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 it's 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 at 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.