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Questions Submitted by Rep. Sablan

Question 1. If Congress finally treats the territories equitably and provides uncapped funding with Federal match determined in the same was as states, what would Puerto Rico do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?

1a. With the additional Federal funding, what specific investments could you make to improve eligibility and benefits over time?

Answer. For the first time since the beginning of the program, Puerto Rico would be able to stabilize the Government Health Plan by having adequate funding for the provision of services. Currently, Puerto Rico covers many mandatory services for all beneficiaries, and additionally covers some optional services such as dental care, pharmacy benefits and some behavioral health services. Providing all mandatory services such as Nursing Facility Care and Non-Emergency Medical Transportation requires reliable long-term funding, sufficient time to assess the need and current provider capacity in Puerto Rico and remedy any deficiencies in capacity and infrastructure to support the new services. ASES is fully committed to initiating these projects if the funding is available.

Specific investments include provider capacity, development, and availability; management capacity and subject matter expertise within the Medicaid agency; IT solutions; and stakeholder outreach and training for Medicaid staff, the provider

community, the managed care organizations, and broader stakeholder community. In addition, with the available funding Puerto Rico would:

- Increase provider reimbursement;
- Provide life-saving Hepatitis-C drugs;
- Provide improved financial support to hospitals;
- Provide Medicare Part B Premium coverage for approximately 282,000 Medicaid and Medicare dual eligible individuals that pay the Medicare Part B premium out-of-pocket or opted not to enroll in Medicare Part B due to the cost; and
- Adjust the Puerto Rico Poverty Level to cover more uninsured or underinsured individuals.

In the event that Puerto Rico receives sustainable funding sufficient to cover the costs of providing long-term care, we would also invest in the administrative framework required to support the provision of these services and begin reimbursing the same.

Question 2. What improvements in your healthcare infrastructure would be needed?

2a. Would dedicated up-front funding be needed to make those changes?

Answer. Funding would be needed for Puerto Rico to be able to begin reimbursement of mandatory services that are not currently being provided. Dedicated up-front funding would also be needed to create the necessary infrastructure to begin providing such services and perform responsible oversight of the same. We would need to build and improve infrastructure across all areas of the program in order to be able to operate in a more "state-like" manner. Puerto Rico would need to invest in additional staff and staff training and development at Medicaid and ASES. We would continue and expand investments in IT solutions to efficiently oversee the Managed Care Organizations (MCOs) and we need to build formalized structures from policy to payment for any new services.

We would need to invest in our providers and support their capabilities with regard to electronic health records (EHR) and provide adequate reimbursements such that they may invest in upgrades to infrastructure and equipment. We are working on a strategy to ensure dollars earmarked for increased provider reimbursement reach providers under managed care, whether the provider is an individual practitioner or part of a larger group practice. We cannot fully accomplish this without the reliable long-term solution we are requesting.

Question 3. Would provider payments have to be increased and to what extent?

Answer. Providers are leaving the island for a variety of reasons, including the low reimbursement rates that barely covers the basic cost of providing services and for the lack of financial stability to improve their practices, equipment and technology. The number of registered physicians in Puerto Rico continues to decrease due to low reimbursement rates and lack of infrastructure. This is especially problematic with key specialty physicians. An increase of provider rates to a minimum of 70 percent of Medicare rates in Puerto Rico is necessary to begin the process of retaining our providers.

Question 4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could Puerto Rico make to ensure residents get high quality health care in other ways that meets their needs?

Answer. As indicated in the responses to Questions 1 and 2, significant changes to the array of services or system of care will require planning, resources and time. Some changes may require recruiting provider types, building licensing requirements, and modifying Puerto Rico regulations to account for services that do not currently exist, like free-standing birth centers. In addition, ASES must work cooperatively with the Fiscal Oversight Management Board (FOMB) and the ASES Board of Directors to plan and implement substantial changes to the program. Some initial changes which could occur in the near-term would include immediate coverage of Hepatitis C drug, increases to provider reimbursements that will allow Puerto Rico to rebuild the network, and increases to the Puerto Rico Poverty Level. It could also increase its staff to levels that would allow improved oversight of the program, noting that Puerto Rico currently only spends approximately 2.5 percent of program budget on administration of the Government Health Plan, compared to approximately 5 percent administrative spending in other states. This shortfall in

human resources would have to be addressed in the event Puerto Rico begins providing mandatory services it currently is unable to.

Question 5. Overall, what do you see as the necessary steps to better ensure access to quality, comprehensive care for Puerto Rican residents and what would be a reasonable timeline to reach such a goal?

Answer. Puerto Rico's primary need is sufficient and reliable long-term funding that will allow it to improve provider reimbursements and provide services it is currently unable to due to low funding levels. The transition from the Medicaid program as it is delivered today to a more robust and state-like program would be accomplished in stages, with some areas completed more quickly (in the next 0–2 years) while others such as the addition of long-term care or complex IT solutions may take more than 5 years.

Question 6. What will you have to cut if you go off the cliff?

Answer. Puerto Rico would have to conduct a review of all current benefits and potentially remove any services that are not required under Medicaid rules, such as Pharmacy coverage and Dental coverage, which would be catastrophic to the health and well-being of Puerto Rico's population. Our review may also identify mandatory benefits for which we will need to apply strict limitations to access those services that may not exist today. In addition, Puerto Rico currently covers an additional 125,000 enrollees who do not otherwise qualify under the current Medicaid eligibility rules using only Puerto Rico funds. These low-income individuals and families may lose coverage completely, and at less than $800.00 per month income, will be unable to afford private coverage. Puerto Rico will have to pay for most required Medicaid services entirely from local funds that are not available in our budget at this time.

Puerto Rico will be unable to improve hospitals, clinics, and other healthcare infrastructure as funds will have to be diverted to current Medicaid obligations. We will also continue to lose medical providers as they emigrate outside of Puerto Rico because we will not be able to ensure reasonable reimbursements to retain this critical workforce. Our healthcare workforce shortage is compounded by our inability to attract new medical professionals to Puerto Rico due to concerns of financial instability, which is especially problematic regarding specialty providers needed to treat prevalent health conditions.

Question 7. What will be the impact on individuals and the healthcare delivery system in the territory, when Obamacare funding ends this year?

Answer. It is expected that a catastrophic chain of events will occur. Current enrollees may lose essential benefits and experience increasing shortages of providers, particularly specialists. These shortages will result in increased wait times for appointments, which in turn creates worsened medical and behavioral health conditions. In the event no further additional funding is identified and drug coverage has to be terminated, Puerto Rico will have effectively ceased covering the medical needs of its most vulnerable population, one which will be unable to provide for itself. This would certainly mean the difference between life and death for many beneficiaries.

Puerto Rico may also have to end all coverage for the current population that receives health care using only local funds. Those who are able, will leave the island to seek more reliable care in Florida, Texas, New York and other continental states, thus damaging the stability of Puerto Rico and incurring additional costs for those Medicaid programs.

If we reduce services, we will have to prepare for the negative impact on people's health and will most likely face a mental health crisis as individuals and families continue to struggle to have their most basic needs met.

Questions Submitted by Rep. González-Colón

Question 1. Ms. Avila, to have a broader picture of what insufficient funds would look like on the ground, how many people in Puerto Rico will lose their healthcare coverage if we do not address the impending Medicaid cliff? How will they see their benefits or coverage reduced?

Answer. Currently the Puerto Rico Poverty Level used to determine eligibility for Medicaid is less than the Federal Poverty Level. This means that only a small fraction of people who would be eligible for Medicaid in Florida or Alabama are eligible for Medicaid in Puerto Rico. Puerto Rico's already extremely low thresholds for Medicaid eligibility mean that we are unlikely to further reduce our eligibility standards. However, we do cover an additional 125,000 individuals who are not

eligible under our Federal program using only local funds. These government enrollees may lose coverage if no further Federal funding is appropriated. Reductions in benefits are almost certain and would be focused on non-mandatory benefits such as dental and prescription drug coverage.

Question 2. Last Congress, in response to the devastation of Hurricanes Irma and Maria, we successfully secured an increase in the Federal cap to $4.8 billion for Puerto Rico's Medicaid program at 100 percent FMAP, which expires at the end of this fiscal year. Within this, an increase was to be made available if HHS certified that Puerto Rico had taken steps to report reliable data to the Transformed-Medicaid Statistical Information System and had established a Medicaid Fraud Control Unit.

2a. Has Puerto Rico been able to access the entire $4.8 billion increase in the cap, including the additional $1.2 billion?

Answer. Yes, Puerto Rico met the required standards to access all funds. The report to Congress issued by the Centers for Medicare and Medicaid Services (CMS) noted that Puerto Rico implemented the requested requirements faster than any other state or territory. This demonstrates Puerto Rico's capacity to operate a program of the highest standards so long as adequate funding is available.

Question 3. Did HHS certify that Puerto Rico was reliably reporting data and established a Medicaid Fraud Control Unit? What is the status of the implementation of a Medicaid Fraud Control Unit in Puerto Rico?

Answer. Yes, the island's Medicaid Fraud Control Unit (MFCU) is fully certified and operational. It has already received referrals and is conducting investigations, in coordination with the HHS-OIG.

Question 4. How does the long-standing, unequal treatment under the Medicaid program, and the fact that we are facing a cliff every couple of years, impact the Government of Puerto Rico's ability to budget for, modernize and reform our healthcare system? How does it impact your ability to deliver high-quality services to our most vulnerable citizens?

Answer. Without predictable, long-term funding solutions, the Government of Puerto Rico is unable to plan and reliably manage necessary changes and improvements to the Medicaid program such as adding mandatory benefits like nursing home facilities, expanding eligibility standards, or increasing provider payments. The temporary funding solutions that Puerto Rico has received in the past have been helpful and necessary but have resulted in short-term solutions that do not allow Puerto Rico to responsibly plan and strategize for the future. Puerto Rico needs the security to invest in sustainable permanent solutions on which our beneficiaries and providers can count on.

Additionally, facing a funding cliff every few years consumes considerable time and effort in order to create contingency plans, budget scenarios, and devising strategies to advocate for Federal funds. The time and money spent on this recurring matter can be better spent on improving the program and quality of services offered.

Question 5. As you are aware, over the last couple of years Puerto Rico has been facing a shortage of doctors. Some estimates show that from 2006 to 2016, the number of physicians and surgeons on the island dropped from 14,000 to 9,000. This trend was undoubtedly exacerbated by the 2017 hurricanes.

5a. Can you elaborate on how many doctors are currently on the island and briefly discuss how the Medicaid cliff and the uncertainty of funds contribute to our shortage of physicians? How does it prevent us from attracting new medical professionals?

Answer. The question for Puerto Rico's Medicaid program is not just the number of physicians available on the island, but instead the number who are willing to participate as providers in the Medicaid program where reimbursement rates are very low. The number of providers has decreased over the years due (in part) to low reimbursement rates, deteriorating infrastructure, and practice conditions. As Puerto Rico has difficulty incentivizing new physicians to move to or stay on the island, older physicians are retiring and reducing the available workforce.

The exodus and attrition of providers is especially critical for specialist who receive much higher reimbursement rates and enjoy more favorable work conditions on the mainland. The uncertainty of Federal funds has not permitted Puerto Rico's Medicaid program to invest in provider reimbursements and payment arrangement that can attract and retain our healthcare professionals. In fact, the FOMB has permitted ASES to temporarily suspend planned provider reimbursement cuts thanks to the BBA funding provided after the hurricanes. However, this temporary stay is only permitted while these funds are available. Therefore, the long-term planning of initiatives that can help retain and attract providers is not dependent on the

amount of funding available at any given moment, but the certainty that any initiative that we develop will have enough financing from both local and Federal funds in the longer term.

