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STRENGTHENING HEALTHCARE IN THE U.S. TERRITORIES FOR TODAY AND INTO THE FUTURE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

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[1] The report has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20190620/109671/HHRG-116-IF14-20190620-SD013.pdf.

STRENGTHENING HEALTHCARE IN THE U.S. TERRITORIES FOR TODAY AND INTO THE FUTURE

THURSDAY, JUNE 20, 2019

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:29 a.m., in room 2322, Rayburn House Office Building, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

Members present: Representatives Eshoo, Engel, Butterfield, Castor, Sarbanes, Luján, Schrader, Kennedy, Cárdenas, Welch, Ruiz, Kuster, Kelly, Barragán, Blunt Rochester, Soto, Pallone (ex officio), Burgess (subcommittee ranking member), Guthrie, Griffith, Bilirakis, Long, Brooks, Mullin, Hudson, Carter, Gianforte, and Walden (ex officio).

Staff present: Jeffrey C. Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Saha Khaterzai, Professional Staff Member; Josh Krantz, Policy Analyst; Aisling McDonough, Policy Coordinator; Joe Orlando, Staff Assistant; Alivia Roberts, Press Assistant; Rick Van Buren, Health Counsel; C. J. Young, Press Secretary; Mike Bloomquist, Minority Staff Director; Jordan Davis, Minority Senior Advisor; Margaret Tucker Fogarty, Minority Staff Assistant; Caleb Graff, Minority Professional Staff Member, Health; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; and J. P. Paluskiewicz, Minority Chief Counsel, Health.

Ms. ESHOO. Good morning, everyone. The Subcommittee on Health will now come to order. The Chair now recognizes herself for 5 minutes for an opening statement.

The committee is not in order.

Thank you.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Welcome to the witnesses, everyone that is in attendance here today.

At the end of this coming September, the five U.S. territories face a Medicaid cliff, which means the supplementary Medicaid funding provided to the territories through the Affordable Care Act will run out. Without this Federal funding, over 1.5 million enroll-

ees, including many children, could lose their healthcare. Each is an American citizen, and they are being treated differently than the constituents of every Member in this room.

For too long, the territories have struggled with inadequate Federal funding for their Medicaid programs because Federal law caps Medicaid funding for the territories. The territories also receive a fixed Federal Medicaid match that is lower than the rate they would receive if they were States.

Due to these restrictions, the territories routinely run out of Medicaid funds. Over the past decade, Congress has voted on five separate occasions to provide stopgap funds to certain territories. Even with these supplements, the funding for the territories is well below what a State Medicaid program would receive. In the territories, Medicaid spends an average of $1,866 per enrollee. In the States, on average, Medicaid spends more than four times that amount.

In the States, the Medicaid program has a flexible financing structure. This structure guarantees funding if more individuals enroll due to an economic downturn, an epidemic, or a natural disaster. The territories do not have a guarantee. When disaster strikes, as it did with the 2017 hurricanes and the 2018 typhoons, the territories were forced to make very hard choices about coverage and services at the worst possible time.

Simply put, the territories' Medicaid funding does not meet their needs. In Puerto Rico, 85 percent of residents report they are worried that they will be unable to access healthcare if they need it. A recent study found breast cancer patients in the territories were 82 percent less likely to receive timely radiation therapy.

In American Samoa, Guam, and Commonwealth of the Northern Mariana Islands, the public hospitals face staff shortages due to low salaries, poor infrastructure, and high rates of uncompensated care. All of these challenges exist before—before, Members—the Medicaid cliff hits on September 30th. If we allow that to happen, Puerto Rico would go from over 2 billion in Federal funding to just 380 million. The other territories would have similar cuts of upwards of 70—that is 7–0—percent of their Medicaid funding. These cuts would have dire consequences to hundreds of thousands of American citizens, and I think this is a crisis.

Today, we have to ask a vital question: How can we fail to care for so many American citizens based solely on where they live? So we want to hear from the witnesses what the loss of the Medicaid funds will mean to the people you serve and what Congress should do to improve the situation, both in the immediate future and in the long term.

Thank you for traveling such distances to be with us today. We all appreciate it. And I know for some of you that it was a multiday journey to be with us. So we all appreciate your time and your willingness to answer our subcommittee's questions. And I now would like to recognize the time remaining to the gentleman from New Mexico, Mr. Luján.

[THE PREPARED STATEMENT OF MS. ESHOO FOLLOWS:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

At the end of this coming September, the five U.S. territories face a "Medicaid cliff," which means the supplementary Medicaid funding provided to the territories through the Affordable Care Act will run out. Without this Federal funding, over 1.5 million enrollees, including many children, could lose their healthcare.

Each is an American citizen and they're being treated differently than the constituents of every Member in this room.

For too long the territories have struggled with inadequate Federal funding for their Medicaid programs because Federal law caps Medicaid funding for the territories. The territories also receive a fixed Federal Medicaid match that is lower than the rate they would receive if they were States.

Due to these restrictions, the territories routinely run out of Medicaid funds. Over the past decade, Congress has voted on five separate occasions to provide stopgap funds to certain territories.

Even with these supplements, the funding for the territories is well below what a State Medicaid program would receive. In the territories, Medicaid spends an average of $1,866 per enrollee. In the States, on average, Medicaid spends more than 4 times that amount.

In the States, the Medicaid program has a flexible financing structure. This structure guarantees funding if more individuals enroll due to an economic downturn, an epidemic, or a natural disaster.

The territories do not have a guarantee. When disaster strikes, as it did with the 2017 hurricanes and the 2018 typhoons, the territories were forced to make hard decisions about coverage and services at the worst possible time.

Simply put, the territories' Medicaid funding does not meet their needs.

In Puerto Rico, 85% of residents report they're worried that they'll be unable to access healthcare if they need it. A recent study found breast cancer patients in the territories were 82% less likely to receive timely radiation therapy. In American Samoa, Guam, and the Northern Mariana Islands, the public hospitals face staff shortages due to low salaries, poor infrastructure, and high rates of uncompensated care.

All of these challenges exist before the Medicaid cliff hits on September 30th. If we allow that to happen, Puerto Rico would go from $2.3 billion in Federal funding to just $360 million. The other territories would have similar cuts of upwards of 70% of their Medicaid funding. These cuts would have dire consequences to hundreds of thousands of American citizens. This is a crisis.

Today we must ask a vital question: How can we fail to care for so many American citizens based solely on where they live?

I want to hear from the witnesses what the loss of the Medicaid funds will mean to the people you serve and what Congress should do to improve the situation both in theimmediate future and in the long term. Thank you for traveling to be with us today.

I now recognize Congressman Ben Ray Luján for the remainder of my time.

Mr. LUJÁN. Thank you, Chairwoman Eshoo and Chairman Pallone. The lack of adequate funding for Medicaid programs in the territories is not only unacceptable, it is inhumane. Funding for territories' Medicaid programs has never been enough, and if Congress fails to act before September 30th, the Medicaid cliff could leave the territories in an even more dire financial situation. We are talking about people not being able to access basic healthcare, the sick unable to see a doctor, children without care.

Territory officials have described the expiration of these Federal funds as catastrophic, and people are scared. Estimates predict a third to a half of Puerto Rican Medicaid enrollees are at risk for losing coverage. And in the U.S. Virgin Islands, estimates show 18,000 people out of the 28,000 current enrollees could lose coverage. That is more than 60 percent.

These are our fellow Americans. Congress must embrace them as fellow citizens and stop jeopardizing their access to healthcare. I thank you, and I yield back.

Ms. ESHOO. The gentleman yields back, and the Chair is now pleased to recognize Dr. Burgess, the ranking member of the Subcommittee on Health, for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, and I appreciate the recognition.

During our last extenders hearing 2 weeks ago, I made note of the fact that we had left out an incredibly important piece of the conversation, Medicaid in the United States' territories. So I do want to thank you, Chairwoman Eshoo, for committing to hold this hearing, and I especially want to thank our representatives from each of our Nation's territories for having traveled such distances to be here today. I also want to recognize our representatives who waived on to the subcommittee, Representative Jenniffer González-Colón and Ms. Radewagen from American Samoa, who have joined us today for this subcommittee hearing.

The five United States territories—Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands—each have a vulnerable population that depends on Medicaid and the Children's Health Insurance Program. The structure of these programs is different from that in the individual States. However, these programs are equally important, as these are United States citizens. The funding for Medicaid in some of our territories was last reauthorized in the Bipartisan Budget Act of 2018, but that funding is set to expire at the end of this September. It is critical that we act in a timely manner to reauthorize this funding.

Over the course of the past few years, the territories have suffered tremendous damage from natural disasters. Hurricanes, typhoons—what were already at-risk populations have been made even more vulnerable as they have suffered destruction of their homes and their infrastructure, and in some cases healthcare professionals have left the territories for the mainland United States.

As the territories continue to recover and prepare for future potential disasters, we need to be mindful of their inhabitants' access to healthcare and ensure adequate Medicaid funding that is integral to maintaining that access. As Dr. Schwartz points out in her testimony, the territories have sufficient funding to cover their expenses through the end of this fiscal year, which is rapidly approaching. However, it is the long-term challenge that we are facing today.

I also think it is worth noting that Puerto Rico has by far the most enrollees and faces challenges that are not necessarily relevant in the other territories, but as we move forward in the process of extending Medicaid funding for all the five territories, we must remember that each territory is unique and may require a different approach in our legislation. Each territory has different benefits for its citizens, and only Puerto Rico uses Medicaid Managed Care, while other territories operate in the fee-for-service sys-

tem. It is critical to ensure adequate funding for the territories so that they operate their Medicaid programs appropriately.

I also believe it is important to have accountability measures and fraud detection and prevention. For our own States, the House has passed a permanent reauthorization of the Medicaid Fraud Control Units earlier this week, and we should perhaps think of a similar standard for the territories, especially if increased funding is provided in September. As we saw in Puerto Rico following the enactment of the Bipartisan Budget Act of 2018, it is possible for the territories to adopt and successfully implement program integrity measures.

I hope we can use this hearing as an opportunity, an opportunity to have a productive conversation about any potential changes to the Federal payment mechanisms in the Medicaid programs in the territories, as we are willing to engage on this issue, but we need to strike the right balance between funding and structure of these programs so that they can succeed, be good shepherds of the taxpayer dollars, and deliver the services when and where they are needed.

Again, I would like to thank all of our witnesses for being part of this. As the Chair will have noted, many of you traveled days to get here, and for that we are very appreciative. I look forward to your testimony.

I21[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you, Madame Chair. During our last extenders hearing 2 weeks ago, I noted that we had left out an incredibly important piece of the conversation—Medicaid in U.S. territories. I would like to thank Chairwoman Eshoo for her commitment to hold this hearing, and I would especially like to thank the representatives from each of our Nation's territories for traveling such distances to be here today. I would also like to recognize Representative Jenniffer González-Colón from Puerto Rico, who is waiving onto our subcommittee for this hearing.

The five U.S. territories, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, each have a vulnerable population that depends on Medicaid and the Children's Health Insurance Program. The structure of these programs is different than those of the individual States; however, these programs are equally important, as these are United States citizens. The funding for Medicaid in some of the territories was last reauthorized in the Bipartisan Budget Act of 2018, but that funding is set to expire at the end of this September. It is critical that we act in a timely manner to reauthorize this funding.

Over the course of the past few years, the territories have suffered tremendous damage from natural disasters, including hurricanes and typhoons. What are already at-risk populations have been made more vulnerable as they have suffered destructions of their homes and infrastructure, and in some cases, healthcare professionals have left the territories for the United States.

As the territories continue to recover and prepare for potential future devastation, we need to be mindful of their inhabitants' access to healthcare, and ensuring adequate Medicaid funding is integral in maintaining that access.

As Dr. Schwartz points out in her testimony, the territories have sufficient funding to cover their expenses through the end of this fiscal year; however, it is the long-term challenge that we are facing today. I also think it is worth noting that Puerto Rico has by far the most enrollees and faces challenges that are not necessarily relevant to the other territories. As we move forward in the process of extending Medicaid funding for all of the five territories, we must remember that each territory is unique and requires a different approach in our legislation.

Each territory has different benefits for its citizens, and only Puerto Rico uses Medicaid managed care, while the other territories operate fee-for-service systems.

While it is critical to ensure adequate funding for the territories to operate their Medicaid programs, I also believe that it is important to have appropriate accountability measures and fraud detection and prevention. For our own States, the House passed a permanent reauthorization of Medicaid Fraud Control Units earlier this week, and we should hold the territories to a similar standard—especially if increased funding is provided in September. As we saw in Puerto Rico following the enactment of the Bipartisan Budget Act of 2018, it is possible for the territories to adopt and successfully implement program integrity measures.

I hope that we can use this hearing as an opportunity to have a productive conversation about any potential changes to the Federal payment mechanisms in Medicaid programs in the territories. We are willing to engage on this issue, but we need to strike the right balance between funding and structuring these programs such that they can succeed and being good shepherds of taxpayer dollars.

Again, I would like to thank all our witnesses for being part of this important conversation today. I yield back.

Mr. BURGESS. And let me yield, Ms. Chairwoman.

Mr. PALLONE. Mr. Ranking Member, would you yield a minute? Just some time. I just wanted——

Mr. BURGESS. Don't you have your own time?

Mr. PALLONE. No, but this is procedural.

Mr. BURGESS. As the chairman of the full committee, you usually get a lot of time.

Mr. PALLONE. Well, all I wanted to say is my understanding is that the Delegates that are here today from the various territories, when they waive in they are not actually allowed to participate, but some of them have statements, Madam Chair. So I was going to ask unanimous consent that the sStatement of Mr. Sablan and any of the other Delegates that are here be submitted for the record.

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you. That is all.

Ms. ESHOO. The gentleman yields back. I now would like to recognize the chairman of the full committee, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Madam Chair.

Today, our committee continues its efforts to ensure that all Americans have access to healthcare, whether they live in one of the 50 States or one of the 5 territories. The territories are on the verge of a financial and humanitarian crisis. Experts predict that, unless Congress acts, none of the territories will have enough Federal funds to support their Medicaid programs next year. Puerto Rico could potentially spend all its Federal funds in a matter of months, facing a shortfall of billions of dollars for the year.

And it is no secret how we got here. For years, the territories have been operating their Medicaid programs under Federal funding caps that haven't kept up with the needs of the people who live there. The Affordable Care Act provided increased funding that has helped the territories for the past decade, but that expires at the end of this year.

Natural disasters in the territories have also put increased strain on their Medicaid programs that required Congress to provide addi-

tional support to ensure people didn't lose access to care. Medicaid in the territories doesn't operate like it does in the States. Each territory only receives a certain amount of Federal funds that is supposed to last them the whole year. It is essentially a block grant.

In the States, increases in State Medicaid spending are matched with an increase in Federal Medicaid funding. And this means that, in times of economic downturn or in the period following a natural disaster when state Medicaid spending increases, the State receives an automatic increase in Federal Medicaid dollars.

But that is not how it works for the territories. Once they spend their annual allotment, they have to pay for their Medicaid costs using local funds. And this outdated system forces the territories to pay a substantial amount out of their own pockets to ensure that people there have access to healthcare. It is also a stark reminder of why block grants for Medicaid simply don't work. The Federal funding shortfall means most of the territories aren't able to provide the full range of benefits that State Medicaid programs are required to cover. Payments to doctors and hospitals are so low that providers are leaving the islands for the States.

While Congress has provided some time-limited increases to the territories' Medicaid funding, we need a longer-term solution. Doling out Federal funds in dribs and drabs has led to uncertainty about the financial future of the programs and calls into question the long-term sustainability of the territories' Medicaid programs if Congress fails to act.

And that is why we are here today, to discuss the Medicaid cliff facing the territories and what we can do to avert a catastrophe. As we will hear today, without additional funds hundreds of thousands of people in the territories could lose their healthcare coverage. Some territories have said they would have to stop covering prescription drugs, dental care, durable medical equipment, and community health centers, and others have said they expect to lose even more providers.

And none of this really has to happen. We can all see the cliff coming, but if we work together, we can stop the territories from going off it. We can ensure that they can continue to provide care to the people who need it the most, we can stop the flight of doctors and providers from the islands, and we can provide the certainty and sustainability that the territories deserve.

Several Members recently introduced legislation that would provide Puerto Rico with both the amount of Federal funds requested by the Governor and establish a path to help transition its Medicaid program to a full State-like program. And this would provide sufficient funds to Puerto Rico to ensure its people receive the healthcare services they need.

And I want to thank the Members for their hard work on this bill, especially Representative Soto, who is on our committee. I hope this can potentially be a roadmap to help strengthen the Medicaid program in other territories. And I also want to thank the witnesses for being here today, particularly those who have traveled long distances to share your expertise with us.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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The territories are on the verge of a financial and humanitarian crisis. Experts predict that unless Congress acts, none of the territories will have enough Federal funds to support their Medicaid programs next year. Puerto Rico could potentially spend all its Federal funds in a matter of months, facing a shortfall of billions of dollars for the year.

It's no secret how we got here. For years, the territories have been operating their Medicaid programs under Federal funding caps that haven't kept up with the needs of the people who live there. The Affordable Care Act provided increased funding that's helped the territories for the past decade, but that expires at the end of this year. Natural disasters in the territories have also put increased strain on their Medicaid programs that required Congress to provide additional support to ensure people didn't lose access to care.

Medicaid in the territories doesn't operate like it does in the States. Each territory only receives a certain amount of Federal funds that's supposed to last them the whole year. It's essentially a block grant. In the States, increases in State Medicaid spending are matched with an increase in Federal Medicaid funding. This means that in times of economic downturn, or in the period following a natural disaster, when State Medicaid spending increases, the State receives an automatic increase in Federal Medicaid dollars. That's not how it works for the territories. Once they spend their annual allotment, they have to pay for their Medicaid costs using local funds. This outdated system forces the territories to pay a substantial amount out of their own pockets to ensure the people there have access to healthcare. It's also a stark reminder of why block grants for Medicaid simply don't work.

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None of this has to happen. We can all see the cliff coming, but if we work together, we can stop the territories from going off it. We can ensure that they can continue to provide care to the people who need it the most. We can stop the flight of doctors and providers from the islands. And we can provide the certainty and sustainability that the territories deserve.

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I also want to thank the witnesses for being here today, particularly those that traveled long distances to share your expertise with us.

Thank you.

Mr. PALLONE. I wanted to yield to Representative Soto. But just if I could say, I think many of our Members went after Hurricane Maria to Puerto Rico and the Virgin Islands. And when we were on that trip, both Stacey and Jenniffer representing the Virgin Islands and Puerto Rico were very helpful in explaining the problems with Medicaid at the time, so we learned a lot on that trip.

But now I would like to yield to Representative Soto.

Mr. SOTO. Thank you, Mr. Chairman. We know that Puerto Ricans, the 3.3 million on the island, are experiencing a Medicaid crisis. Hospitals in disrepair, over 6,000 doctors have left the island over the past few years, debt increases just to try to keep the Medicaid program afloat, which ended up, in part, causing the PROMESA issues that we face, but it was mostly on display after Hurricane Maria, the decline in the healthcare infrastructure there.

So I wanted to join Congresswoman Velázquez and the Puerto Rican Task Force to introduce legislation yesterday. I want to thank Governor Rosselló for his leadership and input in that legislation as well as our Commissioner, Jenniffer González-Colón. It would be a $15.1 billion bill with an 83 percent Federal match transition period of 4 years from 2020 to 2024, followed by a 10-year transition period after that. Obviously, a game changer.

And thank you again, both Chairwoman Eshoo and Chairman Pallone, for your consideration of this important legislation.

Ms. ESHOO. The gentleman yields back. It is a pleasure to recognize Mr. Walden, the ranking member of the full committee, for his 5 minutes for an opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Oh, good morning, Madam Chair. And good morning to our witnesses and those in the audience. Thank you for being here.

As the chairman of the committee mentioned, I led that CODEL, that congressional delegation trip to Puerto Rico and Virgin Islands, and it was a real eye-opener. And I know you all are still suffering, and in other places around the globe, from these terrible hurricanes. And we saw a hospital, as I recall it was in the Virgin Islands, that had to be shut down because of the mold and the water and the damage and, you know, we really appreciated your help, Stacey and others, in this effort. So we stand ready to do our part again. And today marks, I think, a really important step forward as we help you face these challenges in the territories.

We have the honor of having before this committee a representative from each of the U.S. territories' Medicaid programs, and we are really pleased that you are here because we need to hear directly from you about the challenges you face due to the coming funding cliff in September. I know some of you had to quite literally fly around the world to join us here today, so we thank you for that. I complain about my trip to the West Coast every week, and I know you are a long way past that, so I will quit complaining.

We are also pleased to have before us Anne Schwartz, the executive director of MACPAC. You and your team's work has been really helpful and invaluable over the years, so we are glad you could join us as well.

As we know, the additional funding for the territories that they have received over the last decade expires September 30th, and this could have detrimental effects for each of the five territories here today. These consequences are not lost on me. It is a commitment. We will work together in a bipartisan way to find a solution

that avoids this cliff and gets these programs on a more sustainable path.

Last Congress, under my leadership, this committee led a robust bipartisan response to the damage inflicted by the Hurricanes Maria, Harvey, and Irma. I led a bipartisan delegation to Puerto Rico and the U.S. Virgin Islands to see the devastation firsthand and hear from people on the ground. I was thankful then and am now to Representative González-Colón for her work and help on this important issue.

Among other visits, the healthcare facilities we saw on both islands were in dire conditions, not only because of the direct damage sustained during the storms, but also because of the sustained lack of power to the islands after those storms. It was also our committee that pushed for the 2 years, a hundred percent funding included in the Bipartisan Budget Act of 2018 to help respond to that crisis, and we are interested to know how that funding has helped in the recovery.

Included in the BBA was an incentive for both Puerto Rico and the Virgin Islands to draw down additional funds should those territories improve data reporting and program integrity measures, because we all care about those as well, conditions that both territories have met. That is good progress, but I would also like to hear from you both on what else we can do to improve program integrity as we look for ways to fund the existing shortfalls.

Another reason this hearing is so important is that we need you all to help differentiate your territories' specific needs. Too often in Congress you all get lumped together, and that is not fair and it is not right. But as each of your territories makes clear, we have five distinct programs with five distinct sets of challenges and program designs, and understanding those differences will be key. We know how critical this situation is, and we are very thankful to each of you for being here today and your willingness to work with us over the coming months, and I look forward to your testimony.

I mentioned the work of Representative González-Colón, who has joined us on the dais. She is attending today's hearing but cannot participate due to our committee rules. That is the tradition of the committee, but she does work us over pretty well all the time on these issues. And I would also recommend that any Member that has a question regarding the current circumstances in Puerto Rico work with her. There is no better way to understand the issue, and she is a fierce advocate for Puerto Rico.

We are also really pleased to welcome from American Samoa another terrific advocate, Representative Radewagen, who champions American Samoa. We are pleased to have her as well. And, of course, the gentlelady from the Virgin Islands too, who played host to us when we there and visiting. We are glad for her advocacy and help as well.

And, Madam Chair, with that we will get on about our business. Thank you for having this hearing. We look forward to working with you to a positive outcome, and I yield back.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Today marks an important step forward in our work to address the healthcare challenges faced by our territories.

We have the honor of having before this committee a representative from each of the U.S. territories' Medicaid programs. We are thrilled to have each of you here as we thought it imperative to hear directly from each of you about the challenges you face due to the coming funding cliff in September. I know some of you had to quite literally fly around the world to join us here today, so thank you. We are also pleased to have before us Anne Schwartz, the Executive Director of MACPAC. You and your team's work on the territories has been invaluable over the years, and we are so glad you are able to join us today.

As we know, the additional funding for the territories that they have received over the last decade expires September 30th, and this could have detrimental effects for each of the five territories here today. Those consequences are not lost on me. It is my commitment that we will work together, in a bipartisan way, to find a solution that avoids this cliff and gets these programs on a more sustainable path.

Last Congress, under my leadership, this committee led a robust bipartisan response to the damage inflicted by hurricanes Maria, Harvey, and Irma. I led a bipartisan delegation of Members to Puerto Rico and the U.S. Virgin Islands to see the devastation firsthand. I was thankful then and am thankful now to Rep. González-Colón for her work and help on this important issue. Among other visits, the heathcare facilities we saw on both islands were in dire conditions, not only because of the direct damage sustained during the storms, but also because of the sustained lack of power to the islands after the storms.

It was also our committee that pushed for the 2 years of 100% funding included in the Bipartisan Budget Act of 2018 to help respond to the crisis, and we are interested to know how that funding has helped the recovery. Included in the BBA was an incentive for both Puerto Rico and the Virgin Islands to draw down additional funds should those territories improve data reporting and program integrity measures, conditions that both territories met. That's good progress, but I would also like to hear from you both on what else we can do to improve program integrity as we look for ways to fund the existing shortfalls.

Another reason this hearing is so important is that we need you all to help differentiate your territories' specific needs. Too often in Congress you all get lumped together, but as each of your testimonies make clear, we have five distinct programs with five distinct sets of challenges and program designs. Understanding those differences will be key.

We know how critical this situation is, and we are very thankful to each of you for being here and for your willingness to work with us over the coming months. I look forward to your testimony.

I mentioned the work of Representative González-Colón. She is attending today's hearing today but cannot participate due to committee rules. I would recommend that any Member that has questions regarding the current circumstances in Puerto Rico talk with Ms. González-Colón. There is no better authority and no fiercer advocate for the people of Puerto Rico.

Thank you, and I yield back.

Ms. ESHOO. I thank the gentleman. He yields back. The Chair would now like to remind Members that, pursuant to committee rules, all Members' written opening statements shall be made part of the record.

I now would like to introduce the witnesses for today's hearing, thank them each and all again for being with us. First, Dr. Anne Schwartz, the executive director of Medicaid and CHIP Payment and Access Commission. Welcome to you.

Angela Avila, welcome to you. She is the executive director, Puerto Rico State Health Insurance Administration. Welcome and thank you to you.

Sandra King Young, the Medicaid director, American Samoa State Agency, welcome and thank you to you.

Maria Theresa Arcangel—what a beautiful name, Arcangel. We want all the committee members to be archangels, how is that?

[Laughter.]

Ms. ESHOO. She is the chief Human Service Program administrator, Division of Public Welfare, Guam Department of Public Health and Social Services, thank you to you.

And is it "Mi-hall"?

"Mi-cal"?

Ms. RHYMER-BROWNE. "Mi-cal."

Ms. ESHOO. Michal Rhymer-Browne, the assistant commissioner of the United States Virgin Islands Department of Human Service, Oversight of the Medicaid Division.

And last but not least, Helen Sablan, the Medicaid director, Commonwealth of the Northern Mariana Islands State Medicaid Agency.

So again, thank you, and welcome to each one of you. The Chair is going to recognize each witness for 5 minutes. The light on the—you see them, light boxes before you. When it turns red, stop. How is that? Just like on the road.

So let me begin with Dr. Schwartz. You are recognized for 5 minutes.

STATEMENTS OF ANNE L. SCHWARTZ, PH.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION; ANGELA AVILA, EXECUTIVE DIRECTOR, PUERTO RICO STATE HEALTH INSURANCE ADMINISTRATION; SANDRA KING YOUNG, AMERICAN SAMOA MEDICAID DIRECTOR; MARIA THERESA ARCANGEL, CHIEF HUMAN SERVICE ADMINISTRATOR, DIVISION OF PUBLIC WELFARE, GUAM DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES; MICHAL RHYMER-BROWNE, ASSISTANT COMMISSIONER, DEPARTMENT OF HUMAN SERVICES, U.S. VIRGIN ISLANDS; AND HELEN C. SABLAN, MEDICAID DIRECTOR, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

STATEMENT OF ANNE L. SCHWARTZ, Ph.D.

Dr. SCHWARTZ. Good morning, Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee. I appreciate the opportunity to share the MACPAC's work as this body considers the role of Medicaid and CHIP in the five U.S. territories.

As you know, MACPAC is an independent, nonpartisan advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of HHS, and the States on issues affecting these programs. The Commission's 17 members, including Chair Melanie Bella and Vice Chair Chuck Milligan, are appointed by the Comptroller General.

As in the States and DC, Medicaid and CHIP play a vital role in providing access to health services for low-income individuals in the territories. The challenges are similar to those in the States, populations with significant healthcare needs, an insufficient number of providers, and constraints on local resources. With some exceptions, the territories operate under similar Federal rules and are subject to oversight by CMS.

There is a somewhat tired old saying that, if you have seen one Medicaid program, you have seen one Medicaid program. This is because, despite common rules, State programs vary widely. For the purposes of the hearing today, it is important to note both that

territory Medicaid programs differ from the States and they also differ from each other. These differences reflect their unique geography, history, local economy, and health system infrastructure.

My written statement goes into detail as to how Medicaid operates in the territories, and if you are interested in even more information, MACPAC has published fact sheets describing each territory's program. But the most important point I wish to share today, one that has already been mentioned several times, is that Federal policy for financing Medicaid in the territories has led to chronic underfunding. This is because the policy differs from the States' in two key ways.

First, territorial Medicaid programs are constrained by a ceiling on Federal funding referred to as the section 1108 cap or allotment. Territories receive a relatively small amount funding each year regardless of changes in enrollment and use of the services. In comparison, states receive federal funding for each state dollar spent with no cap.

Second, the Federal Medical Assistance Percentage, the FMAP, or matching rate, is statutorily set at 55 percent. For the states, the FMAP provides higher reimbursement to those with lower per capita incomes relative to the national average and vice versa. This reflects States' differing abilities to generate local revenues to fund their Medicaid programs.

If the FMAPs for the territories were set using the formula used for the States, the matching rate for all 5 territories would be much higher, and in most cases the maximum of 83 percent. Congress has stepped in at multiple points with fiscal relief, most notably in 2010 as part of the Affordable Care Act, more recently in the aftermath of Hurricane Irma and Maria.

The Balanced Budget Act of 2018 provided Puerto Rico and the U.S. Virgin Islands with additional funds available at a 100 percent matching rate. Earlier this month, a disaster relief bill provided supplemental funds for the Commonwealth of the Northern Mariana Islands at a hundred percent FMAP through the end of this fiscal year, and it also allowed American Samoa and Guam to access the remaining ACA funds during this period at a hundred percent matching rate. As a result of these actions, all five territories should now have sufficient funding to cover program expenses through the end of fiscal year 2019. However, because all sources of supplemental fund will expire at the end of the calendar year, we anticipate that all five will experience funding shortfalls at some point in fiscal year 2020.

As the Commission noted in its analysis of Puerto Rico's Medicaid program in our recently issued report to Congress, the history of responding to crises with short-term infusions of funds has caused a great deal of uncertainty. An additional time-limited allotment of Federal funds would certainly prevent a fiscal cliff and would in the short term ensure the continued delivery of critical health services to eligible individuals. But it would not address the underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term reliable access for Medicaid beneficiaries residing in these jurisdictions.

Thank you for the opportunity to share MACPAC's analyses, and I am happy to answer any questions.

[The prepared statement of Dr. Schwartz follows:]

MACPAC | Medicaid and CHIP Payment and Access Commission

Statement of
Anne L. Schwartz, PhD, Executive Director

Medicaid and CHIP
Payment and Access Commission

Before the
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives

June 20, 2019

Medicaid and CHIP Payment
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Summary

Medicaid and CHIP play a vital role in providing access to health services for low-income individuals in the five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. The territories face similar issues to those in the states: populations with significant health care needs, an insufficient number of providers, and constraints on local resources. With some exceptions, they operate under similar federal rules and are subject to oversight by the Centers for Medicare & Medicaid Services.

However, the financing structure for Medicaid in the territories differs from state programs in two key respects. First, territorial Medicaid programs are constrained by an annual ceiling on federal financial participation, referred to as the Section 1108 cap or allotment (§1108(g) of the Social Security Act). Territories receive a set amount of federal funding each year regardless of changes in enrollment and use of services. In comparison, states receive federal matching funds for each state dollar spent with no cap.

Second, the federal medical assistance percentage (FMAP), often referred to as the matching rate, is statutorily set at 55 percent rather than being based on the territory's per capita income, as is the case with states. If it were set using the formula used for states, the matching rate for all five territories would be the maximum: 83 percent.

These two policies have resulted in chronic underfunding of the program in the territories, requiring Congress to step in at multiple points to provide additional resources. In addition to a substantial infusion of federal funds in 2010 under the Patient Protection and Affordable Care Act, the Balanced Budget Act of 2018 provided Puerto Rico and USVI with further funding available at a 100 percent FMAP until September 30, 2019. Earlier this month, enactment of the Additional Supplemental Appropriations for Disaster Relief Act of 2019 provided additional funds to CNMI at 100 percent FMAP through the end of this fiscal year (FY). It also allowed American Samoa and Guam to access their remaining ACA funds during this period at a 100 percent matching rate; these funds would otherwise have gone unspent given constraints on these territories' ability to provide the non-federal share.

All five territories should now have sufficient funding to cover program expenses through the remainder of FY 2019. However, because all sources of supplemental funds will expire in 2019, MACPAC anticipates that all five will experience federal funding shortfalls in FY 2020. The territories must consider how to proceed. Options include funding Medicaid entirely with unmatched local funds if available, cutting services, rolling back eligibility, reducing or suspending provider payments, or a combination thereof.

As Congress considers the pending shortfall, it is important to note that an additional infusion of federal funds would avert a fiscal cliff and ensure the continued delivery of critical health care services to eligible individuals in the short term. However, such action would not address underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term, reliable access to care for Medicaid beneficiaries residing in these jurisdictions.

Statement of Anne L. Schwartz, PhD, Executive Director Medicaid and CHIP Payment and Access Commission

Good morning Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee. I am Anne Schwartz, executive director of the Medicaid and CHIP Payment and Access Commission (MACPAC). As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing policies for Medicaid and the State Children's Health Insurance Program (CHIP) and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on issues affecting these programs. The Commission's 17 members, including Chair Melanie Bella and Vice Chair Chuck Milligan, are appointed by the U.S. Government Accountability Office (GAO). While the insights and information I will share this morning are based on analyses conducted by MACPAC's staff, they are in fact the views of the Commission itself. We appreciate the opportunity to share MACPAC's work as this body considers the role of Medicaid and CHIP in the five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands (USVI).

As in the states and the District of Columbia, Medicaid and CHIP play a vital role in providing access to health services for low-income individuals in the territories. The territories face similar issues to those in the states: populations with significant health care needs, an insufficient number of providers, and constraints on local resources. With some exceptions, they operate under similar federal rules and are subject to oversight by the Centers for Medicare & Medicaid Services (CMS).

However, the financing structure for Medicaid in the territories differs from state programs in two key respects. First, rather than having an open-ended financing structure, territorial Medicaid programs are constrained by an annual ceiling on federal financial participation, referred to as either the Section 1108 cap or Section 1108 allotment (§1108(g) of the Social Security Act (the Act)). This means that territories receive a set amount of federal funding each year regardless of changes in enrollment and use of services. In comparison, states receive federal matching funds for each state dollar spent with no cap.

Second, the federal medical assistance percentage (FMAP), often referred to as the matching rate, is statutorily set at 55 percent rather than being based on per capita income. If it were set using the formula used for states, the matching rate for all five territories would be the maximum: 83 percent.

These two policies have resulted in chronic underfunding of the program in the territories, requiring Congress to step in at multiple points to provide additional resources. In addition to a substantial infusion of federal funds in 2010 under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as

amended), the Balanced Budget Act of 2018 (BBA 2018, P.L. 115-123) provided Puerto Rico and USVI with further funding available at a 100 percent FMAP until September 30, 2019. Earlier this month, enactment of the Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L.116-20) provided additional funds to CNMI at 100 percent FMAP through the end of this fiscal year (FY). It also allowed American Samoa and Guam to access their remaining ACA funds during this period at a 100 percent matching rate; these funds would otherwise have gone unspent given constraints on these territories' ability to provide the non-federal share.

MACPAC's most recent estimates suggest that all five territories should now have sufficient funding to cover program expenses through the end of FY 2019. However, because all sources of supplemental funds will expire in 2019, MACPAC anticipates that all five will experience federal funding shortfalls in FY 2020.

In the face of such a shortfall, the territories must consider how to proceed. Options include funding Medicaid entirely with unmatched local funds if available, cutting services, rolling back eligibility, reducing or suspending provider payments, or a combination thereof. The specific date of funding exhaustion in each territory will depend on actual spending.

As the Commission noted in its analysis of Puerto Rico's Medicaid program in its June 2019 report to Congress, the history of responding to crises with short-term infusions of funds has caused a great deal of uncertainty. Although an additional time-limited allotment of federal funds would prevent a fiscal cliff and ensure the continued delivery of critical health care services to eligible individuals in the short term, it would not address the underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term, reliable access to care for Medicaid beneficiaries residing in these jurisdictions (MACPAC 2019d).

