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`0:00:00` I Thank you. Thank you. Thank you. I love you, I love you, I love you

`0:02:30` Thank you. Thank you. Thank you. Thank you. Thank you.

`0:05:00` Thank you. Thank you. I love you. Thank you. ¶¶ Thank you.

`0:08:00` Let's go. Thank you. Thank you.

`0:09:30` Oh, my God. Thank you. Oh, my God. Oh, my God. Thank you. Thank you. Oh, my God.

`0:13:00` Thank you. Thank you. Thank you. Thank you.

`0:15:00` Oh, my God. Thank you. I love you. I love you.

`0:17:00` Oh, my God. Thank you. Let's go. [3 such phrases repeated 8 times · standby audio before the proceeding, transcribed by the recogniser as speech]

`0:21:30` Let's go. I love you.

`0:22:30` Thank you. Thank you.

`0:23:30` Thank you. Thank you.

`0:24:30` Thank you. Thank you. Thank you.

`0:26:00` Thank you. Thank you. Thank you.

`0:27:30` I love you Thank you. Thank you. Thank you.

`0:29:30` Thank you. We'll be right back.

0:30:30 Thank you. Let's go.

0:31:30 Thank you. Thank you. I love you. Y nunca me ha dejado de soltar Thank you.

0:34:00 Good morning. Good morning. The Committee on Health Hospitals and Human Services is now on the record, and I want to say a pleasant good morning to all of my esteemed colleagues, the invited testifiers, central staff, and the viewing and listening audience. As always, we give thanks and praises to the Most High and blessings to all. I want to take a quick moment to recognize that March is National Kidney Month, a reminder that kidney disease affects one in seven Americans, and that many who have it may not know they have it. Diabetes and high blood pressure are both contributors factors to kidney disease And just to give you some of the early warning signs of kidney disease There's a change in urination You could have more frequent urination or urinating less Also you can have foamy or bubbly urine dark urine, bloody urine or tea colored urine feeling unusually tired or weak and also sudden swelling in their feet ankles and face diabetes and high blood pressure which contribute to

0:35:47 kidney disease are both prevalent in the Virgin Islands and they are the leading causes of this disease. Early detection through simple blood and urine tests can make a life-saving difference. And I encourage all residents, especially those already diagnosed with diabetes, high blood pressure, or a family history of kidney disease, to speak with their health care provider about getting tested. Let us use this month, National Kidney Month, as a call to action to protect our kidneys, protect our health, and protect our families. Today's hearing is particularly significant. Our hospitals are in a state of emergency.

0:36:43 That's right, they are in a state of emergency even though it has not been officially declared. and the people of the Virgin Islands deserve answers, accountability, and a clear path forward. We have two blocks on today's agenda. In Block 1, we will receive operational updates from the Department of Human Services and the Office of Disaster Recovery. Block 2 will receive a comprehensive update from the executive leadership of our territorial hospitals. We will proceed in an orderly manner and remember to please silence all electronic devices.

0:37:33 Mr. Clerk, can you please call the roll? Senator Hubert L. Frederick? Present. Senator Hubert Frederick, present. Senator Marvin A. Blyden? Senator Blyden, absent. Senator Ray Fonseca? I'm here.

0:38:00 Senator Fonseca, present. Senator Alma Francis Heiliger? Present. Senator Francis Heiliger, present. Senator Kenneth L. Gittins? Senator Giddens, absent. Senator Milton E. Potter, here. Senator Potter, present. Senator Kurt A. Valey, here. Senator Valey, present. Mr. Chair, five present, two absent. Thank you, Mr. Clerk. We do have a quorum and can proceed. Mr. Clerk, is there any correspondence to be read into the record? Yes, Mr. Chairman.

0:38:43 Correspondence from the Honorable Marvin A. Blyton, Senator, dated March 24, 2026, to the Honorable Ray Fonseca, Chairman, Committee on Health, Hospitals, and Human Services of the 36th Legislature of the Virgin Islands. Dear Mr. Chair, I am writing to respectfully inform you that I will be tardy to today's meeting of the Committee on Health, Hospitals, and Human Services. Please mark my initial absence as excused, and I look forward to joining the hearing at the earliest opportunity. Sincerely, Marvin A. Blyton, Senator, 36th Legislature of the Virgin Islands. That concludes the reading of correspondences, Mr. Chairman. Thank you, Mr. Clerk. We will now begin Block 1, wherein the committee will receive an operational update from the Department of Human Services. Mr. Clerk, can you please read Block 1 into the record? Block 1.

0:39:56 Is my call? Block 1. The committee will receive an operational update from the Department of Human Services on the administration of the Medicaid State Plan, including outstanding child care balances and related financial obligations. The Department will also provide updates on key projects, including the status of Herbert Grigg Home for the Aged and Queen Louise Home, the development of CMS-certified long-term elderly care facilities, and the construction timeline and relocation plans for the new human services facility. Additionally, the Department will address strategies to reduce hospital borders through expanded long-term care capacity, as well as updates on federally funded child care initiatives and Head Start program expansion. Testimony should include clear timelines, measurable outcomes, and accountability benchmarks to ensure effective service delivery. Invited testifiers, the Honorable Avril George, Commissioner, Department of Human Services, Ms. Adrienne L. Williams-Octalian, Executive Director, Office of Disaster Recovery. This concludes the meeting of Block 1, Mr. Chairman.

0:41:24 Thank you, Mr. Clerk. We will now proceed. Welcome, Commissioner Avril-Georges. I see you over there in the Fritz-Louets. I want to start with a mic check over on St. Croix. If you can briefly give your name and identify yourself. We'll start with the Honorable Avril George, Commissioner.

0:41:55 Commissioner Avril George, Department of Human Services. Assistant Commissioner Carla Benjamin. Deputy Commissioner, Operational Maintenance, Hugh Nicholas St. Craig. Can you repeat that with me? Mr. Maureen Akilah Bryan, Disaster Recovery Specialist. Excuse me. Deputy Commissioner, can you repeat that your name didn't come over

clear? Deputy Commissioner of Operational Maintenance, Hugh Nicholas St. Croix. That concludes St. Croix.

0:42:32 We'll start with Assistant Commissioner Ms. Dorsett Phillips. Good morning. Tayshia Phillips-Dorsett, Assistant Commissioner. Good morning. Lydia McGrath Purcell, Chief Financial Officer. Good morning, Raul DeMason, Deputy Commissioner of Human Resources and Labor Relations. Good morning, Gary Smith, Medicaid Director. Good morning, Masika Lewis, Administrator, Office of Head Start.

0:43:06 Good morning, Tishma Tuckah Lance, Administrator for the Office of Child Care and Regulatory Thank you to all the testifiers and welcome once again, Commissioner Avil, oh I'm sorry, yes proceed. Good morning, Kishma Vincent, Administrator, Senior Citizen Affairs. Good morning, Sean Georges, Deputy Commissioner for Operations, St. Thomas St. John District.