Question 6. You mentioned in your written statement that due to Puerto Rico's unequal treatment under the Medicaid program and the historically low funding we receive, the island has been forced to limit Medicaid eligibility to income levels well below the Federal poverty level used by the states.

6a. Do you have an estimate of how many Medicaid eligible individuals are currently not covered in Puerto Rico because of the disproportionately low level of Federal funding? How many more people would we be able to cover if the island received state-like treatment?

Answer. If Puerto Rico received state-like treatment, the Federal Medical Assistance Percentage (FMAP) would be approximately 83 percent, and the amount of Federal funds received would not be capped. This would allow Puerto Rico to increase the Puerto Rico Poverty Level (PRPL) to cover currently uninsured populations. Based on projections, we would increase the PRPL to provide Federal Medicaid to approximately 140,000 additional individuals.

Question 7. It is my understanding that although the Federal rules for Medicaid benefits generally apply to the island, Puerto Rico provides only 10 of Medicaid's 17 mandatory benefits, in large part due to insufficient funding.

7a. Could you provide examples of services currently covered by Medicaid in the 50 states but that you are not able to offer in Puerto Rico due to this unequal treatment?

Answer. Due to inadequate Federal funding and unequal treatment, Puerto Rico is unable to provide the same Medicaid benefits to its residents as states provide. As a result, the nearly 1.5 million Medicaid recipients in Puerto Rico do not receive:

- Home Health Services for those entitled to Nursing Facility Services
- Nursing Facility Services
- Certified Pediatric and Family Nurse Practitioner Services
- Non-Emergency Medical Transportation
- Nurse Midwife Services
- Freestanding Birth Center Services
- Emergency Services for Legalized and Undocumented Aliens

Question 8. Ms. Avila, would you agree that not addressing the Medicaid cliff, in Puerto Rico and the rest of the U.S. territories, will cost the Federal Government and the American taxpayer more money over time than if we enact a solution now?

8a. For instance, any money that is currently being saved by not giving Puerto Rico equal treatment will likely be at least partially offset by the additional costs borne by the Federal Government and state governments as a result of conditions-based migration from Puerto Rico to the U.S. mainland?

Answer. Yes, our experience has been that the need for appropriate medical care does not disappear simply because it is not available. Puerto Ricans have been moving to the U.S. mainland for a variety of reasons for a long time, including the need for improved health care. When they do, they join a state-side Medicaid program and begin accessing care at a rate that is twice or even four times more expensive than in Puerto Rico, who currently has the lowest per member per month rates among the states. Knowing that people will seek medical care with or without insurance coverage and that the care provided in a planned and preventative manner is better and less expensive care, it is certainly more cost-effective to enact a long-term sustainable funding solution now.

8b. Isn't it more cost-effective to enact a long-term solution?

Answer. Analysis performed by the Medicaid and CHIP Payment and Access Commission (MACPAC) has shown that the total Medicaid spending per enrollee in Puerto Rico is less than just the Federal Share of Medicaid spending for the lowest cost state. The analysis accounts for the additional benefits that are covered in the United States and are not covered in Puerto Rico to make apt comparisons. This means that if a Puerto Rico enrollee moves to any of the states, the Federal Government will be paying more per person than the total cost per person of providing care in Puerto Rico (Federal + Local funds). This spending difference will also grow over time because healthcare cost increases tend to be higher in the mainland United States than in Puerto Rico.

Question 9. Over the past few years this Committee has made it a priority to ensure Puerto Rico has the necessary tools to improve our economy and stabilize our finances although it's important to recognize that this Committee doesn't have jurisdiction over the Medicaid program.

9a. Could you discuss how the Medicaid cliff hurts these efforts? That is, how does it hurt Puerto Rico's economy and our efforts to balance our budget and stabilize our finances?

Answer. The Medicaid program is approximately 30 percent of the Government's FY 2020 budget and provides healthcare benefits to close to half of the island's population. Consequently, the Medicaid programs expenditures, in the form of reimbursement to providers, contracting of local vendors, and payment for ancillary services is a large contribution to the Puerto Rico healthcare industry and ultimately the island's economy. If the program does not receive any additional Federal funding, the financing of the Medicaid program will decrease, because the funding gap leftover by the cliff cannot be replaced with state funds. Consequently, the money that is paid to our providers, hospitals, ancillary healthcare workers and for administrative support will greatly decrease and will cause a downstream economic decrease, job loss, and further deterioration of the healthcare infrastructure.

As long as the funding provided for the program is insufficient, the Government must allocate funds from other necessary services such as education, roads, and infrastructure projects thus hurting the overall economy and investment.

The Congressional Task Force on Economic Growth in Puerto Rico report of the 114th Congress recommended that Puerto Rico and the territories should be treated in a more equitable and sustainable manner in Medicaid funding for many reasons, including to "stabilize and strengthen the fiscal condition of the territory governments." Sufficient and long-term Federal funding for the Medicaid program will mean that Puerto Rico will have the ability to adequately compensate providers, increase hospital investment, incentivize investment in healthcare infrastructure and provide security to our healthcare workers and beneficiaries that the program will improve and provide better quality services. Undoubtedly, this certainty will have a positive economic effect for Puerto Rico's economy as a whole as the Congressional Task Force on Economic Growth in Puerto Rico recognized.

Question 10. It has been said that there is no real "Medicaid Financing Cliff" for Puerto Rico because the Financial Oversight and Management Board established by PROMESA has required the Government of Puerto Rico to assume that no further Federal financing will be provided and to fund this program as part of the Fiscal Plan.

10a. Why should Congress increase the funding for the Puerto Rico Medicaid program, if according to some, sufficient local funds have been set aside for this purpose?

Answer. The premise that there are sufficient local funds set aside for this purpose is incorrect. The method by which the FOMB considers the expiration of Federal funds in relation to the long-term financing of the program, is not by providing additional local funds to replace the gap leftover by the Medicaid Cliff, but by making "significant reductions in healthcare spending necessary." The fiscal plan details the "stop-gap measures" that will be implemented to compensate for the loss of Federal funding such as: reduction in provider reimbursement, elimination of benefits, restricting access to care, and increases in member cost-sharing. Furthermore, the FOMB has not evaluated the viability of these stop-gap measures or taken into account the downstream effects of these cuts for the Puerto Rico healthcare system and Puerto Rico's economy as a whole.

While we agree that some initiatives presented in the fiscal plan are achievable and are being diligently implemented, such as improving quality of care via value-based payments, and reducing fraud, waste, and abuse, to conclude that the fiscal plan provides a path for a sustainable Medicaid program with no additional Federal funding is false.

Question 11. How will the overall healthcare system and the non-Medicaid population in Puerto Rico be affected if Medicaid funding is not increased for FY 2020?

Answer. If no additional funds are appropriated, the cost of health care in Puerto Rico is expected to rise overall. The amount of uncompensated care borne by our hospitals, Federally Qualified Health Centers and other safety net providers will rise. Much of that cost will be passed on through higher fees and premiums to individuals with private insurance and those who are uninsured. Shortages of providers will continue to increase, and general health outcomes will worsen. When people are

unwell, they are less productive at home and at work and ultimately further deteriorate the well-being of the island's economy overall.

Question 12. Currently, the Social Security Act provides for capped Medicaid funding for the territories. For FY 2017, the cap in Puerto Rico was $347.4 million. How much did the Medicaid program benefits actually cost?

Answer. Approximately $2.4 billion in Medicaid-only spending, at current program levels, which reflects unsustainably low provider rates and does not include certain mandatory services such as nursing health facilities, hepatitis C drugs, and non-emergency medical transportation, among others.

Vice Chair SABLAN. Thank you very much, Ms. Avila.

We are going to go to questioning. Members will have 5 minutes.

But before I do that, I would like to ask unanimous consent—I have a set of six questions. I can hear all of us here speaking to the fact that we all want to be part of the full Medicaid program, state-like. So, I have the six questions that I am going to ask you to take home, and if you could provide us your written response within 10 days, they would become a part of the record.

And it is not just a matter of money. There are many requirements that all of us, our governments, have to set up before we could become eligible for the full program like any state or like the District of Columbia.

So, if I may, I have for each one of you, all of the state directors—and Helen can share with Esther and work together on responses.

Thank you, all of you, for your valuable testimony.

The Chair will now recognize Members for questions. Under Committee Rule 3(d), each Member will be recognized for 5 minutes.

I would like to recognize myself—actually, I am going to recognize the gentlelady from American Samoa first. She needs to catch a flight.

Congresswoman Radewagen, you have 5 minutes, please.

Mrs. RADEWAGEN. Thank you, Vice Chairman Sablan and Ranking Member González-Colón, for putting together this hearing on the Medicaid cliff currently facing the U.S. territories.

The Medicaid funding provided by the ACA is set to expire this calendar year, and the lack of a funding solution will be particularly harmful for American Samoa, as I know it will be for the other territories.

I would like to thank our witnesses for making the long trip to Washington to testify before the Committee today. Welcome. Each of your firsthand experiences will provide Congress with an accurate assessment of the situation.

ACA's first allotment of funds became available in July 2011, long before I and many of us here were elected to Congress. Those funds were only accessible after the normal annual allotment was exhausted.

The Medicaid and CHIP Payment and Access Commission, otherwise known as MACPAC, published a fact sheet for American Samoa which has a historical table of total Medicaid spending from Fiscal Year 2011 to Fiscal Year 2017, taken from reported expenditures to the Centers for Medicare and Medicaid Services. The

average total Medicaid expenditure in American Samoa, according to MACPAC's report, is $30 million for that period.

Mr. Chairman, I ask for unanimous consent to enter into the record a March 2019 MACPAC report on Medicaid and CHIP in American Samoa; a May 2019 MACPAC issue brief on territory exhaustion of Federal Medicaid funds; the April 2016 GAO report on Medicaid in the U.S. territories; and a letter to Governor Lolo Matalasi Moliga dated March 15, 2019.

Vice Chair SABLAN. Without objection, so ordered.

Mrs. RADEWAGEN. I do have a couple of questions here for the Director.

The maximum FMAP is statutorily set at 83 percent. Now, if Congress is unable to align the territory FMAP formula to that of the states, is there a level that American Samoa, given an appropriate Federal cap, would be able to sufficiently operate the Medicaid program?

Ms. YOUNG. The answer to that question would be yes.

Our major Medicaid provider is the hospital, and the hospital has the best payment method under the state plan, which is a certified public expenditure. So, we don't have a real issue with the local match or the FMAP with our local hospital. It really has to do with the new services and any future planned services that we want to do outside of the hospital, which is very much needed, and this includes the Department of Health.

I cannot comment exactly on what the appropriate FMAP would be that we could give that would make it sustainable. But based on historical utilization of what we have used, it would be about 80 percent, minimum 80 percent, for FMAP. But we can definitely do more financial analysis, study our history of spending, and give you a more accurate FMAP.

Mrs. RADEWAGEN. Thank you. Thank you for your response.

We know the FMAP and the Federal caps need to be changed because they are not equitable to the territories. FMAP aside, what is the needed amount of Federal funding to fully support American Samoa's Medicaid system?

Ms. YOUNG. Currently, we have submitted information that what we would like to request is a $30 million annual allotment for Medicaid.

