Commonwealth of the Northern Mariana Islands
Office of the Governor
Commonwealth Medicaid Agency

March 15, 2021

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health

Subject: U.S. House of Representatives Committee on Energy and Commerce Hearing "Averting a Crisis: Protecting Access to Health Care in the U.S. Territories"

Written Testimony of Helen C. Sablan, Medicaid Director
Commonwealth of the Northern Mariana Islands

The Commonwealth of the Northern Mariana Island (CNMI) is grateful to the U.S. House of Representatives Committee on Energy and Commerce and heartened with the Committee hearing notice that recognized:

> "The U.S. territories are once again facing a fiscal cliff that, if crossed, would endanger access to health care services for millions of Americans," Pallone and Eshoo said, "Congress has a responsibility to ensure that the Medicaid programs in the territories continue to receive the resources and support they need to care for their residents. This is especially critical right now as they work with limited resources to respond to the COVID-19 pandemic. Next week we will hear from policy experts as we consider legislation to avert the looming fiscal cliff and ensure that the territories can continue to provide medical care to those in need."[1]

The Commonwealth Medicaid Agency (CMA) is submitting testimony on behalf of the CNMI and will provide a quick summary of the Medicaid Fiscal Cliff and what it means for the U.S. citizens in the Territory, describe some of the program initiatives that CNMI has undertaken to comply with provisions of the Further Consolidated Appropriations Act, 2020 (PL 116-24), and more broadly discuss program improvements the CNMI would like to undertake given a fair, firm, and predictable financial base. However, before doing so, I would like to further express our very deepest appreciation, on behalf of the CNMI, for the Congressional actions in calendar years 2019 and 2020. There are truly no words to fully communicate our profound gratitude for the response of the Congress to Medicaid and health care challenges of the smallest U.S. Territory.

My testimony offered today is based on the belief and premise that the U.S. citizens of the CNMI are Americans and should be treated and provided the same opportunity to receive Medicaid services as any other American in

[1] House of Representatives Committee on Energy and Commerce. (2021, March 10). E&C Announces Hearing On Medicaid In The U.S. Territories. [Press release]. https://energycommerce.house.gov/newsroom/press-releases/ec-announces-hearing-on-medicaid-in-the-us-territories. Note: underscores and italics for all cited references may be added for emphasis.

the States. All Americans should be treated the same, whether the U.S. citizen lives in an Insular Territory or a State.

The Major Difference in the Medicaid Program in the States and Territories

The Medicaid and CHIP Payment and Access Commission (MACPAC) testimony to Congress in 2019 provides insight on the Medicaid Fiscal Cliff. The MACPAC testimony directly identifies the challenges of the CNMI and all Medicaid programs in U.S. Territories that result from the difference in the financing of the Medicaid program between the States and Territories. The MACPAC states that:

> "… [T]he financing structure for Medicaid in the territories differs from state programs in two key respects. First, territorial Medicaid programs are constrained by an annual ceiling on federal financial participation, referred to as the Section 1108 cap or allotment (§1108(g) of the Social Security Act). Territories receive a set amount of federal funding each year regardless of changes in enrollment and use of services. In comparison, states receive federal matching funds for each state dollar spent with no cap, and it is important to note that an additional infusion of federal funds would avert a fiscal cliff and ensure the continued delivery of critical health care services to eligible individuals in the short term. However, such action would not address underlying challenges with the financing structure that make it difficult for territorial officials to plan, manage, and sustain long-term, reliable access to care for Medicaid beneficiaries residing in these jurisdictions.
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> Second, the federal medical assistance percentage (FMAP), often referred to as the matching rate, is statutorily set at 55 percent rather than being based on the territory's per capita income, as is the case with states. If it were set using the formula used for states, the matching rate for all five territories would be the maximum: 83 percent.
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> These *two policies have resulted in chronic underfunding of the program in the territories*, requiring Congress to step in at multiple points to provide additional resources."[2]

The CNMI implores the U.S. Congress to address the chronic underfunding of the program as described in the MACPAC testimony to Congress in 2019. In doing so, the Territory Medicaid programs will be positioned to focus attention on how the Medicaid program can make improvements to improve care, population health and lessen the overall cost of Medicaid care. Today, again, it is impossible to do so because the CNMI is unable to predict whether a Medicaid Fiscal Cliff will materialize in FY 2022 or beyond. The CNMI Medicaid program is unable to explore innovations implemented in States and waiver program opportunities because of the Section 1108 ceiling. The Section 1108 ceiling results in the territories unable to plan for programs like States and are instead like a "Sword of Damocles" that hangs over the CNMI and all Territories.