0:43:40 Thank you, thank you. Commissioner Avil George, you may proceed with your testimony. Good morning, Honorable Chairman, Senator Ray Fonseca, members of the Committee on Health, Hospitals, and Human Services, distinguished colleagues, and the viewing and listening audience. My name is Avril George, and I'm honored to serve as the Commissioner of the Virgin Islands Department of Human Services. Joining me today are key members of my leadership team who play vital role in advancing the department's mission, and I believe they all introduce themselves. Our team appears before you today to address critical issues that directly affect the safety, stability, and well-being of residents of this territory. My testimony will focus on areas of the highest operational and strategic importance. Medicaid state plan modernization, long-term care capacity, early childhood services, and infrastructure redevelopment. These initiatives are interconnected.

0:44:43 interconnected. Each represents both a policy obligation and a moral responsibility to the people we serve. The Medicaid Assistance Program remains one of the territory's most essential programs providing health care coverage to approximately 18,729 residents, representing a large share of the territory's population. For many of our residents, Medicaid is not simply an insurance card. It is access to chemotherapy, dialysis, cardiac intervention, behavioral health services, pediatric specialty care, and life-sustaining medications that would otherwise be financially unattainable. The stability of this program is therefore both a fiscal responsibility and a human one. DHS is engaged in a comprehensive state plan gap analysis designed to consolidate and modernize the Virgin Islands Medicaid state plan. Over many years, amendments were developed in both paper-based and online formats, resulting in a fragmented structure that makes it difficult to present a single, consolidated, authoritative version of the plan. We are currently compiling all existing state plan amendments into one complete and unified document. In 2025-2026, DHS undertook one of the most extensive state plan modernization initiative in its history. These works include consolidating decades of SPAs into a single authoritative Medicaid state plan, conducting a full gap analysis to identify outdated, missing, or inaccurate provisions, Prioritizing amendments that impact compliance, reimbursement and eligibility, and enhancing transparency by preparing a publicly accessible consolidated state plan.

0:46:41 Today, DHS has indexed 147 historical SPAs across paper and electronic format, identified 62 SPAs requiring consolidation, and flagged 18 provisions as outdated, including rate methodologies and eligibility references, and determined 11 sections requiring full rewrite for federal compliance. We anticipate having a consolidated version prepared by April 2026, after which it will be made publicly accessible to improve transparency and stakeholder clarity.

0:47:22 Beyond consolidation, we are conducting a detailed review to identify any missing, outdated, or inaccurate provisions within the state plan. This review is expected to continue throughout most calendar year 2026. At the conclusion, the department will have a prioritized roadmap of remediation activities to guide future amendments and program improvements. In addition to the gap analysis, the department recently secured federal approval of a significant state plan amendment addressing interventional cardiology IC services. services. This amendment updated the reimbursement methodology for on-island physician payments for highly specialized cardiac procedures including cardiac catheterizations, angioplasties, and stent placements. The goal of this amendment to increase cardiac specialty physician participation in a Medicaid program, thereby improving access to life-saving cardiac care within the territory. This SBA will serve as a pilot and possible blueprint to examine an alternative Medicaid reimbursement model that may be used for additional medical services for our members. Evaluating the IC model, SBA will ensure that GVIA is able to afford local matches annually in comparison with availability of federal claim dollars. The amendment became effective December 1st, 2025, and was approved by CMS on January 30th, 2026. By strengthening reimbursement alignment with Medicaid's fee schedule, we anticipate improved provider recruitment and retention, reduced reliance on off-island transfers, and enhanced cardiovascular health outcomes for Medicaid beneficiaries. The department is also evaluating

0:49:23 a high priority state plan amendment concerning the local poverty level used to determine Medicaid eligibility. The Virgin Islands local poverty level LPL has not been updated since 2017. DHS is assessing the feasibility of aligning eligibility with 100 percent of the federal poverty level including fiscal impact on the cap federal allotment long-term

sustainability within the section 1108 framework and required eligibility and mmis system updates this analysis includes evaluating long-term sustainability within the territories cap federal medicaid and chip allotments and available local resources as of the close of federal fiscal year 2025, the Virgin Islands had approximately 48 million remaining in section 1108 allotment authority. Any eligibility expansion would require formal CMS approval and system updates to ensure accurate implementation. Our objective is to be responsibly increased access to care while maintaining fiscal discipline within the cap funding structure. Additionally, the department is planning a state plan amendment to establish a cost-plus payment methodology for inpatient hospital services provided outside the territory, particularly in Florida. This initiative is currently in a planning stage and will involve coordination with hospital payer negotiation experts to develop a reimbursement structure that more accurately reflects actual resource utilization for higher acuity patients

0:51:16 while maintaining administrative clarity and sustainability. Beyond these major initiatives the department is advancing several additional state plan amendments in 2026 to strengthen program clarity and compliance. These include amendments addressing application methods, behavioral health and clinic services, justice-involved youth coverage requirements under section 5121 of the Consolidated Appropriations Act, rural health clinic reimbursement methodology, dental service clarity, and transportation coverage standards. Each of these amendments is prioritized based on operational capacity, compliance urgency, and anticipated program impact. Complementing the state plan to work, the department is formalizing Medicaid provider manuals to ensure policies governing coverage, billing, enrollment, and compliance are clearly documented and publicly accessible. Manuals for physician services, applied behavioral analysis services, provider enrollment, and general information have been develop with public comment processes incorporated to allow stakeholder input. This effort enhances transparency, strengthens providers understanding and improves program integrity safeguards. Collectively these Medicaid initiatives reflect a deliberate shift toward modernization, compliance strengthening, improved provider participation and expanded access to care. While the work is complex and resource intensive, it is essential to ensure the long-term stability and credibility of the Medicaid program in the Virgin Islands. Long-term care strategy borders and CMS certified facility development. While Medicaid modernization strengthen access to medical services, access to appropriate long-term placement remains one of the territory's most urgent structural health care challenges. The issue of hospital borders is a direct symptom of the territory's limited long-term care capacity. On average seven to ten medically stable individuals remain hospitalized at any given time because they cannot be safely discharged into our community. Although these individuals no longer require acute medical care, appropriate residential placements are unavailable. As a result of lack of discharge the territory's hospitals are incurring the cost for all of their daily food and ancillary services without CMS reimbursements. Across our hospitals there are mothers recovering from strokes, older men who can no longer live safely on their own