Below I describe how Medicaid operates in the territories, focusing on policies related to eligibility and enrollment, benefits, delivery system, data and reporting, quality and program integrity, and financing. It is important to note that while territory Medicaid programs differ from the states, they also differ from each other, reflecting their unique geography, history, local economy, and health system infrastructure.

My testimony then turns to spending patterns and MACPAC's latest estimates as to when territories will exhaust current supplemental sources of federal funding.

How Medicaid Operates in the Territories

Under the Social Security Act, the territories are considered states for the purposes of Medicaid and CHIP, unless otherwise indicated (§1101(a)(1) of the Act). Two territories, CNMI and American Samoa, operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them. This provision allows the HHS Secretary to waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the FMAP, and the requirement that payment can only be for services otherwise coverable by Medicaid. It is also important to note that while neither provides all of Medicaid's mandatory benefits, these territories are considered in compliance with federal Medicaid law.

Eligibility and enrollment

All five territories are permitted to establish income-based eligibility using a measure other than the federal poverty level (FPL). Guam, Puerto Rico, and USVI use local poverty levels to establish eligibility, which are updated by an amendment to the Medicaid state plan. These three territories are also statutorily exempt from providing Medicaid coverage to certain mandatory groups including poverty-related children and pregnant women and qualified Medicare beneficiaries (§§1902(l)(4)(B) and 1905(p)(4)(A) of the Act). American Samoa and CNMI are exempt from these requirements under their 1902(j) waivers.

American Samoa and CNMI use unique methods to establish income-based eligibility. In American Samoa, Medicaid eligibility is not determined on an individual basis and individuals do not enroll in Medicaid or CHIP as they do in all other territories and states. Instead, federal Medicaid and CHIP funds pay for care provided in the territory in proportion to the population of American Samoans with incomes that would

have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent FPL (CMS 2014). CNMI, the only territory participating in Supplemental Security Income (SSI), uses SSI income and asset standards to determine Medicaid eligibility (CMS 2016a).

Guam, Puerto Rico, and USVI have elected to expand their Medicaid programs to the new adult group up to 133 percent of the local poverty level (CMS 2016a).

All five territories operate Medicaid-expansion CHIP programs (CMS 2015). Puerto Rico is the only territory that uses its CHIP funds to cover additional children whose income levels exceed regular Medicaid eligibility levels. The other four territories use their CHIP funds to pay for services provided to children under age 19 in their Medicaid programs and can access CHIP's enhanced FMAP for these individuals (CMS 2016a).

Territories vary widely in the percentage of their populations covered by Medicaid or CHIP due to differences in eligibility standards and methodologies, as well as differences in economic conditions (Table 1).

TABLE 1. Medicaid and CHIP Enrollment as a Share of the Population, August 2017

Territory	Number of enrollees	Approximate percentage of population enrolled in Medicaid or CHIP
American Samoa	41,214	79 %
CNMI	15,472	33
Guam	35,559	21
Puerto Rico	1,232,367	37
USVI	17,552	16

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Enrollment figures for American Samoa are estimates of the portion of the population below 200 percent of the federal poverty level, the population for which Medicaid pays for health care services. American Samoa does not make individual eligibility determinations and does not have an enrolled population. Enrollment figures for Puerto Rico include 85,188 children enrolled in CHIP as reported by Puerto Rico for September 2017.
Sources: CMS 2018b. Departamento de Salud 2019. MACPAC analysis of population data estimates from the 2017 American Community Survey and Central Intelligence Agency World Factbook as of October 2017.

Benefits

Medicaid benefits vary across territories. American Samoa and CNMI are not required to offer mandatory Medicaid benefits under their Section 1902(j) waivers. Guam, Puerto Rico, and USVI are required to offer all mandatory benefits, but currently Guam is the only territory to do so. For example, USVI does not cover freestanding birth center or rural health clinic services; Puerto Rico does not cover non-emergency medical transportation or nursing facility services, citing lack of infrastructure and funding (GAO 2016).

In all territories, individuals under age 21 are eligible to receive early and periodic screening, diagnostic, and treatment services (EPSDT) (GAO 2016, CMS 2016e).[1] Additionally, all territories provide some optional benefits. For example, all territories cover prescription drugs, clinic services, dental services, and eyeglasses.[2]

In all five territories, Medicaid offers some form of cost-sharing assistance for Medicare enrollees who are also eligible for full Medicaid benefits (CMS 2016b). Medicaid programs in American Samoa, Guam, CNMI, and USVI pay Medicare Part B premiums for dually eligible individuals (CMS 2016e). Puerto Rico pays premiums and cost sharing for Medicare Platino plans, a type of Medicare Advantage special needs plan that includes Medicare Part A and B services as well as outpatient prescription drugs. Almost all dually eligible Puerto Ricans are enrolled in Medicare Platino (CMS 2013).

The Medicare Savings Programs, which provide cost sharing assistance to individuals who would qualify as partially dually eligible individuals in the states, are not available in the territories.[3] Similarly, Medicare Part D plans are not available in the territories, but territorial Medicaid programs typically provide prescription drugs to dually eligible beneficiaries. To offset the cost of doing so, territories each receive an additional allotment from the Enhanced Allotment Plan, also referred to as 1935(e) funding. This allotment is separate from the Section 1108 allotment and can only be used to help pay for prescription drugs for low-income beneficiaries (§1935(e) of the Act).[4]

Delivery system

Puerto Rico is currently the only territory to use managed care, in which the entire Medicaid population is enrolled. Managed care organizations (MCOs) provide commonwealth-wide acute, primary, specialty, and behavioral health services. They are paid risk-based capitated payments. MCOs contract with primary medical groups, which in turn create preferred provider networks (PPNs). Enrollees are auto-assigned to a

health plan but may switch once per year, and do not need referrals for specialists in their PPN (MACPAC 2019d).

The Medicaid programs in the other four territories operate on a fee-for-service basis. In American Samoa, Guam, and CNMI, most Medicaid services are provided by one hospital that is owned and operated by the territory. In recent years, these territories have expanded the availability of services at other locations and increased provision of off-island services when medically necessary or when services are not available in the territory (CMS 2016a, MACPAC 2019a-c).

The territories do not receive a Medicaid disproportionate share hospital (DSH) allotment and therefore do not make DSH payments to hospitals (§1923(f)(9) of the Act).

Data and reporting

Like states, the territories report Medicaid and CHIP budget projections using Form CMS-37 and provide data on enrollment and spending (both aggregate and by category) using Form CMS-64. The territories are not required to report expenditures in excess of their federal limits, although, in general, they report all of their spending (CMS 2016e).

Under their Section 1902(j) waivers, American Samoa and CNMI are exempt from all data and reporting requirements. Additionally, none of the territories are considered states for the purpose of required quarterly reporting of statistical and program expenditure data for CHIP (42 CFR 457.740). Due to administrative capacity constraints, American Samoa, Guam, and Puerto Rico are unable to report all of the same data as states even when they are not statutorily exempt. For example, CMS does not collect EPSDT service data via Form CMS-416 from any of the territories, or data on upper payment limit (UPL) payments for any of the territories except Guam (CMS 2016d).

Use of the Medicaid Management Information System (MMIS), which states typically use for processing claims, has been limited among the territories but is changing. Puerto Rico and USVI now both have a fully operational MMIS certified to report data to the CMS Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS is the primary administrative data set used for Medicaid program oversight and accountability, and includes data on eligibility, enrollment, utilization, and spending. USVI implemented its MMIS in partnership with West Virginia (GAO 2015). For the purposes of developing an MMIS, territories can access federal Medicaid funds that do not apply toward their annual Section 1108 allotments at a 90 percent federal match (CMS 2016c).

The Bipartisan Budget Act of 2018 conditioned a portion of the additional funds it provided to Puerto Rico and USVI on their making improvements to data reporting and program integrity capacity. The territories were required to take reasonable and appropriate steps, as certified by and on a timeline specified by the Secretary, toward establishing methods of collecting and reporting reliable data to T-MSIS and establishing a Medicaid fraud control unit (MFCU). Both Puerto Rico and USVI met their targets on schedule and will receive the full amount of BBA 2018 funds (CMS 2018c). Similarly, under the recent disaster relief legislation, P.L. 116-20, American Samoa and Guam must each submit a plan by September 30, 2019 that describes the steps they will take to collect and report reliable data to T-MSIS.

Quality measurement and program integrity

Territories are not required to participate in many of the quality and program integrity efforts that apply to states. CNMI and American Samoa are exempt from these requirements through their 1902(j) waivers. Puerto Rico, USVI, and Guam are statutorily exempt from the Payment Error Rate Measurement (PERM) program, from facing repayments under the Medicaid Eligibility Quality Control program (MEQC), and are not required to implement asset verification systems with financial institutions (42 CFR 431.954, and§§1903(u)(4) and 1940(a)(4) of the Act).

Some territories have implemented provider screening, as well as provisions related to non-payment for health care acquired and provider preventable conditions. Puerto Rico, whose entire Medicaid population is enrolled in managed care, requires quality reporting in its managed care contracts (CMS 2016e). It further

increased expectations for plans' quality and program integrity responsibilities in its most recent managed care restructuring, implemented in 2018 (MACPAC 2019d).

Puerto Rico and USVI established MFCUs in 2018 and 2019, respectively (CMS 2018c). Guam is also required to establish a MFCU but has not yet done so. Expenditures for establishing an MFCU do not count toward the Section 1108 allotment.

Financing

As noted above, the federal and territorial governments jointly finance Medicaid. Each territory must contribute its non-federal share of Medicaid spending in order to access federal dollars. Non-federal share is matched at the designated FMAP, which is statutorily set for most expenditures at 55 percent. Unlike the states and the District of Columbia, for which federal Medicaid spending is open ended, the territories can only access federal dollars up to the annual Section 1108 allotment.

Federal funding sources and amounts. The territories' Section 1108 allotments are specified in statute, and grow with the medical component of the Consumer Price Index for All Urban Consumers (CPI-U) (§1108(g)). The territories' CHIP allotments are determined by CMS based on prior year spending, the same methodology used for states.

Historically, the amount of Section 1108 allotment funding has been insufficient to fund Medicaid in the territories. In general, once a territory exhausts its annual federal Medicaid and CHIP allotments, it must fund its program with local funds. However, Congress has provided additional federal Medicaid funds on a temporary basis to the territories on multiple occasions. For example, the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) raised each territory's annual allotment by 30 percent for the period between October 1, 2009 and June 30, 2011 (§5001(d) of ARRA).

The ACA also provided the territories with additional federal funding for their Medicaid programs. Under Section 2005, $6.3 billion was to be allocated by the Secretary and made available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $1 billion to the territories, $925 million of which was directed to Puerto Rico and the remainder of which was allocated by the

Secretary. These funds are available to be drawn down between January 2014 and December 2019. In total, this additional funding ranged from $109.2 million for CNMI to $6.3 billion for Puerto Rico (CMS 2016a).

The territories have all accessed these supplemental funds, but have done so at different rates, reflecting differences in the structure of their programs and availability of funds to provide the non-federal share. Puerto Rico and CNMI drew down their allotments more quickly than other territories, with Puerto Rico facing imminent funding shortfalls in FY 2017 and 2018, and CNMI experiencing a gap in federal Medicaid funds in March 2019.

In subsequent legislation, Congress provided further additional funds for certain territories, which are available through September 30, 2019. These additional appropriations were made to address the shortfalls in Puerto Rico and CNMI noted above, and to respond to natural disasters affecting all five territories in 2017, 2018, and 2019. Funding was provided as follows:

- The Consolidated Appropriations Act of 2017 (P.L. 115-31) provided Puerto Rico with an additional $295.9 million.

- BBA 2018 (P.L. 115-123) provided Puerto Rico with an additional $4.8 billion and USVI with an additional $142.5 million in federal Medicaid funds in response to the impact of Hurricane Maria on those territories health systems.
- The Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L. 116-20) provided CNMI with an additional $36 million (Table 2).

TABLE 2. Sources of Federal Medicaid Funding for Territories and Periods of Funding Availability

Territory	FY 2019 § 1108 allotment	ACA			P.L. 115-31	BBA 2018	P.L. 116-20
		§ 2005	§ 1323	Total ACA funds			
	Grows annually with CPI-U	July 2011-September 2019	January 2014–December 2019	July 2011–September or December 2019	May 2017–September 30 2019	FYs 2018 and 2019	January 1 2019–September 30 2019
American Samoa	$12.15 million	$181.31 million	$16.51 million	197.82 million	None	None	None
CNMI	$6.70 million	$100.14 million	$9.11 million	$109.25 million	None	None	$36 million
Guam	$17.97 million	$268.34 million	$24.44 million	$292.78 million	None	None	None
Puerto Rico	$366.70 million	$5.48 billion	$925.00 million	$6.40 billion	$295.9 million	$4.8 billion	None
USVI	$18.33 million	$273.82 million	$24.93 million	$298.75 million	None	$142.5 million	None

Notes: § 1108 allotment reflects the annual federal allotments (or caps) for federal funds that territories receive under Section 1108(g) of the Social Security Act. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-142, as amended). BBA 2018 is the Bipartisan Budget Act of 2018 (P.L. 115-123). CPI-U is the consumer price index for all urban consumers. FY is fiscal year. CNMI is the Commonwealth of the Northern Mariana Islands. P.L. 115-31 is the Consolidated Appropriations Act of 2017. P.L. 116-20 is the Additional Supplemental Appropriations for Disaster Relief Act of 2019. USVI is the U.S. Virgin Islands.
Sources: CMS 2019b; MACPAC analysis of the ACA. BBA, P.L. 115-31, and P.L. 116-20.

Once the available funds expire or are exhausted, territories generally will not be able to spend federal dollars beyond their respective allotments for Medicaid and CHIP.[5]

Federal medical assistance percentage. The FMAP for the territories is set statutorily at 55 percent, unlike those for states which are set using a formula based on states' per capita incomes (§1905(b) of the Act). For the states, the FMAP provides higher reimbursement to those with lower per capita incomes relative to the national average and vice versa, and is intended to reflect states' differing abilities to fund Medicaid from their own revenues. The FMAP for states has a statutory minimum of 50 percent and a maximum of 83 percent.

There are several exceptions to the 55 percent FMAP. The territories' CHIP enhanced FMAP is 91.5 percent (§2101(a) of the ACA; MACPAC 2015a). Like the states, the matching rate for almost all program administration is set at 50 percent (§1903(a)(7) of the Act).

While the territories cannot claim the higher FMAP for covering the ACA's new adult group, they were eligible for a temporary 2.2 percentage point increase in their regular FMAP for all state plan populations between January 1, 2014 and December 31, 2015 (§§1905(y)(1) and 1905(z)(1)(A) of the Act) (CMS 2016b). This raised their FMAPs to 57.2 percent during this period. Additionally, territories are eligible for the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the ACA, which is 93 percent in calendar year 2019 (§1905(z)(2) of the Act). Currently, only Guam, Puerto Rico, and USVI are accessing this early expansion FMAP.[6]

In general, territories must contribute a non-federal share at the applicable matching rate in order to gain access to federal funds. However, Congress made some of the territories' supplemental appropriations available at a 100 percent matching rate, including:

- funds provided for Puerto Rico and USVI under BBA 2018;
- ACA Section 2005 funds expended by American Samoa and Guam between January 1, 2019 and September 30, 2019; and,
- funds provided to CNMI under the recent disaster relief bill.

Sources of the non-federal share. The territories fund the non-federal share of their Medicaid and CHIP programs through general fund revenues and certified public expenditures. Puerto Rico, USVI, and Guam primarily operate using general funds, American Samoa primarily uses certified public expenditures, and CNMI uses a combination (CMS 2016e).

Once they reach their annual cap, territories must cover any additional Medicaid expenses entirely with unmatched territorial or local funds. Historically, this has resulted in FMAPs that are effectively lower than 55 percent. For example, at times, the effective federal contribution for Puerto Rico has been 20 percent or lower (Muñoz et al. 2011, Acevedo-Vilá 2005).

Spending

In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. For American Samoa, CNMI, and Guam, this spending reflects the use of the additional funds available under Sections 2005 and 1323 of the ACA. For Puerto Rico and USVI, it primarily reflects use of BBA 2018 funds. In FY 2019, federal spending over the annual Section 1108 allotment amount is likely to

increase, because all five territories will have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds.

Spending in Puerto Rico accounts for the vast majority of federal Medicaid and CHIP spending in the territories, primarily due to its significantly larger covered population. In FY 2018, federal Medicaid spending in all five territories totaled $2.46 billion, with $2.29 billion (93 percent) attributable to Puerto Rico. Federal CHIP funding totaled $229.6 million, with $173.4 million (76 percent) attributable to Puerto Rico (Table 3).

TABLE 3. Medicaid and CHIP Funding and Spending in the Territories, FY 2018 (millions)

Territory	Medicaid			CHIP		
	§ 1108 allotment	Spending		Federal allotment	Spending	
		Federal	Territory		Federal	Territory
American Samoa	$11.9	$20.1	$15.3	$3.1	$4.6	$0.2
CNMI	6.6	25.0	20.0	7.1	10.6	0.8
Guam	17.6	56.3	29.5	28.1	30.6	2.6
Puerto Rico	359.5	2,290.5	203.0	203.8	173.4	16.1
USVI	17.87	70.0	7.0	7.3	10.4	1.0

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. USVI is the U.S. Virgin Islands. § 1108 allotment reflects the annual federal allotments (or caps) that territories receive under Section 1108(g) of the Social Security Act, while the actual federal spending reflects utilization of the additional allotments provided by the ACA and BBA 2018 as well as spending not subject to the cap on federal financial participation. Federal CHIP allotments are provided under Section 2104 of the Social Security Act. If states and territories exhaust their own available CHIP allotments, they may receive additional funding from unused state CHIP allotments. American Samoa, CNMI, Guam, and USVI received these redistributed funds in FY 2018.
Sources: CMS 2018c; MACPAC 2018b; MACPAC 2019 analysis of CMS-64 financial management report net expenditure data as of March 27, 2019; MACPAC 2018 analysis of American Samoa, CNMI, and Guam Medicaid program expenditure narrative reports.

Exhaustion of Federal Medicaid Funds

Because annual Section 1108 funds have been historically inadequate to cover the federal share of Medicaid spending, all five territories have relied on supplemental funds since 2011. However, as noted above, all sources of supplemental funds will expire in 2019, and MACPAC anticipates federal funding shortfalls in all five territories in FY 2020. The specific date of funding exhaustion in each territory will depend on the extent to which actual spending matches projections, and the amount of unspent funds available (Table 4).

TABLE 4. Date of Expected Federal Medicaid Funding Shortfall by Territory

Territory	Date range for shortfall
American Samoa	July–September 2020
CNMI	April–June 2020
Guam	April–June 2020
Puerto Rico	March 2020
USVI	January–March 2020

Notes: CNMI is the Commonwealth of the Northern Mariana Islands. USVI is the U.S. Virgin Islands. Date range indicates the timeframe in which the territories will exhaust available federal funds. Sufficient funds may not be available for the entirety of the timeframe, as territories may exhaust available funds earlier or later in the period depending on actual spending and other specific circumstances.
Sources: MACPAC 2019 analysis of CMS 2019a, b; CMS-37 projections of spending for FYs 2019–2020 submitted in May 2019.

Additionally, having sufficient federal funding available to cover Medicaid spending at the 55 percent FMAP does not necessarily indicate that all health needs will be met; several territories have struggled to generate the non-federal share needed to draw down federal funds. At times, lack of local funds, rather than federal funds, has caused territories to suspend payments to providers or deny services. For example, in the territories relying on a single hospital that provide the local share through certified public expenditures, that hospital's physical capacity to provide services limits expenditures and thus the amount of non-federal share that can be raised. Furthermore, certified public expenditures cannot be used to provide the non-federal share for services provided outside the hospital, which include costly off-island services for individuals with complex health care needs (King Young 2019). Difficulty generating non-federal share has been a key barrier to American Samoa's ability to draw down federal dollars (CMS 2018a).

Endnotes

[1] While all territories technically provide the EPSDT benefit under the state plan, there are instances of limitations on the benefit. For example, a report by the 2011 President's Task Force on Puerto Rico's Status found that the children in Puerto Rico's Medicaid program only received limited benefits through EPSDT (Muñoz et al. 2011).

[2] Historically, territories were not included in the Medicaid drug rebate program but may have received territorial government-mandated price concessions and other discounts. Effective April 1 2020, territories will be included in the Medicaid drug rebate program but may request a waiver to opt out (CMS 2016d).

[3] Unlike the states, the territories are not required to establish Medicare Savings Programs (§ 1905(p)(4)(A) of the Act).

[4] Individuals in the territories are not eligible for the Medicare Part D Low-Income Subsidy (§1935(e)(1)(A) of the Act).

[5] Federal funds for the Enhanced Allotment Plan, electronic health record incentive program payments, and the establishment and operation of eligibility systems, Medicaid Management Information Systems (MMIS), and—beginning on July 1, 2017 for Puerto Rico and January 1, 2018 for USVI—Medicaid fraud control units do not apply toward the annual Section 1108 allotment.

[6] Because of these exceptions to the FMAP, the overall federal share of spending can be higher than 55 percent. For example, in FY 2017, federal spending covered 66.4 percent of total spending in Puerto Rico (MACPAC 2019d).

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Ms. ESHOO. Thank you, Dr. Schwartz.

I would just like to take a moment to welcome to our hearing—I saw her come in the door—our colleague, Congresswoman Nydia Velázquez. Thank you for being here, and thank you for the legislation that you have authored and was dropped yesterday. I see Congresswoman Stacey Plaskett here, and I want to recognize her and thank her for her presence. And I also want to recognize Congressman Sablan from the Northern Mariana Islands for joining us. And if someone comes and takes that seat, you take another one.

Nydia, would you like to come up and join us too? OK, hold onto that seat then. OK. But we are glad that you are here, and you are always welcome. It is an honor to have each one of you here.

I now would like to recognize Ms. Avila. You are recognized for 5 minutes for your testimony.

STATEMENT OF ANGELA AVILA

Ms. AVILA. Good morning, Mrs. Chairman Eshoo, Mr. Chairman Pallone, Ranking Member Walden, and Mr. Ranking Member Burgess, and members of the committee. Thank you for the opportunity to testify today on Puerto Rico's healthcare system. I am honored to be here on behalf of the Government of Puerto Rico and to be joined at the witness table with colleagues from the other territories.

Puerto Rico's Medicaid program serves approximately 1.5 million people, nearly half of the total population and some of our Nation's most vulnerable citizens. We serve approximately 425,000 children, 305,000 elderly and disabled, and more than 17,000 pregnant women at any given time. Our beneficiaries are served by a network of thousands of healthcare providers such as doctors, nurses, and health technicians, 64 hospitals, 20 federally qualified health centers, and 900 pharmacists.

Puerto Rico's Medicaid system has been chronically underfunded due to a historically low Federal Medicare Assistance Percentage, known as FMAP, a correspondingly high local matching requirement, and the cap on Federal funding. Currently, we are operating under increased Medicaid funding and temporary 100 percent FMAP through the Bipartisan Budget Act of 2018, or BBA, which we received in the aftermath of Hurricane Maria, the worst natural disaster in our Nation's history.

It is only through this additional Federal funding and the increased FMAP provided in the BBA that Puerto Rico has been able to sustain its healthcare system. We thank the members of this committee who worked to ensure Puerto Rico had received the necessary funding. We have made great progress in our program since the devastating hurricanes, thanks to the BBA. However, all that progress is in jeopardy due to the uncertainty of no additional Federal funding.

With the upcoming expiration of the BBA on September 30, the increased Medicaid funding and the temporary 100 percent FMAP Puerto Rico received through the BBA will expire. If no action is taken for fiscal year 2020, the FMAP will revert to the statutorily mandated 55 percent FMAP up to the Federal Medicaid funding cap of approximately 380 million.

This will result in effective Federal matching, including remaining ACA funds, of 30 percent for the program in fiscal year 2020 and 13 percent in fiscal year 2021. Once this funding is exhausted, Puerto Rico will 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, this level of local funding is not an option.

Unless Congress acts, we will be faced with potentially catastrophic damage to our Medicaid program. We will be forced to potentially remove any services that are not required under Medicaid rules, such as pharmacy coverage and dental coverage that are already limited. We may have to end coverage for the current population who receive healthcare with local funds, and we will continue to lose more of our Medicare providers because of low reimbursement rates.

Last month, Governor Rosselló submitted Puerto Rico's official Medicaid ask to Congress, 5 years of funding at an 83 percent FMAP for a total of 15.1 billion in funding. This funding will provide Puerto Rico with stability in the short term while we work together on a sustainable, long-term funding mechanism. The short-term, critical sustainability measures needed to stabilize the healthcare system in Puerto Rico are keeping physicians within the system to avoid critical shortages, providing lifesaving Hep C drugs, adjusting the Puerto Rico poverty level to increase fairness in Medicaid eligibility, and providing Medicare Part B premium assistance.

The Medicaid cliff that Puerto Rico is facing is an emergency that must be dealt with urgently. I love my island, and it is my home and I am committed to working with Congress to create the Medicaid program that all of us can be proud of. Thank you for the opportunity to meet these urgent matters, and I welcome any questions you may have. Thank you.

[The prepared statement of Ms. Avila follows:]

GOBIERNO DE PUERTO RICO
Administración de Seguros de Salud

Hon. Ricardo A. Rosselló Nevares
Gobernador

Sra. Ángela M. Ávila Marrero
Directora Ejecutiva

Statement of Angela Avila
Executive Director
Puerto Rico State Health Insurance Administration/Administración De Seguros De Salud
U.S. House of Representatives Committee on Energy and Commerce
Oversight Hearing: "Strengthening Health Care in the U.S. Territories for Today and Into the Future"
Thursday, June 20th at 10:30 A.M. – 2322 Rayburn House Office Building

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Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo, Ranking Member Burgess, and Members of the Committee:

Thank you for the opportunity to testify today on Puerto Rico's healthcare system, and how we can work together to strengthen it to better serve the nearly 3.2 million U.S. citizens who call Puerto Rico their home. I am honored to be here on behalf of the Government of Puerto Rico and to be joined at the witness table with my colleagues from the other territories. We are united in our need for sustained federal funding for our healthcare systems so that we can provide adequate healthcare to our people.

While we are here today to discuss ways Congress can strengthen healthcare in the U.S. territories, in Puerto Rico, the looming threat to our healthcare system is the impending Medicaid funding cliff and the significant and detrimental impact this cliff will have if Congress fails to act. Puerto Rico's Medicaid program serves approximately 1.5 million people, nearly half of the Puerto Rico's population, including 425,000 children, 305,000 elderly and disabled individuals, and more than 17,000 pregnant women at any given time. The population we serve makes Puerto Rico's Medicaid and CHIP program the 15th largest in the United States, ranked by enrollment.[1] Our

[1] Based on CMS February 2019 enrollment data. https://data.medicaid.gov/Enrollment/2019-02-Updated-applications-eligibility-determina/7gzq-etgt/data

beneficiaries are served by over 5,000 doctors, 64 hospitals, 20 federally qualified health centers, 900 community pharmacies, and thousands of healthcare professionals such as nurses and health technicians who dedicate much of their time to take care of Medicaid patients. The large proportion of the population that receives healthcare benefits through Medicaid makes the Program a key pillar of the Puerto Rico's overall healthcare system.

As this Committee is well-aware, in just a few short months, on September 30th of this year, the increased Medicaid funding and the temporary 100% Federal Medical Assistance Percentage (FMAP) Puerto Rico received in the aftermath of Hurricane Maria through the Bipartisan Budget Act of 2018, P.L. 115-123, (BBA) will expire. It is only through this additional federal funding and the 100% FMAP provided in the BBA, that Puerto Rico has been able to sustain its healthcare system. We thank the Members of this Committee who worked to ensure Puerto Rico received this necessary funding and the 100% FMAP. The FMAP permitted Puerto Rico to maintain the continuity of the program without having to rely on limited State funds during the emergency period. Additionally, the BBA allowed Puerto Rico to launch a new managed care model, strengthen program oversight, add new HIV prescription drugs to the formulary[2], and work towards the first dental reimbursement rate increase in 25 years.

We have made great progress in our program since the devastating hurricanes, thanks to the BBA, however; all that progress is in jeopardy due to the uncertainty of no additional federal funding.

[2] Trograrzo, Jaluca, and Biktarvy were added to the prescription drug coverage in December 2018.

Supplemental Federal Funding Background

The two main financing mechanisms for Puerto Rico's Medicaid program has been the section 1108[3] capped funds and supplementary increases to this funding from American Recovery and Reconstruction Act (ARRA)[4], Affordable Care Act (ACA)[5], Consolidated Appropriations Act of 2017[6], and the Bipartisan Budget Act of 2018[7]. Over the last decade, Puerto Rico has taken advantage of the additional federal funding by further complying with mandatory Medicaid benefits, expanding income eligibility thresholds through ACA expansion, improving its managed care model and strengthening program integrity and IT infrastructure. However, over this time, increased medical trends, aging population demographics, and large increases in prescription drug costs have consumed a significant portion of the additional funding provided to Puerto Rico. While these issues affect Medicaid programs in all States, they enjoy the guarantee of unlimited federal funding at the appropriate federal matching percentage (calculated based on income per capita in each State), which Puerto Rico is currently excluded from. While States have been able to deal with these challenges in great measure because of the flexibility of their financing, Puerto Rico has been forced to forego long-term planning for its Medicaid program aimed to improve outcomes and strengthen its healthcare system. Because of this, it has had to focus on short-term fiscal measures to comply with statutory budget constraints and federal requirements. For example, Puerto Rico has had to limit provider reimbursement increases, reduce administration margin for

[3] 42 U.S.C. 1308.
[4] P.L. 111-5.
[5] P.L. 111-48.
[6] P.L. 115-31.
[7] P.L. 115-123.

Managed Care Organizations (MCOs), not provide all mandatory Medicaid benefits, and been forced to not cover lifesaving drugs because it is unable to leverage federal financing.

The result of the historical piecemeal financing for Puerto Rico is a weakened healthcare system, inadequate reimbursement rates, provider shortages, and limited access to care for some of the most vulnerable residents of the island, such as children and elderly Medicaid and Medicare dual eligibles.

Effect of Hurricanes on Healthcare

The catastrophe of Hurricanes Irma and Maria in September 2017 and their effect on the Puerto Rico healthcare infrastructure, particularly hospitals, was exacerbated by years of limited healthcare financing. Due to low reimbursement rates our facilities were forced to make fiscal decisions, such as closing hospital wings, aimed at short-term cost containment, rather than investments that could prepare for such disasters. These facilities are still recovering from the hurricanes and still face the same difficult choices because they do not have any certainty that reimbursement rates will increase to levels that would compensate for their investment. Additionally, many providers have made the difficult decision to leave Puerto Rico to move to the States in search of better salaries, benefits, and practice conditions.

Having a limited healthcare infrastructure and workforce also made recovery from the hurricanes difficult, as evidenced by the brigades of medical professionals that came to aid the American citizens of Puerto Rico. If Puerto Rico had been able to provide its healthcare workers with adequate reimbursement rates, it may have been better able to cope with the disasters and its immediate effects. Notably, a significant number of deaths in the aftermath of the hurricanes were

elderly American citizens that were unable to care for themselves during the emergency. If Puerto Rico had adequate funding to provide home health and nursing care facility services for Medicaid beneficiaries, which it is currently unable to provide, many of these deaths could have been avoided. Thus, the biggest challenge that Puerto Rico continues to face in its recovery is the lack of funding to make improvements to its healthcare infrastructure to better care for patients, retain and attract healthcare providers, and make available the services that our population desperately needs.

Puerto Rico Medicaid Funding Request

On May 1, 2019, 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% FMAP for five years in order to prevent the collapse of the healthcare system.[8] The request would provide certainty in the short term while Congress works with the Government of Puerto Rico to determine a sustainable, long-term funding mechanism that eliminates the statutory inequity and allows us to meet the healthcare needs of our most vulnerable residents. The 83% FMAP – which is the matching rate that would be available to Puerto Rico under the statutory formula applied to the States – is necessary to access the increased federal funding given the shortage of local funds.

This funding certainty and stability for Puerto Rico's Medicaid program would also allow for responsible long-term budget planning and strategizing between the Government of Puerto

[8]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.

Rico and the FOMB. 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. For example, primary care physicians are paid only 19% of the Puerto Rico Medicare fee.[9] 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 the Sates's Medicaid system, currently, Puerto Rico's Medicaid system does not cover Hepatitis-C virus treatments, including those that are capable of curing the condition, even though 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 in the long term (approximately five years) by investing in treatments which would avoid costly hospitalizations, dialysis, complications due to cirrhosis, and care to support organ-transplanted patients, not to mention the avoidance of the psychological and emotional toll of undergoing such physical deterioration. The provision of Hepatitis C treatments is a perfect illustration of how providing certainty of funding can allow Puerto Rico to better maximize its available resources to bring about long-term savings as well as improvements to the overall health of the population.

[9] MACPAC June 2019 Report to Congress.

- **Prevent collapse of hospital system due to losses** – According to the latest Centers for Medicare and Medicaid Services (CMS) cost reports, over 50% of Puerto Rico's hospitals reported losses. Because Medicaid covers over half of the population in Puerto Rico 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, beneficiaries pay Part B premiums directly through Social Security check deductions, which for most recipients is their sole source of income. Since premiums can be as high as $135.50 per month, some elderly residents must choose between food, rent and healthcare. This is a choice only American citizens in Puerto Rico are forced to make, as it is a covered Medicaid benefit in the States.

- **Adjust the Puerto Rico Poverty Level to increase fairness in Medicaid eligibility** – Due to the disproportionately low level of federal Medicaid funding, Puerto Rico has been forced to limit Medicaid eligibility to income levels well below the Federal Poverty Level (FPL). The Puerto Rico Poverty Level (PRPL) is less than 50% of the FPL. For example, Puerto Rico covers individuals with income up to 138 percent of the PRPL, which is $11,736 annually for a family of four or approximately 46 percent of the FPL for a family

of the same size in 2019 on the mainland. As a result, a significant percentage of vulnerable families and individuals in Puerto Rico lack healthcare coverage.

Currently, Puerto Rico covers approximately 120,000 individuals with incomes between $610.00 —which is the income threshold for Medicaid eligibility— and $800.00 monthly gross income, using only local revenues with no access to federal matching funds. In the event that no additional funding becomes available Puerto Rico may cease to cover these beneficiaries and they may have no choice but to move to the States in search of adequate healthcare coverage.

Consequences of the Medicaid Cliff

Absent swift Congressional action for fiscal year 2020, Puerto Rico's FMAP will revert to the statutorily mandated 55% FMAP for most of our Medicaid program, up to the Federal Medicaid funding cap of approximately $380 million, which is the only source of recurrent Medicaid funding for Puerto Rico. If Puerto Rico only receives its statutory cap of $380 million at the fixed FMAP of 55% for FY20, federal funding of Puerto Rico's Medicaid will only last three (3) months. The capped amount, in addition to the remaining Affordable Care Act (ACA) funds, would mean an effective FMAP of only approximately 30% in fiscal year 2020 and 13% in fiscal year 2021. This, compared to the 83% FMAP Puerto Rico would receive by statute if determined by the income per capita formula.

Unless Congress acts before September 30, 2019, Puerto Rico will face potentially catastrophic changes to its Medicaid program and overall 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 may have to end coverage for the current low-income population (earning between $610.00 and $800.00 a month in gross income) that receives healthcare using only local Puerto Rico funds with no federal matching.

- 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 professionals because we will not be able to ensure reasonable reimbursement. 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 with regards to specialty providers needed to treat complex 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% increase in suicide rates.

In summary, once the cap established by Section 1108 of the Social Security Act 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% local funding. Given Puerto Rico's current

financial situation, additional local funding is not available, such that the only alternative is to cease providing services by either reducing eligible individuals, cutting benefits, or both.

Program Integrity Efforts and Oversight

Since July 1, 2011, Puerto Rico has received $11.4 billion in supplemental Medicaid funding and has focused every effort to maximize these funds providing medical benefits to as many enrollees as possible. There are 7 states that receive at least that amount of federal funding in one year.[10] Puerto Rico's total Medicaid spending per enrollee is 38% lower than just the federal share of the State with lowest spending per enrollee.[11] In addition, program administration expenditures, as a percent of total cost, is lower than the national average. Puerto Rico has made extraordinary efforts and worked tirelessly to provide the best care for its citizens with the fewest resources. We recognize that additional long-term Federal support comes with additional responsibility 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), which is fully operational.
- We enhanced our most recent Managed Care Organization (MCO) Contracts with additional requirements related to encounter data, program integrity activities, achieving

[10] Sources: For state and territory spending: MACPAC, 2018, analysis of CMS-64 FMR net expenditure data as of July 20, 2018. For all other spending (MCFUs, survey and certification, VFC program): CMS, 2018, *Fiscal year 2019 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2019-CJ-Final.pdf.