This is based on the historical spending out of the Medicaid spending that we have. I provided a chart of expenditures, historical expenditures, based on the availability of the ACA, that shows that we need, for the hospital alone, an additional $8 million for the $20 million Federal share, and then we would need an additional $10 million for all new services for Federal share. That would make it a $30 million Federal share block grant increase for American Samoa.

Mrs. RADEWAGEN. Thank you, Director.

I have more questions that I will be submitting for the record.

Mr. Chairman, I yield back.

Vice Chair SABLAN. Thank you.

The gentlelady yields back.

I would like to recognize myself, but before doing so, I ask unanimous consent to enter into the record a letter from the Financial Oversight and Management Board for Puerto Rico; a letter from

the Association of Asian Pacific Community Health Organizations; a letter from national and community organizations, supported by many organizations, actually, a list over 20; and also a letter from the Guam Regional Medical City that I have been asked to submit for the record.

Miss GONZÁLEZ-COLÓN. Mr. Chairman?

Vice Chair SABLAN. Yes?

Miss GONZÁLEZ-COLÓN. Mr. Chairman, sorry to interrupt. Can I do the same thing and introduce something?

Vice Chair SABLAN. When I recognize you, yes, you can.

Miss GONZÁLEZ-COLÓN. OK. Perfect.

Vice Chair SABLAN. Thank you.

I now recognize myself for questioning.

Ms. Sablan, hafa adai, Helen. Welcome. I want to compliment you on how you and all your colleagues, including Ms. Muna, manage the Obamacare money.

American Samoa, Guam, and the U.S. Virgin Islands, they have hundreds of millions of dollars of Obamacare funding unspent, but you have been able to use up all your money. Is that correct?

Ms. HELEN SABLAN. Yes.

Vice Chair SABLAN. And you used certified public expenditures to make the local match and release the Federal funds. Is that also right?

Ms. HELEN SABLAN. Yes. We work at the hospital to use the CPE for our local match.

Vice Chair SABLAN. And that is good, because the Commonwealth Government would have had to match the $109 million we put into Obamacare with about $50 million of local funds, but the Commonwealth did not make that match, did it?

Ms. HELEN SABLAN. No. We don't have the money.

Vice Chair SABLAN. That is interesting, actually, because, all last year, the Chairman of the Northern Marianas Legislature Ways and Means Committee kept bragging about how he was responsible for the biggest budget ever in the Commonwealth history, yet he could not find matching funds for Obamacare Medicaid money.

So, again, I understand that you have had to stop making medical payments to private providers at this time, yes?

Ms. HELEN SABLAN. That is right.

Vice Chair SABLAN. And you also have had to stop paying for Medicaid patients to use the federally qualified Kagman Community Health Center. Is that correct?

Ms. HELEN SABLAN. Yes.

Vice Chair SABLAN. Could the Kagman Community Health Center also use the CPE system to make the local match?

Ms. HELEN SABLAN. No.

Vice Chair SABLAN. OK.

While I know that our legislature is not paying its share for Medicaid, it is not your responsibility. You have to do the best you could with what you were given—or, actually, not given, I guess I would have to say, right?

Ms. HELEN SABLAN. Yes.

Vice Chair SABLAN. And, working with the Federal Centers for Medicare and Medicaid Services, the Marianas' congressional office

was recently able to help you get another $8.2 million, but that has to be adjusted, and we could now be down at $4 million.

But we also have another $36 million in the disaster supplemental appropriation, where it is my hope that you could see yourself through the end of the year.

Would that help you, help your program?

Ms. HELEN SABLAN. Yes. Thank you, Congressman. That would be very much appreciated.

Vice Chair SABLAN. OK. Again, I want to thank you.

I have a little bit more time.

Now, Ms. Muna, thank you also, Esther, for coming here, and thank you for helping managing this program and, of course, their only hospital.

What I want to know, Ms. Muna, is how important Obamacare funding has been to the hospital. You said local funding was cut in 2010, from about $40 million to $5 million, for your hospital. But then Obamacare began in 2011. Without Obamacare, would the hospital have stayed open?

Ms. MUNA. I don't think so.

Vice Chair SABLAN. At the same time you were losing local funding, you were also in danger of losing CMS certification. Without Obamacare, would you have lost certification?

Ms. MUNA. Absolutely.

Vice Chair SABLAN. Wow. And, of course, if you lost certification, that would mean Medicare patients, as well as Medicaid patients, probably as well as private insurance patients, could not use the hospital. Is that correct?

Ms. MUNA. That is correct.

Vice Chair SABLAN. So, you testified that Obamacare money made it possible to see more patients and to expand services. You tripled your medical staff, added specialty services, including oncology, and implemented a quality assurance unit. Is that right?

Ms. MUNA. That is correct.

Vice Chair SABLAN. And Medicaid money helped?

Ms. MUNA. Yes, absolutely.

Vice Chair SABLAN. And as a result of these improvements, patient outcomes have improved for our Northern Marianas patients?

Ms. MUNA. Yes, and we will be able to have it at home.

Vice Chair SABLAN. And readmission rates have improved?

Ms. MUNA. Correct.

Vice Chair SABLAN. You said that the hospital revenues also quadrupled during this time. It looks like the improvement in services that Medicaid made possible helped to make the hospital more financially viable. Is that true?

Ms. MUNA. Yes, it is true.

Vice Chair SABLAN. So, to summarize, the Obamacare that Congress provided you, $109 million, meant the hospital stayed open, helped you keep your certification, expand services, improve patient outcomes, and add to your bottom line.

Ms. MUNA. Yes.

Vice Chair SABLAN. OK.

In my last 10 seconds, ladies, please, the six questions you have, I would really like for you to respond in writing to the Committee

in 10 days. It is going to be part of the hearing record. It is critical that we answer that as completely and as correctly as possible.

Thank you. My time is up.

At this time, I would like to yield to my colleague, the Ranking Member, Miss González.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Chairman.

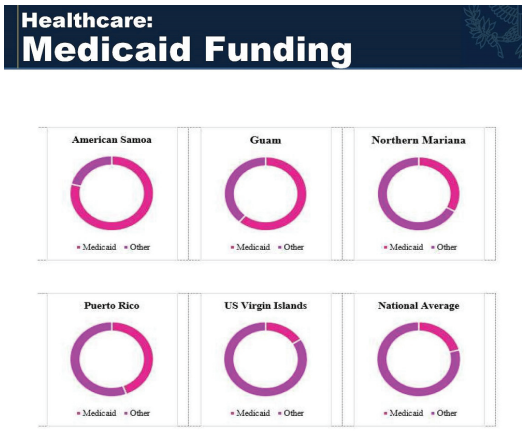
And before my time commences, I want to ask unanimous consent to put in the record a memorandum of the Medicaid financing in Puerto Rico and the U.S. Virgin Islands made by the Kaiser Foundation. They were in a panel yesterday of health care that we did here with the Puerto Rico administration, Moran Group, and many others in the private sectors. So, this will be one.

And the second one will be a letter from the Puerto Rico Hospital Association to be introduced in the record.

Vice Chair SABLAN. Without objection, so ordered.

[The information follows:]

PowerPoint Slides submitted by Rep. Gonzalez-Colon



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	Puerto Rico	50 States & DC
FMAP	55%	Between 50-83% based on per capita income
Federal Funding	Limited to $357.8mm	No limit

If the FMAP formula applied, the federal government would have to provide 83% (instead of 55%) of Medicaid funds.

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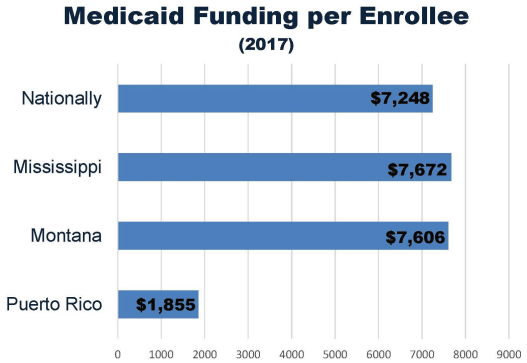

STATEMENT FOR THE RECORD
JAIME PLA CORTES
EXECUTIVE PRESIDENT OF THE PUERTO RICO HOSPITAL ASSOCIATION

Chairman Grijalva, Ranking Member Bishop and Committee Members:

Thank you for the opportunity to present my statement on behalf of the Puerto Rico Hospital Association (PRHA) representing our 58 hospital members and over 45 thousand plus health care professionals and staff. Hospitals are the core of our island's health care system and vital to the quality of life for the 3.4 million U.S. Citizens residing in our Territory; the Commonwealth of Puerto Rico.

We appreciate this hearing's attention to the impending "Medicaid Cliff" facing Puerto Rico's Medicaid system in the third quarter of 2019. Without action by Congress, we face the devastating loss of 85% of our Federal Medicaid funding likely forcing a large number of Medicaid enrollees to lose their coverage and jeopardize the financial viability of our island's hospital system.

It is vitally important to note that the Medicaid Cliff and the uncertainty it has created over the past decade has been a major contributing factor to the loss of doctors, specialists and health care professionals who have been recruited away by Stateside health care systems offering more generous compensation packages. The uncertainty and financial squeeze imposed on Puerto Rico's hospitals and other providers has made it very difficult to offer attractive and competitive compensation packages to retain our experienced, bilingual medical staff and professionals. The inability of our Medicaid system to provide a reimbursement increase for hospitals and other providers since 2011 due to the combination of the reduced level of Federal funding along with uncertainty of the impending Medicaid Cliff has been a primary factor for this loss.This has certainly impacted the ability of Puerto Rico's health care system to provide readily available care to the Medicaid population as well as to the general population throughout Puerto Rico.

For example, we have witnessed a significant loss of doctors, specialists and healthcare professionals over the past decade. The waiting lists to see specialists has grown and it is impacting the availability of care. In the area of Pediatrics, we only have one remaining Child Psychologist currently serving the entire island of Puerto and I will emphasize that the majority of children born on our island are Medicaid eligible. Overall, we have witnessed a significant drop in the overall availability of specialists over the past decade increasing waiting times for patients and general decrease in availability of specialized care.

Another consequence of the uncertainty created by the Medicaid Cliff is the impact on the ability of Puerto Rico's hospitals to modernize and upgrade their physical plant and facilities as well as medical diagnostic and treatment technologies. Approximately, 90% of local hospitals are privately owned and have 30–40 year old buildings and physical plant. These hospitals are dependent on bank financing to make physical improvements

and upgrades. However, the short-term approach to addressing the Medicaid Cliff has resulted in the Puerto Rico's banks being hesitant to provide financing for improvements. Puerto Rico's hospitals are willing to invest and want the most state-of-the-art facilities and equipment to provide quality health care. We must remember that banks always look at the long-term ability of their clients to repay their loans and without the guarantees provided by a permanent solution to the Medicaid Cliff, bank financing has been limited. This lack of financing has delayed and frozen the ability of local hospitals to modernize and obtain the best medical technologies.

We must also draw attention to the recently negotiated Debt Restructuring Agreement (RSA) between Puerto Rico's electric utility monopoly, PREPA, and its bondholders. Respected Third Party experts predict this RSA will cause an increase of 28% in costs to consumers and local hospitals. Hospitals do not receive any discounted rate from PREPA and this will only burden local hospitals further with financial pressures. The PRHA has joined many organizations in opposition to this RSA and we hope the Federal Courts will reject it.

