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THE INSULAR AREAS MEDICAID CLIFF

Thursday, May 23, 2019

House of Representatives,

Committee on Natural Resources,

Washington, D.C.

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

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

Also Present: Representative Plaskett.

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

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

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

Under Committee rule 4(f), any oral opening statements at hearings are limited to the Chairman and the Ranking Member. Therefore, I ask unanimous consent that all other members' opening statements be made part of the hearing record if they are submitted to the clerk by 5:00 p.m. today.

[The opening statements follow:]

******** COMMITTEE INSERT ********

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

Hearing no objection, so ordered.

Good morning again, everyone.

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

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

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

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

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

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

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

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

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

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

The path forward is unclear. Certainly, more money is needed, and an equitable

matching rate. But there is also the need for each of the insular areas to build capacity to deliver care. Because, ultimately, the goal is not just to have the same funding as States. What we want is medical care for those who need it in the insular areas to be every bit as good as medical care in the States.

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

Lastly, I want to report that one of the meetings we arranged for the directors to add value to their time in Washington has paid off. Some of you already knew this prior to coming here. But you met yesterday with staff from the Senate Finance Committee and the House Energy and Commerce Committee. We also arranged for you to meet with administration officials of CMS, the Centers for Medicare and Medicaid Services.

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

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

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

[The prepared statement of Vice Chair Sablan follows:]

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

Miss González-Colón. Thank you, Vice Chairman.

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

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

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

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

For the 50 States and the District of Columbia, Medicaid provides a guarantee of

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

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

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

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

Moreover, as a result of the state of emergency called for Hurricanes Irma and Maria in 2017, we again increased the Federal cap to $4.8 billion, for the first time, 100 percent Federal cost share to the Fiscal Year 2019, to keep Puerto Rico's Medicaid program operational.

All these additional sources of Federal funding for Puerto Rico in the Medicaid program will expire in September of this year.

For my island, the Medicaid cap set by statute in the Fiscal Year 2020 will be approximately $375 million, with no additional source of Federal funding available. This

means that Puerto Rico will exhaust its Federal Medicaid allotment in the first 3 months of Fiscal Year 2020 and will bear the expense in excess of 85 percent of the Federal program, placing additional pressure on sparse territory resources. And I know this is going to be happening in all territories as well.

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

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

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

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

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

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

solution on this issue.

Thank you, Chairman.

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

******** COMMITTEE INSERT ********

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

I now recognize the Chairman of the full Committee, Chairman Raúl M. Grijalva.

Mr. Grijalva. Thank you very much. No opening statement, Mr. Chairman. Just to thank you for organizing a meeting. I think it is an excellent panel, and I am here to learn something on which direction legislatively we are going to go in terms of dealing with this issue.

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

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

With that, I yield back.

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

And I would now like to introduce our witnesses.

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

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

Welcome to the two of you.

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

program.

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

Mrs. Radewagen. Thank you, Mr. Chairman.

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

Vice Chair Sablan. Thank you.

And I will now recognize the Ranking Member for introduction of her --

Miss González-Colón. And thank you, Mr. Sablan.

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

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

Vice Chair Sablan. All right.

And I recognize Ms. Plaskett to introduce the witness from the United States Virgin Islands.

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

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

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

as well.

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

Thank you.

Vice Chair Sablan. Thank you, everyone.

And, again, witnesses are welcome.

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

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

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

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

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

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

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

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

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

In addition to these challenges of access to care, delivering health services in a

remote island is more costly, with the high cost of shipping, and we are competing with U.S. hospitals for the same workforce. Fifteen years ago, with only the capped and inadequate Medicaid funding and the CNMI undergoing a major economic crisis due to several global and U.S. Federal policy shifts, the hospital struggled to stock medical supplies and recruit healthcare workers.

The 2007 CMS survey revealed many problems. With no funding improvements, paydays were missed; doctors and nurses left the island. In September 2012, CMS issued a termination notice to our hospital. It was clear that, without adequate funding, the CHCC could not sustain lifesaving services, much less the healthcare needs of our residents.

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

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

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

orthopedic surgery, and, as of this month, oncology.

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

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

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

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

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

Thank you.

[The prepared statement of Ms. Muna follows:]

******** INSERT 1-1 ********

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

We are trying to get our witnesses' testimony, and then -- because some members will need to run to vote.

But, Ms. Sablan, you are recognized for 5 minutes.

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

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

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

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

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

2018, including the Category 5 Super-Typhoon Yutu.

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

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

The median income for a family of four, based on data provided by the U.S. Census in 2010, shows that the CNMI family earned $19,958 in the same year that the average U.S. family earned $61,564. If we just step back for a minute and think about just this basic information, we can clearly understand why so many residents in the CNMI rely on Medicaid for healthcare or are uninsured. The more than 16,206 individuals in the Medicaid program constitute 46 percent of the U.S. citizens in the CNMI.

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

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

step in our undertaking because I understand the effects on our people and our health system.

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

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

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

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

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

******** INSERT 1-2 ********

Vice Chair Sablan. Thank you. Another perfect-timing witness. And so thank you very much, Ms. Sablan.

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

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

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

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

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

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

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

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

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

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

Instead, section 2005 of ACA provided Guam with $268 million, which partly alleviated the financial shortfall not only of our Medicaid program but also of Guam's locally funded medical assistance program, where most of the COFA citizens qualify. This funding allowed Guam to shift the cost of COFA migrants' emergency services to Medicaid. But the 45-percent required local match provides hardship in fully expanding the program to cover more uninsured population. Unfortunately, Guam would not be able to expend all the ACA funding, which will expire this fiscal year.

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

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

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

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

[The prepared statement of Ms. Arcangel follows:]

******** INSERT 1-3 ********

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

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

Did I get that right, Ms. Browne?

Ms. Rhymer-Browne. "Michal."

Vice Chair Sablan. All right. Okay. You are recognized for 5 minutes.

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

Ms. Rhymer-Browne. Chairman Sablan, Ranking Member Bishop, and members of the Committee, thank you for the opportunity to provide testimony on the significant impacts to our healthcare system and the people of the United States Virgin Islands in light of the impending Medicaid fiscal funding cliff, which will impact us beginning October 2019.

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

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

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

As a people, we want to convey our heartfelt gratitude, appreciation, and thanks

for the concern and the support that you and your colleagues in Congress have provided as we continue to recover from the unprecedented damages caused by Hurricanes Irma and Maria, two Category 5 hurricanes which ravaged the Virgin Islands in September of 2017.