[11] After adjusting for benefits covered and enrollment mix. From MACPAC June 2019 Report to Congress.

improved health outcomes, and one of the highest Medical Loss Ratios in the nation at 92%.

- We are conducting retrospective claims audits to ensure minimization of waste.
- We are strengthening program oversight by enhancing encounter data quality validation and developing a provider portal that gives visibility to their data.
- We are paying capitation rates that reward MCOs based on quality of services rendered through conditions based rates cells and risk adjusted per member per month (PMPM) rates.
- We have taken a step towards value-based payments and measuring hospitals on quality by implementing an inpatient hospital DRG payment system in FY 2020.

We believe that all of these efforts, 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 Puerto Rico's ongoing commitment to ensuring the integrity, oversight of our programs, and responsible stewardship of the Federal Medicaid funding that we receive.

How Can the Puerto Rico Medicaid Program Improve

Only through long-term adequate federal funding, can Puerto Rico continue program reforms and initiatives that can improve health outcomes and achieve efficiencies that will strengthen our healthcare system.

For example, ASES is currently designing and implementing a Diagnosis Related Group (DRG) payment system for hospital stays, similar to most Medicaid programs in the United States, which will go-live in FY2020. The system will tie hospital reimbursement to acuity of patient care and ultimately the quality of services provided. One key decision is to enhance the payment to hospitals that provide medical education, which would both incentivize new hospitals to develop a residency program and adequately compensate the facilities that already have them established. However, due to fiscal constraints, we are currently unable to project any enhancements in payment without reducing reimbursement rates to the facilities that cannot support these programs.

Many Medicaid beneficiaries also do not have access to transportation to their medical visits, for which reason Non-Emergency Medical Transportation (NEMT) is a mandatory Medicaid benefit. In Puerto Rico this benefit is generally not covered and is only provided through exception in extraordinary cases. Transportation on the island is difficult due to the geography of rural areas and lack of public transportation alternatives. Our goal is to be able to provide NEMT as a full benefit, which will reduce costs in the long term because it would avoid unnecessary ambulance rides and provide greater access to preventive and maintenance care.

In 2017, 20 percent of the Puerto Rico population was age 65 or older, 4 percentage points higher than the U.S. average and higher than all States except Florida and Maine.[12] Puerto Rico does not provide Long Term Services and Support (LTSS) to this population due to lack of funding, and consequently does not have adequate infrastructure currently in place to provide the benefit even if the funding was available. Therefore, to be able to provide care to our elderly we

[12] Census 2017.

need to strategically plan on how to provide this benefit and invest in the infrastructure so it is available in the future. In other States the cost of this benefit can be up to a third of total program expenditures. This cost is prohibitive for Puerto Rico to even consider implementation at this time.

Mental Health services are a priority for any Medicaid program, and new initiatives and reforms are needed to improve the quality and access to these services in Puerto Rico. Many State programs have developed models and proposed waivers for community based services that address the social and mental determinants of health. For example, Puerto Rico is evaluating a peer support services program that is already implemented by most States, which could serve as the bridge between mental health services and the community, led by those that are in recovery and have experienced mental health issues themselves.

These reforms and initiatives are some of Puerto Rico's long-term priorities and goals for its healthcare system, which require smart planning and implementation. Puerto Rico would be in a much better position to enact this and other key policies if the Medicaid cliff is resolved with adequate and sustainable long-term funding.

Conclusion

We reiterate our gratitude to Members of this Committee that worked to ensure that necessary funding was made available to Puerto Rico through the Bipartisan Budget Act of 2018. The increased funding and matching rate provided in the BBA allowed Puerto Rico to avoid a catastrophic Medicaid funding cliff during the aftermath of the worst natural disaster and public health emergency Puerto Rico has faced in recent memory. However, the respite provided by the

BBA will soon end as the funds expire on September 30, 2019, and the Medicaid cliff is upon us once again.

As we have stated in previous meetings with the Administration, in testimony before Congress, and recently the Medicaid and CHIP Payment and Access Commission (MACPAC) June 2019 report to Congress, although Puerto Rico is generally considered as a State for Medicaid purposes, including program requirements and responsibilities, its Medicaid funding has been insufficient for decades. 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, culminating in the impending fiscal cliff which if not addressed by Congress in the next months will threaten the sustainability of the Puerto Rico's healthcare system.

The Medicaid cliff that Puerto Rico is facing is an emergency that must be dealt with urgently. As this Committee knows, the Government of Puerto Rico is currently in the midst of finalizing the FY19-20 state budget, which must happen by June 30, 2019. In addition, over the next month we will review the reasonability of premium for the next MCO contract year covering the period of November 1, 2019 to October 31, 2020. Given the uncertainty of federal funds during the period subject to negotiation, we ask that Congress address this issue in the next available legislative vehicle. Our proposal will allow Puerto Rico to continue providing urgent health care services to its citizens while we work to rebuild our healthcare infrastructure, 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.

Medicaid in Puerto Rico is the source of insurance that our people, both beneficiaries and providers depend on the most. If Congress wants to strengthen healthcare in Puerto Rico, then it must provide our Medicaid program with a sustainable, long-term funding that meets the needs of the American citizens of Puerto Rico. Eliminating the reoccurring "funding cliffs" would permit the Government of Puerto Rico make much needed investments, implement long-term strategies to improve outcomes, achieve efficiencies, and strengthen healthcare services in Puerto Rico.

I am grateful for the opportunity to share these facts with you and thank you for allowing me to present my written testimony before this Committee. 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 Americans 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.

Ms. ESHOO. Thank you very much.

You know, it isn't—I want to make note of something. It isn't very often that a full panel of witnesses are all women, so I want to make note of that. Thank you. I think it is wonderful. Thank you.

[Applause.]

Ms. ESHOO. Ms. Young, you are recognized for 5 minutes for your testimony.

STATEMENT OF SANDRA KING YOUNG

Ms. YOUNG. Talofa, Chairwoman Eshoo, Ranking Member Burgess, and members of the committee. Thank you for the opportunity to testify before your committee on how to strengthen healthcare in the U.S. territories. I want to recognize that this is the first time that American Samoa and the other territories have this extraordinary opportunity to testify before this committee that has jurisdiction over Medicaid issues. A few weeks ago, we also testified before the Natural Resources Committee.

This is a monumental step forward for the territories and our efforts for advocacy on Medicaid programs. The challenges with the U.S. territories are unique, and a cookie-cutter approach will not work. However, we do have some things in common. The key to strengthening healthcare in American Samoa and the territories lays with fixing two key statutory provisions in our Medicaid programs.

First, the cap on the territories' Medicaid block grants must be lifted or increased. American Samoa has 12 million in this fiscal year, and we receive a nominal 2 to 3 percent increase every year.

With the availability of the Affordable Care Act Medicaid funding in 2011, we were able to draw, on average, an additional 5.4 million a year. In 2017, our Medicaid agency added four new Medicaid services and providers to our program. With these new services, we exhaust our block grant in the second quarter.

Funding these new services is limited also by the availability of our local matched dollars. This year, we suspended our new services in March because we had exhausted our 2 million in local match. That suspension was just lifted in the first week of June when the disaster supplemental bill was made available, providing us with relief with a 100 percent FMAP up until September 30th, 2019, for the 152 million ACA money that we couldn't spend.

We do anticipate the cost of these new services to increase over the next 5 years, and our initial estimate to ensure adequate coverage is around 10 million a year, if we provide comprehensive coverage as required by our Medicaid State Plan and Social Security Act. If we are to continue with block grants, then American Samoa must have an increase of at $30 million a year in Federal Medicaid dollars.

Second, the current FMAP percentage is unsustainable for our government. We would like to propose a more sustainable FMAP rate of 90 percent Federal, 10 percent local match for at least the first few years, or a straight application of the FMAP formula based on American Samoa's actual poverty levels. Critical is the principle that both the cap and the FMAP must be addressed to-

gether. These two issues are interdependent, and one should not happen without addressing the other.

Third, American Samoa has a unique 1902(j) waiver that allows us to manage our very small Medicaid program from being over-regulated. Some of the things unique to our program is that we do not do individual enrollment for Medicaid because we administer a presumptive eligibility program allowed under our waiver. It is the position of our government that we want to maintain this statutory waiver that best suits the unique challenges we face as a remote island territory.

Lastly, what is the real impact to our people when we don't have enough Medicaid Federal and local funding for our program? In short, once the ACA money expires in September, we will stop our off-island medical referral program for medically necessary care not available on island. We will stop payments for wheelchairs, CPAP machines, and prosthetics. We will stop payments for the Medicare dual eligible beneficiaries. The only Medicaid provider that we will continue to fund will be our one hospital.

But Medicaid services like prostate or breast cancer treatment and all cancer treatments, knee or hip replacements, heart surgeries for adults, or rheumatic heart disease surgeries for our children will simply not be covered. That we must intentionally make decisions that could leave our people permanently incapacitated physically or mentally, or at worst, the risk of loss of life is morally unconscionable.

This committee and Congress have the power to help American Samoa and the other territories finally fix the statutory barriers so we don't have to make these decisions. Everyone deserves to receive lifesaving treatments, even in the territories. On behalf of our people and our government, again I appreciate your time and efforts to hold this hearing. May God bless and guide you in the important work that you do for this country. I am happy to answer any questions. Thank you.

[The prepared statement of Ms. Young follows:]

STATEMENT OF
SANDRA KING YOUNG
AMERICAN SAMOA MEDICAID DIRECTOR
BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES – JUNE 20, 2019

Honorable Chair Eshoo, Ranking Member Burgess, and Members of the Committee, it is my pleasure to extend to you greetings from my Governor Lolo Matalasi Moliga and Lt. Governor Lemanu Peleti Mauga. On behalf of the American Samoa Government and our people, thank you for the opportunity to submit to the committee this written testimony to provide input on the subject matter of this hearing, "Strengthening Healthcare of the U.S. Territories for Today and Into the Future." For the first time in our history, American Samoa and the other territories have this extraordinary opportunity to share with this Congressional Committee, the heavy financial and human tolls that inadequate federal Medicaid funding has on our peoples and our local governments. We thank you sincerely for the opportunity to share with you proposed solutions to these challenges.

American Samoa's Health Care System

American Samoa (AS) is located half-way between Hawaii and New Zealand and is a two-to-three days travel by air to Washington, D.C. Our five inhabited islands have only one hospital and five community health clinics under the umbrella of the Federally Qualified Health Centers. The only hospital that serves approximately 60,000 people is located on the main island and two of the clinics are located on two of the outer islands. Any emergency or acute care cases from the outlying islands must be transferred to the main island via boat or airplane. Medically necessary or emergency care that is not available on island must be referred off-island to New Zealand (NZ) or Hawaii (HI). We send our patients to NZ where the medical care is affordable. In the case of AS, Medicaid is fundamentally our only health insurance plan. Medicaid is the key funding source that supports the whole AS health care system.

Medicaid Cap and FMAP for the Territories

The AS Medicaid program was approved in 1982 with a special 1902(j) waiver where the only provisions of federal law that cannot be waived by AS are the FMAP rate, the cap and the mandatory medical benefits. These two statutory barriers have caused significant hardships for our government. This prohibition against waiving the capped funding and the FMAP has had an unintended effect which basically puts AS in a compromising position of not being able to provide coverage for all the mandatory medical benefits—as mandated by the Social Security Act. In addition to not being able to cover all the mandatory medical benefits, our territory cannot fully cover the medical benefits that we do provide. When our block grant is exhausted in the second quarter, the local government must find supplemental appropriations to cover

the shortfall. In essence this further increases our local match outlays to as high at 80% and for a poor territory, this is an extremely heavy and unsustainable financial obligation.

Impact of the Affordable Care Act Medicaid Funding

The availability of the ACA funding helped provide financial relief to our local hospital which no longer had to take out loans to continue operations after our regular annual Medicaid funding was exhausted. It also helped AS expand the Medicaid program to add new benefits and new providers.

The only challenge was, AS could not come up with the local match requirements. 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. 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 continues be limited to the extent of available local matching dollars. Without more local match funds to serve more patients and add more services, AS cannot spend its ACA funds in the time allotted.

Since Governor Lolo Matalasi Moliga and Lt. Governor Lemanu Peleti Mauga came into office in January 2013, 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, our government was never going to be able to expend the full *$197,800,000* million made available to American Samoa within the timeframe 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. 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. With the addition of our new providers, we exhaust our regular Medicaid funds in the 2nd quarter. Our territory's historical spending of ACA funds has averaged only *$ 5.4 million* a year. We estimate given our historical spending of ACA and of the new services and trending of those services into the future, AS needs approximately $30 million a year in federal Medicaid dollars to effectively support comprehensive health care services. With a steady increase per year, this would be a more sustainable level of funding in the form of a block grant. Again, our government will have to find new sources of local revenues to raise the local match.

Congressional Action Needed to Strengthen the Territories Health Care Systems

We have always understood that only Congress can fix the Medicaid cap for the territories and fix the FMAP issue. Congress must either lift the cap or increase the cap on territorial block grants to give the territories sufficient Medicaid funding.

Second, Congress must allow the territories to use the same poverty level formula to set our FMAPs as is used by the states. 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 is similar to the wealthiest states in the country but if the FMAP formula were applied the same way as the states, American Samoa would have approximately an 70-80% federal FMAP rather than the current 55%.

Third and of utmost importance is the principle that both the cap and the FMAP must be addressed simultaneously. Fixing one and not the other will not help American Samoa or the other territories now and in the future. Lifting or raising only the cap won't be sustainable for us if the local FMAP match remains high and our governments cannot raise the local revenues to draw the increased federal funds. Raising only the FMAP without raising the cap simply means that we will exhaust our block grant faster like in the 1st or 2nd quarter. These two steps are complementary and must be addressed together.

Absent an increase in the statutory cap placed on the territories or the lifting of the cap, American Samoa will be forced to suspend all new Medicaid benefits after the expiration of the ACA funds this September. 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.

Caveat for American Samoa's 1902(j) Waiver

A question has been asked whether the territories want to be treated like the states. It depends. For American Samoa similar to the Commonwealth of the Northern Marianas Islands, we have a 1902(j) waiver that has provided our program much relief from federal regulation that does not make sense for our small island government or our small program. This waiver allows our program to be innovative in how to manage our limited funding and it also allows us

to waive certain federal Medicaid regulations that don't apply to our program or are fiscally unsupported. The federal regulations that the states are subject to are extremely rigorous and appropriate for billion-dollar budgets and millions of people. But American Samoa has a small population with a presumptive eligibility program, four providers and with a very small Medicaid budget in the world of Medicaid funding. A lot of federal regulations do not make sense for American Samoa. However, depending on what Congress decides to do with the lifting or raising of our block grant and the FMAP, that may help determine how much we should be treated like a state. We understand and support the principles of program integrity and we welcome efforts in promoting accountability. We only ask that we are given any opportunities to provide input on potential legislation that will impact our program because of its unique characteristics. For now, American Samoa requests that we maintain our 1902(j) waiver but we are open to deliberations on this issue if it helps move our program forward in a sustainable manner.

Real Impact of Medicaid on Our People

Consider the case of a young 30-year old nurse and mother of five who is alive and fully functioning today after experiencing a traumatic brain hemorrhage—she is alive today because the additional Medicaid funds from ACA 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.

Additional Medicaid funding 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 there was more Medicaid funding under ACA. All of these success stories hinge on the presence of the 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 and fix the FMAP.*

Again, 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 individuals from the private sector and service industries. All of them rely on Medicaid for health care. As the Medicaid Director from American Samoa here in the U.S., I do not have health insurance coverage—until I return home where I am covered while on island. Medicaid is the lifeline for the people of American Samoa and without additional funds in the new fiscal

year to offset the loss of the ACA funds, we face an unconscionable medical crisis that could have been prevented.

I look forward to working with the Committee to provide it with any information it needs to address these issues for American Samoa and our sister territories. Thank you again Madame Chair and the members of this committee for this opportunity to appear before you today. We are deeply grateful to the Committee for providing this forum for the territories to bring our voices to Congress on how it can truly help the territories with our Medicaid cap and FMAP challenges.

Ms. ESHOO. Thank you very much.

I now would like to recognize Ms. Arcangel for her 5 minutes for testimony.

STATEMENT OF MARIA THERESA ARCANGEL

Ms. ARCANGEL. Hafa adai, Madam Chair and Ranking Minority Members. On behalf of Governor Leon Guerrero and the people of Guam, thank you for inviting us to testify regarding the healthcare issues that Guam Medicaid recipients endure and the cliff Guam will face if there is no immediate action taken by this Congress beginning fiscal year 2020 to increase the territories' Federal Medical Assistance Percentage and increase or remove the Federal funding cap.

Like many stateside rural areas, Guam suffers from shortage of primary care providers and specialists. HRSA has qualified Guam as both a medically underserved and a health professional shortage area. The shortage of health professionals is attributed to the difficulty in recruiting providers due to Guam's remote location, the physician salary that is not comparable to U.S. rate, and the high cost of malpractice insurance on Guam.

Clearly, there remains a shortage of primary care physicians, which is felt most especially among the Medicaid recipients who struggle finding a permanent medical home because of providers' refusal to accept patients due to low reimbursement and the late payments. Thus, Medicaid clients are forced to seek treatment at the emergency room, which is more costly. Additionally, due to gaps in the tertiary care services, there are instances when off-island doctors refuse to accept Medicaid's referrals due to untimely reimbursement.

In some instances, patients needing to transfer from Guam Hospital to a highly equipped off-island medical facility must stay longer in our hospitals for several days before treatment can be obtained. As a result, patients' condition worsens, requiring air ambulance. Similarly, the cost of medical supplies and equipment are more expensive in Guam due to the limited distributors as compared to hundreds of companies available here. The high shipping costs and vendors' tendency to impose a higher price on medications due to lack of competition contribute to the high cost.

All these factors add to the high cost of healthcare in Guam. The migration of FAS citizens in any U.S. soil under the Compact of Free Association according to the U.S. Census in 2013, there were 17,170 Compact migrants on Guam. In fiscal year 2017, Guam estimated that 38.5 million was spent on healtcare and welfare services for this population. Moreover, of the 110.8 million expenditures of Guam Medicaid in fiscal year 2018, $29 million or 27 percent of total amount were spent for FAS population's healthcare needs. The influx of COFA citizens created an additional hardship on Guam's economy. As a result, the government is unable to guarantee the availability of 45 percent local matching funds required to draw down the Federal grant awards.

The U.S. territories administer the Medicaid under Federal regulations that are different from the 50 States and District of Columbia. Guam Medicaid's FMAP rate is fixed at 55 percent. However, the FMAP for 50 States and DC varies by States' per capita income

between 50 percent to 83 percent. In addition, the Federal Medicaid funding to Guam is subject to an annual cap, which is 18.38 million for next fiscal year, unlike the States and DC that are open-ended.

Clearly, there is a huge disparity on the Medicaid funding distribution of Guam in comparison to the U.S. States. Those differences on Medicaid rules affect the quality of healthcare provided to program recipients and contribute to the economic destabilization of Guam. Due to increase in utilization, the number of eligibles, and new treatment modality and others, Guam's Medicaid expenditures increased by 323 percent over the past decade, 26 million in fiscal year 2009 and 110.8 million in fiscal year 2018.

If no action is taken to increase the FMAP and remove the Federal funding cap, Guam Medicaid could be forced to terminate more than 50 percent of its 43,000 eligibles. This will further increase Guam's estimated uninsured population rate of 24.8 percent in fiscal year 2017. Hence, in order to improve the healthcare services of our Medicaid recipients, Guam proposes to increase the U.S. territories' FMAP and remove the Federal funding cap.

Thank you for the opportunity to testify on this important issue. We hope that the committee will develop a solution to assist the U.S. territories in resolving the longstanding disparity on Medicaid funding distribution that affects our economy.

[The prepared statement of Ms. Arcangel follows:]

Written Testimony of Ms. Maria Theresa Arcangel
Chief Human Service Program Administrator
Division of Public Welfare- Guam Department of Public Health and Social Services
Committee on Energy and Commerce Oversight Hearing
"STRENGTHENING HEALTH CARE IN THE US TERRITORIES FOR TODAY AND INTO THE FUTURE"
June 20, 2019

Hafa adai, Mr. Chairman and Ranking Minority Members, 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. I oversee the administration of Medicaid.

On behalf of Governor Leon Guerrero and the people of Guam, we thank you for inviting us to testify before the Committee on Energy and Commerce regarding the health care issues that Guam Medicaid Program recipients endure and the cliff Guam will face if there is no immediate action taken by the Congress beginning Fiscal Year 2020 to increase the territories Federal Medical Assistance Percentage (FMAP) and remove or increase the federal funding cap.

My testimony will cover the Medicaid issues in several contexts: 1) Cost of healthcare and access to healthcare services, 2) immigration of the Compact of Freely Associated States citizens, 3) Guam financial issues, and 4) 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% and Guam's annual Medicaid federal capped funding.

The cost of providing health care in Guam is quite high due to its unique geographic location and the lack of tertiary care facilities and healthcare professionals. 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 some 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.

Additionally, due to gaps in tertiary care services, there are instances when off-island hospitals/doctors refuse to accept Guam Medicaid Program's 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. In other instances, patients needing to be transferred from Guam Memorial Hospital to a highly equipped off-island medical facility must stay longer in Guam hospitals for several more days before treatment can be obtained. As a result, patients' condition worsens requiring air ambulance.

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.

All these factors add to the high cost of health care in Guam, which contribute to Guam's economic problem.

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 from the Federated States of Micronesia (FSM) (Pohnpei, Yap, Kosrae, Chuuk), the Republic of Marshall Islands, and the Republic of Palau to the U.S. 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 estimated 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% of the total expenditures were spent for FAS population health care needs. There is no equitable reciprocal health care 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 45% local matching funds required to drawdown the federal grant awards to pay the medical providers timely for the services rendered to program recipients.

The U.S. territories administer the 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%, the same as the other U.S. territories. However, the FMAP for the 50 states and DC varies by states per capita income, which ranges from 50% to 83%. 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. Section 1108 of the Social Security Act provide Gu with $17.97 million dollars (administration and medical services payments) for fiscal year 2019. This funding increases yearly based on Medical Consumers Price Index. The FY 2020 Regular Medicaid funding would be $18.38 million dollars. This fund 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 Program Integrity has a processes and procedures in place to detect fraud, waste, and abuse on both providers and recipients' utilization of services. Currently, the Guam Medicaid Program, administered by the Bureau of Health Care Financing Administration, under the auspices of the Department of Public Health and Social Services, Division of Public Welfare (DPW), employs stringent, comprehensive processes for ensuring Medicaid Integrity. These processes are managed by the divisions' Quality Assurance and Fraud Unit (QAFU), Prior Authorization Unit, Utilization Review and Claims Unit, as well as the Program Management Unit (PMU). The goal of each of these units is to detect, reduce, and eliminate fraud, waste, and abuse in the Medicaid Program.

Despite the above procedures/processes, Guam Medicaid's expenditure increased by 323% 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 no action is taken to increase the FMAP and remove the federal funding cap, Guam Medicaid Program could be forced to decrease its income guideline and terminate more than 50% of its current eligible individuals. This will further increase the rate of the estimated uninsured population, which was 24.8% (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 healthcare 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 (Guam Memorial Hospital Authority-GMHA) even more, which continues to struggle because of EMTALA (Emergency Medical Treatment and Labor Act). Furthermore, GMHA does not receive any additional payment from Medicaid/Medicare Disproportionate Share Hospital (DSH) for providing medical services to a large number of Medicaid and low-income uninsured patients because it is only applicable to the US states, which is another disparity on federal funding distribution. This will continue to heighten the financial problem of Guam.

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 U.S.). 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% 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 increase the US territories FMAP and remove the Medicaid federal funding cap.** 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 Energy and Commerce for this oversight hearing. We hope that the committee will develop a solution to assist Guam and the other U.S. territories in resolving the long-standing disparity on Medicaid funding distribution that affects our economy.

Thank you for the opportunity to provide written testimony on this important issue.

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.

Ms. ESHOO. Thank you very much.

I now would like to recognize Ms. Rhymer-Browne for 5 minutes for your testimony.

STATEMENT OF MICHAL RHYMER-BROWNE

Ms. RHYMER-BROWNE. Madam Chair Eshoo, Chairman Pallone, Ranking Member Walden, Ranking Member Burgess of the Health Subcommittee, 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 United States Virgin Islands considering the impending Medicaid fiscal funding cliff which will impact us beginning October 1, 2019. I am Michal Rhymer-Browne, assistant commissioner of the Virgin Islands Department of Human Services, and I have the distinct privilege to have oversight of the Medicaid Division.

I must also thank today, Kimberley Causey-Gomez, my commissioner nominee, my boss, of the Virgin Islands Department of Human Services, who has extended to us her complete support as we prepared to come here to this important committee meeting. 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, which ravaged our territory in September of 2017.

We are a resilient people, but my testimony today is truly intended to actualize the empathy and to request your continued urgent support to address the critical Federal and local funding crisis we are facing here in our healthcare system in the Virgin Islands. My testimony is here today, and I just feel the need as I am sitting here with you to speak from my heart, and I will go back a little bit to the script.

But as I am sitting here, I am sitting here with some hope, but I reflected just a few moments ago when I was sitting under a palm tree on one of our beaches one day on a cultural holiday. And I was called by our Medicaid director to tell me of a little boy who was just born about 3 days ago who had deteriorated digestive system and he would die in a few days.

At that point, we faced the decision of whether we would send this child off island, and at that point we were terrified because we said if we send this child, we may not be able to pay immediately. But I called my commissioner and I recommended that we help to save this child. This child was just born 3 days ago. As I was sitting there under the palm tree, I felt fear. I felt real fear that this child would die. And it was then we made the decision to move forth even with the cap at that time, even before our hundred percent FMAP. We were terrified at the choices we had to make.

And as I am sitting here with some hope, I reflect on sitting at my dining room table just a few weeks ago, probably—no, a couple months ago—when I got the call from a teacher of a 20-year-old boy who had graduated early and she said, "He is in the hospital

and he is paralyzed and he needs to be airlifted. He is one of your Medicaid members, can you send him?"

At that point, we had to make the decision. And I knew that our monies were running out under the BBA 100 percent funding, but I said we must, we must send this man, this young man, so he can walk again. And I will share with you 3 weeks ago we got this call that this young man is walking again because we made the decisions, the tough decisions.

And in the U.S. Virgin Islands as I am sitting here, I sit here with hope, but I want to share with you that we need your help. We need your urgent help. We understand. We understand that permanent fixes may not be able to be done, but we need your support even if it is another hundred percent for a couple of years, even it is in the future you make a permanent fix.

But as we approach this Medicaid funding cliff, I appeal to you, help us in the U.S. Virgin Islands. Help us in all of the U.S. territories. You can make a difference, and I know by your votes, one by one, if we put them together and with the larger Congress, we can make a difference for the people of the U.S. Virgin Islands and the other territories.

So, I thank you. You have my testimony in writing. You can ask me questions. But just now I feel like I needed to speak from my heart.

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

MICHAL RHYMER-BROWNE
U.S. VIRGIN ISLANDS

Written Testimony of
Michal Rhymer-Browne Assistant Commissioner of the
United States Virgin Islands Department of Human Services
Oversight of the Medicaid Division
Before the House Committee on Energy and Commerce

June 20, 2019

Chairman Pallone, Ranking Member Walden, 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 United States Virgin Islands, in light of the impending Medicaid fiscal funding cliff which will impact us beginning October 1, 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. I must also thank Kimberley Causey-Gomez, Commissioner Nominee 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 of 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% Federal matching rate will expire. Along with this, we are projecting we will lose access to the nearly $146.1 million in remaining Federal funding provided under the Affordable Care Act (ACA). It is only through this additional federal funding and the 100% 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% 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% matching rate, that funding is projected to only cover 26% (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% local funding. That local funding is not available, our citizens will not be able to receive the essential healthcare 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 five-year (Fiscal Years 2020-2024) Medicaid funding request:

1. 100% 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% 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). a correspondingly high local matching requirement, and 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 very 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 health care 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. Towards 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 on-line 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, which is operated by the Virgin Islands Department of Justice. An MOU was executed between the Virgin Islands Department of Human Services, under which V.I. Medicaid is operated, and the Department of Justice in December of 2018. This MOU spells out the terms of the operation of the V.I. Medicaid Fraud Control Unit and describes how both Departments will collaborate to ensure fraud, waste, and abuse is detected and a corrective plan put in place.

- 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). Of the Top 12 Issues listed by CMS for T-MSIS Phase I, the U.S. Virgin Islands has completed all items and there are no outstanding issues found as of Friday June 14, 2019. The VI's Current Production Run, April 2019 data set was sent May 17th, and all 8 files were accepted and were processed by CMS. We have begun Phase II of the T-MSIS implementation, and of the Top 23 Issues listed by CMS for Phase II, VI has completed all items and there are also no issues found as of Friday June 14, 2019.

- An Expression of Interest Form was completed and submitted to the Medicaid Innovation Accelerator Program (IAP) on December 3, 2018. The goal for this IAP opportunity is to support the VI Medical Assistance Program in our Medicaid delivery system reform efforts by improving our Data Analytic Capacity. The Kickoff Data Analytic call was on April 24, 2019. A Data Analytic Cohort Work Plan has consequently been developed. Seven Virgin Islands Medicaid staff members are currently listed as team members to include a Systems Analyst, Eligibility & Enrollment staff, Quality Control, Claims, Clinical, and Management level staff. The IAP will assist the V.I. Medicaid Program in developing a analytic strategy for analyzing our Medicaid Program. It will also assist V.I. Medicaid to use data to drive programmatic decision making improving statistical programming and data modeling skills. The IAP will also facilitate the integration of Medicaid data with other data sets.

- 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.

- The U.S. Virgin Islands Medicaid Program submitted an IAPD to the U.S. Department of Health and Human Services last week requesting close to $15 million to implement a territory wide health information exchange system.

- Program Integrity in V.I. Medicaid is extremely important. To further enhance our Program Integrity, A Joint Operating Agreement (JOA) signed between the Southeastern Unified Program Integrity Contractor (SE UPIC) and the Medical Assistance Program (MAP), dated March 21st, 2019. The purpose of Medicaid Program Integrity Coordination is to work with the Virgin Islands Medicaid program to identify potential fraud, waste, and abuse. Medicaid program integrity is a collaborative effort between CMS, SE UPIC (under contract to CMS), US Virgin Islands Dept. of Human Services – Medical Assistance Program and the established Virgin Islands Medicaid Fraud Control Unit

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.

The positive impact of the BBA 100% FMAP funding has enabled V.I. Medicaid to literally save lives and improve the quality of life for thousands of Virgin Islanders. Without this funding, we would not have been able to afford to approve and facilitate the off island medical care for MAP members who have been diagnosed with extremely complex cancer disease, severe orthopedic conditions, and to save the lives of those members who experienced traumatic physical injuries, which required specialized medical care not currently available in our territory's hospital

facilities which are still in compromised physical states caused by Hurricanes Irma and Maria in 2017. As we fast approach the end of our FY 2019 BBA funding, V.I. Medicaid Director, Gary Smith, and his staff, are already being faced with fiscal challenges in being able to make timely payments to our Medicaid Providers. It is painfully obvious that we are already approaching the "Medicaid Cliff" and the ramifications for the health and well being of our most vulnerable population of U.S. citizens who reside in the U.S. Virgin Islands are severe.

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 health care services to our citizens while we work to rebuild our health care 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.

Ms. ESHOO. Thank you very much. I like the sounds of your heart.

I now would like to recognize—oh, that is it for the—no, we have Ms. Sablan. I would now like to recognize you for your testimony, and you have 5 minutes. Welcome.

STATEMENT OF HELEN C. SABLAN

Ms. SABLAN. Thank you. Good morning, honorable chairs, ranking members, and Members of the United States House of Representatives. We are very heartened that the committee of jurisdiction over the Medicaid program is holding this hearing and that Chairman Pallone recognized that the U.S. territories are on the verge of a humanitarian and financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for the next year and beyond. That is the plain truth.

The Commonwealth of the Northern Mariana Islands is indeed on the verge of a humanitarian health, healthcare system, and financial crisis because of the differences in the way the law treats territories versus the States. Avoiding the crisis will require an act of Congress because the difficulties are statutory.

Before proceeding, I would like to express our deepest appreciation to Congress for the passage and enactment of H.R. 2157 that included Medicaid disaster assistance for the CNMI resulting from the Category 5 Super Typhoon Yutu. While recovery efforts were initiated, a slower onset disaster was in the making.

Throughout 2018, CNMI was sliding to the edge of the Medicaid fiscal cliff because the temporary funding was running out in fiscal year 2019. In March 2019, we reached and fell off the cliff with a complete exhaustion of Medicaid funds from the section 1108 budget caps, temporary increases by section 2005 of the Affordable Care Act, and small amount from section 1323 of the ACA.

While it is complete free fall, we fortunately landed on a ledge with the passage of H.R. 2157. The ledge of the Medicaid fiscal cliff is tenuous, and that ledge will crumble on September 30 of this year. As of October 1, we will only have limited section 1108 CHIP and EAP funding. We will not have sufficient funding to support all mandatory services and many critical optional services. For example, medications and surgery will be severely cut or eliminated.

The fiscal crises in the CNMI were made worse by adding to the debt obligation as well. The health system will be crippled because providers will stop taking Medicaid beneficiaries. There will be substantially more uninsured patients because the Medicaid program will effectively be ended. CHCC will not have funds for drugs, laboratory reagents, and other supplies. Frustrated clinicians and nurses may once again leave the CNMI, and all of this will affect the health of the whole population. The U.S. citizens of the CNMI are huddling on the ledge today but hope Congress will provide a path up the cliff and enable the territories to avert disaster.

As shown in written testimony, there are 16,206 U.S. citizen beneficiaries enrolled in the Medicaid and CHIP programs today, or about 49 percent of the total U.S. citizens in the CNMI. The median household income for a CNMI family was less than one-third of the rest of the United States. And more will fall on the ledge because the CNMI government just instituted austerity measures

where government employees have been placed on a mandatory reduced work schedule.

There are two well-understood major causes of fiscal cliff, the section 1108 budget caps and the FMAP. Both require acts of Congress to fix.

First, section 1108. The territories receive a budget appropriation under section 1108. The budget caps were established decades ago and do not bear any relationship to the actual cost of healthcare today, in the CNMI today. The ACA recognized the problem and provided a temporary increase of hundred million amount of expended from 2011 to 2019. During this period, the CNMI Medicaid was able to increase eligibility and add optional services. In FY 20, the CNMI total expenses and IBNR was around 71 million. Compared to the total of FY 2020, CMS allotted funds so the shortfall will be about 48 million.

Second, the FMAP for the territories is an artificial percentage, unlike the FMAP for States, that is calculated based on per capita income relative to the national average. Although CNMI has much lower per capita income than most of all States, it must use a fixed and inequitable FMAP percentage. That makes it impossible for the CNMI government to fully fund the CNMI share.

Finally, before closing my oral statement, I would like to say that the CNMI is very well aware of the requirements for submitting data to the Transformed Medicaid Statistical Information System, which is the T–MSIS, and establishment of a Medicaid Fraud Control Unit. We are fully committed to do so and have demonstrated our commitment and progress in our written testimony.

In closing, the U.S. citizen Medicaid beneficiaries in the CNMI are clearly on the verge of a humanitarian and financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for the next year and beyond. The CNMI is in desperate and dire situation and huddling on the edge. We are humbly pleading Congress to eliminate the section 1108 caps and provide us equal treatment with all States and that Congress apply the FMAP percentage using the same method for the States. Thank you one more time for the time in hearing our issues.

[The prepared statement of Ms. Sablan follows:]

Commonwealth of the Northern Mariana Islands
State Medical Agency
Office of the Governor

U.S. House of Representatives Committee on Energy and Commerce Committee
Hearing on the Strengthening
Health Care in the U.S. Territories for Today and Into the Future

Written Testimony of Helen C. Sablan, Medicaid Director
Commonwealth of the Northern Mariana Islands

June 20, 2019

Honorable Chairman Frank Pallone; Ranking Member Greg Walden of the Committee on Energy and Commerce and Subcommittee on Health; Chairwoman Anna Eschoo and Ranking Member Michael C. Burgess of the Subcommittee on Health; and Members of the United States House of Representatives

Thank you so very much for holding a hearing on the Health Care in the U.S. Territories for Today and Into the Future. We are very *heartened* that the Committee of Jurisdiction over the Medicaid program is having this hearing and that Chairman Pallone has accurately recognized that the U.S. Territories "are on the verge of a humanitarian and financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for next year and beyond."