BACKGROUND:

Like many States, America's largest Territory; Puerto Rico, operates its Medicaid system by enlisting managed care to serve a jurisdiction of 3.5 million U.S. Citizens. However, that is where the similarity ends as Puerto Rico's eligibility for Federal Medicaid funding is statutorily capped at $375 million annually, limiting the total amount of funding it can receive compared to any State which operates with no funding cap. Oregon for example has a similar population size, although with a much smaller poverty level and still receives $5 billion in Federal Medicaid funding.

An estimated 1.25 million of PR's population is now eligible for Medicaid. Hurricane Maria left the island with a weaker economy and reduced population. However, the Medicaid-eligible population has increased as a proportion of the population and the majority of newborns today are Medicaid eligible.

Every health care provider in PR is a Medicaid provider including all hospitals, doctors and community health care centers. Without action by Congress, it is projected that PR will lose an estimated 85% of its Federal funding later in 2019, when the Cliff occurs with terrible consequences for the local health care system. To maintain the current level of overall Medicaid funding, it will require an allocation of $1.625 Billion in Federal funding to just maintain the balance while returning to the 55% FMAP.

Many Stateside policymakers have made an incorrect assumption about Medicaid coverage available in Puerto Rico, unfortunately, reduced Federal support has also caused limitations in what Puerto Rico's Medicaid system will offer Medicaid-eligible patients. Some of the important coverage offered Stateside that is not available to Puerto Rico's Medicaid population due to financial constraints include these listed below:

- **Durable medical equipment**
- **Home healthcare**
- **Other non-durable medical products**
- **Skilled Nursing care facilities**
- **Continuity care retirement communities**
- **Rehab**
- **Institutional rehab services**

We argue it's time to come up with a permanent solution that provides long-term stability to our health care system so that our hospitals retain our doctors and health care professionals currently being recruited away by better salaries and stable health care systems located Stateside.

In previous years, Puerto Rico health care providers have asked to remove this funding cap and provide for equitable treatment under Medicaid for our Medicaid system. Congress last attempted to address this need in the FY 2018 by providing for an allocation of additional funds with the anticipation that these funds would be exhausted in the last quarter of FY 2019. Congress also waived the FMAP requirement to provide a local match due to the devastating impact of the hurricane on local government finances. CMS has since certified that PR's Medicaid system has met the requirements to establish a Medicaid Fraud Unit and provide for better data collection. Time has now passed, and these additional funds are now projected to be exhausted at the end of the Federal Government's FY 2019; only one quarter of the way through Puerto Rico's upcoming fiscal year.

A PERMANENT SOLUTION NOW IS NEEDED DURING THE MID-YEAR OF 2019:

The Governor's recent request on May 1st for an allocation of $15.1 Billion to be dispursed over five years with an 83% FMAP is a major step forward toward this goal. We believe that permanently removing the statutory cap will help Congress achieve this goal to provide greater confidence to our health care system and allow for delivery of the highest quality health care which we all wish to deliver to the U.S. Citizens of Puerto Rico.

The Puerto Rico Medicaid system needs to enter into contracts for its FY 2020 Medicaid Program immediately because CMS must certify that these contracts are actuarily sound before they can go into effect for the local FY 2020 operating budget for the coming year. Without the confidence of certainty regarding the level of funding available, it will be very difficult to attract willing contractors to administer and implement a managed care system between July 1, 2019, and June 30, 2020. The current fiscal state of the local government prevents it from making up any of the difference; something no State would be asked to do.

We continue to urge removing the current statutory cap to allow equal access for Medicaid funding needed to maintain a quality health care system for the 1.25 million Medicaid eligibles in Puerto Rico. Frankly, the uncertainty of Federal funding complicates our ability to retain and recruit doctors and other vital health care professionals who are constantly tempted to leave our island for higher salaries elsewhere in the United States. The uncertainty over Congress's resolution of the Medicaid Cliff also hampers the ability of local hospitals to obtain bank financing for moderation and upgrades.

We ask that a provision be included in the first available Federal funding package to be acted on by Congress to provide continuity for Puerto Rico's health care system. We've suggested language which provides a permanent solution to prevent the Cliff from occurring in the coming year by eliminating the statutory cap on Puerto Rico's Medicaid funds.

PR's health system and its hospitals are under a tremendous amount of financial stress because of the island's weak economy and overall underfunding by Medicaid. The lack of certainty regarding funding complicates the ability to meet CMS requirements for operation of PR's Medicaid program for the coming Fiscal Year beginning July 1, 2019.

Here's the sense of urgency: Many doctors and health care professionals would prefer to remain in their homes in Puerto Rico but the lack of certainty is weakening their resistance to being recruited away by other offers. Hospitals are laying off workers and continue to reduce services. Local hospitals also struggle to obtain the bank financing needed to upgrade and modernize their facilities. It will take many years to recover the current capacity of PR's health care system if more talented and experienced health professionals leave the island and hospitals are unable to modernize their facilities. By providing certainty through a permanent solution, Congress can inject the needed sense of confidence to PR's hospitals necessary to continue delivering the high level of quality care expected by patients and the Federal government and retain top medical staff.

We also emphasize that Congress has continually returned to face this issue of the Medicaid Cliff and removing the cap will eliminate the need for Congress to return to the issue time and time again. Removing the statutory cap will be the permanent solution to this perennial problem facing Puerto Rico and the Congress.

We are prepared to collaborate and provide whatever information is necessary to address and solve this urgent issue and we look forward to working with you.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Chairman.

Now we will begin with my line of questioning.

In the case of Puerto Rico, actually, I have some slides regarding some of the data that it is important to know, the difference.

This is the Medicaid funding that has been approved for all the territories. When you see the difference of the spending in terms of how much is Federal funding approved and how much is state-funded or territories put in their money, you can see that most of our territories are actually doing the spending by using local funds to comply with the requirements of the programs.

If the Congress is not acting, a lot of people are going to lose their insurance, a lot of people are going to lose their services. And that is the reason behind this hearing.

The other information I want to show is how different it is, the spending for territories and for the states. In the case of Puerto Rico, as an example, you can have Mississippi and many other states receiving more than $7,000 per enrollee and less than $2,000 to our territory. And I know this is kind of the same thing with the rest of the territories as well.

That is the reason the FMAP, the formula for the matching funds, needs to be changed. There are several options to this. We can have 100 percent Federal cost share, like we did during the bipartisan bill last year, and Puerto Rico got $4.8 billion for 2 years, and they are going to be expired in December; or we can lift the cap of 55 percent, and that would allow in the case of Puerto Rico, with their per capita, up to 83 percent of Federal funding.

And I think this is the best way to do it, just allowing the territories to have the same formula as the states. And that is a bill that we actually filed.

And there, we are talking about how much money we will be receiving in each state if we don't do something with that. In that case, I would like to ask—this is the difference between some states for Medicaid funding per enrollee. We are not talking about a difference of just 20 percent. It is up to 70 and 80 percent of difference, the funding that the states are receiving.

In the case of Puerto Rico, we are losing providers, we are losing doctors. Our professionals in the healthcare system are receiving less than half of whatever other professionals are receiving in the mainland. And that is the reason we are losing a doctor per day during the last years. During the last 10 years, we have been losing a lot of our professionals, even lacking specialized physicians.

So, Ms. Avila, I would like to begin with you, and I would love to have an answer directly in "yes" or "no" or the numbers.

How many people in Puerto Rico will lose their healthcare coverage if we do not address the impending Medicaid cliff? And how many people will see their benefits or coverage service be reduced if Congress is not acting by September of this year?

Ms. AVILA. We have found out, according to the reading statements that we are——

Miss GONZÁLEZ-COLÓN. Just a number. I just need a number.

Ms. AVILA. Well, approximately 600,000 lives. And that will be if we can keep the program viable for Puerto Rico.

Miss GONZÁLEZ-COLÓN. OK, 600,000 people may lose their insurance if we do not act by September.

Ms. AVILA. That is right.

Miss GONZÁLEZ-COLÓN. OK.

In the last Congress, I just said that we received $4.8 billion that were approved and the President signed after the hurricane season. As of this Sunday, $1.2 billion were made available through HHS if Puerto Rico certified that they have reliable data to the Transformed Medicaid Statistical Information System and established a Medicaid fraud control unit.

The question will be, has Puerto Rico been able to access the entire allocation of $4.8 billion, including the additional $1.2 billion?

Ms. AVILA. Yes. The answer is yes.

Miss GONZÁLEZ-COLÓN. OK. Did HHS certify that Puerto Rico had reliable reporting data and established a Medicaid fraud control unit?

Ms. AVILA. Yes, that is correct.

Miss GONZÁLEZ-COLÓN. How does the unequal treatment under the Medicaid program and the fact that we are losing a lot of our people every year—how does the Government of Puerto Rico have the ability to budget for, modernize, and reform our healthcare system if we don't receive the money?

Ms. AVILA. We are not allowed to forecast any funding that we don't have any assurance. It has to be certified. This is because the fiscal board requires that.

Miss GONZÁLEZ-COLÓN. So,the Oversight Board required to the island to include all future plans regarding health care. And that means, if we don't receive the money, the state, in this case Puerto Rico, needs to put up front the money from the state to do the job that the Federal Government is supposed to do in the state.

Ms. AVILA. Yes, that is correct.

Miss GONZÁLEZ-COLÓN. Thank you.

I will wait for a second round of questions. Thank you, Mr. Chairman.

Vice Chair SABLAN. I like the Ranking Member's suggestion. But thank you.

At this time, I would like to recognize the gentlelady from the U.S. Virgin Islands, Ms. Plaskett, for 5 minutes.

Ms. PLASKETT. Thank you, Mr. Chairman.

And thank you to all of the witnesses who are here.

I didn't see Mr. Smith with you, sitting behind you. I guess he is there to provide support and any additional information.

Thank you, as well, for being with us.

I wanted to just get straight to the questions, because I know in your written testimony you give a lot more statistics and a lot more specific examples of how this has affected us.

We have seen on the chart that was demonstrated by my good friend and my colleague about the difference between what we have provided locally as well as what the Federal Government has provided.

But one of the things that I need to highlight and I think would be important for you to highlight, specific to the Virgin Islands—which may be different from other places; I am not sure. You stated that there were approximately how many people that would need to come off of the books or the support that we are receiving now if this funding ends? Meaning, how many people presently have we been able to include that no longer will be able to receive those services?

Ms. RHYMER-BROWNE. We would have to reduce upward of 15,000 individuals of the 27,000, approximately, members of the Medicaid program.

Ms. PLASKETT. Great.

But I think another number that was not brought out that I would love for you to—if you have that number, is, how many individuals would we like to bring on the rolls that we believe qualify for Medicaid but we have not given those services to?

Ms. RHYMER-BROWNE. An additional 15,000 to 20,000 individuals who would be eligible for the Medicaid program.

Ms. PLASKETT. So, there are individuals that are presently in the Virgin Islands, maybe in other territories as well, who are just not receiving any health insurance. We have a large population that have no health insurance that would qualify except for the fact that there is this arbitrary cap that has been put on the amount of money that Congress gives to us.

And the Virgin Islands, rather than going out and borrowing money, finding other ways, we have done the fiscally prudent and responsible thing and said we just can't service those individuals. Is that correct?

Ms. RHYMER-BROWNE. Exactly. That is correct.

Ms. PLASKETT. And how are some of the other ways that this is impacting us? If you can talk about the hospitals in the Virgin Islands.

Presently, we do not receive DSH, as other places do, for the disproportionate share for hospitals that is an additional bump-up that is given in rural areas. Although the Virgin Islands qualifies for it, meets the qualifications, Congress and CMS have said we would not receive that.

