NEAL R. GROSS & CO., INC.

RPTS SHIPLE

HIF171140

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

THURSDAY, JUNE 20, 2019

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:31 a.m., in Room 2322 Rayburn House Office Building, Hon. Anna G. Eshoo [chairwoman of the subcommittee] presiding.

Members present: Representatives Eshoo, Engel, Butterfield, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Welch, Ruiz, Kuster, Kelly, Barragan, Blunt Rochester, Soto, Pallone (ex officio), Burgess, Guthrie,

Griffith, Bilirakis, Long, Brooks, Mullin, Hudson, Carter, Gianforte, and Walden (ex officio).

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

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

The committee is not in order.

Thank you.

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

At the end of this coming September, the five U.S. territories face a Medicaid cliff, which means the supplementary Medicaid funding provided to the territories through the Affordable Care Act will run out. Without this federal funding, over 1.5 million enrollees, including many children, could lose their health care. Each is an American citizen and they are being treated differently than the constituents of every member in this room.

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

Due to these restrictions, the territories routinely run

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

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

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

In American Samoa, Guam, and the Commonwealth of the

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

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

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

the time remaining to the gentleman from New Mexico, Mr. Lujan.

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

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

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

Ms. Eshoo. The gentleman yields back and the chair is

now pleased to recognize Dr. Burgess, the ranking member of the Subcommittee on Health, for 5 minutes for his opening statement.

Mr. Burgess. Thank you and I appreciate the recognition.

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

The five United States territories, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, each have a vulnerable population that depends on Medicaid and the Children's Health Insurance Program. The structure of these programs is different from that in the individual states. However, these

programs are equally important as these are United States citizens. The funding for Medicaid in some of our territories was last reauthorized in the Bipartisan Budget Act of 2018, but that funding is set to expire at the end of this September. It is critical that we act in a timely manner to reauthorize this funding.

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

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

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

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

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

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

And let me yield, Ms. Chairwoman. The Chairman. Mr. Ranking Member, would you yield a minute? Just some time. I just wanted --

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

The Chairman. No, but this is procedural.

Mr. Burgess. As the Chairman of the full committee you usually get a lot of time.

The Chairman. Well, all I wanted to say is my understanding is that the delegates that are here today from

the various territories when they waive in they are not actually allowed to participate, but some of them have statements, Madam Chair. So I was going to ask unanimous consent that the statement of Mr. Sablan and any of the other delegates that are here be submitted for the record.

Ms. Eshoo. So ordered.

The Chairman. Thank you. That is all.

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

The Chairman. Thank you, Madam Chair.

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

And it is no secret how we got here. For years, the

territories have been operating their Medicaid programs under federal funding caps that haven't kept up with the needs of the people who live there. The Affordable Care Act provided increased funding that has helped the territories for the past decade, but that expires at the end of this year.

Natural disasters in the territories have also put increased strain on their Medicaid programs that required Congress to provide additional support to ensure people didn't lose access to care. Medicaid in the territories doesn't operate like it does in the states. Each territory only receives a certain amount of federal funds that is supposed to last them the whole year. It is essentially a block grant.

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

But that is not how it works for the territories. Once they spend their annual allotment, they have to pay for their Medicaid costs using local funds. And this outdated system

forces the territories to pay a substantial amount out of their own pockets to ensure that people there have access to health care. It is also a stark reminder of why block grants for Medicaid simply don't work. The federal funding shortfall means most of the territories aren't able to provide the full range of benefits that state Medicaid programs are required to cover. Payments to doctors and hospitals are so low that providers are leaving the islands for the states.

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

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

and community health centers, and others have said they expect to lose even more providers.

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

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

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

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

But now I would like to yield to Representative Soto.

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

So I wanted to join Congresswoman Velazquez and the Puerto Rican Task Force to introduce legislation yesterday. I want to thank Governor Rossello for his leadership and input in that legislation as well as our commissioner, Jenniffer Gonzalez Colon. It would be a $15.1 billion bill with an 83 percent federal match transition period of 4 years

from 2020 to 2024, followed by a 10-year transition period after that. Obviously, a game changer.

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

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

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

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

territories.

We have the honor of having before this committee a representative from each of the U.S. territories' Medicaid programs and we are really pleased that you are here, because we need to hear directly from you about the challenges you face due to the coming funding cliff in September. I know some of you had to quite literally fly around the world to join us here today, so we thank you for that. I complain about my trip to the West Coast every week, and I know you are a long way past that so I will quit complaining. We are also pleased to have before us Anne Schwartz, the executive director of MACPAC. You and your team's work has been really helpful and invaluable over the years, so we are glad you could join us as well.

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

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

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

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

else we can do to improve program integrity as we look for ways to fund the existing shortfalls.

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

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

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

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

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

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

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

Sandra King Young, the Medicaid Director, American Samoa

State Agency, welcome and thank you to you.

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

[Laughter.]

Ms. Eshoo. She is the Chief Human Service Program Administrator, Division of Public Welfare, Guam Department of Public Health and Social Services, thank you to you.

And is it Michal?

Ms. Rhymer-Browne. Michal.

Ms. Eshoo. Michal?

Ms. Rhymer-Browne. Michal.

Ms. Eshoo. Michal Rhymer-Browne, the Assistant Commissioner of the United States Virgin Islands Department of Human Service Oversight of the Medicaid Division.

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

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

road.

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

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

STATEMENT OF ANNE SCHWARTZ

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

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

the Comptroller General.

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

There is a somewhat tired old saying that if you have seen one Medicaid program you have seen one Medicaid program. This is because despite common rules, state programs vary widely. For the purposes of the hearing today, it is important to note both that territory Medicaid programs differ from the states and they also differ from each other. These differences reflect their unique geography, history, local economy, and health system infrastructure.

My written statement goes into detail as to how Medicaid operates in the territory, and if you are interested in even more information, MACPAC has published fact sheets describing each territory's program. But the most important point I wish to share today, one that has already been mentioned

several times, is that federal policy for financing Medicaid in the territories has led to chronic underfunding. This is because the policy differs from the states in two key ways.