The Commonwealth of the Northern Mariana Islands (CNMI) is indeed on the verge of a humanitarian health, health care system, and financial crisis and I would like to share with you the nature, urgency, and impacts that the "Medicaid Fiscal Cliff" will have on the U.S. citizens and the health care system of the CNMI. I will do my best to explain the nature of the Medicaid Fiscal Cliff and its critical role in the health care of the Territory today and tomorrow. I have directly incorporated into this testimony, parts of the testimony provided to the Committee on Natural Resources.

Before proceeding, however, I would like to express our very deepest appreciation for the passage and enactment of HR 2157 that provides Medicaid Disaster Assistance for the CNMI. As many of you are aware, the CNMI was devasted by Super Typhoon Yutu, a Category 5, on October 25, 2018, leading to a Presidential Disaster Declaration. While recovery efforts were initiated, a slower onset disaster was in the making.

Throughout 2018, the CNMI was sliding to the Medicaid Fiscal Cliff where temporary funding for the Medicaid Program in the Territories would end in FY 2019. In March 2019, the CNMI Medicaid program reached and fell off of the Medicaid Fiscal Cliff with the complete exhaustion of Medicaid funds from Section 1108 of Title XIX, temporary increases in Medicaid funding for the Territories provided by the Affordable Care Act, and the small amount from Section 1323 of the ACA made available because the CNMI did not elect to develop a Health Insurance Exchange. We were in a free fall toward catastrophe.

Fortunately, with the passage of HR 2157 by Congress, the CNMI, landed on a Ledge. The Ledge of the Medicaid Cliff is tenuous and will crumble on September 30 of this year; and, without intervention from the U.S. Congress, the CNMI will plunge into a humanitarian and fiscal crisis. The U.S. citizens of the

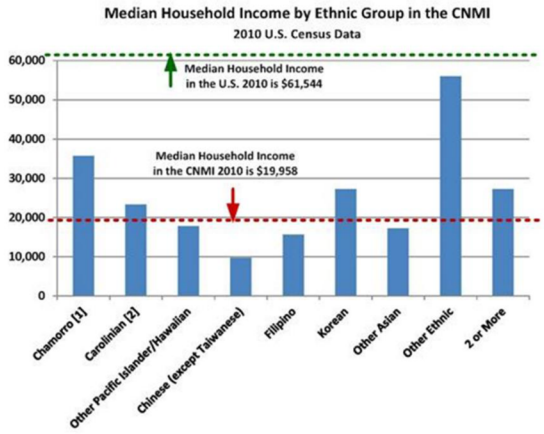
CNMI Medicaid program are huddling on the ledge today, hopeful that the U.S. Congress will reveal and provide a path up the cliff, and enable Territories to avert falling into the crisis. The CNMI Medicaid program is critical to the health of the U.S. citizen Medicaid beneficiaries and the health system of the CNMI for today and into the future.

BASIC INFORMATION ON THE CNMI AND MEDICAID

There are 16,206 U.S. citizen beneficiaries enrolled in the Medicaid and CHIP programs today. The percentage of U.S. citizens in the Territory is estimated 61.6% or 33,196 of the total population of 53,890 in the CNMI.[1] This means that Medicaid and CHIP provides critical healthcare services for about 49% 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, below, 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.[2] 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 from the U.S. Census from the CNMI State Innovation Model Plan



As a result of the low-income levels in the CNMI, there should be no surprise that 49% of the eligible U.S. Citizens in the CNMI are enrolled in the Medicaid program. In 2016, the overall uninsured rate was

[1] 2016 CNMI CSD Household Income and Expenditures Survey. http://commerce.gov.mp/hies-2016-population
[2] 2010 U.S. Census.

estimated to be 34% of adults.[3] The 20% of the population that have private health insurance include the government employees which account for about 10% of the population.[4]

Further, the CNMI Medicaid program foresees that more will soon be huddled on the ledge. Just this month, following the losses of Government revenue given Typhoon Yutu, the CNMI Government instituted "austerity" measures. Specifically, government employees have been placed on a 4-day work week. The CNMI Government further restricted funding allocations of the Public School System (PSS). The PSS, in turn, is rolling back salaries and benefits. Given the pay scale of many of the employees that are affected, the Medicaid program foresees enrollment increases, the full extent cannot be known today.

THE MEDICAID FISCAL CLIFF IN THE CNMI

For many years since becoming a U.S. Territory in 1978 and participant in the Medicaid program since 1979, the CNMI has had to struggle with artificial Section 1108 budget caps under Title XIX and an artificial Federal Medical Assistance Percentage (FMAP). The Section 1108 budget cap for the CNMI Medical Assistance Program rose to only *$4.964 million for FY 2012* and the FMAP was statutorily adjusted through the ACA to 55%.

In 2010, Section 2005 of the Affordable Care Act (ACA) recognized the inadequacy of the funds to improve health care for the Medicaid beneficiaries and provided some much-needed relief by temporarily adding to the Section 1108 budget cap an additional amount of $100.14 million to be used from 2011 to 2019 for the CNMI and an additional $9.11 million under Section 1323 that would be available only after the Section 1108 budget caps and Section 2005 ACA increases were expended.[5] Additionally, as noted, the Federal Medical Assistance Percentage (FMAP) for the Territories was also permanently increased to 55% through the ACA in 2012.

The Base Section 1108 funding for the CNMI in 2012 was $4.964 million. Hence, the Medicaid Program was limited in Eligibility and Benefits. The increase provided under the ACA enabled the CNMI Medicaid Program to increase eligibility, deliver on Mandatory Medicaid services throughout these years, and to implement additional "Optional" services under the Medicaid program. The temporary funds under the ACA will end for the Territories on September 30, 2019.

For the CNMI, the temporary increases under the ACA were exhausted at the end of March 2019 and did not last to September 30, 2019. At the end of March, all Medicaid Medical Assistance Program (MAP) and temporary increases under Section 2005 of the ACA were completely exhausted, including the Section 1323 funding of the ACA made available because the CNMI elected not to implement a Health Insurance Exchange (HIE).

THE GAP BETWEEN EXPENSES AND THE SECTION 1108 BUDGET CAPS IN FY 2020

The CNMI will fall off of the Ledge of the Medicaid Fiscal Cliff for FY 2020 without Congressional action. For FY 2020, the Centers for Medicare and Medicaid Services (CMS) has informed the CNMI that the Section 1108 Budget cap for FY 2020 will be $6.85 million, the Children's Health Insurance Program will be $11.2 million, and the amount of the Enhanced Allotment Program will be $195,318. These amounts are completely inadequate to support the current Medicaid Program services in FY 2020.

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[3] 2016 Non-Communicable Diseases Risk Factor and Hybrid Survey. In 2016, the CHCC NCD Bureau conducted the Non-Communicable Diseases Risk Factor and Hybrid Survey was the first population-based, household survey to measure prevalence of non-communicable diseases and related risk factors in the CNMI.

[4] *Note*. Data sources are disparate and much of the data is extrapolated from multiple data sources.

[5] MACPAC. *When will the Territories Exhaust Federal Medicaid Funding?* (May 2019) https://www.macpac.gov/wp-content/uploads/2019/05/When-will-the-territories-exhaust-federal-Medicaid-funding.pdf

To show the *magnitude of the inadequacy*, Table 1, below, shows the Medicaid program expenditures and Accounts Payables at the end of FY 2018 and illustrates the FY 2019 estimated spending and shortfalls. This shortfall includes the $36 million to be received in Medicaid Disaster Assistance.

Table 1 – Summary of FY 2018 Expenditures and Accounts Payables 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	$6.17
FY 2019 CHIP Program Allocation	$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
FY 2019 Enhanced Allotment Program	$0.18
Total Federal and CNMI Medicaid Funds for 2019	**$29.02**
FY 2019 Projected Shortfall Given 2018 Expenditures and APs or Disaster Assistance Needed Based on 2018 Actual Expenditures and Unbooked IBNR	**$42.40**
Amount appropriated under HR 2157 signed into law	$36.00
Estimated FY 2019 Shortfall with $36 Million provided for Disaster Assistance and does not include additional AP accumulating.	$6.40

*Note numbers may not add up due to rounding.

Table 1 clearly shows the gap between the Section 1108 and CHIP funding when compared to 2018 Medicaid expenditures and Accounts Payable Incurred But Not Reported (IBNR). Further, for FY 2019, even with the additional funding provided by the much welcomed and needed HR 2157 disaster relief for FY 2019, the CNMI Medicaid will carry forward into FY 2020 an additional balance that cannot be estimated at this time.

There is much to be learned from this comparison. One lesson is that CMS provided to Congress the estimate of $36 million that was needed for the remainder of the current FY 2019. The CMS is very knowledgeable of the financial situation because the financial reporting required of the CNMI and because CMS releases the allotments for all Medicaid funding sources. The Disaster Assistance was provided at 100% FMAP. However, even if the additional amount of $36 million were to be provided at the current 55% FMAP or $19.8 million then, the total difference for the FY2019 would be $19.8 million plus the already expended amounts of $13.8 million or a total of $33.6 million as of September 30, 2019.

The FY 2020 Fall Off the Ledge of the Medicaid Fiscal Cliff

The CMS has informed the CNMI that for FY 2020, the Section 1108 Cap will be $6.85 million, CHIP budget will be $11.20 million, and the Enhanced Allotment Plan (EAP) will be $195,318 for a total of $18.24 million.

Table 2 projects the FY 2020 shortfall through a comparison of the FY 2018 Medicaid Expenses and Accounts Payables. The Table shows the shortfall to be approximately $42.40 million, even with a commitment of CNMI share at $5.46 million, the amount currently under consideration by the CNMI Legislature due to the financial shortfalls following Typhoon Yutu.

Table 2 – Summary of FY 2018 Expenditures and Accounts Payables and FY 2020 Shortfall Given the End of Additional Funding under the ACA

FY 2020 Allocation Provided by CMS	In Millions*
FY 2020 Section 1108 Allocation	$6.85
FY 2020 CHIP Allocation	$11.20
FY 2020 Enhanced Allotment Plan	$0.19
Total FY 2020 Allocation by CMS	**$18.24**

FY 2020 CNMI Proposed Budget Currently Under Consideration	**$5.46**
Total Federal MAP and CNMI Medicaid Funds for 2019	**$29.02**
FY 2018 Expenditures and Accounts Payables (AP) Incurred But Not Booked (IBNR)	**$71.42**
FY 2020 Medicaid Shortfall	**$42.40**

*Note: the numbers may not add up due to rounding.

THE UNDERLYING CAUSES OF THE MEDICAID FISCAL CLIFF

The Medicaid Fiscal Cliff for the U.S. Territories exists because of the differences in the financing of the Medicaid program between the States and Territories and requires Congress to resolve the inequities.

The two primary statutory inequities between the States and Territories: are the Section 1108 Budget caps under Title XIX and the Federal Medical Assistance Percentage (FMAP). The nature of these differences and impact on the Medicaid program in the Territories is well understood by agencies of the U.S Government and the nonprofit organizations that study health care such as the Medicaid and CHIP Payment and Access Commission (MACPAC), Congressional Research Service (CRS), and Kaiser Family Foundation (KFF), among many others.

The following is a brief summary of these two issues and examples of how this impacts the Medicaid Program in the CNMI and other Territories.

1. <u>Section 1108 of Title XIX</u>

The Section 1108 of Title XIX *establishes budgetary caps* for the Medicaid program for the Territories. In contrast, the States are provided federal funds based on the cost of Medicaid mandatory and optional benefits that are statutorily enabled, proposed by States and Territories through a Medicaid State Plan (Amendment), and reviewed and approved by the Centers for Medicare and Medicaid Services (CMS).

The Section 1108 budget caps were established decades ago and as described by MACPAC are tied to the Consumer Price Index (CPI).[5] MACPAC observes that the CPI has not kept up with Medicaid spending. More important, the amounts were established when the program only provided assistance for the aged, blind, disabled, and Aid for Families with Dependent Children. This is completely inadequate as demonstrated by estimated requirements of an additional $36 million for the Medicaid Disaster Assistance for the last six (6) months of FY 2019.

So, how does this impact the Medicaid Program in the Territories?

Example of an Optional Service under Medicaid

The Medicaid Program has a Mandatory and Optional set of services. Now, if a State wanted to elect providing an Optional service, subject to CMS approval, the State would get an automatic increase in the funding and the State would have to finance the increased State share.

However, if the CNMI, as a Territory, wanted to implement an "Optional" Medicaid service, the cost of the Optional service would need to be accommodated within the existing Section 1108 budget cap. There would be no increase in Federal funding under the Section 1108 Budget caps under Title XIX, even though the Optional Services exists in law and regulation for all States and Territories.

Medications – An Optional Service

The following is an example. Under the Medicaid program, "Medications" for beneficiaries are an "Optional" and not "Mandatory" program service.

Everyone understands the importance of medications in health care and the continuously increasing and high costs of drugs. Further, we all understand, the importance of medications and the severe detriment for low-income beneficiaries with chronic diseases such as diabetes who are unable to get insulin and other medications. The same is true for Medicaid beneficiaries with or at risk of cardiovascular disease who are unable to obtain medications such as statins that are well-proven to lessen the risk of heart attacks and stroke.

Without medication these beneficiaries are left in vulnerable situations in the short and long-run for the health of these individuals; and, ultimately it will cost the health system even more in health care spending.

The good news is that all States provide for Medicaid drug coverage in their programs and so does the CNMI, today. However, the bad news is that the CNMI Medicaid program has been, and will continue to be, deliberating whether medications will be covered in FY 2020 if the CNMI has to live with only the Section 1108 budget caps. The reason is that the CNMI will have to prioritize the services provided by the Commonwealth Healthcare Corporation, a public safety-net health care system or the many mandatory services. The CNMI CHCC health system includes a sole community hospital, ancillary clinics, ancillary services (e.g., pharmacy, laboratory, radiology), and clinics on the remote islands of Tinian and Rota. There are also private providers, including many off-island providers. However, if the CNMI Medicaid program prioritizes payments to the CHCC, then, there will not be sufficient funding for private providers or medication benefits. The short and long-term consequences are clear and do not need further description here.

CNMI was able to support some important Optional benefits such as medications because of the increased funding under the ACA. However, the increase has been exhausted and no further amounts are available today for FY 2020 that starts on October 1 of this year, a few months from now.

2. The Federal Medical Assistance Percentage or FMAP

The second major problem is the FMAP, the federal share of the Federal-State or Federal-Territory amounts for the Medicaid Mandatory and Optional benefits.[6] The calculation of the FMAP of expenditures for States is determined through a formula, as described by Congressional Research Service, "designed so that the federal government pays a larger portion of Medicaid costs in States with lower per capita incomes relative to the national average (and vice versa for States with higher per capita incomes)."[7]

Given the major income differences identified in Figure 1, it is intuitively clear that the FMAP for the CNMI, if calculated in the same way as the FMAP is calculated for States, would be closer to the statutory

[6] MACPAC. *Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands (March 2019)*. https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Commonwealth-of-the-Northern-Mariana-Islands.pdf

[7] Congressional Research Service. *Medicaid's Federal Medical Assistance Percentage (FMAP) (April 2018)*.

cap of 83% for the FMAP. Instead, the FMAP for the Territories is currently statutorily set to 55% Federal and 45% Territory share of Medicaid expenses.[8]

Impacts of the Artificial and Inequitable FMAP

Table 3, below, illustrates how the artificial FMAP of 55% requires the CNMI, as a Territory, to fund a substantially higher Territory Share than if the FMAP were to be calculated in the same way as States. Table 3 uses a total Medicaid Program expense of $50 million, a hypothetical round number close to the FY 2018 Actual Expenditures in Table 1.

Example 1 in Table 3 shows the current statutory FMAP for CNMI and all U.S. Territories. Example 2 uses an FMAP of 75% Federal and 25% State Share. The 75-25% share is very realistic given the CNMI income levels shown in Table 3.

Table 3 shows that for every $50 million in total Medicaid expenditures, the difference between the FMAP at 55% and 75% results in a $10 million difference.

Table 3 – Application of the FMAP and Implications for Federal-Territory Share

Federal Medical Assistance Percentage (FMAP) and CNMI Share		
Example 1 – Artificial FMAP	**FMAP**	**CNMI Share**
Statutory FMAP Set for Territories	**55%**	**45%**
2018 Medicaid Expenditures of $50,000,000	$27,500,000	$22,500,000
Example 2 – FMAP under State Formulas	**FMAP**	**CNMI Share**
FMAP Using Formula for States	**75%**	**25%**
2018 Medicaid Expenditures of $50,000,000	$37,500,000	$12,500,000

A $10 million difference represents 20% of the total hypothetical expense and highlight the substantial difference in the amount that the CNMI would have to fund. Hence, even with the lifting of the Section 1108 budget caps and applying the State Share FMAP formula to the CNMI, the CNMI will be challenged to meet the Territory Share. Nonetheless, it is equitable but would not remove the responsibility of a Territory from having to finance its fair State/Territory share. The CNMI actual direct expenditure for FY 2018 was $10.44 million. So, the CNMI would still need to find additional funding even if the FMAP were calculated the same as States.

Clearly, the FMAP for the Territories should be calculated the same as the States. Doing so would appropriately reflect the relative income and poverty levels equally between the States and Territories. Not doing so would place an unfair burden on the Territories that are more impoverished than all States.

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

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

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 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. Alternatively, the CNMI Medicaid Program may have to limit eligibility leaving those eliminated to become uninsured and further strain the CHCC public healthcare system.

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 an intellectual exercise to balance the so-called "best interests" with "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 each decision will have on the health of the people that we serve and I am frightened for the short and long-term impacts that will occur. There is no escaping the fact that the CNMI is facing a humanitarian and fiscal crisis.

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 healthcare and the impacts that the 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? How do we tell a patient, parents, and loved ones that we are sorry, but we will no longer help with 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 will have.

The Impacts of the Medicaid Fiscal Cliff on the Health of U.S. Citizen Beneficiaries and the Health System in the CNMI

The additional temporary funding provided under the ACA enabled the CNMI to improve its Mandatory and Optional benefits and arrived in time to enable much needed improvements to the health care system in the CNMI. The additional funds that were provided under the ACA will end on September 30, 2019 for all of the Territories and are essential to the health care of the 16,206 Medicaid beneficiaries currently enrolled in the CNMI.

If Congress does not act, we believe that the 49% of the U.S. citizen population in the CNMI will become essentially uninsured shortly after the first quarter of FY 2020, unless the CNMI Medicaid program reserves all funds for the CHCC public corporation. The CNMI Medicaid Program has not made decisions on how the limited funds will be used and is consulting with CMS, the CHCC, Medicaid providers, and Medicaid beneficiaries. Any decision will have both short and long-term dire and devastating consequences for the health of the Medicaid beneficiaries and have equally serious consequences for the health system in the CNMI.

The situation is dire and desperate, and simply and directly a function of the fact that the Medicaid programs in the Territories are not treated the same as the States as well as the limited budgetary resources of the Territory; and, as a result, the U.S. citizens of CNMI will fall off the Medicaid Fiscal Health Cliff if the inequities are not addressed.

Impacts on the CNMI Government and the Safety Net Health System

The U.S. Government Accountability Office (GAO), about three 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 unless the CNMI Medicaid program cuts or eliminates services including off-island care, dental services, and even drugs, and not pay the CHCC for the full amounts that the CMS has determined are appropriate to pay under the CPE methodology. We have been praying for another year of 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.

The CNMI Medicaid program is planning severe cuts that will impact our U.S. citizens and damage our health system. However, without relief from the Section 1108 caps and an equitable FMAP, there is no other option. Further, for the record, the amounts will not be sufficient to fully pay the CHCC based on the amounts due from CMS calculations.

Impacts on the Commonwealth Healthcare Corporation

The CNMI Medicaid program is also very aware and worried with the impact the shortfalls will have on the safety-net 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% 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*. Further, this would mean that all other expenses and services, including Medications, and many other basic Mandatory and Optional services would need to be curtailed. The CNMI Medicaid program will need to limit radiology read services (because we have no radiologist on island) or referrals for advanced MRI and CT studies, 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. Clearly, this will lead to a humanitarian and fiscal crisis. What are we to do?

IMPROVING MEDICAID PROGRAM ADMINISTRATION

The CNMI is fully aware that the U.S. Territories of Puerto Rico and the U.S. Virgin Islands have recently implemented their Medicaid Enterprise Systems (MES) and further acknowledges that the U.S. Congress in HR 2157 requires American Samoa and Guam, two Pacific Territories, to initiate the planning for submitting data to T-MSIS and establishing a Medicaid Fraud Control Unit (MFCU). That would leave the CNMI as the only U.S. State or Territory that has not yet planned or implemented a Medicaid Management Information System (MMIS), submitting data to the Transformed Medicaid Statistical Information System (T-MSIS), and establishing a Medicaid Fraud Control Unit (MFCU).

The CNMI wishes to make clear that the Territory is well aware of and has wanted to implement an MMIS, submit data to T-MSIS, and establish a Medicaid Fraud Control Unit and Claims Data Warehouse. We have a full understanding and appreciation of how these systems and programs would not only help the CNMI improve the administration and management of the Medicaid Program, but will greatly facilitate the work of a Medicaid Fraud Control Unit and enable the CNMI to use detailed Medicaid claims and encounter data to improve care, population health, and lessen the long-term costs. We are further aware of how other States are using Health Information Technology and Health Data to assess the ongoing quality of care, improve coordination of care, understand the health of the Medicaid populations so that waiver and other programs can be targeted for improvements, and to lessen the costs through focused Medicaid waiver programs including Managed Care and other programs.

The only reason why the CNMI has not yet initiated the planning and implementation of a full MMIS is based on the fact that if the increased funding under the Affordable Care Act ends, the CNMI Section 1108 budget cap, together with the CHIP funding, would only be around $18.24 million. Since the cost of implementing a MMIS, submitting data to T-MSIS, and initiating a data warehouse has cost the next smallest U.S. Territory $46 million, even with a partnership with another state, the question was whether committing to such an expense, given the small amounts of Section 1108 and CHIP funding of $18.24 million, made sense.

In 2017, the CNMI Medicaid Program directly asked this question in a meeting with CMS Region IX. We expressed the concern that the CNMI Medicaid program would become one of the highest proportional State or Territory in MMIS spending when compared to beneficiaries or any other metric of size. Further, the ongoing administrative costs for activities, even with the federal funding support would be significant expense for a small Territory. Even the CMS team agreed that the benefit/cost and effectiveness/cost of a full system, given the 1108 budget cap of $6.85 and $11.20 million for CHIP, may be an issue for the CMS national program officers.

At the same time, to be clear, the CNMI Medicaid program is fully committed to using healthcare data to improve data collection, management, and analysis of Medicaid claims data. As evidence of this commitment, the CNMI directs attention to two important low-cost activities over the past two years.

CMS Medicaid Innovation Accelerator Program (IAP)

First, the CNMI Medicaid program took a lead role in preparing and submitting an application to the CMS to participate in a Medicaid IAP focused on Medicaid and health care data collection, management, and analytics. The Medicaid IAP was offered on a competitive basis at no charge to both States and Territories. The CNMI Medicaid Program submitted the application with the Territory of Guam and was very fortunate to have been selected by the CMS as a participant in this program.

Following the first year of participation, the CMS IAP program, recognizing the need in the Territories, approved the participation in a second year of the CMS-sponsored IAP for CNMI and Guam.

CNMI Medicaid Claims Data Warehouse

Second, and as further demonstration, the CNMI Medicaid in 2017, following the meeting with Region IX in 2017, requested funding to move forward with preliminary planning for a Medicaid Claims Data Warehouse. At a minimum, the idea was that the CNMI would be able to collect the claims data file electronically and conduct data management with the intent of getting the process to ultimately result in transmitting data to the CMS T-MSIS system.

The CMS approved that request, together with the 90-10% funding, to initiate the planning for that effort. The CNMI Medicaid program explained the importance of this activity and a law was passed for matching funds to support the effort. However, we have had to temporarily delay the project because Typhoon Yutu, a Category 5 typhoon, arrived just at the time when the contractor was on island in October 2018 and the CNMI Medicaid program had to deal with the impending Medicaid Fiscal Cliff.

These activities demonstrate CNMI's commitment to more effectively administer the Medicaid program, even with the limited resources and the major challenges we confront on a daily basis to improve the program and serve our U.S. Citizen beneficiaries.

So, should the U.S. Congress treat the CNMI equally as States and increase its federal expenditures, the CNMI is fully prepared and already committed to make reasonable and appropriate progress to implement a MMIS, submit data to T-MSIS, establish a Medicaid Fraud Control program, and use data analytics to better assess and improve health care, population health, and lessen the costs of health care. The CNMI Medicaid program further believes that the CNMI policymakers would prioritize the required matching funds for Medicaid Enterprise Systems/MMIS/T-MSIS and Medicaid Fraud Control Unit activities, especially if statutorily required.

SUMMARY

The U.S. citizen Medicaid beneficiaries in the Commonwealth of the Northern Mariana Islands are clearly "on the verge of a humanitarian and financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for next year and beyond." During FY 2020, the CNMI will not be able to fully support the Mandatory services; will need to institute reductions in the Optional services, including medications, as just one example.

The CNMI is in a desperate and dire situation; and, the U.S. citizens in the Northern Mariana Islands deserve equity in healthcare. Last year, I asked myself the questions: "How can we get national attention to the plight of the CNMI? And will people hear us?" The Committees on Energy and Commerce and Natural Resources have heard us and has provided an opportunity for our Territory to discuss the Medicaid Fiscal Cliff.

We are humbly pleading for the U.S. Congress to please help the Territories and treat the U.S. citizens of the U.S. Commonwealth of the Northern Mariana Islands equitably and avert the impending humanitarian and financial crisis. We sincerely appreciate that Congress provided Medicaid Disaster Assistance. We are hopeful that Congress will hear us once more and act to mitigate the negative impacts on the health of the Medicaid beneficiaries and the Health Care System in the CNMI.

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

Ms. ESHOO. Thank you. The gentlewoman's time is expired. I now would recognize—the Chair recognizes herself for 5 minutes of questions.

First of all, to the full panel: I think I know the answer to this, but just in case there is someone that doesn't agree, do each of you support having the territories' Medicaid programs treated the same as the States', including lifting the cap on Federal funding and increasing the Federal match—excuse me, anyone disagree?

Ms. RHYMER-BROWNE. No, we do not disagree.

Ms. ESHOO. No, so you all agree. All right.

Ms. RHYMER-BROWNE. We all agree.

Ms. ESHOO. All the women agree. That is terrific.

Ms. YOUNG. Except maybe for me.

Ms. ESHOO. All right, Ms. Young.

Ms. YOUNG. It is not that—I don't disagree, I just want to, and I think I stated this in my written testimony, that there is a caveat about treating American Samoa, in particular, like a State because of our 1902(j) waiver, so it really depends.

We are not averse to further accountability in program integrity issues, but sometimes there are things that don't make sense with Federal laws to apply to us. For example, a few years ago we explored the possibility of acquiring an MMIS system just to do data gathering as required by CMS. But when we looked into it, it would have cost us over $20 million to implement an MMIS system. And when you only have $11 million in Medicaid funding block grant, that doesn't make sense.

So it is not that I am disagreeing, but I am asking the committee that the question of whether we want to be treated like a State, I am wary of that. And I am very happy to work with the committee to define what does that actually mean by if we were going to be treated like States. Thank you.

Ms. ESHOO. Thank you. I think each one of you, or the majority of you, made reference in your testimony to the cost of prescription drugs and air ambulance services. Can you enlarge on that, what percentage of your overall costs that these represent?

Yes, Ms. Avila?

Ms. AVILA. Yes, Angela Avila from Puerto Rico. The cost on pharmacy in Puerto Rico is like this 30 percent of the total expenditure. Our total expenditure is around 2.9 billion, actually, so it is a major part of our expenditures right now.

Ms. ESHOO. What about air ambulance services?

Ms. AVILA. Air ambulances as well, but we don't need to move our beneficiaries from the islands, so our——

Ms. ESHOO. I see.

Ms. AVILA [continuing]. Like ordinary other costs are compared to the States.

Ms. ESHOO. Ms. Young?

Ms. YOUNG. We just recently started implementing off-island referral 2 years ago, so—and with the availability of the ACA money we haven't really seen the real impact on that. But we are looking at maybe spending about $300,000 on air ambulance.

Ms. ESHOO. What about the drugs, prescription drugs?

Ms. YOUNG. The prescription drugs are covered through our one hospital. We do have issues on that. There is just not enough money to cover prescription drugs across the board.

Ms. ESHOO. Ms. Arcangel?

Ms. ARCANGEL. With regards to air ambulance, we utilize air ambulance roughly two to three a year. It costs us $160,000 to send—from L.A. to Guam and Guam to L.A., because the airlines in Guam do not, especially for stretcher cases, they don't take patients for stretcher cases.

Ms. ESHOO. And what about prescription drugs?

Ms. ARCANGEL. For prescription drugs, that is second to the highest of our expenditures. First is the inpatient and then the pharmacy services.

Ms. RHYMER-BROWNE. For the U.S. Virgin Islands, pharmacy costs are extremely expensive for us, and I would daresay about 20 percent of our costs. I just approved a payment of $5 million just last week for just the pharmacy for a couple months. Additionally, the airlifts for our territory in the Virgin Islands have increased because of the damages to both of our hospitals. So we have to send the traumatic cases, the serious complex cancer cases to the mainland.

Ms. ESHOO. Ms. Sablan?

Ms. SABLAN. For CNMI, we spend about 25 percent on our prescription drugs. For air ambulance that is being done we use—actually, we don't have that available on the islands, so we have to use either out of Guam or out of the Philippines, and that is costing us a lot of money. I would say about 300-some thousand.

Ms. ESHOO. Thank you very much. I believe my time is expired, so I will recognize the ranking member of the subcommittee, Dr. Burgess, for his 5 minutes of questions.

Mr. BURGESS. Yes. And before I am recognized for question time, I have a unanimous consent request that the committee accept the testimony of Congresswoman Jenniffer González-Colón as for her opening statement as part of the record.

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. So I have a number of questions, and some of them are complex, so I will submit those in writing so we can get to the majority of the ones that answering in person I think would be advantageous. I don't need for you all to go through a bunch of numbers. We can do that on paper, and that will be a better way to approach that.

But, Ms. Avila, in Puerto Rico—and I did travel to Puerto Rico with Representative González-Colón a couple of times, once about a week and a half after the storm and it was pretty rough, and then with the subcommittee, with then-Chairman Walden.

But one of the things that just was very—I am a physician by background. One of the things that was striking to me was, you know, the docs at the hospital, OK, they are there. They have got maybe the lights back on, the run of the generators full-time. It is dicey, but things are manageable. But then when they go home, their houses are dark and not air-conditioned. Their families have been in that environment all day.

So you can just imagine the pressure on the doctors, say: "Hey, those nice people from the University of Miami called me again today, and they want you to come interview for a nice job there." So that is hard when you are—yes, I get the commitment to their patients in the hospital, but then you go home and you are faced with a family that is saying, "I don't know why we can't do what they are asking."

So how has it been over the past couple of years keeping your doctors in Puerto Rico?

Ms. AVILA. Thank you for the question. Angela Avila. It has been a real challenge just to keep our doctors in the island. Since 2014, we have been seeing like the exit of our healthcare professional because of their frustration and their economic circumstances, they need to go and face attending our beneficiaries, and that is why we are looking for to be like a full Medicaid program and be able to provide home care services.

Right now we have identified that home care services are part of the new way of doing medicine in the States and in the territories. It is the right way to do it, and at the long run we will see the savings because we will save inpatient and admissions, they are so expensive if we have all that support, the other programs.

So yes, it is a challenge for our doctors. The ones that have been—that stay in the island is because they love to be there, it is not because of economic reasons. And what we are looking is just for the basic baseline compared to a lower rate, reimbursement rate than in the States, but reasonable for our doctors to be able to serve the population.

Mr. BURGESS. So did the hundred percent FMAP, did that help?

Ms. AVILA. Oh, it will be a golden opportunity for our island to work with the healthcare system there.

Mr. BURGESS. So, Ms. Arcangel, let me ask you this. Are you also suffering from not being able to keep doctors on the island? Do they leave you after a period of time, or are they likely to stay?

Ms. ARCANGEL. No. Yes, they do leave after a few months or a year. They do leave because of the nonpayment and low reimbursement as well as the low rate of salaries of the physicians.

Mr. BURGESS. Is there anything other—the funding questions aside, are there any other aspects that you can think of that would help when it comes to getting doctors to come to the island?

Ms. ARCANGEL. We should provide more incentives by increasing the rate of their salaries, especially for our federally qualified health centers. They come and go. They don't stay in Guam.

Mr. BURGESS. So let me ask you a question about that, because you mentioned liability insurance in your testimony.

Ms. ARCANGEL. Yes.

Mr. BURGESS. I think you were the only one that did. You got my attention because liability reform is something we have done in Texas and has been extremely helpful. Now the federally qualified health centers, those doctors are covered under the Federal Tort Claims Act. Is that not correct?

Ms. ARCANGEL. Yes, but.

Mr. BURGESS. So is that helpful in keeping doctors in Guam?

Ms. ARCANGEL. True, but then again the rate of, you know, the physician salary is very low. That is why they don't stay much in Guam.

Mr. BURGESS. Have you looked at any of the—some of the States have done liability reform, California and Texas two of the most notable. Have you looked at that as far as the activities in Guam as well? I will tell you from the standpoint of a physician practicing in Texas, it has been an attractant. I mean, it is easier to get a doctor to come to New Jersey because of what our liability rates are in Texas. I am not saying we are stealing doctors from New Jersey, but we could.

Ms. ARCANGEL. Oh. That is a good idea. We will try to look at that. Yes.

Mr. BURGESS. I will be glad to follow up with you on that.

Ms. ARCANGEL. Thank you.

Ms. ESHOO. The gentleman's time is expired and he yields back. I now would like to recognize the chairman of the full committee, Mr. Pallone, for his 5 minutes of questions.

Mr. PALLONE. Thank you, Madam Chair. I thought I was going to get a New Jersey joke there for a while. I didn't know what Dr. Burgess was up to. Anyway, my questions are of Ms. King Young, and I want to thank you for being here.

We have heard a lot today about the consequences the fiscal cliff faces, you know, provides to the territories, and I am especially concerned about the effects going over the cliff would have on people in the territories. And it sounds like you all would have to make some terrible choices to cut back on coverage, benefits, provider pay. It is also clear that none of you here today wants to implement these cuts, but you will have no choice if we don't provide you with additional Federal funds.

And it seems to me that what is at the core of the problem that you all described is the completely outdated way the Federal Government funds the territories' Medicaid programs. In a State Medicaid program, the Federal Government matches State spending. If the State spends a dollar on Medicaid, the Federal Government spends at least a dollar and oftentimes spends a lot more. In other words, there is no limit on how much Federal funds a State gets.

But it sounds like that is not the deal you all get, so you are all getting far less Medicaid funds than the States, and you are putting up way more of your own money. So let me try to get through this, Ms. King Young. Under the current capped allotment approach, your territory only receives a set amount of Federal funding for Medicaid. But what happens if your Federal funding isn't enough to cover your Medicaid expenses?

Ms. YOUNG. Thank you, Chairman Pallone. If we received enough Federal funding for our Medicaid program, it really would allow us to cover all or most of the comprehensive services that are required under the Social Security Act. For example——

Mr. PALLONE. But when you don't get the Federal funding, if it isn't enough, then what happens? How do you deal with the Medicaid expenses if——

Ms. YOUNG. The first thing we will do is we will suspend all of the new services that we recently added and was approved by CMS 2 years ago. It took us a while to implement those because they

had never been done before. Prior to 2017, we only had one Medicaid provider, and that was our hospital.

So all of the new services, medically necessary care that is referred off island to New Zealand will be suspended. We will stop all reimbursements to our federally qualified health centers, the five community clinics, and we will stop all payments to our providers that provide durable medical equipment, prosthetics, and orthotics. And we will also stop payments for the Medicaid dual-eligible population, the copay assistance that we offer them to pay the 20 percent.

Mr. PALLONE. All right, so looking back at your Medicaid spending in 2018, I see that your Federal spending was much more than the 1108 funds or the block grant you received. So where did the additional Federal funds come from beyond the block grant?

