

AVERTING A CRISIS: PROTECTING ACCESS TO HEALTHCARE IN THE U.S. TERRITORIES

VIRTUAL HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SEVENTEENTH CONGRESS FIRST SESSION

MARCH 17, 2021

Serial No. 117-13



Published for the use of the Committee on Energy and Commerce
govinfo.gov/committee/house-energy
energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

46-304 PDF

WASHINGTON : 2022

COMMITTEE ON ENERGY AND COMMERCE

FRANK PALLONE, JR., New Jersey
Chairman

BOBBY L. RUSH, Illinois	CATHY McMORRIS RODGERS, Washington
ANNA G. ESHOO, California	<i>Ranking Member</i>
DIANA DeGETTE, Colorado	FRED UPTON, Michigan
MIKE DOYLE, Pennsylvania	MICHAEL C. BURGESS, Texas
JAN SCHAKOWSKY, Illinois	STEVE SCALISE, Louisiana
G. K. BUTTERFIELD, North Carolina	ROBERT E. LATTA, Ohio
DORIS O. MATSUI, California	BRETT GUTHRIE, Kentucky
KATHY CASTOR, Florida	DAVID B. McKINLEY, West Virginia
JOHN P. SARBANES, Maryland	ADAM KINZINGER, Illinois
JERRY McNERNEY, California	H. MORGAN GRIFFITH, Virginia
PETER WELCH, Vermont	GUS M. BILIRAKIS, Florida
PAUL TONKO, New York	BILL JOHNSON, Ohio
YVETTE D. CLARKE, New York	BILLY LONG, Missouri
KURT SCHRADER, Oregon	LARRY BUCSHON, Indiana
TONY CARDENAS, California	MARKWAYNE MULLIN, Oklahoma
RAUL RUIZ, California	RICHARD HUDSON, North Carolina
SCOTT H. PETERS, California	TIM WALBERG, Michigan
DEBBIE DINGELL, Michigan	EARL L. "BUDDY" CARTER, Georgia
MARC A. VEASEY, Texas	JEFF DUNCAN, South Carolina
ANN M. KUSTER, New Hampshire	GARY J. PALMER, Alabama
ROBIN L. KELLY, Illinois, <i>Vice Chair</i>	NEAL P. DUNN, Florida
NANETTE DIAZ BARRAGÁN, California	JOHN R. CURTIS, Utah
A. DONALD McEACHIN, Virginia	DEBBBIE LESKO, Arizona
LISA BLUNT ROCHESTER, Delaware	GREG PENCE, Indiana
DARREN SOTO, Florida	DAN CRENSHAW, Texas
TOM O'HALLERAN, Arizona	JOHN JOYCE, Pennsylvania
KATHLEEN M. RICE, New York	KELLY ARMSTRONG, North Dakota
ANGIE CRAIG, Minnesota	
KIM SCHRIER, Washington	
LORI TRAHAN, Massachusetts	
LIZZIE FLETCHER, Texas	

PROFESSIONAL STAFF

JEFFREY C. CARROLL, *Staff Director*
TIFFANY GUARASCIO, *Deputy Staff Director*
NATE HODSON, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

ANNA G. ESHOO, California
Chairwoman

G. K. BUTTERFIELD, North Carolina	BRETT GUTHRIE, Kentucky
DORIS O. MATSUI, California	<i>Ranking Member</i>
KATHY CASTOR, Florida	FRED UPTON, Michigan
JOHN P. SARBANES, Maryland, <i>Vice Chair</i>	MICHAEL C. BURGESS, Texas
PETER WELCH, Vermont	H. MORGAN GRIFFITH, Virginia
KURT SCHRADER, Oregon	GUS M. BILIRAKIS, Florida
TONY CARDENAS, California	BILLY LONG, Missouri
RAUL RUIZ, California	LARRY BUCSHON, Indiana
DEBBIE DINGELL, Michigan	MARKWAYNE MULLIN, Oklahoma
ANN M. KUSTER, New Hampshire	RICHARD HUDSON, North Carolina
ROBIN L. KELLY, Illinois	EARL L. "BUDDY" CARTER, Georgia
NANETTE DIAZ BARRAGÁN, California	NEAL P. DUNN, Florida
LISA BLUNT ROCHESTER, Delaware	JOHN R. CURTIS, Utah
ANGIE CRAIG, Minnesota	DAN CRENSHAW, Texas
KIM SCHRIER, Washington	JOHN JOYCE, Pennsylvania
LORI TRAHAN, Massachusetts	CATHY McMORRIS RODGERS, Washington
LIZZIE FLETCHER, Texas	<i>(ex officio)</i>
FRANK PALLONE, JR., New Jersey <i>(ex officio)</i>	

C O N T E N T S

	Page
Hon. Anna G. Eshoo, a Representative in Congress from the State of California, opening statement	2
Prepared statement	3
Hon. Brett Guthrie, a Representative in Congress from the Commonwealth of Kentucky, opening statement	4
Prepared statement	6
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	7
Prepared statement	8
Hon. Cathy McMorris Rodgers, a Representative in Congress from the State of Washington, opening statement	9
Prepared statement	11

WITNESSES

Delegate Gregorio Kilili Camacho Sablan, a Representative in Congress from the Territory of the Northern Mariana Islands	13
Prepared statement	15
Delegate Aumua Amata Coleman Radewagen, a Representative in Congress from the Territory of American Samoa	19
Prepared statement	21
Delegate Stacey E. Plaskett, a Representative in Congress from the Territory of the Virgin Islands	24
Prepared statement	26
Resident Commissioner Jenniffer González-Colón, a Representative in Congress from the Territory of Puerto Rico	31
Prepared statement	33
Delegate Michael F. Q. San Nicolas, a Representative in Congress from the Territory of Guam	38
Prepared statement	40
Anne L. Schwartz, Ph.D., Executive Director, Medicaid and CHIP Payment and Access Commission	43
Prepared statement ¹	
Answers to submitted questions	180
Carolyn L. Yocom, Director, Health Care, Government Accountability Office ...	45
Prepared statement	47
Answers to submitted questions	184

SUBMITTED MATERIAL

Letter of March 16, 2021, from Senator Justo S. Quitugua, Northern Mariana Islands Commonwealth Legislature, to Mr. Pallone, et al., submitted by Ms. Eshoo	76
Statement of Helen C. Sablan, Medical Director, Commonwealth of the Northern Mariana Islands, March 15, 2021, submitted by Ms. Eshoo	79
Letter of March 16, 2021, from Albert Bryan, Jr., Governor, Territory of the Virgin Islands, to Mr. Pallone, et al., submitted by Ms. Eshoo	91

¹Dr. Schwartz's prepared statement has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-Wstate-SchwartzA-20210317.pdf>.

VI

	Page
Letter of March 16, 2021, from James L. Madara, Chief Executive Officer and Executive Vice President, American Medical Association, to Mr. Pallone, et al., submitted by Ms. Eshoo	94
Letter of March 17, 2021, from the Partnership for Medicaid to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	96
Letter of March 17, 2021, from Gary L. LeRoy, Board Chair, American Academy of Family Physicians, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	99
Letter of March 17, 2021, from Adam P. Carbullido, Director of Policy and Advocacy, Association of Asian Pacific Community Health Organizations, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	101
Statement of America's Health Insurance Plans, March 17, 2021, submitted by Ms. Eshoo	103
Letter of January 14, 2021, from Michael Fraser, Chief Executive Officer, Association of State and Territorial Health Officials, to Hon. Gregorio Kilili Camacho Sablan, submitted by Ms. Eshoo	106
Letter, undated, from Esther L. Muña, Chief Executive Officer, State/Territorial Public Health Official, Commonwealth Healthcare Corporation, the Territorial Hospital & Health System, Commonwealth of the Northern Mariana Islands, to Congressional Leaders, submitted by Ms. Eshoo	107
Letter of March 16, 2021, from Edmund Villagomez, Speaker, Northern Mariana Islands Commonwealth Legislature, House of Representatives, et al., to Mr. Pallone, et al., submitted by Ms. Eshoo	110
Statement of the Department of Public Health and Social Services, Government of Guam, March 16, 2021, submitted by Ms. Eshoo	114
Letter of March 17, 2021, from Ralph DLG. Torres, Governor, Commonwealth of the Northern Mariana Islands, to Mr. Pallone, et al., submitted by Ms. Eshoo	117
Letter of March 15, 2021, from Michael W. Cruz, President and Chief Executive Officer, Guam Regional Medical City, to Mr. Pallone, et al., submitted by Ms. Eshoo	119
Statement of Michael Rhymer-Browne, Assistant Commissioner, Virgin Islands Department of Human Services, June 20, 2019, submitted by Ms. Eshoo	122
Report of the Army Corps of Engineers, "Assessment of Health Care Infrastructure and Services, Lyndon Baines Johnson Tropical Medical Center, Pago Pago, American Samoa," April 22–24, 2019, submitted by Ms. Eshoo ¹	
Statement of Sandra King Young, American Samoa Medicaid Director, June 20, 2019, submitted by Ms. Eshoo	132
Report by Epstein Becker & Green, "Medicaid in Puerto Rico: Differences from the States," March 15, 2021, submitted by Ms. Eshoo	136
Letter of March 10, 2021, from Arielle Buyum, Executive Director, Pacific Islands Primary Care Association, to Subcommittee on Health, submitted by Ms. Eshoo	139
Letter of March 17, 2021, from Roberto García, President, Medicaid and Medicare Advantage Products Association of Puerto Rico, to Ms. Eshoo and Mr. Guthrie, submitted by Ms. Eshoo	141
Report of the National Association of Medicaid Directors, "Inaugural Survey of Territory Medicaid Directors," November 2019, submitted by Ms. Eshoo ..	145
Letter of March 17, 2021, from the National WIC Association to Mr. Pallone, et al., submitted by Ms. Eshoo	153
Invoice of March 15, 2021, NWG Advocacy, LLC, to Puerto Rico Hospital Association, submitted by Ms. Eshoo	154
Letter, March 16, 2021, from Esther L. Muña, Chief Executive Officer, Commonwealth Healthcare Corporation, Commonwealth of the Northern Mariana Islands, to Congressional Leaders, submitted by Ms. Eshoo	155
PL 116–4 Congressional Requirements Summary of Activities, January 28, 2021, submitted by Ms. Eshoo	157
Letter of March 17, 2021, from Commonwealth Medicaid Providers from the Commonwealth of the Northern Mariana Islands to Mr. Pallone, et al., submitted by Ms. Eshoo	159

²The report has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-20210317-SD018.pdf>.

VII

	Page
Letter of March 17, 2021, from Lourdes A. Leon Guerrero, Governor of Guam, to Mr. Pallone, et al., submitted by Ms. Eshoo	164
Statement of Jamie Plá Cortés, Executive President, Puerto Rico Hospital Association, March 17, 2021, submitted by Ms. Eshoo	167
Statement of Neil C. Weare, President and Founder, Equally American Legal Defense and Education Fund, March 17, 2021, submitted by Ms. Eshoo	175
Statement of Pedro R. Pierluisi, Governor of Puerto Rico, March 17, 2021, submitted by Ms. Eshoo	177

AVERTING A CRISIS: PROTECTING ACCESS TO HEALTHCARE IN THE U.S. TERRITORIES

WEDNESDAY, MARCH 17, 2021

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

The subcommittee met, pursuant to notice, at 1:02 p.m., via Cisco Webex online video conferencing, Hon. Anna G. Eshoo (chairwoman of the subcommittee), presiding.

Members present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Schrader, Cárdenas, Ruiz, Kelly, Barragán, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio), Guthrie (subcommittee ranking member), Burgess, Griffith, Bilirakis, Long, Bucshon, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Also present: Representative Soto.

Staff present: Jeffrey C. Carroll, Staff Director; Waverly Gordon, General Counsel; Tiffany Guarascio, Deputy Staff Director; Saha Khaterzai, Professional Staff Member; Mackenzie Kuhl, Digital Assistant; Una Lee, Chief Health Counsel; Meghan Mullan, Policy Analyst; Kaitlyn Peel, Digital Director; Rick Van Buren, Health Counsel; C.J. Young, Deputy Communications Director; Sarah Burke, Minority Deputy Staff Director; Michael Cameron, Minority Policy Analyst, Consumer Protection and Commerce, Energy, Environment; William Clutterbuck, Minority Staff Assistant; Theresa Gambo, Minority Financial and Office Administrator; Marissa Gervasi, Minority Counsel, Oversight and Investigations; Grace Graham, Minority Chief Counsel, Health; Caleb Graff, Minority Deputy Chief Counsel, Health; Brittany Havens, Minority Professional Staff Member, Oversight and Investigations; Jack Heretik, Minority Press Secretary; Nate Hodson, Minority Staff Director; Sean Kelly, Minority Press Secretary; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Olivia Shields, Minority Communications Director; Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

Ms. ESHOO. I want to call the Subcommittee on Health to come to order now.

And due to COVID-19, of course, today's hearing is being held remotely, and all Members and witnesses will be participating via video conferencing.

As part of our hearing, microphones, of course, will be set on mute to eliminate any background noise. We know how irritating that is, especially when you are the one that is speaking and there is a lot of noise in the background. So Members and witnesses, you have to remember to unmute your microphones each time you wish to speak.

And documents for the record should be sent to Meghan Mullen at the email address that we have provided to your staffs, and all documents will be entered into the record at the conclusion of the hearing.

The Chair now recognizes herself for 5 minutes for an opening statement.

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

My colleagues, in September of this year the five U.S. territories will face a Medicaid cliff. And I use this term because it means that the supplementary Medicaid funding that is provided to the territories through the Affordable Care Act will run out.

Now, without this Federal funding, over one and a half million enrollees, including many children, could lose their healthcare.

Each is an American citizen, but they are treated differently than the constituents of every member of this subcommittee. Since 1967, the territories have struggled with inadequate Federal funding for their Medicaid programs because the Social Security Act capped Medicaid funding for the territories. So since 1978 Congress is on the record noting that the caps on the Medicaid programs severely affect the territories' health and budgets. But there has been no significant statutory change to this part of the Social Security Act in over 50—five-oh—years.

So this is a very important hearing that I hope we are going to build on and take action to reverse what I am referring to.

Now, because of these restrictions, the territories routinely run out of Medicaid funds. Over the past decade, Congress has voted on six separate occasions to provide stopgap funds to certain territories, including as recently as December 2019.

Except for a temporary increase in Federal funding in FY 2020 and 2021, the funding for the territories is typically three to four times below what a State Medicaid program would receive. In the States, the Medicaid program has a flexible financing structure, which guarantees funding if more individuals enroll due to an economic downturn, a pandemic, or a natural disaster. For the rest of us, that is the way it works. But not for the territories.

So the territories do not have any guarantee. When disaster strikes, the territories are forced to make hard decisions about coverage and services at the worst possible time. Just when they need it most, that is when it hurts them the most.

Fortunately, during the ongoing COVID-19 pandemic and economic downturn, the territories have benefited from an increased Federal match for fiscal years '20 and '21. American Samoa, the

Northern Mariana Islands, Guam, and the U.S. Virgin Islands received an 83 percent Federal match, and Puerto Rico's current Federal match is 76 percent. With this additional money, Puerto Rico was able to cover the cure for hepatitis C for Medicaid patients for the very first time, and the Northern Mariana Islands were able to establish an oncology center to provide cancer treatment locally.

But this funding, colleagues, is going to expire on September 30th, which is why the territories, obviously, need a long-term solution to their Medicaid funding so that they too can meet the needs of their constituents, as we all work to meet the needs of ours. In Puerto Rico 85 percent of residents report they are worried that they will be unable to access healthcare if they need it. 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.

So, if we allow the Medicaid cliff to happen, each of the territories would have to cut—now, listen to this—they would have to cut 69 to 94 percent of their Medicaid program in fiscal year '22. Obviously, percentages this high, we all know, produce dire consequences, and it would—to hundreds of thousands of American citizens.

So we cannot fail to care for so many American citizens based solely on where they live. I think we could probably all agree that this is short-term thinking, except the short-term thinking has been around for an awfully long time, and it has cost the constituents of our colleagues that are with us today to testify, and I am so happy to welcome each one of the Representatives.

My hope is that the hearing will clear a path forward to a long-term financing solution that fits the needs of the territories and our fellow Americans who are part of them. So thank you, and welcome to our witnesses.

We welcome you very warmly to our subcommittee.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

In September of this year, the five U.S. territories will face a “Medicaid cliff.” I use this term because it means the supplementary Medicaid funding provided to the territories will run out. Without this Federal funding, over 1.5 million enrollees, including many children, could lose their healthcare.

Each is an American citizen but they are treated differently than the constituents of every member of this subcommittee.

Since 1967, the territories have struggled with inadequate Federal funding for their Medicaid programs because the Social Security Act capped Medicaid funding for the territories. Since 1978, Congress is on the record noting that the caps on the Medicaid programs severely affect the territories’ health and budgets, but there’s been no significant statutory change to this part of the Social Security Act in over 50 years.

This is a very important hearing that I hope we are going to build on and take action to reverse what I’m referring to.

Because of these restrictions, the territories routinely run out of Medicaid funds. Over the past decade, Congress has voted on six separate occasions to provide stop-gap funds to certain territories, including as recently as December 2019.

Except for a temporary increase in Federal funding for FY 2020 and 2021, the funding for the territories is typically 3 to 4 times below what a State Medicaid program would receive.

In the States, the Medicaid program has a flexible financing structure, which guarantees funding if more individuals enroll due to an economic downturn, a pan-

demic, or a natural disaster. For the rest of us that's the way it works, but not for the territories.

The territories do not have a guarantee. When disaster strikes, the territories are forced to make hard decisions about coverage and services at the worst possible time. Just when they need it most, that's when it hurts them most.

Fortunately, during the ongoing COVID-19 pandemic and economic downturn, the territories have benefited from an increased Federal match for fiscal years 2020 and 2021.

American Samoa, the Northern Mariana Islands, Guam, and the U.S. Virgin Islands received an 83 percent Federal match, and Puerto Rico's current Federal match is 76 percent.

With this additional money, Puerto Rico was able to cover the cure for hepatitis C for Medicaid patients for the very first time. The Northern Mariana Islands were able to establish an oncology center to provide cancer treatment locally.

But this funding is going to expire September 30th, which is why the territories obviously need a long-term solution to their Medicaid funding so they too can meet the needs of their constituents as we all work to meet the needs of ours.

In Puerto Rico, 85% of residents report they're worried that they'll be unable to access healthcare if they need it. 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.

If we allow the Medicaid cliff to happen, each of the territories would have to cut 69% to 94% of their Medicaid program in FY 2022. Obviously, percentages this high, we all know, produce dire consequences and it would be to hundreds of thousands of American citizens.

We cannot fail to care for so many American citizens based solely on where they live. I think we could probably all agree that this is short-term thinking, except this short-term thinking has been around for an awfully long time. And it has caused the constituents of our colleagues that are with us today to testify, and I'm so happy to welcome each one of the Representatives, my hope is that the hearing will clear a path forward to a long-term financing solution that fits the needs of the territories and the Americans that are part of them.

Ms. ESHOO. The Chair now recognizes Mr. Guthrie, who is the wonderful ranking member of our subcommittee, for his 5 minutes for an opening statement.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you, Madam Chair. I appreciate that very much. And thank you for this important hearing, and I want to thank the witnesses. I want to thank my colleagues for being here today representing the people you represent. And I want to—hopefully, we can move forward on this hearing.

So today Medicaid funding for five U.S. territories expires September 30th. And I am concerned the result of such an expiration would have a devastating impact on the residents in each of these territories. I am committed to working in a bipartisan way to find a solution that avoids this funding cliff.

But, unfortunately, the two bills we are discussing today miss the mark and are not bipartisan.

I want to examine how these programs are working for people in the territories while also improving program integrity and maintaining congressional oversight. We should be working together to achieve these goals to ultimately help these Americans.

The hearing today is on the Medicaid programs in the U.S. Virgin Islands, American Samoa, Northern Mariana Islands, Guam, and Puerto Rico. The Federal Government is projected to spend around \$3 billion on these programs this year, or roughly half of the annual budget of the FDA. These five programs cover a little

over 1.3 million people, but over 90 percent of those are in Puerto Rico. For comparison, in my home State of Kentucky, about one and a half million people participate in Medicaid.

This committee has a proud history of working together on these programs. Two years ago we passed unanimously out of committee a bill that would have increased funding for 4 years in Puerto Rico and 6 years for the other territories. These bipartisan extensions included new program integrity measures for each program to make sure Federal dollars were being spent on the people in these programs. Congress ended up increasing funding for 2 years for all five programs. So we are again here to examine ways to move forward.

However, I must point out that, technically, this hearing is a legislative hearing. Although Congress recently passed, in a bipartisan way, the most substantial increase in funding ever to these programs, before us are two partisan bills that remove any guardrails on the amount of Federal spending. We anticipate these bills will cost tens of billions of dollars, and include no policy changes to address program integrity, health outcomes, and a framework for increased flexibility.

Instead of this partisan approach, we should first look at how the bipartisan measures of increased funding and accountability have worked, and what measures should be continued.

It is my hope that the majority will return to the bipartisan tradition of working together on this issue moving forward. Although it is unfortunate the majority chose to start the discussion on these programs with a partisan legislative hearing today, today's hearing is important to discuss the territories' specific needs. Too often, Congress lumps all five programs together. But, as we know, we have five distinct populations with five distinct programs, with five sets of challenges and program designs. Understanding the differences in the programs and making sure any extension considers the unique needs of each population will be key.

We also want to have an open and robust conversation on the program integrity measures that the territories have been working on over the past 2 years. The Government Accountability Office is here today to discuss the report on the contracting issues Puerto Rico and the Center for Medicare and Medicaid Services have had with Puerto Rico's contracting practices.

In addition to the work GAO was doing, the Department of Health and Human Services Office of Inspector General is also conducting two audits of Puerto Rico's Medicaid program. Working with them this spring and summer will be of paramount importance, as we want to be sure that any issues identified are addressed as we work to continue this important funding.

Finally, I just want to reiterate my strong desire for this work to be bipartisan. We have seen time and time again that simply pouring money into something doesn't fix the underlying problem. We can address funding needs for U.S. territories while also ensuring programs better serve residents and program integrity measures are in place. We can do this together, and we can do it together like we have in the past.

I look forward to the discussion, and I yield back.

[The prepared statement of Mr. Guthrie follows:]

PREPARED STATEMENT OF HON. BRETT GUTHRIE

Thank you to the witnesses for being here today. Medicaid funding for five U.S. territories expires September 30th, and I'm concerned the result of such an expiration would have a devastating impact on the residents in each of the territories. I am committed to working together in a bipartisan way to find a solution that avoids this funding cliff, but unfortunately the two bills we're discussing today miss the mark and are not bipartisan. I want to examine how these programs are working for people in the territories, while also improving program integrity and maintaining congressional oversight. We should be working together to achieve these goals to ultimately help these Americans.

The hearing today is on the Medicaid programs in U.S. Virgin Islands, American Samoa, N. Mariana Islands, Guam, and Puerto Rico. The Federal Government is projected to spend around \$3 billion on these programs this year, or roughly half of the annual budget of the Food and Drug Administration. These 5 programs cover a little over 1.3 million people, but over 90 percent of those are in Puerto Rico. For comparison, in my home State of Kentucky, around 1.5 million people participate in Medicaid.

This committee has a proud history of working together on these programs. Two years ago, we passed unanimously out of committee a bill that would have increased funding for four years in Puerto Rico and six years for the other territories. These bipartisan extensions included new program integrity measures for each program to make sure Federal dollars being spent on the people in these programs. Congress ended up only increasing funding for two years for all five programs, so we are again here to examine ways to move forward.

However, I must point out that technically this hearing is a legislative hearing. Although Congress recently passed, in a bipartisan way, the most substantial increase in funding ever to these programs, before us are two partisan bills that remove any guardrails on the amount of Federal spending. We anticipate these bills will cost tens of billions of dollars and include no policy changes to address program integrity, health outcomes, and a framework for increased flexibility. Instead of this partisan approach, we should first look at how the bipartisan measures of increased funding and accountability have worked, and what measures should be continued.

It is my hope that the Majority will return to the bipartisan tradition of working together on this issue moving forward.

Although it's unfortunate the Majority chose to start the discussion on these programs with a partisan legislative hearing, today's hearing is important to discuss the territories' specific needs. Too often Congress lumps all five programs together, but as we know, we have five distinct populations with five distinct programs with five sets of challenges and program designs. Understanding the differences in the programs and making sure any extension considers the unique needs of each population will be key.

We also want to have an open and robust conversation on the program integrity measures that the territories have been working on over the past two years. The Government Accountability Office is here today to discuss their report on the contracting issues Puerto Rico and Center for Medicare and Medicaid Services have had with Puerto Rico's contracting practices. In addition to the work GAO is doing, the Department of Health and Human Services Office of Inspector General (OIG) is also conducting two audits of Puerto Rico's Medicaid program. Working with them this spring and summer will be of paramount importance as we want to be sure that any issues identified are addressed as we work to continue this important funding.

Finally, I just want to reiterate my strong desire for this work to be bipartisan. We've seen time and time again that simply pouring money into something doesn't fix the underlying problem. We can address funding needs for U.S. territories, while also ensuring programs better serve residents and program integrity measures are in place. We can do this in a bipartisan way like we have in the past.

I look forward to the discussion and I yield back.

Ms. ESHOO. The gentleman yields back. I want to say to the gentleman that we have worked with the minority to build this hearing. We worked together on the witnesses.

Yes, there are pieces of legislation out there. We welcome the minority putting forth legislation and/or working with the two main authors of legislation, relative to the subject matter of our hearing.

But this is not partisan. This is bipartisan. This is about American citizens. And so I look forward to hearing from them, and the gentleman yields back.

I now would like to recognize Mr. Pallone, the chairman of the full committee, for his 5 minutes of questions.

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

Mr. PALLONE. Well, thank you, Congresswoman and Chairwoman Eshoo, and I know not only this is an important hearing, but this is something that you care very much about.

And for—I hope I am not missing anybody, but I just wanted to say that I really appreciate the input from all the Congresspeople that represent the territories. I mean, I just have to say, you know, Congressman Sablan has been—I don't think a day goes by without him mentioning this issue to me.

And certainly, when—I think it was in the aftermath of Hurricane Maria—I know we have had so many hurricanes that I can't even remember which—the name of it, but I think it was Maria, when we went down to the Virgin Islands with Congresswoman Plaskett, and with Jennifer, with Congresswoman González. And they were talking about this, you know, the whole time, how we need a permanent solution. This just can't be done, you know, by kicking the can down the road.

And, of course, ever since he has been elected, Congressman San Nicolas has been talking to me about it, as well.

In addition to that, you know, you have, you know, Members like Congressman Soto on our committee and Congresswoman Velázquez, who are of Puerto Rican descent, who—you know, who constantly bring this to our attention and want solutions.

So, look, all of you have been so helpful, and so I am glad that we are having this hearing today, and all of you have an opportunity to express your views. It wasn't that long ago that we had our last hearing on how disastrous it would be for Medicaid funding in the territories to collapse. And I was proud that we were able to work together on a strong bipartisan bill that combined critical increases to the territory's funding and Federal medical assistance with FMAP, you know, for program integrity improvements.

But look, we know that Medicaid in the territories has been chronically underfunded for decades. The consequences of this inequity can be seen in the crumbling health infrastructure, emergency restrictions on provider networks, the failure to offer coverage of certain lifesaving drugs, and even the debt crisis in Puerto Rico.

Years of inadequate Medicaid block grants have forced the territories to divert more of their own dollars to ensure the residents have received the care that they need. And this funding structure has forced the territories to pay more than their fair share for Medicaid, much more than they would have to pay if they were treated like States.

Last Congress the committee passed legislation that would have provided several years of increased funding and a higher FMAP to all the territories. Thanks to the leadership of Representatives Soto

and Bilirakis, we were able to find common ground on this legislation. Unfortunately, I was very disappointed. At the last minute, former President Trump refused to support our bipartisan, bicameral agreement and insisted at the last minute on reducing that long-term solution to 2 years. And because of that, we are now once again on the verge of another crisis.

I believe the stakes are too high. The consequences of inaction are too tragic to continue down a path of short-term fixes. The territories need a permanent solution to their Medicaid funding shortfalls. They need a solution that assures that they can make improvements to their programs with certainty and that the increased funds they are relying on will be there for more than a couple of years. Beneficiaries need certainty about the services they critically need and rely on, and permanent improvements to these critical programs and to the health of beneficiaries can only be expected if Congress guarantees permanent, adequate funding.

So I am glad our colleagues from the territories could be here today to share their perspectives. I know that bipartisan committee staff recently met with health officials from the territories, and we have also received statements for the record from all the territories.

In just over 6 months, the territories will face a catastrophic loss of Federal Medicaid funding that will jeopardize access to care. Long before that, the territories will have to begin the process of contingency planning to make the cuts necessary to address this looming fiscal cliff, and this would include limiting reimbursements to providers, reversing expansions of eligibility that provided thousands of residents with access to Medicaid for the first time, and ending coverage of life-saving medications.

But we can't allow this to happen. We just can't allow this to happen. So bipartisan members of this committee fought hard last Congress to secure additional Medicaid funding. With that funding they have made tremendous progress. But that progress will be lost if we don't act quickly. So we are going to act. We want a permanent solution. We don't want to kick the can down the road.

Thank you again for being here, and thank you to Chairwoman Eshoo for having this hearing and for all the concern that you have expressed and leadership on this issue.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Thank you, Madam Chair, for holding this important hearing. It wasn't long ago that we had our last hearing on how disastrous it would be for Medicaid funding in the territories to collapse. I was proud that we were able to work together on a strong, bipartisan bill that combined critical increases to the territories' funding and Federal medical assistance percentage (FMAP) with important program integrity improvements.

While there may be differences between Republicans and Democrats on how best to address the Medicaid cliff, I think we all agree that we cannot let Medicaid funding in the territories collapse, especially during the COVID-19 public health emergency. The loss of access to healthcare would be devastating.

Medicaid in the territories has been chronically underfunded for decades. The consequences of this historic inequity can be seen in the crumbling healthcare infrastructure, emergency restrictions on provider networks, the failure to offer coverage of certain life-saving drugs, and even the debt crisis in Puerto Rico. Years of inadequate Medicaid block grants have forced the territories to divert more of their own

dollars to ensure their residents have received the care they needed, and it has impeded access to critical healthcare services for the territories' residents.

This funding structure has forced the territories to pay more than their fair share for Medicaid—much more than they would have to pay if they were treated like States. These programs have been starved for decades, and unfortunately these are the results.

Last Congress, this committee passed legislation that would have provided several years of increased funding and a higher FMAP to all the territories. Thanks to the leadership of Representatives Soto and Bilirakis, we were able to find common ground on this legislation. Unfortunately, I was deeply disappointed that, at the last minute, former President Trump refused to support our bipartisan, bicameral agreement and insisted at the last minute on reducing that long-term solution to 2 years. Because of that, we are now, once again, on the verge of another crisis.

The stakes are too high, and the consequences of inaction are too tragic, to continue down a path of short-term fixes. The territories need a permanent solution to their Medicaid funding shortfalls. They need a solution that ensures that they can make improvements to their programs with certainty that the increased funds they are relying on will be there for more than a couple of years. Beneficiaries need certainty about the services they critically need and rely on. And permanent improvements to these critical programs and to the health of beneficiaries can only be expected if Congress guarantees permanent, adequate funding.

I'm glad that our colleagues from the territories could be here to share their perspectives. I also know that bipartisan committee staff recently met with health officials from the territories, and we have also received statements for the record from all of the territories. Hearing directly from the territories, through both their elected representatives and their local health officials, is an important part of this process; and we should make sure their voices are heard.

In just over six months, the territories will face a catastrophic loss in Federal Medicaid funding that will jeopardize access to care. Long before that, the territories will have to begin the process of contingency planning to make the cuts necessary to address the looming fiscal cliff. This would include limiting reimbursement to providers, reversing expansions of eligibility that provided thousands of residents with access to Medicaid for the first time, and ending coverage of life-saving medications. We simply cannot allow this to happen.

Bipartisan members of this committee fought hard last Congress to secure additional Medicaid funding for the territories. With that funding, they have made tremendous progress in improving their Medicaid programs. That progress, however, will be lost if we don't act quickly.

I look forward to hearing from the witnesses today, and I yield back.

Mr. PALLONE. I yield back. Thank you.

Ms. ESHOO. The gentleman yields back.

Thank you for your good words, Mr. Chairman. The Chair now recognizes the ranking member of the full committee, Mrs. Cathy McMorris Rodgers, for her 5 minutes for an opening statement.

Mrs. RODGERS. Thank you—

Ms. ESHOO. Oh, I am sorry.

Mrs. RODGERS [continuing]. Madam Chair—

Ms. ESHOO. Yes, go ahead.

Mrs. RODGERS. Thank you—

Ms. ESHOO. Go ahead, I am sorry.

**OPENING STATEMENT OF HON. CATHY McMORRIS RODGERS,
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF
WASHINGTON**

Mrs. RODGERS. Great. And thanks to my friends and colleagues for being here today.

As others have mentioned, increased funding for Puerto Rico, Guam, the Virgin Islands, Northern Mariana Islands, American Samoa expires September 30th. And I am committed to reauthorizing funding in a way that is best for the people who get Medicaid care in the territories. I hope that we can work together on this

issue to ensure Medicaid is caring for our most vulnerable in the territories and across America.

As I have said many times before, we should be coming together in a bipartisan way to modernize and improve Medicaid, especially for pregnant women and people with disabilities. However, I want to be sure that we discuss three problems I have with this hearing before we have a discussion about extending these important programs.

First, it is important that we hear from the territories themselves and get to ask them questions about their programs. There are serious and valid concerns about how we oversee the Medicaid programs in the territories. If this hearing was later in the year, the OIG could provide an update on their audit. We could review Puerto Rico's report that is due in June.

Over the last decade there has been a dramatic increase in the amount of Federal taxpayer dollars going to Medicaid programs in the territories. Are we seeing health outcome improvements with that spending?

And if we don't have the data to answer that question, there is a gap that we need to address in this reauthorization.

Second, we are going to a straight legislative hearing on two partisan bills. These bills are only introduced—or only have Democrat cosponsors, and they were drafted, unfortunately, without the input from the Republicans. These bills do not address program integrity or getting better data on healthcare outcomes for those that are in Medicaid.

In addition, the last time this committee met on these programs, it reported out bipartisan legislation. It is our hope that the majority will work with us on moving forward in a bipartisan way.

And let's not forget that this committee—who moved a bipartisan bill out of committee 2 years ago that would have funded Puerto Rico for 4 years and the other territories for 6 years—that work should be our model of how to proceed this year.

My third and final concern is not related to the territories but to request that we do some more work on additional challenges in the Medicaid space. We should be investigating the devastating reports about New York underreporting COVID-19 deaths in nursing homes. Families deserve justice.

As I wrote to the majority 2 weeks ago, we should also be working together to understand more about the troubling reports regarding certain States undercounting and potentially falsifying reports of COVID-19 deaths in nursing homes. It appears that a few States took actions early that increased the COVID-19 crisis in nursing homes.

Washington State was one of the first States with an outbreak of COVID-19, and nursing homes were especially hard hit. Washington State provided additional Medicaid funds to nursing homes accepting COVID-19 patients. We should investigate whether the incentive of increased Medicaid dollars made the crisis worse.

This is an important hearing, and I am disappointed that we will not hear or get to ask the questions that I believe need to be asked. Instead, we are going straight to a legislative hearing on two partisan bills when we should be gathering facts, working together on legislation to continue Federal support of these vital programs.

I also encourage the majority to schedule a hearing as soon as possible to learn more about the tools that are available to ensure States accurately report nursing home deaths that COVID-19 or any infectious disease may have, to ensure that future pandemics and Medicaid dollars aren't used as an incentive that ends up further endangering nursing home patients. We owe our families and those who lost someone to COVID-19 nothing less.

And with that, I yield back.

[The prepared statement of Mrs. Rodgers follows:]

PREPARED STATEMENT OF HON. CATHY McMORRIS RODGERS

INTRO

Thank you to the witnesses for being here.

Increased funding for Puerto Rico, Guam, Virgin Islands, Northern Mariana Islands, and American Samoa expires September 30th.

I am committed to reauthorizing funding in a way that is best for the people who get Medicaid care in the territories.

I hope that we can work together on this issue and to ensure Medicaid is caring for our most vulnerable in the territories and across America.

As I've said many times before, we should be coming together in a bipartisan way to modernize and improve Medicaid—especially for pregnant women and people with disabilities.

However, I want to be sure that we discuss three problems I have with this hearing before we have a discussion about extending these important programs.

WITNESSES AND LACK OF INFORMATION

First, it's important that we hear from the territories themselves and get to ask them questions about their programs.

There are serious and valid concerns about how we oversee the Medicaid programs in the territories.

If this hearing was later in the year, the OIG could provide an update on their audits and we could review Puerto Rico's report that is due in June.

Over the last decade, there has been a dramatic increase in the amount of Federal taxpayer dollars going to Medicaid programs in the territories.

I want to know, are we seeing health outcome improvements with that spending?

And, if we don't have the data to answer that question, that is a gap we should address in this reauthorization.

CONCERNS WITH LEGISLATION

Second, we are going straight to a legislative hearing on two partisan bills that were drafted without any input from the Minority.

These bills do not address program integrity, or getting better data on healthcare outcomes for those that are in the Medicaid program.

In addition, the last time this committee met on these programs, it reported out bipartisan legislation.

I would request that the Majority work with us on this moving forward..

Let's not forget that it was this committee who moved a bipartisan bill out of committee two years ago that would have funded Puerto Rico for four years and the other territories for six years.

That work should be our model of how to proceed this year.

NURSING HOME DEATHS

My third and final concern is not related to the territories but to request that we do some work on additional challenges in the Medicaid space.

We should be investigating the devastating reports about New York under-reporting COVID-19 deaths in nursing homes.

Families deserve justice.

As I wrote to the Majority two weeks ago.

... we should also be working together to understand more about the troubling reports regarding certain States undercounting—and potentially falsifying—reports of COVID-19 deaths in nursing homes.

It appears that a few States took actions early on that exacerbated the COVID-19 crisis in nursing homes...

...Washington was one of the first States with an outbreak of COVID-19 and nursing homes were particularly hard hit.

Washington State provided additional Medicaid dollars to nursing homes accepting COVID-19 patients. We should investigate whether the incentive of increased Medicaid dollars made this crisis worse.

CLOSING

This is an important hearing, and I'm disappointed that we will not hear from, and get to ask questions of, the territories themselves.

We should be.

Instead, we are going straight to a legislative hearing on partisan legislation.

...when we should be gathering the facts and working together on legislation to continue Federal support for these vital programs.

I also implore the Majority to schedule a hearing as soon as possible to learn more about what tools are available to ensure States accurately report nursing home deaths from COVID-19 or any infectious disease, and to ensure in future pandemics Medicaid dollars aren't used as an incentive that ends up further endangering nursing home patients.

We owe the families of who lost someone to COVID-19 nothing less.

Ms. ESHOO. The gentlewoman yields back.

I just want to say to my Republican colleagues, you know, you can keep saying that a hearing is partisan, it is fine, but it is kind of a broken record.

Each one of you are legislators. You have a keen interest in this, as you do.

[Audio malfunction] territories to start—to kick off our hearing, each one of them representing a territory. Just as we pride ourselves on knowing our constituents and what their needs are, so do they. So it is a real pleasure to welcome each witness.

First, the Honorable Gregorio Camacho Sablan, a longtime friend and Member of Congress representing the Commonwealth of the Northern Mariana Islands, welcome to you, my friend.

The Honorable Aumua Amata Coleman Radewagen, Member of Congress, and representing American Samoa, welcome to you.

The Honorable Stacey Plaskett, Member of Congress representing the U.S. Virgin Islands, thank you for being with us, Stacey, and it is wonderful to have you with us.

The Honorable Jenniffer González-Colón, Member of Congress representing Puerto Rico.

And the Honorable Michael F.Q. San Nicolas, a Member of Congress representing Guam.

So a warm welcome from the entire subcommittee to each one of you. It is really an honor to have you with us today.

So we are going to begin with Congressman Sablan. You are recognized for 5 minutes, and you need to unmute so we can all hear every word you want to share with us.

STATEMENT OF DELEGATE GREGORIO KILILI CAMACHO SABLAN, A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF THE NORTHERN MARIANA ISLANDS; DELEGATE AUMUA AMATA COLEMAN RADEWAGEN, A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF AMERICAN SAMOA; DELEGATE STACEY E. PLASKETT, A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF THE VIRGIN ISLANDS; RESIDENT COMMISSIONER JENNIFFER GONZÁLEZ-COLÓN, A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF PUERTO RICO; AND DELEGATE MICHAEL F. Q. SAN NICOLAS, A REPRESENTATIVE IN CONGRESS FROM THE TERRITORY OF GUAM

STATEMENT OF HON. GREGORIO KILILI CAMACHO SABLAN

Mr. SABLAN. Good morning. Good morning and thank you to Chairs Pallone and Eshoo and Ranking Members McMorris Rodgers and Guthrie for holding today's hearing, "Averting a Crisis: Protecting Access to Healthcare in the United States Territories."

It feels like Groundhog Day. Not 2 years ago, the Medicaid director from the Marianas testified before this committee, along with their counterparts from other insular areas, on averting the crisis they faced with the end of Obamacare Medicaid money.

The subcommittee did avert that crisis, and it is through your work, Public Law, 116-94, and you provided the Marianas Medicaid with \$60 million in fiscal year 2020 and fiscal year 2021. This funding made a huge difference, especially because the economic effects of this unexpected pandemic doubled medical enrollment in the Marianas from about 16,000 then to 32,000 today.

But the money you helped provide was only a temporary fix.

Could we have the first slide, please?

[Slide.]

Mr. SABLAN. Come October 1st, funding for Medicaid in the Northern Marianas will drop back to the statutory cap, \$7.2 million, or an 88 percent reduction. This is the crisis we now must avert.

My proposal in H.R. 265 is simply to repeal the statutory cap. Sixty Members have cosponsored my proposal, including several committee chairs and the two Republican Members whose districts are affected. So my bill is bipartisan.

Lifting the cap may seem an invitation to spend, but in fact the \$60 million provided in both fiscal 2020 and 2021 have proven an accurate estimate of actual need over the last 2 years. And that amount lines up closely with a 2018 Congressional Budget Office estimate that permanently lifting the cap for the Marianas will only result in a \$15 million annual increase in spending.

That relatively modest investment has already proven its worth. Not only was the Marianas Medicaid program able to handle the sudden increase in enrollment as people lost income during the pandemic, the certainty of funding allowed our only hospital, which depends on Medicaid for 44 percent of revenues, to invest in capacity, saving money and increasing quality of care.

Could we have the second slide, please?

[Slide.]

Mr. SABLÁN. Knowing Medicaid funds would be available, the hospital established an oncology center. Now, instead of sending cancer patients off island to Guam or Hawaii, most can get treatment in the Marianas. And look at the results: off-island referrals down by 90 percent. Not only are we saving transportation and housing costs for off-island referrals, but fewer people sick with cancer must leave their families and face the rigors of travel. What a virtual circle.

By investing in Medicaid, Congress has lowered costs and improved care. How much more the Marianas could do if we had continued certainty of adequate Medicaid funding.

Let me note it is not just Medicaid patients who have benefited from this oncology center. Everyone in the community, even those with private insurance, are better off because of the funding Congress, you, provided in Public Law 116–94.

But with greater funding comes greater responsibility. And Public Law 116–94 required the Marianas and other insular areas to move towards the same program integrity standards that your States all face. And you will see in testimony our Medicaid agency submitted for today's hearing, the Marianas is meeting the program integrity requirements attached to the funding in Public Law 116–94, to the satisfaction of the Centers for Medicare and Medicaid Services. And this determination by CMS did not come in the last 2 months; it was made last year by a Republican administration, further demonstrating the Marianas' commitment to program integrity.

Our legislature passed Public Law 21–35 last year, giving our Medicaid director the authority to transfer funding as necessary to ensure compliance and program integrity measures are always sufficiently funded. It is said she now has more reprogramming authority than our Governor.

In closing, I suggest we rename today's hearing. Instead of saying we are here to avert a crisis, why don't we acknowledge all the positive benefits that resulted from the increased funding we provided less than 2 years ago? We improved the quality of healthcare in the Marianas for those insured by Medicaid and for the whole community. We helped reduce costs. We are increasing the program integrity that is so important to us all.

So let us not say today's hearing is to avoid a crisis. Let us say we are here to seize an opportunity to lift the cap on Medicaid funding in the Marianas so we can continue the progress we have made.

Thank you very much again, Madam Chair, for holding today's hearing. Thank you, everyone, for giving us an opportunity to represent our islands in Congress.

[The prepared statement of Mr. Sablan follows:]

Congressman Gregorio Kilili Camacho Sablan's Testimony
House Committee on Energy and Commerce
Health Subcommittee
Hearing on: "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories"
March 17, 2021
1:00 P.M.

Thanks to Chairs Pallone and Eshoo and Ranking Members McMorris Rodgers and Guthrie for the opportunity to testify at today's hearing: "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories."

It feels like Groundhog Day.

Not two years ago, the Medicaid Director from the Marianas testified before this committee, along with her counterparts from the other insular areas, on averting the crisis they faced with the end of Obamacare Medicaid money.

This Subcommittee did avert that crisis.

Through your work, Public Law 116-94 provided Marianas Medicaid with \$60 million in fiscal years 2020 and 2021.

This funding made a huge difference—especially because the economic effects of this unexpected pandemic doubled Medicaid enrollment in the Marianas—from about 16,000 then to 32,000 today

	2021 P.L. 116-94	2022 no action by Congress
American Samoa	\$85.6	\$13.0
Northern Marianas	62.3	 7.2
Guam	129.7	19.2
Puerto Rico	2,809.1	392.5
USVI	127.9	19.6

Source: MACPAC

But the money you helped provide was a temporary salve. Come October 1, funding for Medicaid in the Marianas will drop to the statutory cap, \$7.2 million—an 88 percent reduction.

This is the crisis we now must avert.

My proposal, in H.R. 265, is simply to lift the statutory cap. Sixty Members have cosponsored that proposal, including several committee chairs and the two Republican members whose districts are affected.

