Commonwealth of the Northern Mariana Islands
State Medical Agency
Office of the Governor

June 5, 2019

Honorable Chair Raul M. Grijalva and Members of the Committee on Natural Resources
United States House of Representatives
Washington, DC 20515

Dear Honorable Chair Raul Grijalva, Vice Chair Gregorio Sablan, and Ranking Member Robert W. Bishop, Ranking Member Jenniffer Gonzalez-Colon and Members of the United States House of Representatives Committee on Natural Resources:

Thank you for your leadership in planning and holding the hearing on the Insular Areas Medicaid Fiscal Cliff of the U.S. House of Representatives Committee on Natural Resources. We sincerely appreciate that interest of the Congress to address the inequities in the Medicaid program. We also deeply appreciate that the U.S. Congress was able to pass HR 2157 and that President Donald J. Trump signed into law the bill that provides Medicaid Disaster Assistance for the Commonwealth of the Northern Mariana Islands for the current Fiscal Year (FY) 2019. At very least, this delays the impacts of falling off the fiscal cliff until September 30, 2019.

As described in the attached, if the inequity in the Section 1108 budget caps and Federal Medical Assistance Percentage (FMAP) is not addressed, then, the CNMI Medicaid program will not be able to cover the expenses of the mandatory benefits of the Medicaid program and optional services that includes drugs beyond the first Quarter of FY 2020. The U.S. citizens of the CNMI will suffer dire consequences and there will be devastating impacts on the system of healthcare in the CNMI.

Please find enclosed our response to questions the Committee has asked of the Commonwealth of the Northern Mariana Islands. We are very hopeful that the U.S. Congress will lift the Section 1108 caps in Title XIX and Federal Matching Assistance Percentage (FMAP) for FY 2020 so that the U.S. citizens in the CNMI are treated the same as the other states.

Should you require any further information, please let us know. We stand by ready to respond to any request given the urgency and seriousness of the situation.

Sincerely,

Helen Sablan
Director

Attachments (1)

c: Honorable Ralph Torres, Governor, CNMI
Honorable Senate President Victor B. Hocog, CNMI Senate
Honorable House Speaker Johnathan Blas T. Attao, CNMI House of Representatives

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Questions from Members of the Committee on Natural Resources of the U.S. House of Representatives and Responses from the Commonwealth of the Northern Mariana Islands (CNMI)

Questions from Democratic Members

1. **If Congress finally treats the territories equitably and provides uncapped funding with federal match determined in the same way as states, what would the Commonwealth of the Northern Mariana Islands do to ensure that Medicaid beneficiaries have access to comprehensive services comparable to what states must provide?**

    a. **With the additional federal funding, what specific investments could you make to improve eligibility and benefits over time?**

CNMI Medicaid Response

The CNMI Medicaid program, today, provides the statutory and regulatory required mandatory Medicaid services. Additionally, the CNMI Medicaid program, today, provides many optional services, including, but not limited to, prescription drugs (all states provide this option), dental services for adults; physical therapy; prosthetic devices; eyeglasses; medical supplies; and, other services. The optional Medicaid services were made possible because of the additional funding available through Patient Protection and Affordable Care Act (ACA).

For FY 2019, the Medicaid Disaster Assistance passed by Congress provides temporary relief to continue the services until September 30, 2019 for the CNMI Medicaid program, and the CNMI greatly appreciates this assistance. The lifting of the Section 1108 caps or a second year of Medicaid Disaster Assistance is not provided for Fiscal Year (FY), then, the CNMI Medicaid program will not be able to fully provide the mandatory services for the full duration of the 2020 Fiscal Year and both mandatory and optional services that are currently being provided will be eliminated or curtailed.

Should equitable funding as the states be provided, then, the amount of the optional services comparable to what the states provide will be substantially improved. Specifically, the CNMI Medicaid program would assess the optional services permitted under the program. We would assess what other states have

done and assess the optional services on the basis of need, feasibility, benefit-cost, effectiveness/cost and other criteria.