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

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

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

Hurricane Irma and Maria.

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

As the Commission noted in its analysis of Puerto Rico's Medicaid program in our recently issued report to Congress, the history of responding to crises with short-term infusions of funds has caused a great deal of uncertainty. An additional time-limited allotment of federal funds would certainly prevent a fiscal cliff and would in the short term ensure the continued delivery of critical health services to

eligible individuals. But it would not address the underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term reliable access for Medicaid beneficiaries residing in these jurisdictions.

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

[The prepared statement of Ms. Schwartz follows:]

**********INSERT 1**********

Ms. Eshoo. Thank you, Dr. Schwartz.

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

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

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

STATEMENT OF ANGELA AVILA

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

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

Puerto Rico's Medicaid system has been chronically underfunded due to a historically low Federal Medicare Assistance Percentage known as FMAP, a correspondingly high local matching requirement, and the cap on federal funding.

Currently, we are operating under increased Medicaid funding and temporary 100 percent FMAP through the Bipartisan Budget Act of 2018, or BBA, which we received in the aftermath of Hurricane Maria, the worst natural disaster in our nation's history.

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

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

This will result in effective federal matching, including remaining ACA funds of 30 percent for the program in fiscal year 2020 and 13 percent in fiscal year 2021. Once

this funding is exhausted, Puerto Rico will have to fully fund the deficit as it has in the past and pay for its Medicaid services with 100 percent local funding. Given the island's current financial situation, this level of local funding is not an option.

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

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

Puerto Rico poverty level to increase fairness in Medicaid eligibility, and providing Medicare Part B premium assistance.

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

[The prepared statement of Ms. Avila follows:]

**********INSERT 2**********

Ms. Eshoo. Thank you very much.

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

[Applause.]

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

STATEMENT OF SANDRA KING YOUNG

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

This is a monumental step forward for the territories and our efforts for advocacy on Medicaid programs. The challenges with the U.S. territories are unique and a cookie-cutter approach will not work. However, we do have some things in common. The key to strengthening health care in American Samoa and the territories lays with fixing two key statutory provisions in our Medicaid programs. First, the cap on the territories' Medicaid block grants must be lifted or increased. American Samoa has 12 million in this fiscal year and we receive a nominal two to three percent increase every year.

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

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

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

Second, the current FMAP percentage is unsustainable for

our government. We would like to propose a more sustainable FMAP rate of 90 percent federal, 10 percent local match for at least the first few years, or a straight application of the FMAP formula based on American Samoa's actual poverty levels. Critical is the principle that both the cap and the FMAP must be addressed together. These two issues are interdependent and one should not happen without addressing the other.

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

Lastly, what is the real impact to our people when we don't have enough Medicaid federal and local funding for our program? In short, once the ACA money expire in September, we will stop our off-island medical referral program for medically necessary care not available on-island. We will

stop payments for wheelchairs, CPAP machines, and prosthetics. We will stop payments for the Medicare dual eligible beneficiaries. The only Medicaid provider that we will continue to fund will be our one hospital.

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

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

[The prepared statement of Ms. Young follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

746

747 **********INSERT 3**********

Ms. Eshoo. Thank you very much.

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

STATEMENT OF MARIA THERESA ARCANGEL

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

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

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

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

All these factors add to the high cost of health care in Guam. The migration of FAS citizens in any U.S. soil under the Compact of Free Association according to the U.S. Census

in 2013, there were 17,170 Compact migrants on Guam. In fiscal year 2017, Guam estimated that 38.5 million was spent on health care and welfare services for this population. Moreover, of the 110.8 million expenditures of Guam Medicaid in fiscal year 2018, $29 million or 27 percent of total amount were spent for FAS population's healthcare needs. The influx of COFAs citizens created an additional hardship on Guam's economy. As a result, the government is unable to guarantee the availability of 45 percent local matching funds required to draw down the federal grant awards.

The U.S. territories administer the Medicaid under federal regulations that are different from the 50 states and District of Columbia. Guam Medicaid's FMAP rate is fixed at 55 percent. However, the FMAP for 50 states and D.C. varies by states' per capita income between 50 percent to 83 percent. In addition, the federal Medicaid funding to Guam is subject to an annual cap, which is 18.38 million for next fiscal year, unlike the states and D.C. that are open-ended.

Clearly, there is a huge disparity on the Medicaid funding distribution of Guam in comparison to the U.S. states. Those differences on Medicaid rules affects the quality of health care provided to program recipients and

contribute to the economic destabilization of Guam. Due to increase in utilization, the number of eligibles, and new treatment modality and others, Guam's Medicaid expenditures increased by 323 percent over the past decade, 26 million in fiscal year 2009 and 110.8 million in fiscal year 2018.

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

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

[The prepared statement of Ms. Arcangel follows:]

**********INSERT 4**********

Ms. Eshoo. Thank you very much.

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

STATEMENT OF MICHAL RHYMER-BROWNE

Ms. Rhymer-Browne. Madam Chair Eshoo, Chairman Pallone, Ranking Member Walden, Ranking Member Burgess of the Health Subcommittee, and members of the committee, thank you for the opportunity to provide testimony on the significant impacts to our healthcare system and the people of the United States Virgin Islands considering the impending Medicaid fiscal funding cliff which will impact us beginning October 1, 2019. I am Michal Rhymer-Browne, Assistant Commissioner of the Virgin Islands Department of Human Services and I have the distinct privilege to have oversight of the Medicaid Division.

I must also thank today, Kimberly Causey-Gomez, my Commissioner Nominee, my boss, of the Virgin Islands Department of Human Services, who has extended to us her complete support as we prepared to come here to this important committee meeting. On behalf of the honorable

Governor Albert Bryan, Jr., and the more than 100,000 American citizens living in the U.S. Virgin Islands, we bring you greetings. And as we say in the Virgin Islands, "a pleasant good morning." As a people, we want to convey our heartfelt gratitude, appreciation, and thanks for the concern and the support that you and your colleagues in Congress have provided as we continue to recover from the unprecedented damage caused by Hurricanes Irma and Maria, which ravaged our territory in September of 2017.