The Medicaid Program in the CNMI

The Commonwealth of the Northern Mariana Islands is located in the western Pacific Ocean and became a U.S. Territory in 1978. In 1979, the Commonwealth Medicaid program was established within the-then Department of Public Health. In 2011, the Department of Public Health became the Commonwealth Healthcare Corporation, a public corporation. The CHCC is unique in that the public corporation is not only responsible for delivering care through the single hospital on the island of Saipan, and clinics on the two largest islands of Tinian and Rota; but, the CHCC is also the Public Health agency that is normally a direct function of State and County governments.

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[2] "Strengthening Health Care in the U.S. Territories for Today and Into the Future", 116. 1 (2019) (Anne L. Schwartz).

To ensure no conflicts of interests in having the provider of services and also be the Medicaid Payer of services provided, the Medicaid Program was transferred as an agency under the Office of the Governor in 2011.

The CMA administers the Medical Assistance Program under Title XIX and the Children's Health Insurance Program under Title XXI and under CNMI Public Law 21-28.

Medicaid Enrollment in the CNMI Before and After the COVID-19 Pandemic

The enrollment in the Medicaid program prior to the coronavirus (COVID-19) pandemic was approximately 16,000 in 2018. The total U.S. citizen population in the CNMI is approximately 37,899 people and has a total Territory population of 51,994 in 2018.[3] The Medicaid program, in 2018, shows the Medicaid population, prior to the COVID-19 was approximately 42% of the U.S. citizens in the Territory and 31% of the total population of the CNMI. The Medicaid program provides essential health care services to a large percentage of the U.S. citizens in the CNMI population, similar to other State Medicaid programs in the U.S. Territories. Given the large population that is enrolled in the program (pre COVID-19), there can be no misunderstanding of the importance of the Medicaid program to the Medicaid members and the overall healthiness of the health system in the CNMI.

Figure 1, below, shows the enrollment in the Medicaid and CHIP program and the increased enrollment under the COVID-19 pandemic following the declaration of a Public Health Emergency (PHE) and the program rules established by the CMS for "Presumptive Eligibility" (PE). The CMS authorized the Commonwealth Healthcare Corporation (CHCC) as a "qualified entity" to screen for PE eligibility and immediately enroll individuals who meet the Medicaid eligibility income criteria.

Figure 1 CNMI Medicaid Enrollment before and after the Pandemic

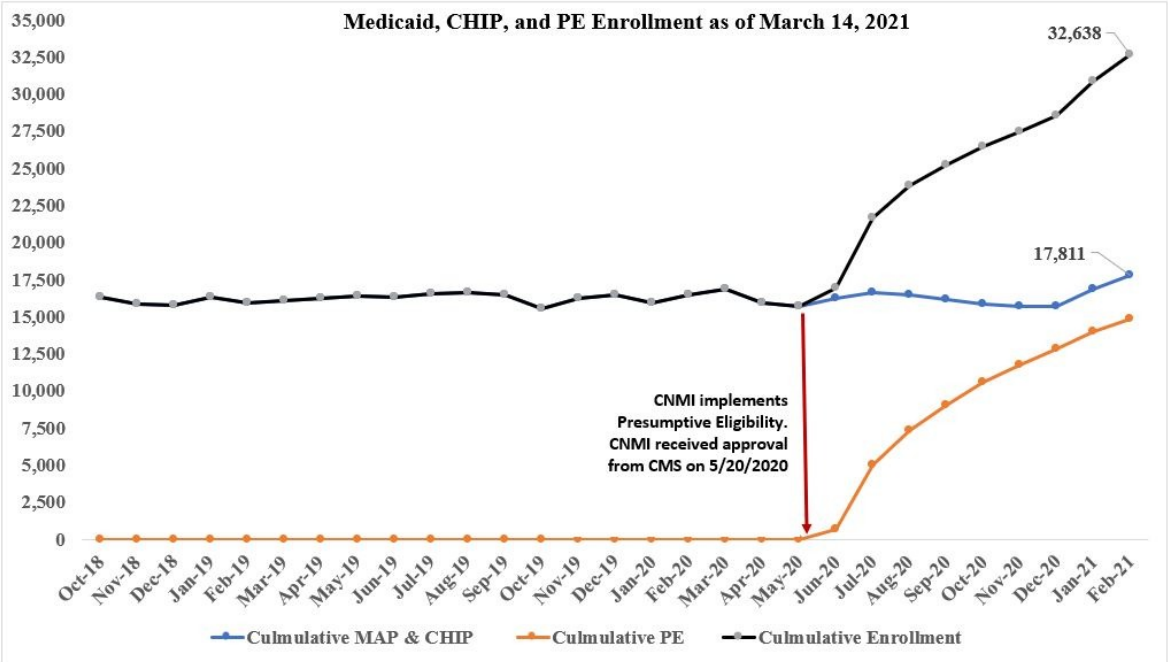

Figure 1 shows the total number of both Medicaid/CHIP and PE enrollment has led to an increase in the covered Medicaid population to 32,638. The Medicaid enrollment represents approximately 63% of the total