The adjustment to the FMAP and the commitment of territorial funding are essential to planning optional services include diagnostic, screening, preventive, and rehabilitative services, respiratory care services, home and community-based services, and other services provided by other states. The CNMI will also be in a position to evaluate managed care service delivery options and the use of Medicaid waivers and other Medicaid program service options to improve care and health of the Medicaid population, and to lessen the cost of healthcare. We would also work closely with the policymakers that would need to appropriate the CNMI matching funds on the value of the proposed optional services.

With respect to eligibility, the CNMI and the CMS implemented a 1902(j) waiver that enables the maximum participation in the Medicaid Program.

2. What improvements in your health care infrastructure would be needed?

The CNMI needs improvements in the clinical, financial, and technology infrastructure. The following is a brief discussion of the needed improvements.

Health Care Services Infrastructure - The clinical and public health infrastructure in the CNMI has significantly improved since the Commonwealth Healthcare Corporation was established as a public corporation in 2011 and the additional Medicaid funding became available through the ACA. There are more clinicians and healthcare services that are currently provided and the quality of services has continuously improved. Still, despite the substantial progress, there are many clinical services that are not currently provided in the CNMI at this time because of the section 1108 caps, the inequitable FMAP, and the high rates of uninsured in the CNMI. The small size of the territory, the lack of specialists, and the uncertainties of Medicaid program fiscal cliff have been barriers to improving the overall healthcare services infrastructure in the CNMI. The CNMI Medicaid program is studying the Medicaid services to determine what are the high priority areas where services and other infrastructure can be effectively provided within the territory. Given the small size of territory, there will be continued reliance on specialized healthcare providers and services that are outside of the CNMI.

Financial Infrastructure - In terms of the financial infrastructure to support the health system, the two main problems remain the Medicaid caps and FMAP, and the high uninsured rate resulting from the repeal of the CNMI Employer Responsibility law for immigrant laborers in 2013. The amount of charity and sliding fee supported care results in additional millions of losses in revenue for the CHCC, the safety net provider in the CNMI. Again, the limited financial infrastructure for health care will be the limited financial structure will be devastated especially since the funds provided under the Section 1108 caps of $6.85 in FY 2020 is not even sufficient to cover the CPE amounts determined by CMS for the CHCC.

The capped amount of $6.85 million and the CHIP amount of $11.2 million and current proposed CNMI appropriation for Medicaid of $5 million are around $48 million short of the 2018 Medicaid expenditures of $53 million and the Incurred But Not Booked Accounts Payable of $18 million. The 16,206 current Medicaid beneficiaries will become uninsured in the CNMI second quarter of FY 2020 without the equitable treatment as states. Finally, it is important to note that the estimated amounts provided by the CMS to Congress of the $36 million amount needed for FY 2019 Disaster Assistance did not include the IBNR Accounts Payables and was based on two quarters of available ACA funding that was exhausted in March 2019. CNMI respectfully requests that in addition to lifting the Section 1108 caps and adjustment of the FMAP, that an additional year of 100% federal funding be provided based on Medicaid Disaster Assistance.

Health Information Technology Infrastructure - The Health Information Technology for Economic and Clinical Health (HITECH) Act was instrumental in helping the nation to establish a Health Information Technology (HIT) infrastructure by incentivizing the use of Electronic Health Records (EHR) systems and providing funding for Health Information Exchange (HIE), and public health information system interfaces. Unfortunately, the CNMI, today, remains behind the states.

In part, the reason is that the small size of the territory has resulted in a different inequity. For example, it should be clearly noted that the CNMI received only $800,000 to plan, design, and implement a Health Information Exchange (HIE). The amount was obviously insufficient. According to the Office of the National Coordinator for Health Information Technology (ONC), the three Pacific territories received the equivalent of a small state. As a result, none of the Pacific Territories had a functioning HIE. Efforts were made to reach out to other states. However, all efforts were rebuffed.

Further, under the HITECH, the CNMI CHCC hospital did not qualify for both the Medicare EHR incentive funding because of a quirk in the law, despite the CHCC's role as a Medicare provider. The HITECH Act failed to mention the territories for the Medicare EHR incentive. As a result, the CHCC was unable to use the full incentive provided to all other State hospitals that provide Medicare services. CHCC was only eligible for the Medicaid EHR Incentive.