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

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

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

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

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

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

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

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

Unless the Congress and the Administration act to support the two requests I have outlined above before September 30, 2019, we will be faced with potentially catastrophic damage to our Medicaid program and our healthcare system, to include having to remove upwards of 15,000 individuals from our Medicaid program who still need healthcare services and having to deny men, women, and, children and infants who need to be transferred to the U.S. mainland for care not available.

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

Thank you very much.

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

******** INSERT 1-4 ********

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

And so thank you again, Ms. Rhymer-Browne.

I would like to, at this time, recognize Ms. Sandra King Young, who is actually not -- this is not her first appearance. She has been here before.

So, Ms. Young, you have 5 minutes, please.

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

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

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

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

And we are a very poor community. Without Medicaid, our people will have no

health insurance coverage, and our healthcare system would face an absolute collapse and insolvency. Medicaid is our people and our territory's lifeline for medical care services.

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

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

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

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

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

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

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

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

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

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

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

For Congress to fail to increase the territories' annual Medicaid block grant and to

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

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

[The prepared statement of Ms. Young follows:]

******** INSERT 1-5 ********

Vice Chair Sablan. Thank you very much for that, Ms. Young.

Ms. Avila from Puerto Rico, you are recognized for 5 minutes.

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

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

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

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

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

However, this supplemental funding will expire on September 30, 2019. If no action is taken for Fiscal Year 2020, the FMAP will revert back to the statutorily mandated 55-percent FMAP, up to the Federal Medicaid funding cap of approximately $380 million.

This level of Federal funding is not sustainable, as it will only cover 19 percent of

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

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

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

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

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

The Medicaid cliff that Puerto Rico is facing is an emergency that must be dealt with swiftly and smartly. I love my island. It is my home. And I am committed to

working with Congress to create a Medicaid program that all of us can be proud of and that provides the necessary care to the 1.5 million U.S. citizens who rely on it.

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

[The prepared statement of Ms. Avilá follows:]

******** INSERT 1-6 ********

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

We are going to go to questioning. So members will have 5 minutes.

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

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

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

[The questions and responses for the record follow:]

******** COMMITTEE INSERT ********

Vice Chair Sablan. Thank you, all of you, for your valuable testimony.

The Chair will now recognize members for questions. And under Committee rule 3(d), each member will be recognized for 5 minutes.

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

Congresswoman Radewagen, you have 5 minutes, please.

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

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

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

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

The Medicaid and CHIP Payment and Access Commission, otherwise known as MACPAC, published a fact sheet for American Samoa which has a historical table of total Medicaid spending from Fiscal Year 2011 to Fiscal Year 2017, taken from reported expenditures to the Centers for Medicare and Medicaid Services. The average total Medicaid expenditure in American Samoa, according to MACPAC's report, is $30 million for that period.

Mr. Chairman, I ask for unanimous consent to enter into the record a March 2019

MACPAC report on Medicaid and CHIP in American Samoa; a May 2019 MACPAC issue brief on territory exhaustion of Federal Medicaid funds; the April 2016 GAO report on Medicaid in the U.S. territories; and a letter to Governor Lolo Matalasi Moliga dated March 15, 2019.

Vice Chair Sablan. Without objection, so ordered.

[The reports and letter submitted by Mrs. Radewagen follow:]

******** COMMITTEE INSERT ********

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

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

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

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

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

Mrs. Radewagen. Thank you. Thank you for your response.

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

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

This is based on the historical spending out of -- the Medicaid spending that we have. I provided a chart of expenditures, historical expenditures, based on the

availability of the ACA, that shows that we need, for the hospital alone, an additional $8 million for the $20 million Federal share, and then we would need an additional $10 million for all new services for Federal share. That would make it a $30 million Federal share block grant increase for American Samoa.

Mrs. Radewagen. Thank you, Director.

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

[The questions submitted for the record by Mrs. Radewagen follow:]

******** COMMITTEE INSERT ********

Mrs. Radewagen. Mr. Chairman, I yield back.

RPTR PANGBURN

EDTR HOFSTAD

[11:07 a.m.]

Vice Chair Sablan. Thank you.

The gentlelady yields back.

I would like to recognize myself, but before doing so, I ask unanimous consent to enter into the record a letter from the Financial Oversight and Management Board for Puerto Rico; a letter from the Association of Asian Pacific Community Health Organizations; a letter from -- oh, my goodness -- from national and community organizations, supported by many organizations, actually, a list over 20; and also a letter from the Guam Regional Medical City that I have been asked to submit for the record.

[The letters submitted for the record by Vice Chair Sablan follow:]

******** COMMITTEE INSERT ********

Miss Gonzalez-Colon. Mr. Chairman?

Vice Chair Sablan. Yes?

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

Vice Chair Sablan. When I recognize you, yeah, you can.

Miss Gonzalez-Colon. Okay. Perfect.

Vice Chair Sablan. Thank you.

And so now I recognize myself for questioning.

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

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

Ms. Helen Sablan. Yes.

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

Ms. Helen Sablan. Yes. We work at the hospital to use the CPE for our local match.

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

Ms. Helen Sablan. No. We do not have the money.

Vice Chair Sablan. That is interesting, actually, because, all last year, the Chairman of the Marianas Legislature Ways and Means Committee kept bragging about how he was responsible for the biggest budget ever in the Commonwealth history, yet he

could not find matching funds for ObamaCare Medicaid money.

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

Ms. Helen Sablan. That is right.

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

Ms. Helen Sablan. Yes.

Vice Chair Sablan. So could the Kagman Community Health Center also use the CPE system to make the local match?

Ms. Helen Sablan. No.

Vice Chair Sablan. Okay.

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

Ms. Helen Sablan. Yes.

Vice Chair Sablan. And, working with the Federal Centers for Medicare and Medicaid Services, the Marianas' congressional office was recently able to help you get another $8.2 million, but that has to be adjusted, and we could be now down at $4 million.

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

Would that help you, help your program?

Ms. Helen Sablan. Yes. Thank you, Congressman. That would be very much appreciated.

Vice Chair Sablan. Okay. Again, I want to thank you.

I have a little bit more time.

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

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

Ms. Muna. I don't think so.

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

Ms. Muna. Absolutely.

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

Ms. Muna. That is correct.

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

Ms. Muna. That is correct.

Vice Chair Sablan. And Medicaid money helped?

Ms. Muna. Yes, absolutely.

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

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

Vice Chair Sablan. And readmission rates have improved?

Ms. Muna. Correct.

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

Ms. Muna. Yes, it is true.

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

Ms. Muna. Yes.

Vice Chair Sablan. Okay.

In my last 10 seconds, ladies, please, the six questions you have, I would really like for you to respond in writing to the Committee in 10 days. It is going to be part of the hearing record. It is critical that we answer that as completely and as correct as possible.

Thank you. My time is up.