What are some of the other ways that our hospital healthcare services are impacted because of the trickle-down effect of not receiving this funding?

Ms. RHYMER-BROWNE. Well, our hospitals on an everyday basis are struggling even now. Since 2017, they have been experiencing extreme infrastructure issues. The hospital is unable, because of the limited monies that we are able to give them, to bring all of the specialties and all of the specialized equipment.

That is one of the reasons that the hospital has frequently called us over the last 2 years to airlift many of the individuals who go there who have real catastrophic illnesses and need specialized procedures. So, the hospital, in effect, has to turn away several individuals who have these extreme circumstances and illnesses, and we have to airlift them to the United States for treatment.

Ms. PLASKETT. Thank you.

I know that our governor has declared an emergency with mental health issues and others. Can you talk about that very briefly?

Ms. RHYMER-BROWNE. Yes. Our behavioral health situation is really burdened right now. Again, the need for more psychiatrists, the need for more of our individuals to have long-term care. Behavioral health services, this has been hampered because of just the inequities of our hospitals and of our Medicaid program as a whole.

It is very, very important for us to also have a skilled nursing facility in both districts of the U.S. Virgin Islands. We don't have a skilled nursing program within the territory. Our hospitals are really, really burdened to provide behavioral health services, as well as our community clinics.

Ms. PLASKETT. Thank you.

And, finally, could you state the things that the Virgin Islands has done, things that we have put in place to provide the compliance and the accountability that Congress has asked for for Medicaid? I know that there are quite a number of systems that we have put in place.

Ms. RHYMER-BROWNE. Certainly.

We implemented the first-ever territory Medicaid Management Information System for claims. The CMS also certified MAGI-compliant our online Medicaid eligibility system. We too implemented a Medicaid fraud control unit in 2018. We also implemented the TMSIS, the Transformed Medicaid Statistical Information System.

We also will be completing all of our cost report audit reconciliations of our two hospitals. We recently completed the Medicaid program integrity review. And we have a host of other programs that we have been going through for the last few years.

And especially with the ACA dollars, we have been able to do all of these things that I just mentioned prior.

Ms. PLASKETT. Thank you so much for all the work that you are doing.

And thank you, Mr. Chairman, for allowing us the opportunity to highlight those for our colleagues here in Congress.

Vice Chair SABLAN. Yes. Thank you.

We are going to have a second round of questioning, and I am going to start with myself, please.

Ms. Rhymer-Browne, you just listed a series of items that you have implemented in your program, establishing the relationship between the extra Medicaid money the Virgin Islands received in last year's disaster appropriations and the improvements you made in administering the program fraud unit. You began reporting data to CMS through the Medicaid Management Information System. But you were able do that because of the incentive funding included in the disaster bill. Is that correct?

Ms. RHYMER-BROWNE. That is totally correct. Without that, we would have been unable——

Vice Chair SABLAN. That was my next question. I think you are reading my script here, right?

Without that incentive funding, would you have been able to add those state-like features to the Virgin Islands Medicaid programs?

Ms. RHYMER-BROWNE. Could you repeat that, please?

Vice Chair SABLAN. Without that incentive funding, would you have been able to do what you did?

Ms. RHYMER-BROWNE. No way. We could not have.

Vice Chair SABLAN. So, it seems to me there is a model there for how we can add other state-like features to the territorial Medicaid programs, that if we provide incentive funding, if we give you the resources you need to build capacity, then you are willing to do it. Is that right?

Ms. RHYMER-BROWNE. We certainly are.

Vice Chair SABLAN. I congratulate the Virgin Islands on the work you are doing. And I do think what is happening in your islands could be a model, again, for how me make Medicaid more state-like in the other insular areas. So, thank you for showing us what can be done.

Let me ask the other directors very quickly: If you had up-front money to make your programs more state-like, in terms of the services you offer and in terms of how you manage your system, would you make those changes, become more like a state?

Ms. Sablan?

Ms. HELEN SABLAN. I think so.

Vice Chair SABLAN. OK.

Ms. Arcangel?

Ms. ARCANGEL. Definitely.

Vice Chair SABLAN. Ms. Young, Director Young, could your program be run like a state if you had state-like funding?

Ms. YOUNG. Yes, I believe so.

Vice Chair SABLAN. Thank you.

And how long do you think that would take? Could you do it over a period of 10 years? Would that be reasonable?

Ms. Sablan?

Ms. HELEN SABLAN. Probably.

Vice Chair SABLAN. Ms. Arcangel?

Ms. ARCANGEL. I believe so, yes.

Vice Chair SABLAN. Ten years? I didn't hear your answer.

Ms. ARCANGEL. Yes.

Vice Chair SABLAN. OK. Wow.

And Ms. Rhymer-Browne?

Ms. RHYMER-BROWNE. Yes.

Vice Chair SABLAN. And, of course, Ms. Avila, I am not ignoring you, it is just that Puerto Rico's program is so huge. But would you also be able to do these things, some of which you are already starting to do?

Ms. AVILA. Yes. The answer is yes. Thank you.

Vice Chair SABLAN. OK.

Look, the fact is that the Federal Government isn't saving money by not treating the territories equally in Medicaid. It has been a big factor in many territorial citizens moving to a state. So, for example, many Puerto Ricans have abandoned the territory for a state. There are more than three-fifths of all people of Puerto Rican heritage who live in the states.

Further, Medicaid programs in the states spend multiples per beneficiary of what territories spend—in the case of Puerto Rico, three times as much.

So, they are not treating us the same, but they are not saving any money.

Right, Ms. Avila? They are not giving you the money, but the Federal Government is not saving money, because your citizens move to Florida and——

Ms. AVILA. I will say that it is more costly for the states to have our residents here.

Vice Chair SABLAN. And also costly to us, because we are having our people leave home.

And, again, I cannot over-emphasize the importance of your written response, as concise and as complete, to the six items I gave you. Those are going to, again, go into the record. It will be shared with the committee of jurisdiction, Energy and Commerce. And it is a plan that would allow its territory to work through a program, get financial incentive to do those things that will get us, hopefully, to a full state-like Medicaid program, not just in terms of money but in terms of services to our citizens.

My time is up. At this time, I yield to the Ranking Member, Miss González-Colón.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Chairman.

And I will take the same question you were asking. You were saying about American taxpayers' money will be more effective if we address this issue now, because in the case of Puerto Rico, at least, more than 1 million Puerto Ricans have just moved to Florida. In our case, we just take a ticket and we move to a state and we receive the full benefits.

So, it will take more money for the United States to address this issue in the long term. If we fix it now, we may save a lot of Federal funds.

In that sense, I would like to ask Ms. Avila, Puerto Rico at this time just offers 10 programs of the 17 Medicaid programs. Is that correct?

Ms. AVILA. Pardon? Could you repeat the question? I am sorry.

Miss GONZÁLEZ-COLÓN. Yes. The Federal rules for Medicaid in Puerto Rico, all the same benefits generally apply to island, but because we don't have enough funds to match the Federal share, we are required to limit a lot of those benefits.

So, we are just offering 10 of 17 programs on the island. Is that correct? Yes or no?

Ms. AVILA. I will say, I don't recall 10 or 17. I can mention——

Miss GONZÁLEZ-COLÓN. Just tell me the programs that do not apply on the island.

Ms. AVILA. Well, right now, we don't cover hep C patients within the program. Either we have a cure right now for that condition or we are not able——

Miss GONZÁLEZ-COLÓN. What other programs?

Ms. AVILA. No emergency transportation. We haven't been able to——

Miss GONZÁLEZ-COLÓN. What other programs?

Ms. AVILA. Long-term care. And we lost a lot of people.

Miss GONZÁLEZ-COLÓN. What other programs?

Ms. AVILA. Those are the main ones that I can highlight right now.

Miss GONZÁLEZ-COLÓN. OK.

You mentioned in your written statement that, due to Puerto Rico's unequal treatment and the historic low funding, we have been forced to limit Medicaid eligibility to income levels well below the Federal poverty level used by the states. Puerto Rico has 47 percent of poverty level.

Ms. AVILA. That is correct.

Miss GONZÁLEZ-COLÓN. So, what benefits are the ones you are limiting?

Ms. AVILA. Well, the main ones would be pharmacy benefits and mental coverage benefits. Drugs are necessary for a healthcare system, and we will not have funds to be able to sustain the drug program within the Medicaid program in Puerto Rico.

Miss GONZÁLEZ-COLÓN. So, in your experience, and having identified areas of the programs, including drugs, how many Medicaid-eligible individuals in the mainland are not currently covered in Puerto Rico because of the disproportionate low-level Federal funding?

Ms. AVILA. We are estimating more than half a million U.S. citizens have not had the right right now to get into the program.

Miss GONZÁLEZ-COLÓN. So, more than half a million American citizens living in Puerto Rico, they are not covered by Medicaid full programs as they were in the states just because of the lack of funding of the treatment of a state of Puerto Rico. And I know it is the same case for the rest of the territories as well. Because if you don't have the funds, you need to be cutting some of the benefits in order to have more people—or trying to at least address the most urgent needs of the islands.

During the years 2006 to 2016, the numbers of physicians, surgeons, and providers of the island dropped from 14,000 to 9,000.

Ms. AVILA. That is correct.

Miss GONZÁLEZ-COLÓN. Has this trend been exacerbated by the hurricanes in 2017?

Ms. AVILA. That is correct. It has been.

Miss GONZÁLEZ-COLÓN. Do we have any number of how many physicians and surgeons we do have on the island at this time?

Ms. AVILA. Well, we are just validating the numbers, but we have received preliminary information that 3,000 or more physicians have left the island since the hurricane.

Miss GONZÁLEZ-COLÓN. So, we can say that between 6,000 and 7,000 physicians and doctors are still on the island?

Ms. AVILA. That is right.

Miss GONZÁLEZ-COLÓN. And that trend will continue if they are paid less than the rest of the physicians that provide the same services that you would receive in the states.

My time is running out, but I do want to have some questions for the record, so you can answer later on. And that will be specifically for all of the territories represented here. I know you do a lot with less resources. And one of those will be: How much did Medicare program benefits actually cost in the states?

And in the case of Puerto Rico, there is no real Medicaid financial help cleared for Puerto Rico. This is the PROMESA Board saying a few weeks ago. Now, in the letter that was submitted for the record, they are endorsing receiving the Medicaid funds for Puerto Rico. And I think that is finally common sense.

But there are some—and this is for American Samoa. During the fiscal year, there was an unused balance of $153 million in Affordable Care Act funds in American Samoa. You explained the reasons for this balance in your testimony.

But my question will be—and you can answer it later on—do we need to do something for the territories so they can spend the money? Is there any other requirement of the Federal Government, CMS, HHS, that was given to the territories so that you can't access those funds? What is the reason behind it?

With that, I yield back the balance.

Vice Chair SABLAN. Thank you.

The gentlelady's time has expired. But I also agree, for American Samoa, it is an anomaly. There are not too many private providers. I found that out after our last time that you were on the witness stand, Ms. Young.

But Ms. Plaskett has 5 minutes, please.

Ms. PLASKETT. Thank you. I won't use the 5 minutes. I am needed in another meeting. But I just wanted to follow up with a couple

of short questions, particularly, of course, for the good woman from the Virgin Islands, Ms. Rhymer-Browne.

You talked about the disaster-related circumstances in which we have been given $100,000, that if we move back to the 55 percent match that had been previously, that that cap would bring us to about $18.7 million, correct?