In the CNMI, the HIT infrastructure to improve clinical care, patient safety, public health and the like, remains a challenge. Even the CHCC health system has not been able to meet the Promoting Interoperability Standards of the CMS to receive the formerly "Stage 2" of Meaningful Use incentives; and *no private providers* in the CNMI have met the standards as well. Of course, this means that the use of HIT and HIE to improve clinical care, undertake care coordination, submit data for public health disease surveillance, and conduct studies on the population health of Medicaid beneficiaries is not equal to the infrastructure of other states. Still, despite these facts, the CNMI Medicaid continues to work with all provider to make progress in all of these areas. There is some health data exchange that use Direct Secure Messaging to comply with both ONC and the Health Insurance Portability and Accountability Act (HIPAA), as amended by the HITECH Act.

Medicaid Enterprise Systems (MES)/Medicaid Management Information System (MMIS) Administrative Information Infrastructure – The CNMI has planned meetings with the CMS to initiate the planning and implementation of an MMIS claims processing both to improve administrative efficiency, eliminate errors with claims, conduct ongoing fraud analysis, and to achieve the national objectives of submitting data to the CMS Transformed Medicaid Statistical Information System (T-MSIS). CNMI has received initial planning funds from the CMS to initiate a Medicaid claims data warehouse that is absolutely integral to enable data analysis to improve care quality; conduct service utilization and cost studies; improve care services and coordination; detect waste/fraud and abuse; and identify opportunities to lessen the cost of health care.

Federal funding is available for these program activities and the CNMI Medicaid program will seek the both federal funding and the local matching funds to move forward with the information technology infrastructure for MES/MMIS and a Medicaid claims and clinical data warehouse. As such, the CNMI Medicaid program is not seeking any "special" treatment to fund the MES/MMIS/Health Information Technology activities. The CNMI is only requesting equity with the funding and FMAP as provided to other states for the Medicaid Assistance program.

The CNMI Government will need to find the match, as all other states have done, for the full MES/MMIS and data warehouse activities so that data can be submitted to the CMS T-MSIS data systems and to enable an effective Medicaid Fraud Control Unit to function with the continuous

monitoring of Medicaid claims. Nonetheless, with equitable funding and FMAP, then, the CNMI would need to prioritize local funding.

3. Would provider payments have to be increased and to what extent?

The provider payments would have to be increased since almost all our providers are paid using Medicare reimbursement. We should use the Medicare reimbursement times 20% at least. Some of the providers are not willing to treat our patients because of the low reimbursement. For example, the Guam Memorial Hospital Authority (GMHA) has not been accepting our patient since 2011 because of the low reimbursement; and, because of the section 1108 caps, we are unable to develop waiver and other programs that can facilitating our desire to improve care, improving quality, improve population health, and lessen costs for the Medicaid program and beneficiaries. However, no provider payment adjustments can be contemplated without equity in the caps and FMAP.

4. Are there particular Medicaid eligibility, benefit or other requirements you wouldn't be able to meet within a reasonable time due to territory-specific limitations, and if so, what changes could the Marianas make to ensure residents get high quality health care in other ways that meets their needs?

The CNMI Medicaid program is constantly assessing ways to improve benefits and at the same time ways to lessen Medicaid expenses. We want to have a fully functional program that is able to efficiently process Medicaid claims, have a Medicaid data warehouse that would enable our program to analyze the cost and quality of care and determine the high-costs areas and areas where we might use waivers and other Medicaid programs to improve care and lessen costs. We believe that there are many program changes that we might be able to accomplish but are unable to do so of the Section 1108 caps, FMAP, and CNMI general funds for a match.

5. Overall, what do you see as the necessary steps to better ensure to quality, comprehensive care for Marianas residents and what could be a reasonable timeline to reach such a goal?