[3] United States Government Accountability Office, 2020. *Commonwealth of the Northern Mariana Islands: Recent Economic and Workforce Trends.*

population.[4] Fortunately, under the Coronavirus Relief Act, additional relief was provided; and, although the total federal expenditures in the CNMI for Medicaid is very small, the inclusion of the Territory as part of the Coronavirus Relief Act, with no differentiation between the Territory and States, was so welcome.

Further, the data shows the importance of having the federal funding be adjusted based on the actual eligibility, enrollment, and services provided by the Medicaid program. All States and Territories wish there will never be pandemics or other natural or economic disasters that will cause spikes in Medicaid enrollment and/or needed services. However, Figure 1 illustrates the importance of removing a fixed cap and having the federal share be based on the enrollment and services provided by the Medicaid program.

When there are no disasters and/or the economy is good, the Medicaid enrollment and services will naturally be lower and require less funding. When there may be a natural disaster or an economic downturn that results in an increase in enrollment and required health care services, the health care spending should increase based on the enrollment and services. The automatic adjustments exist for States under Title XIX but not the Territories, resulting in the need for additional specific appropriations by Congress.

Medicaid Spending within the CNMI

The single largest amount of total spending by the Medicaid program is paid to the Commonwealth Healthcare Corporation (CHCC), the public health care system corporation. The CHCC operates the only hospital in the territory, ancillary clinics and services on the islands of Saipan, Tinian and Rota.

There are only 39 facility providers registered as Medicaid providers in the CNMI. There are also 71 off-island health care providers registered with the Medicaid program in Guam, Hawai‘i, California and elsewhere. The CNMI Medicaid program refers care to other specialized providers for tertiary and other specialty care that is not available within the CNMI. The cost of services that are unable to be provided within the CNMI is high due to the cost of the types of services provides, the cost of transportation and lodging, and other expenses related to off-island transport and care services. The CHCC health system is making progress to improve the specialty care services and has demonstrate the importance of on-island care in lessening the overall cost of health care. However, recent on-island specialty care (e.g., cardiology, advanced radiology) could collapse without appropriate Medicaid program funding.

Program Administration Requirements for the CNMI Medicaid Program

While the funding is not the same as States, the CNMI Medicaid and CHIP programs in the Territory operate under the same law, regulations, and policies and procedures as States. The health care eligibility and services are defined in the Medicaid State Plan Amendments (SPA) and are administered no differently for Territories than the States.

The CNMI is subject to the same process and substantive requirements of Title XIX and CMS rules and regulations. The CNMI SPA that authorizes eligibility, services that will be covered, and administrative procedures is submitted by the CMA and reviewed and approved by the CMS. The SPA describes the covered mandatory and optional services in the Territory and other program administration and management rules and operations. There is some discretion within Title XIX and other health care laws, for example, for the Territory to establish the level of the Modified Adjusted Gross Income (MAGI) level for the cut-off of eligibility. However, the same authority to select a threshold is provided to all other States and Territories.

[4] The increase is a function of “presumptive eligibility” (PE) rules that will remain in effect until end of the Pandemic Health Emergency. The data is based on the determinations by the CHCC and data provided. There may be some differences in the final counts between the PE and regular Medicaid enrollment resulting from the PE rules that continue Medicaid coverage as well as some cases of dual enrollment. Under PHE, the coverage is for all that are legally present in the United States. To be eligible under PE, the applicant must still meet the income criteria.

The CMA, together with American Samoa, does operate under a Title XIX Section 1902(j) waiver which providers for the Secretary of the Department of Health and Human Services (DHHS) to waive certain program requirements. However, the waiver does not apply to the Section 1108 budget caps or the Federal Medical Assistance Percentage (FMAP). Further, the CNMI, has not requested/received a 1902(j) waiver for program operations to date.