Ms. YOUNG. The additional funds came from the Affordable Care Act Medicaid——

Mr. PALLONE. Oh, all right.

Ms. YOUNG [continuing]. Funding that was made available in 2011.

Mr. PALLONE. But now that expires. That additional funds from the ACA, those expire at the end of this year, some in September, the rest in December. Is that correct?

Ms. YOUNG. Yes. That is correct.

Mr. PALLONE. And then you are going to have a significant funding shortfall. Is that correct?

Ms. YOUNG. Yes.

Mr. PALLONE. OK. So I understand that the size of that 1108 cap increases annually at the rate of inflation for medical services. Have those annual increases been sufficient to keep pace with the cost of providing care in the territories, and does that cap increase if Medicaid enrollment increases?

Ms. YOUNG. So, two ways. It is never enough. Our increase per year is about 2 percent a year, and there is a shortfall of about 6 million a year for the hospital alone.

Mr. PALLONE. But does the cap increase if Medicaid enrollment increases?

Ms. YOUNG. So the second answer to that is we do not do individual enrollment in American Samoa. We have a presumptive eligibility program where most of our people are presumed covered under Medicaid, which is about 36,000 people that we cover, so it doesn't affect the money that we get because we don't do individual enrollment.

Mr. PALLONE. So the cap doesn't increase if enrollment increases under that scenario, right?

Ms. YOUNG. No.

Mr. PALLONE. No.

Ms. YOUNG. It is simply a block grant.

Mr. PALLONE. All right, then let me ask you one more question. It sounds like you have to spend a lot more of your local funds on Medicaid than you would if you were a State. That means those local funds can't be used for other critical investments or services. So if you received the same Federal Medicaid funding as a State, it seems you would free up more of your territory's funds for investments and things like infrastructure and education. Is that correct?

Ms. YOUNG. Yes, but it is a very small, nominal amount. The hospital continues to get the subsidy that it needs to operate, but the only money that we receive for local match for the new services is $2 million.

Mr. PALLONE. But if you received the same Federal Medicaid funding as a State, it would free up more of your territory's funds for other things, correct?

Ms. YOUNG. Not really, because we would still have to come up with a local match.

Mr. PALLONE. I see.

Ms. YOUNG. So if the match doesn't change, then it doesn't help us.

Mr. PALLONE. Then it doesn't help you. All right. I just wanted to say, I mean I think it is clear that the simple fact is that the capped allotments that the territories receive from the Federal Government for Medicaid are just not enough to meet the needs of the people who live there. That is obvious, so that is why we have to act. Thank you.

Ms. YOUNG. Thank you.

Ms. ESHOO. The gentleman yields back. And now I would like to recognize the gentleman from Oregon, ranking member of the full committee, Mr. Walden, for his 5 minutes of questions.

Mr. WALDEN. Thank you, Madam Chair.

Dr. Schwartz and Ms. Avila, according to MACPAC, in 2017 the Medicaid program spent an average of $7,654 per year per enrollee, but only 1,866 per year per territorial enrollee, and only 1,844 per year per Puerto Rico enrollee. My colleague from Puerto Rico had this question she wanted me to ask. So how does this difference in Federal Medicaid spending affect the provision of healthcare to low-income individuals, and how does it affect the overall healthcare system in the non-Medicaid population in your territory?

So, Dr. Schwartz, you might just want to tackle this from the MACPAC side and make sure our numbers are right, and Ms. Avila in terms of its implication. I have two other questions.

Dr. SCHWARTZ. I will just say that, in MACPAC's June report, we have an extensive chapter on the situation in Puerto Rico and for which we are grateful for getting a lot of data from the government of Puerto Rico and assess to help us do these analyses. And when we looked at spending per enrollee in Puerto Rico compared to the States and we adjusted for the enrollment mix and we also took out spending on the State side for long-term services and supports, Puerto Rico spending is below any of the other States, so it is substantially lower.

So I will let——

Mr. WALDEN. All right, Ms. Avila?

Ms. AVILA. It is like 36 percent lower than in the other States of the Nation.

Mr. WALDEN. All right, that is helpful. And over the last several years that Congress, led by this committee, has provided billions of dollars in additional funding to help the territories keep your Medicaid programs afloat, these funds have gone well beyond the original caps set forth in section 1108 allotments. And one of the ways we have done that is by temporarily increasing the territories'

FMAP to increase the Federal Government's share of spending, as you all know.

Now, I know that is something we are discussing here today. A problem with that as I see it, though, is that even if we increase the FMAP for your territories, the cap remains. So my question to each of you is, what would happen if we just increased the FMAP for each of your territories without touching the cap? And along with that, for each of your territories—because, again, there are unique challenges and circumstances that you have each addressed—which is a bigger hindrance to adequately funding your program: the cap or the FMAP? If we could just kind of go down the list there.

Ms. AVILA. I am sorry. Angela Avila from Puerto Rico.

Mr. WALDEN. Yes.

Ms. AVILA. In the case of Puerto Rico, our actual cap according to the section 1108 is $380 million, approximately, so our actual expenditure is $2.9 billion. It is no way that we can cover such a high difference between what is the cap amount and what is it for expenditure. So increasing the FMAP will not resolve the problem if we don't increase the cap.

Mr. WALDEN. Got it.

Ms. Young?

Ms. YOUNG. I echo Ms. Avila's, and I think I also stated that in my statement. We cannot fix the FMAP and not also fix the cap, because what will happen is, if you only fix the FMAP, all that means is we will spend our Federal dollars faster and we will exhaust them——

Mr. WALDEN. Got it.

Ms. YOUNG [continuing]. In the first quarter of the fiscal year.

Mr. WALDEN. That would be a problem.

Ms. YOUNG. So it doesn't help.

Mr. WALDEN. Yes, all right.

Ms. Arcangel?

Ms. ARCANGEL. For Guam, our total allotment is only 18.38 million. That includes administration for fiscal year 2020. That will not last for first quarter for adults. So, if there is no increase on the cap, then that means we have to terminate some of our eligibles, adult eligibles. More than 50 percent of them will not have any coverage at all.

Mr. WALDEN. Wow.

All right, next?

Ms. RHYMER-BROWNE. Yes, we need both. We need the FMAP increased and we need the cap, because if we don't have higher monies, just in fiscal year 2020 projected we are supposed to get 18.8 million that will not even last for the quarter. We are already projecting we would have to cut 15 of the 28,787 people, so 15,000 of those would have to be cut if we were just to be given a hundred percent FMAP or raised FMAP with no increase on the cap.

Mr. WALDEN. All right.

Ms. SABLAN. In the CNMI we are actually spending, based on the FY 2018, we spent 53 million, and we were advised that we are only going to get 18 million. That includes the 1108 funding plus a CHIP. So in our case, we want the cap. Our preference is the cap.

Mr. WALDEN. To raise the cap.

Ms. SABLAN. Yes. Raise the cap.

Mr. WALDEN. All right. Thank you all for your testimony. It has been most helpful. Some of us are going back and forth between two subcommittee meetings simultaneously, but we do appreciate your input and counsel as we work together to solve this problem.

So, Madam Chair, thank you for the hearing and I yield back.

Ms. ESHOO. The gentleman yields back. I now have the pleasure of recognizing the gentleman from North Carolina, Mr. Butterfield, for his 5 minutes of questioning.

Mr. BUTTERFIELD. Thank you very much, Madam Chair. And thank you to the six witnesses for your testimony today. I have heard some of it, and my staff has been here for the entire time, and they will tell me the details that I may have missed. But thank you so very much for your testimony.

You know, I am a great friend of the territories. I have been for many, many years. It has always perplexed me that we have treated the residents and the citizens of the territories different from those on the mainland. That has always perplexed me. I have never been given a satisfactory explanation about why that has happened. The Delegates from the territories are great friends of mine, particularly Ms. Plaskett and Delegate Sablan and Delegate San Nicolas from Guam. The five Delegates have just advocated tirelessly and fiercely over the years for equal treatment for your people.

Dr. Schwartz, can you help me in just a few words understand why the citizens of the territories are treated differently?

Dr. SCHWARTZ. The treatment of the territories in the Medicaid program really dates back to the beginning of the program. I was alive in 1965, but I obviously wasn't——

Mr. BUTTERFIELD. I finished high school that year. It was a good year.

Dr. SCHWARTZ [continuing]. At that time. But I think it is a historical artifact of a very complex piece of legislation that has not been updated.

Mr. BUTTERFIELD. To the gentlelady from the Virgin Islands, thank you for your testimony. I have family and friends in your homeland, and we will talk about that later. But I understand that the U.S. Virgin Islands will lose access to Federal funding provided under the ACA at the end of the year.

Ms. RHYMER-BROWNE. Yes.

Mr. BUTTERFIELD. You testified to that. You stated in your testimony that the Virgin Islands will receive only $18 million in Federal funding once the funding expires. I understand that this is only 25 percent of the Federal funding that the territory needs. Is that correct or incorrect?

Ms. RHYMER-BROWNE. Well, we are actually over, we have spent over a hundred million in per annum with the—the 18.8 would really not be sufficient. Additionally, we would be very, very much curtailed in our program accountability and integrity programs, where we are building systems and programs that build accountability. We do have the first-ever territory MMIS claims system. We just completed our eligibility system with our funding and our increased funding. So we would need even more monies to really meet the needs. When we——

Mr. BUTTERFIELD. You don't have it in reserve? You don't have a couple billion dollars in reserve that you could draw from?

Ms. RHYMER-BROWNE. Unfortunately, we don't. Even before the storms we were in dire straits, but now are even more so. Our schools are still devastated. Our hospitals are devastated. Our clinics are devastated. Our roads are still in need of repair. And so the basic infrastructure improvements that need to be made, really, may have to be curtailed if we have to then put more local monies to save the lives of our citizens.

Mr. BUTTERFIELD. That is what I needed in the record. How many beneficiaries could lose access to coverage once these funds expire? Can you quantify the number?

Ms. RHYMER-BROWNE. Yes, about 15,000 or a little bit more. Our numbers have even increased. We have 28,000 members, so approximately 15,000 of them would have to lose coverage.

Mr. BUTTERFIELD. And these are American citizens?

Ms. RHYMER-BROWNE. Yes, they are.

Mr. BUTTERFIELD. Can you discuss the impact on providers and hospital systems very quickly?

Ms. RHYMER-BROWNE. Well, the providers, if we were not able to provide the Medicaid funding for the care that they are providing, we may then have more of the exodus of our providers. Right now we are facing just a dearth of the specialty doctors for orthopedics, for cancer. Our cancer center was decimated during the storm, so our providers are desperately in need. Right now, we are reimbursing them at a hundred percent of the Medicare rate, and many of them for the specialties really need more monies.

Mr. BUTTERFIELD. Ms. Young in her testimony said they would just have to cut off payments. That they just couldn't afford it, they would have to stop reimbursing. Yes.

Ms. RHYMER-BROWNE. Well, in the case if we were to face this kind of cuts that we are looking at in fiscal year 2020, we would have similar hard decisions to make.

Mr. BUTTERFIELD. Thank you. I yield back.

Ms. ESHOO. The gentleman yields back. I now would like to recognize the gentleman from Kentucky, Mr. Guthrie, for his 5 minutes of questions.

Mr. GUTHRIE. Thank you, Madam Chair. And thank you for the opportunity to be here and all the witnesses here.

I will tell you, before the storms in the Caribbean a couple years ago, we were—Dr. Burgess and I and all the both sides of the aisle have been talking about the territories and how we have to work with the Medicaid program. And I know that for the last couple of years in some of the areas, because of the devastation it has been hundred percent FMAP and other adjustments. What we need to look at as we are looking at it today, and I think it is—glad you are having this, Madam Chair—is how to make this program fair to territories and sustainable in the proper moving forward.

And just for an example, I was talking with my friend Ms. Gonzalez and Ms. Radewagen, before—Ms. Plaskett, all of the different members—and in how do you get to be fair? I know in Puerto Rico if the fiscal year 2020 law in is in effect, 370 million will be the cap at—375 million in Puerto Rico, and that is $285 per enrollee as compared to 7,600 in Mississippi or 7,900 in South Dakota.

So those are some of the things that we are looking at to how we move forward. And as I was talking to Ms. Gonzalez earlier, I know there are sets of mandatory benefits and then sets of optional benefits that can move forward. And I guess my question, if Congress was to raise the FMAP or lower the cap—or raise the cap, I guess would be the right word, remove the cap—what would be your priorities?

I don't know if, Ms. Schwartz, this is—Dr. Schwartz—to you, but to the others, what would be your priorities to spend? Do you fund the mandatory benefits and what would be—where would you spend the money? And we will just kind of go down the aisle kind of quickly because I want to ask another question.

Ms. AVILA. Angela Avila from Puerto Rico. Our first priority will be increasing the reimbursement rates for our doctors. The specialists and healthcare providers and our hospitals are in jeopardy.

Mr. GUTHRIE. OK, thank you.

Ms. YOUNG. Our priority would be to continue the new services that we just implemented in the last 2 years.

Mr. GUTHRIE. OK, thank you.

Ms. ARCANGEL. Our priority will be to add additional services, like for nursing services, because we have cap on nursing services and we need a lot of those.

Mr. GUTHRIE. OK, thank you.

Ms. RHYMER-BROWNE. Yes, our priority would be to continue serving the current clients and also go after the 10 to 15 thousand who are currently uncovered but are eligible for Medicaid.

Ms. SABLAN. For CNMI, our priority is to cover the mandatory services plus some of the optional services like medications.

Mr. GUTHRIE. OK, thank you. Yep. That sounds like good priorities to move forward on.

The second, during the Bipartisan Budget Act of 2018, I know Puerto Rico and the Virgin Islands, because of the reactions and the relief, were required to have additional reporting methods move forward. I know that you did those on time, so we appreciate that. But—so what is the current status?

And then the question for the rest of you would be, what program integrity measures—let me do the Puerto Rico and Virgin Islands and then go back. What program integrity measures would you be willing to put in place should Congress increase funding? So current status and what would you like to see in the——

Ms. AVILA. Yes. Our status right now, Puerto Rico already implemented the first phase for the MMIS Puerto Rico. And according to the BBA, $1.2 billion were tied to the compliance with the T–MSIS responsibility for CMS, which we did, and we have the certification from CMS. And also, to establish the Medicaid Fraud Control Unit, and it is already in place in the Justice Department and working. So we complied with the two requirements tied to the BBA.

So next, what will be the improvements on those platforms and controls, we are just working right now with the second module, eligibility and enrollment for the MMIS infrastructure in Puerto Rico. Also, we have been perfecting our contacts with our managed care organizations starting with 92 MLR required through the contracts——

Mr. GUTHRIE. I just have a few seconds left.

Ms. AVILA. Oh.

Mr. GUTHRIE. So I guess Ms. Rhymer-Browne. I am sorry if I said that incorrectly.

Ms. RHYMER-BROWNE. Yes. We did implement the first-ever Territory Medicaid Management Information System. That system has been operating since 2013, and I really believe that we are doing well with that. We also implemented a Medicaid MAGI-compliant online Medicaid eligibility system in July 2017, and that is going well. We also already implemented a Medicaid Fraud Control Unit that is operating under the office of our Attorney General, and we are getting high marks with our T–MSIS efforts for integrity.

We have finished our phase 1. We entered our phase 2, and we were told that all of the top 23 issues for the T–MSIS 2 has been completed.

Mr. GUTHRIE. Thank you. And my time has expired, and I yield back. I appreciated your answers.

Ms. ESHOO. The gentleman yields back. Pleasure to recognize the gentlewoman from Florida, Ms. Castor, for her 5 minutes of questions.

Ms. CASTOR. Thank you, Chair Eshoo. And I want to thank all of the witnesses for being with us today and speaking up for the folks back home.

I think it is patently unfair that we treat American citizens who live in Puerto Rico and the other territories differently when it comes to the healthcare they receive under Medicaid. Chairman Pallone said it is outdated. Dr. Schwartz, you said this has been a chronic underfunding problem for many years. I am heartened by the fact that Representative Soto, Representative Velázquez, and other Members now have come up with legislation that looks like it can help address this large inequity. There is nothing like having the devastation of a major hurricane like Hurricane Maria to shine the light on this inequity, so hopefully we can move to a better place so that all American citizens, no matter where they live, are treated equally.

Ms. Avila, you explained to another congressional committee recently that this fiscal cliff that Puerto Rico is facing would be devastating for folks who rely on Medicaid for their healthcare. I understand that, if you do not receive additional Federal support, it is possible that over 125,000 American citizens in Puerto Rico would lose their access to the doctor's office and health services under Medicaid. That is a staggering number of people. And Ms. Rhymer-Browne just added to that total, and there are others.

And then this—Medicaid is so important because, if you lost that many, if you faced this fiscal cliff, it would simply fray the provider network on hospitals, doctors, and nurses and lead to a major collapse. Could you explain why Puerto Rico would have to cut so many people from health services under Medicaid if this fiscal cliff comes to be?

Ms. AVILA. Thank you. It will be because, as I mentioned, our 1108 section only provide us with a cap amount of $389 million. Our actual cost in the program is $2.9 billion. We have been able to continue as of today because of the segments of additional funding as ACA that is going to be ending on December this year, so

we will be left with only the section 1108, $380 million with an FMAP of 55 percent.

So we are going to have like in aggregate $1.3 billion because Puerto Rico have already identify almost a billion dollars from our local funds to do the matching. So with $1.3 billion, we only can afford just the baseline that we have in services, and we will not be able even to cover dental and pharmacy. And the population that we paid 100 percent with our local funds are the 125,000.

But more than that, we will lose 500,000 Medicaid recipients right now because we will not have enough funds to cover for them.

Ms. CASTOR. And who are we talking about? Explain, because Medicaid usually serves our working-class neighbors that don't have access to any other health insurance. Who are these folks?

Ms. AVILA. We are talking about our more vulnerable citizens in the island. We are talking about people that doesn't earn more than $400 per month, and that means that they cannot earn more than $11,000 a year, in comparison with the States that people earning like more than $30,000 a year to be able to participate of the Medicaid program. So that is the huge disparity that we have right now.

Ms. CASTOR. So I have heard some people argue that, well, can't you just reduce provider rates or make Medicaid more efficient in Puerto Rico. What do you say to that?

Ms. AVILA. In terms of providers' rates, as I mentioned, it will be our priority if we have additional funding, because if we can't pay our physician visit in an ambulatory settlement that it runs like in Puerto Rico like no more than $20 per visit. Here in the States it is more than $100, and that is why our physicians are no longer able to keep providing services. That they are really financing them in some situations.

So even if we have the cap amount, if we don't have doctors who can serve our population we will not be—by our program in Puerto Rico. So that will be the main cost, I will say, of this cliff.

Ms. CASTOR. Thank you very much. I yield back.

Ms. ESHOO. The gentlewoman yields back. I now recognize the gentleman from Florida, Mr. Bilirakis, for his 5 minutes of questions.

Mr. BILIRAKIS. Thank you, Madam Chair. I appreciate it. Thank you for holding this hearing as well.

Ms. Avila, I have a non-Medicaid question for you, but one that I think is important to the overall conversation. On May 13th, Governor Rosselló sent a letter to this committee highlighting additional challenges Puerto Rico faces in the Medicare Advantage Program. As I understand it, enrollment in Medicare Advantage in Puerto Rico exceeds 70 percent compared to the national average of 30 percent, so it is clearly an important part of the island's healthcare system.

But the high enrollment also creates—and it was mentioned just now—but the high enrollment also creates States setting challenges for CMS that contribute to payment rates that are 40 percent below the national average. Can you discuss the role of Medicare Advantage in Puerto Rico, and is this another area the committee should consider as part of creating long-term stability in Puerto Rico's healthcare system?

Ms. AVILA. Definitely, and thank you for the question. Angela Avila from Puerto Rico. Definitely, the Medicare Advantage line of business is crucial in Puerto Rico as well as the Medicaid program and the private sector. But in terms of Medicaid and Medicare, we have a huge penetration in the market because in Puerto Rico we have a high population of elderly that are the ones who participate from the Medicare Advantage programs.

And I don't know if it is just because it is an island people stay there and that is why they tend to select the Medicare Advantage program, and they are underfunding as well when we compare their baseline against the ones that are in the States. So yes, it is still a difference in the Medicare Advantage area as well. And this has been aggravated because of the people losing their jobs and the economic situation of Puerto Rico. The high concentration of beneficiaries are under those two programs, Medicare and Medicaid. And that is why the importance in our economy for both lines of businesses.

Mr. BILIRAKIS. OK, thank you. And this is panelwide. So, as my colleague Ranking Member Burgess mentioned in his opening remarks, often when discussing these issues, we tend to lump each program and the U.S. territories together as one instead of treating them as individual entities within individual challenges. Would you each briefly share your individual challenges and needs?

I know you don't have a lot of time for that, but let's start over here, Doctor, if that is OK.

Dr. SCHWARTZ. Well, I think I will just pass the mic in the interest of time and allow them to——

Mr. BILIRAKIS. OK. OK, maybe mention one challenge each or what have you, your top priority, your top challenge we might be able to address.

Ms. AVILA. For Puerto Rico, the biggest challenge is to keep our doctors and healthcare providers in the island, because if we don't have our professionals serving the population we don't have—you know, money would not be the reason. It would be they have the ability of the healthcare professionals.

Mr. BILIRAKIS. Very good.

What is your greatest need, Ms. Young?

Ms. YOUNG. Our greatest need is we just need more money. If we had more money we would be able to do more things and provide services like long-term support services, things that we can't do right now. So I think it just goes back to, we would like to increase our block grant and change the FMAP. That would allow us to——

Mr. BILIRAKIS. So you have adequate enough providers?

Ms. YOUNG. No, we don't have enough providers. We have one hospital. We have two providers in New Zealand and we have one DME, durable medical equipment provider. But with more money we would be able to work on increasing providers and services as well.

Mr. BILIRAKIS. OK, very good. Thank you.

Ms. ARCANGEL. Our biggest challenge is the providers, also, and at the same time the uninsured population in Guam because our income guideline is very low. It doesn't increase. It is based on

2016, which is 30 to 31 percent below the Federal poverty level of 2016.

Mr. BILIRAKIS. Thank you very much for that information.

Ms. RHYMER-BROWNE. Yes, our biggest challenge would be to continue assisting the 28,000-plus Medicaid members. And, additionally, because of our aging community in the Virgin Islands, one of the biggest challenges is the continuum of care of healthcare services to include skilled nursing facilities, of which we do not have that program in the territory. So that would be a challenge that we would meet if we were able to get more funding.

Mr. BILIRAKIS. Very good, thank you.

Ms. SABLAN. For CNMI, our challenge also is funding. We are spending a lot of—we spent 53 million in 2018, and if the service is not available on the island we have to send our patients off island, either to Guam, the Philippines, Hawaii, or the U.S. mainland. That is our biggest challenge.

Mr. BILIRAKIS. All right, thank you very much. I appreciate it. I yield back, Madam Chair, appreciate it.

Ms. ESHOO. The gentleman yields back. I now would like to recognize the—let's see, where? Ms. Kelly? Oh, I see. Robin Kelly, yes. Congresswoman Kelly from Illinois. I am looking on the wrong side of the aisle here. You are recognized for 5 minutes—I have no question what side of the aisle you are on, I was just looking in the wrong way—for 5 minutes of questioning.

Ms. KELLY. Thank you, Madam Chair and Ranking Member, for having this hearing. And I want to thank all of you for taking the time to come. Actually, my colleague asked some of the questions I wanted to ask, but I wanted to know from Ms. Rhymer-Browne and Ms. Sablan, you didn't talk about providers so much, but are you seeing physicians leave? And the reason I am curious about that question because when I went to the Virgin Islands and Puerto Rico after the hurricanes, and I know Congresswoman Plaskett talked a lot about you had to send people to Puerto Rico, but now you are saying that, you know, you can't really handle what you have. So that must continue to be a problem and just wondering about, both of you.

Ms. SABLAN. Yes, for CNMI because the salary is not that I guess attractive, so they won't stay for long. They will be there for a couple of months or even a year at the most.

Ms. KELLY. And, Ms. Rhymer-Browne?

Ms. RHYMER-BROWNE. For the U.S. Virgin Islands, when it comes to the providers we are really hurting for our specialty providers. And to attract those types of physicians to the territory, you will have to pay more money. So the provider issue is an issue for us, and of course after the storm some of our physicians did relocate and just leave the territory. And now with the damages to our infrastructure with the hospitals and the clinics, the providers are also being hurt there. So the provider issue is one for us that is a challenge.

Ms. KELLY. And, Dr. Schwartz, if you could just snap your finger or wave a magic wand, what are two things that you would ask us to do?

Dr. SCHWARTZ. AS I pointed out in my testimony, the biggest problem is the chronic underfunding. The caps are extremely low

and have not grown over time, and the matching rate creates other challenges, given the ability of the territories to raise the local share. Otherwise, the challenges are obviously different, given they are different health systems.

Ms. KELLY. And I want to thank all of you again. And believe it or not, Madam Chair, I yield back.

Ms. ESHOO. We thank the gentlewoman, and she yields back. I now have the pleasure of recognizing the gentlewoman from Indiana, Mrs. Brooks.

Mrs. BROOKS. Thank you, Madam Chairwoman. And thank you so much, thanks to all of you for coming and for sharing with us. I have a couple of different areas I would like to address.

But, first of all, like so many of my colleagues, my colleagues on this side of the aisle, Representative Radewagen, Representative González-Colón, have shared with us so much. Even though some of us have not been able to travel to the territories, especially after the hurricane, on a very regular basis they have been such incredible advocates for the territories and for all of the healthcare needs of the territories, and so just want to thank them.

I do have a question from Congressman Gonzalez to Ms. Avila. If Congress does not provide for additional funding for Puerto Rico's Medicaid program for fiscal year 2020, how long will the currently assigned Federal Medicaid funding last, if you know?

Ms. AVILA. We have estimated that is going to be available up to March 2020, Federal funds.

Mrs. BROOKS. Thank you.

Ms. AVILA. Thank you.

Mrs. BROOKS. March 2020.

Ms. AVILA. March 2020.

Mrs. BROOKS. I am going to shift a moment because, as the chairwoman knows, we have both been very involved in the biodefense of our country, and very recently the Blue Ribbon Study Panel on Biodefense issued an October 28 report. The title is "Holding the Line on Biodefense: State, Local, Tribal, and Territorial Reinforcements Needed," and I would ask unanimous consent to include this report for the record.

Ms. ESHOO. So ordered.[1]

Mrs. BROOKS. Thank you so much.

Public health systems have to be prepared for biological incidents whether they are naturally occurring or whether they are attacks on our country, on our territories. And we know that this panel of experts identified several areas where territories would benefit from increased Federal assistance in preparing and conducting surveillance of and recovering from biological incidents.

The most recent one that I want to ask, particularly Puerto Rico and U.S. Virgin Islands, has to do with Zika, OK, because the CDC said that, according to the 2017 numbers, Puerto Rico had 620 cases. This was in 2017, the last numbers that I saw, and there could be more. U.S. Virgin Islands had 46 as reported, and we learned as a body just the devastating health consequences of the issues of Zika.

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[1] The report has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF14/20190620/109671/HHRG-116-IF14-20190620-SD013.pdf.

So I would like to start out maybe with you, Ms. Rhymer-Browne. Can you share with us how prepared do you believe the territories are and what additional resources for biological incidents and what additional resources should the Federal Government bring to bear to address this?

And then I am going to jump to you, Ms. Avila, because you have also experienced. Then if there is time, others.

Ms. RHYMER-BROWNE. Yes. Incidents like Zika have been very terrifying for us. Our hospitals, who even before the hurricanes were not as prepared as they should be and even after the hurricanes we are definitely not prepared as we should be. We have been increasingly in the Virgin Islands really trying to improve our responses for all hazards of types of even if it is bioterrorism or anything like that.

But right now, medically, with any kind of biological outbreaks we would really be hard pressed, our healthcare system as it stands, without the additional help. And of course our Medicaid members, which is 28,000-plus of our 100,000 people, if they needed the care they—really, our healthcare system would not be able to sustain that.

Mrs. BROOKS. Thank you.

Ms. Avila, since you have already had to deal with this.

Ms. AVILA. Yes, but in terms of the statistics I don't have the set numbers with me today.

Mrs. BROOKS. That is fine.

Ms. AVILA. I will defer to the epidemiology of Puerto Rico to answer. But as I know we have our labs and we have at the end of 2017, we were without Zika at that moment. So I would like to have the opportunity to give you additional information on that question.

Mrs. BROOKS. Is there any assistance in preparing for a large-scale biological event that you might need or that you know of?

Ms. AVILA. I will say that our needs are so many that every help, every additional money that we will receive, we will have the responsibility to improve our infrastructure for biosecurity, for our extraordinary emergencies that we have been facing. So in general terms, yes, we will need to look forward then and just to invest in the right matter.

Mrs. BROOKS. Thank you. I yield back.

Ms. ESHOO. The gentlewoman yields back. I now would like to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, for 5 minutes of her questions.

Ms. BLUNT ROCHESTER. Thank you very much, Madam Chair, and thank you for this hearing. I want to first share with all of the panelists that, while you may see us coming and going, because there are multiple hearings happening at the same time, this hearing is vital. And we want you to know that we see you, we hear you, you are our family. There are Representatives as is on here on the panel, Stacey Plaskett, Mr. Sablan, people who advocate for you even in our caucus hearings, and so we want you to know that.

In my State of Delaware, our Latin American Community Center, I remember when the hurricane happened and just the fear and the tears. And so my one message to you is that we have not forgotten. I want you to know we have not forgotten, and so I want

to start with that. I want to also recognize—I am glad that our chairwoman talked about the strong women that are in front of us. You make us proud as well, so I want to share that with you as well.

And I really wanted to just give you each an opportunity to highlight the impact. We already know that you start from a very tenuous place with this Medicaid cliff, but I know that natural disasters have an impact on top of that and sometimes, you know, some areas get more attention in the media than others.

So if you could each just share, you know, a little bit about the impact above and beyond when a natural disaster hits, how does that impact you? And I will start with Ms. Rhymer-Browne.

Ms. RHYMER-BROWNE. Yes. I would just like to share, after Hurricane Irma impacted us in the Virgin Islands and Maria soon after, within a matter of about 2 weeks we had to airlift or cruise ship out 8 to 10 thousand people out of our 100,000 population. This separated families. Mothers left with children. Fathers left with children. Entire families left. Even our graduating classes this year were smaller because of the number of people who had to leave.

So the impact is really very great when these hurricanes happen. And with the hurricane of the Medicaid cliff pending, we are really afraid of what will happen. But we will continue to maintain hope change will come.

Ms. BLUNT ROCHESTER. Thank you.

Ms. Arcangel?

Ms. ARCANGEL. For several years we have not experienced any of those, but we are trying to be ready, looking forward to an assistance from the Federal people in case this happens to us.

Ms. BLUNT ROCHESTER. Ms. Young?

Ms. YOUNG. Yes. We also have been fortunate that we have not been hit with any devastating natural disasters in recent years. But if that were the case, the impact would be devastating. We only have one hospital. We only have one airport. And if a hurricane hits and, you know, crashes all of those systems, our only recourse is the fast response from the Federal Government.

And we need more Medicaid money. We would need more Medicaid money to do off-island emergency evacuations that we don't have right now.

Ms. BLUNT ROCHESTER. Ms. Sablan, would you like to share anything?

Ms. SABLAN. Yes. We just got hit by Super Typhoon, and we only also have one hospital that really impacted as a result of that typhoon. And I am glad that there is a lot of help that came, and that really helped us with that.

Ms. BLUNT ROCHESTER. Thank you.

And last, but not least, Ms. Avila?

Ms. AVILA. Well, and for me it is very difficult to talk about our experience because it is like, it is scary. It is terrifying just to think about going through this next time. I have lived in Puerto Rico for all my life, and I have never seen something like we lived under the circumstances of Hurricane Maria. So our experiences have been learning how to be resilient, how to improve our infrastructure not to suffer something like what we live with the hurricanes.

Ms. BLUNT ROCHESTER. Thank you.

Ms. AVILA. Thank you.

Ms. BLUNT ROCHESTER. I wanted you all to have that opportunity because sometimes the media doesn't pick it up.

And, Dr. Schwartz, thank you for initially giving us those two big things that we need to address as well. I yield back.

Ms. ESHOO. The gentlewoman yields back. And I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes of questioning.

Mr. GRIFFITH. Thank you very much, Madam Chair. I appreciate you all being here. I apologize to you all, but I have been in another hearing most of the morning and, accordingly, I am going to yield my time to Dr. Burgess.

Mr. BURGESS. And I thank the gentleman for yielding. I thank him for his work on this committee. It is invaluable.

So let me come back to Guam for a moment. Madam Arcangel, you mentioned in your testimony that one of the biggest issues in Guam is the untimely or delayed payments in Medicaid. Can you enlighten us as to why this is happening?

Ms. ARCANGEL. Well, because at the beginning of fiscal year, the budget appropriation to match the Medicaid current is not enough. So I look for money within my division to match that, so providers wait in the meantime. And at the same time, it depends on the cash flow of the government. So if there is available cash to match the Federal grant, then that is the only time we can pay the providers. So sometimes they wait 3 months, 6 months to get paid for those. So that is the reason why.

And at the same time, the reimbursement of the providers is really low. Even our contracts we don't file on providers, we have thresholds. So if we meet our thresholds and we don't pay them, they don't accept our patients, so the patient stays at the hospital. In the meantime, the cost increases, the expenditure increases.

Mr. BURGESS. So it is a vicious cycle.

Ms. ARCANGEL. Yes, it is a vicious cycle.

Mr. BURGESS. And of course from a provider's standpoint, if your days in accounts receivable are much over 60 or 90 days, it is very, very difficult to run your practice. So I am sympathetic to the doctors who say, "Look, I can't afford to see your patients."

Ms. ARCANGEL. Yes.

Mr. BURGESS. But that does seem like a solvable problem. On the issue of the cap, some of the territories expanded Medicaid under the ACA, and some did not. So for the three that did—Puerto Rico, Virgin Islands, and Guam—has that caused you to reach that 1108 cap faster than before the expansion occurred? So let's start with Puerto Rico.

Ms. AVILA. In the case of Puerto Rico, I don't think that will deplete our 1108 faster because we use the ACA funds first, and then we apply the 1108 cap amounts. So, right now, we have remaining balance from the ACA until December. We have a small remaining balance of ACA, and then we will apply the 1108 cap amounts. So in that case——

Mr. BURGESS. So on the expansion population, in the States they draw down, or originally drew down, a hundred percent FMAP, and

now it is down, I think, to 93 or 94 percent. Does that occur in Puerto Rico as well?

Ms. AVILA. Definitely, yes. Yes.

Mr. BURGESS. So you are actually affecting the burn rate of your dollars under the cap.

Ms. AVILA. So, yes. That is correct.

Mr. BURGESS. OK. Ms. Arcangel, in Guam?

Ms. ARCANGEL. Yes, we finished that in the first month of the fiscal year. The reason being is because our IBNR are not paid. We paid that at the beginning of fiscal year, so we finish 1108 first, and then we need to draw down the request for additional from ACA funding, which is section 2005.

Mr. BURGESS. But does that affect your total under the cap, under the 1108 cap?

Ms. ARCANGEL. Yes, it affects. But this, actually, the ACA helps us. The reason being is because the COFAs, which are under our locally funded program, we utilize the 1108 to pay for those emergency services. That is why we finish it at the beginning of the fiscal year.

Mr. BURGESS. OK, but it still increases your burn rate, it seems to me.

Ms. Rhymer-Browne, let me ask you the same.

Ms. RHYMER-BROWNE. Yes. It definitely—we are, we did expand our Medicaid, so 2012 we had about 12,000. Now we are at over 28,000. So it definitely has, we burn that up very quickly. And, of course, ACA has nothing to do with it, and then for the hundred percent, we were using that because we did not have to match it. Our ACA, we still have about 140 million sitting because we can't afford the 55/45 percent match.

Mr. BURGESS. But on that hundred percent match, was that still calculated under the 1108 cap?

Ms. RHYMER-BROWNE. No. No, it is separate.

Mr. BURGESS. Oh, those were separate dollars you were drawing down. OK.

Ms. RHYMER-BROWNE. Yes. Yes, separate.

Mr. BURGESS. OK. All right, I thank the gentleman for yielding, and I will yield back.

Mr. GRIFFITH. Yield back.

Ms. ESHOO. The gentleman yields back. I recognize the gentleman from Maryland, Mr. Sarbanes, for 5 minutes of his questions.

