

TESTIMONY OF
GOVERNOR JUAN N. BABAUTA
AND
DR. JAMES U. HOFSCHEIDER
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
TO
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM AND
SUBCOMMITTEE ON WELLNESS AND HUMAN RIGHTS

Hearing Date: February 25, 2004

“This ... is about people--children and adults who are sick, poor, and vulnerable--for whom life, in the memorable words of poet Langston Hughes, ‘ain’t been no crystal stair’. It is written in the dry and bloodless language of ‘the law’--statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. But let there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children, AIDS patients unable to get treatment, elderly persons suffering from chronic conditions like diabetes and heart disease who require constant monitoring and medical attention. Behind every ‘fact’ found herein is a human face and the reality of being poor in the richest nation on earth.”
Salazar v. District of Columbia, 954 F.Supp. 278 (D.C.1996).

INTRODUCTION

I am Juan Babauta, Governor of the Commonwealth of the Northern Mariana Islands (CNMI), a small chain of islands located in the western pacific islands, just northeast of Guam. We have been a United States Commonwealth since 1976.

Mr. Chairman, the provision of health care in the CNMI is a subject close to my heart. I was educated and trained as a health care planner. My first job upon returning to the CNMI from receiving my master’s degree at the University of Cincinnati was as the director of the CNMI health planning agency.

In terms of health care, we had virtually no capacity when we entered the United States family. At that time, our main hospital facility consisted of an outdated naval facility, long abandoned by the US. In 1982, with the assistance of the United States, we developed a new hospital facility. That facility is now 20 years old, overburdened, and in need of critical repair and upgrade. It provides services to a much higher population of patients than was ever anticipated.

In addition, our distant, remote location poses other challenges. Our closest U.S. tertiary medical referral center is in Hawaii, some 3,000+ miles to the east. We have issues regarding the adequate provision of health care services to a scattered population on the three major islands with changing health care needs. Each island, although rural in nature requires the development of a certain level of emergency, preventive, and primary health care services. We provide certain basic services on all three islands, with our inpatient care being provided on Saipan. We also are faced with the fact that many patients with complicated medical problems, such as cardiovascular diseases must be referred off-island for definitive diagnostic and therapeutic services. We transport patients to Hawaii and other distant locations at increasing cost and scope. This subset of patients being referred off-island consumes a significant portion of our healthcare budget.

With the advent of 9/11, homeland security priorities, and emerging highly infectious diseases such as SARS, we have had to cope with upgrading and repair of our rapidly aging only hospital facility in the entire NMI, the Commonwealth Health Center. The tropical weather, with its high temperature and humidity, salty air, and unpredictable typhoons, has been unforgiving to our critical health infrastructure. The hospital's entire dilapidated air handling system and boiler need to be replaced and upgraded. The leaking roof needs resurfacing. The rusted, leaking medical supply office needs to be replaced. In terms of response to infectious disease threats such as SARS or intentional release of agents of bioterrorism such as anthrax, we have insufficient resources in part due to the limitations of our health care physical infrastructure. So in terms of facilities, we still have much to do and we must do improvements and upgrades on the health infrastructures on all three major populated islands.

I would like to introduce Dr. James U. Hofschneider, the Secretary for the CNMI Department of Public Health and a practicing physician with the Commonwealth Health Center in Saipan.

Dr. Hofschneider grew up in Tinian, one of the four inhabited islands in the CNMI and was educated at the University of Louisville for college and then at the University of Hawaii for medical school. He did his residency at the University of California in San Francisco and has practiced at the Commonwealth Health Center in Saipan since 1986. During that time, he has witnessed a lot of sophistication and improvement in health care in the United States in general, and in the CNMI in particular.

Unfortunately, the CNMI started out far behind mainland America in meeting the medical needs of the poor, and continues to lag far behind the rest of the country even today. That is why we need your help.

We are providing written reports to the committee regarding the CNMI delivery of health care. Our verbal report today will focus on 4 issues:

- first, our largest health problem, namely the advent and proliferation of diabetes in the CNMI;
- second, the circumstances surrounding the provision of Medicaid services in the CNMI;
- third, our infrastructure challenges in the age of 9/11; and,
- finally, some thoughts on the provision of regional health care, which I consider a key solution to many of the issues we will raise today.

DIABETES

Rate of Diabetes in Indigenous People of the CNMI

The rate of diabetes is disproportionately high among Pacific Islanders and is a overwhelming medical, social, and financial burden. The indigenous Chamorros and Carolinians of the CNMI rank third in the world among adult populations with Type 2 Diabetes; only the Pima Indians and the people of the Pacific island nation of Nauru rank higher. The burden of diabetes in the CNM is high. A significant percentage of the indigenous population suffers from severe diseases related to diabetes and diabetic complications (heart, kidney, and eye diseases). This situation, coupled with the Commonwealth's dwindling financial resources, makes the situation even more desperate.