The Section 1902(j) waiver has never been invoked by the CNMI Medicaid but must remain because there may be some circumstances where the smallest U.S. Territory may need some relief from some requirements. For example, there is a CMS requirement that all States and Territories implement an Electronic Visit Verification (EVV) System to validate claims for Personal Care Services (PCS) by January 2020. The CNMI Medicaid State Medicaid Plan explicitly states that PCS is not covered. However, in recent discussions with CMS, a clarification was provided that the Early Periodic Screening and Diagnostic Treatment (EPSDT) may include PCS services. Since the EPSDT is mandatory, a question has been raised as to whether PCS services should be covered; and, if so, then the CMA may require an "EVV" system. The CMA is in the process of identifying the population that may require this service; but, it is anticipated to be very small. The CMA will discuss the matter with CMS and depending on the circumstances, may request a Section 1902(j) waiver.

The Section 1902(j) recognizes that some requirements may not be fully applicable or reasonable for the two smallest U.S. Territories. The process would require the CNMI to request a specific waiver and for the Secretary of DHHS to approve the request. The main point is that the CMA is administered and managed under Title XIX CMS rules and regulations no differently than States. The major difference between the States and Territories, as described in the MACPAC testimony to Congress, is in the funding of the Medicaid program.

CNMI and Territory Medical Assistance Program Expenditures

In February 2021, MACPAC issued a report on Medicaid and CHIP in the Territories which illustrates the inadequacy of Section 1108. Table 1 below, obtained from the MACPAC report and clearly shows how much funds would have been available to the CNMI under the Section 1108 budget ceiling.[5]

Table 1 MACPAC Territory Section 1108 Allotments FYs 2019-2022 (Millions)

Territories	2019	2020		2021		2022[1]
		Without P.L. 116-94, FFCRA	Current law	Without P.L. 116-94, FFCRA1	Current law	
American Samoa	$12.2	$12.4	$86.3	$12.7	$85.6	$13.0
CNMI	$6.7	$6.9	$63.1	$7.1	$62.3	$7.2
Guam	$18.0	$18.4	$130.9	$18.8	$129.7	$19.2
Puerto Rico	$366.7	$375.1	$2,716.2	$383.7	$2,809.1	$392.5
USVI	$18.3	$18.8	$128.7	$19.2	$127.9	$19.6

[Colored boarders added]

As shown in the last column in Table 1, page above, for the CNMI, the Section 1108 ceiling will be only $7.2 million for FY 2022. This clearly illustrates how the caps are insufficient to meet the needs of the CNMI today.

The key data for the CNMI in the MACPAC table shows amounts that the Section 1108 caps in FY 2019 would have provided to the Territory. The Additional Supplemental Appropriations for Disaster Relief Act, 2019 (PL 116-20) are not reflected in Table 1, previous page, however, is depicted in Table 2 below. Table 2 was obtained from the MACPAC 2021 Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands.[6]

[5] Medicaid and CHIP Payment and Access Commission, 2021. *Medicaid and CHIP in the Territories*. The table is actually Table 2 from the MACPAC report.

[6] Medicaid and CHIP Payment and Access Commission, 2021. *Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands*. This table is actually Table 1 in the MACPAC report.

For FY 2020 and FY 2021, the amount for the CNMI under Section 1108 would have only been $6.9 Million and $7.1 million, respectively. The table further show the amounts from the Further Consolidated Appropriations Act, 2020 and the Families First Corona Virus Response Act.

Table 2 MACPAC Medicaid Funding and Spending in CNMI FYs 2011–2020, by Source of Funds

Year	Medicaid			
	Section 1108 allotment	Federal spending	CNMI spending	Total spending
FY 2020	$63.1	$39.1	$3.6	**$42.7**
FY 2019	$6.7	$49.8	$10.4	**$60.2**
FY 2018	$6.6	$25.0	$20.0	**$45.0**
FY 2017	$6.3	$17.0	$13.4	**$30.4**
FY 2016	$6.1	$20.6	$16.0	**$36.6**
FY 2015	$6.0	$16.2	$12.2	**$28.4**
FY 2014	$5.9	$19.7	$15.7	**$35.4**
FY 2013	$5.6	$16.4	$13.4	**$29.8**
FY 2012	$5.5	$13.8	$11.3	**$25.1**
FY 2011	$6.5	$14.3	$12.6	**$26.9**

Note: CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. Section 1108 allotments reflect the annual federal allotments (also referred to as caps) that territories receive under Section 1108(g) of the Social Security Act. Federal spending in excess of the Section 1108 allotment for FYs 2011 – 2019 reflects utilization of the additional allotments provided by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) and the Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L. 116-20), as well as spending not subject to the caps. Federal CHIP allotments are provided under Section 2104 of the Social Security Act. If states and territories exhaust their own available CHIP allotments, they may receive additional funding from unused state CHIP allotments. CNMI received these redistributed funds in FYs 2016–2018 and again in FY 2020.