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

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

few days.

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

And as I am sitting here with some hope, I reflect on sitting at my dining room table just a few weeks ago, probably -- no, a couple months ago, when I got the call from a teacher of a 20-year-old boy who had graduated early and she said, "He is in the hospital and he is paralyzed and he needs to be airlifted. He is one of your Medicaid members, can you send him?"

At that point, we had to make the decision. And I knew that our monies were running out under the BBA 100 percent funding, but I said we must, we must send this man, this

young man, so he can walk again. And I will share with you 3 weeks ago we got this call that this young man is walking again because we made the decisions, the tough decisions.

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

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

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

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

**********INSERT 5**********

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

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

STATEMENT OF HELEN SABLAN

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

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

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

in the making.

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

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

The fiscal crisis in the CNMI were made worse by adding to the debt obligation as well. The health system will be crippled because providers will stop taking Medicaid beneficiaries. There will be substantially more uninsured patients because the Medicaid program will effectively be ended. CHCC will not have funds for drugs, laboratory

reagents and other supplies. Frustrated clinicians and nurses may once again leave the CNMI, and all of this will affect the health of the whole population. The U.S. citizens of the CNMI are huddling on the ledge today, but hope Congress will provide a path up the cliff and enable the territories to avert disaster.

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

There are two well understood major causes of fiscal cliff, the Section 1108 budget caps and the FMAP. Both require acts of Congress to fix. First, Section 1108, the territories receive a budget appropriation under Section 1108. The budget caps were established decades ago and do not bear any relationship to the actual cost of health care today, in the CNMI today. The ACA recognized the problem and

provided a temporary increase of hundred million amount of expended from 2011 to 2019. During this period, the CNMI Medicaid was able to increase eligibility and add optional services. In fiscal year 20-, the CNMI total expenses and IBNR was around 71 million. Compared to the total of fiscal year 2020, CMS allotted funds so the shortfall will be about 48 million. Second, the FMAP for the territories is an artificial percentage unlike the FMAP for states that is calculated based on per capita income relative to the national average. Although CNMI has much lower per capita income than most of all states, it must use a fixed and inequitable FMAP percentage. That makes it impossible for the CNMI Government to fully fund the CNMI share.

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

In closing, the U.S. citizen Medicaid beneficiaries in the CNMI are clearly on the verge of a humanitarian and

financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for the next year and beyond. The CNMI is in desperate and dire situation and huddling on the edge. We are humbly pleading Congress to eliminate the Section 1108 caps and provide us equal treatment with all states and that Congress apply the FMAP percentage using the same method for the states. Thank you one more time for the time in hearing our issues.

[The prepared statement of Ms. Sablan follows:]

**********INSERT 6**********

Ms. Eshoo. Thank you. The gentlewoman's time is expired. I now would recognize -- the chair recognizes herself for 5 minutes of questions.

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

Ms. Rhymer-Browne. No, we do not disagree.

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

Ms. Rhymer-Browne. We all agree.

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

Ms. Young. Except maybe for me.

Ms. Eshoo. All right, Ms. Young.

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

We are not averse to further accountability in program integrity issues, but sometimes there are things that don't

make sense with federal laws to apply to us. For example, a few years ago we explored the possibility of acquiring an MMIS system just to do data gathering as required by CMS. But when we looked into it, it would have cost us over $20 million to implement an MMIS system. And when you only have $11 million in Medicaid funding block grant, that doesn't make sense.

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

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

Yes, Ms. Avila?

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

right now.

Ms. Eshoo. What about air ambulance services?

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

Ms. Eshoo. I see.

Ms. Avila. -- like ordinary other costs are compared to the states.

Ms. Eshoo. Ms. Young?

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

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

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

Ms. Eshoo. Ms. Arcangel?

Ms. Arcangel. With regards to air ambulance, we utilize air ambulance roughly two to three a year. It costs us $160,000 to send -- from L.A. to Guam and Guam to L.A.,

because the airlines in Guam does not, especially for stretcher cases, they don't take patients for stretcher cases.

Ms. Eshoo. And what about prescription drugs?

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

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

Ms. Eshoo. Ms. Sablan?

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

say about 300-some thousand.

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

Mr. Burgess. Yeah. And before I am recognized for question time, I have a unanimous consent request that the committee accept the testimony of Congresswoman Jenniffer Gonzalez Colon as for her opening statement as part of the record.

Ms. Eshoo. So ordered.

[The information follows:]

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

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

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

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

So you can just imagine the pressure on the doctors, say, "Hey, those nice people from the University of Miami called me again today and they want you to come interview for

a nice job there." So that is hard when you are -- yeah, I get the commitment to their patients in the hospital, but then you go home and you are faced with a family that is saying, "I don't know why we can't do what they are asking."

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

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

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

So yes, it is a challenge for our doctors. The ones that have been that stay in the island is because they love

to be there, it is not because of economic reasons. And what we are looking is just for the basic baseline compared to a lower rate, reimbursement rate than in the states, but reasonable for our doctors to be able to serve the population.

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

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

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

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

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

Ms. Arcangel. We should provide more incentives by

increasing the rate of their salaries especially for our federally qualified health centers. They come and go. They don't stay in Guam.

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

Ms. Arcangel. Yes.

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

Ms. Arcangel. Yes, but.

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

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

Mr. Burgess. Have you looked at any of the -- some of the states have done liability reform, California and Texas two of the most notable. Have you looked at that as far as the activities in Guam as well? I will tell you from the standpoint of a physician practicing in Texas, it has been an

attractant. I mean it is easier to get a doctor to come to New Jersey because of what our liability rates are in Texas. I am not saying we are stealing doctors from New Jersey, but we could.