0:54:11 and individuals with disability who have completed their medical care. All are waiting in the same way. These are patients who should be transitioning into long-term care settings but instead remain in acute care beds simply because the territory lacks adequate placement options. Without sufficient capacity across the continuum, hospitals are forced to function as de facto long-term care providers. A costly and clinically inefficient outcome that also places emotional strain on patients who deserve placements and environments designed for long-term living rather than acute intervention. While the Department of Human Services does not operate acute care hospitals, we recognize that discharge bottlenecks disproportionately impact elderly and medically vulnerable residents. Addressing this challenge requires coordinated investments in bed utilization, staffing stabilization, facility readiness, and regulatory compliance. At Herbert Great Home for the Age on St. Croix, the facility is currently operating with 20 residents and five available beds within a total 40-bed capacity. We currently have five applications pending. The department continues to prioritize the use of existing capacity, recognizing that vacant beds represent both a fiscal inefficiency and a missed opportunity to help relieve hospital discharge congestion. However, the limited availability of five beds is directly tied to current staffing levels rather than physical space constraints. I do believe we have some updated numbers in regards to our bed coverage and we can

0:55:59 provide that at the end of our testimony. While infrastructure can accommodate significantly higher occupancy, safe operations and regulatory standards require appropriate clinical coverage and direct care staffing ratios. With adequate staffing support, the home can make up to 20 beds available for placement. In fiscal year 2025, the legislature appropriated dedicated funding to support operational capacity expansion. This appropriation is being directed towards staffing stabilization and bed activation to expand placement options for medically stable individuals awaiting long-term care. The department has begun deploying these funds to strengthen clinical coverage and direct care staffing levels necessary to safely increase occupancy. Recent hires of two licensed practical nurses and three certified nursing assistants represents the first phase of this expansion effort with additional recruitment actions underway. Because long-term care facilities must operate within strict clinical staffing ratios and regulatory standards, bed activation occurs in deliberate phases aligned with workforce onboarding. At Queen Louise Home for the Age on St. Thomas, the relocation of residents

to the temporary accommodations at Palmscourt Harborview was executed successfully on January 22nd with residents' safety as the primary consideration. The decision to relocate was not taken lightly. For elderly residents, stability of the environment is deeply important and every logistical decision was evaluated through the lens of safety,

0:57:54 continuity, and emotional well-being of our clients, their families, and our community. Queen Louise home currently has 13 residents and three available beds with three applications pending. Operational continuity has been maintained and admission packages are being finalized in coordination with Adult Protective Services to ensure that available beds can be allocated appropriately to both hospital-based and community-based applicants. The Department's approach to addressing hospital borders is twofold. In the short term, efforts are focused on maximizing existing bed capacity, stabilizing staffing, completing pending social studies, and improving placement coordination. In the long term, the Department has embedded CMS certification requirements into facility design, operational planning, and workforce development. CMS certification cannot be retrofitted. It must be planned and funded from the outset. That reality requires us to move deliberately, responsibly, and with long-term sustainability in mind. Federal child care funding and Head Start updates. Just as we work to protect the dignity and safety of our seniors, we are equally committed to investing in the earliest years of life. The Virgin Islands Department of Human Services Office of Head Start has been the Head Start grantee for the United States Virgin Islands for more than 50 years. As a long-standing grantee, DHS administers the Head Start program through consecutive competitive federal grants. The agency must recompete for these grants every five years and must apply annually for continuation of funding. Head Start mission is to promote the school's readiness of children from low income families who are three years old by December 31st up to five years old at enrollment. The program exclusively serves children ages three to five. For many families, Head Start represents far more than early education. It provides structured learning, nutritional support, developmental screening, and family engagement services that help stabilize household and prepare children for long-term academic success. To clarify the early childhood continuum within the

1:00:25 territory, private childcare facilities licensed by VIDHS serves as infants to pre-kindergarten. Early Head Start operated by Lutheran Social Services of the Virgin Islands serve pregnant women and children from birth to age 3. Head Start operated by VIDHS serves children ages 3 to 5. Granny preschools operated by education serve children ages 3 to 5. Children then transition to kindergarten at age 5. It is no duty that Office of Child Care, Head Start and VIDE host a pre-k to kindergarten transition conference annually for parents and guardians of children transitioning to kindergarten. Head Start provides high quality early childhood education for eligible children who might or otherwise remains at home and unengaged and it serves as a family empowerment model that encourages parent participation in all aspects of the program including governance. Parents serve on the Head Start Policy Council, a federally mandated and influential body comprised primarily of parent representatives. For working parents, Head Start provides safe, comprehensive early learning services for parents seeking to enter the workforce. The program offers volunteer pathways and training opportunities that often lead to gain full employment. Children enrolling Head Start benefit from a holistic focus on early learning, health, family well-being, and wraparound support. The VI-DHS Head Start program's federally funded enrollment is 794 students. Distribution was established based on community need assessments and facility capacity available at the time of grant application. St. Croix has 500 children in 25 classrooms, St. Thomas 274 children in 13 classrooms, St. John 20

1:02:35 children in one classroom. Current enrollment is 587 students reflecting St. Croix 338 children in 19 classrooms, St. Thomas 236 children in 12 classrooms and St. John 13 children in one classroom. The enrollment variance reflects the temporary closure of six classrooms due to staffing shortages and a limited weightless in the St. Croix district. Recruitment efforts remain ongoing to restore full classroom capacity. Head Start regulations requires that 10% of enrollment serve children with special needs. Currently 67 enrolled children qualify through either an individualized family service plan, the IFSP, 14 children on an individualized education plan IEP of 53 children. An additional 41 children are suspected of having special needs and are pending evaluation by the Virgin Islands Department of Education. These children receive services including speech therapy, occupational therapy, and resource support from providers who serve Head Start centers directly. DHS secured 42 million in federal funding to rebuild six facilities damaged by Hurricanes Irma and Maria. Each site is being reconstructed to modern, resilient standards, ensuring safe, durable, and developmentally appropriate learning environments for children and families. Construction progress and timeline, Cruise Bay St. John construction completed December 2024, educational services resumes September 2025. Projected completion dates for Anna's Hope is April 20th,

1:04:25 2026. Concordia, April 20th, 2026. Benita Mitchell, May 5th, 2026. Bolongo Bay, May 5th, 2026. Lindbergh Bay, May 5th, 2026. In addition, six community electrical innovation CEI grant applications were submitted for Anna's Hope, Frederickstead, Cruz Bay, Richmond, Savant and Sugar Estate. All sites advance pass eligibility review and completed site visits. If awarded the grants will support installation of solar panels and battery backup systems to reduce outages,

harden infrastructure and strengthen energy resilience at Head Start facilities. Childcare and quality investments. Supporting working families while strengthening providers sustainability. The Office of Child Care and Regulatory Services administers the Territories Child Care Development Fund subsidy program commonly referred to as block grant. This program provides child care subsidies to eligible applicants that are working, volunteering, or are enrolled in training or school for a minimum of 30 hours per week. The subsidies represent a core support for seasoned working families as well as those entering the workforce while simultaneously strengthening power provider quality and early childhood education workforce development across both districts. At present OCCRS is serving 727 children across the territory, supporting 602 families who rely on child care assistance to maintain employment, pursue education, or participate in workforce training. Each