Without the passage of the 2019 Congressional legislation that addressed the completely inadequate funding under Section 1108, all Territories would have seen a collapse in the Medicaid program. The clear result would have been that Americans in the Territories have been dropped from the program or receive substantially less care with undoubtedly some deaths and would have crippled the health care providers in the Territories. An alternative could have been that the Territories assume the 100% cost of the Medicaid program. However, that alternative would have led to a financial disaster for the Territories that already struggling with financial challenges resulting from natural disasters.

Impacts of Section 1108 in 2019

The Patient Protection and Affordable Care Act (PPACA) also recognized the problems of the Section 1108 budget caps and provided a one-time increase to supplement the Section 1108 budget ceiling. While the amounts provided under the PPACA were a welcome relief, the funding under the PPACA was set to expire on September 30, 2019; and, again, in fact, both the Section 1108 and PPACA funds were completely depleted by March 30, 2019, *six full months before the expiration date of PPACA funding and the Section 1108 ceiling in September 30, 2019*.

The CMA operates in constant terror that the Congressional cap will not be sufficient for the Medicaid program expenditures for a future year. As such, it is difficult to plan for expanding health access to services that are authorized under Title XIX when the threat of not having sufficient funding under the Congressional cap to be able to cover current services and when the Medicaid program would have to either eliminate current services and/or restrict eligibility.

When the Medicaid funds were exhausted, the Commonwealth Medicaid Agency (CMA) had no choice but to ***sadly inform Medicaid enrollees and health care providers that health care services*** could only be obtained from the Commonwealth Healthcare Corporation (CHCC), the public safety-net health system. At the same time, ***the Medicaid program informed the CHCC that without Congressional action, the Medicaid program***

would not be able to reimburse the CHCC for the health care provided to the Medicaid beneficiaries. Further, the CMA engaged in the heart wrenching exercise of trying to plan whether the Medicaid program would cut services severely or limit participation in the Medicaid program and even wondered if it was legally permissible under Title XIX and whether or not implementing any such measures would have made the program not compliant with Title XIX.

During the time when the CMA ran out of funds in March 2019, a CHIP beneficiary, a young child had been receiving off-island specialized hospital care. The care was so critical for the CHIP beneficiary that Medicaid program had already paid $1 million for care. Medicaid allowed the child to receive treatments and the health condition of the child was improving, but the child still needed additional care. The Medicaid program struggled with wondering whether the Medicaid program would need to inform the low-income parents that there was no more funding and to seek charity care from the hospital. Further, the Medicaid program wondered if the private hospital would remain a Medicaid provider if the CNMI could not pay for its services. These challenges are the result from the inequities in the financial structure of the Medicaid program between States and Territories.

Congress in 2019 and 2020

The U.S. Congress, fortunately, recognized the imminent and dire predicament of the U.S. citizens and other eligible Medicaid populations in the CNMI, and with other U.S. Territories and:

- Provided Medicaid Disaster Assistance following Typhoon Yutu, a Category 5 typhoon, that was needed because the Section 1108 caps and increases from the Patient Protection and Affordable Care Act were depleted 6 full-months before the end of the fiscal year;

- Passed the Further Consolidated Appropriations Act, 2020 that addressed, at least temporarily, the Medicaid Fiscal Cliff by increasing the Section 1108 Medicaid Assistance Program funding level to $60 million for FY 2020 and FY 2021 and enabled the FMAP to be calculated in the same way as the States; and,

- Provided, under the Families First Coronavirus Relief Act (FFCRA), assistance for the all States and Territories, and included the CNMI, to address the needs of the medically indigent during the period of the COVID-19 Public Health Emergency (PHE). Specifically, the Congress temporarily increased the FMAP for all States and Territories by an additional 6.2% and provided an increase of $3.2 million for the Commonwealth Medicaid Agency.

The much-needed Congressional action enable the CNMI climb up to a ledge on the Medicaid Fiscal Cliff and have a brief respite from the terror. Unfortunately, the CNMI remains on the Medicaid Fiscal Cliff and the health of our Medicaid beneficiaries and health care system remains in serious peril. We, again, implore the Congress to establish parity and enable Americans in the CNMI not to lose the much-needed medical assistance.

Progress on Compliance with the Further Consolidated Appropriations Act

The CMA has submitted the first Annual Report for FY 2020 to the Chairs of the House of Representatives and Senate Health Committees. The CNMI will submit a second report later this year as required by Congress.

The Commonwealth Medicaid Agency *fully understands, and is committed to, meeting the requirements of the U.S. Congress*. The CNMI takes very seriously its fiduciary responsibility to effectively administer the program; guard against Medicaid Fraud, Waste, and Abuse; and, to diligently manage the program to identify and implement opportunities to improve the system of care for Medicaid members and lessen the cost of the Medical Assistance Program.