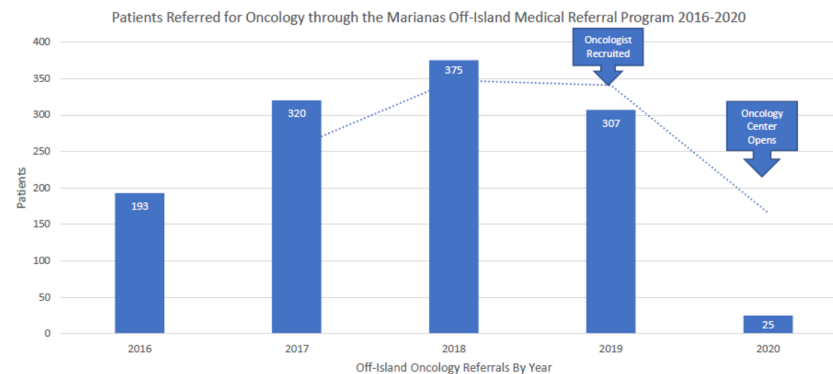
Lifting the cap may seem an invitation to spend. But, in fact, the \$60 million provided in fiscal 2020 and 2021 has proven an accurate estimate of need.

For the Marianas, CBO estimated in 2018 that permanently lifting the cap would result in a \$152 million increase in spending over 10 years. This would have a relatively small impact on federal spending considering that total federal spending for Medicaid was \$408 billion in 2019¹.

That relatively modest investment has already proven its worth. Not only was the Marianas Medicaid program able to manage the sudden increase in enrollment, as people lost income during the pandemic.

But certainty of funding allowed our only hospital—which depends on Medicaid for 44 percent of revenues—to invest in capacity, saving money and increasing quality of care.

Knowing Medicaid funds would be available, the hospital established an Oncology Center. Instead of sending cancer patients “off-island”—to Guam or Hawai’i—most now get treatment in the Marianas. Look at the results:



Source: Commonwealth Healthcare Corporation

Not only are we saving transportation and housing costs for off-island referrals. But fewer people, sick with cancer, must leave their families and face the rigors of travel.

¹ <https://www.cbo.gov/system/files/2020-03/51301-2020-03-medicaid.pdf>

What a virtuous circle: By investing in Medicaid, Congress has lowered costs and improved care. How much more the Marianas could do, if we had continued certainty of adequate Medicaid funding.

Let me note it is not just Medicaid patients who have benefited from this Oncology Center. Everyone in the community, even those with private insurance, are better off because of the funding Congress provided in Public Law 116-94.

But with greater funding comes greater responsibility.

And Public Law 116-94 required the Marianas and the other insular areas to move towards the same program integrity standards that your states all face.

As you will see in testimony the Marianas' Medicaid agency submitted for today's hearing, it is meeting the program integrity requirements attached to the funding in Public Law 116-94 to the satisfaction of the Centers for Medicare and Medicaid Services.

And this determination by CMS did not come in the last two months. It was made last year, by a Republican administration.

I want to brag on the Marianas Medicaid agency a little bit:

- They designated a Program Integrity Lead on June 26 last year, well ahead of the statutory deadline.
- They executed a Joint Operating Agreement with the CMS Unified Program Integrity Contractor.
- They engaged the Commonwealth's Office of Attorney General as the independent Medicaid Fraud Control Unit.
- They prepared the Implementation Advanced Planning Document, a major step toward compliance with the Medicaid Management Information System and the requirement to submit data to the Transformed Medicaid Statistical Information System—and CMS approved the plan.

Further demonstrating the Marianas's commitment to program integrity, our Legislature passed Public Law 21-35² last year, giving our Medicaid Director the authority to transfer funding, as necessary, to ensure compliance and program integrity measures are always sufficiently funded.

It is said she now has more reprogramming authority than our Governor!

In closing, I suggest we rename today's hearing.

² https://cnmilaw.org/pdf/public_laws/21/pl21-35.pdf#page=26

Instead of saying we are here to avert a crisis, why don't we acknowledge all the positive benefits that resulted from the action taken less than two years ago in Public Law 116-94:

- Improving the quality of healthcare in the Marianas for those insured by Medicaid—and for the whole community,
- Reducing costs, and
- Increasing the program integrity that is so important to us all.

Let us not say today's hearing is to avert a crisis.

Let us say we are here to lift the Medicaid cap, so we can continue the progress we have made.

Thank you.

Ms. ESHOO. Thank you——

Mr. SABLAN. I yield back.

Ms. ESHOO. Thank you, Congressman Sablan, and from your lips to every Member's ears. Thank you for joining us today. It is always wonderful to be with you. You are a friend to all of us.

It is now a pleasure to recognize Congresswoman Radewagen for 5 minutes.

We welcome you again. We are delighted that you are here, and you need to unmute so we don't miss a word that you want to share with us.

STATEMENT OF HON. AUMUA AMATA COLEMAN RADEWAGEN

Mrs. RADEWAGEN. Talofa lava. Hello, and good afternoon. Thank you, Chairwoman Eshoo and Ranking Member Guthrie, as well as full committee Chairman Pallone and my friend, Ranking Member McMorris Rodgers, for soliciting the views of American Samoa on our Medicaid program.

And thank you for consideration of mine and my colleagues' bill on improving the insular areas' Medicaid programs, the Insular Areas Medicaid Parity Act, which will provide stable, permanent funding, lift the caps, and maintain an increase to FMAP for the territories.

I know every State and every territory has their unique challenges, as do we. But factually, we are the most remote U.S. jurisdiction in the Medicaid program, almost 10,000 miles away, south of the equator, and have not had any commercial air service to our territory almost 1 year, not since March 23rd, 2020. That was the last commercial flight from Honolulu to American Samoa.

Hundreds are still stranded and going through a monthlong quarantine process—2 weeks in Hawaii, 2 weeks in Pogo Pogo—just to get home after being restricted elsewhere in the country. We have had two of six emergency charters from our local government completed, with four more scheduled over the next 3 months. Our health services and only hospital simply cannot handle a sudden influx of thousands of new arrivals at this time.

Our newly elected Governor, Lemanu P. S. Mauga, and Lieutenant Governor Talauega E. V. Ale have made a submission through their Medicaid director providing updated data on the current capacity, utilization, and program integrity efforts to the committee and will be providing additional information in the days and weeks ahead.

We appreciate the temporary increase in our FMAP, which has been helpful, but we need improvement to our only hospital, which is over 50 years old, in order to expand and improve services and attract broader physician services. And we need more reliable and stable funding than just every 2 years. Our residents and veterans face challenging logistics and most often need to travel to Hawaii for more serious care. And the pandemic has shown us that it has become a limited option to our sick during this crisis. So improvements to our local hospital are needed.

In normal circumstances, our people have only two flights per week to get to Hawaii. That limitation would be recognized alone as an emergency in most jurisdictions. Some of my constituents

who are stranded are stranded because they were off-island receiving care that they could not get in the territory.

So services were reduced due to our closed-border policy, but that policy saved lives and prevented COVID from arriving in American Samoa. Today we are the only part of the United States that is COVID free, absolutely.

So I ask the committee to maintain our current emergency matching level, eliminate the annual ceiling on Federal financial participation referred to as a Section 1108 cap or a Section 1108 allotment. Congress needs to address the funding cliff for the territories. Not doing so would spell financial and medical disaster to our people.

During the pandemic emergency we have been adjusted like other jurisdictions, with an additional 6.2 percent Federal cost share, so we are at an 89.2 percent FMAP. This has been welcomed, as we are indeed very much in a continued emergency state.

And I would argue our program and hospital capabilities have been in an emergency state long before the pandemic. The Army Corps of Engineers recently did a study and report to Congress on the state of the hospital, indicating that it needed a substantial, if not wholesale, modernization, update, or total replacement. The Army Corps found our LBJ Hospital in a state of failure and disrepair due to age and projected repair. And replacement costs between 161 to 900 million dollars, depending on minimum modernization or total replacement.

American Samoa's Section 1108 Medicaid allotment for fiscal years 2020 and 2021 were raised substantially, from about 12.5 to 86 million, with a temporary FMAP increase from 55:45 to almost 90:10. We were able to stretch our local matching funds. With an improved hospital infrastructure, we could utilize even more and potentially reach and exceed our current cap for the next few years. Stable, multiyear funding with caps raised will be key to that progress.

We do not have sizable tourism or diversified businesses and economies like the other territories. The local government and tuna cannery account for nearly half of local jobs, and our small businesses have taken a huge hit with the island closed off. But our young people continue to serve in record numbers in the armed services, with record per capita enlistments in the Army, and our veterans give so much back to our community. We need to carry them through with an improved hospital VA facility.

I look forward to working with members of the Energy and Commerce Committee on our critical Medicaid and hospital funding needs this year.

Thank you, Chairwoman Eshoo, I yield back.

[The prepared statement of Mrs. Radewagen follows:]

AUMUA AMATA COLEMAN RADEWAGEN
AMERICAN SAMOA

COMMITTEE ON SMALL BUSINESS
VICE RANKING MEMBER
SUBCOMMITTEE ON
ECONOMIC GROWTH, TAX, AND CAPITAL ACCESS
SUBCOMMITTEE ON
RURAL DEVELOPMENT, AGRICULTURE, TRADE, AND
ENTREPRENEURSHIP



Congress of the United States
House of Representatives
Washington, DC 20515-5200

COMMITTEE ON NATURAL RESOURCES

SUBCOMMITTEE ON
INDIGENOUS PEOPLES OF THE UNITED STATES
SUBCOMMITTEE ON
WATER, OCEANS, AND WILDLIFE

COMMITTEE ON VETERANS' AFFAIRS
VICE RANKING MEMBER
SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

Written Testimony for Congresswoman Aumua Amata Coleman Radewagen
American Samoa
Committee on Energy and Commerce
Subcommittee on Health
Averting a Crisis: Protecting Access to Health Care in the U.S. Territories
March 17, 2021

Talofa Lava! Hello and good afternoon.

Thank you, Chairwoman Eshoo and Ranking Member Guthrie, for soliciting the views of American Samoa on our Medicaid program.

And thank you for consideration of mine and my colleagues bill on improving the insular areas Medicaid programs, the Insular Areas Medicaid Parity Act, which will provide stable permanent funding, lift the caps, and maintain an increased FMAP for the territories.

I know every state and every territory has their unique challenges as do we.

But Factually, we are the most remote U.S. jurisdiction in the Medicaid program at 7000 miles away -south of the equator- and have not had ANY commercial air service to our territory in almost one year.

Not since March 23, 2020 –that was the last commercial flight from Honolulu to American Samoa. Hundreds are still stranded and going through a month-long quarantine process- 2 weeks in Hawaii and 2 weeks in American Samoa—just to get home after being restricted elsewhere in the Country.

We have had 2 of 6 emergency charters from our local government completed with 4 more scheduled over the next 3 months.

Our health services and only hospital simply cannot handle a sudden influx of thousands of new arrivals at this time.

Our newly elected Governor, Lemanu Mauga and Lieutenant Governor Talauega Ale, have made a submission thru their Medicaid Director providing updated data on the current capacities, utilization and program integrity efforts to the Committee and will be providing additional information in the days and weeks ahead.

WASHINGTON OFFICE
1339 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
PHONE: (202) 225-8577
FAX: (202) 225-8757

WWW.HOUSE.GOV/RADEWAGEN
AUMUA.AMATA@MAIL.HOUSE.GOV

DISTRICT OFFICE
1 FAGATOGA SQUARE LANE
PAGO PAGO, AS 96799
PHONE: (884) 633-3601
FAX: (884) 633-3607

We appreciate the temporary increase in our FMAP, which has been helpful, but we need improvement to our only hospital, which is 50 years old, in order to expand and improve services and attract broader physician services. And we need more reliable and stable funding than just every 2 years.

Our residents and veterans face challenging logistics and most often need to travel to Hawaii for more serious care—and the pandemic has shown us that has become a limited and option to our sick during this crisis, so improvements to our local hospital are needed.

In normal circumstances our people have only 2 flights per week to get to Hawaii; that limitation would be recognized alone as an emergency in most jurisdictions. Some of my constituents who are stranded, are stranded because they were off island, receiving care that could not get in the territory so services were reduced due to our closed border policy –but that policy saved lives and prevented COVID from arriving in American Samoa.

So, I ask the committee to maintain our *current* emergency matching level and eliminate the annual ceiling on federal financial participation, referred to as the Section 1108 cap or Section 1108 allotment.

Congress needs to address the funding cliff for the territories, not doing so would spell financial and medical disaster to our people.

During the pandemic emergency we have been adjusted like other jurisdictions with an additional 6.2% federal cost share, so we are at an 89.2% FMAP.

This has been welcome as we are indeed very much in a continued emergency state—and I would argue our program and hospital capabilities have been in an emergency state long before the pandemic.

The Army Corps of Engineers recently did a study and report to Congress on the state of the hospital indicating that it needed a substantial, if not wholesale, modernization, update, or total replacement. The Army Corps found our LBJ hospital in a state of failure and disrepair due to age and projected repair and replacement costs between \$161-900 million depending on minimum modernization or total replacement.

American Samoa's Section 1108 Medicaid allotment for Fiscal Years 2020 and 2021 was raised substantially from about \$12.5 to \$86 million.

With the temporary FMAP increase from 55-45 to almost 90-10, we were able to stretch our local matching funds.

With an improved hospital infrastructure, we could utilize even more and potentially reach and exceed our current cap in the next few years. Stable multi-year program funding with caps raised will be key to that progress.

We do not have sizable tourism or diversified businesses and economies like the other territories.

The local government and the tuna cannery account for nearly half of local jobs and our small businesses have taken a huge hit with the island closed off.

But our young people continue to serve in record numbers in the armed services with record per capita enlistments in the Army.

And our veterans give so much back to our community we need to carry them through with an improved hospital/ VA facility.

I look forward to working with the Members of the Energy and Commerce Committee on our critical Medicaid and hospital funding needs this year.

Sincerely,

A handwritten signature in blue ink that reads "Aumua Amata". The signature is stylized with a cursive font, featuring a large 'A' and a long, sweeping underline.

Aumua Amata Coleman Radewagen
Member of Congress

Ms. ESHOO. The gentlewoman yields back, and the Chair thanks her for her passionate testimony. We all could hear it in your voice, what the incredible needs are. And we thank you for being with us today.

I am going to go over to the Capitol to vote, and place the committee in the hands of Mr. Sarbanes, who I am sure is going to do a great job.

So over to you, and I believe our next witness is Congresswoman Plaskett.

And thank you for being with us, our friend.

And thank you, John Sarbanes, for taking the—chairing the hearing until I get back. I appreciate it.

VOICE. This meeting is being recorded.

STATEMENT OF HON. STACEY E. PLASKETT

Ms. PLASKETT. Thank you so much, Chairwoman Eshoo and Ranking Member Guthrie. I also want to thank the interim chair, Mr. Sarbanes, for controlling the time right now.

Members of the subcommittee, thank you for allowing me the opportunity to present a brief statement of the views of the healthcare concerns of the U.S. Virgin Islands as it relates to the work of this committee in the 117th Congress.

The Virgin Islands will need significant investments in healthcare in this session. Even before our severe hurricane disasters of 2017 and the COVID-19 pandemic, the healthcare systems in the territories were under great stress.

Specifically regarding Medicaid, the arbitrarily high local match required of U.S. territories by Federal law imposes severe and unsustainable financial demands. Each of the territories tried earnestly to resolve this with little success until, beginning in 2018 in the wake of the unprecedented disasters, more equitable matching rates were allowed on a temporary basis.

In addition, while overall Federal Medicaid funding to the States and the District of Columbia is open-ended, Medicaid in U.S. territories is unfairly subject to annual Federal funding caps. Once the cap is reached, the territory must assume the full cost of Medicaid services.

While the capped Federal funding has been supplemented by additional block grants since 2011, beginning with the Affordable Care Act and continuing through the Further Consolidated Appropriation Act of 2020 and the Families First Corona Response Act, the Virgin Islands and all other territories face yet another cliff on September 30th, as has been discussed. And the Federal matching funds, the FMAP, will drop precipitously, by over 20 percentage points. Tens of thousands of residents of my district will lose access to healthcare unless Congress takes action to eliminate the Federal Medicaid fiscal cliff in the territories once and for all.

Listen, to have us continually come and beg you for money to be treated equitably is absolutely unfair. And all of us, as Members of Congress, all of you on this committee, should be embarrassed that you have Members of Congress asking you to be treated fairly. This is a bipartisan request. If you have seen all of the Members of the territories, we are not just Democrats. We are Republicans and Democrats, and we are all asking for the same thing. So I do

not see why this becomes a question of Republicans and Democrats not all agreeing to what your colleagues, who are Democrat and Republican, are asking of you.

We cannot vote on the floor when final passage on this bill comes. But you know what the will of your colleagues are on both sides of the aisles. And the fact that you continually make us request this is frustrating, and it is demeaning to us, as individuals, as Americans, to have to continually ask for this.

I am grateful that the committee took action to address the Medicaid cliff in the past to provide an additional stream of Medicaid funds from my home in the Virgin Islands and the other territories. That Medicaid—normally is only about \$19 million. It increased to 128.7 million, and all of that money has been used by our district. All that money was needed.

I have here and ask unanimous consent to submit for the record the written testimony of Michal Rhymer-Browne, the assistant commissioner of our Department of Human Services, who testified before the House Committee on Energy and Commerce on June 20th of 2019.

Mr. SARBANES [presiding]. Without objection, that will be entered into the record. Thank you.

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

Ms. PLASKETT. Thank you. And in that testimony, in answer to the ranking member of the full committee Mrs. Rodgers' question, we used that money to put in place compliance as well as oversight over that funds. We have already testified that we have done that.

There are pages of points that she makes, putting the goal for IAP opportunity to support the Medicaid program, the data analytical exchange, having—submitting IAPD to the U.S. Department of Health and Human Services, having MOUs with the Department of Justice to create a Southeastern Unified Program Integrity Project to ensure that this money is used correctly, because we have no intentions for the money not to go to the people who need it most.

I have written testimony, and I will submit that for the record, as well. But again, I am asking for the support that you see of the Members of the territories who represent, you know, territories both in the Pacific as well as in the Caribbean, who are all asking for the same thing for the almost 4 million Americans who reside there.

Thank you, and I yield back.

[The prepared statement of Ms. Plaskett follows:]

Statement of Congresswoman Stacey Plaskett (VI)

House Committee on Energy and Commerce

Subcommittee on Health

Hearing: “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”

March 17, 2021, at 1:00 p.m. via Cisco WebEx

Thank you Chairwoman Eshoo, Ranking Member Guthrie, members of the subcommittee, for allowing me the opportunity to present a brief statement of views on the health care concerns of the U.S. Virgin Islands, as it relates to the work of this committee in the 117th Congress. The Virgin Islands will need significant investments in health care in this session.

Even before our severe hurricane disasters of 2017, and the COVID-19 pandemic, the health care systems in the territories were under great stress. Specifically, regarding Medicaid, the arbitrarily high local match required of U.S. territories by federal law imposed severe and unsustainable financial demands on the territories. Each of the territories tried earnestly to resolve this with little success until, beginning in 2018, in the wake of unprecedented disaster, more equitable matching rates were allowed on a temporary basis.

In addition, while overall federal Medicaid funding to the States and the District of Columbia is open-ended, Medicaid in U.S. territories is unfairly subject to annual federal funding caps. Once the cap is reached, the territory must assume the full cost of Medicaid services.

While the capped federal funding has been supplemented by additional block grants since 2011, beginning with the Affordable Care Act, and continuing through the Further Consolidated Appropriations Act, 2020 and the Families First Coronavirus Response Act, the Virgin Islands and all other territories face yet another “fiscal cliff” on September 30th of this year, when these allotments will expire and the rate of federal matching funds (“FMAP”) will drop precipitously by over 20 percentage points.

Tens of thousands of residents of my district could lose access to health care unless Congress takes action to eliminate the Medicaid fiscal cliff in the territories once and for all. Congress must act to prevent to this potential calamity before September 30th.

I am grateful that this committee has taken action to address the Medicaid cliff in the past to provide an additional stream of Medicaid funds for the Virgin Islands and the other territories through this current fiscal year. For my district, the Virgin Islands, the Medicaid cap, normally only about \$19 million, was increased to \$128.7 million in fiscal year 2020 and \$127.9 million in fiscal year 2021. The FMAP for Medicaid in the Virgin Islands, normally capped at an abysmally low 55% in statute, was also temporarily adjusted to an equitable rate of 83% for both fiscal years 2020 and 2021.

Without this additional funding stream, and another waiver of the otherwise applicable local match, the resulting Medicaid cuts would put health care delivery at risk; not only for Medicaid recipients on our islands, but also for the population at large.

Due to the relatively large number of individuals on Medicaid, our hospitals and other systems depend on Medicaid revenue. Therefore, the loss of Medicaid revenue resulting from the fiscal cliff would hurt health care providers in private practice as well. For the Virgin Islands, going over the cliff in real numbers would mean that Medicaid funding would go from roughly \$127.9 million in fiscal year 2021 to just \$19.6 million in fiscal year 2022. The islands cannot suffer cuts like that and continue to deliver services.

Significantly more funding will be needed, and at a far more equitable matching rate than the permanent statutory rate of 55%, which is the same as that of the wealthiest mainland States. The territories need to continue to have sufficient funding to be able to build capacity to deliver care; because ultimately, the goal is not just to have the same funding as the States. What we need is for medical care for those who need it in American territory to be every bit as good as care in the States.

The fact is that Virgin Islanders and the more than 3 million other American residents of U.S. territory are no less American than those residing in the 50 States and the District of Columbia. It is my strong belief that they ought to receive equitable treatment by the federal government in the Medicaid program. The pre-2017 55% percentage cap on the rate of federal matching funds is nearly 30 percentage points below what it would be if the rate was determined like it is on the mainland United States, where it is based on income per capita. If the Virgin Islands were to be funded in that same way, the territory would be able to make significant inroads towards our goal of equity.

Furthermore, the territories also have important federal health care program needs that fall outside of the Medicaid funding cliff. Equitable treatment in health care financing should not end with general Medicaid funding. It should include recognition that the territories also have challenges resembling many stateside areas, with provisions that aim to reduce the burden of those difficulties, such as providing our hospitals, which serve large numbers of Medicaid and uninsured patients, the same disproportionate share hospital (“DSH”) payments that similar hospitals in the 50 States and the District of Columbia receive.

Even prior to recent natural disasters and the COVID-19 pandemic, the Virgin Islands' two hospitals, publicly owned, have been excluded from the DSH program, despite the disproportionate amount of care provided to low income patients. The exclusion of all of the U.S. territories from Medicaid DSH, and the small territories from Medicare DSH (Puerto Rico receives Medicare DSH), has been a major health issue in the territories for many years. This has resulted in significant uncompensated care cost burdens on providers, hospitals, and local government finances across all of the islands.

These uncompensated care costs, in many ways, were a major reason why the hospitals experienced the extent of their destruction in the event of disaster. For a very long time, the hospitals have been forced to make choices like whether to pay doctors and nurses or to fix a roof. The hospitals in the Virgin Islands still rely on modular structures to come online, while doing triage care, and having people evacuated out for long-term care. Both hospitals remain in a very precarious situation more than three years after back-to-back hurricanes in 2017.

I have sponsored legislation, the Territories Health Equity Act (H.R.1354 in the 116th Congress), joined by my colleagues from the territories, and others, to correct inequities faced by the territories across numerous federal health programs. The bill eliminates the Medicaid funding cap, the Medicaid FMAP limit, and provides for fair inclusion of the territories in the Medicaid and Medicare DSH programs. It also improves the treatment of the territories in the Medicare prescription drug benefit program, and addresses their exclusion from the health insurance exchange program under the Affordable Care Act. I plan to be reintroducing that legislation in the weeks to come, with our Senate partners.

Regarding the Affordable Care Act, I have long been dismayed that it was underinclusive of U.S. territories. The Territories Health Equity Act would allow residents of the territories (where there are no Affordable Care Act insurance marketplaces) who lack employer-provided health care to access marketplace insurance plans offered to Members of Congress and congressional staff.

We must confront the difficult reality that Americans living in the territories are U.S. citizens that have been neglected and allowed to fall behind. I trust that this committee sees the importance of this and is willing to work with us to resolve these issues. Thank you.

Mr. SARBANES. Thank you very much, Congresswoman Plaskett. Resident Commissioner González-Colón, you are now recognized for 5 minutes. Thank you.

STATEMENT OF HON. JENNIFFER GONZÁLEZ-COLÓN

Miss GONZÁLEZ-COLÓN. Thank you, Chair.

Total Federal funding for the territorial Medicaid programs has been inadequate to meet the healthcare expenditures for patients to receive effective diagnosis, treatment, and care. And as a result of that, territories have had to finance a proportionally larger share of the program than any of the 50 States, just as the Member just said.

Puerto Rico, in this case, has received funds to supplement those provided by the Social Security Act to pay for this Medicaid program. These funds have been characterized by their temporary nature and the need for their renewal on a crisis-to-crisis basis, and for the inequity in the reimbursement formula, which is consistently lower in amount with a lower FMAP when compared similarly with the States.

Americans in Puerto Rico should be able to enjoy a Medicaid program with the same standards and benefits enjoyed by Americans elsewhere, and Congress needs to eliminate the artificial funding limits that have forced, in my case, Puerto Ricans, both beneficiaries and providers, to leave their homes and island's healthcare system.

Just in 2019 Puerto Rico sought additional Federal funds to supplement the insufficient Medicaid cap, which at the time provided only for approximately 10 percent of the program total cost, a program which covers only 10 percent—10 of the 17 Medicaid mandatory benefits in Puerto Rico.

We also requested additional funds for measures which were indispensable for the continued operation of the program and for the implementation of additional program integrity measures which we have been successfully implementing, and I think it—that is important to note. Those initiatives took the 2019 baseline Medicaid cost from \$2.8 billion to \$3.5 billion for the years 2020 and 2021 and were accompanied by an increase of investment from 55 percent to 76 percent.

And those initiatives were implemented with \$350 million to increase the eligibility from 40 percent to 85 percent of the Federal poverty level, just to cover approximately 200,000 additional beneficiaries with annual income of less than \$20,000 for a family of four a year, \$190 million to increase reimbursements to Medicare Part B providers and physicians with capitated arrangement.

And I need you to know that this increase of 70 percent of the Medicare fee schedule, which is more about 60 percent of the national average Medicare reimbursement, has been instrumental in helping physicians just to stay afloat during this pandemic.

Many of the mechanisms included in the CARES Act to provide immediate cash flow to healthcare providers in Puerto Rico receiving few—were ineffective with our providers. And why? Because they were receiving fewer dollars per capita from the provider relief fund than any other State, than any other territory, with an exam-

ple of a per capita distribution on the island of \$23.98, compared to the national per capita of \$174.14.

One hundred sixteen million dollars to increase hospital reimbursement to at least 90 percent of the Medicare fees schedule, just to compensate for Medicaid beneficiaries' pension losses, given that the hospitals in Puerto Rico are ineligible for Medicaid DHS payments.

Thirty-eight million dollars to cover hepatitis C treatments, chronic liver disease patients.

And to this day, our island is on track to spend the total incremental amount for the sustainability measures by the end of the fiscal year.

The additional funding that we were provided in 2019, just as the chairwoman explained, will expire on September 30th. And the amount of Federal funds for Puerto Rico's Medicaid program will revert to approximately \$380 million, or just about 10 percent of the program's current total cost.

And this is the reason we need to act swiftly to prevent the territories and Puerto Rico's Medicaid program from becoming underfunded and to provide sufficient funding to allow for a smooth transition into the next fiscal year without cutting benefits, lowering provider payments, or withdrawing coverage for hundreds of thousands of current beneficiaries in the middle of a pandemic.

And that is the reason the Governor of Puerto Rico just asked Congress for additional funds for 2020 and beyond, and to achieve a greater degree of equality in programs that are crucial to healthcare in the island, programs in which Puerto Rico does not have the financial capacity to bear itself, and which are usually provided by Medicaid in the States, such as the nonflu adult vaccination recommended by the CDC, the nonemergency transportation, and diabetes, among many others.

I just urge you and all the members of this committee—I mean, this committee went to Puerto Rico and had roundtables with professionals and with the providers and has addressed this issue in the past, in 2017, in 2018, 2019, 2020. And this is time to do it again. Make the funding available for the territories. This is a priority for millions of Americans who depend on it for our healthcare.

And I just want to say thank you for the invitation to testify, and I yield back.

[The prepared statement of Miss González-Colón follows:]

Statement of Hon. Jenniffer A. Gonzalez Colon
Resident Commissioner of Puerto Rico

Puerto Rico has faced the challenge of inequitable Medicaid funding since the inception of the federal program. The funding provided under Section 1108(g) of the SOCIAL SECURITY ACT has historically been insufficient to meet the needs of the territories' Medicaid programs and bears no relation with the healthcare expenditures needed for its medically indigent population to receive proper and effective diagnosis, treatment, care and medication services.¹ This inadequate funding has resulted in the territories financing a larger proportional share of this joint state-federal program than the States and the District of Columbia have; as well as a more limited program for the Americans in the territories than that available to those in the States and the District of Columbia.

For more than 10 years, Puerto Rico has sought and received supplementary funds beyond the mandated Section 1108 cap to pay for the healthcare services provided to its Medicaid population. These supplementary sources have provided the funding needed to reach the bare minimum revenues needed to fund the complex system that serves around 1.5 million beneficiaries. These funds have been characterized by their temporary nature, the need for the renewal of the funding on a crisis-to-crisis basis and, for the inequity in the reimbursement formula of the territory, which is consistently lower in amount and with a lower Federal Medical Assistance Percentage (FMAP) when compared to similar States.

Americans in Puerto Rico should be able to enjoy a Medicaid program with the same standards and benefits enjoyed by Americans elsewhere. The only way to provide stable Medicaid program in the territories with the benefits that Congress intended for its beneficiaries is to eliminate the artificial limits to funding that affect millions of Americans solely because of where in the United States they have chosen to call their home. Americans in Puerto Rico deserve a Medicaid program with equal funding to that provided to Americans elsewhere. Congress must correct this disparity, which has forced Puerto Ricans—both beneficiaries and providers—to leave their homes and has crippled our Island's healthcare system. Congress has a moral obligation to eradicate these disparities and eliminate discrimination between similarly situated Americans whose basic difference is the zip code where they reside.

During 2019, the Puerto Rico's government appeared before Congress seeking additional funds to supplement the insufficient Medicaid cap which, at the time, accounted for approximately 10% of the program's total cost—a program in which covers only 10 of Medicaid's 17 mandatory benefits.² In addition to the financing it needed to fund its Medicaid program in its then-current

¹ MACPAC. 2019. MEDICAID IN PUERTO RICO: FINANCING AND SPENDING DATA ANALYSIS AND PROJECTIONS. (March 2019a). Available at <https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-in-Puerto-Rico-Financing-and-Spending-Data-Analysis-and-Projections.pdf>.

² Although the federal rules for Medicaid benefits generally apply to Puerto Rico, it currently provides only 10 of Medicaid's 17 mandatory benefits due to insufficient funding. For example, it does not cover nursing facility services, non-emergency medical transportation, or emergency medical services for non-citizens. U.S. Government Accountability Office (GAO). 2016. MEDICAID AND CHIP: INCREASED

form, Puerto Rico also requested additional funding for certain “sustainability measures” which were indispensable for the continued operation of the program and for the implementation of several program integrity measures which Puerto Rico has been embracing and successfully implementing.

The total amount of these initiatives took the 2019 baseline Medicaid costs from approximately \$2.8 billion yearly to approximately \$3.5 billion for federal fiscal years 2020 and 2021. This was also accompanied by an increase of the FMAP from 55% to 76%, greatly increasing federal participation in reimbursement.³ The breakdown of the approximate total reimbursement achieved after approval for the initiatives and increased FMAP is:

1. Increasing the Puerto Rico Poverty Level (PRPL) to 85% of the Federal Poverty Level (FPL). \$350 million

The PRPL is \$10,200 annually for a family of four, or approximately 40 % of the FPL, which was \$25,750 in 2019. The additional funds provided by Congress allowed Puerto Rico to cover over 200,000 additional beneficiaries.
2. Increasing Medicare Part B provider reimbursement to 70% of the current Medicare Fee Schedule \$140 million
3. Increasing physicians with capitated arrangements reimbursement..... \$50 million

Medicaid physician fees are low in Puerto Rico compared to the States for certain services, including primary care and maternity services. For example, from July 2016 to July 2017, Medicaid physician fees were 19% of Medicare for primary care services and 50% of Medicare for maternity services, compared to the

FUNDING IN U.S. TERRITORIES MERITS IMPROVED PROGRAM INTEGRITY EFFORTS. GAO-16-324. Available at <http://www.gao.gov/assets/680/676438.pdf>. It does, however, provide certain optional benefits, including dental services and prescription drugs. CMS. 2012. AMENDMENT TO PUERTO RICO MEDICAID STATE PLAN. (19 Mar 2012). Available at <http://www.medicaid.gov/State-resourcecenter/Medicaid-State-Plan-Amendments/Downloads/PR/PR-11-003-Att.pdf>.

³ In 2011, Puerto Rico’s FMAP was statutorily set at 50 percent; the ACA provided an FMAP increase for Puerto Rico from 50 percent to 55 percent effective July 1, 2011. The found that, when the capped federal contribution was compared with Puerto Rico’s contribution to the health care needs of Medicaid eligible beneficiaries, the effective FMAP rate was estimated to be approximately 18 percent. White House. 2011. REPORT BY THE PRESIDENT’S TASK FORCE ON PUERTO RICO’S STATUS. (March 2011). Available at https://obamawhitehouse.archives.gov/sites/default/files/uploads/Puerto_Rico_Task_Force_Report.pdf.

national average of 66% of Medicare for primary care and 81% of Medicare for obstetric care.⁴

According to Bureau of Labor Statistics, the average annual earnings of family physicians and general practitioners in Puerto Rico are \$86,970, compared to \$211,780 nationally.⁵ This vast disparity in earnings has contributed to an ongoing exodus of younger doctors, which has left the island with an older, shrinking physician workforce. Only 4% of doctors in Puerto Rico are 35 years old or younger, compared to 24% in the States, according to data presented to MACPAC, which leaves the island at risk of further loss of physicians as older doctors retire.⁶

The additional funds provided by Congress allowed Puerto Rico to increase reimbursements to physicians by \$190 million.

This increase in reimbursements has been instrumental in helping physicians stay afloat during this COVID-19 pandemic. Many of the mechanisms included in the CARES Act to provide immediate cashflow to healthcare providers have been based in original Medicare which, because of the low percentage of original Medicare beneficiaries in Puerto Rico, were mostly inapplicable or ineffective. For example, over 50% of healthcare providers in Puerto Rico received payments from the Provider Relief Fund in an amount less than \$1,000 (compared to 17% nationally) and 84% of healthcare providers received payments in an amount less than \$5,000 (compared to 39% nationally). Moreover, providers in Puerto Rico received fewer dollars per capita from the Provider Relief Fund than any State or territory, with a per-capita distribution for Puerto Rico of \$23.98 compared to the national per capita of \$174.14.

⁴ MACPAC. 2019. MEDICAID IN PUERTO RICO: FINANCING AND SPENDING DATA ANALYSIS AND PROJECTIONS. (March 2019). Available at <https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-in-Puerto-Rico-Financing-and-Spending-Data-Analysis-and-Projections.pdf>.

⁵ Bureau of Labor Statistics, Occupational Employment Statistics. (May 2018). Available at https://www.bls.gov/oes/current/oes_nat.htm#29-0000.

⁶ MACPAC, December 2018 Meeting Transcript, p. 268. Available at <https://www.macpac.gov/wp-content/uploads/2017/07/December-2018-Meeting-Transcript.pdf>.

4. Increasing hospital reimbursement to compensate for Medicaid beneficiaries' attention losses..... \$106 million

Hospitals in Puerto Rico are ineligible for Medicaid Disparate Hospital Share payments and receive a minimal amount of Medicare Disparate Share payments because Americans living in Puerto Rico are ineligible for Supplemental Security Income, which is one of the factors in the formula for this program. The funds provided by Congress allowed Puerto Rico to increase reimbursements to hospitals to over 90% of the applicable Medicare Fee Schedule, an amount totaling \$106 million.

5. Covering oral hepatitis C treatment for chronic liver disease patients \$38 million

After further analysis of the cost of the measures, it was decided that the final sustainability measure proposed to Congress— paying the Medicare Part B premium for dual eligible beneficiaries⁷— could not be pursued because its cost would have defunded the other initiatives severely. Additional payments, like the second increase to dentists, were also included in the supplementary revenue sought. As of this date, Puerto Rico is on track to spend the total incremental amount for the sustainability measures of approximately \$700 million by the end of this fiscal year.

The increase in the Section 1108 cap provided under the FURTHER APPROPRIATIONS ACT OF 2020 will expire on September 30, 2021. Therefore, effective on October 1, 2021, the amount of federal funds provided to the Puerto Rico Medicaid program will be capped at approximately \$380,000,000, about 10% of the program's current total cost.

As the end of the Puerto Rico fiscal quickly approaches, Congress needs to act swiftly to prevent the Puerto Rico Medicaid program from becoming underfunded. Any delay will affect the contractual negotiations with the managed care organizations that provide healthcare services to our Medicaid beneficiaries because the lack of additional federal Medicaid funding will cause the FEDERAL OVERSIGHT AND MANAGEMENT BOARD to substantially cut budget for this program. Accordingly, I ask that, we work to provide the Puerto Rico Medicaid program with sufficient funding, at an FMAP of 83%, to allow it to have a smooth transition into the next fiscal year without cutting benefits, lowering provider payments, or withdrawing coverage for hundreds of thousands of current beneficiaries in the middle of this pandemic.

⁷ Americans living in Puerto Rico are ineligible for the Medicaid Savings Programs, which help to subsidize Medicare Part B premiums and copayments. This means that the GHP has to absorb the cost of providing these services to its dually eligible beneficiaries, whether directly or through Medicare Advantage Plans.

The Government of Puerto Rico has estimated that it needs \$4.8 billion for fiscal year 2022 and \$5.1 billion for fiscal year 2023 to continue to run its Medicaid program.⁸ This increase would allow for a greater degree of equality in programs that are crucial to healthcare in the Island. These programs include:

- Medicare Part B premium buy-in payments for dually eligible beneficiaries;
- Long-term care services and support
- Non-flu adult vaccinations as recommended by the CDC;
- Non-emergency transportation;
- Diabetes mellitus DME and supplies; and
- Increased funds for distressed hospitals and dentists.

I urge you to make funding for the Puerto Rico Medicaid program a priority and to provide it with the funding it requires to adequately serve the millions of Americans in Puerto Rico who depend on it for their healthcare. Although our ultimate goal should be full equity, I urge you to work towards providing the Puerto Rico Medicaid program the immediate funding it needs, at the levels requested, to avoid the collapse of our healthcare system.

I again thank you for your invitation to testify on this urgent matter.

⁸ Puerto Rico Fiscal Agency and Financial Advisory Authority (AAFAF), Budget Submitted to the FOMB, March 8, 2021 <https://www.aafaf.pr.gov/wp-content/uploads/Revised-Fiscal-Plan-PR-2021-2022.pdf>.

Mr. SARBANES. Thank you very, very much for your testimony. Congressman San Nicolas, you are now recognized for 5 minutes. Please remember to unmute.

STATEMENT OF HON. MICHAEL F. Q. SAN NICOLAS

Mr. SAN NICOLAS. Thank you, Mr. Chairman, honorable members of the esteemed Energy and Commerce Committee, Chairman Frank Pallone, Ranking Member Cathy McMorris Rodgers, Health Subcommittee Chairwoman Anna Eshoo, and Ranking Member Brett Guthrie.

Let me open by expressing my thanks for your graciousness in inviting Guam and our territory to testify at today's hearing, thanking all of you for your leadership in passing Public Law 116-94, which temporarily increased the Federal Medicaid assistance percentage, FMAP, for Guam to its current rate of 83 percent Federal match to 17 percent local match from the prior 55 percent Federal match and 45 percent local Medicaid matching formula, grossly insufficient for communities like Guam, with among the highest per capita poverty levels in the country.

Additionally, prior to Public Law 116-94, the pool of available matching funds for Guam was limited to approximately \$18 million. And with the sunset of these laws, it will revert to \$19.2 million in fiscal year 2022. In the interim, Public Law 116-94 has increased the pool of available funds to approximately \$130 million.

The whole point of FMAP and a proper pool of Federal matching funds is to enable a formulaic basis for our Federal Government to be able to support the Medicaid program as it is intended. Common sense would assume that, if the Medicaid program is intended to help those of limited resources, similar logic will be applied to the FMAP and Medicaid cap in communities of limited resources to fund Medicaid itself.

With Public Law 116-94, such progress towards basic equality for United States territories has been transformative for us in our Medicaid programs in its ability to reach Americans as intended under the law. The current temporary \$130 million pool at an 83:17 match translates into a Medicaid program funded at approximately \$156 billion overall for Guam, which is \$3,612 per Medicaid enrollee, based on our fiscal year 2020 levels of enrollment at 43,185 people, and a population of 170,000.

Assuming a static level of enrollment and a reversion to FMAP and capped levels and the Medicaid cliff, the amount available per Guam Medicaid enrollee drops precipitously to \$757, from 3,612 to 757, a drop of more than 79 percent. As evidently unsustainable as this is, a drill-down of the implications of this bleak outlook only prove it more so.

First, even at the current elevated levels, Guam's per-enrollee amount of 3,612 is still 32 percent lower than our next-lowest high-data usability jurisdiction. And even today's elevated levels under Public Law 116-94 do not reflect per capita equity.

Second, Medicaid cliff aversion means greater local funding needs to be expended for less Federal match under current circumstances. At \$18 million local funds, or approximately \$8 million, would fund that program entirely, whereas the same \$8 mil-

lion in local funding would result in more than \$47 million in program healthcare, a difference of over 62 percent.

Third, Medicaid cliff aversion means a return to Medicaid-induced medical cannibalism for Guam, with lower caps and lower FMAP leaving Guam to fund Medicaid at a higher matching rate, with a smaller pool, and ultimately picking up 100 percent of the total costs beyond \$750 per enrollee. Such medical cannibalism materializes in deferred maintenance of our facilities and equipment, which today have ballooned our Army Corps of Engineer estimates for a suitable hospital to over \$700 million, due to systemic underfunding of our healthcare system. Medical cannibalism means delayed vendor payments, with an underfunded healthcare system stretching vendor payments to 90 days and beyond, resulting in exponentially higher risk-based pricing.

Further, payment uncertainties implode Medicaid service provider environments. Private healthcare operators are unwilling or unable to accept Medicaid-eligible patients due to unsustainable delays in Medicaid and indigent receivables.

And finally, let us not forget that historic Medicaid inequity is but one of many Federal inequities that have exacerbated healthcare in Guam and in our territories. We do not have supplemental security income on Guam, leaving our disabled without a basic level of support and depriving our community of a pool of resources to fund the operations of medical service providers for those SSI eligible.

We do not have the Affordable Care Act and its corresponding Federal subsidies, leaving many of our people uninsured and underinsured. We must work to also remedy these healthcare gaps for our Americans on Guam to truly build an equitable healthcare system.

The only solution equitable for Americans in Guam is actual equity. Let us complete the work of Public Law 116-94 by permanently closing the territorial and Guam Medicaid gap with FMAP levels concurrent with the rest of the country and lifting of the Medicaid cap also concurrent with the rest of the country.

Thank you, and God bless the United States, Tribes, and territories of America.

[The prepared statement of Mr. San Nicolas follows:]

U.S. House of Representatives Committee on Energy and Commerce

Subcommittee on Health Virtual Hearing

“Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”

March 17, 2021

Hon. Michael F.Q. San Nicolas Member of Congress, Guam

Energy and Commerce Committee Chairman Frank Pallone, Ranking Member Cathy McMorris Rodgers, Health Subcommittee Chairwoman Anna Eshoo, and Ranking Member Brett Guthrie, let me open by expressing my thanks for your graciousness in inviting Guam to testify at today's hearing and for your grace in receiving our testimony.

I would also like to begin by thanking all of you for your leadership in passing P.L. 16-127, which opened the door for today's hearing by temporarily increasing the Federal Medicaid Assistance Percentage (FMAP) for Guam to its current temporary rate of an 83% federal match to a 17% local match. Prior to the enactment of this legislation, our FMAP was limited to a 55% Federal / 45% Local Medicaid matching formula grossly insufficient for communities like Guam with among the highest per capita poverty levels in the country.

In addition to the matching formula, the reach of Medicaid is further determined by the pool of federal matching funds afforded under the program's Medicaid Cap. Prior to P.L. 16-127, the pool of available matching funds for Guam was limited to approximately 18 million dollars, and with the sunset of these laws, it will revert to 19.2 million \$ in FY 2022. In the interim, P.L. 16-127 has increased the pool of available funds to approximately 130 million dollars.

The whole point of FMAP and a proper pool of federal matching funds is to enable a formulaic basis for our federal government to be able to support the Medicaid program as it is intended; to provide help with healthcare costs for people with limited income and resources, including adults, children, pregnant women, our elderly and our people with disabilities. Common sense would assume that if the Medicaid program is intended to help those with limited resources, similar logic would be applied to the FMAP and Medicaid Cap in communities with limited resources to fund Medicaid itself.

With P.L. 16-127, common sense prevails, and such basic equity for our United States Territory of Guam has been transformative in our Medicaid program and its ability to reach Americans as intended under the law.

The current yet temporary \$130MM pool at an 83/17 match translates into a Medicaid Program funded at approximately \$156MM for Guam, which is a healthy \$3,612 per

Guam Medicaid Enrollee based on our FY 2020 levels of enrollment at 43,185. Assuming a static level of enrollment and a reversion to FMAP and Cap levels in FY 2022, the amount available per Guam Medicaid Enrollee drops precipitously to \$757 – a drop of more than 79%. As evidently unsustainable as this is, a drill-down of the implications of this bleak outlook only prove it moreso.

First, even at the current elevated levels, Guam's per Enrollee amount of \$3,612 is still lower than the 2018 figures afforded to the next lowest Per Capita expenditure estimate for states with a high level of data usability at \$5,356. In other words, our elevated levels today are still more than 32% lower than our next lowest high data usability jurisdiction. Even today's elevated levels under P.L. 16-127 do not reflect per capita equity.

Second, the 2022 reversion means greater local funding needs to be expended for less federal match under current circumstances. In 2022, local funds of approximately \$8MM will only translate into less than \$18MM in program healthcare, whereas the same \$8MM would result in more than \$47MM in program healthcare - a difference of over 62%. These aren't just dollars and percentages; these are resources that directly reflect how much care is available for our Medicaid eligible.