Ms. Arcangel. Oh. That is a good idea. We will try to look at that. Yeah.

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

Ms. Arcangel. Thank you.

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

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

We have heard a lot today about the consequences the fiscal cliff faces, you know, provides to the territories, and I am especially concerned about the effects going over the cliff would have on people in the territories. And it sounds like you all would have to make some terrible choices

to cut back on coverage, benefits, provider pay. It is also clear that none of you here today wants to implement these cuts, but you will have no choice if we don't provide you with additional federal funds.

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

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

Ms. Young. Thank you, Chairman Pallone. If we received enough federal funding for our Medicaid program, it really

would allow us to cover all or most of the comprehensive services that are required under the Social Security Act. For example --

The Chairman. But when you don't get the federal funding, if it isn't enough, then what happens? How do you deal with the Medicaid expenses if --

Ms. Young. The first thing we will do is we will suspend all of the new services that we recently added and was approved by CMS 2 years ago. It took us a while to implement those because they had never been done before. Prior to 2017, we only had one Medicaid provider and that was our hospital.

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

The Chairman. All right, so looking back at your Medicaid spending in 2018, I see that your federal spending

was much more than the 1108 funds or the block grant you received. So where did the additional federal funds come from beyond the block grant?

Ms. Young. The additional funds came from the Affordable Care Act Medicaid --

The Chairman. Oh, all right.

Ms. Young. -- funding that was made available in 2011.

The Chairman. But now that expires. That additional funds from the ACA those expire at the end of this year, some in September, the rest in December; is that correct?

Ms. Young. Yes. That is correct.

The Chairman. And then you are going to have a significant funding shortfall; is that correct?

Ms. Young. Yes.

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

Ms. Young. So, two ways. It is never enough. Our increase per year is about two percent a year and there is a

shortfall of about six million a year for the hospital alone.

The Chairman. But does the cap increase if Medicaid enrollment increases?

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

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

Ms. Young. No.

The Chairman. No.

Ms. Young. It is simply a block grant.

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

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

The Chairman. But if you received the same federal Medicaid funding as a state, it would free up more of your territory's funds for other things, correct?

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

The Chairman. I see.

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

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

Ms. Young. Thank you.

Ms. Eshoo. The gentleman yields back. And now I would like to recognize the gentleman from Oregon, ranking member

of the full committee, Mr. Walden, for his 5 minutes of questions.

Mr. Walden. Thank you, Madam Chair.

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

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

Ms. Schwartz. I will just say that in MACPAC's June report, we have an extensive chapter on the situation in Puerto Rico and for which we are grateful for getting a lot of data from the Government of Puerto Rico and assess to help us do these analyses. And when we looked at spending per enrollee in Puerto Rico compared to the states and we

adjusted for the enrollment mix and we also took out spending on the state side for long-term services and supports, Puerto Rico spending is below any of the other states, so it is substantially lower.

So I will let --

Mr. Walden. All right, Ms. Avila?

Ms. Avila. It is like 36 percent lower than in the other states of the nation.

Mr. Walden. All right, that is helpful. And over the last several years that Congress, led by this committee, has provided billions of dollars in additional funding to help the territories keep your Medicaid programs afloat, these funds have gone well beyond the original caps set forth in Section 1108 allotments. And one of the ways we have done that is by temporarily increasing the territories' FMAP to increase the federal government's share of spending, as you all know.

Now I know that is something we are discussing here today. A problem with that as I see it though, is that even if we increase the FMAP for your territories, the cap remains. So my question to each of you is, what would happen if we just increased the FMAP for each of your territories

without touching the cap? And along with that for each of your territories, because again there are unique challenges and circumstances that you have each addressed, which is a bigger hindrance to adequately funding your program, the cap or the FMAP? If we could just kind of go down the list there.

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

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

Mr. Walden. Got it.

Ms. Young?

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

Mr. Walden. Got it.

Ms. Young. -- in the first quarter of the fiscal year.

Mr. Walden. That would be a problem.

Ms. Young. So it doesn't help.

Mr. Walden. Yeah, all right.

Ms. Arcangel?

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

Mr. Walden. Wow.

All right, next?

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

Mr. Walden. All right.

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

Mr. Walden. To raise the cap.

Ms. Sablan. Yes. Raise the cap.

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

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

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

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

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

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

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

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

Ms. Schwartz. -- at that time. But I think it is a historical artifact of a very complex piece of legislation that has not been updated.

Mr. Butterfield. To the gentlelady from the Virgin

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

Ms. Rhymer-Browne. Yes.

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

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

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

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

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

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

Mr. Butterfield. And these are American citizens?

Ms. Rhymer-Browne. Yes, they are.

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

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

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

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

Mr. Butterfield. Thank you. I yield back.

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

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

I will tell you, before the storms in the Caribbean a

couple years ago, we were -- Dr. Burgess and I and all the both sides of the aisle have been talking about the territories and how we have to work with the Medicaid program. And I know that for the last couple of years in some of the areas, because of the devastation it has been hundred percent FMAP and other adjustments. What we need to look at as we are looking at it today, and I think it is -- glad you are having this, Madam Chair -- is how to make this program fair to territories and sustainable in the proper moving forward. And just for an example, I was talking with my friend, Ms. Gonzalez and Ms. Radewagen, before -- Ms. Plaskett, all of the different members -- and in how do you get to be fair? I know in Puerto Rico if the fiscal year 2020 law in is in effect, 370 million will be the cap at -- 375 million in Puerto Rico and that is $285 per enrollee as compared to 7,600 in Mississippi or 7,900 in South Dakota.

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

remove the cap, what would be your priorities?

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

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

Mr. Guthrie. Okay, thank you.

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

Mr. Guthrie. Okay, thank you.

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

Mr. Guthrie. Okay, thank you.

Ms. Rhymer-Browne. Yes, our priority would be to continue serving the current clients and also go after the ten to fifteen thousand who are currently uncovered but are

eligible for Medicaid.