Mr. SARBANES. Thank you, Madam Chair. Thank all of you for being here at this very important hearing, which I think for many of our members is very enlightening. We don't get this kind of testimony probably as often as we should so we can, in real time, understand the issues that you are facing. And you have presented a very united front in terms of the challenges. Obviously, each territory has special issues that need to be addressed and legacy issues and particular history. So I want to thank you for that testimony.

I am very interested, and I think, Dr. Schwartz, you may be the best person to speak to this, sort of the origins of the differences in the formula, the FMAP, where the cap came from. Because it seems to me that, if we are going to address the funding issues

going forward in a sustainable way, we have got to figure out what the arguments are for why those different formulas just are obsolete at this point, why they don't make sense.

And I am sure some that will oppose changing them and making them more robust, making them more equivalent to what the States see, will anchor their opposition in the notion that, because of the special status of the territories, those formulas ought to stay the way they are. And there has been some references as to why it is outdated, why it is obsolete, why it came into existence at a different time that is no longer analogous to where we are today, but I think it is going to be important for us to make the case for that if we are going to get the formulas changed. So if you could maybe speak to that issue, that would be helpful to me.

Dr. SCHWARTZ. Sure. The caps were first added in the 1967 Social Security amendments. Some of these programs started much later than that. We do know that in the Social Security Act at that time there were caps and special formulas for other public assistance programs. And while we don't know what factors Congress considered when setting those caps, I think it is fairly typical that, when new programs are introduced, they build on previous programs.

I would also say that as far back as 1978, the Senate Finance Committee noted that the ceilings on Federal Medicaid expenditures have severely affected the amount of funds available to the territories to operate adequate Medicaid programs. So this is a longstanding problem. There has obviously been some changes over time. The ACA lifted the matching rate from 50 to 55 percent, the various infusions of Federal funds are recognition of that. But there has not been a significant statutory change in the Social Security Act since, you know, for over 40, 50 years.

Mr. SARBANES. Do you know whether—you just alluded to there being other programs different from the ones that are administered by the territories that were subject to different kinds of caps and matching formulas, and that that might have been a basis for putting those in place in these situations, or not.

But do you know if any of those have been changed over time and moved up to where they are equivalent to what the State formulas are and what rationales might have been offered in those instances?

Dr. SCHWARTZ. I don't have that information at my fingertips, but we could certainly get that to you.

Mr. SARBANES. I think that would be very helpful, because we obviously have a very powerful argument based on the needs of the territories, and in some instances the recent challenges that have been faced, let's say, in the case of Puerto Rico and the U.S. Virgin Islands based on the disasters that have occurred.

But I think if we are going to make the most robust argument, it has to be a combination of arguing that the needs are what they are and have to be met in a sustainable fashion and that, the whatever the rationale that previously may have justified the difference in the way the formulas were developed, that that rationale is no longer applicable.

So getting that information, I think, would be extremely helpful. Thank you all for being here today. I yield back.

Ms. ESHOO. The gentleman yields back. I now would like to recognize the gentlewoman from New Hampshire, Ms. Kuster, for her 5 minutes of questioning. And if no other Republicans come back, Mr. Soto will follow and then we will have, I think, have concluded our questions.

So, Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you, Chairwoman Eshoo, for holding this critical hearing today to discuss the remarkable disparities in our healthcare system between the territories and the States. If the conversation today has shown us anything, it is that Medicaid block granting simply does not work. Unfortunately, this example of poor policy is at the expense of Americans who live in the territories represented here.

Though New Hampshire is a far distance, Granite Staters can relate all too well to many of the same issues you described here today. I cannot imagine how we would be able to combat the opioid epidemic in my State if we did not have the resources of the Medicaid program. Most of the people seeking treatment are eligible for healthcare for their substance use disorder and mental health issues because of the Medicaid expansion. As our population ages, it is Medicaid that is the safety net for our most vulnerable citizens.

So I want to thank all of the witnesses for appearing before us today, and I share your view of the challenges facing your Medicaid programs.

Ms. Avila, the Governor of Puerto Rico has submitted a request to Congress for 15.1, in funding, million. Is that the correct number?

Ms. AVILA. Yes, it is, 15.1 billion dollars for——

Ms. KUSTER. Billion.

Ms. AVILA. Billion, for 5——

Ms. KUSTER. Thank you. We try to keep track of the m's and the b's around here.

Ms. AVILA. Yes.

Ms. KUSTER. Fifteen point one billion.

Ms. AVILA. Billion, 5 years.

Ms. KUSTER. OK. And the Governor's request included specific program improvements that Puerto Rico would implement with this temporary funding. And I apologize if you have spoken to this earlier, I was in another hearing. But what are those improvements, and why are they necessary?

Ms. AVILA. Well, starting with the reimbursement rates for our doctors and healthcare professionals, our reimbursement rates if we compare to the ones in the States are lower than 19 percent of what they have.

Ms. KUSTER. Nineteen percent?

Ms. AVILA. Percent of what we pay——

Ms. KUSTER. Of what physicians would receive?

Ms. AVILA. Yes, our physicians. For example, a procedure for, a cardiovascular procedure in the States is paid between 1,000 to 2,000 dollars. In Puerto Rico we will pay no more than $300. Our doctors for a visit, they are paid like 20 to 25 dollars, in comparison to 100, 125 dollars that is in the CMS fee schedules. And what we are trying to do is just to stabilize our system according to what

is gathered in the fee schedules that are part of the programs in the States as Medicare, as Medicaid references, and that way is we will avoid our exodus of providers, because we are losing almost 1.5 doctors per day right now because of the lower payments.

Ms. KUSTER. Lower reimbursement payments.

Ms. AVILA. Yes.

Ms. KUSTER. And can I just ask briefly, the rest of you, is the reimbursement equally low for you for physicians or—I am sorry. Let's just go—if you could.

Ms. YOUNG. For American Samoa it doesn't apply because we only have one hospital that utilizes a certified public expenditure payment method. So we simply pay based on the Medicare cost report that the hospital files every year, and we pay actual costs that it requires to operate the hospital. We don't have independent, private physicians that are Medicaid providers. The only other provider on island that we have is the federally qualified health center.

Ms. KUSTER. And for you?

Ms. ARCANGEL. Our reimbursement rate is actually based on Medicare rate, but for the hospital alone the reimbursement rate is very low, which is 1,600 per day only. That is because of DEPRA. Our private hospital, it is 300 percent higher than our own government hospital.

With regards to physicians, it is also based on Medicare rate or fee schedule. But the thing is, the cost of medical supplies as well as equipment is so high because of the shipping costs, because of there are only few vendors that ship those in Guam, so that there is a tendency on higher costs because of lack of competition.

Ms. KUSTER. My time is almost up, but——

Ms. RHYMER-BROWNE. Yes, the Virgin Islands faces similar situations. We have 100 percent Medicare reimbursement, and so our providers, many of them who need, we need for specialty, do need to charge higher and therefore may not join to become a Medicaid provider.

Ms. KUSTER. Thank you. My time is up. Thank you very much. I yield back.

Ms. ESHOO. The gentlewoman yields back. I now recognize the gentleman from Florida, Mr. Soto, for his 5 minutes of questioning.

Mr. SOTO. Thank you, Madam Chair. Thank you to all the witnesses for being here today. We know we have a financial crisis and a Medicaid crisis that just keeps coming around and coming around again. And for that on behalf of my constituents, you know, we apologize that you all have to go through this over and over again, when there should be a permanent fix. And this committee is intent on trying to fix that long term.

Ms. Avila, you know, we talked a little bit about the Medicaid crisis in Puerto Rico, hospitals in disrepair. Nearly half of Puerto Rico's population is enrolled in Medicaid. Isn't that correct?

Ms. AVILA. Yes, it is correct.

Mr. SOTO. Yes. And we have seen the additional Federal funding for the Medicaid program is set to expire in September. Do you believe another temporary funding increase is sufficient to permanently address the financial challenges facing Puerto Rico's Medicaid problem?

Ms. AVILA. Well, anything that works for us in terms of additional funding, I would never say no. But short term is a very dangerous situation for Puerto Rico, because the short terms doesn't allow us to work with the Fiscal Board to work with investments for long-term periods that will stabilize the model, and we don't suffer those uncertainty periods that hurts a lot our economy.

Mr. SOTO. You know, Puerto Rico used to have 15,000 doctors, and my understanding is over 6,000 have left the island over the past decade or so. Is that correct?

Ms. AVILA. That is correct.

Mr. SOTO. And why have they left?

Ms. AVILA. Because the reimbursement rates. They, you know, the difference from what they can earn here in the States, our doctors are prepared, are credentialized, are—I am sorry—are prepared according to the State standards and regulations. So here they can easily earn three or five times what they are going to be earning in Puerto Rico.

Mr. SOTO. And many are leaving to come to my home State of Florida.

Ms. AVILA. That is right.

Mr. SOTO. You know, we saw Puerto Rico have to go into debt to prop up the Medicaid program because the reimbursement rates were so—the matching rates were so low, and now we are stuck in this PROMESA Fiscal Board system. And then we saw after Hurricane Maria, it wasn't just the devastation of Hurricane Maria that led to people having a lack of access to healthcare, it was also the lack of funding to begin with through Medicaid. Would you agree with that statement?

Ms. AVILA. Of course, 100 percent. It has been a pattern and a trend that is supposed to be fixed way, way before.

Mr. SOTO. I am proud to have introduced, along with Congresswoman Velázquez and the rest of the Puerto Rican task force, a new Medicaid parity bill for Puerto Rico. I talked a little about it, $15.1 billion, 83 percent match for the FMAP. From 2020 to 2024, there would be four enhancement requirements. Hospital payments, physician payments need to be increased, Hep C coverage, and Part B reforms. I understand that at the end of the transition period, though, the bill would provide Puerto Rico with the same financial treatment and FMAP as a State program.

Is Puerto Rico willing to cover all the mandatory Medicaid benefits if it means you would receive State-like funding and FMAP?

Ms. AVILA. The answer is absolutely yes.

Mr. SOTO. And can you discuss the benefits of providing Puerto Rico with sustainable funding? How would that financial certainty impact Puerto Rico's long-term financial problem?

Ms. AVILA. Well, first of all, we will be able to keep our doctors and healthcare professionals. And our hospitals need to be improving their infrastructure in their payment. We pay right now $700 per diem in comparison to thousands of dollars that has been paid in the States. So work with our hospital is an urgent matter as well of improving the poverty level, the income poverty level for Puerto Rico for to make justice to the more vulnerable ones in the island.

Mr. SOTO. Thanks, Ms. Avila.

And, you know, I also want to take a moment to talk a little about the great work that not only my colleague Jenniffer González-Colón has been doing in this area, but also Governor Rosselló back on the island. They have been both drumming this drumbeat since well before Hurricane Maria, and a lot of the input from their ideas were included in this legislation.

And I really appreciate your leadership as well, Ms. Avila. We are going to do our best to end this crisis for good in Puerto Rico with regard to Medicaid. I yield back.

Ms. AVILA. Thank you.

Ms. ESHOO. The gentleman yields back. I now would like to recognize the gentleman from Georgia, Mr. Carter.

Mr. CARTER. Thank you, Madam Chair.

Ms. ESHOO. The only pharmacist in the Congress. How is that?

Mr. CARTER. That is great. Thank you, Madam Chair, I appreciate it. And I appreciate all of you being here. This is certainly something that is very important, obviously, to all of us.

Ms. Avila, I wanted to ask you, it is my understanding that Puerto Rico's largest benefit categories in terms of spending is outpatient prescription drugs and that the amount spent on drugs is projected to be over $800 million in fiscal year 2020. Why is that?

Ms. AVILA. Well, that is why because we work with a rebate program in Puerto Rico, but the rebates are coming to the government directly. It doesn't go to the MCOs, or the managed care organizations, so it is our artificially priced, the drugs are.

Mr. CARTER. I get that. But what I am getting at is, in comparison to the national average, it is much higher. That same program is applied all throughout the country. So you are right, 800 million is somewhat skewed, but at the same time, in comparison to the other numbers with the rest of the country, it is above the national average. And I am just wondering if there is a reason for that.

Ms. AVILA. Well, I will need to look for more information because our pharmacy program is mandatory generic. We are keeping it mandatory, and we have more than 85 percent of those are included in our gestation. So the prices, the drug prices has been increasing in 20 percent, you know.

Mr. CARTER. And I get all that. And again, where I am coming from is just in comparison.

Ms. AVILA. Yes.

Mr. CARTER. I am comparing you to the rest of the country, and in comparison the percentage you spend on prescription drugs is higher than it is elsewhere. I am just wondering why. And also, a lot of indicators are telling us that the outcomes are worsening.

Ms. AVILA. Well, we have a lot of diabetics, hypertension. We have some outliers in our population of those conditions that drive the costs to those extremes that we are looking, but we already have programs in place that monitor the utilization. But the behavior of the population, we haven't had all the programs in place to be able to track to go and look for those programs that monitor the clinical aspects of our population.

But it is a reality, yes. We have sicker people in——

Mr. CARTER. Well, please understand, I am not coming from a critical perspective.

Ms. AVILA. No, I understand.

Mr. CARTER. I am inquisitive as to—and you have just answered some of my next question, and that is, you know, what kind of health problems are you having. I mean, I am from the South, and in the South we are the cardio belt. I mean, we have a lot of cardiovascular disease because of diet or whatever, but that is a big problem we have. Now you have just indicated that diabetes, hypertension—do you have any kind of wellness programs in place that you are trying to push forward?

Ms. AVILA. Yes. Since November 2018, we have implemented a new healthcare model in Puerto Rico, and we are looking higher-quality programs that works with the social determinates of our population, and they need to bring new programs to our, you know, to our healthcare model. We are monitoring those changes as we speak since November 2018. We are in our first 6 months of that new implementation, and we are supposed to be gathering better outcomes.

Mr. CARTER. OK.

Ms. AVILA. Because that is why it was one of the main intentions of that change.

Mr. CARTER. OK.

Let me move to Ms. Sablan and Ms. Young. Your two territories as I understand it—and please forgive me if I am being redundant in my questions, I have had another committee hearing going on at the same time. But it is my understanding that you have a waiver. That your Medicaid and your CHIP programs are under a section 1902(j) waiver. Are you familiar with that?

Ms. YOUNG. Yes.

Mr. CARTER. Ms. Young, you are?

Ms. YOUNG. Yes.

Mr. CARTER. And that waiver is specific, as I understand it, to just your country and Ms. Sablan's country. And I was just wondering, do you feel like that waiver might help some of the other territories? Is that something that has benefited your countries?

Ms. YOUNG. Well, our 1902(j) waiver has——

Mr. CARTER. Excuse me, territories. Excuse me, I am sorry.

Ms. YOUNG. Yes, it has definitely been to our advantage because we are so unique in so many different ways. We don't do individual enrollment. We are very remote. And we also only have one airline that has two flights a week to our territory, so it limits our ability to do a lot of things. But I think as to the other territories, I think it would be best for them.

Mr. CARTER. Right.

Ms. YOUNG. But I have heard that people are interested in our 1902(j) waiver.

Mr. CARTER. Right.

Ms. Sablan?

Ms. SABLAN. Yes, that is a very unique program. And so what happens is, like, we drop off the categorically requirement, and it is applied to anybody that meets our income and resource limit. But we are doing eligibility——

Mr. CARTER. Good, good.

Ms. SABLAN [continuing]. Enrollment.

Mr. CARTER. Well, thank you all for your efforts in making these programs the best that they can be, and we certainly stand ready to help you in any way that we can. So thank you, and I yield back.

Ms. ESHOO. The gentleman yields back. I now have the pleasure of recognizing the gentleman from Massachusetts, Mr. Kennedy, for 5 minutes of his questions.

Mr. KENNEDY. Madam Chair, thank you. Given the fact that I just jumped my good friend from California, I will happily yield. I will trade turns with the gentleman from California, if he is ready.

Ms. ESHOO. Oh, I am sorry.

Mr. CÁRDENAS. That is all right.

Ms. ESHOO. It is my mistake.

Mr. CÁRDENAS. Thank you.

Now, that is a gentleman.

Ms. ESHOO. I think.

Mr. CÁRDENAS. Let me tell you. We use that term loosely around here, but he proved it.

Ms. ESHOO. No, we really mean it. We really mean it.

Mr. CÁRDENAS. Thank you, Madam Chair.

Ms. ESHOO. Gentleman Cárdenas.

Mr. CÁRDENAS. And I much appreciated the courtesy from the gentleman from Massachusetts. Thank you, Madam Chair, for holding this very important hearing.

And my first question is to Ms. Avila regarding doctors and the comparison what is or isn't happening in the territories, specifically Puerto Rico compared to the rest of the country.

I read a report about a family in Puerto Rico who wanted to take their newborn, a 6-week-old baby, to see a pediatric gastroenterologist, but the wait time was several months long. It also told the story of Diago, who was born with severely low muscle tone and travels an hour with his mother and a nurse just to receive medical care.

With two-thirds of children in Puerto Rico on Medicaid, how has the loss of providers affected their ability to receive care?

Ms. AVILA. It is critical right now. There is uncertainty just to think about having 1.5 million beneficiaries without doctors. To be able to serve them is our main concern right now, and that is why our urgent just to do some immediate changes in the reimbursement rates that we are paying to our specialists and our doctors.

Mr. CÁRDENAS. It is my understanding that I heard a stat that over 4,000 doctors have left Puerto Rico since 2006. And according to some estimates, Puerto Rico is losing one doctor per day, currently, and that was before the hurricane. How has this affected wait times for people on Medicaid in Puerto Rico?

Ms. AVILA. It has been increasing the waiting time. We have been stating here that today we account for almost 9,000 doctors in compared to 15 or 14 thousand a couple of years ago. And that will affect children, elderly, and all the population as well throughout the whole island. Because the doctors that serve the Medicaid population also serve the private sector and the Medicare Advantage and traditional Medicare as well, so the island will be affected islandwide.

Mr. CÁRDENAS. OK, across the board.

Ms. AVILA. Across the board, yes.

Mr. CÁRDENAS. Also, can you clarify for the American citizens who are listening to this hearing, a person who is born in Puerto Rico and a person who continues to live in Puerto Rico, whether they are 6 weeks old or 60 years old, is that individual an American citizen?

Ms. AVILA. Yes, it is.

Mr. CÁRDENAS. OK, so we are talking about American citizens.

Ms. AVILA. Yes, we are.

Mr. CÁRDENAS. And that is the case for all the territories, correct? OK. No exception? We are all—the subject matter today is talking about the territories of the United States, individuals who are born there are American citizens. Just like I was born in California, so I have the privilege and the blessing of being an American citizen. Is that the case for all of your constituents who were born in your territory?

Ms. YOUNG. Not for American Samoa. People born in American Samoa are U.S. nationals.

Mr. CÁRDENAS. OK.

Ms. RHYMER-BROWNE. For the Virgin Islands, we are U.S. citizens.

Ms. SABLAN. For CNMI, we are U.S. citizens.

Ms. ARCANGEL. For Guam, they are U.S. citizens, those who are under Medicaid program. But we also want to talk about the COFAs because we also are responsible for the them. They are not U.S. citizens, but the emergency services are incorporated under Medicaid, so technically we use Medicaid to pay for those.

So not only U.S. citizens, but because of the treaty of the U.S. and the Compact of Free Association, so we are also responsible for them.

Mr. CÁRDENAS. So that treaty is a United States treaty?

Ms. ARCANGEL. Yes.

Mr. CÁRDENAS. It is not a United Nations treaty.

Ms. ARCANGEL. No, no.

Mr. CÁRDENAS. So we are not talking about a treaty that other foreign governments or other human beings around the world imposed upon us. This is a treaty that the United States Government agreed to.

Ms. ARCANGEL. Yes.

Mr. CÁRDENAS. So, in the tradition and in the spirit of giving one's word—and a treaty is like giving someone's word in writing—we as the United States should probably follow through with that treaty and the obligations that we as the United States Government agreed to. That make sense?

Ms. ARCANGEL. Yes.

Mr. CÁRDENAS. OK.

Ms. ARCANGEL. And for them we spent $147 million in fiscal year 2017, and the amount that we receive, it is not enough.

Mr. CÁRDENAS. OK, so the amount that you receive, that 147 million comes out of an amount of money that is a shortfall as it is. Is that what you are saying?

Ms. ARCANGEL. Yes.

Mr. CÁRDENAS. OK. The reason why I want to ask those questions is because I think that it is unfortunate that—I don't know why, maybe in American history classes or what have you—a lot

of American citizens think that the people sitting up here are not American citizens, that you are foreigners, and that is not true.

So I just wanted to clarify that for the people watching and listening and just wanted to thank you, and I yield back the balance of my time.

Ms. ESHOO. The gentleman yields back. And now I would like to recognize the gentleman from Massachusetts, Mr. Kennedy, for his 5 minutes of questions.

Mr. KENNEDY. Madam Chair, thank you. There has been some discussion about the (j) waiver, which is essentially a broad waiver authority that is available to American Samoa and the Commonwealth of the Mariana Islands. Crucially, the (j) waiver does not allow—does not allow—the Secretary of HHS to waive the cap amount or the FMAP.

Based on what we have heard from the testimony today and in written statements, it sounds like folks aren't actually asking to expand the (j) waiver. They are asking for adequate, sustainable, long-term finance structure that allows them to operate Medicaid programs the way that they want without the constant threat of a funding shortfall. I think it is also worth reminding everybody that State Medicaid programs already have waiver authority through section 1115 of the Social Security Act.

So, Dr. Schwartz, starting with you, it is my understanding that people generally consider waiver authority available under—to Medicaid, excuse me—under section 1115 to be pretty broad. Would you say that is an accurate characterization?

Dr. SCHWARTZ. Yes.

Mr. KENNEDY. So would expending (j) waiver authority to the rest of the territories increase the size of the Federal funding allotment?

Dr. SCHWARTZ. No.

Mr. KENNEDY. Would expanding the (j) waiver ensure that no beneficiaries lose coverage or benefits or that no providers see pay cuts if a territory exceeds its Federal allotment and doesn't have enough territory funds to cover its Medicaid costs?

Dr. SCHWARTZ. No.

Mr. KENNEDY. So no to the loss of coverage, no to the benefits, no to the pay cuts, and if you exceed the Federal allotment. No, no, no.

Dr. SCHWARTZ. That is correct.

Mr. KENNEDY. We have heard from both territories that currently operate under a (j) waiver, American Samoa and the Northern Mariana Islands, that their Medicaid programs have both experienced significant Federal funding shortfalls. Is it fair to say that a (j) waiver does not guarantee the financial sustainability of a territory's Medicaid program?

Dr. SCHWARTZ. That is correct.

Mr. KENNEDY. Thank you. And that was remarkably efficient. It sounds to me like the Medicare programs do have some flexibility under the law and that this (j) waiver does nothing to address the financial problems that are plaguing the territories as we have heard from multiple witnesses today, and that the waiver authority does not actually address the root cause of those challenges. Instead of looking for ways to weaken the protections of Medicaid, I

hope that we can find a way to work together to find a way to strengthen those programs by providing the territories the funding that they so desperately need.

And, Madam Chair, due to an extraordinarily efficient witness, I will yield back my 3 minutes of time. Grateful.

Ms. ESHOO. The gentleman yields back. And now I would like to recognize the gentlewoman from California, Ms. Barragán, for her 5 minutes of questions.

Ms. BARRAGÁN. Thank you. And thank you all for being here today and for providing testimony.

When I first heard about what was happening, I couldn't help but think and say, "Are you kidding me?" American citizens, even though they are in another place, are not being treated fairly. They are not being treated equally as everybody else. It is my understanding that the territories receive Medicaid funding in the form of a block grant and that States receive open-ended Federal funds while the funds' territories received a fixed amount.

I don't think this is something the American people know about. I think if I were in my congressional district, which is Compton-Watts—very working class, a lot of people who rely upon Medicare/Medicaid and services—they would be shocked to hear that if they lived, say, in Puerto Rico or one of the territories that they actually could have a period of time when their benefits would be effectively cut and said no more.

The block grant funding amount does not come anywhere close to covering the cost of healthcare for the territories' Medicaid enrollees. For instance, Puerto Rico's block grant for fiscal year 2019 is $367 million, while Puerto Rico's total Medicaid expenditures are projected to be nearly $2.8 billion. That is pretty remarkable when you think about the difference in the amount that Puerto Rico has to come up with. That means that the block grant only accounts for 13 percent of Puerto Rico's total need. Now, once the block grant funding runs out, the territories must use their own funds to pay the entire remaining cost of Medicaid healthcare services.

I have been to Puerto Rico twice since Maria hit, and the devastation and the amount of money that it is going to take to recover is pretty remarkable.

Ms. Avila, is there some impact if Puerto Rico needs to use—come up with these extra dollars for the gap, does that mean they may have less money for disaster relief?

Ms. AVILA. Well, starting with we will not have money to cover for all the life that are receiving benefits right now. We will be facing a chaos in the island because this situation is affecting everybody on the island because of the lack of funding, so if something like that happen, we are expecting a mass exodus of Puerto Ricans to the States, and Puerto Rico will need to redefine our healthcare model to be able to comply.

Because our fiscal situation is no way that we can cover with almost more than $1 billion from local funds right now, even the Fiscal Board wouldn't allow us to do so. So we will need to change everything according to what we are doing right now and Medicaid program will be very difficult to meet with all the requirements and of what we have right now in place.

We are not looking for waivers. We are looking for ways to have a stabilized program and in a full capacity complying with all that the programs require.

Ms. BARRAGÁN. OK, so just for the panel, how would you be able to expand coverage and services if the block grants were eliminated and you were treated the same as the States?

Ms. AVILA. We would not be able to cover with that. We would need to change the structure and to have like basic services, and the government will need to start providing services directly through our facilities. So.

Ms. BARRAGÁN. So, I am asking if you got rid of block grants and you were treated like everybody else in the States, would that be helpful? Would that help you expand services?

Ms. AVILA. That will be the answer for Puerto Rico just to be able to comply and have a sustain of our programs. So I didn't understand your first question.

Ms. BARRAGÁN. OK. Any others on the panel?

Ms. ARCANGEL. For Guam, we will go in to reduce the number of uninsured population. We will definitely increase our income guideline and make them eligible under the program.

Ms. RHYMER-BROWNE. For the U.S. Virgin Islands, we would do similarly to expand to the additional 10 to 15 thousand who are eligible, and that will definitely help our underinsured population and also reduce the amount of uncompensated care in our hospitals and our clinics.

Ms. SABLAN. For CNMI, we will provide the mandated services as well as some of the optional services that is important.

Ms. BARRAGÁN. Great. So you say overall healthcare would improve in the territories?

Ms. ARCANGEL. Yes.

Ms. BARRAGÁN. Thank you. I yield back.

Ms. ESHOO. The gentlewoman yields back. I now would like to recognize the gentleman from New York, Mr. Engel, for his 5 minutes of questioning.

Mr. ENGEL. Thank you, Madam Chair. Let me first say U.S. territories are subject to inequitable Medicaid funding policies, and we can see that today. States, for instance, receive Federal matching funds for each dollar they spend in their Medicaid programs, whereas territories are capped by section 1108 of the Social Security Act. And because of these inequities, Congress has had to appropriate additional funding on numerous occasions to avoid shortfalls in territorial Medicaid programs. And this piecemeal funding obviously creates uncertainty, which jeopardizes the ability of territories to provide Medicaid coverage to Americans residing in these communities.

So let me ask you, Ms. Schwartz, what steps can Congress take to ensure that U.S. territories have a steady stream of Federal support for their Medicaid program?

Dr. SCHWARTZ. As I pointed out in my testimony, the chronic underfunding of the territories results from the combination of the very low caps that are provided annually and the very low matching rate. So addressing both of those is needed to address the chronic underfunding.

Mr. ENGEL. OK, thank you. Nearly 2 years ago, Hurricane Maria made landfall in Puerto Rico and the U.S. Virgin Islands, claiming nearly 3,000 American lives. The island is still reeling from the aftermath of this natural catastrophe. And although Congress provided temporary support to Puerto Rico's Medicaid program, it needs significant long-term Federal support. And I believe if we fail to act, Puerto Rico will go off a Medicaid cliff, which could have disastrous consequences for its healthcare system.

So, Ms. Avila, how would the Medicaid cliff affect Puerto Rico's ability to retain and recruit healthcare providers?

Ms. AVILA. Just to clarify, if we receive the funding or if we stay as we are right now?

Mr. ENGEL. If you stayed where you are right now.

Ms. AVILA. Well, we will not be able to comply with the full requirements of the Medicaid program and we will be facing a lack of providers, because providers are leaving the island because we are not able to fulfill their needs in terms of reimbursement rates. So it will be very challenging for Puerto Rico to keep our providers in the island.

Mr. ENGEL. Right. And, of course, as we have been stating today, American citizens are being treated as second-class citizens, and it is really unacceptable. Thank you.

Ms. AVILA. Thank you.

Mr. ENGEL. Let me ask Ms. Young. As chairman of the Foreign Affairs Committee, I am the chairman, I always—I am shocked by the number of people who forget that individuals living in the U.S. territories are American citizens, and Congress has a duty to ensure that the healthcare needs of these Americans are fully met. So I am proud that I voted for the recent disaster supplemental which includes additional funding for territorial Medicaid programs such as those in American Samoa.

So, Ms. Young, would you please describe how this funding will help our fellow citizens residing in American Samoa?

Ms. YOUNG. First of all, thank you, Congressman, for your vote on the disaster supp. The availability of the 100 FMAP percentage for our territory has allowed us to resume critically necessary medical services that we had suspended back in March. And it has also allowed us to pay our bills for the off-island medical referral program, and we are now able—we have reinstated the services for durable medical equipment and prosthetics as well as we will now be able to pay the bills and invoices that have been in arrears for our federally qualified healthcare centers and our community clinics. So it has been an extremely helpful solution for us through the end of September, so thank you for that.

Mr. ENGEL. OK, thank you very much. This is obviously a very important subject. I know that our chair takes it very seriously, and I am looking forward to working with her to continue to make sure that there are not inequities where we pit American citizens against other American citizens. We are all American citizens. We are all equal, and we shouldn't forget that. Thank you, Madam Chair.

Ms. ESHOO. We thank the gentleman and also for your leadership at Foreign Relations, very important.

I don't see any other Members here, so what I will do at this point is to—well, there are only a couple of us here—but for the record, remind Members that, pursuant to committee rules, they have 10 business days to submit additional questions for the record.

And I think the witnesses heard several Members make reference to the fact that they were going to submit questions to you. You will need to answer those, so we ask that you answer them in full and in the most timely way, because the information that is provided to us is really foundational for what we want to do moving ahead.

And I also would like to ask unanimous consent to enter into the record the following. These are documents for the record: a statement from Congresswoman Aumua Amata Coleman Radewagen; a statement from the American Academy of Family Physicians; a statement from the Puerto Rico Chamber of Commerce; a statement from the Financial Oversight and Management Board for Puerto Rico; a statement from the Multi-sectorial Council on Puerto Rico's Health System; a statement from the Partnership for Medicaid; and a statement from America's Health Insurance Plans.

So I ask unanimous consent that these documents be placed in the record. Hearing no objections, they will be placed in the record.

[The information appears at the conclusion of the hearing.]

Ms. ESHOO. Let me just close by saying a few words to the witnesses. I think everyone has recognized that you have traveled a long distance. For several of you, it has taken more than the hours it takes for me to commute across the country every week from California to DC.

I want you to know that your travel is worth it. I believe that collectively this panel has moved the needle, moved the needle on what needs to be done. And the very good question about why these programs have such low caps, low matching rates and that in the stateside they are one figure, in the territories they are another, I can't help but think that there is some bias somewhere from many years ago. But I think that it is a form of negligence to allow it to go on. This has to change, people are desperate, and the overlay of the natural disaster has done more damage to exacerbate what you are already burdened with.

I want to thank my colleagues for being present. Mr. Sablan has been here throughout. Congresswoman Coleman Radewagen—am I pronouncing your name correctly? Thank you. My name is a little odd, so I am sensitive about mispronunciation. You have been here throughout, and we are going to work with you.

I know that my classmate, Congresswoman Nydia Velázquez, has introduced her legislation. The Delegates from the other territories have worked on a bill with Congresswoman Plaskett, 1354. And so I look forward to this committee solving this once and for all. I don't want to see any more Band-Aids and kicking the can down the road. The citizens of our country deserve citizenship that is celebrated, not denigrated.

There is an old saying that many of us use,—and it is an important one—that justice delayed is justice denied. I think healthcare denied is justice denied.

So, on that note, we all thank you for your travels. We thank you for your professionalism, for answer—you really answered Members' questions so well, and we look forward to resolving this and continuing to work with you to resolve it.

So, at this time, the subcommittee is adjourned.

[Whereupon, at 1:11 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

AUMUA AMATA COLEMAN RADEWAGEN
AMERICAN SAMOA

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CHAIRMAN
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COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

Prepared statement for Congresswoman Radewagen for the record regarding the June 20, 2019 House Committee on Energy and Commerce's Subcommittee on Health's Hearing on Strengthening Health Care in the U.S. Territories for Today and Into the Future

June 19, 2019

Thank you to Chairman Pallone, Chairwoman Eshoo, Ranking Member Walden, and Ranking Member Burgess for putting together this hearing on the Medicaid fiscal cliff currently facing the US Territories. As we have learned in the May 23, 2019 hearing on territorial Medicaid in the House Committee on Natural Resources, Medicaid funding provided by the ACA is set to expire later this year.

Almost all of American Samoa's 60,000 residents rely on Medicaid for health care coverage and receive care from a single hospital, the Lyndon B. Johnson Tropical Medical Center (LBJ). Unless Congress addresses the funding cliff soon, American Samoa will be forced to cut critical services beginning October 1 of this year, putting at risk the lives of thousands of Americans; many of them veterans.

Unlike states, territories have an annual allotment of capped federal Medicaid funds and a federal medical assistance percentage (FMAP) that is statutorily set at 55%. The recently passed disaster relief package provides much needed relief to American Samoa with a temporary 100% FMAP rate until the end of FY2019, but it is not enough. American Samoa's Medicaid office has estimated an annual need of $30 Million in federal Medicaid dollars to support the health care needs of my constituents. Unfortunately, American Samoa currently receives just under $12 Million annually – less than half the needed amount. This is inequitable and urgently needs to be addressed.

Long before I was elected to Congress, the ACA introduced $7.3 Billion in Medicaid funds for the territories. Of that amount, only $197.8 Million was made available to American Samoa. The additional funding drastically improved access to health care in the territory and allowed for the expansion of services. Unfortunately, due to CMS rules on the order in which funds could be used and the 55% FMAP, there was no scenario in which American Samoa would have been able to spend $197.8 Million over 10 years.

For comparison, Nebraska's FMAP is currently 54.72%, but has a GDP 190 times greater than American Samoa according to December 2017 data from the Bureau of Economic Analysis.

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Mississippi has the nation's highest FMAP at 76.98%, but still has a GDP 176 times greater than American Samoa. American Samoa is simply unable to generate the local match fund and is being held back by arbitrary statutes put in place decades ago. American Samoans deserve health justice and now is the time to do the right thing.

Going hand in hand with our Medicaid funding cliff, our only hospital LBJ, was built in the 1960's and is in dire need of renovation or replacement. A recently completed assessment of American Samoa's health care infrastructure and services by the United States Army Corps of Engineers found LBJ to be in a state of failure due to age. LBJ will need extensive repair and/or replacement to ensure compliance with basic hospital accreditation standards. The report goes on to project a range of $161 – $900 Million for varying levels of cost of repair or replacement for LBJ to protect the life, health, and safety of patients, staff, and visitors.

American Samoa has long been a faithful territory of the United States, consistently standing up to defend freedom here and abroad with the highest volunteer recruitment for the U.S. Army and other service branches per-capita. Our entire health care infrastructure is collapsing due to neglect and it is time to change the status quo. This is not a hand out – it is a hand up. American Samoa, like our sister territories, needs the support of Congress fix our Medicaid system and our aging LBJ hospital so that we can get back to what we do best – fighting for our community and country.

Sincerely,

Aumua Amata

Aumua Amata Coleman Radewagen
Member of Congress

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 19, 2019

The Honorable Anna Eshoo
Chairwoman
House Committee on Energy and Commerce
Health Subcommittee
Washington, DC 20515

The Honorable Michael Burgess, MD
Ranking Member
House Committee on Energy and Commerce
Health Subcommittee
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

The American Academy of Family Physicians (AAFP), representing 134,600 family physicians and medical students nationwide, in collaboration with the Guam Academy of Family Physicians, the Puerto Rico Academy of Family Physicians, and the U.S. Virgin Islands Academy of Family Physicians, write today to express our concerns over the impact of the impending Medicaid "fiscal cliff." If Congress fails to act, family physicians and the patients they treat in all U.S. territories that operate Medicaid programs, will face significant reduction in resources, which will require reductions in services for thousands.