Third, the 2022 reversion means a return to medical cannibalism for Guam, with lower Caps and lower FMAP leaving Guam to fund Medicaid at a higher matching rate with a smaller pool and ultimately picking up 100% of the tab of costs beyond \$757 per enrollee. With Guam's coffers strained due to present pandemic circumstances and high pre-pandemic poverty levels, medical cannibalism materializes in deferred maintenance of our facilities and equipment, which today have ballooned our Army Corp of Engineers estimates for a suitable hospital to over 700 million dollars due to systemic underfunding of our healthcare system because Guam has been picking up the tab of Medicaid inequity for decades. Medical cannibalism also rears its ugly head in delayed vendor payments, with an underfunded healthcare system stretching vendor payments to 90 days and beyond, depriving the system of better pricing available with net 30 payments and resulting in exponentially higher risk based pricing. Further, payment uncertainties implode the Medicaid service provider environment, with private healthcare operators unwilling or unable to accept Medicaid eligible patients due to unsustainable delays in Medicaid and indigent receivables.

And finally, let us not forget that historic Medicaid inequity is but one of many federal inequities that have exacerbated healthcare in Guam. We do not have SSI, leaving our disabled without a basic level of support and depriving our community of a pool of resources to fund the operations of medical service providers for those SSI eligible. We do not have the Affordable Care Act and its corresponding federal subsidies, leaving many of our people uninsured and underinsured. We must work to also remedy these healthcare gaps for our Americans on Guam to truly build an equitable healthcare system, but today that work focuses on Medicaid.

The only solution equitable for our Americans in Guam is actual equity. FMAP levels concurrent with the rest of the country, and a lifting of the Medicaid Cap also concurrent with the rest of the country.

Honorable Members of the Committee, thank you deeply for the temporary reprieve of P.L. 16-127. Let us now make whole Medicaid for Americans in an American healthcare system by simply applying to Guam what is applied throughout the rest of America.

Thank you, and God Bless the United States, Tribes, and Territories of America.

Mr. SARBANES. Thank you very much, Congressman San Nicolas, and I want to thank all of my colleagues, our colleagues, for their passionate testimony. There is no passion greater than fighting for your constituents, and certainly that was evident today. So thank you all for being with us.

We are now going to turn to a second panel of witnesses on this very important issue and the challenges that are faced in the territories: Dr. Anne Schwartz, who is the Executive Director of the Medicaid and CHIP Payment and Access Commission; and Ms. Carolyn Yocom, Director of Health Care for the Government Accountability Office.

So we are looking forward to hearing from both of you on this topic.

Dr. Schwartz, you are now recognized for 5 minutes. Please remember to unmute, thank you.

STATEMENT OF ANNE L. SCHWARTZ, Ph.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, AND CAROLYN L. YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF ANNE L. SCHWARTZ, Ph.D.

Dr. SCHWARTZ. Thank you, and good afternoon, members of the Health Subcommittee. I appreciate the opportunity to share MACPAC's work as this body considers next steps in Medicaid financing for 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 on issues affecting these programs. I want to note that we do not conduct oversight or do audits.

Medicaid and CHIP play a vital role in providing access to healthcare 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, territories operate under similar Federal rules as States and are subject to oversight by CMS.

It is frequently said that, if you have seen one Medicaid program, you have seen one Medicaid program, and this is because, despite common rules, States have a lot of flexibility in how they manage their programs. But for the purposes of the hearing today, it is important to note both that territory Medicaid programs differ from the States' and that they also differ from each other. And 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 you can find factsheets on the MACPAC website describing each territory's policies related to eligibility, benefits, delivery system, data and reporting, quality, and program integrity. But the most important point I want to underscore today 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 funding referred to as the Section 1108 cap or allotment. Territories receive a relatively small, set amount of Federal funding each year regardless of changes in enrollment and use of services. And in comparison, States receive Federal matching funds 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, in order to reflect States' differing abilities to fund Medicaid from their own revenues. If the FMAPs for the territories were set using the formula used for the States, the matching rate for all five territories would be much higher and, for most, the maximum of 83 percent.

Now, Congress has stepped in at multiple points with fiscal relief, notably in the consolidated appropriations bill passed in December 2019, which increased the 1108 allotments for fiscal year 2020 and 2021, and temporarily raised the FMAP to 76 percent for Puerto Rico, and 83 percent for the other territories. This legislation also directed the territories to make certain programmatic improvements related to data reporting and programming integrity. And, to our knowledge, they have either addressed these issues or made important progress.

The Families First Coronavirus Relief Act enacted last March further increased the 1108 allotments and extended to the territories a 6.2 percentage point increase in the FMAP through the end of the quarter in which the public health emergency ends. This is the same FMAP increase as received by the States.

So, as a result of these actions, all five territories now have enough money to cover program expenses through the end of this fiscal year. However, without additional congressional action, we anticipate that they will all experience funding shortfalls at some point in fiscal year 2022. And at this time MACPAC does not have sufficient data on actual or projected spending to comment on the exact date of exhaustion.

In the face of such a shortfall, the territories will have to make tough decisions. The options before them, including funding Medicaid entirely with unmatched local funds—a scenario we think is unlikely—cutting services, reducing or suspending provider payments, or some combination of these strategies. It is worth noting that territories, like States, are currently prohibited from decreasing eligibility standards or just enrolling beneficiaries if they accept the increased FMAP provided in the Families First legislation.

The history of responding to crises with a short-term infusion of funds has caused a great deal of uncertainty. And while an additional time-limited allotment of funds would certainly prevent a fiscal cliff, it would ensure that, in the short term, a continued delivery of services, but it would not address the underlying challenges with a financing structure that make it difficult for territories to plan, manage, and sustain long-term, reliable access to care for Medicaid beneficiaries residing in these territories.

Thank you for the opportunity to share MACPAC's work, and I am happy to answer any questions.¹

Mr. SARBANES. Thank you very much. I appreciate that, you were exactly 5 minutes. Well done.

Ms. Yocom, you are now recognized for 5 minutes. Please remember to unmute yourself. Thanks very much for being here.

STATEMENT OF CAROLYN L. YOCOM

Ms. YOCOM. My pleasure. Chairwoman Eshoo, Ranking Member Guthrie, and members of the subcommittee, I appreciate the opportunity to discuss GAO's most recent work looking at the Medicaid program in Puerto Rico.

My remarks today focus on key findings from our February report that evaluated Federal oversight of Puerto Rico's Medicaid contracting process. I am going to focus on our findings as they relate to Puerto Rico's contracting reform plan and then also discuss some additional actions needed to improve Medicaid program oversight.

Contracting is central to many States' and territories' Medicaid programs, and effective contracting relies on competition. Competition can reduce costs, improve contractor performance, curb fraud, and promote accountability. Through an open, competitive process, States and territories can evaluate and select contractors who provide the greatest value to their Medicaid programs.

Puerto Rico's plan to reform Medicaid contracting outlines a process but doesn't yet offer details on the substance of the actions it will take. For example, it sets timeframes for determining reforms, but it offers limited information on what these reforms will be and the extent to which they will result in a more competitive process. It is not clear what changes will occur.

And changes are needed. Our review of eight contracting processes did find that one competitive process, the largest, fully disclosed information on factors used to evaluate the proposals and make awards. We didn't find such information on the other two processes. And in the five noncompetitive contracting processes reviewed, three lacked any justification for excluding competition, and the reasons for the remaining were not clear.

Officials explained that Puerto Rico law does not require competition. However, competitive contracts can reduce risks of waste, fraud, and abuse. The concerns we identified underscore the need for Federal oversight.

Unfortunately, the Centers for Medicare and Medicaid Services, or CMS, does not oversee Puerto Rico's contracting procedures, leaving the program at risk. CMS officials noted, however, that the agency has treated Puerto Rico the same as other U.S. territories and States and that CMS does not oversee Medicaid contracting procedures in any State or territory.

Nationwide, contracts make up at least half of Medicaid spending. And in Puerto Rico, this percentage is 96 percent. CMS has taken the position that the States and territories are best suited to ensure compliance with their respective laws. We recommended

¹Dr. Schwartz's prepared statement has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-Wstate-SchwartzA-20210317.pdf>.

that CMS take steps to implement ongoing risk-based oversight of Puerto Rico's Medicaid contracting procedures, citing CMS's statutory requirement to ensure the administration of Medicaid programs using necessary methods for efficient program operations. The agency agreed.

As I believe every witness so far has presented, GAO's work also shows the challenges that Puerto Rico and the territories face compared with State Medicaid programs. Congress has increased funding, allowing the territories to avoid funding shortfalls or to cover more services. However, our work shows that the temporary and inconsistent nature of these increases create uncertainty and can complicate efforts to maintain program changes and retain and then sustain fiscal health. These concerns are real.

The need for an increased focus on program integrity is also critically important. Some improvements, such as Puerto Rico establishing a Medicaid fraud control unit, have been taken. However, more actions are needed to ensure Medicaid spending is meeting the needs of Puerto Rico's beneficiaries.

As Congress considers changes to funding the territories' Medicaid programs, Puerto Rico and other territories must continue to develop and carry out planned reforms, measuring their results, and adjusting oversight as needed to better ensure the efficient use of Medicaid.

This concludes my prepared statement.

I would be pleased to answer any questions.

[The prepared statement of Ms. Yocom follows:]



United States Government Accountability Office

Testimony

Before the Subcommittee on Health,
Committee on Energy and Commerce,
House of Representatives

For Release on Delivery
Expected at 1 p.m. ET
Wednesday, March 17, 2021

PUERTO RICO

Efforts to Improve Competition for Medicaid Procurement

Statement of Carolyn L. Yocom, Director
Health Care



Madam Chairwoman Eshoo, Ranking Member Guthrie, and Members of the Subcommittee:

Thank you for the opportunity to discuss the Medicaid program in Puerto Rico. Among the U.S. territories, Puerto Rico administers the largest Medicaid program, covering over 1 million beneficiaries at a total cost of \$2.5 billion in 2018.¹ Like other states and territories, Puerto Rico implements major functions of its Medicaid program by procuring a variety of administrative and other services from contractors. In calendar year 2018, states and territories paid contractors at least half of the \$619 billion in total Medicaid expenditures. In that same year, Puerto Rico paid contractors at least 96 percent (\$2.4 billion) of its \$2.5 billion in total Medicaid expenditures, primarily to managed care organizations (MCO) for coverage of Medicaid services.²

States' and U.S. territories' Medicaid procurement processes can directly affect their efficient operation of the program and their ability to prevent fraud, waste, and abuse.³ By promoting competition for procurements, states and territories can select contractors that provide the greatest value to their Medicaid programs. Competition also reduces the risk of fraud, waste, and abuse that—if unabated—could increase procurement costs and reduce funding available for Medicaid services to individuals.

In April 2016, we found little assurance that Puerto Rico and other territories' Medicaid funds were protected from fraud, waste, and abuse.⁴ Since then, the Centers for Medicare & Medicaid Services (CMS)—the federal agency in the Department of Health and Human Services (HHS)

¹Five territories of the United States participate in the Medicaid program: American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.

²Under managed care, states and territories typically procure from MCOs a specific set of Medicaid-covered services for Medicaid beneficiaries in return for a set payment per beneficiary, referred to as a capitated rate.

³The term procurement in this report refers specifically to the process of obtaining goods or services via government contract. Each state and territory must provide a Medicaid state plan that describes how it will administer its program according to methods that the Secretary of the Department of Health and Human Services finds to be necessary for the program's proper and efficient operation. 42 U.S.C. § 1396a(a)(4)(A).

⁴See GAO, *Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts*, [GAO-16-324](#) (Washington, D.C.: Apr. 8, 2016).

that oversees Medicaid—and Puerto Rico have taken some steps to improve program oversight.

However, in July 2019, the Department of Justice indicted three individuals, including the former executive director of Puerto Rico's Administración de Seguros de Salud, which oversees the territory's procurements for Medicaid managed care services, for unlawfully steering Medicaid contracts to certain individuals.⁵ These indictments have raised questions about Puerto Rico's Medicaid procurement process, including whether it helps ensure appropriate competition. In light of these and other questions, the Further Consolidated Appropriations Act, 2020, directs Puerto Rico to publish a Medicaid procurement reform plan to combat fraud, waste, and abuse.⁶ Puerto Rico provided Congress with this plan on December 18, 2020.

My testimony today will summarize our February 2021 report on CMS's oversight of Puerto Rico's Medicaid procurement process, including the extent to which this process helps ensure competition.⁷ This testimony will focus on our findings from the report as they relate to Puerto Rico's Medicaid procurement reform plan.

To conduct the work on which this statement is based, we reviewed relevant federal regulations and CMS guidance, interviewed officials from CMS and Puerto Rico, reviewed documentation of the process used to make eight Puerto Rico procurements (three competitive and five noncompetitive) that were in effect as of April 1, 2020, and reviewed Puerto Rico's procurement reform plan. Additional information on our scope and methodology is available in our report. Our work was performed in accordance with generally accepted government auditing standards.

⁵U.S. Department of Justice, *Former Secretary Of Puerto Rico Department Of Education And Former Executive Director Of Puerto Rico Health Insurance Administration Indicted With Four Others For Conspiracy, Wire Fraud, Theft Of Government Funds, And Money Laundering* (San Juan, Puerto Rico: July 10, 2019), accessed November 20, 2020, <https://www.justice.gov/usao-pr/pr/former-secretary-puerto-rico-department-education-and-former-executive-director-puerto-1>.

⁶Pub. L. No. 116-94, div. N, § 202(a)(2), 133 Stat. 2534, 3105 (2019) (codified at 42 U.S.C. § 1308(g)(7)(A)(iii)).

⁷See GAO, *Medicaid: CMS Needs to Implement Risk-Based Oversight of Puerto Rico's Procurement Process Medicaid*, [GAO-21-229](#) (Washington, D.C.: Feb. 5, 2021).

Background

Notable differences exist in the funding and operation of Puerto Rico's Medicaid program as compared with the states.⁸ Similar to states, the federal government and Puerto Rico jointly fund Medicaid to provide health care coverage for low-income and medically needy populations. However, federal law has historically established the federal matching rate for Medicaid expenditures in Puerto Rico at the lowest rate available to states, while matching rates for the states are determined each year based on a formula that takes into account variations in their per capita incomes. In addition, unlike states that receive open-ended federal matching funds, Puerto Rico can access federal funds for Medicaid up to an annual limit. Roughly 40 percent of Puerto Rico's population qualifies for Medicaid, and over the past decade, Congress has provided Puerto Rico with increased federal Medicaid funding.⁹

Similarly, as is the case with states, Puerto Rico's Medicaid program is required to cover certain benefits—known as mandatory Medicaid benefits. However, CMS has not always enforced this program requirement in Puerto Rico. For example, in April 2016, we found that Puerto Rico did not cover seven of the 17 mandatory Medicaid benefits, including nursing facility services and home health services.¹⁰

With respect to Medicaid procurement, HHS regulations apply to both states and Puerto Rico. Specifically, HHS regulations generally require a state or territory to “follow the same policies and procedures it uses for procurements from its non-federal funds.”¹¹ In addition, under HHS regulations, the agency may require a state or territory to comply with federal competition standards that apply to other non-federal entities under limited circumstances, such as when the agency determines that the state's or territory's procurement process for certain procurements is

⁸The differences in Medicaid funding and operation outlined in this section also generally apply to the other four U.S. territories participating in the program.

⁹Most recently, for fiscal years 2020 and 2021, Congress provided additional federal funding for all territories. See Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, div. N, § 202, 133 Stat. 2534, 3103 (2019); Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6009, 134 Stat. 178, 209 (2020)

¹⁰See [GAO-16-324](#).

¹¹See 45 C.F.R. § 75.326 (2019). States and territories must also follow federal requirements regarding the procurement of recovered materials and include certain contract provisions in every purchase order or other contract. See 45 C.F.R. §§ 75.331, 75.335 (2019). According to CMS officials, states and territories must attest in their Medicaid state plans to complying with this requirement.

an impediment to competition that could substantially impact project cost or the risk of failure.¹²

**Puerto Rico's
Procurement Reform
Plan Acknowledges
the Need to Improve
Competition and
Outlines Future
Initiatives**

In the Medicaid procurement reform plan it provided Congress in December 2020, Puerto Rico outlines initial steps to improve competition. In particular, Puerto Rico identifies a guiding principle and area of opportunity related to competition, as well as initiatives to define policies and actions it will use to increase competition. Puerto Rico's plan also notes that agreement from CMS is needed to implement reforms.

For our February 2021 report, we reviewed federal procurement standards that address competitive and noncompetitive procurements. Although states and territories are generally not required to meet these federal procurement standards, these standards were designed to promote competition, which we and other organizations have found to be a cornerstone of procurement. In addition, we previously found that competition can reduce costs, improve contractor performance, curb fraud, and promote accountability.¹³

Competitive procurements. In its procurement reform plan, Puerto Rico states that by April 2021 it will identify procurement information it will make public as part of its competitive procurement process and will make such information public by the end of 2021. Puerto Rico also plans to define criteria for evaluating proposals submitted by potential contractors. However, Puerto Rico's procurement reform plan does not specify whether it will make these criteria public when it issues requests for proposals.

Including such information may promote fair competition and improve agencies' efforts to obtain proposals that are as responsive as possible to their needs. Requests for proposals for two of the three competitive procurements we reviewed did not include certain information on factors

¹² These additional federal procurement standards apply to other non-federal entities, such as local governments, Indian tribes, and nonprofit organizations that participate in the Medicaid program. HHS may require states and territories to follow federal competition standards for two types of procurements: (1) information systems that support Medicaid programs, known as administrative data processing equipment and services; and (2) services from external quality review organizations for an annual review of the quality, timeliness, and access to health care services provided by states' MCOs. See 45 C.F.R. § 95.613(a) (2019); 42 C.F.R. § 438.356(e) (2019).

¹³ See GAO, *Federal Contracting: Opportunities Exist to Increase Competition and Assess Reasons When Only One Offer Is Received*, [GAO-10-833](#) (Washington, D.C.: July 26, 2010).

used to evaluate proposals and make awards, although the largest procurement we reviewed included this information.

Noncompetitive procurements. In its procurement reform plan, Puerto Rico also states that by August 2021, it will identify the circumstances under which the use of noncompetitive contracts is justified, as well as the factors it might consider in making this determination, such as the length of the contract. None of the five noncompetitive procurements we reviewed included documentation of justifications established by federal procurement standards—such as emergencies—which HHS may require a state or territory to comply with under limited circumstances.¹⁴

CMS oversight. As we reported in February 2021, CMS has not overseen Puerto Rico's compliance with the federal requirement that the territory follow the same policies and procedures that it uses for procurements using non-federal funds. According to CMS officials, Puerto Rico is in the best position to ensure compliance with its respective procurement laws. CMS officials stated that the agency has treated Puerto Rico the same as states and other U.S. territories, as CMS has not overseen the Medicaid procurement process in any state or territory.

States and territories must attest to compliance with this federal procurement requirement in their state plan. CMS officials said that they review these attestations when states or territories submit changes to the relevant portion of their state plans, but this occurs infrequently and CMS does not proactively initiate this process. As of October 2020, CMS last reviewed the relevant portion of Puerto Rico's state plan in 2004. CMS officials also told us that the agency has discretion in determining when it can exercise oversight of a state's or territory's compliance with federal procurement requirements; however, the agency does not have documented procedures specifying the circumstances under which it would take such oversight actions.

In our February 2021 report, we recommended CMS take steps to implement ongoing, risk-based oversight of Puerto Rico's Medicaid procurement process. Implementing this recommendation can help CMS meet its statutory requirement to ensure that Puerto Rico administers its

¹⁴These federal procurement standards allow noncompetitive procurements only under limited circumstances, including when (1) the item is available only from a single source; (2) an emergency does not provide sufficient time to conduct a competitive procurement; (3) CMS expressly authorizes noncompetitive procurement; or (4) after solicitation of a number of sources, competition is determined to be inadequate.

Medicaid program using methods that ensure the efficient operation of the program. HHS concurred with this recommendation, and stated that CMS is reviewing Puerto Rico's procurement reform plan against applicable requirements.

As Puerto Rico continues to develop and carry out its planned reforms, implementing our recommendation for ongoing, risk-based oversight of Puerto Rico's Medicaid procurement process could enable CMS to promote competition and efficiency, while preventing fraud, waste, and abuse in the program.

Madam Chairwoman Eshoo, Ranking Member Guthrie, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Carolyn L. Yocom, Director, Health Care at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Susan Anthony, (Assistant Director), Russell Voth, (Analyst-in-Charge), Kelly Krinn, Drew Long, and Jennifer Whitworth.

GAO's Mission	The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.
Obtaining Copies of GAO Reports and Testimony	The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.
Order by Phone	The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm. Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537. Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.
Connect with GAO	Connect with GAO on Facebook , Flickr , Twitter , and YouTube . Subscribe to our RSS Feeds or Email Updates . Listen to our Podcasts . Visit GAO on the web at https://www.gao.gov .
To Report Fraud, Waste, and Abuse in Federal Programs	Contact FraudNet: Website: https://www.gao.gov/fraudnet/fraudnet.htm Automated answering system: (800) 424-5454 or (202) 512-7700
Congressional Relations	Orice Williams Brown, Managing Director, WilliamsO@gao.gov , (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548
Public Affairs	Chuck Young, Managing Director, youngc1@gao.gov , (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548
Strategic Planning and External Liaison	Stephen J. Sanford, Acting Managing Director, spel@gao.gov , (202) 512-4707 U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548



Please Print on Recycled Paper.

Ms. ESHOO [presiding]. I want to thank——

Mr. SARBANES. Ms. Eshoo, I think you are back, so I will turn the reins back over to you, and I will go vote. Thanks very——

Ms. ESHOO. Thank you very much, Mr. Sarbanes. I am sure it went as smooth as glass. Thank you very much.

And thank you to each one of our colleagues who came to be witnesses today. We really appreciate it. First of all, I appreciate it. I think it is a great way for us to begin our hearing, and to the witnesses, to the other witnesses that are with us.

We are now going to move to Member questions, and I am going to recognize myself first for 5 minutes.

To Dr. Schwartz, the last time you testified before our committee you explained that the caps were made in law in 1967—1967, that is 33, 43, 55 years ago. Do you know what Congress' reasoning was for putting the caps in the Social Security Act?

What was—do you know what the intent was, what maybe the debate would have been?

I really—I will be real frank with you. I think that there is a lot of bias in this, but that is my thinking. So can you tell us why they did this?

Dr. SCHWARTZ. I wish I could tell you. This is something they have looked into, because it is frequently asked.

And so we don't know what factors Congress considered when setting the amounts of those caps. They have been commented on as being insufficient going back to the late 1970s. So I am sorry, but the legislative history is not crystal clear on this.

Ms. ESHOO. I see. And when we talk about a long-term solution, how would you describe it?

How would you advise us?

That is what we want to do, or many of us want to do, maybe some don't. How would you spell that out to us?

Dr. SCHWARTZ. So let me first say, in speaking on behalf of the 17 members of the Commission, the Commission hasn't come up with a specific proposal for a long-term solution. And I think that we have merely pointed out that the short-term fixes are problematic because they don't provide an opportunity for the territories to plan and implement in scale and phase the programmatic improvements that——

Ms. ESHOO. Well, they—the hospitals that our colleague pointed out is a case in point. I mean, the hospital is falling apart. Other territories are having to fly patients to other areas. It is expensive to do that. Each one should have—be able to have their own system. If people get sick, they should be covered.

So to Ms. Yocom, is there anything inherent to the territory's financing structure that helps prevent fraud or abuse?

For example, you found that the territories' block grants result in stronger program integrity than if there was the open-ended funding structure that the States have. Can you elaborate on that?

Ms. YOCOM. Congresswoman——

Ms. ESHOO. Did you find any evidence of increases in fraud thanks to the increase in funding?

It seems to me that there are some that are drawing a nexus between the two. So can you be specific about that?

Ms. YOCOM. Sure. I don't believe that that necessarily is the right conclusion to draw from our work.

Our work has found that, very similar to what Dr. Schwartz has mentioned, that the changes to the—the uncertainty of the funding stream does cause a lot of issues for any entity. And——

Ms. ESHOO. Of course.

Ms. YOCOM [continuing]. The territories are not to be excluded. When you have a block grant, compared with a stream that is dependent on needs and beneficiary growth and changes, you have a very different set of circumstances and a very different——

Ms. ESHOO. Yes, but we already know that. We already know that. We are all saying that.

Ms. YOCOM. Right——

Ms. ESHOO. But I am asking you about the specifics relative to—so you do—let me put it this way: You do not find any nexus between fraud in an open-ended funding structure and what the territories have today?

Ms. YOCOM. I don't—I do not believe our work has made that kind of a connection, no——

Ms. ESHOO. Has anybody's work concluded that?

Ms. YOCOM. Not that I am aware of, but——

Ms. ESHOO. Dr. Schwartz, has anyone brought forth evidence relative to a supposed nexus between fraud and abuse and an open-funded—you know, the way the States—the way Medicaid operates for the 50 States?

Dr. SCHWARTZ. Not that I am aware of.

Ms. ESHOO. It is so interesting that this thing keeps coming up. It is like a bad penny.

Anyway, well, I think that my time is used up. The Chair will now recognize the—again, the wonderful ranking member of our subcommittee, Mr. Brett, for his 5 minutes of questions.

Mr. GUTHRIE. Thank you, Madam Chair, I appreciate it. And thanks for everybody being here, my colleagues prior who testified.

And I just want to comment on my opening statement. You know, the subject matter is not part of—this is a bipartisan subject matter we all know we need to—have to address and we have to fix. The difference I was saying is, instead of having a hearing, we are having a legislative hearing on specific pieces of legislation that doesn't have bipartisan input and bipartisan—so we need to work together as we move forward on this, and that is what we need to do.

And first, you know, one of the questions is the cap. And I think all of us—and I have talked with several of my colleagues, spent some time meeting with Delegate—Resident Commissioner González quite a bit, and talked to others about the level of the cap. And the cap is sufficient. The cap in statute that we have had to relieve several times is not sufficient. It is low.

And so, you know, the question—before we say is a cap right or wrong, the question is, is the cap accurate? If it is an accurate cap, is it right? And that is kind of where we are trying to go with it.

And Ms. Schwartz, as we know, none of the territories have requested additional funding over the past 2 years. Would you agree that this would indicate that the cap amount put in place and

trended forward for the past 2 years has been, at a minimum, sufficient to cover the needs of each of the territories?

Dr. SCHWARTZ. I think that the amount of funding that has been available for the past few years has been substantially higher than what was available historically, and we have not heard that it has been insufficient. Twenty twenty was a very [audio problem] year in spending throughout the U.S. because of COVID, and so there is some issues around unspent funds there.

But, you know, year-to-year spending trends can be hard to interpret. But I think we haven't heard anything about these amounts being insufficient.

Mr. GUTHRIE. Thanks, thanks. You know, a cap that is too small is "problemsome." A cap that is accurate is—that is what we would like to address.

And so, Ms. Yocom, and—so talking a little bit about—you said we can conclude certain things from your report. But in your report, the GAO report, you mentioned contracting and procurement concerns that have arisen at both CMS and Puerto Rico.

Around that time, Puerto Rico released a report on how they planned to address program integrity issues moving forward. So then my question would be, are there issues within Puerto Rico's report that we should watch closely, such as issues that are not in alignment with your report?

Ms. YOCOM. You know, I think what is important to keep an eye on is there are two reporting timeframes that Puerto Rico has set. One is in April, where they will discuss ways to make their contracting procedures more competitive, which is a good thing. And then the end is at the end of the year, in 2021, there will be further outlines of timeframes and implementation. I think keeping track of both of those is going to be important, and getting more detail on what steps are going to be taken to make the process more competitive.

Mr. GUTHRIE. OK, thank you. And then, Ms. Yocom also, in your testimony you write that in 2018 procurement costs represented 2.4 billion of Puerto Rico's 2.5 billion in total Medicaid expenditures. That is a startling number, given that a 2019 Federal indictment led to the arrest of Puerto Rico officials who unlawfully steered Medicaid contracts to certain individuals.

We know that CMS requires States and territories to use the same process for Medicaid procurements as they do for nonfederal procurements. However, CMS has not taken steps to ensure Puerto Rico has met this requirement. Should requiring CMS to ensure Puerto Rico has taken the steps be something we should consider putting into place?

Ms. YOCOM. I think it would be important to consider that for not just Puerto Rico but for the States as well. It is clear that CMS doesn't know for certain what is happening, in terms of following procurements.

Mr. GUTHRIE. OK, thank you. And I just want to interrupt again. I know we have discussed my opening statement, and the concern with the two bills is that I want to make sure our colleagues and my fellow members of this committee that—the current system—I know we have changed the caps temporarily—is not sufficient,

and it needs to be addressed, and we want to address it. We want to just work together moving forward to address it.

So I appreciate the time, and I guess I will go vote and come right back. But Madam Chair, I appreciate the time, and I yield back.

Ms. ESHOO. The gentleman yields back. I always appreciate what the gentleman says. I just want to add to the record, though, that the two bills on this subject matter are bipartisan. They are bipartisan.

Mr. GUTHRIE. There are bipartisan sponsors, right, that is right. I am just saying we are going to work together——

Ms. ESHOO. They are.

Mr. GUTHRIE [continuing]. With the committee to——

Ms. ESHOO. And I think that is very important. I think sometimes the cosponsorship of our colleagues from the territories seems to be worth 75 percent rather than 100 percent. But these bills are bipartisan, and they are a part of it. So—which I think is wonderful. So we look forward to working with you on it.

The Chair now recognizes Mr. Pallone, chairman of the full committee, for 5 minutes of questions.

Mr. PALLONE. Thank you, Chairwoman Eshoo, and thanks for emphasizing the bipartisan nature of the bills, because we have approached this in a bipartisan way in the past and will continue to. Thank you.

I mean, the concern that I have, obviously, is that, if Congress fails to act and the territories go over the Medicaid fiscal cliff, the consequences are devastating. And I know that we have a number of territories here, but in Puerto Rico alone I understand it is possible that hundreds of thousands of people could lose their Medicaid coverage if the island doesn't receive additional Federal funding. And, you know, that is ridiculous, in the context of a pandemic.

And also, you know, this is a crisis of our own making. I mean, Puerto Rico has this Medicaid block grant. And, as a result, since 2009 Congress has intervened eight times to either increase their funding or increase their FMAP. And, you know, I just don't want to do this. I don't want to keep kicking this can down the road because the way we do this Medicaid in the territories is fundamentally broken, and now is the time to fix it.

So let me ask Dr. Schwartz. Initially, can you explain why so many people lose coverage if the territories go over the fiscal cliff, if you would?

Dr. SCHWARTZ. So it is basically simple math. If you have less money to spend, there are typically three things you can do: you can cut people, you can cut payment rates, or you can cut benefits.

And when payment rates are low, that may be a difficult strategy. When benefits have been provided, and there are not many optional benefits are provided, it is harder to cut those. And so that is the consequence.

Mr. PALLONE. Well, I think it is also critical—thank you, really, Doctor. But it is really critical to understand who is going to lose coverage, right? These are Medicare—I am sorry, Medicaid, Medicaid beneficiaries. So we are talking about, generally, very low-income individuals, is that correct?

Dr. SCHWARTZ. Yes.

Mr. PALLONE. And then, if you use Puerto Rico as an example—you know, I apologize to the others, but if you use Puerto Rico as an example, it uses its own eligibility levels for Medicaid, and they are generally lower than those that are used in State programs.

So in this scenario, a family of four with a monthly income of \$943, which is lower than the Federal poverty level for one person in the contiguous States, those people could lose their coverage, is that right?

Dr. SCHWARTZ. Yes, generally, although I want to note that Puerto Rico did implement a temporary eligibility expansion, up to 85 percent of the Federal poverty level, at the end of the fiscal year, which would allow a family of four to make approximately \$1,800 per month and remain eligible. But your general point is correct.

Mr. PALLONE. All right. And then, given their low income, it is safe to assume that the people who lose Medicaid would not be able to afford private insurance. Is that correct?

Dr. SCHWARTZ. Yes.

Mr. PALLONE. So we know that declines in coverage lead to declining overall health. When an uninsured person needs care, they tend to show up in an emergency room. So what do you expect is going to happen to the health of these individuals at risk of losing their Medicaid coverage?

Dr. SCHWARTZ. I think we would expect that people would not seek care unless they were in crisis, and that means that they would not receive preventive care, which could be immunizations or routine screenings. They also wouldn't get maintenance care for chronic conditions such as high blood pressure.

Mr. PALLONE. Yes. So, I mean—let me thank you, Dr. Schwartz.

You know, Jenniffer and Stacey and Gregorio, I don't want you to misunderstand what I am saying. I mean, I believe the territories would only roll coverage back as a last resort, but without these additional Federal funds they may have not—they may not have a choice. And that is a choice they should never—that, you know, the territories should never have to make. And we just have to stop—I know I sound like a broken record, but we have to stop.

Madam Chair, we have to stop these short-term fixes and look for a permanent solution. So that is what I know you are trying to do in the context of the Health Subcommittee and all of us in the context of the full committee. And, you know, I just want to make a pledge to all our Congresspeople from the territories that we understand this, and this is what we want to do. We want to have a permanent solution. Thank you, Chairwoman Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman. He yields back.

It is a pleasure to recognize the ranking member of the full committee, Congresswoman Cathy McMorris Rodgers, for 5 minutes of questioning.

Mrs. RODGERS. Thank you. Thank you, Madam Chair, and thank you, everyone, for being with us this afternoon.

I wanted to start with Ms. Schwartz, and I just wanted to ask, do we have any data on the health outcomes in the territories and potential changes in those outcomes since the Federal Government has increased the funding for Medicaid in the territories?

Dr. SCHWARTZ. Sure. In general, I want to say that, in Medicaid, most of the data are focused on managed care arrangements. And four of the territories operate primarily on fee-for-service, with Puerto Rico being the only one in managed care.

And Puerto Rico is moving to increase its various initiatives around quality, including reporting measures to the CMS scorecard, having plan level report cards, using an external quality review organization to calculate quality measures. And so that is all the infrastructure, the baseline activities that it would need to be able to assess quality.

Most of those measures are based on process measures, receipt of certain services that would be recommended from a clinical perspective, and that would be similar to the States, for which there are relatively few outcome measures, I would say, with the exception of low birth weight.

Mrs. RODGERS. Yes, it is something that I would like to see us consider as we are looking at Medicaid, both for the territories and beyond, because I think one of the valuable aspects of the Medicaid program is that we can see better outcomes, we can provide some flexibility to look at getting better outcomes for individuals, potentially even lowering costs, but making sure that that is also built—those kind of measures are built into the program that are encouraging the focus on improved health outcomes. I would like to see that included. Is that something that you think would be beneficial for Congress?

Dr. SCHWARTZ. I think the caution that I would provide would be just ensuring that you have the—that the territories have the necessary infrastructure and the scaled infrastructure to do those sorts of activities. And I think Puerto Rico has been working on that. And the activities for the other territories would also have to be sort of scaled to what their capabilities are.

Mrs. RODGERS. OK. Another question. The Medicaid benefits vary across the territories. American Samoa and CNMI are not required to offer all mandatory Medicaid benefits under their Section 1902(j) waivers. Guam, Puerto Rico, and the Virgin Islands are required to offer all mandatory benefits and are not eligible for the 1902(j) waiver. And currently Guam is the only territory that offers all mandatory benefits.

I would be interested in knowing, do you think that the Federal Government would have better insight into the programs, and why certain benefits are or are not offered in each of the territories, if those territories could get the J waiver, similar to the American Samoa and the Northern Mariana Islands?

Dr. SCHWARTZ. I am not sure if the availability of those services is tied to the authority, the J waiver, versus operating under another authority as to the availability of the providers to provide the specific services in those territories.

So I am not sure what else I could say.

Mrs. RODGERS. OK.

Mr. SABLON. May I suggest something? This is Sablan—

Mrs. RODGERS. Yes.

Mr. SABLON [continuing]. Ranking Member.

Mrs. RODGERS. Yes.

Mr. SABLAN. Yes, I think, for the Northern Marianas, it is possibly the limited number of specialized care that is available in our community. That is why we sent some patients here, whether both in Medicaid or in private insurance, sent them off to Guam, to Honolulu, to Hawaii. And so that is possibly one reason.

The other reason, which Ranking Member Guthrie brought up, is that nobody asked for more money. It is because we get a block grant, and our Medicaid agencies are told to operate within that block grant, you are not going to—you shouldn't expect additional money for this particular fiscal year.

I hope that may provide help, some idea of why we have that waiver.

Mrs. RODGERS. OK, that is helpful, I appreciate you adding those comments.

Miss GONZÁLEZ-COLÓN. Ranking—

Mrs. RODGERS. Yes?

Miss GONZÁLEZ-COLÓN. Can you—it is Jenniffer González. Can you yield just 10 seconds?

Ms. ESHOO. I think that, well, the time has expired, and I would just like to add that one of the rules of the committee, the overall committee, is that once witnesses have spoken, they can't go back to have them speak again. So—with Members.

Mrs. RODGERS. OK.

Ms. ESHOO. OK?

So, Mr. Sablan, you got yourself in under the wire there, my friend.

Mr. SABLAN. My apologies.

Mrs. RODGERS. OK.

Ms. ESHOO. OK?

Mrs. RODGERS. I will talk to them individually. I do have some further questions—

Ms. ESHOO. We will—

Mrs. RODGERS. Thank you very much.

Ms. ESHOO. Sure.

Mrs. RODGERS. I will yield back.

Ms. ESHOO. The gentlewoman yields back, and of course, all Members have the opportunity to submit questions to all of our witnesses. And that is always an important part of what we do. And I know I always take advantage of it, and others should, as well.

It is a pleasure to recognize the gentlewoman from California, Ms. Matsui, for her 5 minutes of questioning.

Ms. MATSUI. Thank you very much, Madam Chair, for calling this very, very important hearing.

I am really deeply concerned about the devastating impact the upcoming Medicaid fiscal cliff may have on patients and providers in the territories. And while it has been positive to hear about the improvements the territories have been able to make over the past 2 years with increased funding to the Medicaid programs, it also highlights all there is to lose if Congress fails to act for the long term.

If we are going to really address the historical inequities that limit access and health outcomes, we cannot be revisiting this funding question year after year. It is time to permanently raise the bar

to ensure adequate funding that will improve our territorial Medicaid programs.

Dr. Schwartz, I want to talk to you a little bit about provider flight. Thank you, by the way, for being here today. It is my understanding that a State Medicaid program needs to ensure that hospitals and providers are reimbursed at rates sufficient to maintain participation in the program. Without adequate pay, providers may stop accepting Medicaid beneficiaries or may seek to provide care elsewhere, which leads to decreased access to healthcare.

In Puerto Rico there was an exodus of providers even prior to the recent catalyst. This island was facing a fiscal crisis, and doctors were making half of what their mainland counterparts were making. Thousands of healthcare providers left. Then Hurricane Maria and COVID-19 hit.

I want to discuss the consequences of lower reimbursement rates in the territories and what that means to access to care.

Dr. Schwartz, I understand that 50 percent of Puerto Ricans are on Medicaid. That is a significant number. With that many families relying on Medicaid, what would be the effect of continued provider flight on the people, including the children of Puerto Rico, and their ability to access care when they need it?

[No response.]

Ms. MATSUI. Dr. Schwartz?

Dr. SCHWARTZ. Yes. Clearly, fewer providers would mean fewer opportunities to receive care, delayed care, gaps in care.

Ms. MATSUI. OK. In 2018 it was reported that about 15 percent of Puerto Rico's provider population left the island after Hurricane Maria. With the increases in Medicaid funding in the last 2 years, has Puerto Rico been able to implement any policies that would help end the flight of providers from the island?

Dr. SCHWARTZ. Sure. Puerto Rico actually has implemented payment increases for certain providers, including acute care hospitals, physician services. Unfortunately, I don't have any information to quantify how those payment increases have affected provider participation in the program or access to care.

Ms. MATSUI. OK, I think that would be helpful to find out.

If Puerto Rico were to go off the fiscal cliff, do you think it would be able to continue paying the increased rates to doctors and hospitals that it has been over the past few years?

Dr. SCHWARTZ. Well, as I said previously, provider payment is one place where any Medicaid program would seek savings. And for Puerto Rico it would be a decision that they would have to make. Among the options, provider payment is often the first step that Medicaid programs face [audio malfunction].

Ms. MATSUI. So if Puerto Rico is forced to reverse the temporary pay increases and cut doctor pay, can you speculate about what effect, if any, that might have on provider flight and access to care?

Dr. SCHWARTZ. Yes, well, we certainly have heard from officials in Puerto Rico that any reductions in provider payment would result in more providers leaving Puerto Rico, or leaving the Medicaid program, and worsen any existing access issues.

Ms. MATSUI. So it is clear to me that, if we really fail to act, these temporary policies that help keep doctors on the island will end, and we will have provider flight.

So I do look forward to working with my colleagues on both sides of the aisle to try to find a permanent fix to the antiquated way that we fund Medicaid in the territories.

And with that, I yield back. Thank you very much.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Virginia, Mr. Griffith, for your 5 minutes of questions, sir.

Mr. GRIFFITH. Thank you very much—

Ms. ESHOO. Nice to see you.

Mr. GRIFFITH [continuing]. Madam Chair. Thank you. And I respect the committee rules, but I do look forward to having a conversation with my colleague, Jenniffer González-Colon, about what she wanted to get in there, that—when she was talking with Mrs. McMorris Rodgers.

That being said, Ms. Yocom, I was concerned to read that the GAO report found Puerto Rico did not take important steps to enable or seek competition. I am, however, pleased to see that GAO found managed care organizations to be a shining example of what is being done right by Puerto Rico's health insurance administrators. I am hopeful that we can build off of what works and what has worked there. Could you tell us more about your findings in relationship to these managed care organizations in Puerto Rico?

Ms. YOCOM. Sure. I want to caveat that what we looked at is the procedures used to establish and award the contracts, and we did find that the largest organization, ASES, was in charge of establishing these contracts with different managed care organizations. And they did, indeed, follow policies that are important to a competitive procurement, and basically letting people know what factors that are going to be rated on, and how important those factors are, relative to each other, as an example of the type of information that they were requesting.

Mr. GRIFFITH. And, you know, what changes do you think could be made to better foster competition in these contracts, or in other things that you looked at?

Ms. YOCOM. Yes, I think there are a couple of things: making sure that those processes are more standardized across the different types of contracts and then, if there truly is no way to make a competitive process, making it clear why you aren't doing something competitive. If it is an emergency, or if it is only one source on the island that can do the work, having those kinds of processes more standardized across the contracting would be important.

Mr. GRIFFITH. I appreciate that. Is there anything that you had that you wanted to tell Congress that you hadn't had an opportunity to tell us?

I know you want to answer questions, but I just want to give you the opportunity, if there is something else that you want to get in, to make sure we—that you want to underline from your report, et cetera.

Ms. YOCOM. Well, I think, beyond the contracting process, our work in the past has really shown the impact of the uncertainty of the fiscal situation and the additional funds. When they—when you are waiting to see what will happen, it is harder to make strong decisions that look beyond the moment. So I think that is critically important to understand.

Mr. GRIFFITH. I appreciate that very much. I have about 2 minutes left. If anyone would like time, I am happy to yield. Otherwise, I can yield back. Is there anybody who wishes to take my time that is left?

[Pause.]

Mr. GRIFFITH. Hearing none, I yield back, Madam Chair.

Ms. ESHOO. Seeing—hearing none, the gentleman yields back.

Now it is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for her 5 minutes of questions.

Ms. CASTOR. Well, thank you, Chairwoman Eshoo, for having this important hearing, and thank you to my colleagues for appearing before us today and fighting to stand up for your neighbors back home.

Dr. Schwartz, under the current capped allotment approach, each territory only receives a set amount of Federal funding for Medicaid. I just want to be crystal clear. If a territory has Medicaid expenses, and it has already hit its cap, it cannot receive any more Federal matching dollars, unless Congress intervenes. Isn't that right?

Dr. SCHWARTZ. Yes.

Ms. CASTOR. And I understand a few years ago the Northern Mariana Islands did, in fact, hit their Federal cap. What changes did that force to health services under Medicaid, as a result?

[Pause.]

Dr. SCHWARTZ. Sorry, yes, it is my understanding that CNMI suspended providing services for a period of time, during which they experienced the funding gap. And, you know, basically, also suggested that certain—only—excuse me—beneficiaries could only be seen by one provider on the island, limiting people's ability to go to their usual source of care.

Ms. CASTOR. I can't imagine that you have a health need and you are limited in this country.

So when a territory uses up its Federal Medicaid allotment, you said in your testimony then they have to turn to their Federal sources to make up the difference. So that, obviously, means that they—it has fewer resources for investments like schools, or modernizing the electric grid, or other services. Is that correct?

Dr. SCHWARTZ. Yes.

Ms. CASTOR. And on top of all this, you know, we have seen some amazing medical breakthroughs, particularly in the field of gene therapy and biologics, and more on the way. And these can be life-saving products, but they are often incredibly expensive, especially when they first come onto the market. When a new, expensive, life-saving medication comes on the market, does the size of the cap increase, if you have a cap?

Dr. SCHWARTZ. No.

Ms. CASTOR. So thank you for answering those questions. You are helping to make it very plain that this Medicaid cliff really puts the citizens that live in the territories at a disadvantage compared to their fellow citizens. I think this underlying system is deeply inequitable, and it has been for a long time.

Even if we raise the caps, the territories will always be one economic downturn or one natural disaster or one medical breakthrough away from being able to fully care for its residents. So I

think it is time that we finally end the unfair treatment for the territories and end Medicaid block grants, ensure that Medicaid is there as the safety net that it is intended to be for all American citizens.

Thanks, I yield back.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure to recognize another wonderful Floridian, Mr. Bilirakis.

You have 5 minutes for your questions.

Mr. BILIRAKIS. Thank you, Madam Chair. I appreciate it, and I want to thank all of you for participating in this hearing. We appreciate it so much.

Ms. Yocom, last Congress I joined my fellow Floridian E&C colleague, Representative Soto, in introducing the Territories Health Care Improvement Act, which added robust program integrity measures in response to the malfeasance. From what GAO has observed to date, has Puerto Rico taken sufficient action to prevent the fraud and theft of government funds, which was at the center of the law enforcement action taken on July 10, 2019?

And if not, what more should occur?

Again, for Ms. Yocom.

Ms. YOCOM. We haven't looked in great detail at what Puerto Rico has done since our—that past work you spoke of. We do know, however, that the contracting risks that we have already talked about are there.

And then additionally, while the Medicaid fraud control unit is set up, it is not coordinating well with the other program integrity efforts on the island.

Mr. BILIRAKIS. OK, you know, you need to please follow up with this, because I think that is a pretty important question that everybody would like to have an answer to.