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

Mr. Guthrie. Okay, thank you. Yep. That sounds like good priorities to move forward on.

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

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

Ms. Avila. Yeah. Our status right now, Puerto Rico already implemented the first phase for the MMIS Puerto Rico. And according to the BBA, $1.2 billion were tied to the compliance with the T-MSIS responsibility for CMS, which we

did, and we have the certification from CMS. And also, to establish the Medicaid Fraud Control Unit and it is already in place in the Justice Department and working. So we complied with the two requirements tied to the BBA.

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

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

Ms. Avila. Oh.

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

Ms. Rhymer-Browne. Yes. We did implement the first ever Territory Medicaid Management Information System. That system has been operating since 2013, and I really believe that we are doing well with that. We also implemented a Medicaid MAGI-complaint online Medicaid eligibility system in July 2017 and that is going well. We also already implemented a Medicaid Fraud Control Unit that is operating under the office of our Attorney General, and we are getting

high marks with our T-MSIS efforts for integrity.

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

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

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

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

I think it is patently unfair that we treat American citizens who live in Puerto Rico and the other territories differently when it comes to the health care they receive under Medicaid. Chairman Pallone said it is outdated. Dr. Schwartz, you said this has been a chronic underfunding problem for many years. I am heartened by the fact that Representative Soto, Representative Velazquez, and other members now have come up with legislation that looks like it can help address this large inequity. There is nothing like having the devastation of a major hurricane like Hurricane

Maria to shine the light on this inequity, so hopefully we can move to a better place so that all American citizens no matter where they live are treated equally.

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

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

Ms. Avila. Thank you. It will be because, as I mentioned, our 1108 section only provide us with a cap amount of $389 million. Our actual cost in the program is $2.9 billion. We have been able to continue as of today because

of the segments of additional funding as ACA that is going to be ending on December this year, so we will be left with only the Section 1108, $380 million with an FMAP of 55 percent.

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

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

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

Ms. Avila. We are talking about of our more vulnerable citizens in the island. We are talking about people that doesn't earn more than $400 per month and that means that they cannot earn more than $11,000 a year, in comparison with the states that people earning like more than $30,000 a year

to be able to participate of the Medicaid program. So that is the huge disparity that we have right now.

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

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

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

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

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

Mr. Bilirakis. Thank you, Madam Chair. I appreciate

it. Thank you for holding this hearing as well.

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

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

Ms. Avila. Definitely, and thank you for the question. Angela Avila from Puerto Rico. Definitely, the Medicare Advantage line of business is crucial in Puerto Rico as well as the Medicaid program and the private sector. But in terms

of Medicaid and Medicare, we have a huge penetration in the market because in Puerto Rico we have a high population of elderly that are the ones who participate from the Medicare Advantage programs.

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

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

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

Ms. Schwartz. Well, I think I will just pass the mike in the interest of time and allow them to --

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

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

Mr. Bilirakis. Very good.

What is your greatest need, Ms. Young?

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

Mr. Bilirakis. So you have adequate enough providers?

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

Mr. Bilirakis. Okay, very good. Thank you.

Ms. Arcangel. Our biggest challenge is the providers, also, and at the same time the uninsured population in Guam because our income guideline is very low. It doesn't increase. It is based on 2016, which is 30 to 31 percent below the federal poverty level of 2016.

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

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

Mr. Bilirakis. Very good, thank you.

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

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

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

Ms. Kelly. Thank you, Madam Chair and Ranking Member, for having this hearing. And I want to thank all of you for taking the time to come. Actually, my colleague asked some of the questions I wanted to ask, but I wanted to know from Ms. Rhymer-Browne and Ms. Sablan, you didn't talk about providers so much, but are you seeing physicians leave? And the reason I am curious about that question because when I went to the Virgin Islands and Puerto Rico after the

hurricanes, and I know Congresswoman Plaskett talked a lot about you had to send people to Puerto Rico, but now you are saying that, you know, you can't really handle what you have. So that must continue to be a problem and just wondering about, both of you.

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

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

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

Ms. Kelly. And, Dr. Schwartz, if you could just snap your finger or wave a magic wand, what are two things that

you would ask us to do?

Ms. Schwartz. AS I pointed out in my testimony, the biggest problem is the chronic underfunding. The caps are extremely low and have not grown over time and the matching rate creates other challenges for the -- given the ability of the territories to raise the local share. Otherwise, the challenges are obviously different given they are different health systems.

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

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

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

But, first of all, like so many of my colleagues, my colleagues on this side of the aisle, Representative Radewagen, Representative Gonzalez Colon have shared with us so much. Even though some of us have not been able to travel to the territories especially after the hurricane, on a very

regular basis they have been such incredible advocates for the territories and for all of the healthcare needs of the territories, and so just want to thank them.

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

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

Mrs. Brooks. Thank you.

Ms. Avila. Thank you.

Mrs. Brooks. March 2020.

Ms. Avila. March 2020.

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

Ms. Eshoo. So ordered.

[The information follows:]

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

Mrs. Brooks. Thank you so much.

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

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

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

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

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

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

Mrs. Brooks. Thank you.

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

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

Mrs. Brooks. That is fine.

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

information on that question.

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

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

Mrs. Brooks. Thank you. I yield back.

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

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

hearings, and so we want you to know that.

In my state of Delaware, our Latin American Community Center, I remember when the hurricane happened and just the fear and the tears. And so my one message to you is that we have not forgotten. I want you to know we have not forgotten and so I want to start with that. I want to also recognize -- I am glad that our chairwoman talked about the strong women that are in front of us. You make us proud as well, so I want to share that with you as well.

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

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

Ms. Rhymer-Browne. Yes. I would just like to share, after Hurricane Irma impacted us in the Virgin Islands and Maria soon after, within a matter of about 2 weeks we had to

airlift or cruise ship out eight to ten thousand people out of our 100,000 population. This separated families. Mothers left with children. Fathers left with children. Entire families left. Even our graduating classes this year were smaller because of the number of people who had to leave.