Rise of Diabetes in the CNMI

The rising incidence of diabetes among the indigenous people of the CNMI can be traced to the rapid outside influence on the islands during and soon after World War II that caused a dramatic departure from traditional living and eating habits. Prior to World War II, the indigenous Chamorros and Carolinians consumed a diet consisting mainly of locally grown fruits and vegetables, fish, seafood, and meat from livestock. During the Japanese times, rice became established as the preferred starch food for ordinary meals as well as party fare, at the expense of tortillas made from locally grown corn. Today, it is not unusual to hear older women complain that young women do not know how to make tortillas properly, nor do they wish to learn. Tortilla making is considered arduous, as one would have to rise at 4:00 A.M. to begin making the tortillas for breakfast. The older people are not as accustomed to a rice diet when compared to the young adults of today. Among the former, corn is preferred above all other starch foods, followed by taro, bananas, sweet potatoes, yams, cassava, and breadfruit. However, today breadfruit is seldom used by Chamorros or Carolinians, an indication of how far their diet pattern has diverged from the longstanding Oceanic norm.

The results of the war forever changed the topography of the main island of Saipan, Tinian, and to a lesser degree, Rota. Leaving the islands practically defoliated, all native plants and crops were destroyed and the most basic agricultural activities were suspended indefinitely. After the islands were secured, the American military forces housed the surviving Chamorros and Carolinians in resident camps, where they were cared for and first introduced to the same processed foodstuffs that were meant for fighting soldiers. Though originally provided for survival, processed foods eventually replaced pre-war diets and basically became a staple in the diet of the Chamorros and Carolinians. Throughout the 1950s and 1960s, the convenience of canned foods and other pre-packaged products reinforced the new "westernized" diet and the reliance on processed foods for the Chamorros and Carolinians.

With the "westernized" diet came a larger variety and abundance of food. These key factors are linked to the increased consumption of food at social rites such as novenas, fiestas, Christenings, weddings and funerals and to a family's status in the community. The new diet and sedentary lifestyle of a non-agrarian economy significantly contributed

to the alarming rate of diabetes, hypertension, heart disease, obesity, and other lifestyle-related diseases.

Not only has the diet changed, but also the physical activity of the local populations changed. During the Japanese occupation of WWII, the native population was thought of more as a hindrance than an asset, yet the Japanese were fairly conscientious of the local population's physical welfare. The Japanese administration expanded health services both in the native communities and in the schools. They drilled the children in calisthenics and encouraged the young men to participate in Japanese wrestling and other sports. Bicycles filled the streets and railroads traversed the islands. Post World War II, owning a vehicle was an indication that one had achieved higher economic status within the community. Today, if someone needs transportation a vehicle is necessary since there is no mass transit system, and there are few sidewalks for walking.

Chamorro and Carolinian peoples, like other Micronesian cultures, stress the importance of interdependence within the extended family and village over individualism. This concept is repeatedly seen in language, customs, social organization, family, and law; it expresses itself in many qualities that were valued by their ancestors. Thus, health care initiatives such as practicing preventive medicine through education are focused on teaching the extended family as a whole. While the many Americans value individualism, our community's approach to controlling and preventing diseases such as diabetes centers on the family unit and is then reinforced by strong community support systems.

The Burden of Diabetes

Type 2 Diabetes is a major health concern for the indigenous population. Latest statistics reveal that there are 3,128 persons with diabetes in the CNMI. It is a leading cause of illness and shortened life span for adults over 20 years of age, resulting in frequent outpatient clinic visits and hospitalizations. 11% of indigenous adults over 25 years of age have diabetes and this percentage steadily increases with age. In the indigenous adults over 40 years old, 26% have diabetes and by 65 years and over, the rate is 32%.

In one published study conducted by the Department of Public Health, the prevalence of diabetic retinopathy in 339-screened persons with diabetes was 70%, which surpasses the estimated 54% prevalence rate seen in mainland U.S. diabetics. This same study also noted that 40% of all cases of blindness in the indigenous population are due to diabetes. These alarmingly high numbers of diabetic retinopathy were confirmed by the results of one eye clinic where 221 diabetic patients were screened in 2002 and 54% had diabetic retinopathy.

Research conducted at the Commonwealth Health Center reveals that diabetic nephropathy is responsible for 75% of the patients who have end stage renal disease and are receiving hemodialysis treatments. This figure compares to that of the mainland United States average of 25%.