The following are some of the steps that will be taken should the caps be lifted and the Federal Matching Assistance Percentage (FMAP) be adjusted to be the same as states or substantially. The CNMI will: (a) continue the review of the Medicaid program to determine optional services and evaluate the other optional services for inclusion; (b) assess the quality of services; (c) analyze alternatives to lessen the cost of care; (d) plan and implement a full Medicaid Enterprise System services; and evaluate the use of Medicaid program options. Just as important, the CNMI Medicaid program, just as one example, will immediately initiate planning to implement waiver programs as a diabetes care/management/education program under Section 1115(c) or Section 1915(i). Diabetes is a major problem in the CNMI and has long-term consequences for Medicaid costs, comorbidities, and debilitating problems such as renal, vision, cardiovascular and others. The program design will be based on the many evidenced-based studies that have shown the efficacy of diabetes self-management and patient education and care coordinated follow-up. The program will be closely coordinated with public health education for the general public and schools and a public awareness campaign organized with the Commonwealth Healthcare Corporation (CHCC).

The CNMI Medicaid program believes that such a program will achieve the objectives of improving care, care coordination, population health, and lessen the costs over a period of time. This would be coordinated with the CHCC, a unique public corporation, that has both clinical and public health functional responsibilities. Due to its unique public corporation structure, the CHCC is well positioned to implement a multi-faceted program intervention that would, as suggested in evidenced-based literature,

result in long-term reductions in diabetes and lessen debilitating and costly diseases such as Chronic Kidney Disease, cardiovascular problems, vision, and the many well-understood comorbidities.

The anticipated reductions from diabetes alone, will lessen the cost of care and serves as only one example of how the CNMI would move forward with implementing programs that not only improve the health of beneficiaries but lessen health care costs at the same time. This will take time. However, the CNMI Medicaid program is fully committed to continuously improving the program for Medicaid beneficiaries.

Waiver programs could not be implemented today because of the gap between the Medicaid funding, as a result of the Section 1108 caps, where the Medicaid program struggled to meet the healthcare financing of the current program.

The CNMI has already initiated a plan to establish a Medicaid Claims Data Warehouse to provide the data needed to evaluate the cost of services, the quality of care, and the population health conditions that are driving healthcare expenditures. The reasonable timeline to reach such a goal is about 3 years because of the limited resources.

6. What will you have to cut if you go off the cliff?

The CNMI Medicaid program was not approaching the cliff but fell off the cliff at the end of March 2019 when ALL federal MAP and ACA increases were exhausted, including even the Section 1323 funding provided to CNMI because it did not elect to establish a Health Insurance Exchange. Now that HR 2157 is signed into law, the mandatory and optional services provided will be continued until September 30 2019. At that time, we will again fall off the cliff within the first quarter given that the capped MAP will not even cover the cost of Medicaid federal share amounts due to CHCC as determined by CMS. So, to be clear, it is not what we will have to cut to preserve the program, the CNMI will not be able to maintain even the mandatory services for the year.

The CNMI has initiated consultation with the CMS Region IX. The purpose of the consultations is to ensure that when services are cut, the program remains even though the federal and local funding will have been exhausted. The situation is that dire. There is no exaggeration since all government and non-government agencies recognize the gap caused by the Section 1108 MAP caps and the FMAP.

Another option could be to have the CNMI Government continue to incur Accounts Payables that could lead to severe financial problems for the territory, Medicaid providers dropping out of the program, and even more severe consequences given the financial situation of the CNMI government following Typhoons Mangkhut and Yutu.

7. What will be the impact on individuals and the health care delivery system in the territory, when Obamacare funding ends this year?

The healthcare of the 16,206 U.S. citizens and Medicaid Beneficiaries will be very severely affected in both the short and long run. Medicaid Beneficiaries that need tertiary cancer care or surgeries and other services that public acute Commonwealth Health Center hospital is unable to provide may need to finance it themselves or use the CNMI citizen benefits if eligible or forego getting the care that they need. If we use the full amount of the Medicaid MAP and CHIP allotment under the caps to pay the public CHCC, then, the CNMI Medicaid program will not be able to pay all other "on-island" or "off-island" Medicaid providers. The CHCC does not have a radiologist on staff, does not provide advanced cancer care treatment, does not have a gastroenterologist, and unable to perform many surgeries.