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

Ms. Blunt Rochester. Thank you.

Ms. Arcangel?

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

Ms. Blunt Rochester. Ms. Young?

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

the federal government.

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

Ms. Blunt Rochester. Ms. Sablan, would you like to share anything?

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

Ms. Blunt Rochester. Thank you.

And last, but not least, Ms. Avila?

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

Ms. Blunt Rochester. Thank you.

Ms. Avila. Thank you.

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

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

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

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

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

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

Ms. Arcangel. Well, because at the beginning of fiscal year, the budget appropriation to match the Medicaid current is not enough. So I look for money within my division to

match that, so providers wait in the meantime. And at the same time, it depends on the cash flow of the government. So if there is available cash to match the federal grant, then that is the only time we can pay the providers. So sometimes they wait 3 months, 6 months to get paid for those. So that is the reason why.

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

Mr. Burgess. So it is a vicious cycle.

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

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

Ms. Arcangel. Yes.

Mr. Burgess. But that does seem like a solvable problem. On the issue of the cap, some of the territories

expanded Medicaid under the ACA and some did not. So for the three that did, Puerto Rico, Virgin Islands, and Guam, has that caused you to reach that 1108 cap faster than before the expansion occurred? So let's start with Puerto Rico.

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

Mr. Burgess. So on the expansion population, in the states they draw down, or originally drew down a hundred percent FMAP, and now it is down, I think, to 93 or 94 percent. Does that occur in Puerto Rico as well?

Ms. Avila. Definitely, yes. Yes.

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

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

Mr. Burgess. Okay. Ms. Arcangel, in Guam?

Ms. Arcangel. Yes, we finished that in the first month of the fiscal year. The reason being is because our IBNR are not paid. We paid that at the beginning of fiscal year, so

we finish 1108 first, and then we need to draw down the request for additional from ACA funding which is Section 2005.

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

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

Mr. Burgess. Okay, but it still increases your burn rate, it seems to me.

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

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

Mr. Burgess. But on that hundred percent match, was

that still calculated under the 1108 cap?

Ms. Rhymer-Browne. No. No, it is separate.

Mr. Burgess. Oh, those were separate dollars you were drawing down. Okay.

Ms. Rhymer-Browne. Yes. Yes, separate.

Mr. Burgess. Okay. All right, thank.

I thank the gentleman for yielding and I will yield back.

Mr. Griffith. Yield back.

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

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

I am very interested, and I think, Dr. Schwartz, you may

be the best person to speak to this, sort of the origins of the differences in the formula, the FMAP, where the cap came from. Because it seems to me that if we are going to address the funding issues going forward in a sustainable way, we have got to figure out what the arguments are for why those different formulas just are obsolete at this point, why they don't make sense.

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

Ms. Schwartz. Sure. The caps were first added in the 1967 Social Security amendments. Some of these programs started much later than that. We do know that in the Social Security Act at that time there were caps and special

formulas for other public assistance programs. And while we don't know what factors Congress considered when setting those caps, I think it is fairly typical that when new programs are introduced, they build on previous programs.

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

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

But do you know if any of those have been changed over time and moved up to where they are equivalent to what the

state formulas are and what rationales might have been offered in those instances?

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

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

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

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

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

have, I think, have concluded our questions.

So, Ms. Kuster, you are recognized.

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

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

So I want to thank all of the witnesses for appearing before us today and I share your view of the challenges

facing your Medicaid programs.

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

Ms. Avila. Yes, it is, 15.1 billion dollars for --

Ms. Kuster. Billion.

Ms. Avila. Billion, for 5 --

Ms. Kuster. Thank you. We try to keep track of the Ms and the Bs around here.

Ms. Avila. Yes.

Ms. Kuster. 15.1 billion.

Ms. Avila. Billion, 5 years.

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

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

Ms. Kuster. Nineteen percent?

Ms. Avila. Percent of what we pay --

Ms. Kuster. Of what physicians would receive?

Ms. Avila. Yes, our physicians. For example, a procedure for, a cardiovascular procedure in the states is paid between 1,000 to $2,000. In Puerto Rico we will pay no more than $300. Our doctors for a visit, they are paid like 20 to $25, in comparison to 100, $125 that is in the CMS fee schedules. And what we are trying to do is just to stabilize our system according to what is gathered in the fee schedules that are part of the programs in the states as Medicare, as Medicaid references, and that way is we will avoid our exodus of providers, because we are losing almost 1.5 doctors per day right now because of the lower payments.

Ms. Kuster. Lower reimbursement payments.

Ms. Avila. Yes.

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

Ms. Young. For American Samoa it doesn't apply because we only have one hospital that utilizes a certified public expenditure payment method. So we simply pay based on the Medicare cost report that the hospital files every year and

we pay actual costs that it requires to operate the hospital. We don't have independent, private physicians that are Medicaid providers. The only other provider on island that we have is the federally qualified health center.

Ms. Kuster. And for you?

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

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

Ms. Kuster. My time is almost up, but --

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

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

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

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

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

Ms. Avila. Yes, it is correct.

Mr. Soto. Yeah. And we have seen the additional federal funding for the Medicaid program is set to expire in September. Do you believe another temporary funding increase is sufficient to permanently address the financial challenges

facing Puerto Rico's Medicaid problem?

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

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

Ms. Avila. That is correct.

Mr. Soto. And why have they left?

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

Mr. Soto. And many are leaving to come to my home state of Florida.

Ms. Avila. That is right.

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

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

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

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

Ms. Avila. The answer is absolutely yes.

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

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

Mr. Soto. Thanks, Ms. Avila.

And, you know, I also want to take a moment to talk a little about the great work that not only my colleague Jenniffer Gonzalez Colon has been doing in this area, but also Governor Rossello back on the island. They have been both drumming this drumbeat since well before Hurricane

Maria, and a lot of the input from their ideas were included in this legislation.