In the CNMI, nine out of 100 people with diabetes are admitted to the hospital for pneumonia every year, but in the U.S., that number is only three per 100. In the CNMI, among 1000 people with diabetes, 12 people undergo limb amputation each year. This rate is much higher than the U.S. national rate of 8.3 per 1000 diabetics. The rate of diabetes-related death is 67 per 100,000, in comparison to the U.S. national average of 79 diabetes-related deaths per 100,000 diabetics.

As these numbers suggest, the costs related to on-island medical care as well as off-island medical care have severely impacted the financial structure of the Commonwealth of the Northern Mariana Islands. In 1997, the Centers for Disease Control and Prevention (CDC) funded the CNMI's Diabetes Prevention and Control Program at \$85K. During that year there were 1,812 persons diagnosed with diabetes. The following chart shows the grant funding by the CDC and the diagnosed persons with diabetes from 1997-2003, when the incidence of the disease greatly increased but the funding did not.

Year	CDC Funding	# Diagnosed with Diabetes
1997	\$85,000	1,812
1998	\$86,700	2,032
1999	\$86,700	2,239
2000	\$88,438	2,495
2001	\$88,438	2,746
2002	\$88,399	3,019

Hemodialysis Expansion

To meet the needs of the increasing number of renal-care patients in the community, the CNMI government is expanding the CHC to include a new facility, which would house additional hemodialysis stations and accommodate a peritoneal dialysis program. The current facility in the hospital is authorized for 14 hemodialysis stations, far less than is needed by the 103+ renal patients under dialysis care and future needs (16% growth rate per year in ESRD patients).

While most hospitals run two shifts of dialysis for patients, the CHC is forced to run four shifts, often necessitating patients to come in as late as one or two in the morning. The demand has been too great, and the government has responded by authorizing the new dialysis project.

Unfortunately, the local funding for the new building fell desperately short of what would ultimately be needed to open the new dialysis center. Funding only included construction of the new building itself, while not taking into consideration the cost of furnishing the building, or equipping it with the necessary medical equipment.

Our people are being robbed of family members' best years due to diabetes. Not only does it affect our children by not having the cultural heritage passed down from one generation to the next but also it robs our community of the most productive years of labor and job experience.

With the increasing incidence of diabetes among the indigenous population (Chamorros and Carolinians) as well as other Pacific Island and Micronesian populations, we are asking for your assistance to adequately fight this traumatic disease negatively affecting our islands. Please consider the following requests to help us treat and effectively lower the incidence of diabetes.

- **Funding to equip our expanded dialysis center now under construction, including required standby and isolation stations (two parts: 42 hemodialysis stations @ \$25,000 per station; 5 automated peritoneal dialysis units @ \$14,000/ unit). \$1,120,000**
- Technical assistance to conduct research projects aimed at children, focusing on prevention efforts.
- Funding for resources to provide families who are affected by diabetes such as pamphlets, informational conferences, and trained diabetes prevention educators to conduct a grass roots campaign to prevent and/or control diabetes.
- Funding for supplies to screen persons in the CNMI who are at risk for diabetes. With the increased focus on screening, we will be able to catch persons with diabetes before the complications arise.
- Funding for physicians who are specialists in diabetes complications. These specialists will assist us in decreasing our outstanding debt related to off-island medical referral.
- Funding to improve local staff capability.

MEDICAID

Title XIX of the Social Security Act¹ establishes the federal medical assistance program ("Medicaid"). Medicaid is a cost-sharing arrangement under which the federal government reimburses a portion (up to 77%) of the expenditures incurred by states that elect to furnish medical assistance to individuals whose income and resources are insufficient to cover the costs of their medical care.²

States are not required to participate in the Medicaid program, but if they voluntarily choose to do so and accept federal funds, they must adopt a "state plan" that delineates the standards for determining eligibility and identifies the extent of Medicaid benefits. The state plan adopted must comply with the federal Medicaid statute and implementing regulations. If the state plan meets minimum federal

¹42 U.S.C. §1396 *et seq.*

²*Skandalis v. Rowe*, 14 F.3d 173, 174-75 (2nd Cir. 1994); 42 U.S.C.A. §1396a *et seq.* The purpose of the Medicaid program "is to help provide medical treatment for low income people," *Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d 170, 172 (3rd Cir.1995), *cert. denied*, 516 U.S. 1093 (1996).

requirements, the Secretary approves it and state expenditures under the plan qualify for federal funds.³