Questions from Republican Members

Questions from Rep. Gonzalez-Colon of Puerto Rico for Ms. Helen Sablan, Director, Commonwealth of the Northern Marinas Islands State Medicaid Agency

1. **How will the overall healthcare system and the non-Medicaid population in the Northern Mariana Islands be affected if Medicaid funding is not increased for FY2020?**

The impacts on the overall healthcare *system* will be clearly devastating for the non-Medicaid populations if the Medicaid funding is not increased for FY 2020.

The main provider of care is the Commonwealth Healthcare Corporation (CHCC), a unique public corporation that was constituted in late 2011. The CHCC is responsible for the sole acute care hospital in the territory; adult, children, family, dental, dialysis clinics on the CHCC campus on Saipan; and clinics on the two remotely populated main islands of Rota and Tinian. The CHCC also has statutory responsibilities for all public health program functions that are operated by state and/or county governments throughout the United States, including a behavioral health program. The unique public corporation is the safety net provider in the CNMI.

There are also several private clinics, a Section 330 Community Health Center, a second renal dialysis clinic, several dental clinics, and a private laboratory. There is no on-island radiologist or gastroenterologist or cancer treatment center, to name only a few of the medical services that are not provided in the CNMI. Medicaid Beneficiaries that need those services must see "off-island" health care providers in Guam, Philippines, Hawaii, and the U.S. mainland.

If a second year of Medicaid Disaster Assistance is not provided or the Section 1108 caps are not eliminated, then, the CHCC will need to survive on a portion of the $6.85 million of total Medical Assistance funding under the caps. This amount, even if all funds were provided to the CHCC, will not even meet the federal amounts the CMS has determined should be provided to the CHCC as the federal share under the Certified Public Expenditure (CPE) methodology. The current CPE amount as determined by the CMS is $1.5 million or $18 million a year based on the CHCC Medicare Cost Reports. So, loss will be $12 million to the CHCC if you assume that all funding is provided to the CHCC. When you include the fact that the CHCC treats the uninsured and provides a sliding fee for indigent patients at a loss of $19 million a year, the impact will be devastating to the CHCC and to health system of the CNMI.

It is critical to understand again that the CHCC includes an acute care hospital that does not cover all types of specialties. As a result, the use of "off-island" providers is unavoidable. Further, even with lifting the Section 1108 caps, there will need to be significant reliance on Providers that are outside of the CNMI since the territory would not have the patient volume to support the specialist within the territory. The CHCC renal dialysis center has been rated highly by the annual CMS conducted surveys. Nonetheless, the CHCC does not have sufficient dialysis stations and must rely on the second dialysis center to meet the number of dialysis patients in the CNMI.

Finally, it should be noted that following the CHCC lost 5 physicians and a significant number of nurses when the CHCC was unable to make payroll due to the financial conditions at the birth of the CHCC. History will repeat itself without lifting the caps and adjusting the FMAP.

2. Currently, the Social Security Act provides for capped Medicaid funding for the territories. For FY2017, the cap in the Northern Mariana Islands was $6.34 million. How much did the Medicaid program benefits actually cost?

As shown in Table 1, below, the actual Medicaid expenditures for FY *2018* was $53.11 Million. With an additional Incurred But Not Booked (IBNR) Accounts Payable of $18 Million, the FY 2018 total was $71.42 Million.

Table 1 – Summary of FY 2018 Expenditures and FY 2020 Shortfall
Given the End of Additional Funding under the ACA

Fiscal Year and Expenditures	In Millions
FY 2018 Total Medicaid Expenditures in FY 2018	$53.11
FY 2018 Accounts Payables - Unbooked (Incurred But Not Reported (IBNR))	$18.31
Total FY 2018 Medicaid Expenditures and Accounts Payables	**$71.42**
FY 2019 Medicaid Section 1108 Budget CAP	$6.48
FY 2019 CHIP Program Budget	$11.20
FY 2019 Remainder of ACA Section 2005 CNMI Allocation	$2.56
FY 2019 CMS Reconciliation for Previous Years	$4.27
FY 2019 CNMI Legislative Appropriations for Match	$4.64
Total Federal and CNMI Medicaid Funds for 2019	**$29.15**
FY 2019 Projected Shortfall Given 2018 Expenditures and APs or Disaster Assistance Needed Based on 2018 Actual Expenditures and Unbooked IBNR	$42.27
CMS Estimated Shortfall of $36M for Disaster Assistance Provided to U.S. House	$36.00
Shortfall even with proposed $36 Million for Disaster Assistance. Note: This does not include any AP that is accumulating since last drawdown of MAP and ACA.	$6.27