Currently, the—are there any territories that—with post-eligibility determination process, for that process to validate beneficiary program eligibility?

Ms. YOCOM. Yes, we haven't done work to speak to that. I don't know if Dr. Schwartz has.

Mr. BILIRAKIS. Dr. Schwartz, would you like to comment on that?

Dr. SCHWARTZ. Well, I know that Puerto Rico has been reporting for the payment error rate measurement program and the Medicaid eligibility quality control program, even though it is—they are technically not required to do so. But I am not aware of what the results from that activity are, or how their error rates compare to other jurisdictions.

Mr. BILIRAKIS. We need these answers, folks.

One question again for Ms. Yocom. Are there any concerns that ineligible providers may also remain enrolled in the Medicaid program throughout the territories, or in any particular territories?

Ms. YOCOM. I would say throughout the territories and throughout the States, that is an area where we need to be doing stronger work of screening and enrolling providers, and making sure that they are not on the OIG list for providers who should be excluded.

Mr. BILIRAKIS. So you said throughout the States, as well.

Ms. YOCOM. Yes, our work has shown that there is still a lot of work to be done there.

Mr. BILIRAKIS. That is something we need to be focused on, then.

Dr. Schwartz, the Northern Mariana Islands, American Samoa, and Guam are required to demonstrate the following by October of this year: progress in implementing methods for the collection and reporting of reliable data to the Transformed Medicaid Statistical Information System, in addition to progress in establishing a State Medicaid fraud control unit. Can you provide us with an update regarding the progress made to date on both fronts, please?

Dr. SCHWARTZ. So the information I have is that Puerto Rico and the U.S. Virgin Islands are both reporting to TMSIS, and Guam is working towards production on that. American Samoa and CNMI are exempt, although CNMI is beginning to work on that. Both Puerto Rico and U.S. Virgin Islands have also established fraud control units. The other three territories have not. American Samoa and CNMI are exempt under their J waiver.

Mr. BILIRAKIS. OK, thank you very much.

And folks, these are American citizens, and we want to help them, obviously. But we need some accountability here, and that is why I believe we are having this hearing.

So I really appreciate it, Madam Chair. And if anyone wants my 22 seconds, they can have it. Otherwise, I yield back.

Ms. ESHOO. Any takers?

[Pause.]

Ms. ESHOO. No hands. OK, we are going to—

Ms. PLASKETT. Madam Chair?

Ms. ESHOO. Yes?

Ms. PLASKETT. This is Congresswoman Plaskett. Thank you so much, Mr. Bilirakis.

I just wanted to submit for the record—I know that leadership on the committee has received a letter from Governor Bryan of the Virgin Islands. I just ask unanimous consent that his letter—I am sure the letters of these other Governors have written to—from the territories that have written—

Ms. ESHOO. It is already in the record.

Ms. PLASKETT. Thank you very much.

Ms. ESHOO. It is already in the record, and we thank you.

Ms. PLASKETT. I appreciate that.

Ms. ESHOO. The gentleman yields back. It is a pleasure to recognize the gentleman from California, Mr. Cárdenas, for his 5 minutes of questions.

Mr. CÁRDENAS. Thank you very much, Chairwoman Eshoo, and I appreciate Ranking Member Guthrie for having this incredibly important hearing.

It is a unique and horrible feeling to be in this great country but feel like a second-class citizen. And I believe today's hearing is exposing how, when it comes to something as precious and as important as human beings' health, it is being treated in the territories as though people are less than human or second-class citizens. And I challenge anybody to try to argue otherwise.

We have heard a lot about the cap, and how harmful it is and it has been to the territories over the years. I want to focus on the other aspect of Medicaid in the territories that is a major detriment to the program, and that is the inequity of how the Federal Medicaid assistance percentage, otherwise known as FMAP, is calculated.

Dr. Schwartz, just the level set—can you briefly explain what the FMAP is, and how it is set for typical State Medicaid programs?
[Pause.]

Mr. CÁRDENAS. Dr. Schwartz?

Dr. SCHWARTZ. Sure.

Mr. CÁRDENAS. OK.

Dr. SCHWARTZ. So the FMAP is based on the State's per capita income, relative to the national average, with higher FMAPs for States with lower per capita incomes, and vice versa.

There is a minimum of 50 percent, and there is a maximum of 83 percent, and those FMAPs are adjusted modestly each year, based on changes in per capita income relative to the national average. And then, for the territories, it is set at 55 percent, unless a specific increase has been given, as under the Families First bill or under the consolidated appropriations bill.

Mr. CÁRDENAS. So therefore, when it comes to States and the FMAP, that means that you get more assistance from the Federal Government if you have a lower economic income.

Dr. SCHWARTZ. That is right.

Mr. CÁRDENAS. OK, thank you.

The FMAP is different for the territories, though. As you stated in your testimony, the territorial FMAP is set by law at 55 percent, which is much lower than what it would be if they were calculated like a State.

Dr. SCHWARTZ. That is right.

Mr. CÁRDENAS. OK. Dr. Schwartz, in your testimony you stated that some of the territories have struggled in the past to generate the local funds necessary to draw down Federal funds. Which territories are you aware of that have struggled with this?

Dr. SCHWARTZ. So, to my knowledge, all the territories have struggled with this, but I believe it has been a particular problem in several of the Pacific territories.

Mr. CÁRDENAS. OK. So the territories, it seems that all of them end up in a position where they have a greater need. And even though there is inadequate funding, even that inadequate funding isn't even drawn down, not because they don't have the need but because they don't have the ability to match and draw down those funds.

Dr. SCHWARTZ. Yes.

Mr. CÁRDENAS. OK, that seems completely backwards to me. And with all due respect, I think Congress has every right and responsibility to recognize this glaring problem and correct it as soon as possible.

Dr. Schwartz, you also said in your testimony that you expect all of the territories to struggle with generating the local Medicaid funds if the FMAP were to revert back to 55 percent. So, even if we do increase the Federal funding, the territories won't be able to take full advantage of it unless we also increase the FMAP, correct?

Dr. SCHWARTZ. Yes.

Mr. CÁRDENAS. OK. So basically, what we have been able to prove recently with our actions of increasing the FMAP for the territories is that that is a much better right-sized give-and-take with

the territories and the Federal Government funding than the 55 percent. Has that been demonstrated?

Dr. SCHWARTZ. Well, I think if you look at what per capita incomes are in the territories, if you calculated them based on the State formula, you would come up with a much higher FMAP.

Mr. CÁRDENAS. Yes. Colleagues, I hope and pray that this hearing does bring us to a point where we actually properly fund.

And one of the things I would like to point out, again, being the territories are being treated like second-class citizens, in my opinion, in this country, if you are of a certain background or what have you, you are not considered suspect, even though you may actually do things that are beyond suspect and even criminal. But when it comes to the territories, I think that we are holding the territories to a standard that is unreal and is unfair, just because they are territories.

There are States and actors within States of the Union that have actually done wrong, and they have been able to even run for office later, get elected to things like, you know, U.S. Senator, what have you. But yet the territories are being held suspect when we truly don't have proof that we should be holding them suspect. Instead, we should be funding them appropriately and also holding them accountable, just like we would any State.

I am sorry, Madam Chair, I am out of time, and thank you very much. I yield back.

[Pause.]

Mr. CÁRDENAS. Madam Chair?

Ms. ESHOO. I thank you for the clarity of your comments. I think that it is a—you painted a tough picture, because that is what it is. But I don't know any one of us—if we were in the position of any one of the territories in our State, we would be shouting out from the top of the Capitol on this. And I think it has just gone on for far too long.

No one really understands why the Congress did what it did a half a century ago. I think this darn thing has gone on long enough. If we haven't learned how essential to life is—and our livelihoods—healthcare—we struggle with it in the 50 States. Why wouldn't it be the same way with people in the territories, who are our fellow citizens, and just squeezing, squeezing, squeezing—it just is beyond me.

Anyway, I want to call on and recognize the gentleman from Missouri, Mr. Long, our friend.

Mr. Long, you have 5 minutes.

Mr. LONG. Thank you, Madam Chair, and thank you all for being here today.

Dr. Schwartz, I wanted to ask you about the history of the J waivers. Two territories in—the Northern Mariana Islands and American Samoa operate their Medicaid and CHIP programs under Section 1902, the J waivers. Why were these two territories granted one, and what have they allowed these territories to do?

Dr. SCHWARTZ. I do not have information at my fingertips about the history of why the J waivers were granted, but we can certainly get that information to you.

I know the J waiver provides an opportunity to waive many areas of the statute, and so I—we can provide that specific infor-

mation to you for the record. And I apologize I don't have it at my fingertips.

Mr. LONG. OK, yes, I really would appreciate it, because I would like to get an answer to that. And I appreciate you following up with my staff on that and getting the information to us.

You may not be able to answer this next question, either, but do they want these waivers to continue? Are you apprised of that? Do you know if they want them to continue?

Dr. SCHWARTZ. I have not heard either way. But again, I can check on that for you.

Mr. LONG. OK—go ahead, I am sorry.

Dr. SCHWARTZ. I just wanted to also, while I had a moment, to correct something I said earlier about the TMSIS data. I mentioned that Puerto Rico and the Virgin Islands were both providing TMSIS data, and several others were exempt. But I want to make clear that, actually, the other three territories must demonstrate progress on TMSIS by October of this year. And so I just want to make sure that that is correctly reflected.

Mr. LONG. OK, thank you.

And Ms. Yocom, obviously, the focus of your report was on Puerto Rico, but I wanted to make sure we didn't neglect the other territories and the good work they have done on their program integrity measures. Are there any things we should consider implementing or reviewing for the other territories?

Ms. YOCOM. I am afraid the work that we have done on all the territories together is likely too old to be helpful here.

In general, what you want your Medicaid program to have is good data, so you know where the money is going; good screening, so you know the providers are eligible and in good standing; and strong eligibility systems, so you are covering the people who need the program the most.

Mr. LONG. OK, OK, thanks, I appreciate that.

And Madam Chairman, I yield back.

Ms. ESHOO. Thank you, Mr. Long, and the gentleman yields back.

It is a pleasure to recognize the gentlewoman from Illinois, Ms. Kelly, for your 5 minutes of questions.

[Pause.]

Ms. ESHOO. Are you on board?

I saw her earlier. All right, then we will go to the gentlewoman from California, Ms. Barragán, for 5 minutes of questions.

Ms. BARRAGÁN. Thank you, Madam Chairwoman. I just wanted to state that I think it is incredibly unfair the territories receive Medicaid funding in the form of a block grant. States receive open-ended Federal funds, for the funds territories receive are fixed. The block grant funding does not come anywhere close to covering the cost of healthcare for the territories' Medicaid enrollees.

And with that I want to yield to a champion on these issues, my former CHC colleague, Darren Soto.

Mr. SOTO. Thank you so much, Representative Barragán, and thank you, Chair Eshoo, for hosting this really critical issue. Representing more island-born Puerto Ricans than any other district, of course, than the island of Puerto Rico and Jenniffer González-Colón herself, this is a key issue.

You know, last term we had a great bill that came out of this committee, where majority and minority staff worked together with the leadership of Chair Eshoo and others. And I co-introduced, with Representative Gus Bilirakis, our Territories Medicaid Parity Bill, and it represented a really great balance. It set a 5-year set of benchmarks. It raised the funding for each of the territories. It literally would have set us on a great path forward. And we know that, sadly, the Senate went back on that deal, despite bipartisan, unanimous support out of our committee, at the urging of then-President Trump, even though I think there was great support among Republicans and Democrats in the Senate, as well.

So, you know, I strongly encourage both our chairs and our ranking members and our majority and minority staff to work together to see if we can get something together that we could both get behind that makes sure we, once and for all, set ourselves at least on a 5-year path to get to 100 percent Medicaid parity.

We heard from champions like Representative Sablan and Radewagen, Plaskett, González-Colón, and San Nicolas about how it set our territories behind. When you think of the billions of dollars that they had to dig deep in from their own local territorial budgets, we saw patients left behind in Hurricane Maria or in the many cyclones we saw out in the Pacific territories. We saw that patients can't get transportation. We saw hospitals that ended up not having enough funding to be maintained, so when they were hit with Hurricane Irma and Hurricane Maria, they looked like they were going to be inoperable for many years.

Ms. Schwartz and Ms. Yocom, my question to you all is, based upon that bill from last term, is there a path we could get at, a 5-year path, to get all the services up to what we need to, equal to States, where we can have that funding be equal?

Is that something you think is achievable in these next 5 years, if we work this out?

Dr. SCHWARTZ. I think the general idea of having a longer-term funding arrangement and a phased implementation of benefits, repayment rates, or eligibility levels makes a lot of sense. I couldn't comment on whether 5 years would be sufficient to do the whole thing.

I also imagine that, across the different territories, you might want to stage the implementation of those different steps differently, depending upon their own needs. And that is the kind of thing that territories and perhaps CMS could comment on and come up with a plan. So I think the general idea of it seems sound.

Mr. SOTO. Thanks.

And Ms. Yocom?

Ms. YOCOM. We would be glad to work with you to help. We think it is definitely a good plan, and we can give it a try. We are glad to help with data and doing the—some of the analysis.

Mr. SOTO. Thank you. Just as we close, you know, the pandemic has exposed how key coverage and services for Medicaid and insurance coverage, generally, is to make sure that Americans in our territories are treated with the same dignity, respect, and access to healthcare as those of us living on the mainland in States.

So I thank you all for this opportunity, and I yield back.

Ms. BARRAGÁN. Madam Chairwoman, I yield back. Thank you.

Ms. ESHOO. The gentlewoman yields back.

It is a pleasure to recognize Dr. Bucshon for your 5 minutes of questions. Good to see you.

Mr. BUCSHON. Good to see you. Thank you, Madam Chairwoman.

Ms. Yocom, aside from contracts not being negotiated in a competitive way in Puerto Rico, one of the more alarming aspects of your report is that CMS is not conducting oversight of Medicaid contracts at any level. I want to ask, what has CMS said about changing this behavior for both the territories and the States moving forward?

And are there requirements Congress should put in place, or policies we should consider for both the territories and States?

Ms. YOCOM. Yes, CMS has said a couple of things to us on this work.

The first was that they did feel like States and territories were in the best position to understand their own laws and regulations when it comes to contracting. They do, however, have authority to step in when there are issues or concerns that would lead them to want to know more information about contracting processes. I think that is an important thing to look at.

When we asked CMS what circumstances might lead them to do that, they did not have a response for us. So, within current law and regulation, that seems like a really important place to start, is under what circumstances do you want the Federal Government in and assisting?

The last thing CMS said is that it would provide technical assistance, and they can, if need be, withhold Federal monies if they deem that necessary.

Mr. BUCSHON. Thank you very much for that response. I appreciate it. It sounds like we have got a little bit of work to do in that space.

Ms. YOCOM. I think so.

Mr. BUCSHON. Ms. Schwartz, the two bills before the subcommittee today would remove the caps from all the territories. If either of these were signed into law, would the territories be in compliance with the Medicaid program?

Dr. SCHWARTZ. Well, I have not read these bills in detail.

Removing the caps, in and of itself, does not mean that all territories will be providing the full suite of services, or conducting a full set of oversight or data-reporting measures that are required of the States. And, you know, you would need to be explicit on all of those items.

Also, I just further want to comment that, as—removing the caps without addressing the FMAP is problematic for the reasons shared earlier.

Mr. BUCSHON. Yes, and I was going to follow up with that, and it seems maybe a more important discussion is to provide long-term certainty and fix some of the other underlying problems. What does the long-term certainly look like, and what can Congress do to help provide that certainty for the territories?

Dr. SCHWARTZ. So a couple of issues have been raised about—or concerns about the adequacy of the program from the territories, one being provider payment and then the second being the breadth of the benefits.

And for a program administrator, committing to an increase in provider payment without certainty about the availability of the funds to back up those provider payment increases, I think, would be difficult.

And similarly, for extending a benefit, I think all Medicaid programs are in this situation, that they do not like to provide benefits and then have to be able to say the next year, “No, sorry, there is not enough money, and we are not going to provide that.” It is very disruptive to providers. It is, obviously, very disruptive to beneficiaries, who have expectations.

So those are some examples of how the uncertainty affects the program on a very day-to-day basis.

Mr. BUCSHON. OK, well, thank you.

I also want to know—it seems, you know, like we are going to work off the extension we passed 2 years ago. But we need to understand, for a long-term fix, we really need to find a way to pay for the services, and that need must be part of our work moving forward.

I would—as a healthcare provider, I want everyone who is a U.S. citizen—territories, the—and all the other States—to have the same access to quality medical care as everyone does in my State, Indiana, and the rest of the country. So this is really a critical issue for our territories that we really need to find a solid, long-term solution to ensure that the U.S. citizens in the territories really have the same quality of program, and program integrity, as well as the same amount of resources, financially, for quality healthcare. And I want to make—I want to be part of that solution.

Madam Chairwoman, I yield back.

Ms. ESHOO. Those are very generous comments, Dr. Bucshon.

The Chair is delighted to recognize the gentlewoman from Washington State, Dr. Schrier, for 5 minutes of questions.

Not there? Then we will call on the gentlewoman from Massachusetts, Ms. Trahan, for your 5 minutes of questions.

Not there? Well, we—I think a lot of Members have left their seats to go over to the Capitol to vote. Let’s see who is next.

VOICE. It should be—look at the Republicans, Mr. Dunn.

Ms. ESHOO. Mr. Dunn—from where?

Mr. Dunn, are you there?

[Pause.]

Ms. ESHOO. Then Dr. Joyce, you are recognized. Thank God you are there.

Mr. JOYCE. It is great to be here. Thank you, Chair Eshoo, thank you for holding this, and Ranking Member Guthrie, for allowing us to convene. I would also like to thank my colleagues on their first panel for their testimony here today.

First, Ms. Schwartz, too often we make policy with each of the territories getting lumped together. Can you give us some examples of how they differ from each other?

Dr. SCHWARTZ. Sure. Here is one quick example. In 2019 the number of enrollees in Puerto Rico was 1.2 million. In the Commonwealth of the Northern Mariana Islands it was a little over 16,000. In Puerto Rico, they have a managed care infrastructure, and in the other territories it is primarily fee-for-service. So those

are some good examples of the scale and the scope differences across the various territories.

Mr. JOYCE. In face—continuing along that line, Ms. Schwartz—in face of these differences, not only geographic, but the number of insured lives that can be covered effectively, how should we as Members of Congress be better addressing this?

And that is for you, Ms. Schwartz.

Dr. SCHWARTZ. Sure. I think the one suggestion that I would make and plan for enhanced requirements to go with an enhanced funding is consultation with the territories about their capacity to provide those requirements and staging those in a way that is consistent, both with what the committee wants to achieve and what is realistic in the short and the long term.

Mr. JOYCE. Ms. Yocom, I understand that we do have a need for stability and the goal of increasing the cap and FMAP for the territories. Specifically, I want to discuss Puerto Rico.

Last Congress this committee agreed on bipartisan proposals to provide 4 years of relief tied to important program integrity measures. However, I am concerned with what occurred with the former Director of SS and the GAO findings related to procurement processes. What are concrete steps that SS has taken to address the concern from the GAO's report on program integrity?

Ms. YOCOM. Well, as I noted earlier, Puerto Rico has produced a contracting reform plan, and it has two key points where the details that they flesh out their plan with will be very important to know about. The first deadline is in April, where their plan says they will talk more about how they will foster competition and what kind of steps they will take to improve contracting procedures.

And then the second one is at the end of this year, which has more detail on how they are going to go about it.

I think keeping track of that, thinking about standardization across contracting processes as Puerto Rico considers how to implement its plan, is going to be two really important things to do.

Mr. JOYCE. What steps has the Governor committed to take as part of this revised fiscal plan?

Ms. YOCOM. You know, I don't know that I can speak to that. I would be glad to find that out for you.

Mr. JOYCE. Thank you. I think that would be important for us to have that information, as well.

Thank you for the opportunity to have this dialogue, and Chair Eshoo, I yield the remaining time.

Ms. ESHOO. The gentleman yields back. I thank him for his questions. I don't see any other Members at this time that I can recognize from either side of the aisle.

So I want to once again thank this panel of witnesses for your testimony today and, of course, our colleagues that headed up the hearing from the territories. We appreciate each one of you and your sharing your—you know, answering the Members' questions. Hearings are very important, and we always learn from them.

I am going to submit the—

VOICE. There's over 30 documents.

Ms. ESHOO [continuing]. Over 30 documents. They are statements for the record. And I want to ask my colleague, the ranking

member of the subcommittee, if he would grant a unanimous consent request that those be—those statements be placed in the record, so we don't have to read 30 of them——

Mr. GUTHRIE. Yes, ma'am. No objection.

Ms. ESHOO [continuing]. With you.

Mr. GUTHRIE. No objection, yes.

Ms. ESHOO. Thank you. Thank you.

[The information appears at the conclusion of the hearing.¹]

Ms. ESHOO. Pursuant to committee rules, Members have 10 business days to submit additional questions for the record, and I am sure that the witnesses will respond promptly to any questions that you receive. It is a very important part of our hearing process.

And at this time, the subcommittee is adjourned. Thank you, everyone.

[Whereupon, at 3:16 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

¹One document, an Army Corps of Engineers report, has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-20210317-SD018.pdf>.



Senator Justo S. Quitugua, M.Ed.

Chairman: Health, Education, and Welfare

Chairman: Resources, Economic Development and Programs

Vice President of the Senate

22nd Northern Marianas Commonwealth Legislature – The Senate
P.O. Box 500129, Saipan, MP 96950 Telephone No. (670) 664-8874/76

March 16, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health

Dear Congressional Leaders:

Averting A Crisis: Protecting Access to Health Care in the U.S. Territories

The Commonwealth of the Northern Mariana Islands (CNMI) Legislature became aware that an important hearing on “Averting A Crisis: Protecting Access to Health Care in the U.S. Territories” is planned for March 17. We, the undersigned representatives of the House of Representatives of the CNMI Legislature, would like to offer testimony on the matter.

It is vitally important that our Territory be funded in the same way as States and for the Medicaid eligible U.S. citizens of the Territory to be treated no different than any other Medicaid eligible citizens in the States.

The House Health Committee description of the hearing – “The U.S. territories are once again facing a fiscal cliff that, if crossed, would endanger access to health care services for millions of Americans” and that “Congress has a responsibility to ensure that the Medicaid programs in the territories continue to receive the resources and support they need to care for their residents. This is especially critical right now as they work with limited resources to respond to the COVID-19 pandemic” – is absolutely correct and the CNMI Legislature encourages the U.S. Congress to correct the inequities between States and Territories in the Medicaid program.

In testimony before Congress on the Medicaid Fiscal Cliff by the Medicaid and CHIP Payment and Access Commission (MACPAC), the major differences between the States and Territories is in the financial treatment.

The funding levels in Section 1108 of Title XIX, as shown in the latest report of the Medicaid and CHIP Payment and Access Commission (MACPAC) reported in February 2021 shows the extent to which the section 1108 caps are insufficient to meet the needs of health care for the Medicaid population in the Territory. Further, it is vitally important that the Congress apply the Federal Medical Assistance Percentage (FMAP) using the same formula that is applied

to determination of the FMAP for States. The elimination of the section 1108 cap and the application of the same methods of Medicaid financing will help to enable the Medicaid program in the CNMI to provide the same level of care and services to the Medicaid eligible citizens in the states, ensure that the health system and providers are reimbursed appropriately for the care provided, and enable the Commonwealth Medicaid Agency to plan and manage the program. The House of Representative of the CNMI sincerely hopes that the U.S. Congress will correct the unequal treatment.

Our Legislature became well-informed of the Medicaid program over the past three years as a result of a major typhoon in 2018 that devastated the island and its tourism-based economy, the depletion of the additional budgeted amounts under the Patient Protection and Affordable Care Act (ACA), and the emergence of the COVID-19 pandemic and attendant economic consequences.

The Legislature, in 2019, saw the monumental importance that the U.S. Congress was holding first-time hearings to address the “Medicaid Fiscal Cliff” resulting from the inequity in the way Medicaid is financed between States and Territories. The Legislature further recognized that the Territory would fairly expect to administer and manage the Medicaid program as the States do.

In 2019, the CNMI Legislature

“The Legislature further finds that the U.S. Congress may require that the Commonwealth Medicaid program to submit data to the "Transformed Medicaid Statistical Information System" and establish a Medicaid Fraud Control Unit as a condition to the increased funding for the Medicaid program. To achieve this objective, the Medicaid Agency may need to fully implement a "Medicaid Management Information System" as all other states and the U.S. territories of Puerto Rico and the Virgin Islands have already accomplished.

...

Accordingly, the purposes of this legislation are to: (a) recognize, establish, and organize the Medicaid Agency as an agency in the Executive Branch of the CNMI; (b) direct the agency to plan, design, implement, and operate Medicaid Enterprise Systems that includes, among others, the ability to efficiently and effectively process claims for Medicaid services and submit data to the T-MSIS or replacement system as may be required; (c) establish a claims and clinical data warehouse, and promote health information exchange; and, (d) provide a community health record system that would enable beneficiaries to see their medical information.

The Legislature unanimously passed SB 21-28 and the Governor signed the bill into law as PL 21-28 on May 22, 2020.

Further, in the FY 2020 budget appropriations law (PL 21-35), the Legislature specifically established a “MES and Compliance” budget code into the Medicaid budget to highlight the importance of compliance and the need to make reasonable and appropriate

progress to implement Medicaid Enterprise Systems and submit data to the T-MSIS system. The Legislature further provided the authority for the Medicaid Director to transfer appropriations among the Administration, Medical Payments, and MES and Compliance budget categories so that there is some flexibility given the austere budget resulting from the COVID-19 economic impacts.

Our Legislature clearly understands the importance of the Medicaid and CHIP programs to the health care of our citizens and is fully committed to ensuring that our Commonwealth Medicaid Agency will administer, manage, and further develop the program to provide the highest quality of care and manage the costs of the program.

Our Legislature requests that the U.S. Congress rectify the long-standing inequity in the financing of the Medicaid program between the States and Territories so that the CNMI and U.S. Territories and citizens do not fall off the Medicaid Fiscal Cliff. The summary testimony by MACPAC in 2019 summarizes the centrality of the issue well.

“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.”¹ [Underscore added for emphasis.]

On behalf of the 2nd CNMI Senate Standing Committee on Health, Education, and Welfare members, I respectfully request that the U.S. Congress provide parity in the program by eliminating the section 1108 budget caps and enable the Federal Medical Assistance Percentage to be calculated in the same way as other states.

Respectfully,



Justo S. Quitugua
Chairman

¹ 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.



Commonwealth of the Northern Mariana Islands
Office of the Governor
Commonwealth Medicaid Agency

March 15, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health

Subject: U.S. House of Representatives Committee on Energy and Commerce Hearing “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”

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

The Commonwealth of the Northern Mariana Island (CNMI) is grateful to the U.S. House of Representatives Committee on Energy and Commerce and heartened with the Committee hearing notice that recognized:

“The U.S. territories are once again facing a fiscal cliff that, if crossed, would endanger access to health care services for millions of Americans.” Pallone and Eshoo said, “Congress has a responsibility to ensure that the Medicaid programs in the territories continue to receive the resources and support they need to care for their residents. This is especially critical right now as they work with limited resources to respond to the COVID-19 pandemic. Next week we will hear from policy experts as we consider legislation to avert the looming fiscal cliff and ensure that the territories can continue to provide medical care to those in need.”¹

The Commonwealth Medicaid Agency (CMA) is submitting testimony on behalf of the CNMI and will provide a quick summary of the Medicaid Fiscal Cliff and what it means for the U.S. citizens in the Territory, describe some of the program initiatives that CNMI has undertaken to comply with provisions of the Further Consolidated Appropriations Act, 2020 (PL 116-24), and more broadly discuss program improvements the CNMI would like to undertake given a fair, firm, and predictable financial base. However, before doing so, I would like to further express our very deepest appreciation, on behalf of the CNMI, for the Congressional actions in calendar years 2019 and 2020. There are truly no words to fully communicate our profound gratitude for the response of the Congress to Medicaid and health care challenges of the smallest U.S. Territory.

My testimony offered today is based on the belief and premise that the U.S. citizens of the CNMI are Americans and should be treated and provided the same opportunity to receive Medicaid services as any other American in

¹ House of Representatives Committee on Energy and Commerce. (2021, March 10). E&C Announces Hearing On Medicaid In The U.S. Territories. [Press release]. <https://energycommerce.house.gov/newsroom/press-releases/ec-announces-hearing-on-medicaid-in-the-us-territories>. Note: underscores and italics for all cited references may be added for emphasis.

the States. All Americans should be treated the same, whether the U.S. citizen lives in an Insular Territory or a State.

The Major Difference in the Medicaid Program in the States and Territories

The Medicaid and CHIP Payment and Access Commission (MACPAC) testimony to Congress in 2019 provides insight on the Medicaid Fiscal Cliff. The MACPAC testimony directly identifies the challenges of the CNMI and all Medicaid programs in U.S. Territories that result from the difference in the financing of the Medicaid program between the States and Territories. The MACPAC states that:

“... [T]he 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, and 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.

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.”²

The CNMI implores the U.S. Congress to address the chronic underfunding of the program as described in the MACPAC testimony to Congress in 2019. In doing so, the Territory Medicaid programs will be positioned to focus attention on how the Medicaid program can make improvements to improve care, population health and lessen the overall cost of Medicaid care. Today, again, it is impossible to do so because the CNMI is unable to predict whether a Medicaid Fiscal Cliff will materialize in FY 2022 or beyond. The CNMI Medicaid program is unable to explore innovations implemented in States and waiver program opportunities because of the Section 1108 ceiling. The Section 1108 ceiling results in the territories unable to plan for programs like States and are instead like a “Sword of Damocles” that hangs over the CNMI and all Territories.

The Medicaid Program in the CNMI

The Commonwealth of the Northern Mariana Islands is located in the western Pacific Ocean and became a U.S. Territory in 1978. In 1979, the Commonwealth Medicaid program was established within the then Department of Public Health. In 2011, the Department of Public Health became the Commonwealth Healthcare Corporation, a public corporation. The CHCC is unique in that the public corporation is not only responsible for delivering care through the single hospital on the island of Saipan, and clinics on the two largest islands of Tinian and Rota; but, the CHCC is also the Public Health agency that is normally a direct function of State and County governments.

² "Strengthening Health Care in the U.S. Territories for Today and Into the Future", 116. 1 (2019) (Anne L. Schwartz).

To ensure no conflicts of interests in having the provider of services and also be the Medicaid Payer of services provided, the Medicaid Program was transferred as an agency under the Office of the Governor in 2011.

The CMA administers the Medical Assistance Program under Title XIX and the Children's Health Insurance Program under Title XXI and under CNMI Public Law 21-28.

Medicaid Enrollment in the CNMI Before and After the COVID-19 Pandemic

The enrollment in the Medicaid program prior to the coronavirus (COVID-19) pandemic was approximately 16,000 in 2018. The total U.S. citizen population in the CNMI is approximately 37,899 people and has a total Territory population of 51,994 in 2018.³ The Medicaid program, in 2018, shows the Medicaid population, prior to the COVID-19 was approximately 42% of the U.S. citizens in the Territory and 31% of the total population of the CNMI. The Medicaid program provides essential health care services to a large percentage of the U.S. citizens in the CNMI population, similar to other State Medicaid programs in the U.S. Territories. Given the large population that is enrolled in the program (pre COVID-19), there can be no misunderstanding of the importance of the Medicaid program to the Medicaid members and the overall healthiness of the health system in the CNMI.

Figure 1, below, shows the enrollment in the Medicaid and CHIP program and the increased enrollment under the COVID-19 pandemic following the declaration of a Public Health Emergency (PHE) and the program rules established by the CMS for "Presumptive Eligibility" (PE). The CMS authorized the Commonwealth Healthcare Corporation (CHCC) as a "qualified entity" to screen for PE eligibility and immediately enroll individuals who meet the Medicaid eligibility income criteria.

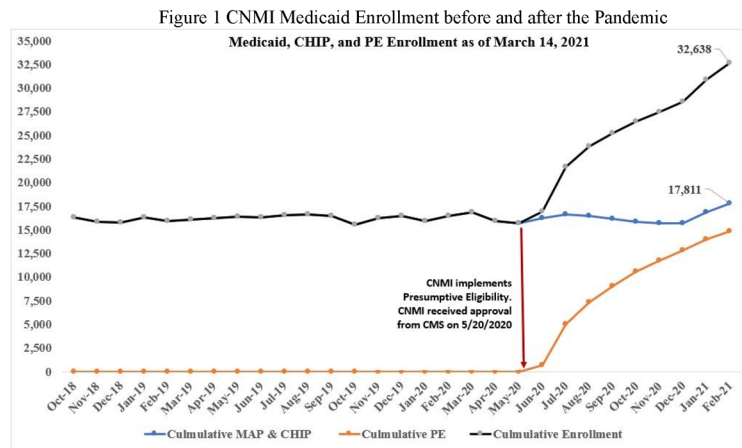


Figure 1 shows the total number of both Medicaid/CHIP and PE enrollment has led to an increase in the covered Medicaid population to 32,638. The Medicaid enrollment represents approximately 63% of the total

³ United States Government Accountability Office, 2020. *Commonwealth of the Northern Mariana Islands: Recent Economic and Workforce Trends*.

population.⁴ Fortunately, under the Coronavirus Relief Act, additional relief was provided; and, although the total federal expenditures in the CNMI for Medicaid is very small, the inclusion of the Territory as part of the Coronavirus Relief Act, with no differentiation between the Territory and States, was so welcome.

Further, the data shows the importance of having the federal funding be adjusted based on the actual eligibility, enrollment, and services provided by the Medicaid program. All States and Territories wish there will never be pandemics or other natural or economic disasters that will cause spikes in Medicaid enrollment and/or needed services. However, Figure 1 illustrates the importance of removing a fixed cap and having the federal share be based on the enrollment and services provided by the Medicaid program.

When there are no disasters and/or the economy is good, the Medicaid enrollment and services will naturally be lower and require less funding. When there may be a natural disaster or an economic downturn that results in an increase in enrollment and required health care services, the health care spending should increase based on the enrollment and services. The automatic adjustments exist for States under Title XIX but not the Territories, resulting in the need for additional specific appropriations by Congress.

Medicaid Spending within the CNMI

The single largest amount of total spending by the Medicaid program is paid to the Commonwealth Healthcare Corporation (CHCC), the public health care system corporation. The CHCC operates the only hospital in the territory, ancillary clinics and services on the islands of Saipan, Tinian and Rota.

There are only 39 facility providers registered as Medicaid providers in the CNMI. There are also 71 off-island health care providers registered with the Medicaid program in Guam, Hawai'i, California and elsewhere. The CNMI Medicaid program refers care to other specialized providers for tertiary and other specialty care that is not available within the CNMI. The cost of services that are unable to be provided within the CNMI is high due to the cost of the types of services provided, the cost of transportation and lodging, and other expenses related to off-island transport and care services. The CHCC health system is making progress to improve the specialty care services and has demonstrated the importance of on-island care in lessening the overall cost of health care. However, recent on-island specialty care (e.g., cardiology, advanced radiology) could collapse without appropriate Medicaid program funding.

Program Administration Requirements for the CNMI Medicaid Program

While the funding is not the same as States, the CNMI Medicaid and CHIP programs in the Territory operate under the same law, regulations, and policies and procedures as States. The health care eligibility and services are defined in the Medicaid State Plan Amendments (SPA) and are administered no differently for Territories than the States.

The CNMI is subject to the same process and substantive requirements of Title XIX and CMS rules and regulations. The CNMI SPA that authorizes eligibility, services that will be covered, and administrative procedures is submitted by the CMA and reviewed and approved by the CMS. The SPA describes the covered mandatory and optional services in the Territory and other program administration and management rules and operations. There is some discretion within Title XIX and other health care laws, for example, for the Territory to establish the level of the Modified Adjusted Gross Income (MAGI) level for the cut-off of eligibility. However, the same authority to select a threshold is provided to all other States and Territories.

⁴ The increase is a function of "presumptive eligibility" (PE) rules that will remain in effect until end of the Pandemic Health Emergency. The data is based on the determinations by the CHCC and data provided. There may be some differences in the final counts between the PE and regular Medicaid enrollment resulting from the PE rules that continue Medicaid coverage as well as some cases of dual enrollment. Under PHE, the coverage is for all that are legally present in the United States. To be eligible under PE, the applicant must still meet the income criteria.

The CMA, together with American Samoa, does operate under a Title XIX Section 1902(j) waiver which provides for the Secretary of the Department of Health and Human Services (DHHS) to waive certain program requirements. However, the waiver does not apply to the Section 1108 budget caps or the Federal Medical Assistance Percentage (FMAP). Further, the CNMI, has not requested/received a 1902(j) waiver for program operations to date.

The Section 1902(j) waiver has never been invoked by the CNMI Medicaid but must remain because there may be some circumstances where the smallest U.S. Territory may need some relief from some requirements. For example, there is a CMS requirement that all States and Territories implement an Electronic Visit Verification (EVV) System to validate claims for Personal Care Services (PCS) by January 2020. The CNMI Medicaid State Medicaid Plan explicitly states that PCS is not covered. However, in recent discussions with CMS, a clarification was provided that the Early Periodic Screening and Diagnostic Treatment (EPSDT) may include PCS services. Since the EPSDT is mandatory, a question has been raised as to whether PCS services should be covered; and, if so, then the CMA may require an “EVV” system. The CMA is in the process of identifying the population that may require this service; but, it is anticipated to be very small. The CMA will discuss the matter with CMS and depending on the circumstances, may request a Section 1902(j) waiver.

The Section 1902(j) recognizes that some requirements may not be fully applicable or reasonable for the two smallest U.S. Territories. The process would require the CNMI to request a specific waiver and for the Secretary of DHHS to approve the request. The main point is that the CMA is administered and managed under Title XIX CMS rules and regulations no differently than States. The major difference between the States and Territories, as described in the MACPAC testimony to Congress, is in the funding of the Medicaid program.

CNMI and Territory Medical Assistance Program Expenditures

In February 2021, MACPAC issued a report on Medicaid and CHIP in the Territories which illustrates the inadequacy of Section 1108. Table 1 below, obtained from the MACPAC report and clearly shows how much funds would have been available to the CNMI under the Section 1108 budget ceiling.⁵

Table 1 MACPAC Territory Section 1108 Allotments FYs 2019-2022 (Millions)

Territories	2019	2020		2021		2022 ¹
		Without P.L. 116-94, FFCRA	Current law	Without P.L. 116-94, FFCRA ¹	Current law	
American Samoa	\$12.2	\$12.4	\$86.3	\$12.7	\$85.6	\$13.0
CNMI	\$6.7	\$6.9	\$63.1	\$7.1	\$62.3	\$7.2
Guam	\$18.0	\$18.4	\$130.9	\$18.8	\$129.7	\$19.2
Puerto Rico	\$366.7	\$375.1	\$2,716.2	\$383.7	\$2,809.1	\$392.5
USVI	\$18.3	\$18.8	\$128.7	\$19.2	\$127.9	\$19.6

[Colored borders added]

As shown in the last column in Table 1, page above, for the CNMI, the Section 1108 ceiling will be only \$7.2 million for FY 2022. This clearly illustrates how the caps are insufficient to meet the needs of the CNMI today.

The key data for the CNMI in the MACPAC table shows amounts that the Section 1108 caps in FY 2019 would have provided to the Territory. The Additional Supplemental Appropriations for Disaster Relief Act, 2019 (PL 116-20) are not reflected in Table 1, previous page, however, is depicted in Table 2 below. Table 2 was obtained from the MACPAC 2021 Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands.⁶

⁵ Medicaid and CHIP Payment and Access Commission, 2021. *Medicaid and CHIP in the Territories*. The table is actually Table 2 from the MACPAC report.

⁶ Medicaid and CHIP Payment and Access Commission, 2021. *Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands*. This table is actually Table 1 in the MACPAC report.

For FY 2020 and FY 2021, the amount for the CNMI under Section 1108 would have only been \$6.9 Million and \$7.1 million, respectively. The table further show the amounts from the Further Consolidated Appropriations Act, 2020 and the Families First Corona Virus Response Act.

Table 2 MACPAC Medicaid Funding and Spending in CNMI FYs 2011–2020, by Source of Funds

Year	Medicaid			
	Section 1108 allotment	Federal spending	CNMI spending	Total spending
FY 2020	\$63.1	\$39.1	\$3.6	\$42.7
FY 2019	\$6.7	\$49.8	\$10.4	\$60.2
FY 2018	\$6.6	\$25.0	\$20.0	\$45.0
FY 2017	\$6.3	\$17.0	\$13.4	\$30.4
FY 2016	\$6.1	\$20.6	\$16.0	\$36.6
FY 2015	\$6.0	\$16.2	\$12.2	\$28.4
FY 2014	\$5.9	\$19.7	\$15.7	\$35.4
FY 2013	\$5.6	\$16.4	\$13.4	\$29.8
FY 2012	\$5.5	\$13.8	\$11.3	\$25.1
FY 2011	\$6.5	\$14.3	\$12.6	\$26.9

Note: CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. Section 1108 allotments reflect the annual federal allotments (also referred to as caps) that territories receive under Section 1108(g) of the Social Security Act. Federal spending in excess of the Section 1108 allotment for FYs 2011 – 2019 reflects utilization of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) and the Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L. 116-20), as well as spending not subject to the caps. 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. CNMI received these redistributed funds in FYs 2016–2018 and again in FY 2020.

Without the passage of the 2019 Congressional legislation that addressed the completely inadequate funding under Section 1108, all Territories would have seen a collapse in the Medicaid program. The clear result would have been that Americans in the Territories have been dropped from the program or receive substantially less care with undoubtedly some deaths and would have crippled the health care providers in the Territories. An alternative could have been that the Territories assume the 100% cost of the Medicaid program. However, that alternative would have led to a financial disaster for the Territories that already struggling with financial challenges resulting from natural disasters.

Impacts of Section 1108 in 2019

The Patient Protection and Affordable Care Act (PPACA) also recognized the problems of the Section 1108 budget caps and provided a one-time increase to supplement the Section 1108 budget ceiling. While the amounts provided under the PPACA were a welcome relief, the funding under the PPACA was set to expire on September 30, 2019; and, again, in fact, both the Section 1108 and PPACA funds were completely depleted by March 30, 2019, *six full months before the expiration date of PPACA funding and the Section 1108 ceiling in September 30, 2019.*

The CMA operates in constant terror that the Congressional cap will not be sufficient for the Medicaid program expenditures for a future year. As such, it is difficult to plan for expanding health access to services that are authorized under Title XIX when the threat of not having sufficient funding under the Congressional cap to be able to cover current services and when the Medicaid program would have to either eliminate current services and/or restrict eligibility.

When the Medicaid funds were exhausted, the Commonwealth Medicaid Agency (CMA) had no choice but to *sadly inform Medicaid enrollees and health care providers that health care services* could only be obtained from the Commonwealth Healthcare Corporation (CHCC), the public safety-net health system. At the same time, *the Medicaid program informed the CHCC that without Congressional action, the Medicaid program*

would not be able to reimburse the CHCC for the health care provided to the Medicaid beneficiaries. Further, the CMA engaged in the heart wrenching exercise of trying to plan whether the Medicaid program would cut services severely or limit participation in the Medicaid program and even wondered if it was legally permissible under Title XIX and whether or not implementing any such measures would have made the program not compliant with Title XIX.

During the time when the CMA ran out of funds in March 2019, a CHIP beneficiary, a young child had been receiving off-island specialized hospital care. The care was so critical for the CHIP beneficiary that Medicaid program had already paid \$1 million for care. Medicaid allowed the child to receive treatments and the health condition of the child was improving, but the child still needed additional care. The Medicaid program struggled with wondering whether the Medicaid program would need to inform the low-income parents that there was no more funding and to seek charity care from the hospital. Further, the Medicaid program wondered if the private hospital would remain a Medicaid provider if the CNMI could not pay for its services. These challenges are the result from the inequities in the financial structure of the Medicaid program between States and Territories.

Congress in 2019 and 2020

The U.S. Congress, fortunately, recognized the imminent and dire predicament of the U.S. citizens and other eligible Medicaid populations in the CNMI, and with other U.S. Territories and:

- Provided Medicaid Disaster Assistance following Typhoon Yutu, a Category 5 typhoon, that was needed because the Section 1108 caps and increases from the Patient Protection and Affordable Care Act were depleted 6 full-months before the end of the fiscal year;
- Passed the Further Consolidated Appropriations Act, 2020 that addressed, at least temporarily, the Medicaid Fiscal Cliff by increasing the Section 1108 Medicaid Assistance Program funding level to \$60 million for FY 2020 and FY 2021 and enabled the FMAP to be calculated in the same way as the States; and,
- Provided, under the Families First Coronavirus Relief Act (FFCRA), assistance for the all States and Territories, and included the CNMI, to address the needs of the medically indigent during the period of the COVID-19 Public Health Emergency (PHE). Specifically, the Congress temporarily increased the FMAP for all States and Territories by an additional 6.2% and provided an increase of \$3.2 million for the Commonwealth Medicaid Agency.

The much-needed Congressional action enable the CNMI climb up to a ledge on the Medicaid Fiscal Cliff and have a brief respite from the terror. Unfortunately, the CNMI remains on the Medicaid Fiscal Cliff and the health of our Medicaid beneficiaries and health care system remains in serious peril. We, again, implore the Congress to establish parity and enable Americans in the CNMI not to lose the much-needed medical assistance.

Progress on Compliance with the Further Consolidated Appropriations Act

The CMA has submitted the first Annual Report for FY 2020 to the Chairs of the House of Representatives and Senate Health Committees. The CNMI will submit a second report later this year as required by Congress.

The Commonwealth Medicaid Agency *fully understands, and is committed to, meeting the requirements of the U.S. Congress.* The CNMI takes very seriously its fiduciary responsibility to effectively administer the program; guard against Medicaid Fraud, Waste, and Abuse; and, to diligently manage the program to identify and implement opportunities to improve the system of care for Medicaid members and lessen the cost of the Medical Assistance Program.

The Consolidated Appropriations Act FY 2020 required the CNMI to:

- Make reasonable and appropriate progress to submit data to the T-MSIS;
- Designate a Program Lead for Program Integrity;
- Establish a Medicaid Fraud Control Unit; and;
- Submit an annual report to the Chairs and Ranking Members of the U.S. Congress Committees with jurisdiction over health.

The Commonwealth Medicaid Agency is fully committed to complying with all requirements in Title XIX, CMS program rules and regulations, and takes its responsibility seriously. The following briefly summarizes the commitment, efforts, and progress of the CNMI to meet the requirements of the Further Consolidated Appropriations Act, 2020.