Under federal Medicaid law, if a state chooses to participate in Medicaid (as all states do), then every resident of the state who meets the state's Medicaid eligibility requirements for either mandatory or optional services is entitled to have payment made on his or her behalf by the Medicaid program for those services.⁴

The federal Medicaid program requires that certain categories of medical care must be included in every state's Medicaid plan (mandatory services).⁵ Other categories of medical assistance are "optional," and each state has the discretion to choose whether to cover any particular optional service in its program.⁶ However, when a state elects to provide an optional service, that service becomes part of the state Medicaid plan and is federally funded in accordance with federal program requirements.⁷

Medicaid Population and Costs

Our population is growing. Every day, 3 new Americans are born in the CNMI. Unfortunately, most of these Americans are poor. From FY2002 to FY2003, the number of Medicaid recipients in the CNMI grew from 7,202 to 8,723, a net 1,500 increase.

The cost of medical care for our Medicaid population is now almost \$13.5 million per year. Of that amount, the federal government contributes about \$2.5 million or 19% of the total expenditures. If we were treated like a state instead of a territory, federal financial contribution would be almost 3 times that amount or about \$6,765,000.⁸

Medicaid Services and Federal Financial Participation

For the states, there are 8 kinds of mandatory Medicaid services⁹ and 5 kinds of optional services,¹⁰ for which federal financial participation ranges from 50% in the wealthiest states to 77% in the poorest.

³ See 42 U.S.C. §1396a; Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981); Harris v. McRae, 448 U.S. 297, 301 (1980); Elizabeth Blackwell Health Center for Women, 61 F.3d at 172.

⁴ Kaiser Family Foundation, The Medicaid Resource Book (July 2002), p.51.

⁵ Elizabeth Blackwell Health Center for Women, 61 F.3d at 173.

⁶ Elizabeth Blackwell Health Center for Women, 61 F.3d at 173.

⁷ Tallahassee Memorial Regional Medical Center v. Cook, 109 F.3d 693, 698 (11th Cir. 1997).

⁸ For some purposes, such as the Americans Disabilities Act, the CNMI is treated like a state and has the same obligations and rights as a "state".

⁹ Mandatory Medicaid services include:

A. hospital care (inpatient and outpatient);

B. nursing home care

C. physician services

D. laboratory and x ray services

E. immunizations and other early periodic screening, diagnostic, treatment (EPSDT) services for children

In the CNMI, we receive 19% federal financial participation in the Medicaid program. The federal Medicaid program separates CNMI Americans from other kinds of Americans and provides less Medicaid assistance to them. This is done in four ways:

- A. by “capping” federal fiscal participation to a set amount;¹¹
- B. by limiting the federal-CNMI match to a significantly lower percentage than for the states (50% in the CNMI vs. up to 77% in the states);
- C. by limiting the types of services that are subject to reimbursement; and
- D. by prohibiting disproportionate share public hospital (DSH) payments to the CNMI’s only hospital.¹²

Because of the disparate federal financial participation, CNMI Americans receive federal assistance for only the following services: pharmacy; limited off island acute medical care; and dental/optometric/ophthalmology services.

This compares to the 13 categories of assistance Americans living in the states can receive, both for local care and out of state care, when it is required. As distinguished from any state, all of the cost of the CNMI on island hospital and clinic care (preventative care, prenatal care, immunizations, psychiatric care and counseling, long term care, support services that allow individuals with disabilities to remain at home or work in the community, etc.) is borne solely by the CNMI local government without federal contribution.

The Claimed Rationalization for Disparity in Treatment

-
- F. family planning services
 - G. health center and rural health clinic services
 - H. nurse midwife and nurse practitioner services.
- The Medicaid Resource Book, Kaiser Family Foundation, July 2002, p. 50.

¹⁰ Optional Medicaid services include:

- A. prescription drugs
- B. intermediate care for individuals with mental retardation
- C. home and community based services for individuals with disabilities
- D. personal care and other community based services for individuals with disabilities
- E. dental care and vision care for adults.

The Medicaid Resource Book, Kaiser Family Foundation, July 2002, at p. 50.

¹¹ Territorial governments such as the CNMI have a federally imposed capitation on Medicaid service funds received from the federal government. Territorial governments must provide a 50-50 match for services up to the cap and then pay 100% for all services over the cap.

¹² See Section 4116 of PL 100-203, 42 CFR 431.56, Sections 1902(j), 1108(f), and 1905(a)(1)-(27) of the Social Security Act; Dr. Vernon K. Smith, Making Medicaid Better: Options to Allow States to Continue to Participate and to Bring the Program Up to Date in Today’s Health Care Marketplace (Prepared for the National Governor’s Association), p.14-15.