For FY 2020, the CMS has informed the CNMI of the MAP and CHIP amounts. Based on the formula for the CAPs, the amounts will remain around $19 million. Again, assuming no Medicaid Disaster Assistance or lifting of the Section 1108 caps in Title XIX for FY 2020, the shortfall will be over $42 million, higher than the $36 million estimated by CMS needed for Medicaid Disaster Assistance. This is largely due to the Accounts Payables that are not reflected in the CNMI government financial accounting system.

For the current FY 2019, the CNMI completely exhausted its $6.48 million in the Section 1108 Cap as well as the last of the ACA funding, including the Section 1323 funding since the CNMI did not elect to implement a Health Insurance Exchange.

For FY 2020, the CMS informed the CNMI Medicaid program that the allocation would be $6.85 million for the Medical Assistance Program and $11.20 for the Children's Health Insurance Program. The gap between the FY 2020 allocation and the 2018 Medicaid expenditures, including Accounts Payables, is about $42.27 Million. Again, this staggering amount for the CNMI does not include the 2019 Accounts Payable IBNR that is currently accruing.

3. Could you please provide the Committee actual examples of how the current statutory FMAP of 55% affects the provision of healthcare in the Northern Mariana Islands?

The following are two very specific examples of how the FMAP affects the provision of healthcare in the CNMI Medicaid program. At the same time, please keep in mind that without the lifting of the Medicaid Section 1108 caps, the total amount required will not even be available.

First, the Statutory FMAP of 55-45% affects the provision of healthcare is illustrated by two facts. Fact 1 - the CNMI Legislature has never appropriated sufficient general fund appropriations to match the federal expenditures at the 55-45% level. This helps to explain the IBNR Accounts Payables of $18 million. The IBNR AP amount is for private providers.

If the CNMI did not implement the Certified Public Expenditure (CPE) payment methodology that uses the public expenditures of the Commonwealth Healthcare Corporation, a public corporation, as the CNMI match for both inpatient and outpatient services, then, the *CNMI would NOT have been able to even expend the amounts provided by the ACA* and the optional services would have had to be severely curtain.

Fortunately, the CNMI Medicaid program elected in 2012 to implement the CPE methodology. The federal share based on the CPE payment methodology is calculated by the Centers for Medicare and Medicaid Services (CMS) each year. As a result of the use of the CPE methodology, the CNMI was able to expend the much-needed amounts provided under the ACA for the CHCC; and, as the CHCC testified, was instrumental in helping the CHCC to make improvements. Unfortunately, at the same time, the use of the CPE essentially means that the CHCC did not receive the 45% in the local match. Nonetheless, the CHCC health system has made substantial improvements over the years due to the increased amount under the ACA.

A second example of how the FMAP is a barrier is with payments to private providers. The CNMI government has not appropriated sufficient funds based on the inequitable FMAP requirements of a 45% CNMI share. As described above, this led to the CNMI to use the CPE methodology for payments to the CHCC. But, for the other providers, the inability of the CNMI government to fund the 45% share of the artificial FMAP has resulted in Incurred But Not Reported (IBNR) Accounts Payables of $18 million at the end of FY 2018.

The CNMI Medicaid program, as with all other states and territories, absolutely must match the federal funds that are provided for Medicaid program based on the FMAP. However, since the CNMI Government has not been able to appropriate the full matching requirements needed, the CNMI Medicaid program must defer payments to Private Providers because of the inability of the CNMI to provide a 45% match. This results in the IBNR Accounts Payables. The same problem has occurred in other territories.

If both the Section 1108 and FMAP inequities are corrected, then, the CNMI would be able to pay the non-CHCC providers in a far more timely manner since payments to private providers must be deferred until matching funds are available. This has led many Medicaid providers, especially specialist off-island providers, to stop providing services for the CNMI Medicaid population.