1:06:22 of these children represents a working parent striving for stability, parents who depend on reliable child care in order to maintain employment, pursue education, or participate in workforce training. The current reimbursement rates are structured to reflect age-based care costs. The territory currently pays childcare subsidies in the hundred percentile of childcare costs based upon the 2022 market rate survey and narrow cost analysis of data provided by local childcare providers. Infants 600 per child, toddlers 675 per child, preschoolers 725 per child, after-school care 429 per child. On average participating providers receive between $18,000 and $20,000 per month in subsidy payments depending on enrollment levels and age distribution. Within the territory there are currently 105 licensed child care providers, 56 licensed child care providers on St. Croix, 49 licensed child care providers on St. Thomas. Of those licensed providers 48 are actively participating in the subsidy program. 24 providers on St. Thomas receiving subsidies and 24 providers on St. Croix receiving subsidies. In addition to the licensed formal child care providers OCCRS supports informal child care providers. These are participants in our family friends and neighborhoods FFNS program which allows for subsidy support for child care provider by non-professional providers such as family friends and neighbors. Quality and workforce initiatives include the launch of the

1:08:10 infant toddler micro badge credential program, the annual infant toddler conference, the annual pre-k to kindergarten transition conference in partnership with Head Start and the Department of Education and the relaunch of the quality recognition and improvement system QIS. Homes for the age. The Department of Human Services is executing a dual track strategy for both the Queen Louise home for the age on St. Thomas and the Herbert Gregg home for the age on St. Croix. Stabilizing current operations while advancing long-term redevelopment designs to restore CMS certified nursing facility capacities in the territory. On January 22nd, 2026, residents of the Queen Louise home were safely relocated to Palm Courts, Harborview Hotel, to allow for necessary necessary structural environmental repairs to the existing facility. The relocation week was carefully coordinated to ensure continuity of care with residents immediately resuming meals, medication management and daily supervision under the same Queen Louise nursing and support staff. Senior citizens affairs leadership remains actively engaged in daily oversight at the temporary site. Queen Louise home is currently staffed by one registered nurse serving in a volunteer capacity and one part-time registered nurse, four licensed practical nurses, and 13 certified nursing assistants, supported by one laundry attendant, two custodial staff, and one CSEP worker in institutional support, two cooks, two food service workers, and two CSEP workers in the kitchen, and administratively by one chauffeur and one relations coordinator, and one CSEP employee. The Palm Court Harborview Hotel location was selected based on its ability to meet

1:10:08 residential care requirements including ADA compliant accommodations, secured access controls, generator backup power, adequate dietary capacity, communal space for visitation, and telecommunications infrastructure. Residents are expected to remain temporarily housed for approximately nine months pending completion of repairs and final regulatory clearance. The 40-year pre-design assessment identified significant structural, mechanical, electrical, plumbing, and life safety deficiencies and confirmed that while portions of the facility remain serviceable, major building systems have reached or exceeded their useful life. Identified priorities include comprehensive upgrades to HVAC systems, electrical distribution infrastructure, fire alarm, and suppression systems, roof assemblies, and plumbing lines. In addition, the report highlights the need to reconfigure residence room, improve ADA accessibility, enhance infection control layouts, and modernize nurse stations and clinical support spaces to align with contemporary long-term care standards. Beyond immediate infrastructure stabilization, the department is advancing a long-term redevelopment strategy. The plan rebuild on a newly acquired parcel of land near the Royal Snyder Hospital has entered the 30% schematic design phase in coordination with the Office of Disaster Recovery and Super Project Management Office. The redevelopment strategy is structured around layered federal recovery funding streams. FEMA Public Assistance PA funding has been secured eligible temporary repairs and stabilization work, a FEMA PA amendment for temporary relocation

1:12:05 support was approved on October 3rd, 2024, ensuring financial coverage should phase transition become necessary. These coordinated funding mechanisms ensure compliance with federal recovery and procurement requirements. The rebuild is not a renovation of the existing structure. It represents a foundational expansion of long-term care

infrastructure. The new facility is being designed to meet federal CMS conditions of participation for nursing facilities, positioning the territory to re-establish Medicare and Medicaid certification. This will allow for sustainable reimbursement of participation and bringing the territory back into alignment with national standards for long-term residential care. Herbert Grig Home, the Herbert Grig Home continues to operate as a 24-hour residential skilled nursing facility. Clinical services are overseen by one registered nurse and supported by eight licensed practical nurses who manage medication administration and daily medical needs. While 13 certified nursing assistants and one nursing assistant provides hands-on support with activities of daily living and routine monitoring. Operations are further supported by three laundry workers and one institutional attendant who maintains sanitation and upkeep along with a food service coordinator, two cooks, one institutional food service worker, and three food service workers who manage meal preparation and services. Three CSEP employees also assist across operational areas. DHS actively advancing plans to construct a modern CMS certified long-term K facility on the south side of Herbert Rick property. A federally funded pre-design and feasibility assessment was completed to evaluate structural integrity, code compliance, floodplain considerations, and long-term operational sustainability. The assessment confirmed that full redevelopment rather than piecemeal renovation is the most viable path toward ensuring a resilient code compliant and potentially CMS certifiable long-term care facility. The redevelopment of Herbert Gregg is supported through a layered disaster recovery funding structure including FEMA public assistance funding for eligible repair and replacement components, approved FEMA amendments supporting temporary protective measures and stabilization and coordination with the Office of Disaster Recovery and the

1:14:47 Super Project Management Office SPMO for capital project oversight. These funding mechanisms collectively positions the territory to transition from temporary repair efforts to long-term purpose-built facility designed to meet modern standards of safety, infection control, accessibility, and operational efficiency. The Department's objective is not merely to restore pre-storm conditions, but to construct a facility capable of meeting enhanced regulatory requirements, addressing future long-term care demand, and supporting improved clinical and residential outcomes for early residents. The redevelopment plan also incorporates design considerations necessary should the territory pursue CMS certification in the future. HGH reconstruction is therefore being approached not as a repair project but as a strategic long-term care infrastructure investment for St. Croix.