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

Ms. Avila. Thank you.

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

Mr. Carter. Thank you, Madam Chair.

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

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

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

Ms. Avila. Well, that is why because we work with a rebate program in Puerto Rico, but the rebates are coming to

the government directly. It doesn't go to the MCOs or the managed care organizations, so it is our artificially priced, the drugs are.

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

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

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

Ms. Avila. Yes.

Mr. Carter. I am comparing you to the rest of the country and in comparison, the percentage you spend on prescription drugs is higher than it is elsewhere. I am just

wondering why. And also, a lot of indicators are telling us that the outcomes are worsening.

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

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

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

Ms. Avila. No, I understand.

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

push forward?

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

Mr. Carter. Okay.

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

Mr. Carter. Okay.

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

Ms. Young. Yes.

Mr. Carter. Ms. Young, you are?

Ms. Young. Yes.

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

Ms. Young. Well, our 1902(j) waiver has --

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

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

Mr. Carter. Right.

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

Mr. Carter. Right.

Ms. Sablan?

Ms. Sablan. Yes, that is a very unique program. And so

what happens is like we drop off the categorically requirement and it is applied to anybody that meets our income and resource limit. But we are doing eligibility --

Mr. Carter. Good, good.

Ms. Sablan. -- enrollment.

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

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

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

Ms. Eshoo. Oh, I am sorry.

Mr. Cardenas. That is all right.

Ms. Eshoo. It is my mistake.

Mr. Cardenas. Thank you.

Now that is a gentleman.

Ms. Eshoo. I think.

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

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

Mr. Cardenas. Thank you, Madam Chair.

Ms. Eshoo. Gentleman Cardenas.

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

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

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

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

Ms. Avila. It is critical right now. There is

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

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

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

Mr. Cardenas. Okay, across the board.

Ms. Avila. Across the board, yeah.

Mr. Cardenas. Also, can you clarify for the American

citizens who are listening to this hearing, a person who is born in Puerto Rico and a person who continues to live in Puerto Rico, whether they are 6 weeks old or 60 years old, is that individual an American citizen?

Ms. Avila. Yes, it is.

Mr. Cardenas. Okay, so we are talking about American citizens.

Ms. Avila. Yes, we are.

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

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

Mr. Cardenas. Okay.

Ms. Rhymer-Browne. For the Virgin Islands, we are U.S. citizens.

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

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

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

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

Ms. Arcangel. Yes.

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

Ms. Arcangel. No, no.

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

Ms. Arcangel. Yes.

Mr. Cardenas. So in the tradition and in the spirit of giving one's word, and a treaty is like giving someone's word in writing, we as the United States should probably follow through with that treaty and the obligations that we as the

United States Government agreed to; that make sense?

Ms. Arcangel. Yes.

Mr. Cardenas. Okay.

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

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

Ms. Arcangel. Yes.

Mr. Cardenas. Okay. The reason why I want to ask those questions is because I think that it is unfortunate that -- I don't know why, maybe in American history classes or what have you, a lot of American citizens think that the people sitting up here are not American citizens, that you are foreigners and that is not true.

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

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

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

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

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

Ms. Schwartz. Yes.

Mr. Kennedy. So would expending (j) waiver authority to

the rest of the territories increase the size of the federal funding allotment?

Ms. Schwartz. No.

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

Ms. Schwartz. No.

Mr. Kennedy. So no to the loss of coverage, no to the benefits, no to the pay cuts, and if you exceed the federal allotment, no no no.

Ms. Schwartz. That is correct.

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

Ms. Schwartz. That is correct.

Mr. Kennedy. Thank you. And that was remarkably efficient. It sounds to me like the Medicare programs do

have some flexibility under the law and that this (j) waiver does nothing to address the financial problems that are plaguing the territories as we have heard from multiple witnesses today, and that the waiver authority does not actually address the root cause of those challenges. Instead of looking for ways to weaken the protections of Medicaid, I hope that we can find a way to work together to find a way to strengthen those programs by providing the territories the funding that they so desperately need.

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

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

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

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

that states receive open-ended federal funds while the funds' territories received a fixed amount.

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

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

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

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

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

Because our fiscal situation is no way that we can cover with almost more than one billion dollars from local funds right now, even the Fiscal Board wouldn't allow us to do so. So we will need to change everything according to what we are doing right now and Medicaid program will be very difficult to meet with all the requirements and of what we have right now in place.

We are not looking for waivers. We are looking for ways

to have a stabilized program and in a full capacity complying with all that the programs require.

Ms. Barragan. Okay, so just for the panel, how would you be able to expand coverage and services if the block grants were eliminated and you were treated the same as the states?

Ms. Avila. We would not be able to cover with that. We would need to change the structure and to have like basic services and the government will need to start providing services directly through our facilities. So.

Ms. Barragan. So, I am asking if you got rid of block grants and you were treated like everybody else in the states, would that be helpful? Would that help you expand services?

Ms. Avila. That will be the answer for Puerto Rico just to be able to comply and have a sustain of our programs. So I didn't understand your first question.

Ms. Barragan. Okay. Any others on the panel?

Ms. Arcangel. For Guam, we will go in to reduce the number of uninsured population. We will definitely increase our income guideline and make them eligible under the program.

Ms. Rhymer-Browne. For the U.S. Virgin Islands we would do similarly to expand to the additional 10 to 15,000 who are eligible and that will definitely help our underinsured population and also reduce the amount of uncompensated care in our hospitals and our clinics.

Ms. Sablan. For CNMI, we will provide the mandated services as well as some of the optional services that is important.

Ms. Barragan. Great. So you say overall health care would improve in the territories?

Ms. Arcangel. Yes.

Ms. Barragan. Thank you. I yield back.

Ms. Eshoo. The gentlewoman yields back. I now would like to recognize the gentleman from New York, Mr. Engel, for his 5 minutes of questioning.