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

Miss Gonzalez-Colon. Thank you, Mr. Chairman.

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

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

Vice Chair Sablan. Without objection, so ordered.

[The memorandum and letter submitted by Miss Gonzalez-Colon follow:]

******** COMMITTEE INSERT ********

Miss Gonzalez-Colon. Thank you, Mr. Chairman.

Now we will begin with my line of questioning.

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

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

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

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

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

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

And there, we are talking about how much money we will be receiving in each

State if we don't do something with that. In that case, I would like to ask -- this is the difference between some States for Medicaid funding per enrollee. So we are not talking about a difference of just 20 percent. It is up to 80 and 70 percent of difference, the funding that the States are receiving.

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

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

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

Ms. Avila. Well, we are expecting just -- we have found out, according to the reading statements that we are --

Miss Gonzalez-Colon. Just a number. I just need a number.

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

Miss Gonzalez-Colon. Okay. Six-hundred-thousand people may lose their insurance if we do not act --

Ms. Avila. Immediately.

Miss Gonzalez-Colon. -- by September.

Ms. Avila. That is right.

Miss Gonzalez-Colon. Okay.

In the last Congress, I just said that we received $4.8 billion that were approved and the President signed after the hurricane season. As of this Sunday, $1.2 billion were made available through HHS.

Puerto Rico certified that they have reliable data to the Transformed Medicaid Statistical Information System and established a Medicaid fraud control unit.

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

Ms. Avila. Yes. The answer is yes.

Miss Gonzalez-Colon. Okay. Did HHS certify that Puerto Rico was reliable reporting data and establish a Medicaid fraud control unit?

Ms. Avila. Yes, that is correct.

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

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

Miss Gonzalez-Colon. So the oversight board required to the island to include all future plans regarding healthcare. And that means, if we don't receive the money, the State, in this case Puerto Rico, needs to put up front the money from the State to do the job that the Federal Government is supposed to do in the State.

Ms. Avila. Yes, that is correct.

Miss Gonzalez-Colon. Thank you.

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

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

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

Ms. Plaskett. Thank you, Mr. Chairman.

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

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

Thank you, as well, for being with us.

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

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

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

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

Ms. Plaskett. Great.

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

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

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

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

Ms. Rhymer-Browne. Exactly. That is correct.

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

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

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

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

That is one of the reasons that the hospital has frequently called us over the last 2 years to airlift many of the individuals who go there who have real catastrophic illnesses

and need specialized procedures. So the hospital, in effect, has to turn away several individuals who have these extreme circumstances and illnesses, and we have to airlift them to the United States for treatment.

Ms. Plaskett. Thank you.

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

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

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

Ms. Plaskett. Thank you.

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

Ms. Rhymer-Browne. Certainly.

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

We also will be completing all of our cost report audit reconciliations of our two

hospitals. We recently completed the Medicaid program integrity review. And we have a host of other programs that we have been going through for the last few years.

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

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

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

Vice Chair Sablan. Yeah. Thank you.

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

Ms. Rhymer-Browne, you just -- including in your recent testimony, but you just listed a series of items that you have implemented in your program, establishing the relationship between the extra Medicaid money the Virgin Islands received in last year's disaster appropriations and the improvements you made in administering the program fraud unit; you began reporting data to CMS through the Medicaid Management Information System.

But you were able do that because of the incentive funding included in the disaster bill. Is that correct?

Ms. Rhymer-Browne. That is totally correct. Without that, we would have been unable --

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

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

Ms. Rhymer-Browne. Could you repeat that, please?

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

Ms. Rhymer-Browne. No way. We could not have.

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

Ms. Rhymer-Browne. We certainly are.

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

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

Ms. Sablan?

Ms. Helen Sablan. I think so.

Vice Chair Sablan. Okay.

Ms. Arcangel?

Ms. Arcangel. Definitely.

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

Ms. Young. Yes, I believe so.

Vice Chair Sablan. Thank you.

And how long do you think that would take? Could you do it over a period of 10 years? Would that be reasonable?

Ms. Sablan?

Ms. Helen Sablan. Probably.

Vice Chair Sablan. Ms. Arcangel?

Ms. Arcangel. I believe so, yes.

Vice Chair Sablan. Ten years? I didn't hear your answer.

Ms. Arcangel. Yes.

Vice Chair Sablan. Okay. Wow.

And Ms. Rhymer-Browne?

Ms. Rhymer-Browne. Yes.

Vice Chair Sablan. And, of course, Ms. Avila, I am not ignoring you; it is just that Puerto Rico's program is so huge. But would you also be able to do these things, some of which you are already starting to do?

Ms. Avila. Yes. The answer is yes. Thank you.

Vice Chair Sablan. Okay.

Look, the fact is that the Federal Government isn't saving money by not treating the territories equally in Medicaid. It has been a big factor in many territorial citizens moving to a State. So, for example, many Puerto Ricans have abandoned the territory for a State. There is more than three-fifths of all people of Puerto Rican heritage live in the States.

Further, Medicaid programs in the States spend multiples per beneficiary of what territories spend -- in the case of Puerto Rico, three times as much.

So they are not treating us the same, but they are not saving any money.

Right, Ms. Avila? They are not giving you the money, but the Federal

Government is not saving money, because your citizens move to Florida and --

Ms. Avila. I will say that it is more costly for the States to have our residents here.

Vice Chair Sablan. And also costly to us, because we are having our people leave home.

And, again, I cannot overemphasize the importance of your written response, as concise and as complete, to the six items I gave you. Those are going to, again, go into the record. It will be shared with the committee of jurisdiction, Energy and Commerce. And it is a plan that would allow its territory to work through a program, get financial incentive to do those things that require us -- that will get us, hopefully, to a full State-like Medicaid program, not just in terms of money but in terms of services to our citizens.

My time is up. At this time, I yield to the Ranking Member, Miss Gonzalez-Colon.

Miss Gonzalez-Colon. Thank you, Mr. Chairman.

And I will take the same of question you were asking. You were saying about American taxpayers' money will be more effective if we address this issue now, because in the case of Puerto Rico, at least, more than a million Puerto Ricans have just moved to Florida. In our case, we just take a ticket and we move to a State and we receive the full benefits.

So it will take more money to the United States to address this issue in the long term. If we fix it now, we may save a lot of Federal funds.

So, in that sense, I would like to ask Ms. Avila, Puerto Rico at this time just offers 10 programs of the 17 Medicaid programs. Is that correct?

Ms. Avila. Pardon? Could you repeat the question? I am sorry.

Miss Gonzalez-Colon. Yes. The Federal rules for Medicaid in Puerto Rico, all the same benefits generally apply to island, but because we don't have enough funds to

match the Federal share, we are required to limit a lot of those benefits.