The Consolidated Appropriations Act FY 2020 required the CNMI to:

- Make reasonable and appropriate progress to submit data to the T-MSIS;
- Designate a Program Lead for Program Integrity;
- Establish a Medicaid Fraud Control Unit; and;
- Submit an annual report to the Chairs and Ranking Members of the U.S. Congress Committees with jurisdiction over health.

The Commonwealth Medicaid Agency is fully committed to complying with all requirements in Title XIX, CMS program rules and regulations, and takes its responsibility seriously. The following briefly summarizes the commitment, efforts, and progress of the CNMI to meet the requirements of the Further Consolidated Appropriations Act, 2020.

Data Submission to the Transformed Medicaid Statistical Information System

The Commonwealth Medicaid Agency is well-aware of and has wanted to implement a Medicaid Management Information System (MMIS), submit data to T-MSIS, and establish a Medicaid Fraud Control Unit and Claims Data Warehouse. We have a full understanding and appreciation of how these systems and programs would not only help the CNMI improve the administration and management of the Medicaid Program, but will greatly facilitate the work of a Medicaid Fraud Control Unit and enable the CNMI to use detailed Medicaid claims and encounter data to improve care, population health, and lessen the long-term costs. We are further aware of how other States are using Health Information Technology and Health Data to assess the ongoing quality of care, improve coordination of care, understand the health of the Medicaid populations so that waiver and other programs can be targeted for improvements, and to lessen the costs through focused Medicaid waiver programs including Managed Care and other programs.

The only reason why the CNMI had not yet initiated the planning and implementation of a full MMIS is based on the fact that if the increased funding under the Patient Protection and Affordable Care Act ended, the CNMI Section 1108 budget cap, together with the CHIP funding, would only be around $18.24 million. MMIS systems that transmit data to the CMS T-MSIS data warehouse cost over $10 million dollars for medium sized states and more than $100 million for the largest states per year. The CMA wondered whether the cost of such MMIS systems would have been highly disproportional to the actual federal funding levels for the Medical Assistance Program and raise different questions on the "high costs to 'administer' the program.

Notwithstanding these concerns and based on the passage of the Further Consolidated Appropriations Act, 2020, the CMA submitted to and received approval from the CMS to conduct the planning based on exploration of "reuse" of existing systems that may have already been developed with federal funds, partnerships with other states, and other models to lessen the costs of the MMIS.

The Legislature unanimously passed SB 21-28 and the Governor signed the bill into law as PL 21-28 on May 22, 2020. PL 21-28 states that:

> "Accordingly , the purposes of this legislation are to: (a) recognize, establish, and organize the Medicaid Agency as an agency in the Executive Branch of the CNMI; (b) direct the agency to plan, design , implement, and operate Medicaid Enterprise Systems that includes, among others, the ability to efficiently and effectively process claims for Medicaid services and submit data to the T-MSIS or replacement system as may be required; (c) establish a claims and clinical data warehouse, and promote health information exchange; and, (d) provide a community health record system that would enable beneficiaries to see their medical information."

Further, in the FY 2020 budget appropriations law (PL 21-35), the Legislature specifically established a "MES and Compliance" budget code into the Medicaid budget to highlight the importance of compliance and the need to make reasonable and appropriate progress to implement Medicaid Enterprise Systems (MES) and submit data to the T-MSIS system. The Legislature further provided the authority, in September 2019, for the Medicaid Director to transfer appropriations among the Administration, Medical Payments, and MES and Compliance budget categories so that there is some flexibility given the austere budget resulting from the COVID-19 economic impacts.

PL 21-35 specifically states that:

> "(f) Medicaid Program. The funds appropriated in this Act for the Medicaid Program, including Medicaid Reimbursement – business unit 1951, Medicaid Administration business unit – 1980, and the new business unit for Compliance and Medicaid Enterprise Systems (MES) shall be deemed a single budget reserved for the purposes of Medicaid Administration, Medicaid Reimbursement, and Compliance and Medicaid Enterprise Systems. *The Director of the Commonwealth Medicaid Agency may reallocate the funds appropriated in this Act to any of the expenditure categories, including*, but not limited to, Administration, Reimbursement, and *Compliance and Medicaid Enterprise Systems*"

The Legislature unanimously passed SB 21-28 and HB 21-124 the Governor signed the bill into law and illustrates the policy-level involvement and oversight to ensure that the CNMI will make "reasonable and appropriate" progress to improving on its current Eligibility and Enrollment (E&E) and implement a MMIS with full capabilities to submit data to the T-MSIS system. The provision enables the CMA to prioritize Compliance and Medicaid Systems even to the point of deferring a payment to providers for a period but within the authority provided under law and the Medicaid State Plan Amendments.