1:15:49 Node Hansen permanent redevelopment. The permanent reconstruction of the Node Hansen complex is progressing under the leadership of the Super PMO and Springline Architects. The selected design bill contractor with architectural and engineering plans currently in development as part of the rebuild USVI portfolio. The project is a full-grown replacement of the former facility with architectural and engineering plans now in the development for new four-story purpose-built complex that will house both the Department of Human Services and Department of Health Operations. The design incorporates a modern DOH operational community health clinic on the second level along with consolidated DHS administrative and client service space to support an integrated approach to public health and human services. Procured as part of a bundle design build package, the project structure is intended to maximize delivery efficiency and align long-term infrastructure investments across government programs. The 30% design milestone is anticipated in late March 2026, a key checkpoint for finalizing program scope, validating cost models, and confirming construction sequencing. Once completed, the rebuilt new enhancing complex will centralize critical DHS programs currently spread across multiple temporary sites, allowing for improved client service, streamlined service delivery, and enhanced disaster resilient operations. The redevelopment reflects the Territory's long-term commitment to modernizing public service, infrastructure, and ensuring continuity of care for the community. As designed and planning advanced for the permanent new enhancing facility, the Department has secured temporary lease locations to maintain seamless service delivery. All leases have been fully approved and executed. Two

1:17:53 temporary sites are being utilized. Tutu Park Mall which is the old Viya building and Haven site. The Haven site location is being executed in phases and is designated for non-client facing divisions. Phase one is complete and the site now houses the Medicaid program integrity unit human resources and operations division. At Tutu Park the department is awaiting completion of the interior build out to allow staff to transition into a centralized planned accessible location. This site is particularly advantageous due to its proximity to public transportation and its accessibility for clients requiring in-person support. To put things in perspective, the New Hanson Memorial Hospital building in St. Thomas began construction in the 1940s and opened in 1953. That was 73 years ago. It was built for a different era, under different standards and for a completely different purpose. It was constructed at a hospital in the 1950s, long before modern building codes, long before ADA standards, long before the technology technological infrastructure required to administer federal programs, and long before the health and safety compliance environment that governs human services today. It was never designed to house the administrative backbone of a 21st century Department of Human Services and yet for decades our employees have shown up to work every single day and delivered services from that facility. Not

yesterday, not two years ago, for decades. We know it's old, our employees know it's old, the public know it's old and at this point even the building knows it's old. We have seen Facebook lives, we have seen videos circulating that highlight portions of the surrounding property. Some

1:19:45 are what which are not even under jurisdiction of Department of Human Services, framed as though the conditions develop overnight. Let us be clear, this structure did not deteriorate last week, it did not become outdated this year, it has been aging for generations. But here is what is different now, for the first time in a very long time this is not simply a talking point, it's an active redevelopment effort, interim leases have been secured. Planning and design coordination are underway. Funding alignment is in motion. Permanent redevelopment is advancing through formal procurement and project management channels. Our staff deserve better than a 1953 billion. Our clients deserve better than a 1953 billion and we are no longer managing the limitations of that facility. We are moving to replace it. We are here and we are moving forward. Chairman Faseca and members of the committee, the Department of Human Services operate at the intersection of policy, vulnerability, and public trust. Every program discussed today, Medicaid, long-term care, child care subsidies, Head Start, facility redevelopment, represents more than a line item or construction timeline. It represents a mother in Campa Rico waiting for child care to be able to go to work, a senior in Snyder Regional waiting for dignified long-term care, a a child in St. John waiting for early education, a provider on a network waiting to be paid, an employee in Charlotte and Mali who shows up to work every day in a building that has long exceeded its useful life. We are managing inherited structural challenges, yes, but we are not managing them passively. We are stabilizing Medicaid, we are expanding and modernizing long-term care capacity, we are rebuilding Head Start centers with resilience and sustainability in mind. We are strengthening childcare systems. We are consolidating and redeveloping facilities that have been outdated for generations. These are not cosmetic adjustments, they are structural corrections. The work is complex, the funding layers are intricate, the regularity environment is unforgiving, but the direction is clear. The department is not standing still. We are building systems that can withstand stands, literal and fiscal, and that can serve this territory not just this year but for decades to come. Oversight matters, partnership matters, accountability matters, and we welcome all three because the mission is larger than any hearing, fiscal year, or administration. At the end of the day, the question is simple. Are we leaving a system stronger than we found it? That is the standard we are working toward. We thank you for the opportunity to address this body and we

1:22:32 prepared to answer any questions you may have thank you thank you commissioner avril george for that detail and um very well um organized and presented testimony i like the graphs and the pictures it shows that the department of human services is um involved in many many programs i I think in the government, correct me if I'm wrong, I think Human Services administers the most number of federal grants. So I know that you're busy. I want to note for the record that we have received a testimony from the Disaster Recovery Office presented by Adrian L. Williams-Octalian. I'm not going to read it into the record because no one is here to answer any questions but Senators, it has been received, we're going to make sure it's distributed So I want to start real quickly and the state plan update it was very well put together Question. You have a list of amendments you mentioned that you have in draft form. I just want to clarify, I think it does not need legislative review or authorizations. Correct me and let me know if the state plan can be done through the Department of Human Services without authorization from the legislature.

1:24:24 Senator, I'll let Mr. Gary Smith, who is in St. Thomas, would you answer that question? Either him or Assistant Commissioner Taysha Dorsett. Good morning, Gary Smith, Medicaid Director. That's correct, Senator. No legislation is necessary to submit a State Plan Amendment. Okay, so you do have a date that you plan to submit the update, And we would like to get copies as soon as possible when it's been finalized. One particular question in the state plan. I have a question regarding the low-income physicians being able to bill or the government being able to recoup the hospital services. How is that being addressed? Gary Smith Medicaid Director. So as the Commissioner indicated in her testimony, we just received authorization for the Interventional Cardiologist SPA State Plan Amendment, which allows us to pay the IC physician for those fees as he's an employee of the hospital. Okay, I know Senate President Milton Potter had sponsored a bill in the 35th legislature to authorize the funding for the intervention cardiologists.

1:26:03 I guess when the health department comes, the hospitals come later on, we can find out if that position has been filled. Because if you're telling me now that there'll be additional funding resources, that would be good. It's always good. Part care. Yes, Assistant Commissioner, Ms. Dorsett Phillips. Good morning, Senator Taysha Phillips-Dorsett. I wanted to add one comment on to Director Smith. So the pilot that Director Smith mentioned for interventional cardiology, it doesn't provide additional services to the hospital. What it allows the hospital to do is bill Medicaid outside of the approved bundled inpatient daily rate for the services provided by that specialty. So the actual interventional cardiologist would be paid separately via a separate claim than the services that are currently provided by the hospital via the daily rate. There are a lot of questions, comments and concerns that we get at the Medicaid program regarding why can't we use a similar methodology for all of those hospital employed physicians. The point is we're being very prudent with this

pilot program because if we open up the floodgates then we will need additional dollars for the general fund portion of the claims match. We are capped in federal funding, we're about $142 million right now annually, and most of the claims are split 83%, 17%. Some of them are 90-10, and some of them are 85-15 for children. So we know we are in our fiscal crunch, we've watched the revenue estimation conference that we had recently, and we know that the government is about $140 million in the hole. So we don't want to expand to cause an additional general fund burden that we know DHS cannot afford because we have a cap ceiling.