So we are just offering 10 of 17 programs on the island. Is that correct? Yes or no?

Ms. Avila. I will say, I don't recall 10 or 17. I can mention --

Miss Gonzalez-Colon. Just tell me the programs that do not apply on the island.

Ms. Avila. Well, right now, we don't cover hep C patients within the program. Either we have a cure right now for that condition or we are not able --

Miss Gonzalez-Colon. What other programs?

Ms. Avila. No emergency transportation. We haven't been able to --

Miss Gonzalez-Colon. What other programs?

Ms. Avila. Long-term care. And we lost a lot of people.

Miss Gonzalez-Colon. What other programs?

Ms. Avila. Those are the main ones that I can highlight right now.

Miss Gonzalez-Colon. Okay.

In terms of the -- you mentioned in your written statement that, due to Puerto Rico's unequal treatment and the historic low funding, we have been forced to limit Medicaid eligibility to income levels well below the Federal poverty level used by the States. Puerto Rico has 47 percent of poverty level.

Ms. Avila. That is correct.

Miss Gonzalez-Colon. So what benefits are the ones you are limiting?

Ms. Avila. Well, the main ones would be pharmacy benefits and mental coverage benefits. Drugs are necessary for a healthcare system, and we will not have funds to be able to sustain the drug program within the Medicaid program in Puerto Rico.

Miss Gonzalez-Colon. So, in your experience, and having identified areas of the programs, including drugs, how many Medicaid-eligible individuals in the mainland are

not currently covered in Puerto Rico because of the disproportionate low-level Federal funding?

Ms. Avila. We are estimating more than half a million U.S. citizens have not had the right right now to get into the program.

Miss Gonzalez-Colon. So more than half a million American citizens living in Puerto Rico, they are not covered by Medicaid full programs as they were in the States just because of the lack of funding of the treatment of a State of Puerto Rico. And I know the same case for the rest of the territories as well. Because if you don't have the funds, you need to be cutting some of the benefits in order to have more people -- or trying to at least address the most urgent needs of the islands.

During the years 2006 to 2016, the numbers of physicians, surgeons, and providers of the island dropped from 14,000 to 9,000.

Ms. Avila. That is correct.

Miss Gonzalez-Colon. Has this trend exacerbated by the hurricanes in 2017?

Ms. Avila. That is correct. It has been.

Miss Gonzalez-Colon. Do we have any number of how many physicians and surgeons we do have on the island at this time?

Ms. Avila. Well, we are just validating the numbers, but we have received preliminary information that 3,000 or more physicians have left the island since the hurricane.

Miss Gonzalez-Colon. So we can say that between 6,000 and 7,000 physicians and doctors are still on the island?

Ms. Avila. That is right.

Miss Gonzalez-Colon. And that trend will continue if they are paid less than the rest of the physicians that provide the same services that you would receive in the States.

My time is running, but I do want to have some questions for the record, and so you can answer later on. And that will be specifically for all of the territories represented here. I know you do a lot with less resources. And one of those will be: How much did Medicare program benefits actually cost in the States?

And in the case of Puerto Rico, there is no real Medicaid financial help cleared for Puerto Rico. This is the PROMESA Board saying a few weeks ago. Now, in the letter that was submitted for the record, they are endorsing receiving the Medicaid funds for Puerto Rico. And I think that is finally common sense.

But there are some -- and this is for American Samoa. During the fiscal year, there was an unused balance of $153 million in Affordable Care Act funds in American Samoa. You explained the reasons for this balance in your testimony.

But my question will be -- and you can answer it later on -- do we need to do something for the territories so they can spend the money? Is there any other requirement of the Federal Government, CMS, HHS, has given to the territories so that you can't access those funds? What is the reason behind it?

[The responses to Miss Gonzalez-Colon's questions follow:]

******** COMMITTEE INSERT ********

Miss Gonzalez-Colon. And, with that, I yield back the balance.

Vice Chair Sablan. Thank you.

The gentlelady's time has expired. But I also agree, for American Samoa, it is an anomaly. There are not too many private providers. I found that out after our last time that you were on the witness stand, Ms. Young, also.

But Ms. Plaskett has 5 minutes, please.

Ms. Plaskett. Thank you. I won't use the 5 minutes. I am needed in another meeting. But I just wanted to follow up with a couple of short questions, particularly, of course, for the good woman from the Virgin Islands, Ms. Rhymer-Browne.

You talked about the disaster-related circumstances in which we have been given 100,000, that if we move back to the 55-percent match that had been previously, that that cap would bring us to about $18.7 million, correct?

Ms. Rhymer-Browne. Correct.

Ms. Plaskett. And what is the amount of money if we were given the State-like treatment that it would be at? Do you know what that number would be?

Ms. Rhymer-Browne. I am not sure. However, we are requesting, as I said, for the 100 percent, we would be requesting $251 million for 2 years. And then we would continue at the 83-percent Federal level, and those would be for the next 3 years. But I am not sure exactly that number.

Ms. Plaskett. What the percent of the 83 would be.

Ms. Rhymer-Browne. Yeah.

Ms. Plaskett. We know for 55 percent it would be $18.7 million, right?

Ms. Rhymer-Browne. Yes.

Ms. Plaskett. And that is woefully inadequate.

What would be the delta that you would need from the $18.7 million to satisfy the

needs of all the individuals that would, if given State-like treatment, be eligible for it?

[Ms. Rhymer-Browne confers.]

Ms. Plaskett. You are not sure at this time?

Ms. Rhymer-Browne. We are not sure at this time.

Ms. Plaskett. Okay. But if you could get that number to me --

Ms. Rhymer-Browne. Yes, I will.

Ms. Plaskett. -- that would be really helpful for the record.

One of the other things that I wanted to talk about -- we talked a little bit about the physicians. And can you state specifically what specialty services we are not providing for individuals right now?

Ms. Rhymer-Browne. Yes. There are several cancer-related situations that we need to airlift. Our major cancer center was tremendously damaged on the island of St. Thomas. We used to fly individuals from the island of St. Croix over to St. Thomas, but now that center has been down for the last 2 years.

The orthopedic specialist, the trauma specialist. When we have major accidents and situations, workplace accidents, we have to airlift our members off-island to receive the treatment on the mainland.

Ms. Plaskett. And how does this impact recruiting physicians to the Virgin Islands in terms of, if there is a belief that we will be reduced in our Medicaid treatment moving forward, how will that impact the ability to not just have specialty doctors but to have regular physicians, general practitioners, pediatricians, et cetera, to treat this population?