What is the rationalization for this disparity in which even the richest American states receive proportionately more Medicaid assistance from the federal government than the poorest territories? We are told it is because we do not pay federal income taxes. However, this justification falls apart on closer examination. 60% of CNMI residents are so poor that they would pay no federal income taxes, even if the CNMI were subject to federal taxation. The remaining 40% of the CNMI population consists principally of the working poor and their children, who can ill afford to support the growing medical needs of the islands' poorest citizens. 37% of our children live below the poverty line.

Comparison of Federally Funded Benefits in States vs. the CNMI

Please compare the following benefits under federally funded state Medicaid programs and under our CNMI program.

Type of Service	Federal Contribution to States	Federal Contribution to CNMI
Nursing home care or home health care to elderly persons	50-77% of cost	0
Intermediate group home care or home and community services to developmentally disabled adults	50-77% of cost	0
Inpatient psychiatric care for children	50-77% of cost	0
Personal care assistance for physically disabled adults to live at home	50-77% of cost	0
Any CNMI locally provided medical care (i.e. preventative or acute care, physician, mid-wife, nurse practitioner, physician assistant, hospital, lab, x-ray, screening, diagnostic, treatment, immunization, family planning, or other medical services)	50-77% of cost	0
Transportation to/from medical care	50-77% of cost	0
Pharmacy ¹³	50-77% of cost	50%
Off island acute care	50-77% of cost	50%
Dental/optometric/ophthalmology services	50-77% of cost	50%

This demonstrates the inadequacy of the existing federal support for the CNMI Medicaid program and its indigent clients.

¹³ Medicaid pharmacy expenses are \$1.9 million per year.

Examples of Problems Caused By Lack of Adequate Federal Support

Finally, in real life terms, what does this disparity mean for the people of the CNMI?

When patients in the CNMI must be sent elsewhere for health care, they must be sent not to another city, but off island for care, usually Guam, Hawaii or California. The cost of medical care in both Hawaii and California is among the highest in the U.S., and likely in the world. Transportation and logistical costs for off island care in Hawaii and California are likewise extremely high. (Because of federal funding requirements, Medicaid patients cannot be sent to cheaper and closer destinations like the Philippines, Australia, New Zealand, Japan or Thailand.)

Because the Medicaid program is so under-funded, it is extremely difficult to obtain competent on and off island care for very ill people (especially children). Providers do not want to accept CNMI Medicaid patients because of the delay and difficulty in securing payment from CNMI Medicaid. No new providers want to enter the market of being CNMI off island Medicaid providers. Rates are not what they could be if we could offer timely and sure payment and if there were some competition for CNMI Medicaid business.

CNMI has tried to reduce costs by bringing locum physicians from Hawaii and other states to the CNMI to run periodic specialty clinics. Recently, one of the long time locum providers refused to come to see CNMI patients in Saipan because of the poor Medicaid payment history. He is not the first and he will not be the last to give up on us. The loss of or decrease in locum services means either lack of timely care or even more expensive off island referrals for care, which the CNMI cannot afford.

The CNMI Medicaid program has had Hawaii facilities refuse our patients due to our inability to pay our bills timely. One of our assistant AGs had to actually threaten to file a lawsuit to get a Hawaii hospital to take back its 7 year old leukemia patient who had relapsed shortly after discharge from the hospital in Hawaii. The hospital had demanded that the patient and her family pay up front \$100,000 in cash to return for care. Matters got even worse. The little girl could not get a hearing aid in her last months of life because hearing aid vendors would not trust the CNMI Medicaid program to pay for it.

In another case a few years ago, a CNMI hospital administrator could not get an LA hospital to take a critically sick child without promising to pay rates between 2 and 3 times what the California Medicaid program would pay for the same care. When the collection agency came to call due to delayed and disputed payment, the administrator had to admit that yes, he did agree to pay the amount demanded because he could not find any other hospital willing to take the boy and he would have done or said anything at that point, to get the child the emergency medical care he needed to survive.

The CNMI has also been over charged by off island hospitals and physicians (e.g. between 40-100%) because CNMI Medicaid lacked sophisticated staff and the technical

expertise and computer resources which would have shown that the amounts demanded were excessive, inaccurate, unreasonable and illegal for the services delivered.

CNMI physicians and the local hospital are not paid for their care of Medicaid patients due to the absence of sufficient federal funds. This means new providers will not enter the market and the few that are in the market will eventually leave. The burden of the cost of this local Medicaid care on the CNMI government is crushing.

Request for Assistance with Medicaid

We ask that you **eliminate the cap on federal contributions to our Medicaid program and raise the federal contribution to up to 77% of the cost of Medicaid services. In short, we ask you to give us equal treatment with the states.** This would mean additional federal financial participation of \$4.5 million per year.