1:28:17 Thank you for that additional time. Thank you. I'd like to welcome the Honorable Senator Clifford Joseph. Welcome non-committee member Senator Clifford Joseph. So colleagues, we're going to go to point of info, and also Senator Carla Joseph, the Honorable Rose Chairwoman. Welcome senators. Point of information, Senator Kurt Ville. Thank you so much, and good morning to the people at the Virgin Islands, good morning colleague, good morning to the testifiers.

1:28:51 In reference to the amount of federal dollars allocated for Medicaid, you said that amount is 142 percent 142 million for the claims but i prefer to director smith for the claims director smith 142 million 143 million six hundred thousand dollars okay and we exhaust 143 million every year the allotment increases per the cpi you the medical medical component of the cpi you each year which since my tenure eight years it has never gone over 2.01%. So next year it will increase by 2.01%. Did we exhaust the amount allocated to the budget allowance? No, we did not.

1:29:36 We did not? No. The commissioner stated in her testimony that we did not expend $48 million of that last fiscal year. Okay. During my time, I'll... Yes. I want to follow up on that. But so based on that statement, the account payables, the Medicaid program, what is the balance doing account payables for Medicaid program? Are all the bills paid or you have a balance? What is that? Currently, we have vendors that are owed. We do have outstanding accounts payables.

1:30:15 Approximately how much? Vendors, I would say We have the CFO right here Can the CFO give us that amount? Okay, I'll ask the CFO But to my knowledge, I'd put it at like about $8-9 million And that includes federal and local funds Lydia McGrath Parcell, Chief Financial Officer that is not with the gain well claims that's contractual costs from prior years that were not captured including some of this year what's the number I'll give you the exact number because Gary do you have a number for claims for claims well we've paid to date um thirty million seven hundred twenty two thousand seven hundred four dollars and eighty one cents and that's uh for eighty three thousand one hundred and eighty claims okay so while you get that number um i want to just mention a major accomplishment and i have We just need some clarity in terms of the total amount, because you're saying that $48 million was remaining in section 1108 allotment? Ms. McGrath-Purcel.

1:31:54 Lydia McGrath, Parcell, CFO. The 1108 ceiling specified is specifically for claims. We also have MMIS. We have eligibility and enrollment funding. Those are separate parts of money. Okay, so let's stick to the claims. The $48 million is in reference to claims? Yes. and those are claims that was from fy25 yes okay are you on a calendar or fiscal year fiscal year okay do we have any outstanding claims from fy25 that wasn't paid yes okay and that's what i wanted to know so so what is the correlation behind Returning monies for FY25 But having the monies to pay those claims What was the reason as to why Those claims were not paid Gary Smith, Medicaid director You could have various reasons as to why A claim is not paid I don't know specifically For FY25 I mean, that would require A deeper dive as to There may be claims that haven't even been submitted by providers A provider has Hold on Where I'm going A lot of time we have bottlenecks in the system It could be provided by A result of Providers, etc, etc But at some point, based on the fact That we have federal dollars To deal with these claims Everybody needs to be doing it on time To include the providers So providers can't submit to you Claims five months past After the fiscal year Okay, they can. So when they do, does it come out of the fiscal year 25 allotment, the 1108 allotment, or they're now taking it out of the 26th? They're taking it out of the 26th? Yes, yes. That's why I am saying they can. They must have a cutoff to submit their claims so that we can make sure that DHS is utilizing the federal dollars for that particular fiscal year.

1:34:10 Dr. If I may, Senator Gary Smith, Medicaid Director. Claims is not when the service was rendered, but when the service is paid as far as CMS guidelines. So CMS guidelines allows a provider and the state or territory sets the parameters as to when a provider can submit a claim. timeline is one year so you know that there there can be various issues as to why a claim is not submitted in a timely manner but they have up to one year and then there are also issues where you mentioned the bottleneck you know they may may have been a system issue when they submitted the claim the system may not have been operating properly I mean there are many and various reasons as I mentioned however you know we we are allowed to pay retroactively two years for any type of claim my issue ain't what we're allowed to do my issues where the money is coming from and if you're retroactively paying from this year allotment then that's a different story because I know you said you're doing the the state plan but what there's a lot of concern in reference to charges from the hospitals that this thing can be captured as a result of the state plan but i will get into that during my time of questioning thank you mr chair point of information um lauren center fredericks to what we're discussing mr smith prior prior period

period claims that we are currently evaluating they're not being offset with the current appropriation federal appropriations

1:36:05 we have so then you're using current year appropriations of 2026 monies to pay 2025 claims so then it burdens the 2026 budget we just came from that revenue estimation conference on friday And the OMB director said we are burdened with over $50 million, almost $50 million worth of unplanned obligations. This is one of the reasons why the system is failing us, because we are not matching expenses in the year that we provide the services or the revenues for that year.

1:36:45 No normal entity could function properly that way. so what we need to get to at some point today is how can we make this process more efficiently so that we don't get stuck in this rut of always trying to pay last year's money with this year's new allocation it won't work so gary smith medicaid director you know one one thing that would assist is if we can pay the providers more more consistently the last payment that went out to all providers was sometime back in February so it's nearing this week it will near 30 days since we've made a payment to all providers however we are able to pay the public facilities meaning the two hospitals the FQHC's and the Department of Health clinics because we only pay them the federal share they they are reimbursed on a by the federal share based on a payment model called certified public expenditures which a state plan amendment was submitted back in 2015 and approved because the public facilities are receiving general funds from the government CMS allows you to reimburse them the federal share they are supposed to account for the local match from the funds that they receive from the general fund you know I want to follow up on that and colleagues we We're going to go to a round of six minutes, but I just want to follow up on that question. And Ms. McGrath, were you able to get that number so far, the accounts payable for Medicaid?

1:38:27 Lydia McGrath, Parcells, CFO. I'm going to have the number. The thing with the MMIS and the E&E claims that payments that are outstanding, the federal government is providing 75% and in some cases 90% of that funding. So the burden does not fall squarely on the general fund. Okay, I want to follow up on that specific because you administer both the general fund and the federal funds, right? You pay bills for the Medicaid program and for the regular human services program. Just answer me yes or no. You pay both the bills for the human services, which is general fund, and also the Medicaid, the federal funds.

1:39:16 It comes out of the budget, yes. Okay. So, is there any case where the funds are commingled? In other words, a Medicaid bill is due, but you pay a general fund bill with it, and then when you get reimbursed, you don't commingle the federal and the local funds? no what's your total drawdowns balance right now do you know that i will have to pull that but the the with the medicaid claims yeah i understand we are allowed to draw the funds prior to the transaction yes i understand it's not a burden on the general fund in any way shape or form yes so when gainwell sends the file to finance the fiscal office is copied and then we once the file is uploaded into the Department of Finance's ERP system, we pull the numbers, we perform the draws, once the funds hit Treasury, then Finance issues the checks.