Unlike states' Medicaid funding mechanisms, financing for territorial Medicaid programs is capped and the federal medical assistance percentage for the territories is set by statute at 55 percent, significantly less than that of the states. Because of the demographic and health circumstances unique to the territories, these Medicaid programs have been chronically underfunded. To address this, the Affordable Care Act (ACA), passed in 2010, included a provision that provided $6.3 billion in additional Medicaid federal funding to the territories through September 30, 2019. The Bipartisan Budget Act of 2018 allowed for an additional $5.2 billion for Puerto Rico and the U.S. Virgin Islands only. The Congressional Research Service's report on Medicaid Funding for the Territories found that the territories are increasingly relying on the ACA funding for their Medicaid programs as the current funding system is insufficient.

Congress must act quickly to address the expiration of the territories' temporary ACA Medicaid funds, as all five territories will otherwise experience severe federal funding shortfalls beginning FY 2020. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), territories may be forced to either reduce benefits for Medicaid recipients or restrict coverage, further adding to confusion for beneficiaries and providers alike. Unfortunately, territory Medicaid programs could be affected even earlier than October 1 as "uncertainty about the availability of funds could affect providers' willingness to participate given that Medicaid may not be able to guarantee payment after a certain date."[1] Significant time and resources would be required to notify beneficiaries and providers of any changes ahead of any expiration of funds.

[1] Medicaid and CHIP Payment and Access Commission (MACPAC). (2019). "When Will the U.S. Territories Exhaust Federal Medicaid Funding?" Web.

STRONG MEDICINE FOR AMERICA

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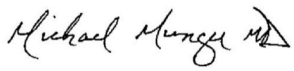
While Congress must address the short-term needs of the territories' Medicaid programs, it also must reconsider the territories' long-term Medicaid financing mechanisms. The current Medicaid funding system is unfair to the territories and leads to more stringent Medicaid eligibility limits, less comprehensive Medicaid benefits to participants, and inadequate payments to health care providers.

One of the AAFP's Core Principles of Medicaid calls for federal financial participation in territorial assistance programs to be equitable. Medicaid beneficiaries, as well as the providers who care for them, are United States citizens and are deserving of the same benefits and access to care as those in the states. It is imperative that Congress act to address the short-term and long-term Medicaid financing challenges in the territories.

Thank you for your consideration. If you have questions or would like additional information, please contact Shelby King, Manager, Center for State Policy, at sking@aafp.org.

Sincerely,



Michael L. Munger, MD, FAAFP
Board Chair

Voz y Acción de la Empresa Privada

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ACCREDITED STATE CHAMBER

By Email: [redacted]

June 19, 2019

Honorable Frank Pallone
Chairman
Committee of Energy & Commerce
US House of Representatives
2125 Rayburn House Building
Washington, DC 20515

Honorable Greg Walden
Ranking Member
Committee of Energy & Commerce
US House of Representatives
2322 Rayburn House Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

The Puerto Rico Chamber of Commerce (PRCC) is an active advocate, promoting ideas on behalf of our 1,200 members for developing a sustainable, growing economy in Puerto Rico. Since 1913, the PRCC has been the voice and action of free enterprise in Puerto Rico. Our mission is to strengthen the development of our members by providing knowledge, multi-sector representation, and protecting the values and foundations of free enterprise. We foster the sustainable development of Puerto Rico and a better quality of life for all its U.S. citizens.

The PRCC is grateful that the Energy & Commerce Committee has chosen to hold a hearing tomorrow about the very dangerous Medicaid funding shortage in Puerto Rico (Medicaid Cliff).

As this Committee is well aware, 44.4 percent[1] of Puerto Ricans live under the poverty level. These people rely mostly in public services and benefits such as Medicaid to cover basic healthcare needs. This number is almost unbelievable when compared with the official poverty rate in the US which according to Census data reaches 12.3 percent.[2]

Approximately 1.3 million Puerto Ricans are covered under Medicaid at a cost of $2.62 billion a year.[3] Unfortunately, because Puerto Rico is a territory, the Medicaid program works differently

[1] https://www.census.gov/quickfacts/pr
[2] https://www.census.gov/search-results.html?q=poverty+level&page=1&stateGeo=none&searchtype=web&cssp=SERP
[3] https://thehill.com/opinion/healthcare/436556-2019-medicaid-funding-cliff-could-cause-mass-migration-from-puerto-rico

than it does in the states. Federal Medical Assistance Percentages (FMAP) are calculated and determined according to "actual costs and needs as economic circumstances change". Most low income states have an FMAP of 70% or above.[4] But because Puerto Rico is a U.S. territory, the FMAP is capped at 55%.[5] This is also considerably lower than the 83% rate based on per capita income that we would receive if we were a state.

Last year Congress approved additional funding (approximately $4.8 billion) which will expire in September 2019. This cliff threatens healthcare coverage for Puerto Ricans which until now have relied on the program for healthcare services. There has to be a permanent solution for this issue.

Please note that there are enormous disparities in Medicare funding for Puerto Rico as well, as the panelists in the hearing today will discuss in detail. Action is necessary now. We support H.R. 813 which would correct some of these disparities in Puerto Rico. Furthermore, we are fully endorsing the petitions made in the letters sent by the Governor of Puerto Rico on May 1, 2019 and May 13, 2019.

There is no doubt the healthcare is an essential service and Puerto Ricans deserve equitable treatment. We thank the Committee for discussing this important issue. The PRCC welcomes the opportunity to collaborate with this and any other Congressional Committee in order to put this urgent healthcare issue on the right path moving forward.

Cordially,

Kenneth Rivera-Robles
President

[4] https://www.businesswire.com/news/home/20190225005910/en/Disproportionate-Medicaid-Funding-Puerto-Rico-Unfair
[5] Id.

FINANCIAL OVERSIGHT AND MANAGEMENT BOARD
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Executive Director

BY ELECTRONIC MAIL

June 19, 2019

The Honorable Anna Eshoo
Chairwoman
Committee on Energy and Commerce, Subcommittee on Health
U.S. House of Representatives
202 Cannon House Office Building
Washington DC 20515

Dear Chairwoman Eshoo:

I am pleased to provide a statement for the record on behalf of the Financial Oversight and Management Board for Puerto Rico, in light of the House Committee on Energy and Commerce, Subcommittee on Health's hearing on "Strengthening Health Care in the U.S. Territories for Today and Into the Future." As always, we are available should the Subcommittee Members have any questions.

Sincerely,

Natalie A. Jaresko

CC: Hon. Ricardo Rosselló Nevares, Governor of Puerto Rico
Hon. Jenniffer González Colón, Resident Commissioner

Financial Oversight and Management Board for Puerto Rico

STATEMENT OF
NATALIE JARESKO, EXECUTIVE DIRECTOR,
FINANCIAL OVERSIGHT and MANAGEMENT BOARD for PUERTO RICO

House Committee on Energy and Commerce, Subcommittee on Health

Hearing on "Strengthening Health Care in the U.S. Territories for Today and Into the Future"

June 20, 2019

Subcommittee Chairwoman Eshoo, Subcommittee Ranking Member Burgess, and Members of the Subcommittee, thank you for the opportunity to provide comments to the Subcommittee 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. For purposes of the record, I am providing an identical statement to the one I provided to the House Committee on Natural Resources for its hearing on "The Insular Areas Medicaid Cliff" on May 23, 2019.

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 Subcommittee 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.

CONSEJO MULTI SECTORIAL de SALUD

June 19, 2019

Congresswoman Anna G. Eshoo
Chairwoman
House Committee on Energy & Commerce / Health Subcommitee

Dear Chairwoman:

The Multi-Sectorial Council for Puerto Rico's Health System (The Council) requests an opportunity to present the following testimony. **We would like to provide the Committee with solutions**, based on evidence, that will address important matters such as mechanisms of oversight, efficiency, and improvements on access and quality to healthcare services.

The Council is an entity created by PR Law 235 of 2015, by which it is affiliated with the University of Puerto Rico (UPR), Medical Sciences Campus. It was created with the purpose of including a diverse group, which includes stakeholders who represent all health sectors as active participants, in the development of health policies for Puerto Rico. It is consistent with the federal mandate to create a strong stakeholder's engagement, under a State Medicaid Advisory Committee, required by CFR 42 sec. 431.12.

Our mandate is to study and offer advice to the government of Puerto Rico, regarding the design of an **integrated healthcare system** under the guiding principles of efficacy, fairness, and responsible fiscal governance. It is also consistent with responsibilities ordered under PROMESA (sec. 201), to "restructure", "ensure the funding of essential public services", and "to improve fiscal governance and internal controls".

While many highlight the very serious problem of funding, we would like to bring to your attention two of the Council's proposals much needed to ensure the best access and quality of care to citizens, while ensuring federal and local funds are used in the most efficient and responsible manner:

1. **A serious and comprehensive assessment** (independent study) of the current model, and implementation of a proposed model that truly ensures federal and local funds would be used in the most equitable, efficient, and fiscally responsible manner, while providing the optimal access and quality of care to beneficiaries. The use of remedies available in the code of federal regulations, that will permit restructuring of our health system, such as Waivers under section 1115 (Medicaid), and the State Innovation Plan under the Affordable Care Act (ACA), could support implementation in Puerto Rico.

2. **There is a need for a proper authority**, under a strong and effective stakeholders engagement body, to conduct analysis, officially contributing in the planning, administration, and design the new healthcare model. This would provide the much needed transparency and ***oversight*** lacking under the current health model. We envision this body as one of citizen and governmental partnership.

Our proposals for serious review and stakeholder engagement authority have been submitted repeatedly to the Governor, the Puerto Rico Legislature, and the Financial Oversight & Management Board (FOMB), in the wake of severe austerity cuts to the government insurance plan (VITAL), and public employees and retirees. We feel this matter have been addressed in a fragmented and dysfunctional manner. There is a generalize dissatisfaction and frustration increasing among beneficiaries and healthcare providers. Poor indicators of general health and serious limitations to access of care are reflected under the government health plan. Meanwhile, there is an increment in funding for fewer participants under the current model. Unfortunately, we have received no response after requesting evidence to support policies included in the Fiscal Plan certified by the FOMB.

We face a precipitous and dramatic decrease in Medicaid funding. But also, because of the way our healthcare model had been organized, thousands of workers have seen employers' contributions to health insurance diminished, or have lost benefits partially or entirely through their jobs, including government retirees. All these are factors creating pressures to restructure our current healthcare apparatus, or expanding Medicaid, an untenable situation for the majority of people in Puerto Rico. Evidence of post-hurricane vital statistics **exposed the fragility** of our healthcare apparatus, a matter that threaten the very lives of people in Puerto Rico.

In the pasts weeks Congress had celebrated two historic hearings on how to finance and deliver health care for every American citizen, and the Congressional Budget Office submitted its latest report on that matter. Reports from six states during the past 2 years have considered and found evidence supporting model change. All these initiatives point to alternatives for financing and delivering more efficacious and fair healthcare services.

This is a crucial moment in Puerto Rico's recovery from the Hurricane, restructuring of our public services and fiscal situation under bankruptcy. The attention this Committee and the rest of Congress is giving to our Island should not fail, because ***all possible angles were not considered***. We trust your efforts along with ours can provide important contributions not only for Puerto Rico, but also to the national debate and the benefit of the American people in all States.

Sincerely,

Dr. Rafael F. Torregrosa
President of The Multi-sectorial Council on Puerto Rico's Health System (PR Law 235)

THE PARTNERSHIP FOR MEDICAID

June 20, 2019

The Honorable Mitch McConnell
Majority Leader
S-230, U.S. Capitol
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader
S-221, U.S. Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
H-232, U.S. Capitol
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
H-204, U.S. Capitol
Washington, DC 20515

Dear Leader McConnell, Leader Schumer, Speaker Pelosi and Leader McCarthy,

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition of health care providers, safety-net health plans, counties and labor—the undersigned organizations wish to express our concern about the impacts of the impending Medicaid "fiscal cliff" on beneficiaries and providers in the U.S. territories, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

Unlike the states, the federal medical assistance percentage (FMAP) for Medicaid payments to U.S. territories are statutorily prescribed and do not take into consideration per capita income. As such, Medicaid programs in the territories are underfunded compared to their state counterparts. Temporary Medicaid funds from the *Affordable Care Act* (ACA) and subsequent legislation in 2017 and 2018 provided critical health care support in the territories, but the vast majority of these funds expire at the end of this fiscal year. Legislation to offset the end of these temporary federal Medicaid funds must pass before September 30. Otherwise the impacts to the territories' budgets, coverage, and patients' health will be severe.

Nearly half of Puerto Rico's 3.2 million residents receive health coverage through Medicaid. If additional federal funds aren't provided, hundreds of thousands of Puerto Ricans' health care coverage will be at risk. If Congress does not act to extend Medicaid funding, the FMAP would revert to the statutorily mandated 55 percent level for most of the Medicaid program with a federal Medicaid funding cap of approximately $380 million. This level of federal support for Puerto Rico's Medicaid program is not sustainable, as it is projected to cover only a fifth of the funding needed during fiscal year (FY) 2020. Should Puerto Rico be limited to its statutory cap of $380 million at the FMAP of 55 percent for FY 2020, federal funding of Puerto Rico's Medicaid would last only three months without cutting benefits—which are already limited to begin with—or disenrolling beneficiaries from the program.[1]

[1] Rudowitz R, Hall C, Lyons B. (2019). "Medicaid Financing Cliff: Implications for the Health Care Systems in Puerto Rico and USVI." Kaiser Family Foundation.

Although Puerto Rico would experience the biggest shortfall, all territories would face challenges should the ACA funds be allowed to expire without a replacement. This unique Medicaid funding system for territories leads to more stringent Medicaid eligibility limits, less comprehensive Medicaid benefits and low payments to health care providers.

We urge Congress to act ahead of the September 30 deadline to address the pending Medicaid fiscal cliff. Recent disaster relief packages under consideration by Congress have failed to address this issue. We encourage both chambers to come together to address the short-term and long-term Medicaid financing challenges in the territories.

If you have any questions, or if the Partnership can be helpful as you consider this issue, please contact Shelby King, First Co-Chair of the Partnership for Medicaid, at (202) 655-4902 or sking@aafp.org.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Dental Association
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Children's Hospital Association
Easterseals
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Council for Behavioral Health
National Health Care for the Homeless Council
National Rural Health Association
The Jewish Federations of North America

cc:
The Honorable Chuck Grassley, Chairman, Senate Committee on Finance
The Honorable Ron Wyden, Ranking Member, Senate Committee on Finance
The Honorable Frank Pallone, Chairman, House Committee on Energy and Commerce
The Honorable Greg Walden, Ranking Member, House Committee on Energy and Commerce

Statement for Hearing on

"Strengthening Health Care in the U.S. Territories for Today and Into the Future"

Submitted to the
House Energy and Commerce Committee
Subcommittee on Health

June 20, 2019

Medicaid is an essential part of American health care. It helps improve the health and financial security of approximately 74 million Americans every day. Two-thirds of Medicaid enrollees – about 55 million Americans – are served by Medicaid managed care. Many of AHIP's members work closely with the states and U.S. territories to provide a health care safety net for vulnerable populations and implement innovative health solutions to improve health outcomes and lower costs.

AHIP Supports a Funding Extension for Puerto Rico's Medicaid Program

Our statement for today's hearing focuses on the need for legislative action to address the public health crisis that could result from the impending exhaustion of temporary federal funding of Puerto Rico's Medicaid program. Recognizing that the territory's high poverty rate and poor economic conditions were seriously exacerbated by Hurricanes Irma and Maria in September 2017 – and that the 3.7 million citizens of Puerto Rico are still experiencing the devastating

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America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

impact of these disasters – we believe it is important for Congress to pass legislation to avoid the loss of this federal funding. Such legislation is urgently needed to ensure that the program can continue to provide high quality health care services – with a strong focus on prevention, care coordination, disease management, and other vital services and supports – to the 1.6 million Puerto Ricans who currently rely on Medicaid to meet their health care needs.

Recognizing the problems Puerto Rico has faced under its current statutory financing structure, Congress has provided limited and temporary funding increases for Puerto Rico's Medicaid program on several occasions. This includes enhanced funding provided by the Bipartisan Budget Act of 2018 that expires in September 2019 and enhanced funding provided by the Affordable Care Act that expires in December 2019.

In a recent report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimates that the expiration of these temporary funds will result in a federal funding shortfall for Puerto Rico's Medicaid program of at least $1 billion in fiscal year 2020.[1] To illustrate the impact of this loss in funding, MACPAC cautions that Puerto Rico could eliminate the Medicaid prescription drug and dental benefits currently provided to Medicaid beneficiaries as optional benefits and still not achieve the level of savings needed. Alternatively, if the temporary funding is allowed to expire and benefits are maintained at current levels, Puerto Rico would have to reduce enrollment by 36 to 53 percent to cope with the estimated funding shortfall. Losses in coverage and/or benefits of this magnitude could have devastating health impacts. Therefore, AHIP urges Congress to pass legislation to extend this urgently needed funding for Puerto Rico's Medicaid program.

Medicaid Provides Value to Consumers and Taxpayers

Medicaid health plans have a long track record in improving health care for vulnerable populations and helping state and territorial Medicaid programs receive maximum value for their health care dollars. AHIP's Medicaid members do this by coordinating care, placing a strong emphasis on preventive health care services, providing disease management services for chronically ill patients, and offering innovative programs to promote the health and well-being of Medicaid enrollees.

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[1] Medicaid and CHIP Payment and Access Commission. *Report to Congress on Medicaid and CHIP*. June 2019. https://www.macpac.gov/publication/june-2019-report-to-congress-on-medicaid-and-chip/

The value of Medicaid health plans is demonstrated by a November 2018 AHIP study which found that individuals with asthma, diabetes or serious mood disorders who are enrolled in Medicaid have far superior clinical experiences than people without coverage.[2] Another recent AHIP study shows that Americans enrolled in Medicaid have far better access to health care and preventive services than those without coverage.[3]

For 1.6 million citizens of Puerto Rico, continued access to the benefits associated with Medicaid coverage through their Medicaid managed care plans depends heavily on Congress taking action to ensure a continuation of the enhanced federal funding for Puerto Rico's Medicaid program.

Conclusion

Thank you for considering our support for legislative action to provide a funding extension for Puerto Rico's Medicaid program. We look forward to working with the committee to address this important priority.

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[2] America's Health Insurance Plans. *The Value of Medicaid: How Coverage Impacts the Care of Serious Chronic Health Conditions.* November 2018. https://www.ahip.org/wp-content/uploads/2018/11/IssueBrief_Medicaid.pdf
[3] America's Health Insurance Plans. *The Value of Medicaid: Providing Access to Care and Preventive Health Services. April 2018*. https://www.ahip.org/wp-content/uploads/2018/04/ValueMedicaid_Report_4.4.18.pdf

CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN
PUERTO RICO - AT LARGE

Committee on Energy and Commerce
Subcommittee on Health

STRENGTHENING HEALTH CARE IN THE U.S. TERRITORIES FOR TODAY AND INTO THE FUTURE

Statement of the
Hon. Jenniffer A. Gonzalez Colon
Member of Congress (PR-At Large)

A healthcare expert once asked "What is Medicaid all about? It's staying true to the mission: to care for people historically left behind."[1] Medicaid protects impoverished children, the frail elderly and people in crisis. But Medicaid is about to leave behind the 1.6 million Americans in the territories whose healthcare depends on this program. I thank the Committee for acknowledging this impending crisis and for holding this hearing to raise awareness of this issue.

In 2017, 1.6 million Americans living in the territories were enrolled in Medicaid. That breaks down to 79% of the population of American Samoa, 21% of the population of Guam, 33% of the population of the Northern Mariana Islands, 47% of the population of Puerto Rico, and 16% of the population of the U.S. Virgin Islands.[2] The national average enrollment for the States and the District of Columbia was 21%.[3]

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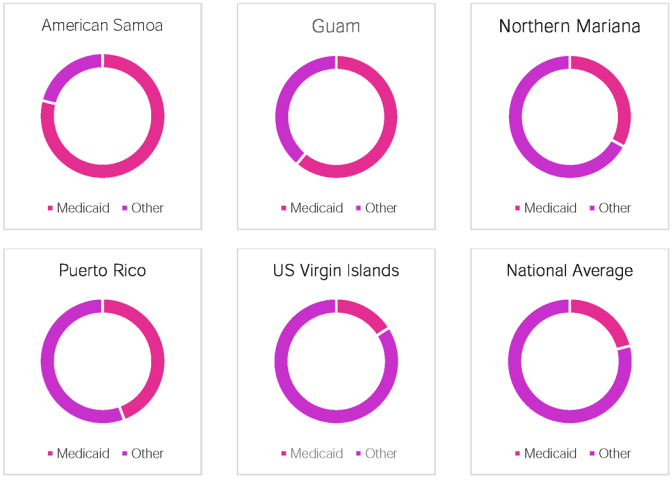
[1] Risa Lavizzo Mourey, former CEO of the Robert Wood Johnson Foundation.

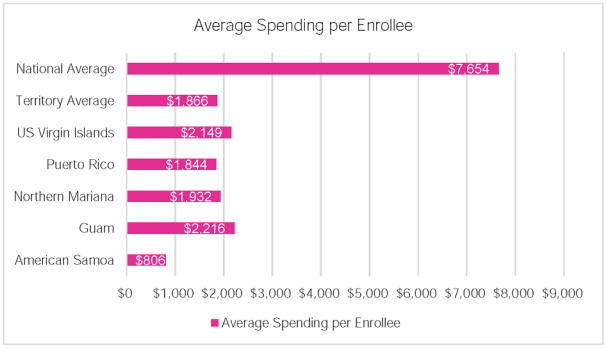
[2] MACPAC Fact Sheet, MEDICAID AND CHIP IN THE TERRITORIES (March 2019), available at https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf.

[3] Kaiser Family Foundation, Health Insurance Coverage of the Total Population (2017), available at https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; K. Buderi, MACPAC MANDATED REPORT, MEDICAID IN PUERTO RICO, Medicaid and CHIP Payment and Access Commission (October 25, 2018), available at https://www.macpac.gov/wp-content/uploads/2018/10/Mandated-Report-Medicaid-in-Puerto-Rico.pdf.



During that same year, the Medicaid program spent an average of $1,866 a year per territory enrollee. The national average (excluding the territories) was $7,654 per year per enrollee.[4]

[4] MACPAC, MACSTATS:MEDICAID AND CHIP DATA BOOK, Exhibit 23. Medicaid Benefit Spending per Full-Year Equivalent for Newly Eligible Adults and All Enrollees by State, FY 2017 (December 2018), available at https://www.macpac.gov/wp-content/uploads/2017/12/EXHIBIT-23.-Medicaid-Benefit-Spending-per-Full-Year-Equivalent-Enrollee-for-Newly-Eligible-Adult-and-All-Enrollees.pdf.



How does this happen? Are territorial enrollees healthier? Are healthcare costs in the territories so much lower than they are in the mainland? The answer to the later questions is, "No. Quite the opposite." And the answer to the first is hard to hear: the territories are subject to a discrimination in healthcare programs to an unprecedented degree that not only affects the healthcare delivery system for the underprivileged and needy, but also destabilizes the availability of healthcare for all residents in all the territories.

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 and, in 2017, ranged from 50% to 75%, with an average national FMAP of 61.5%.[5] The FMAP for the District of Columbia is set by statute at 70%, but without this exception, it would be at the statutory minimum of 50%. The FMAP for the territories is permanently set by statute at 55%, but in contrast to DC, 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% 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 set in 1968, which increases annually with a medical component of consumer price index. Once a territory exhausts its capped federal funds, it no longer receives federal financial support for its Medicaid program during that fiscal year.

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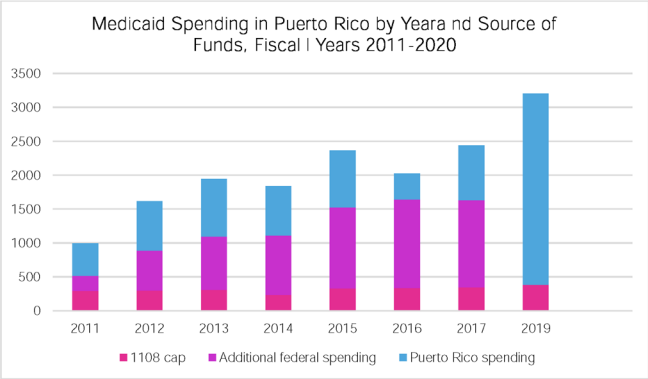
[5] MACPAC, MACSTATS:MEDICAID AND CHIP DATA BOOK, Exhibit 6. Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages by State, FYs 2015–2019 (December 2018), available at https://www.macpac.gov/wp-content/uploads/2018/04/EXHIBIT-6.-Federal-Medical-Assistance-Percentages-and-Enhanced-Federal-Medical-Assistance-Percentages-by-State-FYs-2015%E2%80%932019.pdf.

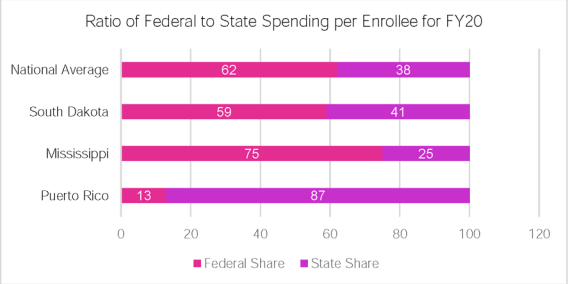
In 2011, the Affordable Care Act granted the territories an additional $8.25 billion in federal funds for their Medicaid programs *in lieu* of establishing a health insurance marketplace. The additional funding for each territory ranged from $109.2 million for the Northern Mariana Islands to $6.325 billion 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.



Congress acted to avert a crisis in Puerto Rico's Medicaid Program with a temporary increase in the federal cap of $2.959 billion for FY18-19 in the CONSOLIDATED APPROPRIATIONS ACT OF 2017. Moreover, as a result of the state of emergency caused Hurricanes Irma and Maria in 2017, we again increased the federal cap to $4.8 billion with 100% FMAP through FY19 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 FY20 will be approximately $375 million, with no additional source of federal funding available. To put this into perspective, this means a federal spending level of $285 per enrollee in Puerto Rico, as compared to $7,672 per enrollee in Mississippi (the State with the highest percentage of its population living under the poverty level); $7,942 per enrollee in South Dakota (the State with the most similar FMAP); and $7,654 per enrollee nationally.



It also means that Puerto Rico will exhaust its federal Medicaid allotment in the first three months of FY20, and will bear the expense in excess of 85% of the federal program, placing additional pressure on sparse territory resources.

On April 12th, I introduced H.R. 2306: the P.R. MEDICAID ACT OF 2019 as an immediate fix while we work on a long-term solution. This bill eliminates the 55% statutory FMAP, in favor of the application of the formula applicable to the States.; currently, the FMAP would be 83%. It also provides for a more realistic statutory cap, taking into account the total projected expenditures of close to $3.2 billion for FY20 and FY21. From FY22 and thereafter, this new statutory cap would be increased by the cost of living index, to provide for inflation. This is not the ideal fix, but it is a workable fix.

Each territory is affected by this inequitable treatment in healthcare funding in individual ways and— other than full equality for all Americans in all federal healthcare programs regardless of their jurisdiction of residence— there is no one-size-fits-all territorial solution. However, all of our Medicaid programs— as currently conceived— are unsustainable, treat Americans in the territories like second-class citizens, and place financial pressures upon local resources to an extent not otherwise placed on any State. This underfunding contributes to larger systemic problems, including lower provider reimbursement rates and provider shortages. It creates a constant state of uncertainty for the local government, for the patients, and for healthcare providers with regards to the viability of the program.

We are here today to listen to each territory talk about the fragile state of their Medicaid programs due to the lack of adequate funding. I trust that these testimonies will help my colleagues to understand the urgent need for action. If we fail to act with the expediency that the situation requires, the provision of healthcare in all the territories will be severely affected, with far reaching repercussion for the rest of our Nation.

Additional Questions for the Record

Subcommittee on Health
Hearing on
"Strengthening Health Care in the U.S. Territories for Today and Into the Future"
June 20, 2019

Anne Schwartz

The Honorable Michael C. Burgess, M.D.

1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

Response

Table 1 provides estimates of federal funding shortfalls for FY 2020 under different scenarios: if only the annual allotment under Section 1108(g) of the Social Security Act were available in FY 2020, per the question above, and under current law -- that is, if territories use Section 1108 funds as well as available Section 1323 funds. Funding under Section 1323 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) is available to territories until December 31, 2020 and thus can be used to cover spending occurring in quarter 1 (Q1) of FY 2020.[1]

A number of factors could influence these estimates. First, estimates are based on federal allotment balances provided to MACPAC by the Centers for Medicare & Medicaid Services (CMS) and FY 2020 spending projections submitted to CMS by the territories on Form CMS-37 in August 2019.[2] Second, we assume that all data are accurate.[3] Third, we note that the amount

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[1] Assuming that spending is equally distributed across quarters, all territories except the Commonwealth of the Northern Mariana Islands (CNMI) are expected to have sufficient ACA Section 1323 funds to cover spending in Q1 of FY 2020 (CMS 2019). CNMI exhausted its Section 1323 funds in FY 2019.

[2] Projections presented in MACPAC's written testimony for this hearing were based on FY 2020 projections submitted to CMS by the territories on Form CMS-37 in May 2019. Between the May and August submissions, projections of federal spending increased by 57.1 percent for American Samoa and 1.8 percent for CNMI. These projections decreased by 63.8 percent for Guam and 2.4 percent for Puerto Rico. There were no changes for the U.S. Virgin Islands.

[3] Data and projections exclude allotments provided to the territories for the Enhanced Allotment Plan (EAP), also referred to as Section 1935(e) funding. This annual allotment, separate from the annual Section 1108 allotment, can only be used to help pay for prescription drugs for individuals dually eligible for Medicare and Medicaid. Excluding the EAP allotment does not materially affect shortfall estimates.

and timing of actual spending may differ from projected spending due to enrollment or utilization changes. Last, other territory-specific circumstances could affect actual shortfall amounts.

TABLE 1. Projected Spending, Section 1108 Allotment, and Estimated Federal Medicaid Funding Shortfall in U.S. Territories, FY 2020 (millions)

Territory	Projected federal spending	Section 1108 allotment	If only Section 1108 funds are used	Current law (If Section 1108 funds and ACA Section 1323 funds are used)
American Samoa	$29.27	$12.43	$16.84	$9.52
CNMI	9.61	6.85	2.76	2.76
Guam	19.74	18.38	1.36	–
Puerto Rico	1,934.70	375.10	1,559.60	1,075.92
USVI	77.35	18.75	58.60	39.26

Notes: ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. USVI is the United States Virgin Islands. Q refers to quarter of the fiscal year. Section 1108 allotment reflects the annual ceiling on federal funds that the territories receive under Section 1108(g) of the Social Security Act. CNMI shows the same shortfall amount under both scenarios because it exhausted its Section 1323 funds in FY 2019 and will have none remaining in FY 2020. Assumes spending is equally distributed across quarters. Spending is projected; actual shortfall amounts will differ depending on amount and distribution of actual spending.
– Dash indicates zero.
Sources: CMS 2019a, b; MACPAC 2019 analysis of CMS-37 projections of spending for FYs 2020 submitted in August 2019.

The Honorable Gus M. Bilirakis

1. The pending Medicaid fiscal cliff is not only an issue for the U.S. Territories but is a U.S. issue – especially for the state of Florida who is often the first to experience the influx of Medicaid patients from the Territories seeking care. This places an additional burden on Florida's Medicaid program, provider network, and patient benefits.

    a. Is the Medicaid program in the U.S. Territories administered differently than in the States, and if so, how?

    b. Is it more costly to manage a chronic disease patient in the U.S. Territories or in the States?

    c. How is the current fiscal crisis impacting the availability of providers in the Territories – is it hard to recruit and retain quality providers?

    d. Does this impact continuity of care and drive unnecessary, costly hospital readmissions?

Response to 1a

Under the Social Security Act (the Act), the territories are considered states for the purposes of Medicaid and CHIP, unless otherwise indicated (§1101(a)(1) of the Act). Below we describe key ways that territories are similar to and differ from states.

Guam, Puerto Rico, and the U.S. Virgin Islands (USVI)

Medicaid program administration in Guam, Puerto Rico, and USVI is similar to state Medicaid programs particularly in terms of the roles, responsibilities, and administrative structures of the Medicaid agency. For example:

Medicaid provides health insurance coverage to enrolled individuals;
eligibility for Medicaid is determined on an individual basis using modified adjusted gross income (MAGI);
Medicaid delivery systems are similar to those in state Medicaid programs (fee-for-service delivery systems are used in Guam and USVI and managed care is used in Puerto Rico); and
the territories administer and oversee their programs and report data and other information to CMS.

Important differences include:

the territories use territory-specific poverty levels, rather than the federal poverty level (FPL), to determine Medicaid eligibility;
only Guam provides all mandatory Medicaid benefits; and
historically, the territories have not been able or required to report all of the same data to CMS as states or required to participate in the same program integrity initiatives.[4]

American Samoa and the Commonwealth of the Northern Mariana Islands (CNMI)

American Samoa and CNMI operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them (§ 1902(j) of the Act). This provision allows the Secretary of Health and Human Services to waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the federal medical assistance percentage (FMAP), and the requirement that payment can only be for services otherwise coverable by Medicaid. This means that they are not required to comply with other federal Medicaid requirements that apply to states, including those related to mandatory benefits, covered populations, program integrity, or data and reporting requirements.

In American Samoa, Medicaid eligibility is not determined on an individual basis and there is no enrollment process. Instead, federal Medicaid and CHIP funds pay for care provided in the

[4] Territories have cited lack of infrastructure and financial resources as barriers to providing all benefits and reporting all data. For example, Puerto Rico does not have long-term care facilities, and thus, does not provide long-term care. CNMI has not yet established a Medicaid Management Information System to report data to the Transformed Medicaid Statistical Information System because of concerns about the cost effectiveness (Sablan 2019).

territory in proportion to the population of American Samoans with income that would have fallen below the Medicaid and CHIP income eligibility threshold of 200 percent FPL.

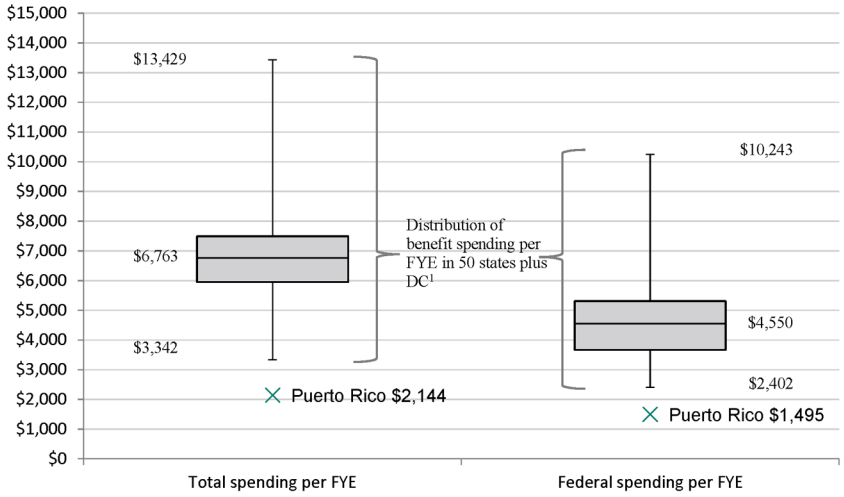
CNMI, the only territory participating in Supplemental Security Income (SSI), uses that program's income and asset standards to determine Medicaid eligibility, covering individuals who meet up to 150 percent of income and resource requirements for SSI but are not necessarily disabled.

In both of these territories, as well as in Guam, the majority of all services are provided by each territory's one public hospital.

Response to 1b

MACPAC does not have detailed information to compare the cost of serving patients with specific health care needs in the territories to the states. However, MACPAC has found that in general, the spending on services to beneficiaries in Puerto Rico is lower than in states. For example, Puerto Rico's projected total spending per full-year-equivalent (FYE) enrollee is $2,144. This is 36 percent lower than the state with the lowest spending ($3,342), 68 percent lower than the median ($6,763) and 84 percent lower than the state with the highest spending ($13,429) (Figure 1). MACPAC does not have data needed to estimate per capita Medicaid spending in the other territories.