Data Submission to the Transformed Medicaid Statistical Information System

The Commonwealth Medicaid Agency is well-aware of and has wanted to implement a Medicaid Management Information System (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 had not yet initiated the planning and implementation of a full MMIS is based on the fact that if the increased funding under the Patient Protection and Affordable Care Act ended, the CNMI Section 1108 budget cap, together with the CHIP funding, would only be around \$18.24 million. MMIS systems that transmit data to the CMS T-MSIS data warehouse cost over \$10 million dollars for medium sized states and more than \$100 million for the largest states per year. The CMA wondered whether the cost of such MMIS systems would have been highly disproportional to the actual federal funding levels for the Medical Assistance Program and raise different questions on the “high costs to ‘administer’ the program.

Notwithstanding these concerns and based on the passage of the Further Consolidated Appropriations Act, 2020, the CMA submitted to and received approval from the CMS to conduct the planning based on exploration of “reuse” of existing systems that may have already been developed with federal funds, partnerships with other states, and other models to lessen the costs of the MMIS.

The Legislature unanimously passed SB 21-28 and the Governor signed the bill into law as PL 21-28 on May 22, 2020. PL 21-28 states that:

“Accordingly , the purposes of this legislation are to: (a) recognize, establish, and organize the Medicaid Agency as an agency in the Executive Branch of the CNMI; (b) direct the agency to plan, design , implement, and operate Medicaid Enterprise Systems that includes, among others, the ability to efficiently and effectively process claims for Medicaid services and submit data to the T-MSIS or replacement system as may be required; (c) establish a claims and clinical data warehouse, and promote health information exchange; and, (d) provide a community health record system that would enable beneficiaries to see their medical information.”

Further, in the FY 2020 budget appropriations law (PL 21-35), the Legislature specifically established a “MES and Compliance” budget code into the Medicaid budget to highlight the importance of compliance and the need to make reasonable and appropriate progress to implement Medicaid Enterprise Systems (MES) and submit data to the T-MSIS system. The Legislature further provided the authority, in September 2019, for the Medicaid Director to transfer appropriations among the Administration, Medical Payments, and MES and Compliance budget categories so that there is some flexibility given the austere budget resulting from the COVID-19 economic impacts.

PL 21-35 specifically states that:

“(f) Medicaid Program. The funds appropriated in this Act for the Medicaid Program, including Medicaid Reimbursement – business unit 1951, Medicaid Administration business unit – 1980, and the new business unit for Compliance and Medicaid Enterprise Systems (MES) shall be deemed a single budget reserved for the purposes of Medicaid Administration, Medicaid Reimbursement, and Compliance and Medicaid Enterprise Systems. *The Director of the Commonwealth Medicaid Agency may reallocate the funds appropriated in this Act to any of the expenditure categories, including, but not limited to, Administration, Reimbursement, and Compliance and Medicaid Enterprise Systems*”

The Legislature unanimously passed SB 21-28 and HB 21-124 the Governor signed the bill into law and illustrates the policy-level involvement and oversight to ensure that the CNMI will make “reasonable and appropriate” progress to improving on its current Eligibility and Enrollment (E&E) and implement a MMIS with full capabilities to submit data to the T-MSIS system. The provision enables the CMA to prioritize Compliance and Medicaid Systems even to the point of deferring a payment to providers for a period but within the authority provided under law and the Medicaid State Plan Amendments.

CNMI Medicaid Claims Data Warehouse

The CMA understands that program management and improvements rely on healthcare data to understand health care costs, the quality of care by providers, population health disparities, and service gaps for the members. The CMA submitted and the CMS approved, in FY 2020, an Implementation Advanced Planning Document (IAPD) to initiate the collection of the claims data file electronically in a secure data enclave and to conduct data management and initiate the data analysis to assess the comparative costs of care, quality of care, gaps in services, and other purposes. These activities demonstrate the CNMI commitment to effectively administer the Medicaid program, even with the limited resources and the major challenges the CMA confronts on a daily basis to improve the care of our U.S. citizen members.

The CNMI policymakers, in 2019 and 2020, as described below, recognized the importance of these efforts, the requirements of the Further Consolidated Appropriations Act, 2020 and passed legislation that provides guidance and the required matching funds for Medicaid Enterprise Systems/MMIS/T-MSIS, Medicaid Fraud Control Unit activities, and other purposes.

Designation of Program Integrity Lead and Medicaid Fraud Control Unit

The CMS acknowledged the CMA designation of a Program Integrity Lead on June 26, 2020. The CNMI Medicaid Agency and Commonwealth is fully committed to program integrity in the Medicaid program and has designated a Program Integrity Lead as required by the Centers for Medicare and Medicaid Services. The CMA has further executed a Joint Operating Agreement (JOA) with the CMS Unified Program Integrity Contractor-West (UPIC-West). The JOA was fully executed on August 17, 2020 and the CMA has received training from both the UPIC-West and CMS. The CMA has also provided the UPIC with claims data from the CHCC and will be submitting a full copy of the Eligibility and Enrollment system and data since the system was initially used. Finally, the CMA has also consulted with the Office of the Attorney General as the independent Medicaid

Fraud Control Unit and will execute a Cooperative Agreement following consultation with the CNMI Legislature.

Response by Congress in 2019

The issue of the Medicaid Fiscal Cliff came to the forefront in 2019 when the additional Medicaid funding provided under the Patient Protection and Affordable Care Act was set to expire on September 30, 2019. The CNMI fell off the Medicaid Fiscal cliff when the Medicaid funds were completely expended in March 2019. With six months left in the fiscal year, the Commonwealth Medicaid Agency informed the beneficiaries to seek care from the Commonwealth Healthcare Corporation (CHCC), the public health system in the CNMI. Concurrently, the Medicaid program informed the CHCC and the private providers that there were no further funds for reimbursements. In 2019, the U.S. House of Representatives held the “Strengthening Health Care in the U.S. Territories for Today and Into the Future” hearing on the Medicaid Fiscal Cliff for the U.S. Territories. The hearings provided a critical first-time ever opportunity for the CNMI, as the smallest U.S. Territory, to offer direct testimony to Congress on the Medicaid program.

The hearings provided the opportunity to provide testimony and share information on the nature, urgency, and impacts of the “Medicaid Fiscal Cliff” on U.S. citizens and the health care system of the CNMI. We were very *heartened* that the Committee of Jurisdiction over the Medicaid program recognized that the U.S. Territories were “on the verge of a humanitarian and financial crisis if the U.S. Congress doesn’t act swiftly to increase their Medicaid funding for next year and beyond.”⁷

The U.S. Congress responded to the issues of the Medicaid Fiscal Cliff with the passage of the Additional Supplemental Appropriations for Disaster Relief Act, 2019 and the Further Consolidated Appropriations Act, 2020. The relief enabled the CNMI to fall on a ledge and not over the cliff.

Request to Establish Parity and Desire to Implement Program Improvements

The CNMI respectfully requests the U.S. Congress to treat fairly the U.S. citizens of the Territory and to establish parity in the financing of the Medicaid program between the States and Territories. By providing parity in the Medicaid program with the States, the CNMI will avert the FY 2022 “Medicaid Fiscal Cliff” and provide the CNMI the financial stability to move forward to improve care and ultimately bend the cost curve in the growth of health care costs with use of innovations and programs using the best practices from other States and Territories. The Insular Area Parity Act would help to achieve that equality.

Parity is further required so that the CNMI is able to make improvements in the Medicaid program. For example, the CNMI, as a community, has been greatly concerned with diabetes, obesity, and Non-Communicable Diseases (NCDs). In 2013, responding to the concerns of the CNMI community, the Governor of the CNMI declared NCDs an emergency and established a Commission to develop an Integrated Plan of Action for dealing with NCDs in the CNMI.

The plan called for a “‘whole of society’ approach resulting from estimates by public health and health care specialists that 7 out of every 10 deaths in the CNMI were attributed to or complicated by NCDs and/or NCD risk factors. During this time, CHCC Dialysis Center had just reported a “126% increase in newly registered renal dialysis patients in 2012 compared to the previous year; with majority of the patients having Diabetes Type II and hypertension; majority are of Chamorro and Carolinian descent, the indigenous people of the Northern Marianas; and wherein CHC, the only hospital in the CNMI, is one of two renal dialysis center sites on the island of Saipan; As of January 2013, CHC reported a total of 107 renal dialysis patients at the Dialysis Center. In 2008, 45% of our 7-10 year old children were found to be obese or overweight.”⁸ The CNMI

⁷ Helen Sablan, Testimony to U.S. House of Representatives Committee, June 20, 2019.

⁸ Governor Eloy Inos, Administrative Directive No.6, Non-Communicable Disease Emergency Directive, April 18, 2013.

Directive was one of many issued by leaders in the Pacific region that that declared NCDs and diabetes and obesity of the a serious crisis in the Pacific.

In 2015, the CNMI was fortunate to receive a competitive planning grant under the CMS State Innovation Model (SIM) funding program. A major recommendation of the stakeholders was to develop a “diabetes prevention and management program” that would be established from a CNMI partnership of public health specialists, providers, schools, and other regional health care specialists to focus on diabetes education and prevention and establish a care management program to improve care, care coordination, patient and public health outcomes, and to lessen the costs of care.

The Commonwealth Medicaid Agency, when asked by visiting external Subject Matter Experts to consider developing a Medicaid waiver program to organize and coordinate a diabetes prevention, control, and management program for Medicaid members, the CMA explained that the limitations of the annual funding prevented any possibility of a multiyear waiver program focused on prevention and diabetes management to lessen the short and long-term costs of NCD and comorbidities.

Given the high prevalence and continued high levels of incidence of NCDs, and coupled with the high costs of care such as dialysis, the Commonwealth Medicaid Agency commits to addressing diabetes, obesity, and related comorbidities should the Section 1108 caps be lifted and FMAP established using the same formula as states. Even if years later, the CMA and CNMI community strongly wants to work on this diabetes prevention and management program; and, should the Congress equalize the financing of the Territories with the States, the CNMI will! However, without parity in the needed Medicaid financing, proposing implementation such a waiver program, even to lessen costs, is not possible. This is only one of many evidence-based innovations from the best practices of other State Medicaid programs that cannot even be attempted today. The CNMI is committed to improving care and population health outcomes of Medicaid members; improving program administration and management to lessen costs; and, protect against fraud, waste, or abuse.

Summary

The Commonwealth of the Northern Mariana Islands and the other U.S. Territories will fall over the Medicaid Fiscal Cliff and plummet into a humanitarian and fiscal crisis without intervention from the U.S. Congress. The U.S. citizens of the Commonwealth Medicaid Agency are huddling on the ledge today and hopeful that the U.S. Congress will reveal and provide a path up the cliff. The Medicaid program is critical to the health of the U.S. citizen Medicaid beneficiaries and to the health system of the CNMI for today and into the future.

The CNMI pleads with the U.S. Congress to treat the citizens in the Northern Mariana Islands the same as citizens in the States. Specifically, we request that Congress extend to the Territories the same terms and conditions as applied to the States. The funding provided in the Further Consolidated Appropriations Act, FY 2020, provides a useful understanding that eliminating the caps in Section 1108 and applying the same program rules and FMAP to the Territory would address a long-standing disparity and enable the program to focus on program improvements and services, all of which are not available to the CNMI today.

The Commonwealth of the Northern Mariana Islands respectfully request that Congress consider clarifying the definition of “state” in Title XIX be defined to read “state is defined to include states, the district of columbia, and territories.” The definition of state to include the Territories would resolve the long-standing inequity and establish parity, eliminate the need for the Section 1108 caps, and enable the FMAP for the Territories to be calculated in the same way as States.

We are hopeful that Congress will correct the inequities and provide parity and fairness among the States and Territories in 2021. Before closing, the CNMI would like to express its appreciation for the passage of the American Rescue Plan Act of 2021, PL 117-2. We believe that this will help to address the COVID-19

pandemic and will enable the CNMI to recover from the depressed economy and alleviate the human distress throughout the United States.

Thank you once again for holding a hearing on the challenges of the Territories and for inviting and enabling the Commonwealth Medicaid Agency to submit testimony. Should there be any questions, please do not hesitate in letting us know.



THE UNITED STATES VIRGIN ISLANDS
OFFICE OF THE GOVERNOR
GOVERNMENT HOUSE
Charlotte Amalie, V.I. 00802
340-774-0001

March 16, 2021

The Honorable Frank Pallone
Chairman
House Energy and Commerce Committee
Room 2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Ranking Member
House Energy and Commerce Committee
Room 1035 Longworth House Office Building
Washington, DC 20515

The Honorable Anna G. Eshoo
Subcommittee Chair
House Energy and Commerce Committee
Room 202 Cannon House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Subcommittee Ranking Member
House Energy and Commerce Committee
Room 2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Stacey E. Plaskett
Member
US House of Representatives
331 Cannon House Office Building
Washington, DC 20515

Dear Chairman Pallone, Ranking Member McMorris Rodgers, Subcommittee Chair Eshoo, Subcommittee Ranking Member Guthrie and Delegate Plaskett:

On behalf of your fellow citizens in the U.S. Virgin Islands (USVI), thank you for your leadership and support in providing the USVI the federal resources needed for our Territory health care system to recover from the significant challenges faced after the 2017 hurricanes and addressing the impacts of the current COVID-19 pandemic. The legislative actions like the Affordable Care Act, the Bipartisan Budget Act of 2018, the Further Consolidated Appropriations Act of 2020, and the various COVID-19 relief measures have provided significant temporary increases in Federal Medicaid funding and Medicaid matching rates for which we are extremely grateful and appreciative. These actions have enabled us to maintain and improve our programs and healthcare system as we continue to address the ongoing challenges to our healthcare and economic infrastructure.

However, as we move through FY 2021, the funding and matching increases from the appropriations act and the coronavirus legislation will come to end, and the USVI (and other US Territories) will once again be facing the same uncertain Medicaid and CHIP program future that we have repeatedly faced in recent years. In fact, without further legislation the USVI Medicaid program will revert to its normal Medicaid cap (approximately \$19-\$20 million) and its normal Medicaid matching rate (55%) which will have devastating consequences to our programs, healthcare system, and budget. This situation commonly referred to as the "fiscal cliff".

Page 2

Congress must act by September 30, 2021 to avert potentially catastrophic damage to our Medicaid program and healthcare system as we move into fiscal year (FY) 2022. Specifically, based upon our most current estimates for FY 2022 the Federal funding that we will need for our Medicaid Program expenditures under the Medicaid Section 1108 cap will be over \$75 million. However, beginning October 01, 2021 we estimate that under current law the Medicaid Section 1108 cap will be only \$19.6 million, leaving a Federal funding shortfall cliff of over \$55.5 million. In addition, if our regular Medicaid matching rate reverts to the current law 55% from the temporary 83% matching rate enacted in 2019 this would require the USVI to provide an additional \$15 million in local matching funds for the Medicaid program which our budget is unable to support. Our estimates assume that all other Federal funding for activities like CHIP and information systems remains unchanged.

We call on the current Congress to enact a permanent solution to this issue for the USVI and the other US Territories, so we no longer have to rely on arbitrary, piecemeal fixes to our healthcare system that promote uncertainty and inequities in how our citizens are treated and how we provide healthcare to our population.

Compared to the fifty states and the District of Columbia, the Medicaid Program (and Medicare Program for that matter) provides significantly less federal assistance to citizens of the U.S. territories. While the Federal government provides Medicaid funding to states on an open-ended entitlement basis, and matches state spending based on need, it arbitrarily caps the total annual Federal health care funding for the territories and matches funds at an artificially low Federal matching level, specified by statute.

Furthermore, under current law, low-income Medicare beneficiaries residing in the territories are ineligible to receive Part D subsidies for their prescription drugs. Hospital payments do not adequately reflect the number of low-income patients treated or uncompensated care provided, and our hospitals are not eligible to receive disproportionate share hospital (DSH) payments to help with this care. This health care crisis will only grow worse when the current temporary Medicaid funding increases expire in September 2021.

We believe that a permanent fix needs to be enacted which addresses, at a minimum, the following areas for the USVI and other Territories and treats our citizens like those in the States and the District of Columbia:

- Remove the annual dollar cap on Medicaid funding and allow the funding to be open-ended based upon the needs of our program.
- Eliminate the artificially low federal medical assistance percentage (FMAP) for Medicaid and allow our FMAP to be determined per the formula in the statute.
- Provide for Medicaid disproportionate share hospital payments.
- Enable our hospitals to rebase their Medicare payments.

In 2019, our Delegate Stacey Plaskett, introduced H.R. 1354, the “The Territories Health Equity Act”, which would address all of our Medicaid concerns for a permanent legislative fix and also address the disparate treatment that the Territories receive under the Medicare Program. We understand that this bill will be reintroduced in the current Congress, and we would like to work with the Congress and the Administration to enact a permanent solution along the lines of the provisions of this bill.

The citizens of the Virgin Islands are grateful for everything that the Federal government is doing to support our recovery from the recent disasters and for providing us with assistance in addressing the impacts of the COVID19 pandemic. However, a critical and necessary component of our ongoing ability to address these issues is the continued viability of our Medicaid program and healthcare system. We believe this viability is dependent on a comprehensive and permanent solution for our Medicaid and CHIP programs as outlined above and we ask your support to address this during the upcoming legislative session.

Page 3

We are also keenly aware 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. Towards that end we implemented a Medicaid Fraud Control Unit (MFCU) in 2018. We also implemented in 2018 the Transformed Medicaid Statistical Information System (TMSIS) with CMS through our Medicaid Management Information System (MMIS). We are of completing cost report audit reconciliation for our two hospital and two Federally Qualified Health Centers (FQHCs) and we are in the process of working on this for our Department of Health Clinics. We have completed the CMS Medicaid Program Integrity (PI) Review and executed a memorandum of understanding with CMS to receive technical assistance in Medicaid PI and Medicaid data analytics. We are working with HHS to finalize and an advance planning document which will provide upwards of \$15 million to implement an island wide health information exchange and cyber security system, another \$5 million to implement a provider enrollment module in our Medicaid Management Information System, and we will shortly begin work to complete the full integration of our Virgin Islands Benefit and Eligibility System (VIBES) in the Virgin Islands. We believe all of these activities indicate our strong ongoing commitment to ensuring the integrity of our programs and our responsible stewardship of the Federal funding we are receiving.

I look forward to working with you to address these critically important issues and to give all citizens in the USVI and other Territories an opportunity to receive quality, affordable healthcare.

Sincerely yours,

A handwritten signature in blue ink, appearing to read 'Albert Bryan Jr.', with a stylized flourish at the end.

Albert Bryan Jr.
Governor



James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

March 16, 2021

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Chair
Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
U.S. House of Representatives
2322-A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone, Ranking Member McMorris Rodgers, Subcommittee Chair Eshoo, and Subcommittee Ranking Member Guthrie:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to urge the Committee on Energy and Commerce to favorably report out legislation to adequately fund Medicaid programs for Puerto Rico, the U.S. Virgin Islands, and other U.S. territories. The federal government continues to provide additional funding to help ensure the island nations and territories can cover the costs of their Medicaid programs, but these resources will expire on September 30, 2021. Unless funding is at least maintained at current levels, Puerto Rico's Medicaid program, for example, will lose 90 percent of its current funding. With the COVID-19 pandemic continuing to affect all U.S. territories, it is imperative that Congress act expeditiously to stabilize the fiscal situation facing Medicaid programs in the island nations and territories.

Puerto Rico is considered a state for most purposes of Medicaid and the State Children's Health Insurance Program and its Medicaid program covers nearly half of its residents. Since the Medicaid program began, however, Puerto Rico has faced the challenge of inequitable funding. Unlike in the 50 states and the District of Columbia, where Medicaid funding is open-ended, Puerto Rico can access federal dollars only up to an annual ceiling, referred to as the section 1108 cap or section 1108 allotment. The amount of funding provided under section 1108 has historically been insufficient to meet the needs of the territories' Medicaid programs, especially in Puerto Rico and the U.S. Virgin Islands, and well below the health care expenditures needed for their medically indigent population to receive proper and effective diagnosis, treatment, care, and medication services. In addition to the section 1108 cap, the territories receive a lower Federal Medical Assistance Percentage (FMAP) of 55 percent.

As a result, for more than a decade, Puerto Rico and the other territories have sought and obtained supplemental funding, i.e., most recently through the FY 2020 appropriations package, (P.L. 116-94) and the Families First Coronavirus Response Act, signed into law on March 18, 2020 (FFCRA, P.L. 116-127).

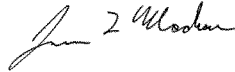
The Honorable Frank Pallone, Jr.
The Honorable Cathy McMorris Rodgers
The Honorable Anna Eshoo
The Honorable Brett Guthrie
March 16, 2021
Page 2

These actions raised Puerto Rico's FY 2020 allotment from \$375.1 million to \$2.7 billion and its FY 2021 allotment from approximately \$383.7 million to \$2.8 billion, and its FMAP temporarily to 82.2 percent (including the 6.2 percent increase for the duration of the national emergency due to COVID-19). Unless Congress acts before FY 2021 ends, Puerto Rico's Section 1108 allotment will revert to approximately \$392.5 million in FY 2022 and its FMAP to 55 percent (i.e., for FMAP, assuming the national emergency expires). It is important to note that the other U.S. territories face similar Medicaid funding and FMAP cliffs in the absence of congressional action.

In light of the financial rules and temporary nature of the supplemental funds, Puerto Rico and the other U.S. territories will need additional resources to finance their future share of Medicaid costs so that their residents can receive the care they need. With the September 2021 deadline looming, Congress, at the very least, should provide additional resources to ensure the continued fiscal sustainability of Medicaid programs in Puerto Rico, the U.S. Virgin Islands, and the other U.S. Territories. In addition, the AMA urges the Committee and your colleagues in the House of Representatives to permanently lift the section 1108 cap.

Thank you for your leadership and for considering our views.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim L. Madara".

James L. Madara, MD



March 17, 2021

The Honorable Anna G. Eshoo
Chairwoman, Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

The undersigned member organizations of the Partnership for Medicaid, a nonpartisan, nationwide coalition made up of organizations representing clinicians, health care providers, safety net health plans, and counties, write to express our views on Medicaid in the U.S. territories and the subcommittee's hearing, "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories." We commend the work of the subcommittee to highlight the detrimental effects of the Medicaid fiscal cliff for the territories on October 1st of this year. Absent Congressional intervention, each territory's Section 1108 allotments will revert to lower levels and their federal medical assistance percentage (FMAP) will be lowered back to 55%.

While we are thankful for Congress' past work to increase Medicaid funding and support over the years, we hope that the Committee will work to pass legislation to address the longstanding inequities in Medicaid affecting the territories. We hope that the Committee will consider H.R.265, the *Insular Area Medicaid Parity Act*, bipartisan legislation introduced by Congressman Sablan and Congresswoman Radewagen, to lift the Medicaid funding cap in the U.S. Territories. The Committee's hearing today demonstrates how Congress can ensure that Americans who reside in American Samoa, Guam, Puerto Rico, the Northern Mariana Islands, and the U.S. Virgin Islands have full access to the benefits of Medicaid. We look forward to working with you to make this legislation a reality.

The Medicaid program continues to be a vital lifeline for vulnerable individuals, families and children. Our members see the value that Medicaid provides to ensure the optimal health and well-being of beneficiaries enrolled in the program. Unfortunately, due to limitations in the funding statute, the Medicaid program operates differently in the U.S. Territories compared to those of the states through capped funding and a fixed federal medical assistance percentage. This discrepancy results in fewer federal dollars supporting territorial governments which in turn affects the financial viability of their Medicaid programs. At a [recent meeting](#) of the Medicaid and CHIP Payment and Access Commission, Medicaid Directors from the territories outlined the challenges their jurisdictions faced as a result of the inequitable funding mechanism of the Medicaid program as they addressed the dual public health and economic crisis arising from the pandemic. The territory leaders linked the existence of capped Medicaid funds and the detrimental effects it has on reimbursing providers fairly, which in turn affects beneficiary access to needed care.

Numerous reports detail the health and economic disparities that exist for residents of the U.S. territories, whose geographic locations and isolation contribute to more disparities. For example, natural disasters such as hurricanes and earthquakes have struck Puerto Rico, Guam, the U.S. Virgin Islands and the Northern Mariana Islands. Additionally, close to a decade ago, American Samoa suffered the devastation of a tsunami. We all understand the importance of Medicaid during these natural disasters, which have provided states with matching funds to help offset unanticipated costs associated

with disasters and in some cases has allowed the program to provide a heightened response, for example by facilitating short-term changes to program rules affecting eligibility, benefits, and provider payment. In terms of economic conditions, all these jurisdictions have experienced prolonged fiscal challenges resulting in rising levels of unemployment and poverty, only made worse by the global pandemic. Finally, residents of the U.S. territories have experienced more health challenges compared to their counterparts in the states. According to the Kaiser Family Foundation, self-reported health is significantly more likely to be fair or poor in Guam (22%) and Puerto Rico (37%) than in the 50 states and D.C. (18%)¹. Chronic disease disparities also exist with studies showing American Samoa having one of the highest rates of obesity and diabetes in the world.

Lastly, addressing the Medicaid funding limitation in the territories will help advance health equity and aim to correct longstanding disparities in health. The unequal treatment of Americans residing in the territories, of whom 98% are racial or ethnic minorities, is only exacerbated by the capped Medicaid funding which deprives some of the most marginalized populations of the federal support their counterparts living stateside enjoy. We hope that the Committee moves to enact policies to promote health justice and advance health equity for Americans in the territories.

In 2019, the Partnership sent a [letter](#) calling on Congress to address the impending Medicaid “fiscal cliff,” that would have resulted in decreased funds for the territories. While Congress has acted to increase funds for the Medicaid program over the years through legislation on a short-term basis, the *Insular Area Medicaid Parity Act* is needed legislation as it corrects this longstanding discrepancy by eliminating the statutorily set funding caps. This bipartisan legislative approach represents a long-term solution for Medicaid beneficiaries residing in the U.S. Territories, while ensuring that territorial governments are given fiscal relief to stabilize the health and economic security of their jurisdictions.

We look forward to passage of this legislation and for the Committee’s work to bring Medicaid parity for the insular areas. If you have any questions please contact Jonathan Westin at the Jewish Federations of North America, First Co-Chair of the Partnership for Medicaid at Jonathan.Westin@jewishfederations.org or Paulo Pontemayor, Second Co-Chair of the Partnership for Medicaid at ppontemayor@chausa.org. Thank you for the opportunity to share our thoughts on this important issue.

Sincerely,
 American Academy of Family Physicians
 American College of Obstetricians and Gynecologists
 American Dental Association
 American Dental Education Association
 American Network of Community Options & Resources (ANCOR)
 Association for Community Affiliated Plans
 The Catholic Health Association of the United States
 Easterseals
 Jewish Federations of North America
 Medicaid Health Plans of America

¹ Kaiser Family Foundation analysis of the 2016 (USVI) and 2017 (50 States and D.C., Guam, Puerto Rico) Behavioral Risk Factor Surveillance System (BRFSS). Significance testing for USVI BRFSS data from 2016 was completed using 2016 BRFSS data for the 50 states and D.C., while significance testing for Guam and Puerto Rico used 2017 BRFSS data. BRFSS data from 2016 and 2017 were not available for American Samoa and Northern Mariana Islands

National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Council for Behavioral Health
National Health Care for the Homeless Council
National Rural Health Association



March 17, 2021

The Honorable Anna Eshoo
Chairwoman
House Committee on Energy and
Commerce, Health Subcommittee
Washington, DC 20515

The Honorable Brett Guthrie
Ranking Member
House Committee on Energy and
Commerce, Health Subcommittee
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 136,700 family physicians, residents, and medical students across the country, I write in response to the hearing: "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories" to share the family physician perspective and the AAFP's recommendations to protect Medicaid access in the territories.

The most immediate concern is the impact of the impending Medicaid fiscal cliff in the U.S. territories. If Congress fails to act before the end of the current fiscal year, all providers, including family physicians, and their patients in American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands, will face significant reduction in resources and access to necessary care.

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 clinicians and hospitals. Unlike states' Medicaid funding mechanisms, financing for territorial Medicaid programs is capped and the federal medical assistance percentage (FMAP) for the territories is set by statute at 55 percent, significantly less than that of the states, despite having higher average Medicaid enrollment than most states. While we appreciate the short-term funding passed in the Affordable Care Act in 2010, the Bipartisan Budget Act in 2018, and the CARES Act in 2020, Medicaid programs in these territories remain chronically underfunded.

Our constituent chapters in the territories represent hundreds of family physicians who have long been proponents of changes to the current funding mechanisms to ensure that the territories are treated more equitably to the states for the purposes to Medicaid financing. Without additional support, the territories will revert to a 55 percent FMAP on October 1, when many physician practices and patients will still be coping with the effects of COVID-19 on their health and financial wellbeing. Any short-term funding options to avert this cliff should remain at the level passed under the CARES Act, but long-term reforms are also needed. **Specifically, Congress should pass H.R. 265, the Insular Area Medicaid Parity Act, which would lift the Medicaid funding cap in the U.S. territories.**

Additionally, these territories are facing an ongoing exodus of physicians from the islands as reimbursement for services remains significantly lower than the same services performed in the U.S. mainland. As of 2016, **physicians and surgeons in Puerto Rico earned a median**

STRONG MEDICINE FOR AMERICA

President Ada Stewart, MD Columbia, SC	President-elect Sterling Ransone, MD Deltaville, VA	Board Chair Gary LeRoy, MD Dayton, OH	Directors James Elzy, MD, Washington, DC Dennis Gingrich, MD, Hershey, PA Tochi Iroku-Malizi, MD, Bay Shore, NY Andrew Carroll, MD, Chandler, AZ Steven Furr, MD, Jackson, AL Margot Savoy, MD, Media, PA	Jennifer Brull, MD, Plainville, KS Mary Campagnolo, MD, Bordertown, NJ Todd Shaffer, MD, Lee's Summit, MO Danielle Carter, MD (New Physician Member), Jacksonville, FL Anna Aukari, MD (Resident Member), Palm Desert, CA Cynthia Ciccotelli (Student Member), Yardley, PA
Speaker Alan Schwartzstein, MD Oregon, WI	Vice Speaker Russell Kohl, MD Stillwell, KS	Executive Vice President R. Shawn Martin Leawood, KS		

March 17, 2021
Page 2 of 2

hourly salary that was less than half of their main land counterparts.ⁱ In Puerto Rico, the current number of primary care physicians only address 1.9 percent of their need.ⁱⁱ Even basic preventative services have a significantly lower uptake in Puerto Rico than on the mainland. According to 2018 CMS data, flu shot uptake in Puerto Rico was at 37 percent compared to 64 percent of Puerto Ricans and 76 percent of Hispanics on the mainland receiving a flu shot.ⁱⁱⁱ **Without adequate reimbursement from Medicaid and Medicare Advantage, physicians are unable to meet basic financial obligations for operating their practice and are unable to make longer-term investments to enhance or grow their practice.**

Furthermore, with higher rates of Medicaid participation and a large percentage of ethnic and racial minority groups, chronic underfunding and continuous re-evaluation of funding levels is crippling an already at-risk population. Ensuing adequate Medicaid funding for U.S. territories is an important step toward achieving health equity. Passing the Insular Area Medicaid Parity Act will allow the U.S. territories to better serve their communities, grow their physician workforces, plan for long-term health care spending, and better respond to future natural disasters.

The AAFP stands ready to partner with you to advance H.R. 265, and to develop policy solutions to strengthen the health care workforce in the U.S. territories. For more information, please contact Erica Cischke, Senior Manager of Legislative and Regulatory Affairs at ecischke@aafo.org.

Sincerely,



Gary L. LeRoy, MD, FAAFP
Board Chair, American Academy of Family Physicians

ⁱ Patron, M. (2017, August 08). Puerto Rico's exodus of Doctors Adds health care strain to dire financial crisis. Retrieved March 16, 2021, from <https://www.nbcnews.com/news/latino/puerto-rico-s-exodus-doctors-adds-health-care-strain-dire-n783776>

ⁱⁱ Kaiser Family Foundation. Primary care health Professional Shortage Areas (HPSAS). (2020, November 05). Retrieved March 16, 2021, from <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D>

ⁱⁱⁱ CMS Office of Minority Health. "Comparing Puerto Rican's Health Status, Access to Care, and Satisfaction with Care to their Mainland Counterparts Prior to Hurricane Maria." October 2018. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CMS-OMH-October2018-Puerto-Rico-Data-Highlight.pdf>

STRONG MEDICINE FOR AMERICA

President Ada Stewart, MD Columbia, SC	President-elect Sterling Ransone, MD Deltaville, VA	Board Chair Gary LeRoy, MD Dayton, OH	Directors James Eltzy, MD, Washington, DC Dennis Gingrich, MD, Hershey, PA Toshi Inoku-Matsumoto, MD, Bay Shore, NY Andrew Carroll, MD, Chandler, AZ Steven Furr, MD, Jackson, AL Margot Savoy, MD, Media, PA	Jennifer Brull, MD, Plainville, KS Mary Campagnolo, MD, Bordertown, NJ Todd Shaffer, MD, Lee's Summit, MO Danielle Carter, MD (New Physician Member), Jacksonville, FL Anna Askari, MD (Resident Member), Palm Desert, CA Cynthia Ciccolilli (Student Member), Yardley, PA
Speaker Alan Schwartzstein, MD Oregon, WI	Vice Speaker Russell Kohl, MD Stillwell, KS	Executive Vice President R. Shawn Martin Leawood, KS		



March 17, 2021

The Honorable Anna Eshoo
Chair, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

RE: Hearing on “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”

Dear Chair Eshoo and Ranking Member Guthrie:

On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO), I thank you for holding today’s hearing, “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories.” AAPCHO commends the subcommittee’s efforts to improve health care access for the more than three million Americans living in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. We support the Insular Area Medicaid Parity Act (H.R. 265), and we urge the subcommittee to act swiftly to enact permanent solutions for the territories that eliminates annual Medicaid funding caps, gives parity in the Federal Medical Assistance Percentage, and meets the needs of their communities.

AAPCHO is a national nonprofit association of 34 community-based health care organizations, 29 of which are Federally Qualified Health Centers (FQHCs), that advocates for the diverse health needs of medically underserved Asian Americans, Native Hawaiians, and Pacific Islanders and the community health providers that serve their needs. AAPCHO’s members are critical health access providers to nearly three quarters of a million vulnerable and low-income patients, providing culturally and linguistically appropriate care that is vital to supporting AA, NH, and PI communities every day.

As the subcommittee notes, the territories face a health care crisis at the end of the fiscal year when Medicaid provisions enacted by Congress just two years ago are set to expire. As you know, Medicaid programs in the territories operate differently than they do in the 50 states. Unlike in the 50 states, federal funding available to provide care to low-income Americans who live in the territories is capped and their FMAP—the percentage of how much the federal government will contribute to health care costs—is set in statute rather than taking into account the territories’ low-income population.

Congress made significant improvements and averted a similar health care crisis in 2019, but those changes were temporary and expire in September of this year. Without Congressional action, the territories will face a fiscal cliff that will lead to significant cuts to health care available to residents and force the territories’ governments divert limited resources from other essential priorities. Prior to the passage of legislation to shore up the territories Medicaid programs in

2019, American Samoa and Guam were unable to provide adequate local matching funds to fully utilize ACA Medicaid funding, and the Northern Mariana Islands had exhausted its additional funds and notified local Medicaid providers that it would not reimburse adult and children outpatient primary care services, forcing providers to either stop providing services or absorb the full costs of these services. Cuts to health care services at this time will be especially dire as the territories, like the rest of the nation and global community, continue to address the COVID-19 crisis and resulting economic challenges.

Additionally, last year Congress made important progress to restore Medicaid eligibility to COFA citizens living in the United States. According to a recent GAO report, about 1 in 5 COFA citizens in the U.S. live in a U.S. territory, primarily in Guam with smaller populations in the Northern Mariana Islands and American Samoa. Congress should ensure that this progress is not jeopardized by the impending Medicaid cliff in September and ensure that the commitments it made to COFA citizens is applied equally throughout the nation.

AAPCHO strongly encourages Congress to make permanent improvements to the territories' Medicaid programs. Congress should ensure the territories' Medicaid programs recognize the unique challenges of their island communities and provide them with long-term stability that addresses the needs of their populations. **Specifically, AAPCHO supports the Insular Areas Medicaid Parity Act (H.R. 265) introduced by Congressman Gregorio Kilili Sablan of the Northern Mariana Islands to remove the territories' annual funding caps. Congress should also remove inequitable matching requirements that are not required of the 50 states.** The territories cannot continue to be hamstrung by inequitable policies that inhibit their residents from having the same access to health care as their fellow Americans in the 50 states.

Again, AAPCHO thanks the subcommittee's efforts to shed light on the health access disparities facing residents of the U.S. territories and working to improve these jurisdiction's Medicaid programs. Now is the time to find permanent solutions to these challenges and for the millions of Americans who call the territories home. AAPCHO is committed to working with you and your Congressional colleagues to improve Medicaid in the American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands in hope of creating a sustainable health infrastructure for the residents of these American island jurisdictions.

Sincerely,



Adam P. Carbullido
Director of Policy and Advocacy



Statement for Hearing on
“Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”
Submitted to the House Energy & Commerce
Subcommittee on Health
March 17, 2021

Medicaid is an essential part of American health care. It helps improve the health and financial security of over 70 million hard-working Americans, children, older adults, people with disabilities, and veterans.¹

As our nation works to overcome the COVID-19 crisis, America’s Health Insurance Plans (AHIP) greatly appreciates the Subcommittee on Health’s focus on the imminent reductions in Medicaid funding for the U.S. territories. Medicaid has long been a critical lifeline to Americans in Puerto Rico, the U.S. Virgin Islands, the Northern Mariana Islands, American Samoa, and Guam. This need has only grown throughout the pandemic and is expected to continue to grow in the years to come.

By passing the *Further Consolidated Appropriations Act, 2020* and the *Families First Coronavirus Response Act (FFCRA)*, Congress took critical steps in providing additional temporary funding for the territories and increasing the federal Medicaid match rates. These important steps were necessary to ensure the stability and vitality of Medicaid through the pandemic, but those funds are set to expire on September 30, 2021, which would have severe negative consequences for the millions of Americans who rely on Medicaid coverage and each of the health care systems in the five territories.

We look forward to working with the Subcommittee to ensure that the most vulnerable residents of the U.S. territories can continue to rely on a viable Medicaid program for their health care needs and to assure that the health care systems relied on by all citizens of territories remain stable as we continue to fight the pandemic.

Medicaid Managed Care’s Unique Role in Puerto Rico

Medicaid has served as an essential safety net in Puerto Rico through the worst disasters, both playing a critical role in the island’s resilience through hurricanes, earthquakes, and a crippling

¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> (September 2020).

global pandemic. Health insurance providers are committed to ensuring that Medicaid is effective and affordable for all enrollees in Puerto Rico.

Medicaid serves over 1.4 million enrollees in Puerto Rico – over half of the island’s residents.² Puerto Rico is also the only U.S. territory that uses a managed care delivery system to provide services. Moreover, Medicaid is a crucial piece to Puerto Rico’s health care financing system due to the island’s high poverty rate and prevalence of health chronic conditions, such as high blood pressure, diabetes, and HIV/AIDS. In 2018, 47.8 percent of all Puerto Ricans had Medicaid coverage.³

Medicaid funding caps have resulted in Puerto Ricans receiving fewer benefits and being subject to more restrictive eligibility requirements as compared with Medicaid programs in states. Failure to provide continued funding for Puerto Rico’s Medicaid program could lead to beneficiaries experiencing further reductions in benefits or more stringent eligibility requirements. To that end, AHIP and our member managed care plans in Puerto Rico are committed to ensuring that Medicaid enrollees maintain their access to affordable, high-quality coverage and care.

For Puerto Rico in particular, the Medicaid program is also critically important to the health of the island’s residents and to the ongoing viability of the island’s provider infrastructure. Continued funding will support efforts by Puerto Rico’s government, its Medicaid managed care plans and their contracted providers to deliver health care to the island’s most vulnerable residents.

Swift Action Needed to Protect Puerto Rico’s Dual Eligible Population

Puerto Rico also has a large number of Medicaid enrollees who are dually eligible for Medicare and Medicare Advantage (MA) plans. As of February 2021, over 610,000 individuals in Puerto Rico were enrolled in an MA plan, representing nearly 80 percent of the island’s Medicare-eligible population.⁴ In addition, nearly 280,000 individuals in Puerto Rico are enrolled in a Dual Eligible Special Needs Plan (D-SNP), which are plans designed to roll benefits from Medicaid and Medicare Advantage into one simple plan, particularly for special needs individuals.⁵

While MA plans face significant funding challenges in Puerto, they still provide basic medical benefits, important supplemental benefits, and other services that address the needs of dually eligible populations. To that end, it is important for Congress to act soon to remedy impending funding shortfalls that could affect the dual eligible population and have implications for MA

² Puerto Rico Medicaid enrollment data available at “[Estadísticas](#),” Medicaid Program, Puerto Rico Department of Health, Aug. 2020.

³ “How States Would Fare Under Medicaid Block Grants or Per Capita Caps: Lessons from Puerto Rico”; Park, E. The Commonwealth Fund, January 6, 2021

⁴ Centers for Medicare & Medicaid Services. (2021). “MA State/County Penetration 2021 03.” Retrieved from <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolldata/ma-state-county/ma-state-county-penetration-2021-03>.

⁵ Centers for Medicare & Medicaid Services. (2021). “SNP Comprehensive Report 2021 03.” Retrieved from <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolldata/special-needs/snp-comprehensive-report-2021-03>.

plan bids that are required to be submitted to the Centers for Medicare & Medicaid Services (CMS) by June 7, 2021. By acting swiftly, Congress can ensure that the health security of hundreds of thousands of dual eligibles in Puerto Rico will be protected.

Recommended Action on the *Insular Area Medicaid Parity Act*

AHIP supports legislation introduced by Rep. Gregorio Kilili Camacho Sablan (I-MP), the *Insular Area Medicaid Parity Act* ([H.R. 265](#)), which would eliminate the Medicaid funding cap in the U.S. territories to give them full access to Medicaid coverage.

Lifting the Medicaid funding cap should be the top priority for Congress in averting a crisis in Puerto Rico and other U.S. territories. However, if Congress fails to pass H.R. 265, AHIP then recommends additional funding similar to the funding provided by the *Further Consolidated Appropriations Act, 2020* and the *Families First Coronavirus Response Act (FFCRA)*. However, that temporary funding is set to expire on September 30, 2021.

As such, AHIP implores Congress work together and create a long-term solution that strengthens Medicaid and protects health care access for the millions of Americans in Puerto Rico and the other territories who rely on the program.

Conclusion

Everyone deserves access to affordable and quality coverage and care, especially as the nation grapples with the COVID-19 pandemic. We thank the members of the Subcommittee for your dedication to address upcoming Medicaid fiscal cliff. We appreciate your leadership as you work to advance guaranteed long-term funding for Puerto Rico and all the territories' residents. We look forward to working with the Congress to ensure that these residents can rely on a viable Medicaid program for their health care needs in the years to come.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS



National Headquarters
2231 Crystal Drive, Suite 450
Arlington, VA 22202
(202) 371-9090

Regional Office
600 Peachtree Street NE, Suite 1000
Atlanta, GA 30308
(202) 371-9090

www.astho.org
@ASTHO

January 14, 2021

The Honorable Gregorio Kilili Camacho Sablan
U.S. House of Representatives
2267 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Sablan:

On behalf of the Association of State and Territorial Health Officials (ASTHO), I am writing in support of the Insular Area Medicaid Parity Act, which seeks to repeal language in section 1108 of the Social Security Act and sunset limitations on Medicaid funding for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa beginning in FY21. We are grateful for your continued leadership in advancing the needs of residents in the Northern Mariana Island and other U.S. territories.

As the organization representing both state and territorial health officials, the disparity in Medicaid financing for the territories is of great concern. While ASTHO is grateful for the extension of Medicaid funding for FY20 and FY21 in the Further Consolidated Appropriations Act, 2020, and later increased funding through the Family First Coronavirus Response Act, it is imperative that Congress provide a permanent solution to Medicaid financing for the U.S. territories because enhanced Medicaid funding and increased federal medical assistance percentage rates expire after Sept. 30, 2021, and the current public health emergency, respectively.

Indeed, providing reliable and sustainable funding for U.S. territories is important and essential to building public health systems for residents to utilize within their communities without having to seek care off-island or in other jurisdictions. U.S. territories should not have to rely on supplemental, temporary funding to provide quality healthcare to their residents. Prioritizing this legislation in the 117th session of Congress supports our vision of advancing health equity and optimal health for all.

We look forward to working with you to address this important priority for U.S. territories. Please contact Jeffrey Ekoma, director, federal government affairs, ASTHO (jekoma@astho.org) if you have any questions.

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer
Association of State and Territorial Health Officials



Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
1 Lower Navy Hill Road Navy Hill, Saipan, MP 96950

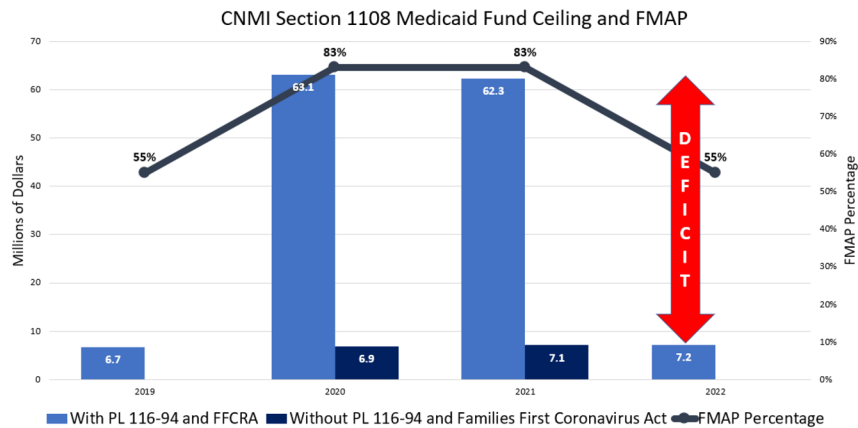


CEO-L21-0385

Dear Congressional Leaders,

The CNMI's healthcare system cannot continue to function without an earnest financial commitment from the federal government to the CNMI's Medicaid program. If it were not for additional funding to the CNMI in excess of the cap from 2011 to 2019, we may have lost our sole hospital. If not for the funding support in 2019, more than 20,000 CNMI residents (nearly 40% of the population) would have been without health insurance during the worst pandemic since the early part of the 20th century.