Ms. Rhymer-Browne. It would greatly reduce it. Before our ACA treatment and getting the additional moneys, we were perhaps maybe at about 200 to 300 providers. We have over 700 now, because individuals were attracted that we had the additional

moneys to provide services for our members. But if we were to be reduced once again, the ability to attract those specializations would be greatly -- it would be very hard for the territory do that.

Ms. Plaskett. Thank you very much.

I saw you had a note. Was there anything you wanted to add?

Ms. Rhymer-Browne. Yes. He has --

Ms. Plaskett. Mr. Smith, she can't read your handwriting. You are not only the Director of Medicaid, you must be a doctor as well.

Ms. Rhymer-Browne. Okay. At the 55-percent Federal, we would require $87.2 million. And at the 83-percent, $52.6 million.

Ms. Plaskett. Okay. Thank you very much.

And I yield back the balance of my time.

Vice Chair Sablan. Thank you.

And I now recognize the gentleman from Nevada, Mr. Horsford, for 5 minutes.

Mr. Horsford. Thank you, Mr. Chairman, for organizing today's hearing on the funding of Medicaid in the U.S. territories. I appreciate the opportunity to discuss the shortfalls of Medicaid funding in our territories and shed light on this very important issue.

To start, I want to make it clear that it is my priority, as a member of this Committee as well as the Ways and Means Committee, to ensure all Americans, including those living in U.S. territories, have access to affordable and quality healthcare.

Sadly, as is often the case with the Federal Government's treatment of American Samoa, the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands, U.S. citizens and nationals living in the insular areas do not receive the same services and benefits afforded to the rest of the American people. That is a very sad fact that we

need to address.

American citizens living in our territories are too often overlooked, mistreated, and forgotten, and the government services many of them depend on are treated similarly. Territories commonly experience higher rates of poverty than States, and, in many cases, our territories depend on Medicaid even more than our States. For example, in American Samoa, because private health insurers refuse to provide the island healthcare coverage, Medicaid is their only option.

Sadly, due to significant shortfalls in Federal Medicaid funding, territories face serious challenges finding the funding needed to support Medicaid coverage for all those who depend on it. These challenges have increased in recent years, as debt crises, decreased tourism, and natural disasters, including hurricanes and typhoons, have added to their burdens and heightened economic distress. As a result, all territories are forced to cut Medicaid programs, heighten eligibility requirements, and limit coverage options.

We cannot continue to stand by while people in need lose their healthcare coverage. Our territories face a significant crisis, and they need this Congress to find a Medicaid funding solution that can address the serious funding setbacks they face.

More than 1.3 million people in U.S. territories rely on Medicaid, which provides health coverage to children, pregnant women, parents, seniors, and individuals with disabilities. Without a Medicaid funding fix, thousands of individuals in need risk losing healthcare coverage and benefits under Medicaid.

I want to thank each one of you for your testimony today. I hope your insight can help the Members of this Congress better understand the challenges our territories face and solutions that are needed.

Ms. Sablan, I want to share my sympathy with you and express my regret that you and your colleagues have been forced to make such tough decisions regarding cuts to

Medicaid.

Can you talk through what services the Commonwealth would be forced to cut if we do not address the Medicaid cliff? Will women not be able to get a mammogram? Will children not be able to have an annual physical? Will seniors lose access to nursing facilities? What options are left for these individuals if they lose their Medicaid coverage?

Ms. Helen Sablan. We will have to cut those optional services and some of the mandatory services, because by first quarter of the fiscal year, we exhaust our 1108 funding.

Mr. Horsford. And explain what you mean by "cut optional services." When I was in the Nevada State Senate and we had a Republican Governor who wanted to cut Medicaid across the board, it meant cutting diapers from seniors in nursing homes, and we rejected that. So what does it mean to you?

Ms. Helen Sablan. Optional services include prescription drugs, dental services, and other care services that is critical for our patients.

Mr. Horsford. And what will happen to those individuals without that support?

Ms. Helen Sablan. Well, if they don't get their medications, then eventually they will end up at the hospital, and that will cost us more money in our in-patient services. As well as dental services, if they are not treated, then they are going to end up in emergency room services, and that costs us more money.

Mr. Horsford. Right. And, again, is it the case that there are no other options available to them?

Ms. Helen Sablan. There are no other options, because they don't afford to get health insurance. The income that they get is pretty much to put food on their table.

Mr. Horsford. Thank you very much.

This is a very important issue, one that affects all the U.S. territories. And I commend the Chairman and the members of this Committee. We have to address this issue, and it cannot continue to persist.

Thank you. I yield back.

Vice Chair Sablan. Thank you. Thank you to the gentleman.

I recognize Mr. Cox from California. No questions?

Mr. Cox. No questions.

Vice Chair Sablan. All right.

There is another Californian at the table here, Mr. Lowenthal.

Mr. Lowenthal. Thank you, Mr. Chair. And I thank you for recognizing the great State of California also.

I have two questions. One is about the future, and one is a little bit about how we got here.

The first question is, if Congress does take the steps we have discussed today to treat the territories equitably, such as providing uncapped Medicaid funding, calculating fund matching in the same way it does for the States, really begins to treat the territories as part of the United States in an equitable and fair way, are there any mandatory Medicaid benefit requirements the territories still wouldn't be able to meet due to territory-specific limitations? Are there still other things that need to be addressed?

Maybe anybody from the Committee.

Are there any unique characteristics of any of the territories that will prevent you from being able to provide mandatory -- well, the mandatory Medicaid benefits?

We have to get rid of the cap. We are hearing that. You have to have the match in an equitable way that doesn't penalize. But what else should we be -- is there anything else we should be looking at also to make sure that the uniqueness of the

territories does not preclude them from receiving certain benefits?

Anybody? Because we are really trying to figure out where do we go from here.

Yes?

Ms. Avila. Mrs. Avila from Puerto Rico.

Besides what is mandatory for the healthcare system within the Medicaid program, just to be able to keep the expert of the doctors and healthcare providers, it is a great challenge for the island and for the other territories as well. So we need to find a way to, with the distance and the structure that we already have, just to start stabilizing the program and see what other needs we need to confront right now.

But it is so urgent just to keep the doctors in the islands, it is so urgent to avoid the hospitals to collapse, that I will say probably we will need to have more support in terms of long-term care to develop the structure to support that population and that area.

But will be, according to the guidelines of the CMS or HHS Federal healthcare program, that we will need to identify what else we can do better just to have a more continued and sustainable program in the island.

Mr. Lowenthal. Okay.

Anybody else want to add something that might be --

Ms. Rhymer-Browne. Yes, I just want to echo, for the long-term care, that this will be a very, very important area for the U.S. Virgin Islands. We have an aging population, and from CMS we definitely would need additional technical assistance to not only obtain a skilled nursing facility certification but to maintain the skilled nursing facility certification. So that technical assistance would be greatly, greatly needed.