Mr. Engel. Thank you, Madam Chair. Let me first say U.S. territories are subject to inequitable Medicaid funding policies and we can see that today. States, for instance, receive federal matching funds for each dollar they spend in their Medicaid programs, whereas territories are capped by Section 1108 of the Social Security Act. And because of these inequities, Congress has had to appropriate additional

funding on numerous occasions to avoid shortfalls in territorial Medicaid programs. And this piecemeal funding obviously creates uncertainty which jeopardizes the ability of territories to provide Medicaid coverage to Americans residing in these communities.

So let me ask you, Ms. Schwartz, what steps can Congress take to ensure that U.S. territories have a steady stream of federal support for their Medicaid program?

Ms. Schwartz. As I pointed out in my testimony in the chronic underfunding of the territories results from the combination of the very low caps that are provided annually and the very low matching rate. So addressing both of those is needed to address the chronic underfunding.

Mr. Engel. Okay, thank you. Nearly 2 years ago, Hurricane Maria made landfall in Puerto Rico and the U.S. Virgin Islands claiming nearly 3,000 American lives. The Island is still reeling from the aftermath of this natural catastrophe. And although Congress provided temporary support to Puerto Rico's Medicaid program, it needs significant long-term federal support. And I believe if we fail to act, Puerto Rico will go off a Medicaid cliff which could have disastrous consequences for its healthcare system.

So, Ms. Avila, how would the Medicaid cliff affect Puerto Rico's ability to retain and recruit healthcare providers?

Ms. Avila. Just to clarify, if we receive the funding or if we stay as we are right now?

Mr. Engel. If you stayed where you are right now.

Ms. Avila. Well, we will not be able to comply with the full requirements of the Medicaid program and we will be facing a lack of providers, because providers are leaving the island because we are not able to fulfill their needs in terms of reimbursement rates. So it will be very challenging for Puerto Rico to keep our providers in the island.

Mr. Engel. Right. And, of course, as we have been stating today, American citizens are being treated as second class citizens and it is really unacceptable. Thank you.

Ms. Avila. Thank you.

Mr. Engel. Let me ask Ms. Young. As chairman of the Foreign Affairs Committee, I am the chairman, I always -- I am shocked by the number of people who forget that individuals living in the U.S. territories are American citizens and Congress has a duty to ensure that the healthcare needs of these Americans are fully met. So I am

proud that I voted for the recent disaster supplemental which includes additional funding for territorial Medicaid programs such as those in American Samoa.

So, Ms. Young, would you please describe how this funding will help our fellow citizens residing in American Samoa?

Ms. Young. First of all, thank you, Congressman, for your vote on the disaster supp. The availability of the 100 FMAP percentage for our territory has allowed us to resume critically necessary medical services that we had suspended back in March. And it has also allowed us to pay our bills for the off-island medical referral program and we are now able -- we have reinstated the services for durable medical equipment and prosthetics as well as we will now be able to pay the bills and invoices that have been in arrears for our federally qualified healthcare centers and our community clinics. So it has been an extremely helpful solution for us through the end of September, so thank you for that.

Mr. Engel. Okay, thank you very much. This is obviously a very important subject. I know that our chair takes it very seriously and I am looking forward to working with her to continue to make sure that there are not

inequities where we pit American citizens against other American citizens. We are all American citizens. We are all equal and we shouldn't forget that. Thank you, Madam Chair.

Ms. Eshoo. We thank the gentleman and also for your leadership at foreign relations, very important.

I don't see any other members here, so what I will do at this point is to -- well, there are only a couple of us here. But for the record, remind members that pursuant to committee rules they have 10 business days to submit additional questions for the record.

And I think the witnesses heard several members make reference to the fact that they were going to submit questions to you. You will need to answer those, so we ask that you answer them in full and in the most timely way, because the information that is provided to us is really foundational for what we want to do moving ahead.

And I also would like to ask unanimous consent to enter into the record the following, these are documents for the record: a statement from Congresswoman Aumua Amata Coleman Radewagen; a statement from the American Academy of Family Physicians; a statement from the Puerto Rico Chamber of Commerce; a statement from the Financial Oversight and

Management Board for Puerto Rico; a statement from the multi-sectoral council for Puerto Rico's health system; a statement from the Partnership for Medicaid; and a statement from America's Health Insurance Plans. So I ask unanimous consent that these documents be placed in the record. Hearing no objections, they will be placed in the record.

[The information follows:]

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

Ms. Eshoo. Let me just close by saying a few words to the witnesses. I think everyone has recognized that you have traveled a long distance. For several of you, it has taken more than the hours it takes for me to commute across the country every week from California to D.C.

I want you to know that your travel is worth it. I believe that collectively this panel has moved the needle, moved the needle on what needs to be done. And the very good question about why these programs have such low caps, low matching rates and that in the stateside they are one figure, in the territories they are another, I can't help but think that there is some bias somewhere from many years ago. But I think that it is a form of negligence to allow it to go on. This has to change, people are desperate, and the overlay of the natural disaster has done more damage to exacerbate what you are already burdened with.

I want to thank my colleagues for being present. Mr. Sablan has been here throughout. Congresswoman Coleman Radewagen -- am I pronouncing your name correctly? Thank you. My name is a little odd, so I am sensitive about mispronunciation. You have been here throughout and we are going to work with you.

I know that my classmate, Congresswoman Nydia Velazquez, has introduced her legislation. The delegates from the other territories have worked on a bill with Congresswoman Plaskett, 1354. And so, I look forward to this committee solving this once and for all. I don't want to see anymore Band-Aids and kicking the can down the road. The citizens of our country deserve citizenship that is celebrated, not denigrated.

There is an old saying that many of us use and it is an important one, that justice delayed is justice denied. I think health care denied is justice denied. So, on that note we all thank you for your travels. We thank you for your professionalism, for answer -- you really answered members' questions so well and we look forward to resolving this and continuing to work with you to resolve it.

So at this time, the subcommittee is adjourned.

[Whereupon, at 1:14 p.m., the subcommittee was adjourned.]