Ms. RHYMER-BROWNE. Correct.

Ms. PLASKETT. And what is the amount of money if we were given the state-like treatment that it would be at? Do you know what that number would be?

Ms. RHYMER-BROWNE. I am not sure. However, we are requesting, as I said, for the 100 percent, we would be requesting $251 million for 2 years. And then we would continue at the 83 percent Federal level, and those would be for the next 3 years. But I am not sure exactly that number.

Ms. PLASKETT. What the percent of the 83 percent would be?

Ms. RHYMER-BROWNE. Yes.

Ms. PLASKETT. We know for 55 percent it would be $18.7 million, right?

Ms. RHYMER-BROWNE. Yes.

Ms. PLASKETT. And that is woefully inadequate.

What would be the delta that you would need from the $18.7 million to satisfy the needs of all the individuals that would, if given state-like treatment, be eligible for it?

[Ms. Rhymer-Browne confers.]

Ms. PLASKETT. You are not sure at this time?

Ms. RHYMER-BROWNE. We are not sure at this time.

Ms. PLASKETT. OK. But if you could get that number to me, that would be really helpful for the record.

Ms. RHYMER-BROWNE. Yes, I will.

Ms. PLASKETT. One of the other things that I wanted to talk about—we talked a little bit about the physicians. And can you state specifically what specialty services we are not providing for individuals right now?

Ms. RHYMER-BROWNE. Yes. There are several cancer-related situations that we need to airlift. Our major cancer center was tremendously damaged on the island of St. Thomas. We used to fly individuals from the island of St. Croix over to St. Thomas, but now that center has been down for the last 2 years.

The orthopedic specialist, the trauma specialist. When we have major accidents and situations, workplace accidents, we have to airlift our members off-island to receive the treatment on the mainland.

Ms. PLASKETT. And how does this impact recruiting physicians to the Virgin Islands in terms of, if there is a belief that we will be reduced in our Medicaid treatment moving forward, how will that impact the ability to not just have specialty doctors but to have regular physicians, general practitioners, pediatricians, et cetera, to treat this population?

Ms. RHYMER-BROWNE. It would greatly reduce it. Before our ACA treatment and getting the additional monies, we were perhaps maybe at about 200 to 300 providers. We have over 700 now, because individuals were attracted that we had the additional monies to provide services for our members. But if we were to be reduced

once again, the ability to attract those specializations would be greatly—it would be very hard for the territory do that.

Ms. PLASKETT. Thank you very much.

I saw you had a note. Was there anything you wanted to add?

Ms. RHYMER-BROWNE. Yes. He has——

Ms. PLASKETT. Mr. Smith, she can't read your handwriting. You are not only the Director of Medicaid, you must be a doctor as well.

Ms. RHYMER-BROWNE. OK. At the 55 percent Federal, we would require $87.2 million. And at the 83 percent, $52.6 million.

Ms. PLASKETT. OK. Thank you very much.

I yield back the balance of my time.

Vice Chair SABLAN. Thank you.

I now recognize the gentleman from Nevada, Mr. Horsford, for 5 minutes.

Mr. HORSFORD. Thank you, Mr. Chairman, for organizing today's hearing on the funding of Medicaid in the U.S. territories. I appreciate the opportunity to discuss the shortfalls of Medicaid funding in our territories and shed light on this very important issue.

To start, I want to make it clear that it is my priority, as a member of this Committee as well as the Ways and Means Committee, to ensure all Americans, including those living in U.S. territories, have access to affordable and quality health care.

Sadly, as is often the case with the Federal Government's treatment of American Samoa, the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands, U.S. citizens and nationals living in the insular areas do not receive the same services and benefits afforded to the rest of the American people. That is a very sad fact that we need to address.

American citizens living in our territories are too often overlooked, mistreated, and forgotten, and the government services many of them depend on are treated similarly. Territories commonly experience higher rates of poverty than states, and, in many cases, our territories depend on Medicaid even more than our states. For example, in American Samoa, because private health insurers refuse to provide the island healthcare coverage, Medicaid is their only option.

Sadly, due to significant shortfalls in Federal Medicaid funding, territories face serious challenges finding the funding needed to support Medicaid coverage for all those who depend on it. These challenges have increased in recent years, as debt crises, decreased tourism, and natural disasters, including hurricanes and typhoons, have added to their burdens and heightened economic distress. As a result, all territories are forced to cut Medicaid programs, heighten eligibility requirements, and limit coverage options.

We cannot continue to stand by while people in need lose their healthcare coverage. Our territories face a significant crisis, and they need this Congress to find a Medicaid funding solution that can address the serious funding setbacks they face.

More than 1.3 million people in U.S. territories rely on Medicaid, which provides health coverage to children, pregnant women, parents, seniors, and individuals with disabilities. Without a Medicaid funding fix, thousands of individuals in need risk losing healthcare coverage and benefits under Medicaid.

I want to thank each one of you for your testimony today. I hope your insight can help the Members of this Congress better understand the challenges our territories face and solutions that are needed.

Ms. Sablan, I want to share my sympathy with you and express my regret that you and your colleagues have been forced to make such tough decisions regarding cuts to Medicaid.

Can you talk through what services the Commonwealth would be forced to cut if we do not address the Medicaid cliff? Will women not be able to get a mammogram? Will children not be able to have an annual physical? Will seniors lose access to nursing facilities? What options are left for these individuals if they lose their Medicaid coverage?

Ms. HELEN SABLAN. We will have to cut those optional services and some of the mandatory services, because by the first quarter of the fiscal year, we exhaust our 1108 funding.

Mr. HORSFORD. And explain what you mean by "cut optional services." When I was in the Nevada State Senate and we had a Republican governor who wanted to cut Medicaid across the board, it meant cutting diapers from seniors in nursing homes, and we rejected that. What does it mean to you?

Ms. HELEN SABLAN. Optional services include prescription drugs, dental services, and other care services that are critical for our patients.

Mr. HORSFORD. And what will happen to those individuals without that support?

Ms. HELEN SABLAN. If they don't get their medications, then eventually they will end up at the hospital, and that will cost us more money in our in-patient services. Also, dental services, if they are not treated, then they are going to end up in emergency room services, and that costs us more money.

Mr. HORSFORD. Right. And, again, is it the case that there are no other options available to them?

Ms. HELEN SABLAN. There are no other options, because they don't afford to get health insurance. The income that they get is pretty much to put food on their table.

Mr. HORSFORD. Thank you very much.

This is a very important issue, one that affects all the U.S. territories. And I commend the Chairman and the members of this Committee. We have to address this issue. It cannot continue to persist.

Thank you. I yield back.

Vice Chair SABLAN. Thank you. Thank you to the gentleman.

I recognize Mr. Cox from California. No questions?

Mr. COX. No questions.

Vice Chair SABLAN. All right.

There is another Californian at the table here, Mr. Lowenthal.

Mr. LOWENTHAL. Thank you, Mr. Chair. And I thank you for recognizing the great state of California also.

I have two questions. One is about the future, and one is a little bit about how we got here.

The first question is, if Congress does take the steps we have discussed today to treat the territories equitably, such as providing uncapped Medicaid funding, calculating fund matching in the same

way it does for the states, really begins to treat the territories as part of the United States in an equitable and fair way, are there any mandatory Medicaid benefit requirements the territories still wouldn't be able to meet due to territory-specific limitations? Are there still other things that need to be addressed?

Maybe anybody from the Committee.

Are there any unique characteristics of any of the territories that will prevent you from being able to provide the mandatory Medicaid benefits?

We have to get rid of the cap. We are hearing that. You have to have the match in an equitable way that doesn't penalize. But is there anything else we should be looking at also to make sure that the uniqueness of the territories does not preclude them from receiving certain benefits?

Anybody? Because we are really trying to figure out where do we go from here. Yes?

Ms. AVILA. Mrs. Avila from Puerto Rico.

Besides what is mandatory for the healthcare system within the Medicaid program, just to be able to keep the expertise of the doctors and healthcare providers, it is a great challenge for the island and for the other territories as well. So, we need to find a way to, with the distance and the structure that we already have, just to start stabilizing the program and see what other needs we have to confront right now.

But it is so urgent just to keep the doctors in the islands, it is so urgent to avoid having the hospitals collapse, that I will say probably we will need to have more support in terms of long-term care to develop the structure to support that population and that area.

But according to the guidelines of the CMS or HHS Federal healthcare program, we will need to identify what else we can do better just to have a more continued and sustainable program in the island.

Mr. LOWENTHAL. OK.

Anybody else want to add something that might be——

Ms. RHYMER-BROWNE. Yes, I just want to echo, for the long-term care, that this will be a very, very important area for the U.S. Virgin Islands. We have an aging population, and from CMS we definitely would need additional technical assistance to not only obtain a skilled nursing facility certification but to maintain the skilled nursing facility certification. So, that technical assistance would be greatly, greatly needed.

Mr. LOWENTHAL. That is looking forward, but the other question I have is—how did we get here? And I don't know if anybody can answer it.

I am just sitting here wondering, in the negotiations, does anybody—maybe Gregorio knows better. In the passage of the ACA, there were benefits. There was the Medicaid expansion. And, in some sense, it did provide for certain kinds of services for the territories. Yet, looking back, it was a terrible hindrance also. It put limits on the territories that it did not put on the rest of the country.

How did that happen?

Vice Chair SABLAN. Will the gentleman yield?

Mr. LOWENTHAL. Yes, I will yield.

Vice Chair SABLAN. When we had passed the Affordable Care Act and the PPA also, under the budget reconciliation process, we had to address the Senate bill. At that time, in all truthfulness, we couldn't go into conference, because when we come out, there would not be enough votes to pass the bill.

Mr. LOWENTHAL. OK.

Vice Chair SABLAN. So, we used the budget reconciliation process. And, of course, we had to go into the Senate version, which the Senate addressed the states, not territories. So, we worked with the White House, and we got increased money in addition to the regular block grants. But those monies were used as block grants itself.

Now, if we are going to get into the full program, there has to also be improvements to not just the procedures and the process of the program but also the care, the standard of care for patients.

The improvements that they would implement to satisfy Medicaid would not just benefit Medicaid patients. They would also benefit the entire patient population and the needs of the territories or combined like they do in the states. So, they would provide services that are not at the present time available to the territories but are available in the states.

And we could do this over a period of 10 years. There would be money to help them, incentivize them to meet those standards. And, at the same time, allow—maybe one territory could get this done in 5 years, and the other one may take 6 years—but allow them to work with the Secretary of HHS. And when they submit plans, when the HHS Secretary approved a plan, and then that territory would get into a full Medicaid program like they do in the states. And the rest would take the additional time they would need.

It will take time. It will take incentivizing them—of course, they would need financial assistance. But, yes, it can be done. It is possible. And that is also, for me personally, that is my hope, that we would get into the full program.

Did I answer the gentleman's question?

Mr. LOWENTHAL. Yes.

Vice Chair SABLAN. Thank you. And your time is up, so——

Mr. LOWENTHAL. And I used my time very wisely.

Vice Chair SABLAN. No question. You always do, Mr. Lowenthal.

Mr. Tonko from New York is recognized for 5 minutes.

Mr. TONKO. Thank you, Mr. Chairman.

And thank you to our witnesses, as well, for being here today.

I believe, in the richest country on Earth, health care should be a guaranteed right for all, full stop, and not just for residents of the 50 states but for all who call themselves Americans. Unfortunately, health care in America has always been segregated between the haves and the have-nots, and the status of Medicaid in the insular areas is no exception.