Mr. Lowenthal. The other question I have is a little bit -- that is looking forward, what you need. How did we get here? And I don't know if anybody can answer it.

I am just sitting here wondering, in the negotiations, does anybody -- maybe Gregorio knows better. In the passage of the ACA, there were benefits. There was the Medicaid expansion. And, in some sense, it did provide for certain kinds of services for the territories. Yet, looking back, it was a terrible hindrance also. It put limits on the territories that it did not put on the rest of the country.

How did that happen?

Vice Chair Sablan. Will the gentleman yield?

Mr. Lowenthal. Yes, I will yield.

Vice Chair Sablan. When we had passed the Affordable Care Act and the PPA also, under the budget reconciliation process, we had to address the Senate bill. At that time, in all truthfulness, we couldn't go into conference, because when we come out, there would not be enough votes to pass the bill.

Mr. Lowenthal. Okay.

Vice Chair Sablan. So we used the budget reconciliation process. And, of course, we had to go into the Senate version, which the Senate addressed the States, not territories. And so we had the -- we worked with the White House, and we got increased money --

Mr. Lowenthal. Right.

Vice Chair Sablan. -- in addition to the regular block grants. But those moneys were used as block grants itself.

Now, if we are going to get into the full program, there has to be also made improvements to not just the procedures and the process of the program but also the care, the standard of care for patients.

The improvements that they would implement to satisfy Medicaid would not just benefit Medicaid patients. They would also benefit the entire patient population and

the needs of the territories or combined like they do in the States. So they would provide services that are not at the present time available to the territories but are available in the States.

And we could do this over a period of 10 years. There would be money to help them, incentivize them to meet those standards. And, at the same time, allow also -- maybe one territory could get this done in 5 years, and the other one may take 6 years -- so allow them to work with the Secretary of HHS. And when they submit plans, when the HHS Secretary approved a plan, and then that territory would get into a full Medicaid program like they do in the States. And the rest would take the additional time they would need.

So it will take time. It will take incentivizing them with -- of course, they would need financial assistance. But, yes, it can be done. It is possible. And that is also, for me personally, that is my hope, that we would get into the full program.

Did I answer the gentleman's --

Mr. Lowenthal. Yes.

Vice Chair Sablan. Thank you. And your time is up, so --

Mr. Lowenthal. And I used my time very wisely.

Vice Chair Sablan. No question. You always do, Mr. Lowenthal.

Mr. Tonko from New York is recognized for 5 minutes.

Mr. Tonko. Thank you, Mr. Chairman.

And thank you to our witnesses, as well, for being here today.

Certainly I believe, in the richest country on Earth, healthcare should be a guaranteed right for all, full stop, and not just for residents of the 50 States but for all who call themselves Americans. Unfortunately, healthcare in America has always been segregated between the haves and the have-nots, and the status of Medicaid in the

insular areas is no exception.

Like many aspects of Federal law, the way that the Medicaid program views the insular area is of second-class citizens, providing fewer resources and less predictability to care for some of our most vulnerable.

The territories are generally poorer than the 50 States but are subjected to Medicaid funding caps and restrictions that have made it significantly challenging for them to provide services to individuals living below the Federal poverty level.

Despite temporary increases in Federal Medicaid funds to Puerto Rico and U.S. Virgin Islands, healthcare systems are fragile, especially in the wake of Hurricanes Irma and Maria. Following these two disasters, residents have struggled with substantial health needs.

It is imperative, I believe, that Congress properly address the Medicaid financing issues. Expiration of funding could result in even more significant shortfalls and could further restrict programs' eligibilities and cut benefits and suspend programs. This could be devastating for territory budgets, coverage, and the healthcare systems more broadly.

So my question to Ms. Sablan and Ms. Young, both American Samoa and the Commonwealth of the Northern Mariana Islands rely on a single hospital to provide most of the care to Medicaid beneficiaries. What are some of the challenges that arise with this model? And would having uncapped Medicaid Federal funding and a higher Federal match help the territories draw in additional providers outside the hospital system?

Ms. Sablan?

Ms. Helen Sablan. Can you repeat your question again? Sorry.

Mr. Tonko. Sure. With your reliance on a single hospital for most of the care for Medicaid-eligible, what are some of the challenges that arise with this model? And would having uncapped Medicaid Federal funding and a higher Federal match help the

territories draw in additional providers outside those in that hospital system?

Ms. Helen Sablan. Okay. So we would have to send our patients off-island, either to Guam, Hawaii, or the U.S. mainland. And it really is costing us a lot of money to send our patients with the cap, the limited cap that we get, and then requiring our local match.

Mr. Tonko. So if we undo the cap and provide a higher Federal match, what is the impact, do you think?

Ms. Helen Sablan. That would really help us. We would be able to provide more services.

Mr. Tonko. And, Ms. Young, do you have any response?

Ms. Young. Yes. To answer the first prong of your question, we provide basic services at our one hospital. And, basically, in our State plan, medically necessary care that is not available in our hospital must be sent off-island. And, currently, we send our patients to New Zealand because it is the closest country to us. It is closer than Hawaii. So everything from orthopedics to cardiology to urology, you know, acute serious pediatrics, go to New Zealand.

If the cap were lifted and we received a better FMAP, that would truly transform our healthcare system. And what is amazing about this situation, if you look at the territories, it doesn't take much in the overall scheme of the Federal budget to just give us a little more in our block grants so that we can fully provide the services to our people and care for them.

So if that cap is lifted and we got a better FMAP, absolutely, we would be able to recruit more providers n our island. Because that is part of our problem. We don't have enough certified doctors for CMS, you know, compliance issues and reimbursement requirements. I think there are three doctors with M.D. degrees from the U.S. that

allows us to claim for Medicare. But if we had more funding to recruit doctors from the U.S. with M.D. degrees, we would be able to, you know, do more of those types of claiming.

Mr. Tonko. Thank you.

Mr. Chair, I yield back.

Vice Chair Sablan. Thank you, Mr. Tonko.

Now I recognize Miss Gonzalez-Colon for 5 minutes.

Miss Gonzalez-Colon. Thank you, Mr. Chairman.

I want to thank Mr. Tonko, Horsford, Soto, and all the members who are here taking into account the situation in the territories. I think it is important for Congress to do something. And I am willing, as Representative of Puerto Rico, to work across the aisle to reach a long-term solution for territories. And I think we can do that in the Energy and Commerce Committee that actually -- they went to the island during the last Congress, both today's Chairman as the Ranking Member at the time. And I think there is a common sense opportunity to reach an agreement.