FIGURE 1. Projected Medicaid Benefit Spending per FYE in Puerto Rico Compared to Distribution of Projected Medicaid Benefit Spending per FYE in 50 States and DC, FY 2020



Notes: FYE is full-year equivalent. FY is fiscal year. DC is District of Columbia. Total spending includes federal and state funds. Excludes Medicaid-expansion CHIP enrollees. Excludes spending for administration and long-term services and supports (LTSS). FY 2013 benefit spending from Medicaid Statistical Information System (MSIS) data were adjusted to reflect CMS-64 totals. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. FY 2013 spending per FYE for each eligibility group was trended forward to FY 2020 using CMS Office of the Actuary (OACT) projected growth rates for that eligibility group. For adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, FY 2017 benefit spending per FYE calculated from CMS-64 spending and enrollment data was trended forward to FY 2020 using OACT projections. To adjust for differences in enrollment mix across states and Puerto Rico, the enrollment mix across eligibility groups in each state was reweighted to match the distribution of enrollees across eligibility groups in Puerto Rico.
[1] Excludes Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.
Sources: ASES 2019a, b. OACT 2018. MACPAC 2019 analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of June 2016; CMS-64 FMR net expenditure data as of July 20, 2018; and CMS-64 enrollment reports as of September 19, 2018.

Response to 1c

The administrative data available to MACPAC cannot be used to assess provider availability, recruitment, or retention. However, based on the work of others, we understand that all five territories have experienced provider access challenges, which predated, but have been exacerbated by, recent natural disasters. Low provider payment rates and uncertainty related to Medicaid fiscal crises have been identified as likely contributing to these challenges. Factors such as the territories' geographic isolation, infrastructure issues, and economic conditions may also play a role.

In Puerto Rico, primary care physician, general surgeon, and dentist availability in has tracked closely with the United States as a whole (AAMC 2017, 2013); however, it varies across geographic regions within the territory. For example, 72 of Puerto Rico's 78 municipalities are designated as medically underserved areas, and 32 are designated as primary care shortage areas (HRSA 2019). Puerto Rico also lacks an adequate supply of certain types of specialists. Prior to Hurricane Maria, 23 percent of municipalities had a shortage of pediatricians and 68 percent had a shortage of obstetrician-gynecologists. In 2017, the supply of emergency room physicians; neurosurgeons; plastic surgeons; and ear, nose, and throat specialists was less than half the rate on the mainland (ASPE 2017).

USVI is designated by the Health Resources and Services Administration as a geographic high needs health professional shortage area and is experiencing shortages of physicians and other clinical staff, including shortages of mental health professionals (USVI Hurricane Recovery and Resilience Task Force 2018).

American Samoa and Guam have similarly experienced shortages of physicians, nurses, and other medical staff and recruitment challenges (Faumuina 2017, DOI 2014). In recent years, they have each covered off-island services if necessary services are unavailable.

MACPAC has limited information about the availability of providers in CNMI. However, like American Samoa and Guam, the territory relies on one public hospital and its ancillary clinics to provide most services. Territory Medicaid officials have expressed concerns about the effects on access to care if CNMI becomes unable to provide access to private or off-island providers due to a lack of federal Medicaid funds (Sablan 2019).

Response to 1d

MACPAC does not have information on effects of the territories' Medicaid fiscal crises on continuity of care or hospital readmissions.

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GOBIERNO DE PUERTO RICO
Administración de Seguros de Salud

Hon. Wanda Vázquez Garced
Gobernadora

Sra. Yolanda Garcia Lugo
Directora Ejecutiva Interina

Additional Questions for the Record

Subcommittee on Health
Hearing on
"Strengthening Health Care in the U.S. Territories for Today and Into the Future"
June 20, 2019

Puerto Rico Health Insurance Administration

The Honorable Michael C. Burgess, M.D.

1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

All federal funding appropriated by the BBA and ACA will have expired on September 30, 2019 and December 31, 2019 respectively. At that time, Puerto Rico will rely on the Section 1108 capped funds and Enhanced Allotment Plan (EAP) funds to finance the Medicaid program. These funds are projected to be exhausted in the second quarter of federal fiscal year (FFY2020). After the exhaustion of the Section 1108 and EAP funds, the entirety of the program will need to be financed with state funds. Our projections are that for FFY2020, which begins October 1, 2019, the effective federal share for Medicaid and CHIP expenditures will be approximately 34%. For FFY2021 the effective federal share will fall below 20%. These estimates do not include the amounts for the measures that the Puerto Rico Government has identified as critical to stabilize, strengthen, and improve the Medicaid program and the island's healthcare system.

The following table shows the shortfall of funds assuming a 55% FMAP. The table also shows the projected 5-year Medicaid and critical sustainability measures expenditures. We also estimate the federal fund amounts for the section 1108 and EAP funds.

Puerto Rico Medicaid Request (Millions)						
Required Medicaid Federal Funds Estimate	**FFY2020**	**FFY2021**	**FFY2022**	**FFY2023**	**FFY2024**	**5-Yr Total**
Medicaid Baseline	$1,878.5	$1,952.1	$2,043.3	$2,139.6	$2,240.9	$10,254.5
Critical Sustainability Measures Federal Share	$367.8	$400.5	$395.7	$397.6	$407.0	$1,968.6
Total	$2,246.4	$2,352.6	$2,439.1	$2,537.2	$2,647.9	$12,223.1
Appropriated Medicaid Funds Projection						
Section 1108	$805.6	$379.2	$385.6	$392.2	$398.9	$2,361.5
EAP	$59.4	$62.5	$65.8	$69.3	$72.9	$329.9
Total	$865.0	$441.7	$451.4	$461.5	$471.8	$2,691.4
Federal Funds Shortfall	$1,381	$1,911	$1,988	$2,076	$2,176	$9,532

Note: The Section 1108 and EAP funds are projected. The grant amounts are calculated each year by HHS based on the change of the medical component of the CPI for Section 1108 and the Medicare Part D per capita growth for EAP funds.

The Honorable Gus M. Bilirakis

1. I understand that program funding in Puerto Rico comes from a variety of funding streams.

    a. Is this patchwork of funding conducive to proper oversight or does it create challenges and if so, what are some of those challenges?

The framework of patchwork funding presents multiple challenges for Puerto Rico, including hindering long-term strategic planning and proper program oversight, such as:

- *Puerto Rico cannot implement provider reimbursement rate increases over the long term to stem the exodus of providers and ensure availability of services in Puerto Rico.*
- *ASES has to delay program enhancements due to large upfront costs even though they might achieve savings in the long term, such as providing coverage for Hepatitis C drugs. These costly treatments require a significant initial investment which Puerto Rico is currently unable to afford without*

sustained federal assistance. In the long term, this investment is expected to result in savings to the Medicaid program through improved healthcare outcomes, reduced hospitalizations, and the avoidance of costly effects of not undergoing Hepatitis C treatment such as the development of cirrhosis, the need for dialysis, the need for liver transplants and associated immunosuppressant drugs, as well as avoiding the mental and emotional toll on patients suffering from these terrible complications. However, without a measure of predictability in the availability of funding from its federal partners, Puerto Rico cannot on its own afford the required initial investment.

- *The patchwork funding framework causes Puerto Rico to waste valuable financial resources on advisors and consultants as well as agency human resources to continually lobby congress for more federal funds.*

- *It also causes challenges when contracting Managed Care Organizations (MCOs) because they require guarantees from the Government that there is enough federal funding for the program.*

- *The Government of Puerto Rico must also comply with the requirements of the Financial Oversight and Management Board (FOMB) created under PROMESA, Pub. L. 114-187. As long as the amount of federal funding remains uncertain in the long term, it is impossible for the Government of Puerto Rico to establish long term policy goals with the FOMB that do not include the threat of benefit cuts or reducing the number of beneficiaries covered under the program. Questions such as whether additional benefits like pharmacy coverage or dental services will need to be eliminated from the program to comply with FOMB requirements will remain unanswered until stable economic funding for the Government Health Plan is secured.*

b. Puerto Rico's hospitals are eligible to receive DSH payments under Medicare. Can you briefly highlight the differences between Medicare DSH and Medicaid DSH?

The main difference between Medicaid and Medicare DSH payments for Puerto Rico, is that Puerto Rico does not receive Medicaid DSH payments, as it was excluded from Section 1923(f)(9) of the Social Security Act's definition of "State". It was also excluded from receiving a Medicaid DSH allotment per Section 1923(f)(2)(A) of the Social Security Act. Notably, Medicaid DSH allotments for years 2003 and thereafter are calculated based on the original allotments in (f)(2)(A), with adjustments as specified in (f)(3), such that the initial exclusion means that Puerto Rico hospitals continue to be excluded from the benefits of DSH payments, in spite of their dire need for the same.

The Medicaid DSH program is a joint federal-state program where additional payments are made to hospitals that serve a large number of Medicaid and low-income uninsured patients "to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients." (MACPAC, March 2014 Report to Congress). States have significant flexibility to structure their DSH program, for which reason DSH programs vary widely throughout the country, and the federal government reimburses each state for its share of DSH spending at the state's regular Federal Medical Assistance Percentage (FMAP) rate.

States may specify in their State Medicaid Plans how funds are distributed to individual hospitals and which hospitals qualify for payments. However, states are required to include all hospitals that have: (1) a Medicaid inpatient utilization rate one standard deviation or more above the mean for all hospitals in the state, or (2) a low-income utilization rate exceeding 25 percent.

There are multiple annual limits to federal Medicaid DSH payments. The three most significant limits are:

1. *A limit on total annual federal DSH reimbursement to each state: The cap for each state is calculated based on its DSH allotment for the previous fiscal year (FY), adjusted for inflation.*
2. *A hospital-specific DSH limit: A hospital's DSH payments in a given year cannot exceed its net cost of providing care to Medicaid patients and the uninsured.*
3. *The ACA imposed annual reductions to each state's DSH limit. The imposition of those reductions have been delayed.*

Unlike Medicaid DSH payments, Puerto Rico is eligible for Medicare DSH payments. And in contrast to Medicaid DSH payments, which vary by State, Medicare DSH payments are based upon a standard national formula, a component of which is the wage index. Because of the manner in which the formula is applied, Puerto Rico's Medicare DSH payments are suppressed by what is known as the "wage index spiral". This phenomenon has been described by MedPac as one in which hospitals that successfully moderate increases in hourly wages relative to the national average increase will see a decrease in their wage index, and therefore their DSH payments: "They will then receive lower payments, which may create pressure to exert even tighter control over costs . . . If hospitals succeed at keeping wage increases below the national average again, their wage index could decrease still further." (MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare, pg. 130 (June 2007))

Puerto Rico is particularly susceptible to this spiraling effect. As recently stated by the Medicaid and Medicare Advantage Product Association of Puerto Rico (MMPA) and the Puerto Rico Hospital Association in their June 24, 2019 joint letter to CMS (attached), wages for Puerto Rico in general are reported to be significantly lower than the national average. The cost of living in Puerto Rico, however, is comparable

to that of the United States, and in fact the 55th costliest area out of 297 examined Metropolitan Statistical Areas in the U.S., with higher prices than the U.S. average in most categories. (see Institute of Statistics of Puerto Rico, Cost of Living Index, (https://estadisticas.pr/files/inventario/indice_de_costo_de_vida/2017-12-21/One_pager_COLI%202016Q3_2017Q3.pdf).

Due to comparatively low Medicare reimbursements and rising nonlabor costs, hospitals in Puerto Rico must therefore keep wages low, which feeds into the "wage index spiral" described above.

In general terms, Medicare DSH payments are generally available only to acute care hospitals that participate in the Medicare inpatient prospective payment system and whose percentage of low-income patients is above 15 percent. The Medicare program uses the number of Medicaid patient days as a percentage of total patient days plus the number of Supplemental Security Income (SSI) Medicare patient days as a share of Medicare patient days to calculate a hospital's percentage of low-income patients. This means that in the States, SSI patients with both Medicaid and Medicare are weighted more heavily. However, because residents of Puerto Rico are ineligible for SSI, a proxy is used in the calculation of DSH payments for uncompensated care.

Under Medicare, hospitals may also be eligible for Medicare DSH payments under alternative criteria established by federal law. Under federal alternative criteria, hospitals are eligible for Medicare DSH payments if they: are located in an urban area; have 100 or more beds; and can demonstrate that more than 30 percent of their revenue comes from state and local government payments for care provided to low-income patients not covered by Medicare or Medicaid.

Medicare DSH payments flow directly from the federal government to individual hospitals as increases to the hospital's normal diagnostic-related group (DRG) payments. The payment increase varies from hospital to hospital, and depends on a number of factors, including a hospital's bed count and its location. Although the Affordable Care Act implemented additional changes to the DSH payment system, the above provides a general understanding of the concepts applicable to the same.

June 24, 2019

VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1716-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2020 Rates

The Medicaid and Medicare Advantage Products Association of Puerto Rico (MMAPA) and the Puerto Rico Hospital Association (PRHA) submit the following comments on the Proposed Rule, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2020 Rates, (IPPS Proposed Rule). We wish to thank the Centers for Medicare & Medicaid Services (CMS) for your time and attention to improving the Medicare program for beneficiaries in Puerto Rico.

We are appreciative of CMS' track record of exercising its administrative authority to correct or mitigate unintentional disparities in the treatment of providers and plans in Puerto Rico under various Medicare payment formulas. CMS staff and leadership were also instrumental in mitigating the impact of Hurricane Maria and speeding the recovery of the local health care system. We are particularly grateful that CMS has responded in this proposed rule to our long-standing concerns over disparities in the wage index system.

Our comments and recommendations herein are offered for the purpose of maintaining stability in the Puerto Rico health care system and reducing the rate of provider migration to the States.

I. SUMMARY OF COMMENTS

- CMS should finalize its policy as proposed to mitigate wage index disparities between high and low wage index hospitals that perpetuate economic and health care disparities arising from the current flawed methodology.

- Alternative methods to provide relief to rural hospitals, which may be developed later, should not prevent CMS from providing the proposed wage index relief in 2020 to address the long-standing problems identified by CMS.

- CMS should continue its 2019 policy to use only proxy data regarding low-income insured days from FY 2013 to determine the amount of uncompensated care payments for Puerto Rico hospitals in 2020.

II. Proposals To Address Wage Index Disparities Between High and Low Wage Index Hospitals (Section III.N)

a. CMS is Appropriately Responding to Provider Feedback

CMS proposes to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The proposed increase in the wage index for these hospitals would be equal to half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals. Correspondingly, CMS would decrease the wage index values for hospitals with high wage index values but preserve the rank order among those values.

CMS acknowledges that the underlying wage index system has increased the gap between the wage indexes of the high and low wage States to a much larger degree than what the wage index was initially designed to address, the difference in labor markets across the country for comparable services. CMS is right to refer this "situation as the 'downward spiral.'"[1]

We thank CMS for responding to the requests by us and other rural health care stakeholders to use its authority to institute an alternative system to halt the "death spiral" that perpetuates economic and health care disparities arising from the current flawed methodology. Moreover, we encourage CMS to establish the policy for at least a 10-year period, longer than the 4 years proposed, considering the need for stability in future payment expectation in order for hospitals to evolve in their cost structure incorporating higher health professional wages.

b. External Confirmation of the Underlying Problem and Disparity

CMS' position is supported by several other entities that have completed analysis and called for the current wage index system to be replaced due to deficiencies and inaccuracies.

i. Medicare Payment Advisory Commission

In several reports to Congress, MedPAC has documented the wage index's "problem" of the downward spiral effect. It was articulated as a phenomenon in which hospitals that successfully moderate increases in hourly wages relative to the national average increase will see

[1] 84 9394

a decrease in their wage index. "They will then receive lower payments, which may create pressure to exert even tighter control over costs . . . If hospitals succeed at keeping wage increases below the national average again, their wage index could decrease still further."[2] As such, MedPAC recommended Congress implement an entirely new wage index system.

ii. HHS Office of the Inspector General

In its report, Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments, OIG noted "continuing and significant vulnerabilities"[3] and recommended comprehensive reform the hospital wage index system, including the option of a commuting-based wage index. In particular, OIG noted that existing policies under the wage index "create a benefit for a minority of States that is then funded by a majority of States, including States that are overwhelmingly rural in character."

iii. Institute of Medicine

In April 2012, the Secretary commissioned the Institute of Medicine (IOM) to evaluate CMS' implementation of the wage index. In the report, IOM's Committee on Geographic Adjustment Factors in Medicare Payment proposed a set of recommendations for modifying the hospital wage index in both the method used in its construction and the data used in its calculation. The IOM noted the adverse effects the current wage index has on provider payment accuracy, transparency, timeliness and administrative burden.

IOM called for a model using hourly wage data from the BLS Occupational Employment Survey rather than from hospital cost reports. The IOM also recommended measuring hourly wages using data for all health care workers, rather than only hospital workers, and using a fuller set of occupations incorporated in the hospital wage index occupational mix adjustment.

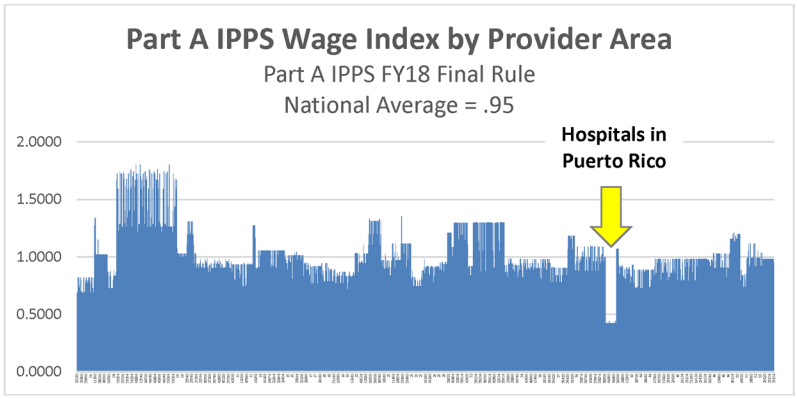
a. Puerto Rico as an Example of the Flaws in the Wage Index

In order to understand how the Puerto Rico Medicare Part A wage index relates to all Puerto Rico wages, we reviewed the most recent data available in the Occupational Employment Statistics (OES) of the Federal Bureau of Labor Statistics (BLS). Not surprisingly, wages for Puerto Rico in general are reported to be significantly lower than the national average. Currently, the latest statistics from the BLS show that the hourly weekly wage for Puerto is $509. On the other hand, the hourly weekly wage for the United States, as of 2017, is $1,021.[4] However, the revealing observation from BLS data is that the average annual wage is approximately 57% of the

[2] MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare, pg. 130 (June 2007).
[3] HHS OIG, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare* Payments (A-01-17-00500) (Nov. 21, 2008).
[4] https://www.bls.gov/regions/new-york-new-jersey/news-release/countyemploymentandwages_puertorico.htm

U.S. average[5], which is significantly higher than the relative position of the Medicare Part A wage index for Puerto Rico (0.38 of a 0.95 US average).

The MMAPA chart below illustrates the severity of the wage index disparity.



iv. Apart from Wages, Costs in Puerto Rico are High Relative to the 50 States

As evidenced in the data from the Cost of Living Index (COLI) performed by the Council for Community and Economic Research, the cost of living in Puerto Rico is not by any means cheaper. In fact, out of 297 MSAs, the data reported for third quarter of 2017 places Puerto Rico as the 55th costliest area of 297, with higher prices than the U.S. average in most categories.

Cost of Living Relative to 297 Metropolitan Statistical Areas in the States
Cost of Living Index (San Juan MSA) for 2017 T3[6]

Category	Index Avg = 100
Grocery Items	118.5
Housing	89.8
Utilities	163.5
Transportation	98.9
Miscellaneous Goods and Services	106.2
Overall Cost of Living Index	106.7

[5] May 20162017 State Occupational Employment and Wage Estimates Puerto Rico, Bureau of Labor Statistics, https://www.bls.gov/oes/current/oes_pr.htm
[6] Institute of Statistics of Puerto Rico, Cost of Living Index, https://estadisticas.pr/files/inventario/indice_de_costo_de_vida/2017-12-21/One_pager_COLI%202016Q3_2017Q3.pdf

Regarding key healthcare inputs, we note the following for the case of Puerto Rico:

- Prescription drugs are purchased in the national market at the same U.S. average prices
- Housing, office and construction costs are similar to U.S. averages
- Equipment and medical supplies are acquired in the national market at the same U.S. average prices
- Diagnostic machines, computers and electronics are acquired from the U.S. national market at the same U.S. average prices
- For all the above materials, equipment, and goods, transportation costs also increase final purchasing price in Puerto Rico

v. Adverse Impacts of the Wage Index on Puerto Rico

In light of Medicare reimbursements that lag far behind the 50 States, and rising non-labor costs, hospitals in Puerto Rico have no choice but keep wages low and watch the most qualified health care professionals move to higher wage areas in the 50 States. As health professionals and physicians are U.S.-educated and bilingual, the States are a natural escape route from such suppressed wages. It is estimated that almost two physicians leave Puerto Rico for the States every day. The situation certainly makes it impossible for hospitals to play a role in Puerto Rico wage growth.

b. Alternative Relief Later Should Not Preclude Meaningful Relief Now

We are aware that some stakeholders have endorsed the need to provide relief to hospitals in low wage index areas but are requesting that such relief not come in a budget neutral manner from within the wage index system. We understand from some health care stakeholders that CMS has previously made hospital payment adjustments which were not budget neutral. We appreciate and support the efforts from all stakeholders who are developing specific proposals to end the wage index death spiral and appropriately reimburse facilities in rural and low age areas, whether in a budget neutral manner or not.

Nevertheless, CMS and other independent stakeholders have identified for more than ten years the negative impact on facilities in low wage areas. By deferring relief in 2020, CMS would affirmatively subject facilities in low wage areas to another year of the death spiral of reimbursements. By finalizing its proposal to provide relief to low wage facilities in 2020, CMS does not preclude Congress or CMS from partnering with stakeholders to refine and improve the wage index system in future years.

III. UNCOMPENSATED CARE PAYMENTS – METHODOLOGICAL CONSIDERATIONS FOR CALCULATING FACTOR 3 (SECTION IV.F.4.C.(3)(D))

CMS proposes to continue the 2018 and 2019 policy to use only proxy data regarding low-income insured days for FY 2013 to determine the amount of uncompensated care payments for Puerto Rico hospitals, and Indian Health Service and Tribal hospitals. We similarly support the

continuation by CMS of the use of 14% of a hospital's Medicaid days as a proxy for SSI days for hospitals in Puerto Rico that lack data from FY2013. The continued use of these proxies is appropriate because CMS agrees with stakeholders that "uncompensated care data reported by these hospitals need to be further examined before the data are used" in calculating uncompensated care payments. The zero-sum nature of the calculation of uncompensated care payments is such that any remaining inaccuracy and lack of uniformity in the data reported can have a very large negative impact on hospitals that underreport.

IV. Timely Corresponding Adjustment in Medicare Advantage benchmark calculation

As stated above, MMAPA and the PRHA are in full support of the proposed adjustment to the Part A IPPS wage index calculation. Moreover, we urge its finalization as a policy that addresses critical issues in low cost hospitals that we have presented to CMS for many years. The initiative of the current Administration and CMS to get a tangible positive step done is commendable, and immediately needed.

In parallel, we also emphasize the importance of updating pricing provisions in the MA benchmark calculation as soon as possible in the programs' cycle. With 97% of all duals with Medicare A & B receiving their health care through the MA program in Puerto Rico, and an overall MA penetration of close to 75%, the CMS policy objective can only be achieved with the implementation of its full effect both in Traditional FFS and MA.

We assure CMS that the proposed policy has been very positively received by the health care stakeholder community in Puerto Rico in general. We look forward to this transformative step in Part A policy that will give a new chance to the improvement and quality efforts of hospitals and health care of the poorest geographies across the nation.

Sincerely,

James P. O'Drobinak
President, Medicaid and Medicare Advantage Product Association of Puerto Rico (MMAPA)
CEO, Medical Card System, Inc. (MCS)
Governor's Task Force for Healthcare Parity

Jaime Plá-Cortés
Executive President
PR Hospital Association
Governor's Task Force for Healthcare Parity

Richard A. Shinto, MD
CEO, InnovaCare, Inc.
Past-President and MMAPA Board

Roberto García Rodríguez, Esq.
President & CEO, Triple-S Management Corp.
Past-President and MMAPA Board

Luis A. Torres-Olivera, Esq.
President, Humana Puerto Rico
MMAPA Board Member

Juan Dominguez
First Medical Health Plan
MMAPA Board Member

Enclosure

c: MMAPA Board
Dr. Rick Shinto, MMM
Roberto García, SSS
Juan Dominguez, First Medical
Luis Torres, Humana
Jaime Pla

Additional Questions for the Record

Subcommittee on Health
Hearing on
"Strengthening Health Care in the U.S. Territories for Today and Into the Future"
June 20, 2019

Sandra King Young

The Honorable Michael C. Burgess, M.D.

1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

Based on a given FMAP, funding shortfalls would be as follows based on prior year spending. This does not account for all the mandatory and optional services that American Samoa would like to provide but cannot provide because of the statutory capped Medicaid funding and American Samoa's inability to raise the local match requirement.

0% Local/100% FMAP = $ 8,355,677.00

24% Local/76% FMAP = $ 6,350,315.00

17% Local/83% FMAP = $ 6,935,212.00

45% Local/55% FMAP = $ 4,595,622.00

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

LOURDES A. LEON GUERRERO
GOVERNOR, MAGA'HÅGA

JOSHUA F. TENORIO
LT. GOVERNOR, SIGUNDO MAGA'LÅHI

LINDA UNPINGCO DENORCEY, MPH
DIRECTOR

LAURENT SF DUENAS, MPH, BSN, RN
DEPUTY DIRECTOR

AUG 28 2019

Honorable Michael C Burgess, MD
Ranking Member, Committee on Energy and Commerce
US House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

RE: Strengthening Health Care in the U.S. Territories for Today and Into the Future
Oversight Hearing Additional Question

Dear Honorable Burgess:

This is in response to your letter, dated August 15, 2019 regarding the additional question given to each US territory representative to respond to after the oversight hearing entitled "Strengthening Health Care in the U.S. Territories for Today and Into the Future" conducted by the House of Representative, Committee on Energy and Commerce held on June 20, 2019.

Question:

In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

Response:

Yearly, the Guam Medicaid program faces financial and operational challenges due to the local matching requirements. In FY 2018 the Guam Medicaid Program total combined medical payment ($110.9 million) and administrative ($2.3 million) expenditures was $113 million. In FY 2019 there is a drastic increase in expenditures due to access to 100% federal matching rate. This allowed Guam Medicaid Program to adjudicate and pay providers claims in a timely manner. Thus, reducing provider and clients' complaints. Additionally, off-island referrals for treatment of Medicaid patients is being processed without difficulty or delay. Moreover, recruitment of vacant positions is currently being processed to efficiently manage and implement the program mandates.

With Medicaid FMAP increased to 100%, the current Medicaid expenditure as of August 28, 2019 is $155,178,928.32 (federal and local-Medical payments and admin). This amount includes CHIP current expenditure of $33,166,211.49 (Federal and Local).

Based on the aforementioned current expenditure, **Guam Medicaid's estimated total expenditure for FY 2019 is $166 million (Medicaid and CHIP)**. Therefore, if Guam Medicaid federal funding for FY 2020 is only from Section 1108, which is $18.38 million, Guam would be severely under funded and would need to come up with the additional funding of $147.62 million.

FISCAL YEAR 2020 PROJECTED EXTENDITURE	
Projected FY 2020 Expenditure	$ 166,000,000
Section 1108	-$ 18,380,000
Additional Funding Needed	**$ 147,620,000**

Sincerely,

Ma. Theresa L. Arcangel

MARIA THERESA L. ARCANGEL
Chief Administrator
Division of Public Welfare

Concurred By:

LINDA UNPINGCO DE NORCEY, MPH
Director

Additional Questions for the Record

Subcommittee on Health
Hearing on
"Strengthening Health Care in the U.S. Territories for Today and Into the Future"
June 20, 2019

Michal Rhymer-Browne

The Honorable Michael C. Burgess, M.D.

1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

In response to your letter dated August 27, 2019, I am providing the attached response to the question for the record submitted on behalf of the Honorable Michael C. Burgess. Based upon our current FY 2020 projections the Virgin Islands Medicaid Program is facing a Federal funding shortfall ("fiscal cliff") totaling $53,234,502.

As you can see in our response, even if the Congress were to enact enough Federal funding to support the projected expenditures subject to the Section 1108 allotment, the Virgin Island would be required to match those expenditures with Virgin Islands funds totaling $40,891,296. In fact, we would have to come up with a total of $46,464,588 in local funding to support our entire Medicaid program. The Virgin Islands does not have the local funding available to support this level of local Medicaid matching funds.

This lack of local funding, as we continue to rebuild our infrastructure and our economy since the two major hurricanes, is why I requested during the hearing that the Congress and the Administration consider providing the Virgin Islands at least 2 additional years of Federal funding at 100%. We are pleased to see that your Committee supports at least one additional year of 100% funding in H.R. 2328 as we continue the difficult work of hurricane recovery. We need both the Federal funding increase and increases in the Federal matching rates included in the Bill to provide us with a more equitable treatment under the Federal Medicaid program. Without this The Virgin Islands faces the devastating impacts outlined in my testimony before your Committee.

Again, thank you and your Committee for the continued support of the Territories and we look

forward to working with you to enact legislation which will ensure the continued ability of the Virgin Islands to provide the much needed health care services for our population through our Medicaid Program.

If you have any further questions or need any additional information, please do not hesitate to contact me on [redacted]

Commonwealth of the Northern Mariana Islands
State Medicaid Agency
Office of the Governor

August 30, 2019

Honorable Dr. Michael C. Burgess, M.D.
Ranking Member
Subcommittee on Health
U.S. House of Representatives
Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Representative Burgess, M.D.:

Thank you for your question that follows:

> "1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?" [underscore added]

The best direct answer to the question is that the CNMI is facing an estimated shortfall of close to $65.01 million in FY 2020 based on 2018 Expenditures and Incurred But Not Booked (IBNR) Accounts Payables (AP). The following explains how this amount is estimated.

- Table 1, next page, shows the FY 2018 Expenditures and Incurred But Not Booked Accounts Payables shows the Section 1108 allotments to be woefully inadequate and has led to the Medicaid Fiscal Cliff. Further, the Federal Medical Assistance Percentage (FMAP) of 55% does not reflect the per-capita income levels for the CNMI relative to the national average. As a result, the CNMI has had to use the Certified Public Expenditures (CPE) methodology to reimburse the Commonwealth Healthcare Corporation (CHCC), a public health system. Unfortunately, that has meant for years, the CHCC has been provided 45% less than it should be receiving to provide services to the U.S. citizens in the CNMI due to the financial situation of the CNMI Government.

- In FY 2018, the CNMI Medicaid Program expended and had an IBNR of about $74.6 Million for both the Medicaid Medical Assistance Program (MAP) and the Children's Health Insurance Program (CHIP), including the Enhanced Allotment Program (EAP) amount used solely for the distribution of Part D medications to dual-eligibles (Medicare and Medicaid).

- The Centers for Medicare and Medicaid Services (CMS) has informed the CNMI that for FY 2020, the Section 1108 Allotment will be only $6.85 Million.
- With the end of the increase provided under the Patient Protection and Affordable Care Act (PPACA) for the CNMI Medicaid Medical Assistance Program (MAP), the gap in federal funding is estimated at around $65.01 Million short given the Section 1108 budget caps.
- The temporary increased funding provided under the PPACA ends on September 30, 2019. However, for FY 2019, an additional amount of $36 million was provided under Disaster Relief Act (DRA) funding for the CNMI.

Table 1 - FY 2018 Actual Medicaid Expenditures and IBNR Expenses

Budget Item Description	Amount in Millions	Notes
FY 2018 Medicaid and CHIP Expenditures with the Enhanced Allotment Program (EAP) and CNMI Matching Share	$ 56.60	This amount was reported on the CMS-64 reporting form to the Centers for Medicare and Medicaid Services (CMS) and includes the Medical Assistance Program (MAP), the Children's Health Insurance Program (CHIP), the Enhanced Allotment Program (EAP), and the CNMI Matching share expenditures.
FY 2018 IBNR	$ 18.00	This is the IBNR that is not on the CMS-64 form.
Total FY 2018 Expenditures and IBNR Expenses	**$ 74.60**	Note that this amount includes the CNMI CHCC expenditures and reflects only the 55% reimbursement under CPE since CNMI Government has been unable to fully fund the matching share at 45%.

Notes:
1. In FY 2018, the Commonwealth Healthcare Corporation (CHCC) was paid a total of $10.57 Million in FY 2018 through the Certified Public Expenditures (CPE) payment methodology. This amount represents only the federal share of 55%. Under 100% Disaster Relief Act (DRA) funding, the monthly amount increases to include the 45% for FY 2019. This would be an additional $712,385 per Month or $8,548,625 for the CHCC a year. The CHCC needs the additional funding. However, the CNMI Government has not been able to support the CNMI-share in the past due to financial limitations.

As shown in Table 2, below, the following is the estimated financial shortfall that the CNMI Medicaid Program will confront in FY 2020 if no relief is provided to the current Section 1108 budget caps.

Table 2 - FY 2020 Budget Shortfall Projections Based on CMS Section 1108 Less CHIP and EAP Appropriations, and Increased Amounts for 100% Disaster Assistance under CPE

FY 2018 Total Medicaid-Only Expenditures and IBNR	$ 74.60	From Table 1. Includes CHIP program expenditures and CNMI Matching.
FY 2020 Section 1108 Allotment	$ (6.85)	CMS Federal Allotment Based on Section 1108.
FY 2020 CHIP Allotment	$ (11.20)	CHIP federal funds are taken out since they are funded under separate appropriations.
FY 2020 EAP Allotment	$ (0.19)	EAP federal funds are taken out since they are funded under separate appropriations.
FY 2018 CHCC CNMI Match	$ 8.65	CNMI 45% Match for CHCC CPE based on 100% Disaster Relief Act.
Total FY 2020 Estimated Medicaid Medical Assistance Program Shortfall	**$ 65.01**	The estimated shortfall is based on 2018 Expenditures and assumes a Medicaid Disaster Relief Act program funding increase for 100% of the CPE expenditures.

Notes:
1. The Section 1108 of $6.344 million allocation in FY 2018 was completely inadequate to support the Medicaid program. Fortunately, the Section 1108 capped amount was supplemented by temporary increased funding under the Affordable Care Act that expires in FY 2019. All funds under the ACA were actually expended in March 2019, as reported by CMS and the CNMI.
2. If 100% funding for two years under HR 3631 is provided, then, the CNMI Commonwealth Healthcare Corporation would receive an additional amount of funding.
3. Healthcare costs continue to increase each year. So, the projected shortfall is based on FY 2018 actual and incurred expenses. Further, in a small program such as the CNMI, a few "outlier" medical cases (e.g. off-island referrals for cancer care and other debilitating medical conditions requiring specialized care) could result in significantly increased spending for a period of time.
4. HR 3631 will provide $60 Million in Funding at 100% for the first two years. Given the projections, this amount will still result in a shortfall based on FY 2018 Expenditures and IBNR and general annual increases in the cost of health care. However, it is very welcome and the CNMI Medicaid program has lessened the expenditures for private primary care providers based on the CNMI State Medicaid Plan.

The CNMI experienced two typhoons in the past three years. The latest, Super Typhoon Yutu, was a Category 5. The typhoon has exacerbated the financial condition of the CNMI; and, in May 2019, the CNMI Government instituted "austerity" measures that includes government employees placed on a forced "leave" for a day every two weeks to lessen payroll expenses.

So, the CNMI will simply not be able to support the Medicaid program in the amounts of the projected shortfall and the CNMI Medicaid program will have to drastically curtail current services to the eligible U.S. citizens. It is not certain where the cuts will be made. However, given the magnitude of the shortfall, it is completely certain that the CNMI Government does not have the financial resources to close the gap and the U.S. citizens in the territory will be severely impacted from the lack of care and services (including drugs) which will, with very high probability, lead to mortality and long-term morbidities.

We are imploring you to please help avert the impending crisis. We are on a ledge below the cliff and hoping for a way back up.

Please do not hesitate in letting us know if there are any further questions and thank you once again for your follow-up question.

With Respect and Hope,

Helen C. Sablan
Director
Medicaid State Agency
Commonwealth of the Northern Mariana Islands

c: Honorable Chairman Frank Pallone, Honorable Ranking Member Greg Walden, and Honorable Members of the House Committee on Energy and Commerce.

Honorable Chairwoman Anna G. Eshoo and Honorable Members of the House Subcommittee on Health.

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