Alternatively, if you feel you cannot do so, we ask that you **increase federal financial participation to pay for a 50% share of mandatory Medicaid services already being provided without federal financial participation through the CNMI's Commonwealth Health Center for local inpatient hospital and outpatient care.** That would be an additional \$3.1 million in federal funds. Either alternative would greatly improve our ability to meet the health needs of our poor patients.

THE COMMONWEALTH HEALTH CENTER

Capacity, Number of Patient Visits, and Cost

The Commonwealth Health Center ["CHC"] is the only hospital for a community of 70,000 people. It has a 74-bed capacity and was originally designed and built in the early 1980's to serve a maximum population of 36,000. The facility is now overburdened and in need of systems repair, upgrade, and hardening for security purposes.

The Emergency Room in the CHC handles over 20,000 visits/year. 60% of visits are pediatric patients. Out patient visits exceed 76,000/ year. The number of hemodialysis patients receiving treatment in 2003 totaled 103. Of those, 41 patients were forced to take hemodialysis treatments late into the night, due to overcrowding and the limited number of hemodialysis units.

The 74-bed hospital has, on average, 6,000 admissions per year. There were 1,400 deliveries in 2003. Patients that are seriously ill, or need further diagnostic and therapeutic procedures not available at CHC, are sent, at CNMI government expense, to off-island referral centers. Off-island care has been averaging over \$5 million per year and is a tremendous burden to the CHC budget, which is currently funded at a near record low due to the economic downturn following September 11.

The CNMI spends over \$40 million a year to support the Department of Public Health to provide critical medical and health related services. We spend several million dollars a year in order to hire quality professional clinical staff from outside the CNMI, including North American-trained doctors at competitive salaries and over 150 nurses and ancillary personnel to provide the best possible service on island for all residents and visitors.

We are spending several million dollars to expand the infrastructure to increase the number of hemodialysis stations and to increase the ambulatory care space for better access to primary care as well as to care for patients with tuberculosis. In addition, we have opened and enhanced two wellness centers for women and children to improve access to immunization and prenatal services. Yet payment for services rendered has always been lacking, with total collections decreasing with the sluggish economy as the number of indigent patients increase.

In 2003, over 60% of the unpaid accounts receivable at the CHC were from the indigent population (Medicaid, Medically Indigent Assistance Program, self-pay or uninsured.) However, we have and must continue to provide services, regardless of inability to pay. The CNMI needs the help of the Congress and the federal government now to keep the CHC a sustainable and viable center for care.

Despite CHC's relatively small size, it is required to accommodate an excessive number of facilities and services, since it is the only hospital in all of the CNMI. The physical plant design is intelligent and the construction was well executed when it was built. This combination has resulted in the ability of the building to provide an excellent service to its community for the past almost 2 decades. However, there are some critical issues that must be addressed if this facility is to continue to function and perform well into the 21st century.

Emerging Infectious Disease Response Capacity

The CNMI is the closest U.S. territory to Southeast Asia, and is prone to a myriad of potentially deadly infectious diseases of enormous public health significance. The largest and most threat to the CNMI is Severe Acute Respiratory Syndrome (SARS), which broke out in the region during 2002-2003, and may be recurring. Luckily, during last season's outbreak, the CNMI was spared from any cases of SARS, and the local health infrastructure did not have to deal with containment and treatment of SARS. **Because of our proximity to China where the epicenter of the SARS epidemic started and the number of travel between Asia and the CNMI, our risk for importation of SARS from Asia was judged by WHO and local officials as moderate to high but yet our local capacity to respond to a SARS outbreak was minimal. Had a single case of highly infectious SARS reached the CNMI and spread, the island's health infrastructure and clinical staff would have been severely crippled.** The community has limited resources and immediate capacity to control, contain, and treat the

disease. Potential disaster might have ensued had a single case of highly infectious SARS been brought to the CHC.

With the hospital's lack of proper ventilation, and no quarantine units, the entire hospital itself would have turned into one massive quarantine site. All medical staff, ancillary staff, administration and patients breathe the same air, and would be potentially exposed to aerosolized infectious agent.

Our intensive care unit only has four beds, with virtually zero surge capacity. The hospital's structure itself is an 'open air' structure, where it would be a near impossibility to monitor all incoming and outgoing traffic.

The CNMI is a tourist destination for Asia and receives over 1500 passengers per month via direct flights from China through China Southern Airlines, and several indirect flights per week from China (including Hong Kong SAR, Taiwan) via other airlines. The CNMI also is home to a non-resident labor pool of almost 30,000 workers, a significant portion of which live in close-quarter dormitories and 'barracks' located adjacent to the garment factories where they work.