And there are two bills that have been filed, one of Ms. Plaskett that has been sponsored by all the Members of the territories in a bipartisan way, H.R. 2306. And the other one is H.R. 1354. And I commend the Members that could cosponsor those bills that would find a solution, a permanent solution, in taking the cap of 55 percent off or increasing the funding for Medicaid in Puerto Rico and the rest of the territories as well.

And I want to commend Mr. Soto for always being an original cosponsor of all those bills. And I think this is something that we can achieve during this Congress knowing that most of the territories suffered different disasters, including typhoons and hurricanes, during the last 2 years.

Ms. Arcangel, you were willing to answer the last question, and the time was up.

Did you finish?

Ms. Arcangel. Thank you, Senator -- sorry.

Miss Gonzalez-Colon. Not yet. When we become a State, I will be a Senator. But now, I will be here in the House. Go ahead.

Ms. Arcangel. I am used to speaking to Guam senators. I am sorry.

Yeah, so to answer the questions of the Congressman from New York, increasing the FMAP and removing the cap will definitely help all the territories.

One, for Guam, our experience is, because of lack of funding, local funding, we are unable to match the Federal. So what happens then is, because we have the late payments to our providers, they don't accept our patients, even for off-island providers. What happens? Our patients become more sick, their condition becomes more complicated, so the cost of healthcare increases. While we are waiting for a local match to draw down the Federal funding, our patients are staying in the hospital.

Though we have two hospitals, we don't have a tertiary center, really, that is complete with specialties who can handle these people, even for nurses. Tertiary centers requires all the professionals in order for them to completely heal the patient. But these patients are waiting months in order to go off-island because the providers off-island does not want to accept our payments because of the late payments.

Miss Gonzalez-Colon. Thank you.

Ms. Arcangel. And one more thing with regards to --

Miss Gonzalez-Colon. Don't use up my time.

Ms. Arcangel. Okay. I am sorry. I just wanted to emphasize --

Vice Chair Sablan. I will give you an extra minute.

Miss Gonzalez-Colon. Okay. Perfect.

Go ahead.

Ms. Arcangel. Sorry. I just wanted to emphasize that the territories does not receive any DSH money. And that will help our hospital.

Miss Gonzalez-Colon. The DSH money, for the knowledge of the members, is disproportionate share hospital segment. And that means that the low-income patients are being attended by many of the hospitals without receiving their fair share in order to make that happen.

Same thing happened with the low-income subsidy and the HIT, the health insurance tax. Our hospitals are paying a tax included in the ObamaCare, but we can't benefit for the tax incentive that the law provided for those hospitals. In the case of Puerto Rico, we are paying more than $200 million a year in the health insurance tax without getting the benefit. And I know it would be the same for all the hospitals because we don't have the exchange.

So there are several parts of healthcare problems. Medicaid is one of them. Medicare is another problem as well. And I began the questioning during my last turn to the lady from American Samoa. And I know -- we knew each other.

How long you been in the post, Ms. Young?

Ms. Young. Six years.

Miss Gonzalez-Colon. Six years. So what is the reason that American Samoa has not used or spent the money that was allocated to the island?

Ms. Young. Up until 2017, we only had one Medicaid provider, which is the hospital. And the hospital doesn't provide all of the mandatory services under the Medicaid program.

In trying to reform our Medicaid State plan to add new providers to try and help us draw the Federal money, the barrier for that was the local match. So, for the first time, our government was -- when our administration came in, there was a lot of old debt

that their priorities was to focus on. So we weren't able to get local match for new services until 2017.

Our hospital doesn't require a local match, but all new services outside of the hospital requires a local match.

Miss Gonzalez-Colon. And I would yield. And I would love to have recommendations from the territories that have not spent the Medicaid funds. Give me any problems you are facing. You have been 6 years there, so there should be some recommendations in order to actually draw that money.

With that, I will yield back.

Vice Chair Sablan. The gentlelady's time has expired. Thank you.

And I will recognize the gentleman from Florida, Mr. Soto.

Mr. Soto. Thank you, Chairman Sablan. That does sound nice. Not as good as "Grijalva," but still.

Chairman, I am still with you. I am Team Grijalva. But I love Sablan.

RPTR ALLDRIDGE

EDTR HOFSTAD

[12:03 p.m.]

Mr. Soto. There has been a long-running injustice in this country -- and I think we all understand that -- with our territories with regard to healthcare, taxes, benefits, even the right to vote. And we continue to be in this Committee to right those wrongs, to fix those injustices.

In Puerto Rico, under the current Medicaid system, we have seen over 6,000 doctors leave the island, many of them for our great State of Florida; hospitals in disrepair; debt added to try to prop up a Medicaid program -- all because Puerto Rico is not treated equally for purposes of Medicaid. And I know there is a similar story in each of our territories, and that is why we are here today.

I have the honor of serving on the Energy and Commerce Committee that has been -- the name has been invoked about 100 times today. So you are looking at someone who will be working in both committees on this issue specifically.

But it gets worse than that, with Hurricane Maria or Typhoon Yutu. You know, our territories have been decimated by some of these storms. And it has led to tragic deaths that are in part because of the lack of money in the healthcare system to be able to provide people with healthcare after these emergencies, including in Puerto Rico and the Virgin Islands and in the Northern Mariana Islands, along with other areas.

So, if you remember nothing else, it is time to end this injustice. And that is why we appreciate all of you coming from so far away, from so many different corners of the United States to be here today and to make sure that Americans have healthcare equality throughout the territories.

I want to thank my fellow hermana Boricua, Representative Gonzalez-Colon, as

well as Representative Plaskett and Sablan and San Nicolas and Radewagen and others. Because H.R. 2306 and 2304 are great ideas and starting points of where we need to be in Energy and Commerce with regard to these bills, as well as here.

We would like to remove the cap altogether, and we would like territories to be treated as States and get the same type of treatment that they would get otherwise. And I think that is where we want to go with either these bills or with sort of a combination of them.

Another bill that we will be working on is to give access to the Affordable Care Act exchanges, which right now the territories don't have access to. In my family's native island of Puerto Rico, only 30 percent of people are on employer-based insurance, which is mind-blowing compared to the States. And so we need to boost that up.

I noticed -- and this is where I am going to get to my question for each of you -- because you are not fully funded with Medicaid, some of you aren't providing all the services yet, although Guam -- who is from Guam? Guam is doing all the services already. So you get the gold star for today. Very impressive. You are not getting the full funding to do that.

But for each of you, going down the list, it would be great to hear, if we provided you the full FMAP funding that you would get as a State, whether you believe you could provide, over the course of a certain number of years, all these services.

And we will start with Ms. Avila, and we will go down the list. If you got the full Medicaid treatment that a State would, the full funding, would you be able to provide all the services under a mandatory Medicaid benefit? And what kind of time period would you need?