1:40:16 Yes, but Ms. McGrath, please answer the question that I'm asking you. I didn't ask you for the detailed dissertation on that process. All I wanted to know was what is the federal funds drawdown balance? Do you have that? I'm unsure when you say the federal funds drawdown balance. You don't have any drawdowns balance because remember, part of the issue while Human Services was in a consent decree with education and the Department of Health was implementing an improving system so that we could improve the cash flow coming into the federal government. And I know Human Services has a lot of federal funds. So what is the balance and the procedure for the drawdowns? I want to see how it's operating and the systems.

1:41:08 Overall for the entire department or for Medicaid? No, for the whole department. We draw the funds as soon as the checks are cut. So when a check run happens on a Tuesday, the staff prepares the draws and they perform them Wednesday morning. So then the checks are released once the draws. So it's less than two days, you're telling me. Yeah, and for payroll, we do it the same day. If payroll generates on Thursday, we prepare the draws for Thursday and draw the funds. Okay, good. I'm glad to hear that.

1:41:41 So, colleagues, the line is, the lineup is going to be Senator Hubert Fredericks, Senator Kurt Vallee, Senator Milton Potter, Senator Alma-Francis Heiliger, Senator Clifford Joseph, and Senator Carla Joseph. Senator Hubert Fredericks, you're recognized for your six minutes. Thank you very much, Mr. Chair. A pleasant good morning, colleagues. You are welcome. testifiers, listening and viewing audience, my office, central staff, really happy to have the opportunity to speak to the Department of Human Services today. Very important agency and one that covers a lot of critical services for our community. Commissioner George, how are you doing today? I'm doing fine, Senator. Thanks for blessing us today with your presence and having your team here wanted to talk some more about the border issue with the hospital you touched on it in your testimony I see we're making progress in terms of hiring staff where are we in terms of getting some more capacity at Herbert Gregg in particular on St. Croix to get that facility up to near capacity because I think you said it was a 40 bed facility in your testimony Senator we're currently going through the process of hiring additional staff sorry

Commissioner Avril George we're currently going through the process of hiring additional staff and getting the beds available to take in mobile but more individuals not only borders from but members from our community it's an ongoing process I think in Herbert Gregg we have taken borders from the hospital if i'm not mistaken i think um i'll ask kishma vincent to update you guys based on the information provided and in testimony how much borders does wang louis currently have

1:43:45 mr vincent good morning kishma vincent administrator senior citizen affairs um currently our border count that's eligible for the herbert grig home on st croix um is one so one from wang the way and i i think they had around six five or six currently you have to look at at those that are eligible for um admission so that's why i said eligible we have one one female so so educate us on that process once the border is identified do they contact human services right away and then you do your evaluation to see if they qualify for a placement yes through our through our adult protective services department um we do an intake we do an evaluation part of that is of course they have to be seniors so they have to be um 60 and over in order to qualify they have to we are not a skilled nursing home so we also have to look at at their needs to see if we are able to handle their needs so that's part of the process so commissioner i was told that they typically just dump them some family will just leave their family members in the hospital and at that point they're indigent i assume and so we have to figure of from there where to go right? You're correct. But I'll have the hospital give you more in depth of their processes when they come before you. DHS only concern in assisting the hospital is who qualifies for Department of Human Services facility based on our requirements and if available space is there. Other than that we're not involved with all borders. We just go on a basis of who meets our

1:45:49 qualification to be placed in our facilities. In your testimony you spoke about cardiology being the new basis of Medicaid reimbursement. Family planning seems to be a broader spectrum of services that we have a need for. Did anyone consider family practice as being one of the areas we wanted to address as well to see if we could get our reimbursement from Medicaid. If I'm not mistaken, DHS goes by what is federally approved for a significant state plan. We don't get the ability to choose what services should be in there. I'll have Mr. Smith expound on that. Gary Smith, Medicaid Director. Could you repeat the question, Senator, please? Yes, so in the testimony we spoke about cardiology being the new state plan focused so we could try to extract more Medicaid payment. I was thinking about why is it we didn't also pursue family planning because that's a broader spectrum of services that we need, diabetes, everything else that goes in there, and that would help us a whole lot. Gary Smith, Medicaid director.

1:47:09 So, you know, that's part of the gap analysis for our state plan. And, you know, those areas where we need to add services to be able to provide additional access to care for the community and our citizens is being performed in that gap analysis of the state plan. The gap analysis, does it specify a time-sensitive period that we're going to start pursuing other aspects? Yeah, the gap analysis is going to continue through this calendar year, and as the issues come up, they are brought forward, and we prioritize, you know, which areas we need to take action on.

1:48:01 I kind of wish we were meeting next month or May, because it seemed like the deadlines, Mr. Chape, I could just conclude. Yes, yes. Most of the deadlines I've seen, the testimonies are coming up in the next 60 days, but we'll have an opportunity again to follow up on those benchmarks to see where we are with the state plan. Thank you very much, Mr. Chair, for the time. Thank you very much for your responses. Yes, thank you, Vice Chair, Senator Fedrick. Okay, you know, I wanted to discuss quickly the head start.

1:48:40 because I think this is a major accomplishment and I would like to say publicly that I think the Human Services Department is a very competent department. You're very well managed and in my second term I can see the vast improvement in this department. So the five Head Start buildings I want to ask you about the Bologna one. It's scheduled to be completed on May 5th. So I note in your testimony on page 6 where you said you were funded for 794 students, and I think your enrollment is about 587. So it shows that you have a capacity. you can accommodate about 207 more or less. How many are going to be in each of the facilities of the five Head Start facilities? Do you have the numbers?

1:49:51 I'll report a question to Ms. Lewis on your St. Thomas and Ms. Lewis. Masika Lois, Administrator for the Office of Head Start. So for Bolongo, that will accommodate 80 students on St. Thomas, Limburg Bay will accommodate 20 students on St. Thomas, Minetta Mitchell is going to be a nutrition store room and administrative building on the St. Croix the Concordia site will accommodate 20 students and the Anna's Hope site will be administrative building for the St. Croix District Office of Head Start. Okay so that's a total of 120 Head Start students 80 plus 20 plus 20 120 so those are going to be new students so some head start going transfer from some of the other facilities. So for the Bolongo site we will be closing the Wilhelm George Center and so those students will move over to the Bolongo site and of course currently Wilhelm George will host, normally host 76 children but that number will be increased by four so Bolongo will now host 80 students and in Limburg Bay which is on western side of our island they will host 20 students and on St. Croix for Concordia that would be an additional 20 students. Okay that's that's a big facility Bologna so the water how are they

gonna get water they have systems the building is built with systems are you gonna have because I don't think there's any portable water over there right? So that particular site we do have it's not systems but we do have water tanks that are at the Bolongo site as well so we have quite a few of water tanks there I do think there is some portable water there as well I can verify but we do have water tanks as

1:51:57 emergency systems in all of our head starts okay 80 students so you're talking about plastic water tanks concrete what type of water tanks you talking about so i will get the logistics of that information for you exactly how much water thanks and the um this is the what material is used for it okay thank you senator curtville you're recognized for your six minutes thank you mr chair do we presently have anyone on the waiting list for Yes, for the 2025-2026 school year we currently have on St. Thomas for the waitlist 110 students on St. Croix 13 and on St. John 1.