CNMI Medicaid Claims Data Warehouse

The CMA understands that program management and improvements rely on healthcare data to understand health care costs, the quality of care by providers, population health disparities, and service gaps for the members. The CMA submitted and the CMS approved, in FY 2020, an Implementation Advanced Planning Document (IAPD) to initiate the collection of the claims data file electronically in a secure data enclave and to conduct data management and initiate the data analysis to assess the comparative costs of care, quality of care, gaps in services, and other purposes. These activities demonstrate the CNMI commitment to effectively administer the Medicaid program, even with the limited resources and the major challenges the CMA confronts on a daily basis to improve the care of our U.S. citizen members.

The CNMI policymakers, in 2019 and 2020, as described below, recognized the importance of these efforts, the requirements of the Further Consolidated Appropriations Act, 2020 and passed legislation that provides guidance and the required matching funds for Medicaid Enterprise Systems/MMIS/T-MSIS, Medicaid Fraud Control Unit activities, and other purposes.

Designation of Program Integrity Lead and Medicaid Fraud Control Unit

The CMS acknowledged the CMA designation of a Program Integrity Lead on June 26, 2020. The CNMI Medicaid Agency and Commonwealth is fully committed to program integrity in the Medicaid program and has designated a Program Integrity Lead as required by the Centers for Medicare and Medicaid Services. The CMA has further executed a Joint Operating Agreement (JOA) with the CMS Unified Program Integrity Contractor-West (UPIC-West). The JOA was fully executed on August 17, 2020 and the CMA has received training from both the UPIC-West and CMS. The CMA has also provided the UPIC with claims data from the CHCC and will be submitting a full copy of the Eligibility and Enrollment system and data since the system was initially used. Finally, the CMA has also consulted with the Office of the Attorney General as the independent Medicaid

Fraud Control Unit and will execute a Cooperative Agreement following consultation with the CNMI Legislature.

Response by Congress in 2019

The issue of the Medicaid Fiscal Cliff came to the forefront in 2019 when the additional Medicaid funding provided under the Patient Protection and Affordable Care Act was set to expire on September 30, 2019. The CNMI fell off the Medicaid Fiscal cliff when the Medicaid funds were completely expended in March 2019. With six months left in the fiscal year, the Commonwealth Medicaid Agency informed the beneficiaries to seek care from the Commonwealth Healthcare Corporation (CHCC), the public health system in the CNMI. Concurrently, the Medicaid program informed the CHCC and the private providers that there were no further funds for reimbursements. In 2019, the U.S. House of Representatives held the "Strengthening Health Care in the U.S. Territories for Today and Into the Future" hearing on the Medicaid Fiscal Cliff for the U.S. Territories. The hearings provided a critical first-time ever opportunity for the CNMI, as the smallest U.S. Territory, to offer direct testimony to Congress on the Medicaid program.

The hearings provided the opportunity to provide testimony and share information on the nature, urgency, and impacts of the "Medicaid Fiscal Cliff" on U.S. citizens and the health care system of the CNMI. We were very *heartened* that the Committee of Jurisdiction over the Medicaid program recognized that the U.S. Territories were "on the verge of a humanitarian and financial crisis if the U.S. Congress doesn't act swiftly to increase their Medicaid funding for next year and beyond."[7]

The U.S. Congress responded to the issues of the Medicaid Fiscal Cliff with the passage of the Additional Supplemental Appropriations for Disaster Relief Act, 2019 and the Further Consolidated Appropriations Act, 2020. The relief enabled the CNMI to fall on a ledge and not over the cliff.

Request to Establish Parity and Desire to Implement Program Improvements

The CNMI respectfully requests the U.S. Congress to treat fairly the U.S. citizens of the Territory and to establish parity in the financing of the Medicaid program between the States and Territories. By providing parity in the Medicaid program with the States, the CNMI will avert the FY 2022 "Medicaid Fiscal Cliff" and provide the CNMI the financial stability to move forward to improve care and ultimately bend the cost curve in the growth of health care costs with use of innovations and programs using the best practices from other States and Territories. The Insular Area Parity Act would help to achieve that equality.

Parity is further required so that the CNMI is able to make improvements in the Medicaid program. For example, the CNMI, as a community, has been greatly concerned with diabetes, obesity, and Non-Communicable Diseases (NCDs). In 2013, responding to the concerns of the CNMI community, the Governor of the CNMI declared NCDs an emergency and established a Commission to develop an Integrated Plan of Action for dealing with NCDs in the CNMI.