Ms. Avila. Well, we were talking about that. We will start immediately just adjusting the reimbursement rates to our medical providers.

And I will say that in a timeframe of no more than 3 years we will be able to stabilize the program as it needs right now. Because the uncertainty that we have, it is one of the most --

Mr. Soto. I understand. My time is limited, so I just want to get to other people,

Ms. King Young?

Ms. Young. Thank you. Yes, we would be able to do a lot more if we were treated equitably like the States and releasing uncapped funding as well as an improvement in the FMAP.

Mr. Soto. Ms. Rhymer-Browne?

Ms. Rhymer-Browne. Yes, we would definitely be able to do more. And one of the areas would be to increase -- well, even develop our skilled nursing facilities and not have a cap when we do have the skilled nursing facilities.

Mr. Soto. And we already covered Guam. So Ms. Sablan?

Ms. Helen Sablan. We will definitely provide all the services that is mandated. Right now, there are some that we are not covering because --

Mr. Soto. Of course. Because you are not getting full funding. I understand that.

And Ms. Muna?

Ms. Muna. We are already providing some of the services, and we will be definitely expanding and providing more services for the community at home.

Mr. Soto. Thanks.

And I yield back.

Vice Chair Sablan. I thank the gentleman.

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

Mr. Grijalva. Thank you very much, Chairman Sablan. And like I said earlier, I appreciate you putting this meeting together, this hearing -- it is impactful -- to shine a brighter light on this inequity that every one of you has spoken to, both in your oral and written testimony.

And it is an equal-treatment issue, to me, very fundamentally and very simplistically. And the way to deal with that unequal treatment is to create resource equity on par with what communities here in the United States on the mainland receive, period. That is the goal.

And I look forward to the various legislation under Mr. Sablan and the Representatives from all the territories and Puerto Rico. I think that from that would come a significant piece of legislation that we can look at, promote. And certainly I would be talking with Chairman Pallone about expediting a good piece of legislation, to start to move that.

Having said all that, I really want to ask one question to all of you. And it was a question that -- just one question. And thank you all for making the effort and coming from such a long way to be here.

The one question is: If you had to choose between a larger Federal match, around 85 percent, okay, for example, 85 percent, or more money or just more resources and more money but the same 55/45 match that is present, which would you prefer and why?

I think that is the question. Why don't we just add more money to what exists versus fundamentally changing the -- making the formula equitable, the reimbursement formula equitable?

But that is the one question for all of you. And we can begin with Ms. Muna. Then we can just go down the panel, if you don't mind.

Thank you, Mr. Chairman.

Ms. Muna. If we were going to choose, we would have to choose the more money over the FMAP. And the reason is, even if you increase the FMAP -- for us personally in the hospital, we use the certified public expenditure. If the funds are not available, you won't be able to -- even if you increase the FMAP, it would basically just be faster for you to expend the money rather than having actual cash available to pay for services that you are going to provide at home.

Mr. Grijalva. Okay. Thank you.

Ms. Helen Sablan. I go with removal of the cap instead of the FMAP. And the reason why is we are spending more. We are spending over $72 million.

Ms. Arcangel. The same way for Guam. We spent $110.8 million last year. So, if you are just going to increase the FMAP, our current cap right now is $17.97 million. That is not enough to pay for those services. So we prefer to increase the funding.

Ms. Rhymer-Browne. Very hard. We would need more money, so definitely we want the cap off. But the FMAP is needing to be off as well, because more money and still have the 55-percent FMAP would make no sense. We can't make it. We can't go after it, as seen in the ACA dollars.

Ms. Young. I think for American Samoa, this is an interesting question. I think, in an ideal situation, both of these options need to be addressed simultaneously, complementary. But if we were given an option, then we would have to go for the more money, lifting of the cap.

But what we would have to do as a territory, then, is we would have to permanently omit and eliminate all outside providers outside of the hospital, because our government is not able to raise the local match. And we would have to, I think -- and I think we can do that over years, continually improve our hospital and use our CPE

method that doesn't require the match.

Ms. Avila. We will need to agree with Virgin Islands that it is a combination of both. Even though we have more money, if we don't have the local match to be able to comply with the matching funds, we are not doing anything good for the program.

So it would be an increase of both relatively. We need to have more money, and we need to have a higher FMAP to be able to do the matching of funds and not to be in the situation that Puerto Rico is facing right now. Because trying to cope with the matching of 45 percent has taken our island to a financial situation that we are living today with the fiscal board and looking for funds to be able to pay what we get to be able to sustain the program and pay for the matching.

Mr. Grijalva. Thank you.

Mr. Chairman, I hope that going forward under your leadership that the consensus, the fact that all stakeholders are before us, that, as we move forward or move legislation, that we seek to continue to promote that con consensus. It makes the effort much more powerful, to be honest with you.

And so, with that, thank you very much again for the hearing. I yield back, sir.

Vice Chair Sablan. Thank you, Mr. Chairman.

I am going to take the liberty of asking Ms. Muna if she could respond, maybe take 30 seconds, 1 minute, to respond to Mr. Tonko's question.

Ms. Muna. About expending services?

I mean, if you remove the cap -- yes. If you remove the cap -- you know, there are a lot of opportunities for us to reform our healthcare system, given the opportunity to have that predictable funding. You have to have predictable funding and sustainable funding.

And if you are able to have those, then you will be able to basically manage the

population, bring healthcare reform, bring population health, and have a healthier population for your people. And that is an opportunity for us that we would love to have.

Thank you.

Vice Chair Sablan. Thank you.

Thank you very much, everyone.

And I just want to let everyone know that we didn't hold this hearing just on our own. We have been working with outside groups. We have been working with the Energy and Commerce Committee staff on trying to address this also. We don't want to blind-side them.

So, again, I will emphasize really the importance of giving us complete and as concise an answer to those six items I gave to you.

I also would like again -- I am really pleased with the Virgin Islands model that they have started. And I understand that some of you have agreed to kick back and, on your own -- pay your own bill, of course -- but at somewhere, maybe at Longworth Cafe, sit back and talk a little bit more on how to address -- on a model, so we could put together something for legislation.

But I want to thank the witnesses for their truly, truly valuable testimony and many of the members for their questions, their patience.

The members of the Committee may have some additional questions for our witnesses, and we would ask you to respond to these in writing. Under Committee rule 3(o), members of the Committee must submit witness questions within 3 business days following the hearing, and the hearing record will be held open for 10 business days for these responses.

[The written questions and answers follow:]

******** COMMITTEE INSERT ********

Vice Chair Sablan. If there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 12:18 p.m., the Committee was adjourned.]