Medicaid is an entitlement program designed to provide health and long-term care coverage for Americans with low incomes. Costs of the program are shared between the state or territorial government and the federal government, but U.S. territory governments are expected to bear a much larger share of the costs than U.S. state governments.

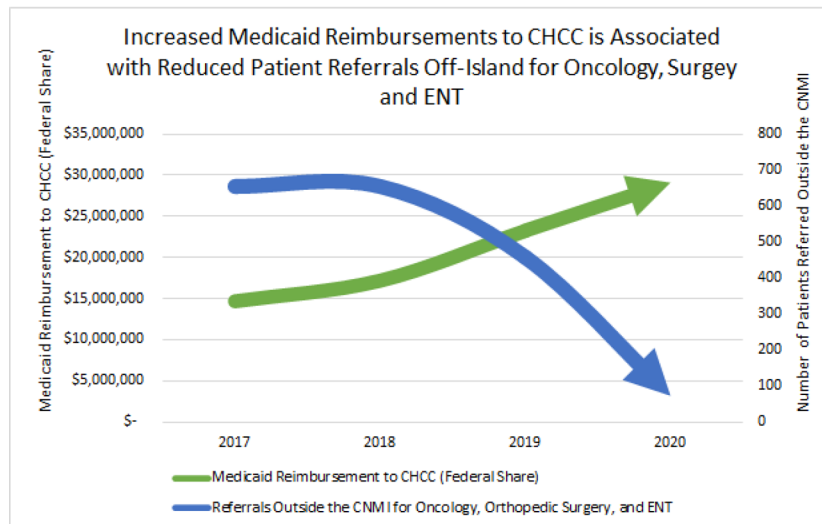


Notes: Section 1108 allotments reflect the annual federal allotments (or caps) for federal funds that the CNMI receives under Section 1108(g) of the Social Security Act. P.L. 116-94 is the Further Consolidated Appropriations Act of 2020. FFCRA is the Families First Coronavirus Response Act (P.L. 116-127). Data source: This graph is adapted from data presented in Table 2 of a February 2021 MACPAC Factsheet titled, "Medicaid and CHIP in the Territories".

P.O. Box 500409 CK, Saipan, MP 96950
Telephone: (670) 236-8201/2 FAX: (670) 233-8756

Unlike U.S. states, U.S. territories face an arbitrary statutory cap on the total amount of federal funds for the program and a federal medical assistance percentage (FMAP) which does not consider the financial circumstances of a territory, unlike FMAP determinations for U.S. states. In 2019, Public Law 116-94 only *temporarily* expanded the section 1108 statutory cap for the CNMI from roughly \$7mil per year to \$60mil per year for FY 2020 and 2021 respectively, and increased the federal medical assistance percentage (FMAP) to 83% for each year. However, absent a long-term statutory solution, the CNMI government would need to pick up a huge gap in Medicaid funding next, likely upwards of \$50mil. In the CNMI's FY 2021 budget, the CNMI's estimated total resources for the year were just over \$100 million. The CNMI government is hurting. Despite successful containment of the virus on the islands, COVID-19 has eliminated its primary economic driver: tourism. The CNMI government cannot make up the huge gap between the arbitrary federal cap and the expenditures of the CNMI's Medicaid program.

Expansion of services in the CNMI is challenging, but significant gains have been made in recent years. In large part due to improved Medicaid reimbursements in recent years, the Commonwealth Healthcare Corporation has been able to establish podiatry, ENT, orthopedic surgery, and oncology services on Saipan, with these specialists also making visits to Tinian and Rota.



Data Sources: Referral data is from the CNMI Governor's Medical Referral Program. Data on the federal share of Medicaid Reimbursement to the CHCC is from the CHCC's revenue data.

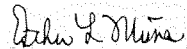
In 2017, when 14% of all referrals for off-island care through the CNMI Governor's Medical Referral Program were for orthopedic surgery, the CHCC was able to hire an orthopedic surgeon. Last year, in 2020, just 4% of total referrals were for orthopedic surgery. In 2018, 6% of total off-island referrals for the program were for ENT, and in 2020, ENT referrals made up just 1% of the total. In 2019, the CHCC was able to hire an oncologist who has led the establishment of an oncology center which opened in

2020. In 2019, 16% of all referrals were for oncology, and in 2020, this reason for referral was just 2% of the total.

Public Law 116-94 appropriately tied the expanded funding to stipulations that the CNMI make progress to establish a Fraud Control Unit, and to submit data to a Transformed Medicaid Statistical Information System (T-MSIS). Fulfilling these conditions will be a considerable challenge for the CNMI's Medicaid program, and the CHCC, as the largest Medicaid provider in the CNMI, stands in full support of the CNMI Medicaid program to make long-needed updates to claims collection and adjudication processes.

We ask that Congress stabilize Medicaid financing for the CNMI so that CNMI health care service providers can make long-term plans for improvements to the scope and quality of care that we provide. Help us maintain our progress in the CNMI.

Sincerely,



Esther L. Muña, PhD, FACHE

Chief Executive Officer

State/Territorial Public Health Official

Commonwealth Healthcare Corporation, the Territorial
Hospital & Health System



NORTHERN MARIANAS COMMONWEALTH LEGISLATURE
HOUSE OF REPRESENTATIVES
P.O. BOX 500586 SAIPAN, MP 96950

March 16, 2021

The Honorable Frank Pallone
Chair
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable Anna Eshoo
Chair
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

RE: Support for the Insular Area Medicaid Parity Act (H.R. 265)

Dear Congressional Leaders:

Thank you for conducting this important hearing, "Averting A Crisis: Protecting Access to Health Care in the U.S. Territories." We, the undersigned members of the 22nd House of Representatives, Northern Marianas Commonwealth Legislature, strongly support H.R. 265, the Insular Area Medicaid Parity Act, introduced by our Northern Mariana Islands Delegate to the U.S. Congress, the Honorable Gregorio Kilili Camacho Sablan.

The citizens of the Commonwealth of the Northern Mariana Islands (CNMI), and millions of fellow Americans residing across the U.S. insular areas, have long faced chronic underfunding of Medicaid; and now an impending Medicaid "fiscal cliff" jeopardizes access to critically needed health care. H.R. 265 begins to correct that serious inequity by lifting the cap on general Medicaid funding to the Territories that is set forth in Section 1108 of Title XI, the Social Security Act.

The major disparity between Medicaid in the Territories and Medicaid in the States is in the financial treatment, as highlighted in recent reports to Congress by the Medicaid and CHIP Payment and Access Commission (MACPAC). Unlike the States, statutory annual ceilings apply to Medicaid funding in the Territories regardless of changes in enrollment or services. The Section 1108 caps have resulted in historically insufficient resources to meet the health care needs of our Medicaid eligible citizens. Another statutory inequity lies in the Federal Medical Assistance Percentage (FMAP), or the matching rate, which for the Territories is fixed at 55% Federal to 45% Non-Federal share for most Medicaid expenses.

Thus, in addition to supporting the removal of the Section 1108 caps, we recommend that Congress apply to the Territories the same FMAP formula that is used for the States and that takes into account the relative income and poverty levels of our jurisdictions. Eliminating the Section 1108 caps *and* applying an equitable method of determining the FMAP will enable the Medicaid programs in the Northern Marianas and the other Territories to provide the same level of care that Medicaid eligible citizens receive in the States, ensure that health care providers are reimbursed appropriately for the services delivered, and allow the Territories to plan and manage the Medicaid programs as the States do.

We are keenly aware of the vital importance of the Medicaid program to the health and welfare of the people we represent, especially over the past several years as our communities in the Northern Marianas have grappled with back-to-back typhoon disasters, the depletion of federal supplemental budgeted amounts for Medicaid under the Patient Protection and Affordable Care Act, and the ongoing impacts of the Covid-19 global pandemic. We are committed to ensuring that our Commonwealth Medicaid Agency is equipped to implement and further develop the program to provide high-quality care to Medicaid eligible citizens, while responsibly managing the costs of the program.

We understand that the Commonwealth, like other U.S. insular areas, is expected to administer the Medicaid program as the States do. In May 2020, the Commonwealth Legislature unanimously passed, and the Governor signed into law, a bill to reorganize and establish the CNMI Medicaid Agency (Agency) in the Executive Branch of the government; to direct the Agency to plan, design, and implement Medicaid Enterprise Systems (MES); to establish a claims and clinical data warehouse and promote health information exchange; and to provide a community health record system to enable beneficiaries to see their medical information. That bill became CNMI Public Law 21-28. Monitoring the effective implementation of the new law is one of the top priorities of the leadership in the 22nd CNMI House of Representatives.

Further, the Commonwealth's general appropriations act for fiscal year 2021 specifically established a "Compliance and Medicaid Enterprise Systems (MES)" business unit in the Medicaid budget to highlight the importance of compliance and the need to make reasonable and appropriate progress to implement the MES. The Legislature also granted authority to the CNMI Medicaid Director to reallocate funds as needed among the budget categories for Administration, Reimbursements, and Compliance and MES, to provide flexibility given the austere budget resulting from the economic impacts of Covid-19.

But we need the help of Congress to provide enduring solutions to the inequities and chronic funding shortfalls and uncertainties affecting Medicaid in the Northern Marianas and throughout the insular areas. In 2019, MACPAC reported to Congress that while "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 [...], 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.”¹

MACPAC’s findings remain true today. Parity in financing is key to protecting access to care for millions of Americans living in the Territories, and ensuring the long-term sustainability of our Medicaid programs. Parity is especially crucial now, as we work with limited resources to respond to the Covid-19 pandemic. We urge Congress to rectify the long-standing inequities that threaten to push the Commonwealth and other island communities off the Medicaid fiscal cliff, by removing the Section 1108 budget caps and enabling the FMAP to be calculated for the insular areas in the same way as the States.

Thank you for your consideration of the health care needs of the people of the Northern Marianas and all the Territories.

Sincerely,



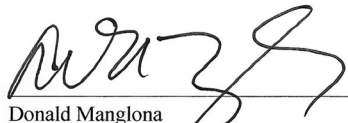
Edmund Villagomez
Speaker



Christina Sablan
Chair, Health and Welfare



Blas Jonathan Attao
Vice Speaker



Donald Manglona
Chair, Ways and Means



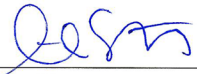
Ralph Yumul
Floor Leader



Vicente Camacho
Chair, Federal and Foreign Affairs

¹ 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.

Re: H.R. 265, Insular Areas Medicaid Parity Act
 Letter of Support – 22nd CNMI Representatives
 March 16, 2021
 Page 4 of 2



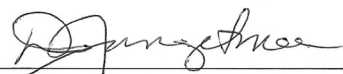
 Leila Staffler
 Chair, Education and the Workforce



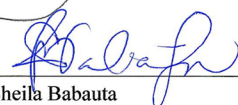
 Celina Babauta
 Chair, Judiciary and Governmental Operations



 Edwin Propst
 Chair, Gaming



 Denita Yangetmai
 Chair, Commerce, Tourism, and Cannabis



 Sheila Babauta
 Chair, Natural and Cultural Resources



 Richard Lizama
 Chair, Public Utilities, Transportation, and
 Communications

cc: The Honorable Gregorio Kilili Camacho Sablan, 117th U.S. House of Representatives
 Ms. Helen Sablan, CNMI Medicaid Agency



GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT



LOURDES A. LEON GUERRERO
GOVERNOR, MAGALUP

JOSHUA F. TENORIO
LT. GOVERNOR, SINDICO MAGALUP

ARTHUR U. SAN AGUSTIN, MHR
DIRECTOR

LAURENT SF DUENAS, MPH, BSN
DEPUTY DIRECTOR

TERRY G. AGUON
DEPUTY DIRECTOR

Guam Medicaid Program Testimony

This testimony will cover Guam issues in several contexts: 1.) Guam's Uninsured Population, 2.) Access to Healthcare Services and Affordable Healthcare Costs, 3.) Coronavirus Pandemic, 4.) Guam's Financial Instability, and 5.) Healthcare Disparity.

The uninsured population of Guam is high due to the high cost of living and insurance premium. Most goods or commodities are imported. The Cost of living in Guam is 41.09% higher than in the United States, a family of four estimated monthly cost is \$4,543.31 without rent, and a single person estimated monthly cost is \$1,332.15 without rent (numbeo.com/cost-of-living/country).

This population is not qualified under the Guam Medicaid because of the program's low-income guideline. Though Guam's current minimum wage is \$8.75, the monthly average income for a full-time employee is \$1,517 per month; most people still do not qualify because Guam Medicaid's eligibility determination is based on monthly gross income. The income guideline for a household size of 1 and 4 are \$1,103 and \$2,280, respectively.

People without insurance coverage are less likely to have access to healthcare than people who are insured. These individuals are less likely to receive preventive care and other necessary healthcare services as well. People tend to prioritize food security and house stability over health. Because of lack of insurance, these people are more likely to have chronic conditions early in life. This drives the Medicaid expenditures higher because people would only apply and qualify under the program during the most vulnerable stage of their life.

In addition, the cost of providing healthcare in Guam is higher because of its unique geographic location, lack of tertiary center, and difficulty of recruiting health care professionals. Guam continues to suffer from shortage of primary care physicians, medical specialists, and other health care professionals. Health Resources and Services Administration (HRSA) continues to designate Guam as Medically Underserved Area. The difficulties in accessing healthcare (facilities and specialist) may lead to worse health outcomes by increasing patients' physical and emotional stress, reducing the likelihood of seeking follow-up care, and limiting proximal family support. Due to lack of tertiary center, Guam patients need to compete with other off-island patients and wait for appointments from accepting physician/medical facility. The patient's condition worsens while waiting to be transported off-island and, in some instances, may require air ambulance before appropriate medical treatment is coordinated and received.

Furthermore, the economic downturn due to the coronavirus pandemic provided adversity to the people of Guam. They either lost their jobs or experienced reduced work hours. More

Department of Public Health & Social Services
155 Hester Place, Hagatña, GU 96910
www.dphss.guam.gov

Guamanians became uninsured during this period of hardship and leaned on the Medicaid Program for their health care needs. The number of new and reopen Medicaid applications processed in May 2020 until the end of Fiscal Year 2020 went up by more than twice the applications processed in March-April 2020.

Medicaid New and Reopen Applications Processed

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	TOTAL
MAP	375	314	723	835	783	1023	810	4863

More importantly, Guam's economy is heavily dependent on the tourism industry and US military spending. Due to COVID-19 pandemic, the revenue became unstable. As a result, the government may not be able to guarantee the availability of local funds to match the succeeding Medicaid federal grant after FY 2021 if the local match stays at 45%.

The Medicaid Program in Guam differs from the 50 states and the District of Columbia. In the last 2 years, Guam Medicaid Program benefitted from the increases in the federal funding cap and the Federal Medical Assistance Percentage (FMAP) brought about by PL 116-20 and PL 116-94 which provided an opportunity to improve its provider relation, claims processing and payment timeliness, increase patients' access to care, increase income guideline and providers' reimbursement. However, the increase on FMAP and the funding cap are time-limited and expire at the end of Fiscal Year 2021.

Disparity on healthcare across the nation exists, but more so in Guam because of its geographic location, lack of medical professionals, limited access to care, lack of program flexibility, and the long-standing federal regulation on Medicaid Program as it pertains to the FMAP and the funding cap, not to mention the distribution of Disproportionate Share Hospital payments to cover the costs of providing care to uninsured patients in the Territories.

Addressing these disparities is crucial not only from an equity stand point but also from a growth stand point in Guam's healthcare system. By addressing these disparities, we can remove the limit of our ability to improve and strengthen our fragile healthcare system and respond to the fast-changing demands of standard medical care to provide quality healthcare services by developing a comprehensive system of care, focusing more on prevention and primary care, addressing the social determinants of health, and reducing the unnecessary high costs of services due to delayed treatment.

The Guam Medicaid expenditures will continue to grow due to increasing medical cost brought about by new drugs, advancing medical technology or new mode of treatment and new health standards or policies, not to mention increase on number of eligible and healthcare services utilization. The Medicaid expenditures (administration and payment to providers) in FY 2020 was \$160.6 million. This is more than 348% increase in comparison to FY 2011 of \$35.9 million. Furthermore, the number of Guam Medicaid enrollees has grown for the past several years, which will continue to grow with the inclusion of COFAS.

**Medicaid (Admin and Medical Payments) and Medically Indigent Program
Expenditures**

Fiscal Year	Total No. of Medicaid Eligibles	Total Medicaid Payment	Total Medicaid Admin Expenditure	TOTAL MEDICAID EXPENDITURES	Total MIP Undocumented Alien Expenditure Charge to Medicaid	Total No. of COFAS MIP Eligibles	Total MIP COFAS Expenditures
2011	35,701	\$ 33,894,279	\$ 1,987,461	\$ 35,881,740	\$ 1,366,917	7,995	\$ 3,948,746
2012	40,433	\$ 46,877,383	\$ 2,069,609	\$ 48,946,992	\$ 5,104,120	7,915	\$ 3,996,307
2013	43,603	\$ 73,499,383	\$ 2,736,446	\$ 76,235,829	\$ 7,230,355	9,603	\$ 1,940,654
2014	44,528	\$ 86,846,732	\$ 3,026,042	\$ 89,872,774	\$ 6,494,115	8,221	\$ 2,897,898
2015	44,033	\$ 81,596,426	\$ 2,688,562	\$ 84,284,988	\$ 7,698,765	8,242	\$ 5,426,886
2016	43,673	\$ 95,382,705	\$ 2,636,618	\$ 98,019,323	\$ 7,227,552	8,353	\$ 5,728,512.66
2017	43,476	\$ 108,609,905	\$ 2,650,294	\$ 111,260,199	\$ 11,946,140	8,357	\$ 7,816,814.43
2018	43,549	\$ 110,876,286	\$ 2,348,585	\$ 113,224,871	\$ 15,054,321	8,485	\$ 5,519,300.18
2019	43,804	\$ 151,062,508	\$ 2,920,243	\$ 153,982,751	\$ 25,651,502	8,654	\$ 8,537,602.57
2020	43,387	\$ 157,256,853	\$ 3,499,583	\$ 160,756,436	\$ 23,416,478	8,122	\$ 7,154,492.55

The Table above depicts the 10-year Medicaid and Medically Indigent Program (Local Program) expenditures.

If no action is taken to resolve this long-standing regulation that affects the Territories, Guam will then revert to receiving fewer federal dollars which is approximately \$19 to \$20 million annually. The inclusion of COFAS Citizens under Medicaid may alleviate some Guam financial hardships, but it is only for COFAS. This does not include the US Citizens living in Guam. In addition, the required local match of 45% will continue to be a financial hardship for the government.

This will deter both on-island and off-island providers from accepting Medicaid patients resulting in more expensive medical treatment. Patients tend to wait until their condition worsens and are forced afterwards to go to the hospital emergency room that will accept them because of EMTALA.

Guam plans to increase the current Medicaid income guidelines and determine applicant's eligibility based on the net rather than gross monthly income in order to reduce our uninsured population, increase the benefits, such as adding long term care services or home community-based services to reduce acute inpatient hospital admission to attain a healthy community. Guam needs a sustainable funding, not a limited-time funding to achieve this plan and create a comprehensive healthcare system that will last to produce better healthcare outcomes for our citizens and promote a healthy Guam community.

We, the Territories, urge the US Congress to end this long-standing disparity on Medicaid funding. Whether we live in a State or Territory, our rights to healthcare services as US Citizens should be the same.

Theresa L. Arcangel 3/15/21
THERESA L. ARCANGEL
Chief Human Services Administrator
Division of Public Welfare, DPHSS

Arthur U. San Agustin
ARTHUR U. SAN AGUSTIN, MHR
Director, DPHSS

RALPH DLG. TORRES
Governor



ARNOLD I. PALACIOS
Lieutenant Governor

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
OFFICE OF THE GOVERNOR

March 17, 2021

GOV20-045

The Honorable Frank Pallone
Chairman
House Committee on Energy and Commerce

The Honorable Cathy McMorris Rodgers
Ranking Member
House Committee on Energy and Commerce

The Honorable Anna Eshoo
Chairwoman
House Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
House Subcommittee on Health

Re: U.S. House of Representatives Committee on Energy and Commerce Hearing “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”

Dear Chairman Pallone, Ranking Member McMorris, Subcommittee Chairwoman Eshoo, and Subcommittee Ranking Member Guthrie,

First of all, thank you for conducting this hearing, “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories,” to examine the administration of the Medicaid program in the U.S. Territories, the disparities in the program between the States and Territories, and most importantly the current capped funding applicable to the U.S. Territories.

As the Governor of the Commonwealth of the Northern Mariana Islands (CNMI), I write this letter in support of H.R. 265, the “Insular Area Medicaid Parity Act.”

Medicaid is a critical component of the health care landscape of the CNMI, as it funds many of the basic health care services and medical needs of our vulnerable island population. Unfortunately, the current capped level of Medicaid funding set forth in the Section 1108 of the Social Security Act has been a restraint to meeting the broader healthcare needs of the people of the CNMI.

We are very appreciative for recent actions taken by the U.S. Congress following the natural disaster of Super Typhoon Yutu in 2018n and during the COVID-19 pandemic, which have bolstered significantly, albeit temporarily, the CNMI’s resources for healthcare, and helped avert what was a looming health crisis. We are once again at a juncture where we are faced with future critical imbalances between Medicaid-related health needs and costs and an inadequate level of funding resources to address these.

It cannot be stressed enough how critical Medicaid, the Children’s Health Insurance Program

(CHIP), and the Presumptive Eligibility enrollment has been to the health of the people of the CNMI. Since the onset of the COVID-19 pandemic, enrollment in these programs has effectively doubled, from around 16,000 in April of 2020 to over 32,000 in February of 2021.

Medicaid's contribution to the overall health of the CNMI extends beyond Medicaid enrollment. The resources directed through Medicaid support our Commonwealth Healthcare Corporation (CHCC) allowing them to retain the care of professionals including cardiologists and radiologists, and support improvements to health care services, that support the health of the wider community. The ability to keep these specialists in the Commonwealth would not be possible without this indirect support from Medicaid.

Another disparity that should be examined is the application of the Federal Medical Assistance Percentage (FMAP) to the CNMI and other territories, which has set a matching rate for the territories at 55% instead of basing this on per-capita income as is the case in the states. The application of the FMAP based on the CNMI's per-capita income, would result in a significantly greater level of Medicaid reimbursements.

I am in full support of CNMI Delegate Gregorio Kilili Camacho Sablan's bill, H.R. 265, to amend the Social Security Act to eliminate the current funding ceiling for Medicaid in the territories beginning in 2021.

The CNMI has already had to go through the exercise of notifying Medicaid beneficiaries that their assistance for their medical care was sunseting and informing health care providers that the Medicaid program would be unable to cover reimbursements for care. I implore Congress to extend the same level of healthcare assistance to the people of the CNMI and other U.S. Territories as is granted the states, and to apply the same calculation for the FMAP to the territories that is used for the states. U.S. citizens that live in the CNMI and other U.S. Territories, should be afforded no less assistance for healthcare than those that reside in states.

Thank you again for holding this important hearing, and for considering the concerns of the people of the CNMI and the other U.S. Territories.

Sincerely,



RALPH DLG. TORRES

Governor of the Commonwealth of the Northern Mariana Islands



March 15, 2021

The Honorable Frank Pallone
Chair
Committee on Energy & Commerce
U.S. House of Representatives

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable Anna Eshoo
Chair
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

RE: GRMC Testimony for “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”

Dear Congressional Leaders:

We are pleased that you have scheduled a hearing for the Energy and Commerce Subcommittee on Health titled “Averting a Crisis: Protecting Access to Health Care in the U.S. Territories” this Wednesday, March 17, 2021, to address the Medicaid Funding Cliff that the five U.S. Territories will experience at the end of this fiscal year if the U.S. Congress and President are unable to provide a legislative remedy. We hope that a permanent solution, rather than another temporary fix, will be provided this time.

The Territories generally record the nation’s lowest per capita incomes and, therefore, should be eligible to receive the maximum Federal Medical Assistance Percentage (FMAP) rate of 83%. Instead, the FMAP rate in the Territories has been arbitrarily and unfairly pegged at 55%, which is equated to the nation’s highest per capita income states (e.g., California and New York). There should be parity and the FMAP formula should be applied in the Territories the same way that it is applied in all 50 states using per capita income. To make matters worse, federal Medicaid spending in the Territories is also subject to an annual cap (Section 1108) that does not apply in the 50 states or the District of Columbia.

The Guam Medicaid program has benefited from the limited-term supplemental Medicaid funding provided by the FY 2020 appropriations package (P.L. 116-94) and the Families First Coronavirus Response Act (FFCRA, P.L. 116-227), which raised Guam’s cap from \$18.4M to \$130.9M in FY 2020 and from \$18.8M to \$129.7M in FY 2021 while also raising the FMAP from 55% to 83%. However, if Congress does not provide additional funding, the annual cap will go back into effect on October 1, 2021 and will restrict federal Medicaid spending in Guam to only \$19.2M in FY 2022 after being \$129.7M in FY 2021, an 86% reduction of \$110.9M. The FMAP will also go back down to 55% from 83%, a 34% drop. We urge the U.S. Congress to permanently eliminate the annual cap and provide the same FMAP formula that is used in all 50 states. If nothing is done to assist the Territories, the FY 2022 impact will be catastrophic.

Congressional Leaders
March 15, 2021
Page 2

Prior to the recent increased cap and FMAP, the Government of Guam (GovGuam) was frequently unable to cover the local match requirement due to lack of funding. As a result, Guam healthcare providers, including GRMC, had to wait many months for payment for Medicaid claims. For this reason, most local clinics did not accept Medicaid patients. If nothing is done to prevent Guam from falling off the Medicaid Funding Cliff, Medicaid beneficiary access to healthcare will once again become severely restricted since it is likely that private clinics will stop accepting Medicaid patients again. This will result in patients not getting proper care in a timely manner and overutilization of hospital emergency rooms for nonemergent care due to lack of access to primary and urgent care.

There are only two civilian hospitals in Guam including Guam Regional Medical City (GRMC), a 130-bed private acute care hospital, and the Guam Memorial Hospital Authority (GMHA), a 161-bed government acute care hospital. Prior to GRMC opening, GMHA was consistently at 100% occupancy since it was the sole hospital supporting Guam's population of approximately 170,000. Even with GRMC and GMHA both serving the community now, there remains a shortage of beds to support the needs of the growing population. The bed shortage was even more pronounced during the COVID-19 pandemic. Guam's population is expected to increase by approximately 10% over the next five years due to the military buildup and relocation of 5,000 marines and their family members from Okinawa, Japan. Based upon historical audit reports for both hospitals, Medicaid has represented about 20-25% of the payer mix for each hospital. As a result of the recent reinstatement of Medicaid coverage for Compact of Free Association (COFA) nation citizens living in the U.S. or the Territories from the Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau, we expect the number of Guam Medicaid beneficiaries to dramatically increase. Therefore, it is likely that GRMC and GMHA will see their Medicaid payer mix increase while their ability to get reimbursed from GovGuam greatly diminish if the U.S. Congress does not provide additional funding by FY 2022.

According to the Guam Department of Public Health and Social Services (DPHSS) 2020 4th quarter report, there were approximately 43,238 Medicaid beneficiaries on Guam. In addition, there were approximately 11,136 Medically Indigent Program (MIP) beneficiaries. Since COFA nation citizens in Guam that have been enrolled in the MIP program are now eligible for Medicaid if consent is provided by the Governor of Guam, approximately 75% of the MIP beneficiary population (8,352) may migrate over to the Medicaid program and bring the total Medicaid beneficiary population up to about 51,590 (a potential 19% increase). If the U.S. Congress does not eliminate the annual cap and provide the FMAP formula the same way that it is calculated for the 50 states (which would provide an 83% federal match), the Guam Medicaid program would likely have to consider reducing benefits, shrinking the network of providers, and reducing the number of people eligible for Medicaid by lowering the income qualifying criteria. This would be disastrous since the February 2021 MACPAC report for Guam indicates that Guam's current eligibility criteria caps the income of a family of four at only 61% of the 2021 Federal Poverty Level (FPL). It's hard to imagine that we may have to lower the income qualifying criteria even further if U.S. Congress does not provide additional Medicaid funding.

Congressional Leaders
March 15, 2021
Page 3

Following are some of the significant Guam Medicaid program improvements that would likely result from the U.S. Congress passing legislation that will eliminate the Medicaid annual cap and provide the FMAP based upon per capita income in the Territories:

- Increased income qualifying criteria to at least 133% of the Federal Poverty Level (FPL), currently at 61% of FPL.
- Increased enrollment in the Medicaid program, reducing our high uninsured rate that was estimated at 21% in the 2010 census.
- Increased payments to health care providers.
- Reduced time to reimburse health care providers.
- An expanded health care provider network on Guam and off-island.
- Increased covered benefits to include Automatic Implantable Cardioverter Defibrillators (AICDs), Hyperbaric Oxygen Therapy for advanced diabetic wound care, bariatric surgery, speech therapy, and home health physical therapy, to name just a few.

Thank you for holding this important hearing. We request the help of the U.S. Congress and President Biden to provide the necessary funding for the U.S. Territories and their respective Medicaid programs by eliminating the annual funding caps and implementing the FMAP formula using per capita income the same way that it is applied in all 50 states. We additionally request your consideration in approving an increase in funding for prescription drug coverage to low-income seniors and inclusion of the Territories in the Medicaid Disproportionate Share Hospital (DSH) program.

Sincerely,



Michael W. Cruz, MD, MBA
President & CEO

cc: The Honorable Michael San Nicolas, Congressman, Guam
The Honorable Gregorio Kilili Camacho Sablan, Congressman, Northern Mariana Islands
The Honorable Lourdes Leon Guerrero, Governor of Guam
The Honorable Joshua Tenorio, Lieutenant Governor of Guam

**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, Ranking Member Burgess 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 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

and 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 September 30, 2019, we project to 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. When the BBA expires, we will also 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 of Congress, we need your support to avert catastrophic damage to our Medicaid program, which will undoubtedly also impact the larger healthcare system. On September 30, 2019, 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 will be established. This is not sustainable, given the current state of our Medicaid program. Since the hurricanes damaging impact in 2017, our Medicaid has been even more in demand and is now the only major source of medical insurance to persons who are poor, disabled, pregnant, and elderly. 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 de-stabilized 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. We are also encouraged by Bill S. 1773, The Territories Health Equity Act of 2019, introduced by Senator Bernie Sanders. Bill S. 1773 seeks to correct long-standing inequities in federal health care funding to the territories, including the U.S. Virgin Islands. However, we understand from various informal discussions with Congressional and Administration staff that such a permanent fix may not be possible at this time, especially before September 30, 2019. However, if a permanent fix is not imminent, we are 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). 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, be provided be provided for three additional fiscal years to the U.S. Virgin Islands at an 83% Federal matching rate. This would be in lieu of our expected \$18.8

million Medicaid cap. 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. After this five-year interim plan, we strongly urge this 83% FMAP be maintained permanently for the U.S. Virgin Islands.

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. The U.S. Virgin Islands Medicaid program has suffered undue financial burden from an arbitrarily low federal matching rate (FMAP), a correspondingly high local matching requirement, and the limited capped Federal funding. 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 more than doubled our Medicaid program to over 27,000 individuals from approximately 12,000 individuals in 2012, increased total expenditures under our Medicaid program to over \$120.5 million, provided much needed healthcare services to our people, and maintained 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 increased costs to us, which we are unable to support with local funding as delays in the rebuilding of our healthcare infrastructure continue.
- The Virgin Islands is already considered a health professional shortage area by HHS and we anticipate that this will be exacerbated with the decrease in Medicaid funding. 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 must be provided mainly in the community.

A decrease in Medicaid federal funding will impede our ability to support the mental and behavioral health crisis we are currently facing in the U.S. Virgin Islands. These funds are needed to pay providers and reimburse facilities for services provided. 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 implemented various activities, which will ensure that this accountability continues:

- We implemented the first ever Territory Medicaid Management Information System (MMIS) in 2013 so our Providers could electronically submit their claims and once the claims are adjudicated receive payment in thirty (30) days or less.
- 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, 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 Medicaid 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 an analytic strategy for analyzing our Medicaid Program. It will also assist the V.I. Medicaid Program 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. We will also 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 the V.I. Medicaid Program is extremely important. To further enhance our Program Integrity, A Joint Operating Agreement (JOA) was 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 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 facilitate 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. Please note that our hospitals 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 and a more permanent solution 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 the Virgin Islands 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.

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

Honorable Chair Pallone, Ranking Member McMorris Rodgers, Subcommittee Chair Eshoo and Subcommittee Ranking Member Guthrie and Members of the Energy and Committee. On behalf of Governor Lemanu Peleti Mauga, Lt. Governor Talauega Eleasalo Va'alele Ale, 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, "Averting a Crisis: Protecting Access to Health Care in the U.S. territories."

Further Consolidated Appropriations Act (FCAA), 2020 and Families First Coronavirus Response Act (FFCRA)

In December 2020, for the first time in the history of the Medicaid program in American Samoa, the Further Consolidated Appropriations Act provided a historical increase to U.S. territories capped annual allotments and increased the FMAP to 83% up from 55%. The FFCRA provided an additional \$2.3 million in funding and 6.2% to the FMAP increasing the FMAP to 89.2%—essentially lowering the local match requirement to 10.8%.

The annual funding increase of \$86.3 million and the 89.2% FMAP increases were a tremendous help to the American Samoa. It gave the territory the breathing room it needed to pay its medical bills and to provide comprehensive medical treatment to patients as permitted under the Medicaid State Plan. Due to the limited local match and the uncertain future of the territory's Medicaid funding ending in FY2021, the Medicaid agency was still unable to increase services and expand the territory's provider network without a permanent, reliable and stable funding stream.

Again, American Samoa and the other U.S. territories will face another funding cliff at the end of FY2021. Without an extension on this \$84 million in funding for American Samoa, The AS Medicaid program will have to suspend all medical care services outside of the hospital. The hospital itself will face a funding shortfall of \$15 million.

The consolidated appropriations law required the territory to comply with specified reporting and program integrity actions. To date, American Samoa continues to work with the Centers for Medicare and Medicaid Services (CMS) on program integrity policies and procedures to implement oversight responsibilities on existing and future providers. The Medicaid agency appointed a Program Integrity Manager who is the Point of Contact for all program integrity activities. Because the American Samoa Medicaid State Agency administers a small Medicaid program with only four providers, CMS under the territory's 1902(j) waived the requirement of establishing a Medicaid Fraud Control Unit in lieu of appointing a Program Integrity Manager and creating a Program Integrity Division in the Medicaid office. American Samoa's end of the year report is forthcoming shortly to the Committee.

Challenge due to the Limited Local Match

Although much gratitude is extended to the Congress for the increase in the territory's Medicaid funding, the key problem that remained was the government's inability to increase the local match that was needed to increase services. While the American Samoa government's annual Medicaid funding was increased from \$11 million to \$84 million each for FY2020 and FY2021, the local match funding remained at \$2 million for FY2020 (level funding from 2018 and 2019). The Medicaid program was able to stretch its \$2 million for its three providers; the Off-island referral program, the FQHC, the DMEPOS and the Medicare co-pay services. The LBJ Hospital received \$26.2 million and the remaining providers received \$2.8 million due to the reduction in services because of the closed borders policy. At the end of FY2020, the Medicaid agency returned \$52.5 million back to the U.S. Treasury as it was unable to expend it due to the limited local match and the closed borders in 2020.

Under the new administration of Governor Lemanu and Lt. Governor Talauega, the local match funding remains at \$2 million as appropriated by the local legislature (*a.k.a.* Fono) for FY2021. However, the Governor and Lt. Governor are deeply committed to increasing the local match from local revenues as needed by the Medicaid program for FY2021—until the next budget cycle when they can submit a new budget statutorily increasing the Medicaid program's local match in FY2022.

COVID-19 Impact

On March 26, 2020, to prevent the COVID from entering the territory, the American Samoa government adopted a strict border closure policy. All incoming and outgoing commercial, government and private transportation services were suspended. The mobility of people in and out of American Samoa was essentially prohibited. This policy was maintained through the end of the last administration until February 1, 2021, when the new administration under Governor Lemanu and Lt. Governor Talauega, began repatriation flights from the U.S. American Samoa had closed its borders for nearly one year. The closed border policy, although it protected the territory from exposure to COVID, it had a devastating financial, emotional and psychological impact on families separated for eleven months.

Impact of border closure on medical care services

COVID caused the closure of not only the American Samoa borders, but also New Zealand which is the medical referral destination for American Samoa patients. For several months, emergency medical charters were suspended until COVID was under control in NZ and all non-emergency/elective medical treatments were prohibited. With the AS and NZ borders closed, AS patients needing medically necessary care not available on island were denied access to life-saving medical treatment. The Medicaid agency proposed and received approved from the Governor to facilitate a medical charter to Honolulu, HI, to allow patients to travel one-way to the U.S. for non-emergency medically necessary care. The return of medical referral patients was not guaranteed until such time American Samoa would be ready to open up its borders. Since tAS and NZ border closures, Medicaid has carried out five Airbus330 medical charters from American Samoa to Honolulu to transport 779 patients and their medical escorts to the US for medical care. With the newly operated repatriation flights from the U.S. into American Samoa, Medicaid has begun the repatriation of patients previously referred off-island.

Congressional Action Needed to Strengthen the Territories Health Care Systems

- (1) Create a permanent funding stream for the territory's Medicaid programs.
- (2) Waive the FMAP for the territory's whose local funds are insufficient to meet the local match requirement.
- (3) In the absence of waiving the FMAP, permanently set the FMAP for the territories at 83%.

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%.

Both the annual 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 interdependent 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 and reserve its Section 1108 funding for the LBJ hospital. 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 increased annual 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.

Background American Samoa's Health Care System and Medicaid Program

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 with 150 beds and five community health clinics under the umbrella of the Federally Qualified Health Centers. The hospital does not have an MRI machine so all diagnostic needs requiring an MRI scan need to be done off-island. The hospital serves approximately 55,000 people and it 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). AS patients are sent to NZ where the medical care is affordable. In the case of AS, Medicaid is the territory's health insurance plan.

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 as 80% and for a poor territory, this is an extremely heavy and unsustainable financial obligation.

Conclusion

The American Samoa government and Medicaid agency 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 Chairs Pallone and Eshoo, Ranking Member Rodgers and Guthrie, and the members of this committee for the opportunity to submit this written testimony.

Medicaid in Puerto Rico: Differences from the States

I. Eligibility

In Puerto Rico, just under 50% of individuals live below the poverty line and receive health care coverage through the Medicaid program.¹ While the percentage of Puerto Ricans enrolled in Medicaid is already higher than in any state,² eligibility is determined based on the Puerto Rico Poverty Level (“PRPL”), rather than the federal poverty level (“FPL”) and is only 40% of the FPL.³ Therefore, Puerto Ricans eligible for Medicaid are significantly poorer than individuals eligible for Medicaid in the states and a significantly larger share of the Puerto Rican population would be eligible for Medicaid if the FPL applied. For example, a family of four in Puerto Rico would be eligible for Medicaid only if its modified adjusted gross income was \$11,316 or lower, whereas a family of four in the states would be eligible if its modified adjusted gross income was \$26,500 or lower.⁴

II. Capped Federal Funding

The federal share of Puerto Rico’s Medicaid funding is capped and varies by year based on Congressional appropriation. The statutorily capped federal share leaves a significant gap compared to what the federal government would contribute to a State’s Medicaid program. In order to mitigate this funding shortfall, which in 2019 was \$2.433 billion, Congress has intermittently provided stopgap federal funding to help, generally related to broader national policy efforts or to help respond to specific crises in Puerto Rico.⁵ One such example was in 2011 when the Affordable Care Act made \$5.4 billion available to the program between 2011 and 2019,⁶ and most recently Congress increased Puerto Rico’s 2020 federal funding from \$375.1 million to \$2.7 billion and its 2021 federal funding from \$383.7 million to \$2.8 billion.⁷ There has been no additional funding allocated past 2021, so under current law Puerto Rico will receive only \$392.5 million in 2022, producing an even larger funding gap than in 2019.⁸

III. Incomplete Mandatory Benefits

According to a U.S. Government Accountability Office report, Puerto Rico is unable to offer 6 of the 15⁹ mandatory Medicaid benefits required under the Social Security Act because existing

¹ See Medicaid.gov, *Puerto Rico: Medicaid Overview*, available at <https://www.medicaid.gov/state-overviews/puerto-rico.html>.

² See Medicaid.gov, *Percentage of Population Enrolled in Medicaid or CHIP by State*, available at <https://www.medicaid.gov/state-overviews/scorecard/percentage-of-population-enrolled-medicaid-or-chip-state/index.html>; MACPAC, *Medicaid and CHIP in Puerto Rico*, p. 2 (Feb. 2021) available at <https://www.macpac.gov/wp-content/uploads/2020/08/Medicaid-and-CHIP-in-Puerto-Rico.pdf>.

³ See MACPAC, *supra* note 2, at 1; Katie Perreira et al., *Environmental Scan of Puerto Rico’s Health Care Infrastructure*, p. 14, The Urban Institute (Jan. 2017) available at <https://www.urban.org/research/publication/environmental-scan-puerto-ricos-health-care-infrastructure/view/full-report>.

⁴ See *id.*

⁵ See e.g., 42 U.S.C. 1308(g); P.L. 116-94 (“Further Consolidated Appropriations Act, 2020”); P.L. 116-94 (“Families First Coronavirus Response Act”).

⁶ 42 U.S.C. 1308(g); see *id.*

⁷ P.L. 116-94; P.L. 116-94; see MACPAC, *supra* note 2, at 3.

⁸ See MACPAC, *supra* note 2, at 4.

⁹ There is debate as to whether there are 15 or 17 mandatory Medicaid benefits. The two not included in the below chart are “medical or surgical services by a dentist” and “emergency services for certain legalized aliens and undocumented aliens.” Puerto Rico covers dental services but not emergency services for aliens. See U.S. Government Accountability Office, *Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts*, p. 12 (April 2016) available at <https://www.gao.gov/assets/gao-16-324.pdf>.

Medicaid in Puerto Rico: Differences from the States

federal funding is insufficient to support a comprehensive program.¹⁰ Mandatory benefits not covered in Puerto Rico include non-emergency medical transportation, nursing facility services, certified pediatric and family nurse practitioner services, nurse midwife services, nursing facility services for individuals aged 21 or older, freestanding birth center services, and emergency medical services for non-citizens.¹¹

Mandatory Benefits¹²	
Inpatient hospital services	Federally qualified health center services
Outpatient hospital services	Laboratory and X-ray services
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services	Family planning services
Nursing Facility Services*	Nurse Midwife services*
Home health services*	Certified Pediatric and Family Nurse Practitioner services*
Physician services	Freestanding Birth Center services (when licensed or otherwise recognized by the state)*
Rural health clinic services	Non-Emergency Transportation to medical care*
Tobacco cessation counseling for pregnant women	* Mandatory benefits not covered by Puerto Rico's Medicaid program

IV. The Lack of Medicare Cost-Sharing Assistance

While Medicaid in Puerto Rico is able to provide Medicare Part A and B cost-sharing assistance to fully dual eligible members,¹³ unlike the states, Puerto Rico is not required to, and does not, offer a Medicare Savings Program (“MSP”) to aid other elderly Medicare beneficiaries in affording premiums and cost-sharing.¹⁴ The MSP provides premium and cost-sharing assistance to partial-benefit dual-eligible Medicare-Medicaid beneficiaries.¹⁵ This cost-sharing assistance is crucial for low-income elderly Medicare beneficiaries to afford outpatient care because under traditional Medicare, beneficiaries’ out-of-pocket spending is not capped.¹⁶

¹⁰ See *id.*

¹¹ See *id.*

¹² S.S.A. § 1905(a); Medicaid.gov, *Mandatory & Optional Medicaid Benefits*, available at

<https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>.

¹³ Dual eligible refers to beneficiaries who fully qualify for both Medicaid and Medicare. 45% of Medicare beneficiaries in Puerto Rico are dual eligible, compared with a national average of 18%. See Kaiser Family Foundation, *Dual Eligibles as a Percent of Total Medicare Beneficiaries (2019)* available at <https://www.kff.org/medicaid/state-indicator/duals-as-a-of-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹⁴ S.S.A. § 1905(p)(4)(A); see Puerto Rico State Plan, p. 23 (May 1993) available at

https://www.medicaid.pr.gov/pdf/stateplan/08_SPA_Attach1.pdf; MACPAC, *supra* note 2, at 3.

¹⁵ 42 U.S.C.A. § 1320b-14.

¹⁶ See Laura Keohane et al., *Medicare Advantage Members’ Expected Out-Of-Pocket Spending For Inpatient and Skilled Nursing Facility Services*, 34 Health Affairs (2015) available at

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681704/#:~:text=Traditional%20Medicare%20does%20not%20offer,out%20of%20pocket%20expenses,&text=Additional%20programs%20protect%20low%20income,traditional%20Medicare%20and%20MA%20plans>.

Medicaid in Puerto Rico: Differences from the States

Further, unlike the states, residents of Puerto Rico are not automatically enrolled in Medicare Part B.¹⁷

V. No Prescription Drug Subsidy

Unlike low-income seniors in the states, residents of Puerto Rico are not eligible for the Medicare Part D low-income subsidy (“LIS”).¹⁸ The LIS, also known as “Extra Help”, is available to low-income Medicare beneficiaries with incomes up to 150% of the FPL and provides an approximate \$5,000 annual value to assist beneficiaries in affording prescription drugs.¹⁹

Instead of permitting Medicare beneficiaries in Puerto Rico to utilize the LIS, the Social Security Act creates a separate drug subsidy to the Puerto Rico Medicaid program called the Enhanced Allotment Program (“EAP”), which provides a more limited amount of funding to reduce prescription drug expenses for dual eligibles.²⁰ Federal EAP funds must be matched at Puerto Rico’s normal Medicaid matching rate, up to a defined cap.²¹ While the EAP uses the same matching rate as Puerto Rico’s general federal match, EAP expenditures do not count toward the cap on general federal Medicaid dollars, and may only be used for prescription drug assistance.²²

Puerto Rico’s EAP funding is between \$40-50 million annually, which is substantially less money per capita than would be allotted under the LIS available to the states.²³ Because EAP funding is provided based on a federal match, Puerto Rico often cannot afford to appropriate enough to receive the full match up to the EAP cap, and therefore does not utilize the entire pot of federal funding, in spite of its beneficiaries’ need for the subsidy money.²⁴

March 15, 2021

¹⁷ S.S.A. § 1837(f).