The plan called for a "'whole of society' approach resulting from estimates by public health and health care specialists that 7 out of every 10 deaths in the CNMI were attributed to or complicated by NCDs and/or NCD risk factors. During this time, CHCC Dialysis Center had just reported a "126% increase in newly registered renal dialysis patients in 2012 compared to the previous year; with majority of the patients having Diabetes Type II and hypertension; majority are of Chamorro and Carolinian descent, the indigenous people of the Northern Marianas; and wherein CHC, the only hospital in the CNMI, is one of two renal dialysis center sites on the island of Saipan; As of January 2013, CHC reported a total of 107 renal dialysis patients at the Dialysis Center. In 2008, 45% of our 7-10 year old children were found to be obese or overweight."[8] The CNMI

[7] Helen Sablan, Testimony to U.S. House of Representatives Committee, June 20, 2019.
[8] Governor Eloy Inos, Administrative Directive No.6, Non-Communicable Disease Emergency Directive, April 18, 2013.

Directive was one of many issued by leaders in the Pacific region that that declared NCDs and diabetes and obesity of the a serious crisis in the Pacific.

In 2015, the CNMI was fortunate to receive a competitive planning grant under the CMS State Innovation Model (SIM) funding program. A major recommendation of the stakeholders was to develop a "diabetes prevention and management program" that would be established from a CNMI partnership of public health specialists, providers, schools, and other regional health care specialists to focus on diabetes education and prevention and establish a care management program to improve care, care coordination, patient and public health outcomes, and to lessen the costs of care.

The Commonwealth Medicaid Agency, when asked by visiting external Subject Matter Experts to consider developing a Medicaid waiver program to organize and coordinate a diabetes prevention, control, and management program for Medicaid members, the CMA explained that the limitations of the annual funding prevented any possibility of a multiyear waiver program focused on prevention and diabetes management to lessen the short and long-term costs of NCD and comorbidities.

Given the high prevalence and continued high levels of incidence of NCDs, and coupled with the high costs of care such as dialysis, the Commonwealth Medicaid Agency commits to addressing diabetes, obesity, and related comorbidities should the Section 1108 caps be lifted and FMAP established using the same formula as states. Even if years later, the CMA and CNMI community strongly wants to work on this diabetes prevention and management program; and, should the Congress equalize the financing of the Territories with the States, the CNMI will! However, without parity in the needed Medicaid financing, proposing implementation such a waiver program, even to lessen costs, is not possible. This is only one of many evidence-based innovations from the best practices of other State Medicaid programs that cannot even be attempted today. The CNMI is committed to improving care and population health outcomes of Medicaid members; improving program administration and management to lessen costs; and, protect against fraud, waste, or abuse.

Summary

The Commonwealth of the Northern Mariana Islands and the other U.S. Territories will fall over the Medicaid Fiscal Cliff and plummet into a humanitarian and fiscal crisis without intervention from the U.S. Congress. The U.S. citizens of the Commonwealth Medicaid Agency are huddling on the ledge today and hopeful that the U.S. Congress will reveal and provide a path up the cliff. The Medicaid program is critical to the health of the U.S. citizen Medicaid beneficiaries and to the health system of the CNMI for today and into the future.

The CNMI pleads with the U.S. Congress to treat the citizens in the Northern Mariana Islands the same as citizens in the States. Specifically, we request that Congress extend to the Territories the same terms and conditions as applied to the States. The funding provided in the Further Consolidated Appropriations Act, FY 2020, provides a useful understanding that eliminating the caps in Section 1108 and applying the same program rules and FMAP to the Territory would address a long-standing disparity and enable the program to focus on program improvements and services, all of which are not available to the CNMI today.

The Commonwealth of the Northern Mariana Islands respectfully request that Congress consider clarifying the definition of "state" in Title XIX be defined to read "state is defined to include states, the district of columbia, and territories." The definition of state to include the Territories would resolve the long-standing inequity and establish parity, eliminate the need for the Section 1108 caps, and enable the FMAP for the Territories to be calculated in the same way as States.

We are hopeful that Congress will correct the inequities and provide parity and fairness among the States and Territories in 2021. Before closing, the CNMI would like to express its appreciation for the passage of the American Rescue Plan Act of 2021, PL 117-2. We believe that this will help to address the COVID-19

pandemic and will enable the CNMI to recover from the depressed economy and alleviate the human distress throughout the United States.

Thank you once again for holding a hearing on the challenges of the Territories and for inviting and enabling the Commonwealth Medicaid Agency to submit testimony. Should there be any questions, please do not hesitate in letting us know.