The risk of transmission of SARS, once on island, in close-quarter dormitories used by workers, could result in an epidemic of enormous proportions, quickly overwhelming the local health resources and the only hospital and crippling the staff. There is not alternative hospital facility to quarantine and care for the patients severely affected by SARS.

Furthermore, while there is no human-to-human transmission reported, Avian Flu is nonetheless a threat to the Asian and Pacific region. Avian influenza A(H5N1) has spread among chicken populations in China, and Vietnam, and cross-species transmission (from infected birds to people) has proved to be more fatal than SARS, with a mortality rate reportedly as high as 75%. Should the virus mutate, acquire the capacity to spread from human to human, and gets introduced into the CNMI, the CHC is unable to adequately handle the spread of this, or other emerging infectious diseases, based on the hospital's aging infrastructure, and limited capacity, and improper ventilation system.

Currently, any major outbreak of a dangerous emerging infectious disease would result in lost of many, many lives, devastate the health infrastructure and local economy, and necessitate the intervention of outside government agencies, costing an enormous amount of dollars to respond, contain, and treat any epidemic. Enhancing and hardening of the CHC and its capacity to prevent the spread of any such outbreaks would greatly improve the health care environment, save lives, and mitigate the cost of outside intervention that would otherwise be required.

Bioterrorism Response Capacity

The CNMI is very close to a region of the world associated with an increasing level of political terrorist activities. As a U.S. Flag Territory, the CNMI is a potential

target of terror in the Pacific. With the advent of bombings in Bali, Indonesia, and the potential links to other terrorists through the Asia and Pacific regions, the risk of terror in the CNMI has never been so great. Similar to emerging infectious diseases, our capacity to prevent and handle intentional release of agents of bioterrorism is severely limited by the hospital facility's "open-air" structure allowing multiple accesses to the building and the original design limitations of the ventilation and air handling system (resulting in a closed ventilation system with re-circulation of potentially contaminated air).

Infrastructure Status

Because of age, harsh temperatures, high relative humidity (79% average), rain, and inclement weather like typhoons and tropical storms, the CHC has been battered and beaten over its 20-year existence. The main concern with the structure is the leaking roof, deteriorated state of certain critical equipment and systems such as HVAC (heat, ventilation, and air conditioning), boiler, etc have corroded and reached the end of service life and need replacement. In addition, because of the hemodialysis building expansion project, the entire water supply system needs to be upgraded and enhanced (potable water, medical grade water, water for fire suppression, and decontamination).

Three reports were published in recent years analyzing the functionality and sustainability of the CHC. First was a Facilities Assessment done by Casey Conner, CPE, CHFM, CEM, who was the hospital's Plant Engineer and Maintenance Manager. The second was a Structural Analysis by SSFM Engineers Inc, of Hawaii (May 2000). The third was an Energy Audit and Technical Analysis sponsored by the CNMI Energy Office, and done by Conner Incorporated.

All three reports were focused on different areas of the CHC's infrastructure, but all resoundingly agreed on a common theme: **to continue functioning over the next several years, the CHC must upgrade, repair/renovate, and harden its infrastructure and critical facilities.** The reports were succinct in noting that **without the needed upgrades and renovations, the building will not be viable for continued safe hospital operations.**

Request for Assistance

The critical infrastructure upgrade needs of the CHC are detailed in the Facilities Assessment Report and supplemented by the Energy Audit and Technical Analysis. The total cost of these upgrades and repairs is estimated to be \$12 million plus dollars (2002). The CHC administration has identified funds for development of a Master Plan. Although we have begun to replace and upgrade some of the key utility components (such as oxygen machine, telemetry system, phone system, the x-ray equipment, and telemedicine), much more remains to be addressed. **The necessity of speeding up capital improvement funding is becoming critical, as equipment failures are evident.** Furthermore, certain projects will, while solving other issues and concerns (such as space

and patient accessibility and service), in fact exacerbate others. The new hemodialysis building is such an example. While solving the problems of patient access and service, it will create severe water shortage issues once the facility is open. Also the existing CHC infrastructure cannot support the required demands of this project in several other areas.