¹⁸ S.S.A. § 1860D-14(a)(3)(F); S.S.A. § 1935(e)(1)(A).

¹⁹ See Social Security Administration, *Understanding the Extra Help with Your Medicare Prescription Drug Plan*, p. 1 (Feb. 2021) available at <https://www.ssa.gov/pubs/EN-05-10508.pdf>; 114th Congress, *Congressional Task Force on Economic Growth in Puerto Rico: Report to the House and Senate*, p. 26 (Dec. 2016) available at <https://www.finance.senate.gov/imo/media/doc/Bipartisan%20Congressional%20Task%20Force%20on%20Economic%20Growth%20in%20Puerto%20Rico%20Releases%20Final%20Report.pdf>.

²⁰ *Id.*

²¹ See *id.*

²² S.S.A. § 1935(e)(1)(A).

²³ See 114th Congress, *supra* note 19, at 26.

²⁴ See *id.*



Pacific Islands Primary Care Association

Website: pacificislandspca.org
E-mail: info@pacificislandspca.org

Honolulu Office
737 Bishop Street, Suite 2075
Honolulu HI 96813-3211
Phone: 808-537-5855
Fax: 808-537-6868

Regional Office
Marina Heights II, Suite 208
PO Box 5617 CHRB
Saipan, MP 96950
Phone: 670-322-5617

Board of Directors

President
Nena Tolenoa
Kosrae Community Health Center
Kosrae, Federated States of
Micronesia

March 10, 2021

Vice President
Vincent Castro
Kagman Community Health
Center
Commonwealth of the Northern
Mariana Islands

House Energy and Commerce Committee
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Secretary
Dr. Josephine Salmon
Pohnpei Community Health
Center
Pohnpei, Federated States of
Micronesia

Re: Insular Area Medicaid Parity Act (H.R. 265)

Treasurer
Dr. Louisa Santos
Pacific Basin Dental Association

Dear Congressional Leaders,

Lele Ah Mu
American Pacific Nursing
Leaders' Council

As the organization representing the nine Pacific region's Federally Qualified Health Centers (FQHCs) and the 73,826 medically underserved patients they serve, the Pacific Islands Primary Care Association (PIPCA) supports the Insular Area Medicaid Parity Act (H.R. 265). PIPCA is committed to supporting and promoting the improvement and expansion of quality primary care capacity of FQHCs in the US affiliated Pacific Islands, including Guam, Commonwealth of the Northern Mariana Islands and American Samoa.

Elisapeta Ponausua
American Samoa Community
Health Center
American Samoa

The Insular Area Medicaid Parity Act will resolve many of the Medicaid coverage disparities currently faced by those in the territories. I urge you to consider the following:

Dr. James Yaingeluo
Chuuk Community Health Center
Chuuk, Federated States of
Micronesia

- Americans in the territories are no less American than those living in the US states. All U.S. citizens must be treated fairly and equitably regardless of the location of their American home.
- The territories will face the same Medicaid "cliff" for which a band-aid solution was made in 2019. A long-term solution is needed. Eliminate the cap, increase the FMAP.
- For the disaster-prone island territories, Medicaid financing must be responsive, becoming easier for Americans to access when they are most vulnerable without needing to wait for additional appropriations from Congress.
- Medicaid is built as a counter-cyclical program: its federal support expands to meet rising needs during an economic downturn. However, for the territories, Medicaid program funding is stagnant regardless of economic conditions.
- The 1108 cap on federal contribution and low federal matching rate for territory Medicaid programs are arbitrary – the funding disparity is not supported by fair or substantial cause.
- Equal treatment for territory Medicaid programs would enable the insular areas to keep their health care system on its current positive trajectory.
- Medicaid reimbursement is a critical source of revenue for health care service providers. Adequate Medicaid financing has a direct impact on the availability of health care services for all residents in the territories.

Glorine Jeadrik
Ebeye Community Health Center
Republic of the Marshall Islands

Kathleen Mae C. Fernandez
Guam Community Health Centers
Guam

Tom Nadeau
Northern Pacific Environmental
Health Association

Everlynn Joy Temengil
Pacific Behavioral Health
Collaborating Council

Dr. Robert Maddison
Pacific Basin Medical Association

Esther Muna
Pacific Island Health Officers'
Association

Edolem Ikerdeu
Palau Community Health Center
Republic of Palau

John Gilmataw
Wa'ab Community Health Center
Yap, Federated States of
Micronesia

I write today in support of HR 265 and to ask for your support to ensure that the Americans living in the territories are afforded fair and equitable treatment under the Medicaid program. Many covered entities are struggling with severe financial losses as a

result of the COVID-19 pandemic. They cannot afford to be unfairly treated when providing the healthcare their patients need.

Thank you very much for your prompt consideration of this important matter.

Sincerely,

A handwritten signature in cursive script, appearing to read "Arielle Buyum".

Arielle Buyum
Executive Director



March 17, 2021

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
U.S. House Committee on Energy and Commerce
Washington, DC 20510

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
U.S. House Committee on Energy and Commerce
Washington, DC 20510

Dear Chairwoman Eshoo and Ranking Member Guthrie:

The Medicaid and Medicare Advantage Products Association of Puerto Rico ("MMAPA") applauds your convening the hearing today on "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories." We offer the views below in strong support of permanent solutions to the long-standing inequities in Puerto Rico's treatment under federal health care laws, particularly Medicaid and Medicare Advantage.

About MMAPA

MMAPA is a non-profit, member-driven trade association composed of the leading Medicaid and Medicare Advantage organizations in Puerto Rico: First Medical, Humana, MCS, MMM/PMC, Plan de Salud Menonita, and Triple-S Advantage. Founded in 2009, MMAPA advocates for increased government investment in the Puerto Rican health care system. MMAPA's mission is to develop policy proposals that sustain and improve funding for Medicaid and Medicare Advantage beneficiaries and the Puerto Rican health care system at large. To achieve this, MMAPA members educate, advocate to, and collaborate with local and federal officials to stabilize and increase investments in the island's health care system.

Medicaid

The 1.4 million U.S. citizens in Puerto Rico who rely on Medicaid face an immediate crisis: over 75% of the federal funding for the program will evaporate on October 1, 2021 unless Congress acts this year.

Current federal law caps Puerto Rico Medicaid funding and contributes at a far lower federal matching rate than if Puerto Rico were treated like a state. This longstanding inequitable treatment leads to less care, lower reimbursement to providers, and reduced access to coverage. In recent years, Congress has intervened and provided short-term legislation to increase funding and a higher matching rate. Most recently, Congress provided \$5.7 billion for 2020 and 2021, as well as

an increase in the federal matching rate to 76%, rather than the statutory 55% matching rate. Current short-term funding expires on September 30, 2021, at which time funding will revert to the statutory amount of approximately \$392 million and a 55% matching rate.

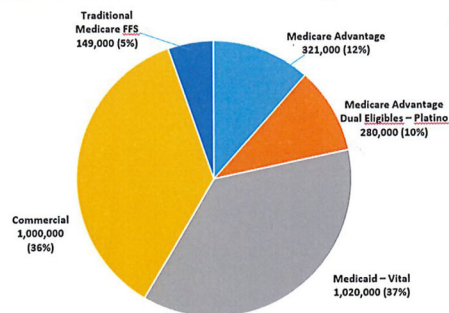
The situation on the ground commands Congress's attention. 43% of Puerto Ricans are living in poverty, compared to just 13% in the states. Puerto Rico's population has significantly higher rates of hypertension, diabetes, asthma, HIV/AIDS, and other medical conditions. This situation could make Puerto Rico an important test case for demonstrating the value of addressing the social determinants of health. Instead, however, due to unpredictable and insufficient funding Puerto Rico continues to lag in long-term investments in its fragile healthcare system. An attached white paper delineates the differences between the Medicaid program in Puerto Rico and the states.

While MMAPA deeply appreciates the funding Congress has provided to the Island's Medicaid program in recent years, the time to provide certainty is now. The simplest and most equitable manner to do this is by removing the statutory cap on funding and permitting a federal matching rate on par with the states, and we endorse that approach. Recognizing fiscal realities, however, we would welcome the opportunity to discuss other approaches so long as they would adequately address the enormous needs of the U.S. citizens of Puerto Rico and also provide the long-term funding needed to invest in critical health and wellness programs. In doing so, as we have in the past, we are prepared to partner with Congress and the Puerto Rico government to enact and abide by all appropriate program integrity safeguards.

Medicare Advantage

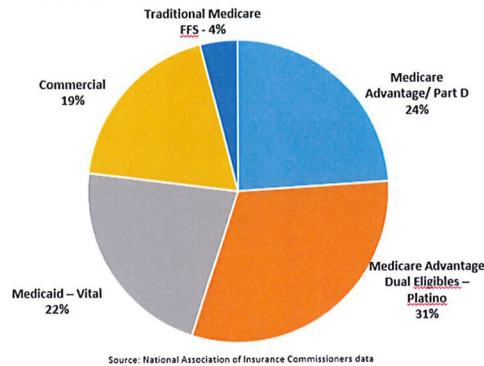
It is impossible to have a discussion about Puerto Rico's healthcare system without also evaluating the needs of its Medicare Advantage program. Medicare Advantage (MA) is a cornerstone healthcare program that sustains patients and providers in Puerto Rico, particularly for the 280,000 elderly Medicaid beneficiaries enrolled in MA Dual Eligible Special Needs Plans (D-SNPs). It is largely because of the shortfalls in Medicaid funding that the MA program plays an outsize role in providing stable health care in Puerto Rico.

Puerto Rico Distribution of Health Care Coverage - 2020 Estimate

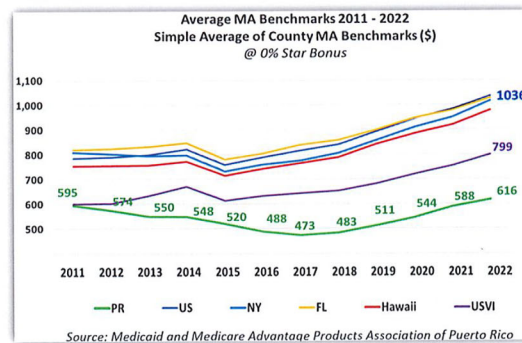


80% of Medicare beneficiaries in Puerto Rico choose MA, leading to an enrolled population of approximately 601,000 in 2020, the 8th largest MA population in the U.S. Due to the high local poverty rate and lack of availability of certain subsidy programs offered in the U.S., many low-income seniors cannot afford Medicare Part B or Part D premiums, therefore MA plans are an essential option to access outpatient medical and prescription drug services. MA plans serve many of our most vulnerable residents, including the 98% of dual eligibles who have chosen to receive their Medicaid benefits through an MA plan. Stability in the MA program is therefore essential to the sustainability of the entire Puerto Rico health care system.

Estimated Distribution of Health Care Resources



MA plans strive to support the Puerto Rico health care system in spite of the fact that MA rates in Puerto Rico have been falling behind the national average for 7 years. Historic inequities in the structure of Puerto Rico's health care system have depressed MA benchmarks to levels that are inconsistent with MA funding in other parts of the United States. Puerto Rico's MA rates are now 41% below the national average and 23% below the rates in the US Virgin Islands.



In spite of limited discretionary relief from CMS, the gap is widening between Puerto Rico MA benchmarks and those in the states. This funding disparity is compounded by the statutory disparity of Puerto Rico being excluded from the Medicare Part D Low Income Subsidy, which would enhance pharmacy benefits for approximately 400,000 beneficiaries.

Part of averting a crisis and protecting access to health care in Puerto Rico is preventing MA rates from falling further behind the national average. We urge Congress to establish a Minimum Standard Benchmark in the MA program that would ensure Puerto Rico rates are more in line with geographic and statistical norms. Reforming MA payment issues now will (1) immediately enhance the quality of care for dual eligibles and other vulnerable Medicare beneficiaries, (2) motivate residents and key healthcare providers in the island to forgo additional migration to the mainland, and (3) encourage future investment in Puerto Rico's healthcare system infrastructure; all of which are urgently needed.

MMAPA has worked closely with Resident Commission Jenniffer Gonzalez to address the MA and related Puerto Rico health care disparities over the last several years. We want to thank her for her thoughtful work in this area and on all aspects of Puerto Rico's fragile healthcare system. We highly recommend that the subcommittee consider her legislation in these areas as soon as possible.

Again, MMAPA greatly appreciates the opportunity to present these views. We stand ready to assist the subcommittee in any way we can to provide meaningful, long-term legislative solutions to Puerto Rico's health care issues.

Sincerely,



Roberto Garcia
President and CEO, Triple S Management Corporation
President, MMAPA

Attachment

Inaugural Survey of Territory Medicaid Directors

November 2019



Introduction

The National Association of Medicaid Directors (NAMD) serves Medicaid Directors from all 50 states, the District of Columbia, and the five U.S. territories: American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands.

Each year, NAMD administers its Operations Survey to Medicaid Directors in the 50 states and District of Columbia, and presents the information collected in an annual Operations Survey Report. For the first time, NAMD administered a new, territory-specific survey to the five U.S. territories for FY 2018. This survey is NAMD's first attempt to help elevate awareness and appreciation of the unique nature of the territories' programs as well as the unique financial challenges they face.

Just as the U.S. territories' Medicaid programs differ from that of the states, they also differ drastically from each other, especially in population size, and therefore also in the number of beneficiaries (as of September 2017):

- Puerto Rico (1.2 million beneficiaries)
- American Samoa (41,000 beneficiaries)
- Guam (35,000 beneficiaries)
- US Virgin Islands (23,000 beneficiaries)
- Commonwealth of the Northern Mariana Islands (17,000 beneficiaries)

Additionally, the territories have distinct standards and processes for determining eligibility. Guam, Puerto Rico and the US Virgin Islands are permitted to use the local poverty level to establish income-based eligibility for Medicaid, and are exempt from statutory requirements to provide poverty-related eligibility to children and pregnant women, as well as qualified Medicare beneficiaries. CNMI uses the income and resource requirements for the federal Supplemental Security Income (SSI) program to automatically qualify people for Medicaid. In American Samoa, Medicaid pays for care provided at a specified medical center in proportion to the number of residents with incomes below Medicaid income eligibility standards. For that reason, eligibility is not individually determined. There are also differences in what benefits are provided, the structure of delivery systems, and much more. For a more detailed analysis of the differences between the territories' programs, please see MACPAC's Fact Sheet from July 2019.²

This survey is NAMD's first attempt to help elevate awareness and appreciation of the unique nature of the territories' programs as well as the unique financial challenges they face.

Medicaid Directors and their Programs in the U.S. Territories

In April 2019, the median territory Director tenure was 24 months (**Figure 1**) with three of the Directors having started in 2017, and the other two Directors having served for over 6 years. While this is slightly higher than the median tenure for the states, which was 21 months for FY 2018, it is still a short amount of time, which reflects a number of factors, including, but not limited to, turnover of political administrations, changes in program priorities, low salary, private sector opportunities and burnout.

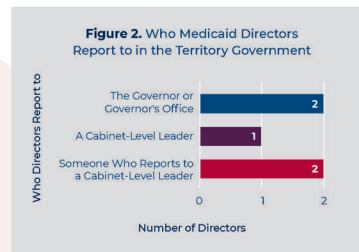
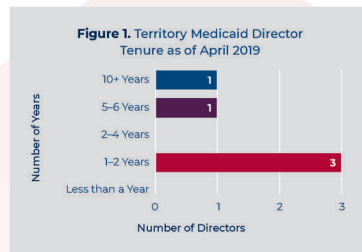
In FY 2018, the salaries of Medicaid Directors in the U.S. territories averaged approximately \$67,000. The salaries of Medicaid Directors in the States averaged approximately \$145,000.

As is also true in the states, in the territories, Medicaid Directors have a wide variety of reporting structures within their territorial government. In 2018, two of the territory Directors reported directly to the Governor or Governor's office, one Director reported directly to a cabinet-level leader,

and the remaining two reported to someone who reports to a cabinet-level leader. (**Figure 2**)

All the Medicaid Directors reported that there are some expertise and knowledge gaps within their workforce. These gaps can be attributed to the relatively small populations of their territory, low compensation packages that make it difficult to hire expert staff, and to the remoteness of the territories, which makes off-island hiring a challenge. These hiring struggles have led to gaps in technical areas such as code updates and National Correct Coding Initiatives (NCCI) edits, as well as much larger gaps in information technology (IT), policy, and financial areas.

Territorial Medicaid Directors and their teams have to be creative when addressing these challenges. Some territories have begun to outsource care to programs outside of the U.S. and/or outsource programmatic work to consultants, while others are utilizing external sources for technical assistance.



Financial Challenges in the U.S. Territories

Since the establishment of Medicaid in 1965, the federal government has used a complex formula to determine each state's Federal Medical Assistance Percentage (FMAP). This dictates how the federal and state governments share in the cost of the program.³ For the 50 U.S. states,⁴ the federal government calculates a state's FMAP rate using a formula which compares the per capita income for each state relative to the national average.⁴ In statute, the federal government's share of Medicaid program spending must be at least 50%.⁵ In the 50 states, Title XIX of the Social Security Act allows FMAPs to be as high as 83% federal spending where per capita incomes are the lowest. Currently the highest state FMAP rate is 77%. In addition, for the 50 U.S. states and the District of Columbia there is no cap on how much the federal government can contribute, it is an open-ended federal entitlement in which the federal government must match all appropriate state spending.

This is not the same for the U.S. territories. The territories all have a fixed FMAP rate of 55% federal and 45% state dollars, regardless of actual per capita income. Additionally, unlike the 50 states, the territories are subject to a statutory cap on federal Medicaid funding (often referred to as a capped allotment or block grant), which grows only with the medical component of the Consumer Price Index (CPI-U). The federal funding cap are as follows for each individual territory as of FY 2018:

- Puerto Rico—\$359.5 million
- US Virgin Islands—\$17.87 million
- Guam—\$17.6 million
- American Samoa—\$11.9 million
- Commonwealth of the Northern Mariana Islands—\$6.6 million⁶

* For the District of Columbia, the FMAP rate is not determined by the FMAP formula, rather it is set at 70% per section 4725(b) of the Balanced Budget Act of 1997, P.L. 105-33.

Financial Challenges in the U.S. Territories (Continued)

Additional Funding for the U.S. Territories

Aside from the capped federal funding, Congress has provided additional, temporary federal Medicaid funds for Puerto Rico and the territories on a limited number of occasions to address economic downturns and natural disasters. For example, the American Recovery and Reinvestment Act (P.L. 111-5) raised each territory's annual allotment by 30 percent for the period between October 1, 2009 and June 30, 2011.

Additionally, since 2011, the territories have had access to additional federal funds through three provisions in the Affordable Care Act (ACA). The territories have all accessed these supplemental funds, but have done so at different rates. The three main funding provisions are the following:

1. **The ACA permanently increased the traditional territory federal matching rate from 50 percent to the current rate of 55 percent** (plus 2.2 percentage points for 2014 and 2015) and provided the territories with a higher matching rate for non-disabled adults without children (87 percent in 2017).
2. **The ACA also provided a total of \$6.3 billion in federal Medicaid funds** (in addition to the allotments) which the territories could access between July 2011 and September 2019.
3. **The ACA provided \$1.0 billion in additional Medicaid funding for those territories that did not establish health insurance exchanges.** Because none of the territories established exchanges, the \$1.0 billion was distributed among all of the territories for the period of January 1, 2014, through December 31, 2019.

Congress has also made multiple adjustments to Medicaid funding for the territories in the aftermath of natural disasters which have impacted the territories at different points since 2017. For example, in response to Hurricanes Maria and Irma, in 2018 Congress increased the allotments for Puerto Rico and the US Virgin Islands and made additional funding available contingent on certain steps. Importantly, for this additional funding only, Congress increased the federal match rate from 55% to 100%—which essentially removed the requirement of spending local dollars in order to access the federal disaster funding. Following Typhoons Mangkhut and Yutu, in 2019 Congress approved similar disaster funding provisions for CNMI, American Samoa, and Guam. Congress recently extended these disaster relief provisions for all of the territories through November 21, 2019.

Congress has provided additional, temporary federal Medicaid funds for Puerto Rico and the territories on a limited number of occasions to address economic downturns and natural disasters.

Financial Challenges in the U.S. Territories (Continued)

Although the additional funding provided by the ACA and the disaster relief bills has been critical to the territories over the past few years, the underlying fiscal construct poses significant ongoing challenges. The first financial challenge the territories face is that each year, they deplete their capped federal funds well before the end of the fiscal year. Three of the five territories deplete their capped federal funds in the 1st quarter, with the other two depleting them between the 2nd and 3rd quarter, so that by the 4th quarter of every fiscal year, not a single territory has any federal funds left due to the cap.

The second financial challenge that the territories face is an inadequate FMAP rate of 55%. One territory reported that in 2010, the US median household income was \$61,544, while the territory's median income was \$19,958. If this territory were given the same FMAP calculation that state Medicaid programs follow, the territory FMAP would be the 83% statutory max.

All of the territories have difficulties supplying the non-federal share for their programs. Without those dollars, they are unable to draw down the federal match. Due to this, many territories are forced to run their programs at a perpetual deficit.

When these challenges coincide in the later quarters of the fiscal year, the territories are then completely liable for the remaining Medicaid expenditures made that year—there are no federal dollars available to them. This creates one of two scenarios in the territories: some of the more resource constrained territories simply shut down the program and notify providers that they will no longer be paid for the rest of the fiscal year. The remaining territories that are able to do so try to backfill the gaps with territorial/local funding, which leads to an effective match rate for the territories as low as 13% federal and 87% territorial.

The problems discussed above regarding the high territorial match rate and inability of the territories to identify funding for the non-federal share, has also affected the territories' ability to draw down their allotted ACA funds. Millions of federal dollars have been "left on the table" to potentially expire. In FY2019, one territory had a Medicaid ACA balance of \$181 million, and they had only drawn down \$46 million, leaving \$135 million to expire, as the territorial government could not identify a source of funding for the non-federal share. In the Spring of 2019, Congress passed provisions permitting territories to continue using the ACA funds through the end of 2019, allowing several of the territories who had been unable to fully draw down on these funds to attempt to do so (for some territories this amount exceeds \$150 million).

Three of the five territories deplete their capped federal funds in the 1st quarter, with the other two depleting them between the 2nd and 3rd quarter, so that by the 4th quarter of every fiscal year, not a single territory has any federal funds left due to the cap.

Territory Recommendations

When asked about how to improve their Medicaid program, territory Directors' main recommendation focused on the financial challenges they face due to insufficient capped federal funds and inequitable FMAP rates. Primarily, the territories have recommended lifting the Section 1108 (g) of the Social Security Act federal budget cap and allowing the territories to use the same FMAP calculation that states do, based on per capita personal income. Two additional recommendations from the territories were to establish specific service contractors for non-available services and supplies just for the territories, and to allow territory hospitals to receive Disproportionate Share Hospital (DSH) payments.

The historical lack of funding has required the territories to operate their Medicaid programs very differently than the states. Congress has stressed that if the federal government were to appropriate additional funding for the territories, they would want to ensure that the additional funding would be spent appropriately and in a meaningful way. All five of the territories recognize this expectation and the emphasis CMS and Congress put on reporting and fiscal responsibility. The territories are all taking a variety of steps to strengthen their infrastructure

in many ways which would justify any potential increase in funding. Examples of these efforts include:

- Implementing advance IT reporting software, MMIS, Medical Claims Data Warehouses, and reporting to CMS via T-MSIS;
- Implementing Fraud Control Units;
- Taking steps to receive technical assistance in program integrity activities from external contractors; and
- Working with CMS Program Integrity and Office of Inspector General to receive recognition for their program integrity work.

However, territorial Medicaid programs should not be expected to look identical to state programs, due to their difference in geographical, political, and fiscal situations. Because of this, they cannot and should not be treated exactly like states. Instead, as the territories work towards increased and improved accountability and integrity in their Medicaid programs, they should receive increasingly equitable funding to the 50 U.S. states and DC, to adequately fund their programs throughout the entire fiscal year.

Primarily, the territories have recommended lifting the Section 1108 (g) of the Social Security Act federal budget cap and allowing the territories to use the same FMAP calculation that states do, based on per capita personal income.

Methodology

Between February and April of 2019, the five U.S. territory Directors received a 10-question survey via email. These 10 questions all required fill-in-the-blank, qualitative responses. The responses to these questions were analyzed by the NAMD staff, and a narrative was created using reference material from MACPAC, Thorn Run Partners, the Kaiser Family Foundation and other resources.

Acknowledgments

The National Association of Medicaid Directors (NAMD) first thanks its U.S. territory members for their time and thoughtful insight in responding to this survey and the significant contributions of their staff. We recognize that this survey requires a significant amount of time and effort, and that there are always numerous demands on their time, and we greatly appreciate their commitment to this new survey effort. NAMD thanks Dawn Cutler for her assistance in administering the survey tool, collecting and analyzing the resulting data, and serving as one of the primary authors of this report. NAMD also thanks Thorn Run Partners for their background research and contribution of the "Additional Funding for the U.S. Territories" section of the report.

Endnotes

- ¹ Medicaid and CHIP Payment and Access Commission (MACPAC). "Medicaid and CHIP in the Territories." July 2019. <https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf>
- ² Medicaid and CHIP Payment and Access Commission (MACPAC). "Medicaid and CHIP in the Territories." July 2019. <https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf>
- ³ The Henry J. Kaiser Family Foundation. "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)." September 30, 2012. <https://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/>
- ⁴ The Henry J. Kaiser Family Foundation. "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)." September 2012. <https://kff.org/wp-content/uploads/2013/01/8352.pdf>
- ⁵ The Henry J. Kaiser Family Foundation. "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." July 15, 2019. <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colid%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁶ Medicaid and CHIP Payment and Access Commission (MACPAC). "Medicaid and CHIP in the Territories." July 2019. <https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf>



National WIC Association

2001 S Street NW, Suite 580
Washington, DC 20009-1165
☎ 202 232 5492 ☎ 202 387 5281
www.nwica.org

March 17, 2021

The Honorable Frank Pallone
Chair
House Energy and Commerce Committee

The Honorable Cathy McMorris Rodgers
Ranking Member
House Energy and Commerce Committee

The Honorable Anna Eshoo
Chair
Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health

Dear Chair Pallone, Ranking Member McMorris Rodgers, Chair Eshoo, and Ranking Member Guthrie:

On behalf of the National WIC Association, the 12,000 service provider agencies we represent, and the approximately 6.25 million women, infants, and young children our members serve, we write to express our strong support for H.R. 265, the Insular Area Medicaid Parity Act. Especially as the nation grapples with ongoing crises of maternal and infant mortality, eligible families living in the U.S. territories should have equivalent access to Medicaid services to assure optimal health, especially during pregnancy, postpartum periods, infancy, and early childhood.

WIC's nutrition assistance and counseling is tailored to improve pregnancy, birth, and child health outcomes. As part of WIC's client services, WIC providers work to ensure that participating families have access to healthcare services – largely provided to low-income populations through Medicaid. Prenatal support provided jointly through WIC and Medicaid is instrumental at reducing preterm births, low birthweights, and other complications that could lead to significant first-year and life-long medical costs. WIC participation, especially when complemented by Medicaid coverage, reduces the likelihood of infant mortality by as much as 33 percent.

Five U.S. territories – American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands – are organized as State WIC Agencies, serving over 132,000 individuals each year and operating at an equal level with geographic states, the District of Columbia, and 33 Indian Tribal Organizations. This structure empowers all 89 State WIC Agencies to deliver effective supports to families expecting or raising young children. WIC services provided by territorial agencies has been especially critical at making healthy foods more affordable, supporting healthier outcomes for pregnancies and infants, and reducing childhood obesity rates.

Medicaid should adopt a similar model to ensure that eligible families living in the U.S. territories have access to quality healthcare. The Insular Area Medicaid Parity Act is a significant step forward in strengthening territorial healthcare infrastructure and enhancing the level of care that families can obtain to ensure optimal health outcomes. We thank the Subcommittee for its leadership in considering this much-needed legislation.

Sincerely,
The National WIC Association

Berry Kelly
South Carolina
Chair

Sarah Flores-Sievers
New Mexico
Chair-Elect

Beth Beachy
Illinois
Chair Emeritus

Meaghan Sutherland
Massachusetts
Secretary

Melinda Morris
Colorado
Treasurer

Rev. Douglas A. Greenaway
Washington, DC
President & CEO

NWG ADVOCACY LLC

March 15, 2021

INVOICE FOR MARCH ADVOCACY

Invoice for legislative advocacy services provided by NWG on behalf of the Puerto Rico Hospital Association per the agreement providing for a \$8000 retainer each month

Retainer payment: \$8,000.00

TOTAL BILL: \$8,000

Please remit payment by the end of the month. Electronic payment is requested.

Domestic Incoming Wire Information Name: Congressional Federal Credit Union Address: P.O. Box 23267, Washington, D.C. 20026-3267

Telephone: 703.934.8300

ABA Routing Number: 2540-7434-5

Credit To: NWG ADVOCACY LLC Account 174595-16



Pacific Island Health Officers' Association

Executive Secretariat

737 Bishop Street, Suite 2075, Honolulu, Hawaii 96813

Tel: (808) 537-3131 | Fax: (808) 537-6868

Website: www.pihoa.org | Facebook | LinkedIn

BOARD OF DIRECTORS

PRESIDENT

The Honorable Esther L. Muna
Chief Executive Officer
Commonwealth Healthcare Corporation
Saipan, Commonwealth of the Northern
Marianas Islands

VICE PRESIDENT

His Excellency Surangel S. Whippis, Jr.
President of the Republic of Palau
Acting Minister of Health
Ministry of Health
Koror, Republic of Palau

SECRETARY

The Honorable Marcus Samo
Acting Secretary of Health & Social Affairs
FSM National Government
Palikir, Pohnpei, FSM

TREASURER

The Honorable Bruce Bilmon
Minister of Health
Ministry of Health & Human Services
Majuro, Republic of the Marshall Islands

MEMBERS

The Honorable Motusa Tuileama Nua
Director of Health
Department of Health Services
Pago Pago, American Samoa

The Honorable Arthur San Agustín
Director of Public Health & Social Services
Department of Public Health & Social
Services
Hagatna, Guam

ASSOCIATE MEMBERS

Chief Executive Officer
LBJ Tropical Medical Center
American Samoa
Director of Public Health
Commonwealth of the Northern
Mariana Islands
Hospital Administrator
Commonwealth of the Northern
Mariana Islands
Director of Health Services
Chuuk State Dept. of Health, FSM
Director of Health Services
Kosrae State Dept. of Health, FSM
Director of Health Services
Pohnpei State Dept. of Health, FSM
Director of Health Services
Yap State Dept. of Health, FSM
Chief Executive Officer and Administrator
Guam Memorial Hospital Authority
Director
Guam Behavior Health & Wellness Center
Secretary of Health
Republic of the Marshall Islands
Director, Bureau of Hospital & Clinical
Services, Republic of Palau
Director of Public Health
Republic of Palau

AFFILIATE MEMBERS

American Pacific Nursing Leaders Council
Association of USAPI Laboratories
Cancer Council of the Pacific Islands
Northern Pacific Environmental Health
Association
Pacific Basin Dental Association
Pacific Basin Medical Association
Pacific Behavioral Health Collaborating Council
Pacific Chronic Disease Council
Pacific Islands Primary Care Association
Pacific Post-Secondary Education Council
Pacific Resources for Education
and Learning
Secretariat of the Pacific Community

March 16, 2021

PIHOA COMMUNIQUE 2021-02

Letter of Support for **Bill H.R.265 - Insular Area Medicaid Parity Act** for the US Pacific Island Territories of American Samoa, Commonwealth of the Northern Mariana Islands and Guam

Dear Congressional Leaders,

We, the Chief Health Officials of the six US-affiliated Pacific Island (USAPI) Territories of American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI) and Guam, and the US Freely Associated States of the Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI), and the Republic of Palau, wish to convey our collective support for **Bill H.R.265** to achieve Medicaid parity for the US Pacific Island Territories of American Samoa, Commonwealth of the Northern Mariana Islands and Guam, including our territorial brothers and sisters in Puerto Rico and the US Virgin Islands.

This bill is long-overdue in addressing a legacy of structural (legislative) inequities that have severely restricted the ability of our limited-resource healthcare systems to provide an adequate level of comprehensive and quality care appropriate to the needs of our American Pacific Islander communities. Today's disproportionately high rates of communicable and non-communicable diseases exhibited across all of our island territories is an unfortunate testament to this legacy, and where a significant amount of healthcare expenditures is spent on tertiary care and off-island medical referrals to hospitals in the Philippines, Taiwan and New Zealand. It is a sad legacy, indeed, to see our US citizen, American residents needing to travel to foreign countries to seek more advanced medical care. Americans in the US Pacific Territories are no less American than those living in the continental US states, and as such, must be accorded the same rights to health as all other US citizens.

More specifically:

1. All US Territories will face the same Medicaid "cliff" for which a band-aid solution was made in 2019. A long-term solution is needed. Simply put, eliminate the cap and increase the FMAP.
2. For our disaster-prone island territories, Medicaid financing must be responsive, becoming easier for Americans to access when they are most vulnerable without needing to wait for additional appropriations from Congress.
3. Medicaid is built as a counter-cyclical program: its federal support expands to meet rising needs during an economic downturn. However, for the territories, Medicaid program funding is stagnant regardless of

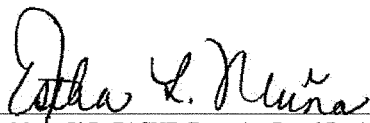
economic conditions, and despite the fact that in the past five years alone, American Samoa, CNMI and Guam collectively experienced three Category 5 typhoons, multiple and current Dengue, Zika and Measles outbreaks, and a global pandemic (Super Typhoon Yutu that hit the CNMI in 2018 was the second strongest recorded typhoon/cyclone ever to hit US soil).

4. The 1108 cap on federal contribution and low federal matching rate for territory Medicaid programs are arbitrary – the funding disparity is not supported by fair or substantial cause.

Medicaid reimbursement is a critical source of revenue for US Pacific Territorial healthcare service providers. Case in point, one out of three CNMI residents were enrolled in Medicaid before the pandemic, and now during the pandemic, roughly three out of four are enrolled. Consequently, the health of our American communities is directly dependent upon adequate, equitable and reliable Medicaid financing.

We urgently request Congressional leadership to support in full and without prejudice, **Bill H.R.265 - Insular Area Medicaid Parity Act**, to remove these structural barriers to assure a fair and adequate level of federal investment in our healthcare systems. In turn, this will enable us to build on current successes for more sustainable and resilient healthcare systems focused on cost-effective and impactful primary care and prevention services.

With Respect:



Dr. Esther Mula, PhD, FACHE, Executive Board President
Chief Executive Officer, Commonwealth Healthcare Corporation
United States Commonwealth of the Northern Mariana Islands



Ms. Emi Chutaro, MSc, Executive Director
Pacific Island Health Officers' Association (PIHOA)

Cc:

1. His Excellency President Surangel Whipps, Jr., Executive Board Vice-President, Acting on behalf of the Honorable Minister of Health, Palau Ministry of Health, Republic of Palau
2. The Honorable Bruce Bilimon, Executive Board Treasurer, Minister of Health and Human Services, Marshall Islands Ministry of Health, Republic of the Marshall Islands
3. The Honorable Marcus Samo, Executive Board Secretary, Acting on behalf of the Secretary of Health, National Department of Health and Social Affairs, Federated States of Micronesia
4. The Honorable Motusa Tuileama Nua, Executive Board Member, Director of Health, American Samoa Department of Health, United States Territory of American Samoa
5. The Honorable Arthur San Agustin, Executive Board Member, Director of Public Health and Social Services, Guam Department of Health and Social Services, United States Territory of Guam

PL 116-94 Congressional Requirements Summary of Activities

The Puerto Rico Department of Health, Medicaid Office and ASES, hereinafter referred to as the PR Medicaid Enterprise, have been working since the enactment of Federal ACT: P.L. 116-94, Further Consolidated Appropriations Act, 2020 (Dec 16, 2019); on activities to support the following Congressional Requirements established by the Act:

PL 116-94 Requirement	PL 116-94 Section	Report Due Date to Congress
1. Review Program Integrity Office Policies / Procedures / Staffing	(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(i)	Appointment of Integrity Lead Officer on June 2020 complied / Integrity Procedures and more staffing Ongoing
2. Develop Payment Error Rate Measurement (PERM) plan	(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(ii)	In process due date is June 2021
3. Develop Contracting Reform Plan	(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(iii)	Report Delivered on due date 12-20-2020, Implementation of the plan is underway
4. Review Medicaid Eligibility Quality Control (MEQC) Policy / Procedures / Staffing	(133 STAT 3106), Division N, Title 1 §202(a)(7)(A)(iv)	Due date is June 2021 and currently ongoing
5. Evaluate Dual Eligible Special Needs Plan	(133 STAT 3107), Division N, Title 1 §202(b)	Due date June 2021 evaluation ongoing
6. Develop Annual Report	(133 STAT 3108), Division N, Title 1 §202(a)(9)	The 2020 report was submitted before due date of October 2020 / The 2021 report is ongoing
7. Develop Report on Contracting Oversight and Approval	(133 STAT 3109), Division N, Title 1, Subtitle B, §202(f)(2)	Report Delivered at due date 12-20-2020, Implementation underway
8. Evaluate Current Process of Managed Care Payment	(133 STAT 3110), Division N, Title 1, Subtitle B, §202(f)(3)	Report Delivered 12-20-2020, no further action needed
9. Develop Scorecard Reporting Measures	(133 STAT 3111), Division N, Title 1, Subtitle B, §202(f)(4)	Report Delivered 12-20-2020, no further action needed
10. Develop Financial Executive Summary for CMS 37/64 Reporting	(133 STAT 3111), Division N, Title 1, Subtitle B, §202(f)(4)(1)	Previous reports has been submitted to CMS in compliance CMS 64 – 1/31/21 CMS 37 – 2/15/21
11. Evaluate Current Contract Requirements and CMS Reporting	(133 STAT 3111), Division N, Title 1, Subtitle B, §202(f)(4)(2))	As requested by CMS Contract reform plan was submitted to Congress and CMS
12. Implement Scorecard Reporting System	(133 STAT 3111), Division N, Title 1, Subtitle B, §202(f)(4)	Report Delivered 12-20-2020, Implementation underway
13. Develop Policies and Procedures for Penalties	(133 STAT 3107), Division N, Title 1 §202(c)	Quarterly (if applicable)

To meet the Congressional mandates, Puerto Rico took the following actions:

- Issued a Request for Quotations in February 2020 to obtain proposals from vendors to assist in complying with the Congressional Mandate. The proposal was adjudicated to Deloitte and the engagement commenced on September 20, 2020 with ASES, DOH and Medicaid.
- From September 2020 through December 20, 2020; Puerto Rico held multiple meetings, interviews and workshops with the Department of Health, Puerto Rico Health Insurance

Administration and Medicaid to define the vision, guidelines and principles around Contracting Reform

- Puerto Rico Submitted the required Annual Report to Congress on October 31, 2020 as part of the compliance to Requirement 6 – Develop Annual Report.
- Medicaid enterprise conducted a thorough review of Government of Puerto Rico Laws, Regulations and Executive Orders was to understand the procurement and contracting legal framework in place for the Government and the Medicaid Enterprise Agencies
- Multiple review meetings were held of all Medicaid Enterprise to draft, review, finalize and publish five requirement reports due by December 20, 2020.
- Puerto Rico responded on November 13, 2020 to initial inquiries from the U.S. Government Accountability Office (GAO) on our contracting processes received on October 29, 2020. This report provides the PRDOH's response to GAO's request for an update on the status of Puerto Rico's development of a contracting reform plan.
- Puerto Rico provided a response to Congress for the following reports required by December 20, 2020:
 1. Develop Contracting Reform Plan – Requirement 7
 2. Develop Report on Contracting Oversight and Approval – Requirement 7
 3. Evaluate Current Process of Managed Care Payment – Requirement 8
 4. Implement Scorecard Reporting System – Requirement 11
 5. Evaluate Current Contract Requirements and CMS Reporting – Requirement 12
- The Puerto Rico Medicaid Enterprise is continuing to work on the development of reports of other requirements that are due during the course of the first six months of 2021 as highlighted on the table above.
- We are also working on some of the recommendations and commitments made to Congress regarding Contracting Reform, Oversight, Evaluation of MCO payments and Implementation of Scorecard Measures.

Further details on each requirement response and plans can be obtained by reviewing the PL116-94 Summary Document which provides the following information:

- A review of the requirement as established in P.L 116-94
- A current status description of what has been done by the Puerto Rico Medicaid Enterprise
- A review of the activities that have been performed to date by the agencies of the Puerto Rico Medicaid Enterprise,
- A summary of planned activities that will continue to be further addressed by Puerto Rico in compliance with the requirements.

As demonstrated herein, the Puerto Rico Department of Health, Medicaid and ASES are all working collaboratively with the goal of meeting each of the mandated requirements of Congress. Our teams are engaged and progressing along the schedules as detailed in this summary.

March 17, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health

Subject: U.S. House of Representatives Committee on Energy and Commerce Hearing "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories"

Dear Congressional Leaders,

As private medical providers in the Commonwealth of the Northern Mariana Islands (CNMI), we, the undersigned private health care providers are submitting this letter for two reasons.

First, we are writing in support of Insular Area Medicaid Parity Act HR 265 and ask for your support to ensure that the Americans living in the CNMI and other territories are afforded fair and equitable health care under the Medicaid program.

We further request Congress to treat the territories no different from the states in Title XIX. This may be achieved by defining "states" as "States, the District of Columbia, and Territories," eliminating the section 1108 caps, and enabling the Federal Medical Assistance Percentage (FMAP) to be calculated using the same methodology applied to the determination of the FMAP for States. The Medicaid program must be treated the same as the States so that the U.S. citizens of the CNMI are able to obtain the same level of health care benefits provided by Medicaid programs in the States.

Second, the private Medicaid health care providers in CNMI would also like to thank the U.S. Congress for responding to the needs of the territory in 2019 by passing P.L. 116-20 Disaster Relief Act, 2019 in June 6, 2019 and P.L. 116-94 Further Consolidated Appropriations Act, 2020 in December 20, 2019. If Congress is unaware, in 2019, when the Medicaid funding under the section 1108 caps and the balance from the Patient Protection and Affordable Care Act was completely depleted in March of 2019, six months before the end of the fiscal year, the Medicaid program directed the Medicaid beneficiary to seek care only to the Commonwealth Healthcare Corporation (CHCC), the public safety-net system. The Medicaid program made that recommendation because there was no money to pay for the services for the Medicaid beneficiaries; and, this included the CHCC, the public health care corporation that could not turn away patients seeking health care. The limitation created many issues and worries, not to mention the long waiting times for primary care and other services for the Medicaid beneficiaries.

The health care providers that are undersigned to this letter urge the U.S. Congress to address the inequities by passing an Insular Area Medicaid Parity Act that treats the Medicaid program in the Territories and the State the same, lifts the section 1108 caps, and applies the same FMAP formula used to calculate the federal/state share based on income levels among states.

Addressing the caps and the FMAP as part of the Insular Area Medicaid Parity Act will put territories on the same foundation as the States.

We understand that the Medicaid program will need to manage the program as any other state. In this regard, our policymakers and Medicaid has made clear that the CNMI is seriously and fully committed to management best practices, accountability, and compliance.

Further, please consider the following in your deliberations:

- Americans in the CNMI are no less American than those living in the U.S. States. All U.S. citizens must be treated fairly and equitably regardless of the location of their American home.
- The 1108 cap on federal contribution and low federal matching rate for territory Medicaid programs are arbitrary – the funding disparity is not supported by fair or substantial cause.
- The territories will face the same Medicaid financial “cliff” for which a band-aid solution was made in 2019. A long-term solution is needed. Eliminate the cap, increase the FMAP.
- For the disaster-prone island territories, Medicaid financing must be responsive, becoming easier for Americans to access when they are most vulnerable without needing to wait for additional appropriations from Congress.
- Medicaid is built as a counter-cyclical program: its federal support expands to meet rising needs during an economic downturn. However, for the territories, Medicaid program funding is stagnant regardless of economic conditions. In the past five years alone, the CNMI has experienced three category-5 typhoons and a global pandemic.
- One out of three CNMI residents were enrolled in Medicaid before the pandemic, and roughly three out of four are enrolled now. The health of CNMI residents is dependent upon adequate Medicaid financing.
- Equal treatment for territory Medicaid programs would enable the CNMI to keep our health care system on its current positive trajectory.
- Medicaid reimbursement is a critical source of revenue for CNMI health care service providers. Adequate Medicaid financing has a direct impact on the availability of health care services for all residents in the CNMI.
- Medicaid provides coverage for essential services for beneficiaries who, due to social determinants of health, have conditions which needs access to preventative services.

Thank you very much for your prompt consideration of this important matter. We urge you to support the Insular Area Medicaid Parity Act HR 265 so that we may continue to provide the needed healthcare services our community deserves.