1:52:53 Okay, on St. Thomas 110, St. Croix 13, St. John 1, and that as a result of not having sufficient space? Specifically for St. Thomas, that comes down to not having sufficient staff. On St. Croix, we are actively recruiting, so that on St. Croix... So hold up, so St. Thomas, you have the space for the 110, but you don't have the staff? we have um yes we have approximately one two like about three different classrooms schools on st thomas and three on st croix we have six classrooms that are closed and are you recruiting teachers for st thomas we are recruiting teachers for the territory yes we are okay so with the additional space that's coming online staffing is still going to be a major issue Yes, staffing is a concern right now.

1:53:45 So we have to be able to fix a staffing issue. We'll say additional capacity coming online is going to remain unfilled because there's not staff. We do have positions that are currently advertised. We have completed some interviews as well. But one of our major issues is actually finding staff that are qualified to actually come on board. that's the major challenge right now so that's a major issue and I just want to put out oh there is not just capacities just not having a building it's it's having individuals to fill the role of teacher and paraprofessional etc to get those programs going so we need to see how we could come up with a plan which is hard because it's all across government fine qualified individuals and And going back to Medicaid, because I just wanted to dig on issues, hopefully that we can provide some additional services or recoup additional monies. We're allocated $142 million in federal funds, and the federal government expects us to match 17% of that amount.

1:54:56 So on average, it's about 14% for claims. So the match that you're respecting us then is close to $20 million? I would say yes. Are you allocated that $20 million in your budget? No, sir. So what are you allocated in your budget? This fiscal year, $9.1 million, I believe, plus a waiver of $1.8 million. Okay, so $10.2 million?

1:55:29 Yeah. so if it's 20 million dollars to get the i did the entire 142 million that you only get in 10 then you only have access to 71. if your numbers i know you're a mathematician so probably yes so why are you guys not advocating for more money commissioner if we're able to put up 10 million dollars more to get 70 million dollars that could flow into the hospitals the clinics providers why are we not getting a request for a line item to be able to deal with a medicaid match and increase commissioner um we have been trying but it's across government i i know that across government um we just come from the same revenue estimating two minutes but we're looking at not just providing dollars and not getting a return we're looking at 10 million dollars allowing us to infuse 70 million dollars more in to the healthcare industry which is less monies that we have to provide to the hospitals etc so at some point Mr. Chair and for this budget cycle coming up I would like for human services to provide as a line item or an amount that this institution could provide as a line item that would meet the match now you're saying one thing Mr. Smith you're saying that for the hospitals that you consider the match to

1:57:16 be the appropriation that we give to them correct do you give the hospital do you reimburse the hospital the 17% no we do not because you say that the government is giving them an allotment yes sir so what does that equate to can that now increase the amount from 17 million how much does the hospital bill that we're not providing the 17% match that we could add to this yeah I would I mean, that would be included in the match amount to maximize and leverage the total funding we're getting from the federal government to pay claims. Right, but I need to know if hospital claims are 70 million and we're not providing the 17%. That's 17 out of the 142. So now, what is 70% of the 71 that is left that we need to match? Because when we meet with the hospitals and did this committee along with the members of this body, had a meeting with snyder we had a meeting with gfl and at that meeting some of the doctors had concerns in reference to services that are provided that are not reimbursed because of the state plan you know are there some issues with that i'm i'm not aware of any services that are not time that are not covered by you know some services at the hospital let me ask a different question. In your evaluation or re-evaluation or re-analysis of the gaps in the state plan, et cetera, who are the stakeholders at the table? Do you have individuals in the clinics, the providers, the hospital that are speaking as to areas within the state plan that need to be fixed? Those meetings will begin in June, Senator, as part of the gap analysis.

1:59:01 Why so long for, yes ma'am. Taysha Phillips-Dorsett, Assistant Commissioner. Senator, we do get inquiries on several occasions from different medical entities, providers in the community, et cetera. And when we do get those inquiries, we then meet with our very done project managers. We look at the schedule for the state plans that are already in the queue, and then we try to address. The reason we were able to get CMS to approve the interventional cardiology one at the end of December is because it came as an inquiry from Schneider Regional in about November 2024. So it took us about a year to get that plan amendment crafted and for CMS to approve it.

1:59:56 They have about a window of maybe 60 days or so that they take to approve. So we're doing them one by one as they come in. Okay, we need to speed up the process. But the question I'm asking, have you written to Freddysad Health Center, East End, JFL, Snyder, as to give you feedback as to recommended changes for the state plan or areas of the state plan that's presently an impediment to them providing service. Not in a formal setting.

2:00:28 Yeah. Gary Smith, Medicaid Direct, we'll take that back as an action item, Senator. Okay. I think we need to get that done as quick as possible. Mr. Chirin, can I ask one more question? I was going back now to, I guess it'll be EHR or my friend, Ms. McGrath.

People named in this transcript

SUSPECTED, and a finding aid only. Names were matched by machine against the spellings used across all 426 of our transcripts, and the title is the one used in the room. Being named here is NOT evidence that a person attended or spoke · only that the name was said. Speech recognition mishears names, so a spelling may be wrong even where no alternative is offered.

6x **Senator Hubert Frederick**
the surname alone also matches: Lorenzo Fedricks
heard in this transcript as: Fedrick, Hubert Fredericks, Hubert L. Frederick

5x **Commissioner Avril George**
heard in this transcript as: Avil George, George

4x **Senator Alma Francis-Heyliger**
heard in this transcript as: Alma Francis Heiliger, Alma-Francis Heiliger, Francis Heiliger

4x **Senator Clifford Joseph**

4x **Senator Kurt Vialet**
heard in this transcript as: Kurt A. Valey, Kurt Ville, Valey

4x **Senator Milton E. Potter**
heard in this transcript as: Milton Potter, Potter

4x **Senator Ray Fonseca**
heard in this transcript as: Fonseca

3x **Senator Carla Joseph**

3x **Senator Kenneth L. Gittens**
heard in this transcript as: Giddens, Kenneth L. Gittins

3x **Senator Marvin Blyden**
heard in this transcript as: Blyden, Marvin A. Blyden

2x **Commissioner Carla Benjamin**