Like many aspects of Federal law, the way that the Medicaid program views the insular area is of second-class citizens, providing fewer resources and less predictability to care for some of our most vulnerable.

The territories are generally poorer than the 50 states but are subjected to Medicaid funding caps and restrictions that have made it significantly challenging for them to provide services to individuals living below the Federal poverty level.

Despite temporary increases in Federal Medicaid funds to Puerto Rico and the U.S. Virgin Islands, healthcare systems are fragile, especially in the wake of Hurricanes Irma and Maria. Following these two disasters, residents have struggled with substantial health needs.

It is imperative, I believe, that Congress properly address the Medicaid financing issues. Expiration of funding could result in even more significant shortfalls and could further restrict programs' eligibilities and cut benefits and suspend programs. This could be devastating for territory budgets, coverage, and the healthcare systems more broadly.

So, my question to Ms. Sablan and Ms. Young, both American Samoa and the Commonwealth of the Northern Mariana Islands rely on a single hospital to provide most of the care to Medicaid beneficiaries. What are some of the challenges that arise with this model? And would having uncapped Medicaid Federal funding and a higher Federal match help the territories draw in additional providers outside the hospital system?

Ms. Sablan?

Ms. HELEN SABLAN. Can you repeat your question again? I'm sorry.

Mr. TONKO. Sure. With your reliance on a single hospital for most of the care for Medicaid-eligible, what are some of the challenges that arise with this model? And would having uncapped Medicaid Federal funding and a higher Federal match help the territories draw in additional providers outside those in that hospital system?

Ms. HELEN SABLAN. We would have to send our patients off-island, either to Guam, Hawaii, or the U.S. Mainland. And it really is costing us a lot of money to send our patients with the limited cap that we get, and then requiring our local match.

Mr. TONKO. If we undo the cap and provide a higher Federal match, what is the impact, do you think?

Ms. HELEN SABLAN. That would really help us. We would be able to provide more services.

Mr. TONKO. And, Ms. Young, do you have any response?

Ms. YOUNG. Yes. To answer the first prong of your question, we provide basic services at our one hospital. And, basically, in our state plan, medically necessary care that is not available in our hospital must be sent off-island. And, currently, we send our patients to New Zealand because it is the closest country to us. It is closer than Hawaii. So, everything from orthopedics to cardiology to urology, to acute serious pediatrics, go to New Zealand.

If the cap were lifted and we received a better FMAP, that would truly transform our healthcare system. And what is amazing about this situation, if you look at the territories, it doesn't take much in the overall scheme of the Federal budget to just give us a little more in our block grants so that we can fully provide the services to our people and care for them.

So, if that cap was lifted and we got a better FMAP, absolutely, we would be able to recruit more providers in our island. Because that is part of our problem. We don't have enough certified doctors for CMS with compliance issues and reimbursement requirements. I think there are three doctors with M.D. degrees from the United States that allows us to claim for Medicare. But if we had more funding to recruit doctors from the United States with M.D. degrees, we would be able to do more of those types of claiming.

Mr. TONKO. Thank you.

Mr. Chair, I yield back.

Vice Chair SABLAN. Thank you, Mr. Tonko.

I now recognize Miss González-Colón for 5 minutes.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Chairman.

I want to thank Mr. Tonko, Horsford, Soto, and all the Members who are here taking into account the situation in the territories. I think it is important for Congress to do something. And I am willing, as the Representative of Puerto Rico, to work across the aisle to reach a long-term solution for the territories. And I think we can do that in the Energy and Commerce Committee—they went to the island during the last Congress, both today's Chairman as the Ranking Member at the time. And I think there is a common-sense opportunity to reach an agreement.

There are two bills that have been filed, one from Ms. Plaskett that has been sponsored by all the Members of the territories in a bipartisan way, H.R. 2306. And the other one is H.R. 1354. And I commend the Members that could co-sponsor those bills that would find a solution, a permanent solution, in taking the cap of 55 percent off or increasing the funding for Medicaid in Puerto Rico and the rest of the territories as well.

And I want to commend Mr. Soto for always being an original co-sponsor of all those bills. I think this is something that we can achieve during this Congress knowing that most of the territories suffered different disasters, including typhoons and hurricanes, during the last 2 years.

Ms. Arcangel, you were willing to answer the last question, and the time was up. Did you finish?

Ms. ARCANGEL. Thank you, Senator—sorry.

Miss GONZÁLEZ-COLÓN. Not yet. When we become a state, I will be a Senator. But now, I will be here in the House. Go ahead.

Ms. ARCANGEL. I am used to speaking to Guam Senators. I'm sorry.

Yes, so to answer the questions of the Congressman from New York, increasing the FMAP and removing the cap will definitely help all the territories.

One, for Guam, our experience is, because of lack of local funding, we are unable to match the Federal. So, what happens then is, because we have the late payments to our providers, they don't accept our patients, even for off-island providers. What happens? Our patients become more sick, their condition becomes more complicated, so the cost of health care increases. While we are waiting for a local match to draw down the Federal funding, our patients are staying in the hospital.

Though we have two hospitals, we don't have a tertiary center, really, that is complete with specialists who can handle these

people, even for nurses. Tertiary centers requires all the professionals in order for them to completely heal the patient. But these patients are waiting months in order to go off-island because the providers off-island do not want to accept our payments because of the late payments.

Miss GONZÁLEZ-COLÓN. Thank you.

Ms. ARCANGEL. And one more thing with regards to——

Miss GONZÁLEZ-COLÓN. Don't use up my time.

Ms. ARCANGEL. OK. I'm sorry. I just wanted to emphasize——

Vice Chair SABLAN. I will give you an extra minute.

Miss GONZÁLEZ-COLÓN. OK. Perfect.

Go ahead.

Ms. ARCANGEL. I'm sorry. I just wanted to emphasize that the territories do not receive any DSH money. And that will help our hospital.

Miss GONZÁLEZ-COLÓN. The DSH money, for the knowledge of the Members, is disproportionate share hospital segment. And that means that the low-income patients are being attended by many of the hospitals without receiving their fair share in order to make that happen.

Same thing happened with the low-income subsidy and the HIT, the health insurance tax. Our hospitals are paying a tax included in the Obamacare, but we can't benefit for the tax incentive that the law provided for those hospitals. In the case of Puerto Rico, we are paying more than $200 million a year in the health insurance tax without getting the benefit. And I know it would be the same for all the hospitals because we don't have the exchange.

So, there are several parts of the healthcare problems. Medicaid is one of them. Medicare is another problem as well. And I began the questioning during my last turn to the lady from American Samoa. And I know that we knew each other. How long you been in the post, Ms. Young?

Ms. YOUNG. Six years.

Miss GONZÁLEZ-COLÓN. Six years. What is the reason that American Samoa has not used or spent the money that was allocated to the island?

Ms. YOUNG. Up until 2017, we only had one Medicaid provider, which is the hospital. And the hospital doesn't provide all of the mandatory services under the Medicaid program.

In trying to reform our Medicaid state plan to add new providers to try to help us draw the Federal money, the barrier for that was the local match. So, for the first time, our government was—when our administration came in, there was a lot of old debt that their priority was to focus on. So, we weren't able to get local match for new services until 2017.

Our hospital doesn't require a local match, but all new services outside of the hospital require a local match.

Miss GONZÁLEZ-COLÓN. And I would yield. And I would love to have recommendations from the territories that have not spent the Medicaid funds. Give me any problems you are facing. You have been 6 years there, so there should be some recommendations in order to actually draw that money.

With that, I will yield back.

Vice Chair SABLAN. The gentlelady's time has expired. Thank you.

I will now recognize the gentleman from Florida, Mr. Soto.

Mr. SOTO. Thank you, Chairman Sablan. That does sound nice. Not as good as "Grijalva," but Chairman, I am still with you. I am Team Grijalva, but I love Sablan.

There has been a long-running injustice in this country—and I think we all understand that—with our territories with regard to health care, taxes, benefits, even the right to vote. And we continue to be in this Committee to right those wrongs, to fix those injustices.

In Puerto Rico, under the current Medicaid system, we have seen over 6,000 doctors leave the island, many of them for our great state of Florida; hospitals are in disrepair; debt is added to try to prop up a Medicaid program—all because Puerto Rico is not treated equally for purposes of Medicaid. And I know there is a similar story in each of our territories, and that is why we are here today.

I have the honor of serving on the Energy and Commerce Committee that—the name has been invoked about 100 times today. So, you are looking at someone who will be working in both committees on this issue specifically.

But it gets worse than that, with Hurricane Maria or Typhoon Yutu, our territories have been decimated by some of these storms. And it has led to tragic deaths that are in part because of the lack of money in the healthcare system to be able to provide people with health care after these emergencies, including in Puerto Rico and the Virgin Islands and in the Northern Mariana Islands, along with other areas.

So, if you remember nothing else, it is time to end this injustice. And that is why we appreciate all of you coming from so far away, from so many different corners of the United States to be here today and to make sure that Americans have healthcare equality throughout the territories.

I want to thank my fellow hermana Boricua, Representative González-Colón, as well as Representatives Plaskett, Sablan, San Nicolas, Radewagen, and others. Because H.R. 2306 and H.R. 2304 are great ideas and starting points of where we need to be in Energy and Commerce with regard to these bills, as well as here.

We would like to remove the cap altogether, and we would like territories to be treated as states and get the same type of treatment that they would get otherwise. And I think that is where we want to go with either these bills or with sort of a combination of them.

Another bill that we will be working on is to give access to the Affordable Care Act exchanges, which right now the territories don't have access to. In my family's native island of Puerto Rico, only 30 percent of people are on employer-based insurance, which is mind-blowing compared to the states. So, we need to boost that up.

I noticed—and this is where I am going to get to my question for each of you—because you are not fully funded with Medicaid, some of you aren't providing all the services yet, although Guam—who is from Guam?—Guam is doing all the services already. You get

the gold star for today. Very impressive. You are not getting the full funding to do that.

But for each of you, going down the list, it would be great to hear, if we provided you the full FMAP funding that you would get as a state, whether you believe you could provide, over the course of a certain number of years, all these services.

We will start with Ms. Avila and we will go down the list. If you got the full Medicaid treatment that a state would, the full funding, would you be able to provide all the services under a mandatory Medicaid benefit? And what kind of time period would you need?

Ms. AVILA. Well, we were talking about that. We would start immediately just adjusting the reimbursement rates to our medical providers.

And I will say that in a time frame of no more than 3 years we will be able to stabilize the program as it needs right now. Because the uncertainty that we have, it is one of the most——

Mr. SOTO. I understand. My time is limited, so I just want to get to other people,

Ms. Young?

Ms. YOUNG. Thank you. Yes, we would be able to do a lot more if we were treated equitably like the states and releasing uncapped funding as well as an improvement in the FMAP.

Mr. SOTO. Ms. Rhymer-Browne?

Ms. RHYMER-BROWNE. Yes, we would definitely be able to do more. And one of the areas would be to increase—well, even develop our skilled nursing facilities and not have a cap when we do have the skilled nursing facilities.

Mr. SOTO. And we already covered Guam. Ms. Sablan?

Ms. HELEN SABLAN. We will definitely provide all the services that are mandated. Right now, there are some that we are not covering because——

Mr. SOTO. Of course. Because you are not getting full funding. I understand that.

And Ms. Muna?