In summary, the CNMI's one and only hospital facility is urgently in need of systems upgrade, redesign, repair/renovation in order to continue to provide critical medical services to our isolated community in the Western Pacific Basin. The infrastructure and its systems are being pushed far beyond their intended limits, and some are also at risk of system failure. Although our needs are lengthy, **the most critical needs are for upgrade of the water system and the ventilation/space cooling systems. We respectfully ask this Committee to assist the CNMI in funding for upgrade of the Water System, essential for support of the hemodialysis expansion and the entire hospital, and secondly, for funding of the Ventilation/Space Cooling redesign, equipment, and renovation, to protect our community for the risks of immerging infectious diseases such as SARS.**

<u>CHC Structural Projects the</u>	<u>Estimated Cost in 2002 Dollars</u>
<i>Water system (include medical grade, potable water, rainwater catchment, fire suppression, waste)</i>	<i>\$3 Million</i>
<i>Ventilation/space cooling</i>	<i>\$ 3Million</i>
Replacement of steam system	\$300,000
Medical Supply building	\$3 Million
Replacement of medical vacuum system	\$150,000
Resurface of roof and its structures	\$500,000
Medical air	\$100,000
Parking design and construction	\$1.5-\$ 3 million
Telecommunication (nurse call, security, fire alarm, bioterrorism, and homeland sec. upgrade)	\$200,000
Energy management/lighting (after the above changes are made, then lighting will be the primary concern)	\$300,000
<hr/>	
Total Infrastructure Improvements	\$12,050,000-13,550,000

CONCLUSION

These needs are substantial. We would appreciate any help you can give us in meeting these challenges. In so doing you will lessen the wide disparity in the quality and quantity of hospital services between the indigenous people of the CNMI and other Americans. Thank y

REGIONAL HEALTH CARE

- Every year, millions of dollars are spent by all the Micronesian island states for off-island medical treatment of patients in Hawaii, the US Mainland, and the Philippines. The CNMI alone spent over \$5 million for off-island referrals in one fiscal year. How much does Guam spend? How much does Palau spend? How much does the FSM spend? Simply, we are spending too much.
- It is not simply cost. Patients and families have to travel long distances, and be away from home for prolonged periods of time in a culturally challenging environment. In addition to government expenditures, families also spend a significant amount of financial resources at these referral centers. Travel cost alone for the CNMI exceeded \$1 million
- It may be that in an earlier day, off-island referrals were the proper choice. Today, however with the advent of diagnosis via telemedicine, with enlarging populations creating economies of scale in the provision of services, and perhaps more importantly with the increasing number of indigenous persons who are doctors or other medical professionals, new solutions for the delivery of health care are feasible and must be explored.
- Further, high quality health care services are a critical component of the infrastructure needed to attract the more capital intensive activities we see as the next stage of economic development in our region.
- My vision is to develop our own regional health care centers for example, to redirect all our tertiary care patients to Guam, rather than the PI or Hawaii. My vision is for Guam to build on and strengthen the delivery of services in specialized areas so as to accept and receive patients referred from the CNMI. With this support and understanding the CNMI would turn its attention toward becoming the regional center for pediatric care. My vision is for the FSM and Palau to also develop regional facilities in certain areas
- My vision is simply to re-direct part of all of our government and private expenditures to the development of our health resources in a regional manner; a form of re-investment in the neighborhood.
- My vision already exists in the State of Alaska. As Governor Murkowski stated in a letter on this subject

“There are villages and communities in Alaska that are as remote from centers for specialized health care as the most isolated islands and atolls in Micronesia, yet we have taken advantage of technology to markedly improve the ability of the local communities to provide care. In the case of the governments in Micronesia, that technology, as well as a better-focused use of facilities, could provide far better levels of care within the island than is possible now even with off-island referrals. A coordinated approach could also relieve some of the local governments of the maintenance costs for facilities and services that are duplicated on neighboring islands”.

- My vision already exists in a small way today here in Micronesia. We are already sharing some resources. Today, 2/3 of all our referral patients already go to Guam and we share some specialties (e.g. CNMI - ENT, ortho, ID, plastics/reconstruction surgery, ophthalmology, nephrology, urology); But we must go farther.
- I propose that we all embrace (buy in) this regional network concept. We must begin to develop new ideas and new concepts.
- We need long-term regional commitment from everybody. Goals must be clearly defined. We must think regionally. The CNMI supports the development of a Veterans Hospital in Guam because this type of regional approach is the best way to address those needs.
- Health care costs have sky rocketed. We are spending more and more resources on health care and projections are that costs will increase.
- My vision changes the way we have looked at medical referral. I propose that united as a region, we can best address our individual needs as well as our neighbors.

CONCLUSION

I know that these are substantial requests for assistance and that you have many worthy competing concerns. However, we would appreciate any help you can give us in meeting these challenges to improve the medical care we provide. In so doing, you will lessen the wide disparity in the quality and quantity of medical services between the indigenous people of the CNMI and other Americans. Thank you.