Sincerely,

The Commonwealth Medicaid Providers from the Commonwealth of the Northern Mariana Islands:

<i>Norma S. Ada</i>	<i>Dr.</i>	<i>Medical Associates of the Pacific, LLC</i>	<i>Mar. 13, 2021</i>
Full Name	Title	Agency	Date
<i>GLORIA SALAZAR</i>	<i>MANAGER</i>	<i>TRI CORP HEALTHCARE SPECIALTIES</i>	<i>3/13/21</i>
Full Name	Title	Agency	Date
<i>GLORIA SALAZAR</i>	<i>MANAGER</i>	<i>TRI CORP PACIFIC SLEEP CENTER</i>	<i>3/13/21</i>
Full Name	Title	Agency	Date

GLORIA SALAZAR	MANAGER	MARIANAS VISITING NURSES	3/13/21
Full Name	Title	Agency	Date

GLORIA SALAZAR	MANAGER	TEMPER NURSING CARE	3/13/21
Full Name	Title	Agency	Date

GLORIA SALAZAR	MANAGER	PT REHAB CENTER	3/13/21
Full Name	Title	Agency	Date

Jennifer Armia	Billing Asst.	Marianas Eye Int.	3/13/21
Full Name	Title	Agency	Date

Emie Ito	Office Manager	Hard Eye clinic	3-13-21
Full Name	Title	Agency	Date

Angie Mister	CNMI Audiological Services		3-13-21
Full Name	Title	Agency	Date

IRMA PALADY	DENTIST	SMILE MARIANAS, INC.	3/12/21
Full Name	Title	Agency	Date

George Cruz	Administrator	Marianas Home Care + Hospice	03/12/21
Full Name	Title	Agency	Date

George Cruz	Administrator	Pacific Wellness Ctr.	03/12/21
Full Name	Title	Agency	Date

George Cruz	Administrator	Enigma Hinombo Family Clinic	03/12/21
Full Name	Title	Agency	Date

George Cruz	Administrator	Allied Medical Supplies	03/12/21
Full Name	Title	Agency	Date

George Cruz	President	Marianas Health Services, Inc.	03/12/21
Full Name	Title	Agency	Date

Full Name	Title	Agency	Date
-----------	-------	--------	------

Jay Selis	Front desk	Health Prof	3-12-21
Full Name	Title	Agency	Date

Jay Selis	Front desk	St. Jude	3-12-21
Full Name	Title	Agency	Date

Jaymie Kanda	Pharmacist	PHI Pharmacy	3/12/21
Full Name	Title	Agency	Date

Kevin C. Guerrero	President	Priority care Marianas Global Ventures, LLC.	3/12/21
Full Name	Title	Agency	Date

Vanessa Diaz	Admin	DFEMS	3/12/2021
Full Name	Title	Agency	Date

Gemma Aledia	Supervisor	Eucen Medical Health Services EMHS	3/12/2021
Full Name	Title	Agency	Date

Theodore R. Parker	Owner	Brabo Pharmacy	3/12/2021
Full Name	Title	Agency	Date

Ellen Vty P. Dizon	Authorizer	Medquest Medical	3/12/2021
Full Name	Title	Agency	Date

DAVID VANZANT	DENTIST	DENTAL CARE	03/12/21
Full Name	Title	Agency	Date

Dr. Michael Hall	Dentist	XNEWAVE	3/12/21
Full Name	Title	Agency	Date

Nicole Cornelison	Admin	Marianas Dental Center	3/15/2021
Full Name	Title	Agency	Date

Ron Cruz	Finance Director	MMS, LLC	3/15/21
Full Name	Title	Agency	Date

Dr. Nelson Krum	Dentist/owner	Paradise Dental Spa	03/15/2021
Full Name	Title	Agency	Date

Margarita Aldan	CLINIC DIRECTOR	SHIPAN SDH CLINIC	3/15/21
Margarita Aldan	Community Health Worker	Kagman Clinic	3/15/21
Margarita Aldan	Community Health Worker	Tirian Isla Clinic	3/15/21

LOURDES A. LEON GUERRERO
GOVERNOR



JOSHUA F. TENORIO
LI. GOVERNOR

UFISINAN I MAGA'HÂGAN GUÅHAN
OFFICE OF THE GOVERNOR OF GUAM

March 17, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce

The Honorable Cathy McMorris
Ranking Member
Committee on Energy and Commerce

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health

**RE: United States House of Representatives, Committee on Energy and Commerce,
Subcommittee on Health Hearing – “Averting a Crisis: Protecting Access to Health
Care in the US Territories”**

Written Testimony of Governor Lourdes A. Leon Guerrero for the Record

At the outset, I would like to express my thanks, on behalf of the people of Guam, for the passage of the Further Consolidated Appropriations Act, 2020 (Public Law 116-94)¹ which has allowed for an increase in the Medicaid cap from \$18.38 Million to \$127 Million and increased the Federal Medical Assistance Percentage (FMAP) from 55% to 83%. There was an immediate impact to the Medicaid program on the island.

Historically, the Guam Medicaid Program, and those of the other territories, has operated as a block grant requiring local matching funds at the rate of 45%. 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. 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. By historically requiring a relatively high match rate and the application of a cap, the result has been a program that has been plagued with long delays in payments to providers, limitations on the services provided, and the ability to expand the health provider network.

In the short time that this act has been in effect, the Guam Medicaid program has been able to make significant strides in critical areas. The program has been able to process all healthcare claims timely and provide payments to providers regularly as there are no delays resulting from

¹ See Division N - Health and Human Services Extenders, Title 1 Health and Human Services Extenders, Subtitle B- Medicaid Provisions Public Law 116-94 113 STAT.3108.

Written Testimony: Averting a Crisis: Protecting Access to Health Care in the US Territories
 March 17, 2021
 Page 2

the dependency of available local resources for the match. Consequently, there has been an increase in access to health care services as providers are more willing to accept Medicaid patients. Moreover, the increased funding provided Guam the opportunity to increase the Medicaid Program income eligibility guidelines to the maximum permitted by Title XIX and reduce the number of the uninsured population. These actions are always reviewed by the Centers for Medicare and Medicaid Services (CMS), the federal administrators of the program. It is our hope that Congress will see fit to permanize this temporary situation and provide equitable access to health care for the citizens of Guam and the other territories in the same way it is available to the States and the District of Columbia.

The timely processing of claims also reduces the opportunity for fraud and disallowed costs resulting from lost or misplaced supporting documentation. The requirement for the designation of a Program Integrity Lead within the Medicaid program has been met. Further, I have designated the Director of the Department of Administration to establish a Medicaid Fraud Control Unit (MFCU). Having the MFCU completely separate and outside of the Department of Public Health and Social Services that administers the Guam Medicaid Program underscores our commitment to comply with all federal regulations and vigilantly guard against fraud, waste and abuse. This unit will be staffed by auditors and accountants who will receive specialized training by the CMS and the Unified Program Integrity Contractor (UPIC-West) to carry out the applicable federal mandates.

Our Guam Medicaid Program has also been working with the CMS to meet the requirement in P.L. 116-94 to submit data to the Transformed Medicaid Statistical Information System (T-MSIS). We fully appreciate the importance of this reporting requirement and will make reasonable and timely progress in this regard. Specifically, the Guam Medicaid program meets with the CMS on a weekly basis and will be preparing an Implementation Advanced Planning Document (IAPD) to initiate the changes that are required to our current system to be able to submit data to the T-MSIS.

The Medicaid program, additionally, is in the process of planning a claims and data warehouse and decision support system to enable the examination of program costs and will be working with the CMS to plan and implement a health information exchange so that Medicaid patient care and coordination, patient access to information, and patient safety can be improved.

Our administration is looking forward to the ability to expand the Guam Medicaid Program. The section 1108 budget could never meet the needs of the Medicaid program when coupled with the match. However, we are finally able to actively explore the opportunities available in other states to expand services and to reimburse other health care providers in the public sector to receive reimbursement for the cost of services provided to Medicaid beneficiaries. The negative impact on our program, and those of the other territories, is that if this temporary section 1108 funding is not permanized through treating the territories the same as the states, then, our efforts to improve care to the U.S. citizens of Guam cannot be realized.

By making the situation permanent we will be able to effectively plan for providing increased services to our most vulnerable population. We would be able to provide the type of

Written Testimony: Averting a Crisis: Protecting Access to Health Care in the US Territories
March 17, 2021
Page 3

benefits that Medicaid recipients throughout the Nation currently enjoy like access to long-term health care, outpatient physical therapy, more preventative care, school-based health care, more prescriptions drug coverage among others. Without a permanent solution and with the inclusion of Compact Migrants to the eligibility pool, we will be forced to reduce the already limited covered benefits. This will have the opposite effect of the intended outcome of the Medicaid program.

The United States Citizens who call Guam home deserve to be treated equitably in all respects, most especially when it comes to access to health care. Our ability to provide quality health care to the poorest among us, to provide benefits aimed to prevent repeat hospitalization, to provide early intervention, to provide a better quality of life overall through increased access to health care hinges largely on providing a permanent solution to the Medicaid funding issues facing Guam and all of the territories.

I wish to thank this Committee, its leadership, the Members of Congress who represent the Insular Areas who have championed this effort, most especially Congressmen Sablan and San Nicolas who have worked closely with us up to this point and whom we know we can count on to continue these efforts on behalf of our people.

Senseramente,



LOURDES A. LEON GUERRERO
Governor of Guam



STATEMENT BY JAIME PLA CORTES
EXECUTIVE PRESIDENT OF THE PUERTO RICO HOSPITAL ASSOCIATION
before the
U.S. House Health Subcommittee of the Committee on Energy and Commerce

***"HEARING ON "AVERTING A CRISIS: PROTECTING ACCESS TO
HEALTHCARE IN THE U.S. TERRITORIES"***

Wednesday, March 17, 2021

Chairwoman Eshoo, Ranking Member Guthrie and Subcommittee Members:

Thank you for the opportunity to present my statement on behalf of the Puerto Rico Hospital Association (PRHA) representing our 68 hospital members and over 45 thousand plus health care professionals and staff. Hospitals are the core of our island's health care system and vital to the quality of life for the 3.2 million U.S. Citizens residing in our Territory; the Commonwealth of Puerto Rico.

We wish to ask the Members of this subcommittee to address the need for equal treatment of U.S. Citizens residing in Puerto Rico under the Federal Healthcare Programs, Medicaid and Medicare. Every provider in Puerto Rico is a Medicaid provider and historically, we have received disparate treatment even while we serve to provide the highest quality of care for local residents and visitors.

Like every hospital system in the USA, we have faced great challenges over the past year as the COVID-19 pandemic has threatened the health of our communities while placing extreme financial challenges on our hospital system.



We also ask to draw the Subcommittee's attention to the urgent need to prevent the impending "Medicaid Cliff" facing Puerto Rico's Medicaid system in the third quarter of 2021. Without immediate action by Congress, we face a devastating loss of 85% of our Federal Medicaid funding likely forcing a large number of Medicaid enrollees to lose their coverage and jeopardize the financial viability of our island's hospital system. It would also jeopardize the financial stability of every hospital in Puerto Rico.

We have always urged a permanent solution to the need for equal treatment for Puerto Rico. Two years have gone by very quickly since Congress chose to provide additional funding (P.L. 116-94) to prevent the previous Medicaid Cliff in 2019. However, we now approach another Cliff in September of this year and we again urge that Congress repeal the statutory cap on Medicaid funding for Puerto Rico and provide permanent and equal treatment for our health care system and the U.S. Citizens whom we serve.

It is important to point out:

1. Providers in Puerto Rico are forced to operate with much lower reimbursement rates than their counterparts in the States. In fact, our Medicaid reimbursements are barely one-half or less than the U.S. average.
2. The Medicaid Cliff and the uncertainty it has created over the past decade has been a major contributing factor to the loss of doctors, specialists and health care professionals who have been recruited away by Stateside health care systems offering more generous compensation packages. The uncertainty and financial squeeze imposed on Puerto Rico's hospitals and other providers has made it very difficult to offer attractive and competitive compensation packages to retain our experienced, bilingual medical staff and professionals. The inability of our Medicaid system to properly reimburse our hospitals and other providers due to the combination of the



reduced level of Federal funding along with uncertainty of the impending Medicaid Cliff has been a primary factor for this loss. This has certainly impacted the ability of Puerto Rico's health care system to provide readily available care to the Medicaid population as well as to the general population throughout Puerto Rico.

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

3. Another consequence of the uncertainty created by the Medicaid Cliff is the impact on the ability of Puerto Rico's hospitals to modernize and upgrade their physical plant and facilities as well as medical diagnostic and treatment technologies. Approximately, 90% of local hospitals are privately owned and have 30-40 year old buildings and physical plant. These hospitals are dependent on bank financing to make physical improvements and upgrades. However, the short-term approach to addressing the Medicaid Cliff has resulted in the Puerto Rico's banks being hesitant to provide financing for improvements. Puerto Rico's hospitals are willing to invest and want the most state-of-the-art facilities and equipment to provide quality health care. We must remember that banks always look at the long-term ability of their clients to repay their loans and without the guarantees provided by a permanent solution to the Medicaid Cliff, bank financing has



been limited. This lack of financing has delayed and frozen the ability of local hospitals to modernize and obtain the best medical technologies.

BACKGROUND:

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

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

proportion of the population and the majority of newborns today are Medicaid eligible.

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



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

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

We argue it is time to come up with a permanent solution that provides long-term stability to our health care system so that our hospitals retain our doctors and health care professionals currently being recruited away by better salaries and stable health care systems located Stateside. It takes years to recruit and replace lost doctors, specialists and other key health care professionals lost to higher paying opportunities elsewhere.

In previous years, Puerto Rico health care providers have asked to remove this funding cap and provide for equitable treatment under Medicaid for our Medicaid system. Congress last attempted to address this need in the FY 2020 by providing for an allocation of additional funds with the anticipation that these funds would be exhausted in the last quarter of FY 2021. Congress also waived the FMAP requirement to provide a local match due to the devastating impact of the hurricane on local government finances. CMS has since certified that PR's Medicaid system has met the requirements



to establish a Medicaid Fraud Unit and provide for better data collection. Time has now passed, and these additional funds are now projected to be exhausted at the end of the Federal Government's FY 2021; only one quarter of the way through Puerto Rico's upcoming fiscal year.

A PERMANENT SOLUTION NOW IS NEEDED in 2021:

We believe a fair solution is to provide State like treatment for Puerto Rico. This requires permanently eliminating the statutory cap and discriminatory FMAP for Congress to achieve this goal to provide greater confidence to our health care system and allow for delivery of the highest quality health care which we all wish to deliver to the U.S. Citizens of Puerto Rico.

The Puerto Rico Medicaid system needs to enter into contracts for its FY 2022 Medicaid Program immediately because CMS must certify that these contracts are actuarially sound before they can go into effect for the local FY 2022 operating budget for the coming year. Without the confidence of certainty regarding the level of funding available, it will be very difficult to attract willing contractors to administer and implement a managed care system between July 1, 2021, and June 30, 2022. The current fiscal state of the local government prevents it from making up any of the difference; something no State would be asked to do.

We continue to urge equal access for Medicaid funding needed to maintain a quality health care system for the 1.4 million possible Medicaid eligible in Puerto Rico. Frankly, the uncertainty of Federal funding complicates our ability to retain and recruit doctors and other vital health care professionals who are constantly tempted to leave our island for higher salaries elsewhere in the United States. The uncertainty over Congress's resolution of the



Medicaid Cliff also hampers the ability of local hospitals to obtain bank financing for moderation and upgrades.

We ask that a provision be included in the first available Federal health care funding package to be acted on by Congress to provide continuity for Puerto Rico's health care system. We welcome the opportunity to work with you to develop the best and most appropriate legislative language to achieve this goal.

PR's health system and its hospitals are under a tremendous amount of financial stress due to the challenges of Covid-19, the island's weak economy and overall underfunding by Medicaid. The lack of certainty regarding funding complicates the ability to meet CMS requirements for operation of PR's Medicaid program for the coming Fiscal Year beginning July 1, 2021.

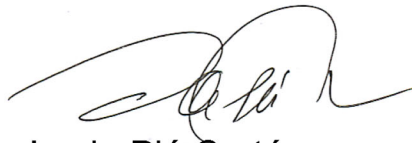
By providing certainty through a permanent solution achieving equal treatment for the U.S. Citizens of Puerto Rico, Congress can inject the needed sense of confidence to PR's hospitals necessary to continue delivering the high level of quality care expected by patients and the Federal government and retain top medical staff.

We also emphasize that Congress has continually returned to face this issue of the Medicaid Cliff. A permanent solution to this perennial problem facing Puerto Rico and the Congress is the best solution.

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



Contact information:



Jamie Plá Cortés
Executive President
Puerto Rico Hospital Association
Villa Nevárez Professional Center, #101
San Juan, Puerto Rico 00927
Phone: 787-764-0290

**Statement of Neil C. Weare, President and Founder
Equally American Legal Defense and Education Fund**

Averting a Crisis: Protecting Access to Health Care in the U.S. Territories:

Hearing Before the House Committee on Energy and Commerce, Subcommittee on Health

March 17, 2021

Chair Eshoo, Ranking Member Guthrie, and distinguished Subcommittee members:

My name is Neil Weare, and I am the President and Founder of Equally American Legal Defense and Education Fund. We are a nonpartisan civil rights law organization that fights to advance equality and civil rights for the 3.5 million Americans living in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands. Our values are centered on the basic principle that all Americans should have equal rights and representation, wherever they live.

Let me begin by thanking the Subcommittee for holding today's hearing. Protecting access to health care in the territories is indeed a national concern and should thus be a national priority. The territories, as you know, have neither voting rights nor voting representation in Congress. That shackles them with added burdens when trying to seek redress for their interests here in Washington. So our organization applauds the proactive approach this subcommittee is taking to avert a crisis of health care access in the territories.

Protecting access to health care in the territories is a matter of basic fairness. As you know, Medicaid funding is typically allocated to the states based on the per-capita income of their residents. But citizens in U.S. territories have historically received less funding than citizens in states with similar per-capita incomes. Moreover, Medicaid funding for the territories has long been arbitrarily capped well below the territories' actual needs. This uncertainty, instability, and vulnerability discourages providers in the territories from serving low-income patients, which has life and death consequences. It also has created significant financial strains on territorial governments, contributing to a structural debt crisis in each territory. No American should be denied access to health care for arbitrary and discriminatory reasons. Yet that is exactly what is happening today in the territories.

Protecting access to health care in the territories is also a matter of racial equity. Ninety-eight percent of Americans living in the territories identify as racial or ethnic minorities, or indigenous peoples. These communities have historically faced impediments to equitable access to health care. This ongoing discrimination against citizens in U.S. territories is an unfortunate legacy of

the *Insular Cases*, which for over a century have relegated those living in the territories to a second-class status. Rooted in the same unrepentantly racist notions as *Plessy v. Ferguson*'s separate-and-un-equal racial segregation, the *Insular Cases* sanctioned a colonial relationship between the United States and citizens in its territories that is not substantively unlike the one rejected during our Nation's founding. *Plessy* has thankfully been since overturned, but the *Insular Cases* regrettably remain on the books. Until that changes, we encourage this Subcommittee to lead the charge against discriminatory treatment of the territories. We cannot change the regrettable injustices of the past. But we can choose to make a fairer, more equitable future for all Americans.

Protecting access to health care in the territories also implicates the Constitution's guarantee of equal protection. The Supreme Court is currently considering *United States v. Vaello-Madero*, which challenges the federal government's arbitrary exclusion of residents of Puerto Rico from the Supplemental Security Income program. Like Medicaid, SSI provides a safety net to some of our country's most vulnerable citizens. *Vaello-Madero* also has broad implications for Americans living in American Samoa, Guam, and the U.S. Virgin Islands, who are likewise denied access to SSI benefits. Recently, Members of Congress called on the Biden-Harris Department of Justice to stop defending arbitrary discrimination against residents of the territories (see [attached](#)). Regardless what position DOJ ends up taking, we hope that the Supreme Court will agree that arbitrarily discriminating against otherwise eligible Americans based solely on where they live is indeed unconstitutional. However, the Subcommittee need not and should not wait for the courts to ensure equal protection. We encourage an immediate legislative fix that ensures that citizens in the territories are able to fully enjoy federal programs like Medicaid and SSI that other American communities take for granted.

Protecting access to health care in the territories is needed to avoid a looming crisis. Favorable Medicaid treatment for territorial residents that was initially enacted as temporary will soon end without further congressional action. If that happens, the territories will face a Medicaid "cliff," making it likely that funding will run out part way through the year, jeopardizing lives. We therefore urge your support for eliminating Medicaid's general funding limitation for the territories altogether, and for making this permanent. This has long been a priority for the Members of Congress who represent citizens in the territories. We especially thank Congressman Kilili Sablan of the Northern Mariana Islands for his outstanding leadership on this issue through the introduction of the Insular Area Medicaid Parity Act, H.R. 265, which currently has over 60 bi-partisan co-sponsors.

Equally American applauds your attention to these important issues, which too often are neglected or forgotten by the federal government. We stand ready as a resource to support your work to protect access to health care for the 3.5 million U.S. citizens who live in the territories. Thank you for the opportunity to present written testimony.



GOVERNMENT OF PUERTO RICO
OFFICE OF THE GOVERNOR

**Written Testimony submitted by the
Honorable Pedro R. Pierluisi
Governor of Puerto Rico
before the U.S. House of Representatives Committee on Energy and Commerce,
Health Subcommittee
Hearing on "Averting a Crisis: Protecting Access to Health Care in the U.S.
Territories
March 17, 2021**

Chairman Pallone, Health Subcommittee Chairwoman Eshoo, Ranking Member McMorris Rodgers, Health Subcommittee Ranking Member Guthrie, and Members of the Committee:

We thank you for the opportunity to submit a statement to the Subcommittee to discuss how to protect access to healthcare for the millions of Americans who reside in the U.S. Territories. I come to you today on behalf of 3.2 million American citizens, in my capacity as the Governor of Puerto Rico.

Medicaid is the primary federal program designed to provide access to healthcare for Americans with limited resources, including many of the Nation's most vulnerable populations. The vulnerable U.S. citizens in Puerto Rico have the same need for quality healthcare as those on the mainland, but historical limitations and shortfalls in Medicaid funding for Puerto Rico limit access and place a far higher burden on the local program that is placed on any other U.S. jurisdiction. The COVID-19 pandemic has only exacerbated these challenges.

Since the early days of the Medicaid program, Puerto Rico has continuously urged Congress to provide an adequate funding stream that does not place Americans residing in Puerto Rico at a disadvantage, and starting with the Affordable Care Act, there have been some improvements. However, those improvements have been temporary, and Puerto Rico, every couple of years, has faced a massive funding cliff and a potential humanitarian crisis as a result, as it will again happen at the end of the current fiscal year. Although Puerto Rico participates in the Medicaid program, its effective Federal Medical Assistance Percentage ("FMAP") has always been below where it would be if the FMAP were determined as it is for the states. Currently, the territorial FMAP is set by statute at 55 percent, but would likely be above 80 percent if based on a formula that takes into account Puerto Rico's average per capita income. In addition, Puerto Rico's Federal Medicaid funding is capped, and as a result, its effective FMAP is usually far lower than the statutory amount.

Specifically, the Affordable Care Act ("ACA") provided a block grant to the territories, which expired on December 31, 2019. The Consolidated Appropriations Act of 2017 provided Puerto Rico with nearly \$300 million in additional Medicaid funds, and the Bipartisan Budget Act of 2018 provided Puerto Rico and USVI with funds that were available until September 30, 2019. The Further Consolidated Appropriations Act of 2020, provided Puerto Rico and the other U.S. territories an increase in Section 1108(g) of the Social Security Act (SSA) capped funds and an increase in the FMAP.

Puerto Rico was allocated an increased capped funding of \$2.6 billion for fiscal year (FY) 2020¹, and \$2.7 billion for FY 2021, at an increased FMAP of 76 percent. The increased capped funding for FY 2020 and FY 2021, respectively, were also subject to a potential annual increase of \$200 million, if the Secretary of Health and Human Services (HHS) certified that Puerto Rico established a reimbursement floor, implemented through a directed payment arrangement plan, for physician services covered under Medicare Part B at a rate not less than 70 percent.²

For FY 2021, the total cost of Puerto Rico's Medicaid program is roughly \$3.7 billion, of which roughly \$3 billion is the capped Federal share (resulting in a blended FMAP of roughly 82%). The increased funding has had a very positive effect on the Island's health care programs by:

- Allowing substantial increases to provider compensation: elevating Medicare Part B reimbursement to 70 percent of Medicare Fee Schedule
- Providing hospitals DRG-based increases amounting to \$106 million
- Providing \$50 million dollars to Primary Care Providers ("PCP")
- On the beneficiary side, it allowed raising the poverty level to 85 percent of the federal poverty level, which enabled up to 200,000 new members
- Funded the Hepatitis-C initiative to start eradication of the disease by 2030

While these increases have helped provide greater access to healthcare for our vulnerable populations, Puerto Rico now faces a Medicaid fiscal cliff on September 30, 2021. In effect, if Puerto Rico were to "hit the cliff," federal Medicaid funding would revert to the historical Section 1108 allotment – about \$392.5 million – and the remaining Medicaid expenditures would have to be covered with local funds.

¹ The Government of Puerto Rico initially was unable to obligate the totality of the appropriated funds for FY 2020 due to a rejection by the Financial Oversight and Management Board (FOMB) of Puerto Rico to implement the Puerto Rico Poverty Level (PRPL) initiative that would have resulted in an estimated additional 200,000 new beneficiaries joining Puerto Rico's Medicaid program in 2020. The FOMB denied the implementation of the initiative because the appropriated federal funding for Puerto Rico's Medicaid program was only for two years.

In accordance with PROMESA (P.L. 114-187), the FOMB did not want to approve a program with new beneficiaries that would face a fiscal cliff. On October 16, 2020, the FOMB approved the Government of Puerto Rico's petition to temporarily expand Medicaid coverage under the Vital Plan to more than 200,000 new beneficiaries due to the gravity of the COVID-19 pandemic. On December 11, 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Vital Plan.

² Puerto Rico has been working since the Consolidated Appropriations Act of 2020 on improvements to its Medicaid Program requested by Congress. A report on those activities is attached to this statement.



If no action is taken by Congress, the effects would include the following:

- Revert to the \$392.5 million cap and the 55 percent FMAP which is far below the current \$2.8 billion that Congress allocated for FY21. It would create an enormous budget shortfall, and it is far below what is needed to operate the program on a state-like basis, as discussed further below

This funding gap would force the Island's program "Vital" to:

- Rollback all increments afforded to primary care providers as described above
- Un-enroll over 200,000 Medicaid beneficiaries due to a scale back on poverty levels
- Un-enroll between 350,000-400,000 Medicaid beneficiaries in addition to the 200,000 mentioned above to cover the budget gap referenced above

COVID-19 has affected Puerto Rico as severely as it has affected other parts of the Nation, and the impact on Medicaid has been increased expenses to cover tests, vaccinations, and treatments. The program has been able to leverage the additional funding to cover these services without any effect on the negotiated premium. A side effect, however, has been a noticeable and persistent drop in hospital utilization, endangering the long-term viability of several hospitals.

I support the efforts of Resident Commissioner Jenniffer González-Colón and others in Congress to propose changes in Medicaid funding for Puerto Rico that are big, bold, dramatic, and historic, in keeping with the changes this Congress already has enacted with respect to the application of the Child and Earned Income Credits in Puerto Rico. It is time to move from the uncertain and unstable temporary funding system for Medicaid and transition to a state-like program and an FMAP based on Puerto Rico's per capita income relative to that of the Nation.

I recognize that state-like treatment will require an expansion of the Medicaid services offered in Puerto Rico. It is my view that American citizens in Puerto Rico with limited resources should have the same basic healthcare services that Americans enjoy anywhere else in the United States, and we are prepared to work with Congress to transition promptly to a fully-funded state-like Medicaid system.

We ask Congress to seize this moment when Puerto Rico faces a Medicaid cliff and the resulting public health crisis to instead provide adequate and stable long-term funding to provide the life-saving services patients require to meet their medical needs and to retain medical specialists by providing competitive reimbursements as it does for Americans in the fifty states and the District of Columbia.

I thank the members of this Subcommittee for addressing this vital topic and for taking into consideration the health care needs of vulnerable U.S. citizens in Puerto Rico and in the U.S. Territories.



Attachment—Additional Questions for the Record

**Subcommittee on Health
Hearing on
“Averting a Crisis: Protecting Access to Health Care in the U.S. Territories”
March 17, 2021**

Anne Schwartz, Ph.D., Executive Director, Medicaid and CHIP Payment and Access Commission

The Honorable Gus Bilirakis (R-FL)

1. The pending Medicaid fiscal cliff is not only an issue for the U.S. Territories, but is also a U.S. issue – especially for the state of Florida which 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 it more costly to manage a chronic disease patient in the U.S. Territories or in the States?

MACPAC does not have data to compare the cost of managing a patient with chronic disease in the U.S. territories to the cost in the 50 states and District of Columbia. However, we know that spending per full-year equivalent (FYE) enrollee is substantially lower in each territory than it is for the 50 states and the District of Columbia. For example, in fiscal year (FY) 2018, the state with the lowest spending per FYE spent \$3,802; the median state spent \$6,380. By contrast:

- American Samoa spent \$1,407;
- the Commonwealth of the Northern Mariana Islands (CNMI) spent \$2,880;
- Guam spent \$3,292;
- Puerto Rico spent \$2,034; and
- the U.S. Virgin Islands (USVI) spent \$2,895 (Schwartz 2021).

It is important to note that these statistics exclude spending for long-term services and supports, which the territories generally do not provide. We are also unable to adjust for differences in health status of enrollees, or enrollment mix (i.e., the distribution of enrollees across different eligibility groups).

Lower spending per FYE in the territories may reflect several factors. For example, the Section 1108 cap limits available funding for Medicaid services. In addition, territories that have difficulty raising the nonfederal share of expenditures may be limited in their ability to draw down federal matching funds, limiting resources available for services and other program costs. For example, some territories faced challenges drawing down additional federal funds available in FY 2018 through the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and the Bipartisan Budget Act of 2018 (BBA, P.L. 115-123).

Lower spending per enrollee may also reflect lower provider payment rates. Prior MACPAC work found that Medicaid physician fees are lower in Puerto Rico compared to other states for certain services, including primary care and maternity services. For example, from July 2016 to July 2017, Medicaid physician fees were 19 percent of Medicare rates for primary care services and 50 percent of Medicare for maternity services, compared to the national average of 66 percent of Medicare rates for primary care and 81 percent of Medicare for obstetric care (MACPAC 2019). We do not have similar data for other territories, although anecdotal information indicates that provider payments are also low in other territories.

Territories incur substantial costs for patients who must be treated off island. Territories commonly send patients to Hawaii, the U.S. mainland, or even New Zealand when specialists or services are unavailable in the territory, incurring costs for transportation and boarding in addition to the cost of care. Territories negotiate payment rates with off-island providers on a case-by-case basis, and must often pay rates that are higher than the state or territory's Medicaid payment rates (Sablan 2021, Smith 2021, Galva Rodriguez 2021). As a result, the cost of care for an individual patient treated off-island may be higher than the cost of care for an individual patient residing in a state who can be treated locally.

- b. How is the current fiscal cliff and pandemic impacting the availability of providers in the territories – is it hard to recruit and retain quality providers?

Territories report facing substantial challenges recruiting and retaining health care providers; these challenges predate the current fiscal cliff and COVID 19 pandemic.

Provider recruitment and retention challenges facing the territories are not specific to Medicaid. Puerto Rico has experienced major declines in the physician workforce over the last decade or longer, consistent with larger trends of outmigration among Puerto Ricans, which are particularly pronounced among working-age adults (MACPAC 2019). Other territories also report difficulty retaining and recruiting providers, citing their relatively small populations, geographically isolated locations, lack of training opportunities, and low salaries compared to physician salaries elsewhere (including on the U.S. mainland) (MACPAC 2019, DPHSS 2021, Plaskett 2021).

Medicaid's financing structure may also contribute to territories' ability to recruit and retain providers. Limits on funding due to the annual Section 1108 cap on federal Medicaid funds and

the 55 percent federal medical assistance percentage (FMAP) make it difficult for territories to increase provider payment levels. In some cases, lack of funding has led some territories to delay or suspend payments, circumstances that run counter to efforts to recruit and retain quality providers.

Territories have at times been able to maintain or increase provider payment rates during periods in which temporary additional federal funds and enhanced FMAPs are available. However, Medicaid fiscal cliffs (i.e., points at which temporary additional funds and enhanced FMAPs expire) including the one that will occur on October 1, 2021 and the one that occurred on October 1, 2019, create substantial uncertainty for providers. For example,

- Since the enactment of the Further Consolidated Appropriations Act, 2020, (P.L. 116-94), Puerto Rico has implemented provider payment increases necessary to maintain an adequate provider network. Puerto Rico Medicaid officials have indicated that they will have to roll back the increases if additional federal Medicaid funds are not provided beyond September 2021 (Galva Rodriguez 2021).
- In March 2019, CNMI experienced a lapse in federal Medicaid funds and had to suspend payments to providers. CNMI also restricted services to those provided by the Commonwealth Healthcare Corporation, meaning Medicaid beneficiaries could not see private providers during this time. (Schwartz 2021).
- In several instances, Guam has delayed payments to providers because of difficulty raising the nonfederal share required to draw down federal matching funds (GRMC 2021).

MACPAC does not have data to examine the effects of the pandemic on provider recruitment or retention efforts. However, experience with past emergencies, including hurricanes and typhoons, suggest how disruptions of tourism and other economic sectors can affect Medicaid. Territories may experience challenges raising the nonfederal share, even at the temporarily enhanced matching rates, constraining resources available to pay providers and creating additional uncertainty.

Emergencies can also accelerate outmigration and affect supply of physicians and other health care workers. For example, following Hurricane Maria in September 2017, between 2017 and 2018, Puerto Rico lost an estimated 123,399 residents to outmigration, almost double the amount observed in the previous three years (MACPAC 2019).

- c. Does this impact continuity of care and drive unnecessary, costly hospital readmissions?

MACPAC does not have data to assess continuity of care in the territories, how continuity of care may be affected by the availability of providers, or effects on hospital readmissions.

2. Has the pandemic impacted the territories' ability to make meaningful progress towards implementation of program integrity requirements and, if so, how, and how might this Committee address those challenges?

While uncertainty about future funding can make it difficult for the territories to make program investments, according to the territories, they are either in compliance with program integrity requirements imposed by the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), or on track to comply by the deadline (ASES 2021, Guerrero 2021, King Young 2021, Sablan 2021, Smith 2021). In some cases, they are implementing additional systems that promote program integrity. For example, CNMI and USVI have initiated efforts to implement electronic visit verification systems for personal care services and health information exchanges (Sablan 2021, Smith 2021). MACPAC does not have independent sources of information that would enable us to comment further.

References

- Department of Public Health and Social Services (DPHSS). 2021. Testimony submitted to the U.S. House of Representatives Committee on Energy and Commerce, March 17, 2021. Washington, DC. <http://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-20210317-SD014.PDF>.
- Galva Rodriguez, J. 2021. Presentation before the Medicaid and CHIP Payment and Access Commission, March 4, 2021. Washington, DC. https://www.macpac.gov/public_meeting/march-2021-macpac-public-meeting/.
- Guam Regional Medical City (GRMC). 2021. Testimony submitted to the U.S. House of Representatives Committee on Energy and Commerce, March 17, 2021. Washington, DC. <http://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-20210317-SD016.pdf>.
- King Young, S. 2021. Testimony submitted to the U.S. House of Representatives Committee on Energy and Commerce, March 17, 2021. Washington, DC. <http://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-20210317-SD019.pdf>.
- Leon Guerrero, L., 2021. Testimony submitted to the U.S. House of Representatives Committee on Energy and Commerce, March 17, 2021. Washington, DC. <http://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-20210317-SD029.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. Chapter 5: Mandated report—Medicaid in Puerto Rico, in the *June 2019 Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/mandated-report-medicare-in-puerto-rico-2/>.
- Plaskett, S. 2021. Testimony before the U.S. House of Representatives Committee on Energy and Commerce, March 17, 2021. Washington, DC. <http://docs.house.gov/meetings/IF/IF14/20210317/111335/HHRG-117-IF14-Wstate-P000610-20210317.pdf>.
- Sablan, H. 2021. Presentation before the Medicaid and CHIP Payment and Access Commission, March 4, 2021. Washington, DC. https://www.macpac.gov/public_meeting/march-2021-macpac-public-meeting/.
- Schwartz, A.L. 2021. Testimony before the U.S. House of Representatives Committee on Energy and Commerce, March 17, 2021. Washington, DC. <https://www.macpac.gov/publication/testimony-medicare-and-chip-in-the-u-s-territories/>.
- Smith, G. 2021a. Presentation before the Medicaid and CHIP Payment and Access Commission, March 4, 2021. Washington, DC. https://www.macpac.gov/public_meeting/march-2021-macpac-public-meeting/.

U.S. HOUSE OF REPRESENTATIVES
 COMMITTEE ON ENERGY AND COMMERCE, SUBCOMMITTEE ON HEALTH
 “AVERTING A CRISIS: PROTECTING ACCESS TO HEALTH CARE IN THE U.S.
 TERRITORIES”

Wednesday, March 17, 2021

Questions for the Record

The Honorable Gus Bilirakis

Question 1: HHS’s OIG determined in their December 2020 report that the risk of improper Medicaid payments made in Puerto Rico could be increased because CMS hasn’t provided a recent review of their Medicaid program in addition to not having the Medicaid Management Information System fully operational.

a. To your knowledge, do these concerns persist?

Other than our recent report and related testimony on the Medicaid procurement process in Puerto Rico, our prior work reviewing Puerto Rico Medicaid, including the potential for improper payments, predates the Department of Health and Human Services (HHS) Office of Inspector General’s December 2020 report. However, with regard to CMS review of Puerto Rico’s Medicaid program, GAO reported on a 2016 program integrity review that CMS was conducting in Puerto Rico. The focus of this review was to examine the territory’s oversight of the Medicaid program and to assess program integrity activities performed by managed care organizations (MCO).¹ The August 2016 review required Puerto Rico to submit a corrective action plan to address the review’s findings, which the territory did in September 2016. CMS has not completed a program integrity review in Puerto Rico since 2016.

With respect to the Medicaid Management Information System (MMIS), in January 2021, we reported that the completeness and accuracy of states’ Transformed Medicaid Statistical Information System (T-MSIS) data improved, but not all data were meeting applicable standards.² Two T-MSIS data sources—priority items and analytic files—showed similar trends for Puerto Rico. In certain areas, Puerto Rico’s T-MSIS data compares favorably with states in that it has successfully submitted data that CMS considers a top priority. In other areas—such as the ability to use 2016 T-MSIS data for research and analysis—Puerto Rico had not submitted sufficient data. Since our January 2021 report was issued, CMS data show that Puerto Rico has further improved the completeness and accuracy of T-MSIS data, the results of which can be found on CMS’s web site and on the CMS Data Quality (DQ) Atlas.³

¹HHS, Centers for Medicare & Medicaid Services, Center for Program Integrity. *Puerto Rico Focused Program Integrity Review Final Report*, (Baltimore, MD: August 2016).

²GAO, *Medicaid: Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met*, GAO-21-196, (Washington, D.C.: Jan. 14, 2021).

³For additional information on CMS’s DQ Atlas, see <https://www.medicaid.gov/dq-atlas/welcome>.

- b. HHS's OIG additionally mentioned in their report that as of July 2020, Puerto Rico's Health Insurance Administration and Medicaid Fraud Control Unit were not coordinating program integrity efforts with the Medicaid Program Integrity Unit which would allow them to share information and define program integrity responsibilities. Additionally, Puerto Rico's Health Insurance Administration delegated responsibility for provider oversight to the Managed Care Organizations without establishing procedures for monitoring the program integrity efforts of these Managed Care Organizations.
 - o To your knowledge has Puerto Rico's Health Insurance Administration taken meaningful steps to address this concern which, if left unaddressed, increases the risk of improper program payments?

GAO has not examined coordination between ASES and Puerto Rico's Medicaid Fraud Control Unit (MFCU). Our most recent related work predated the creation of Puerto Rico's MFCU, where we recommended that CMS reexamine the agency's program integrity strategy and develop a cost-effective approach to enhancing Medicaid program integrity in the territories, including requiring territories to establish a MFCU or working with them to obtain necessary exemptions or waivers from applicable program oversight requirements.⁴ In November 2018, Puerto Rico applied for federal certification of a MFCU, which HHS certified in December 2018. Puerto Rico's MFCU was staffed in January 2019. In an August 2020 report, the Puerto Rico Department of Justice reported that 41 cases of possible fraud had been referred to the MFCU, of which 16 remained open.⁵

- c. Did GAO observe procedures for reporting Medicaid overpayments on Form CMS-64 with Puerto Rico's Medicaid Fraud Control Unit or Program Integrity Unit?

The scope of recent GAO reviews of Puerto Rico's Medicaid program has not included procedures for reporting overpayments on the Centers for Medicare & Medicaid Services (CMS) Form-64. We have previously reported that the limited detail on the types and volume of services provided in the territories can hinder program integrity efforts, including making it difficult to identify potential fraud, waste, and abuse. Moreover, because Puerto Rico's Medicaid program is entirely managed care, the territory reports payments made to MCOs on the CMS Form-64 rather than report service-level expenditures. Under their contracts with ASES, the MCOs providing services to Medicaid beneficiaries in Puerto Rico are required to submit encounter data to ASES, which could provide insight on service-level utilization. However, in our prior work, CMS officials told us they do not collect or review these data on a regular basis.⁶

⁴GAO, *Medicaid and CHIP: Increased Funding in U.S. Territories Merits Improved Program Integrity Efforts*, GAO-16-324, (Washington, D.C.: Apr. 8, 2016). Since this report was issued, the U.S. Virgin Islands also established a MFCU and the three remaining territories—American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam—obtained the necessary exemptions or waivers from CMS.

⁵Puerto Rico Department of Justice, *Informe de Logros del Departamento de Justicia 2017-2020*, (San Juan, Puerto Rico: August 31, 2020).

⁶See GAO-16-324.

d. Does Puerto Rico and the territories have a sufficient level of trained staff with the institutional knowledge and skill necessary to effectively manage potential risk in the Medicaid program?

GAO has not assessed the sufficiency of Medicaid program staff in the U.S. territories. Our prior work has shown that the territories are subject to a capped allotment and frequently have exhausted available federal Medicaid funds. We also found examples of program integrity efforts that CMS officials said the territories did not perform because funds spent on these efforts would reduce the amount of Medicaid funds available for services. Specifically, CMS officials said that the territories, other than Puerto Rico, had not established separate program integrity units because they lack adequate funding and personnel to do so. Medicaid funds spent on such oversight efforts would reduce the amount of funds available for the provision of health care services—that is, count against the Medicaid capped allotments for the territories.⁷

Regarding federal program oversight efforts, we also reported that CMS officials had assigned officials to the five territories to assist in program integrity efforts, and that their role was generally focused on providing technical assistance.⁸ The activities of these officials varied across the territories, ranging from resolving complaints to more proactive efforts to identify trends indicating fraud, waste, and abuse.

e. I understand that program funding in territories comes from a variety of funding streams. Is this patchwork of funding conducive to proper oversight or does it create challenges and if so, what are some of those challenges and how might this Committee address?

GAO has previously reported that multiple funding streams can complicate program efficiency and effectiveness, but are not necessarily problematic in and of themselves.⁹ Multiple federal programs, such as Medicare and Medicaid, as well as various HHS grant programs, fund health care services in the territories, as well as in all states. Our prior work found that Medicare was the single largest source of health care funding, representing over three-quarters of total funding in the territories.¹⁰ Because Puerto Rico represents over 90 percent of the total territory population, we found that the aggregate spending numbers masked the often significant variation in the sources of funding among the territories. Specifically, while the proportion of federal spending by source in Puerto Rico largely mirrored the aggregate numbers, health care grant funding represented a much larger proportion of health care funding in the other four territories, largely due to their comparatively smaller Medicare populations. Various HHS agencies also distribute health care grants to the territories to support health care services and outreach programs.

⁷See GAO-16-324. Although the FMAP for costs associated with establishing a MFCU is 90 percent for 3 years, any expenditures relating to the establishment and operation of a MFCU would count against the territories' capped Medicaid allotment.

⁸One CMS official was assigned program integrity responsibilities for American Samoa, Guam, and CNMI, and another CMS official was assigned such responsibilities in Puerto Rico and the U.S. Virgin Islands.

⁹See GAO, *Fragmentation, Overlap, and Duplication: An Evaluation and Management Guide* GAO-15-49SP (Washington, D.C.: Apr. 14, 2015).

¹⁰See GAO, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, (Washington, D.C.: Oct. 14, 2005). The Department of the Interior also funds health infrastructure and provides technical assistance to all territories but Puerto Rico.

Our prior work did not examine the oversight implications of this funding patchwork, although, as noted, this is not unique to the territories. However, our ongoing work examining the federal government's response to the COVID-19 pandemic has identified the potential for duplicate or overlapping payments in cases where federal funds are targeted to the same population. Specifically, COVID-19 funds are available through multiple agencies within HHS, as well as agencies outside of HHS, such as the Small Business Administration. In our September 2020 report, we found the potential for duplicate or erroneous payments for COVID-19 testing of uninsured individuals by the Health Resources and Services Administration (HRSA) and CMS, both within HHS. While HRSA and CMS have implemented controls, the potential for these duplicate payments continues to exist, underscoring the importance for continued federal and state oversight.¹¹

Question 2: Has the pandemic impacted the territories' ability to make meaningful progress towards implementation of program integrity requirements and, if so, how, and how might this Committee address those challenges?

The Further Consolidated Appropriations Act, 2020 (Act) (P.L. 116-94), contained provisions to improve Medicaid program integrity in Puerto Rico including by directing Puerto Rico to publish a Contracting Reform Plan. While addressing the public health emergency posed by COVID-19 has been a top priority in the territories (as it is in the states), Puerto Rico has taken steps to address program integrity issues that were identified by the Act. Continued updates from Puerto Rico on these and other related efforts, as well as risk-based oversight of Puerto Rico's procurement process by CMS, as we recommended in our February 2021 report, could help ensure that these efforts continue and help inform Committee efforts to address program integrity challenges.

In December 2020, Puerto Rico issued a Contracting Reform Plan in response to the requirements set forth in the Act. In its April 2021 semi-annual report to Congress, Puerto Rico reported making progress toward implementing certain of these contract reforms by establishing a threshold to require competitive procurement methods for all Medicaid-funded professional services contracts over \$150,000, formalizing the process for responding to contracting document requests from CMS, and building a contract document inventory. These reported activities may address concerns raised in our February 2021 report about the absence of important steps to promote competition in Puerto Rico's Medicaid procurements that we reviewed.¹² Puerto Rico also reported making progress on other program integrity efforts including establishing and appointing a lead to the Program Integrity Unit and improving enrollment verification with employer verification and Public Assistance Reporting Info System checks.

In addition, in response to COVID-19, CMS has made widespread use of program waivers and other flexibilities to expand the availability of Medicare and Medicaid services, maintain access for beneficiaries, and give providers more flexibility in treating beneficiaries. These waivers have allowed states and territories to relax certain program integrity activities related to providers—including licensing requirements, criminal background checks, and site visits—which poses

¹¹GAO, *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions*, GAO-20-701, (Washington, D.C.: Sept. 21, 2020).

¹²GAO, *Medicaid: CMS Needs to Implement Risk-Based Oversight of Puerto Rico's Procurement Process*, GAO-21-229, (Washington, D.C.: Feb. 5, 2021).

program integrity risks. Many of these waivers are scheduled to end after the COVID-19 public health emergency expires, but stakeholders have expressed interest in making some waivers permanent. The ongoing program integrity risks associated with these waivers indicate the need for appropriate CMS oversight. In addition, CMS's January 2021 Pandemic Plan outlines that CMS should evaluate the impact of waivers used to respond to a pandemic to inform planning for future emergencies. Such an assessment could help identify leading practices and implementation challenges to be addressed by states, CMS, and Congress.