Ms. MUNA. We are already providing some of the services, and we will be definitely expanding and providing more services for the community at home.

Mr. SOTO. Thanks.

And I yield back.

Vice Chair SABLAN. I thank the gentleman.

I now recognize the Chairman of the Committee, Mr. Grijalva.

Mr. GRIJALVA. Thank you very much, Chairman Sablan. And like I said earlier, I appreciate you putting this meeting together, this hearing. It is impactful to shine a brighter light on this inequity that every one of you has spoken to, both in your oral and written testimonies.

And it is an equal-treatment issue, to me, very fundamentally and very simplistically. And the way to deal with that unequal treatment is to create resource equity on par with what communities here in the United States on the mainland receive, period. That is the goal.

And I look forward to the various legislation under Mr. Sablan and the Representatives from all the territories and Puerto Rico.

I think that from that would come a significant piece of legislation that we can look at, promote. And certainly I would be talking with Chairman Pallone about expediting a good piece of legislation, to start to move that.

Having said all that, I really want to ask one question to all of you—just one question. And thank you all for making the effort and coming from such a long way to be here.

The one question is—If you had to choose between a larger Federal match, for example, 85 percent, or more money or just more resources and more money but the same 55/45 match that is present, which would you prefer and why?

I think that is the question. Why don't we just add more money to what exists versus fundamentally changing, making the formula equitable, the reimbursement formula equitable?

But that is the one question for all of you. And we can begin with Ms. Muna. Then we can just go down the panel, if you don't mind.

Thank you, Mr. Chairman.

Ms. MUNA. If we were going to choose, we would have to choose more money over the FMAP. And the reason is, even if you increase the FMAP—for us personally in the hospital, we use the certified public expenditure. If the funds are not available, you won't be able to—even if you increase the FMAP, it would basically just be faster for you to expend the money rather than having actual cash available to pay for services that you are going to provide at home.

Mr. GRIJALVA. OK. Thank you.

Ms. HELEN SABLAN. I go with removal of the cap instead of the FMAP. And the reason why is we are spending more. We are spending over $72 million.

Ms. ARCANGEL. The same way for Guam. We spent $110.8 million last year. So, if you are just going to increase the FMAP, our current cap right now is $17.97 million. That is not enough to pay for those services, so we prefer to increase the funding.

Ms. RHYMER-BROWNE. Very hard. We would need more money, so definitely we want the cap off. But the FMAP is needing to be off as well, because more money and still have the 55 percent FMAP would make no sense. We can't make it. We can't go after it, as seen in the ACA dollars.

Ms. YOUNG. I think for American Samoa, this is an interesting question. In an ideal situation, both of these options need to be addressed simultaneously, complementary. But if we were given an option, then we would have to go for more money, lifting of the cap.

But what we would have to do as a territory, then, is we would have to permanently omit and eliminate all outside providers outside of the hospital, because our government is not able to raise the local match. And I think we can do that over years, continually improve our hospital and use our CPE method that doesn't require the match.

Ms. AVILA. We will need to agree with the Virgin Islands that it is a combination of both. Even though we have more money, if we don't have the local match to be able to comply with the matching funds, we are not doing anything good for the program.

So, it would be an increase of both relatively. We need to have more money, and we need to have a higher FMAP to be able to do

the matching of funds and not to be in the situation that Puerto Rico is facing right now. Because trying to cope with the matching of 45 percent has taken our island to a financial situation that we are living today with the fiscal board and looking for funds to be able to pay what we get to be able to sustain the program and pay for the matching.

Mr. GRIJALVA. Thank you.

Mr. Chairman, I hope that going forward under your leadership that the consensus, the fact that all the stakeholders are before us, that, as we move forward or move legislation, that we seek to continue to promote that consensus. It makes the effort much more powerful, to be honest with you.

So, with that, thank you very much again for the hearing. I yield back, sir.

Vice Chair SABLAN. Thank you, Mr. Chairman.

I am going to take the liberty of asking Ms. Muna if she could respond, maybe take 30 seconds, 1 minute, to respond to Mr. Tonko's question.

Ms. MUNA. About expending services?

I mean, if you remove the cap—yes. If you remove the cap, there are a lot of opportunities for us to reform our healthcare system, given the opportunity to have that predictable funding. You have to have predictable funding and sustainable funding.

And if you are able to have those, then you will be able to basically manage the population, bring healthcare reform, bring population health, and have a healthier population for your people. And that is an opportunity for us that we would love to have.

Thank you.

Vice Chair SABLAN. Thank you.

Thank you very much, everyone.

And I want to let everyone know that we didn't hold this hearing just on our own. We have been working with outside groups. We have been working with the Energy and Commerce Committee staff on trying to address this also. We don't want to blind-side them.

So, again, I will emphasize the importance of giving us a complete and concise answer to those six items I gave to you.

I also would like again—I am really pleased with the Virgin Islands model that they have started. And I understand that some of you have agreed to kick back and pay your own bill, of course. But somewhere, maybe at Longworth Cafe, maybe you can sit back and talk a little bit more on how to address a model, so we could put together something for legislation.

I want to thank the witnesses for their truly, truly valuable testimony and many of the Members for their questions and their patience.

The members of the Committee may have some additional questions for our witnesses, and we would ask you to respond to these in writing. Under Committee Rule 3(o), members of the Committee must submit witness questions within 3 business days following the hearing, and the hearing record will be held open for 10 business days for these responses.

If there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 12:18 p.m., the Committee was adjourned.]

[ADDITIONAL MATERIALS SUBMITTED FOR THE RECORD]

Submission for the Record by Rep. Grijalva

STATEMENT FOR THE RECORD
NATALIE A. JARESKO
EXECUTIVE DIRECTOR
FINANCIAL OVERSIGHT AND MANAGEMENT BOARD FOR PUERTO RICO

Chairman Grijalva, Ranking Member Bishop, and Members of the Committee, thank you for the opportunity to provide comments to the Committee on behalf of the Financial Oversight and Management Board for Puerto Rico (the "Board") specific to Puerto Rico as you examine the Medicaid situation in the U.S. territories and consider proposals to address issues as to federal funding for Medicaid services in the territories.

As the bipartisan Congressional Task Force on Economic Growth in Puerto Rico (the "Congressional Task Force") concluded in its Report to the House and Senate of the 114th Congress, on December 20, 2016, federal policymakers seeking to address Puerto Rico's economic and social challenges must include a solution to the future financing of the Medicaid program in Puerto Rico. The Board strongly agrees and previously supported the Bipartisan Budget Act of 2018, which provided additional Medicaid federal funding for Puerto Rico like the Affordable Care Act had.

The Board is very concerned that come September 2019, when that additional funding from the Bipartisan Budget Act and Affordable Care Act expires, Puerto Rico will revert back to the statutorily capped federal funding that it receives for Medicaid, which is a small fraction of what similar states receive. Not only does Puerto Rico have a predefined 55% as its federal matching assistance percentage, but also Section 1108 of the Social Security Act imposes an additional hard, lower cap on Puerto Rico's Medicaid share.

For example, in fiscal year 2018, the Section 1108 cap for Puerto Rico was just under $360 million while the total cost of Medicaid in Puerto Rico was over $2.8 billion. In the absence of one-time funds from Congress through the Affordable Care Act and Bipartisan Budget Act, the cap on matching assistance available to Puerto Rico would have yielded an effective federal match of roughly 13%. Had Puerto Rico received its predefined 55% federal match without a cap, it would have received over $1.3 billion. Had Puerto Rico received the federal match that the most relevant comparable state gets (Mississippi at 76%), it would have received over $1.8 billion.

Each dollar that the federal government does not provide for Medicaid the Government of Puerto Rico must find, while it contends with the devastating aftermath of hurricanes Irma and Maria and attempts to resolve its crushing debt burden. Furthermore, without a long-term solution to the Federal government's share of Puerto Rico's Medicaid costs, the Government of Puerto Rico's spending on Medicaid will account for an unprecedented portion of its annual budget. Absent action by Congress, by fiscal year 2021, the Commonwealth's Medicaid costs are projected to comprise roughly 23% of the General Fund's budget.

While urging Congress to address this major shortfall, the Government of Puerto Rico and the Board have been working on a series of reform priorities for the Island's healthcare system to improve the delivery of high quality, cost-effective care. In particular, the May 2019 Certified Fiscal Plan for the Government of Puerto Rico requires the Government to:

1. Implement systems and controls (e.g., T-MSIS, Medicaid Fraud Control Unit) to reduce fraud, waste and abuse within the public insurance system and ensure that all current enrollees are qualified to receive benefits;
2. Establish value-based payment models to incentivize better care coordination among providers, particularly for those with chronic conditions who currently generate the majority of the Island's healthcare expenditures and suffer from the worst health outcomes;
3. Enable primary care physicians to provide preventive care and encourage a shift toward lower-cost care settings, reducing the number of emergency room visits; and

4. Ensure communities have the infrastructure and coordination capacity to promote efficiency of services and a community-wide focus on health.

These value-based savings measures represent a joint effort between the Government of Puerto Rico and the Board to permanently "bend the curve" on the Island's unsustainable medical cost growth, while also providing better services to the residents of Puerto Rico.

While these reforms are underway and the Medicaid cliff looms, the Board encourages the Committee and the Congress to support the recommendation of the Congressional Task Force to treat Puerto Rico in a more equitable and sustainable manner under the Medicaid program, in order to improve patient outcomes, to strengthen the health care system on the Island and federal oversight of that system, and to reduce the incentive for migration from the Island to the states and the associated financial costs to state governments and the federal government.

Going forward, the Board believes that federal financing of the Medicaid program in Puerto Rico should be more closely tied to the size and needs of its low-income population and that the Commonwealth's recovery and fulfillment of PROMESA's objectives will be significantly aided by the Congress legislating a long-term Medicaid program solution to mitigate the drastic reduction in federal funding for healthcare in Puerto Rico that will happen later this year absent congressional action.

[LIST OF DOCUMENTS SUBMITTED FOR THE RECORD RETAINED IN THE COMMITTEE'S OFFICIAL FILES]

Submissions for the Record by Rep. Sablan

— Letter from the Association of Asian Pacific Community Health Organizations (AAPCHO) to Reps. Grijalva, Bishop, and Sablan dated May 23, 2019.

— Letter from the President and CEO of Guam Regional Medical City (GRMC) to Vice Chair Sablan dated May 23, 2019.

— Pacific Island Health Officers' Association Resolution No. 2019–65–01.

— Letter from Marianas Medical Center to Vice Chair Sablan dated May 13, 2019.

— Letter from Various Asian-Pacific and Pacific Island Organizations to House Majority and Minority Leadership dated May 23, 2019.

Submissions for the Record by Rep. Radewagen

— Letter from Rep. Radewagen to Governor Lolo Moliga of American Samoa dated March 15, 2019.

— Briefing from the Medicaid and CHIP Payment and Access Commission (MACPAC) dated May 2019.

— GAO Report on Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts, GAO-16-324, dated April 2016.

— Fact Sheet from MACPAC on Medicaid and CHIP in American Samoa dated March 2019.

Submission for the Record by Ms. Avila

— Letter from Gov. Rossello to Rep. Pallone and Rep. Walden dated May 1, 2019.

Submissions for the Record by Ms. Muna

— Briefing Packet from Commonwealth of the Northern Mariana Islands Healthcare Corporation dated March 2019.

— Letter from Governor Torres of the Commonwealth of the Northern Mariana Islands to the Secretary of the U.S. Department of Health and Human Services dated April 23, 2019.