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

U.S. House of Representatives Committee on Energy and Commerce Committee
Hearing on the Strengthening
Health Care in the U.S. Territories for Today and Into the Future

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

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Honorable Chairman Frank Pallone; Ranking Member Greg Walden of the Committee on Energy and Commerce and Subcommittee on Health; Chairwoman Anna Eschoo and Ranking Member Michael C. Burgess of the Subcommittee on Health; and Members of the United States House of Representatives

Thank you so very much for holding a hearing on the Health Care in the U.S. Territories for Today and Into the Future. We are very *heartened* that the Committee of Jurisdiction over the Medicaid program is having this hearing and that Chairman Pallone has accurately recognized that the U.S. Territories "are on the verge of a humanitarian and financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for next year and beyond."

The Commonwealth of the Northern Mariana Islands (CNMI) is indeed on the verge of a humanitarian health, health care system, and financial crisis and I would like to share with you the nature, urgency, and impacts that the "Medicaid Fiscal Cliff" will have on the U.S. citizens and the health care system of the CNMI. I will do my best to explain the nature of the Medicaid Fiscal Cliff and its critical role in the health care of the Territory today and tomorrow. I have directly incorporated into this testimony, parts of the testimony provided to the Committee on Natural Resources.

Before proceeding, however, I would like to express our very deepest appreciation for the passage and enactment of HR 2157 that provides Medicaid Disaster Assistance for the CNMI. As many of you are aware, the CNMI was devasted by Super Typhoon Yutu, a Category 5, on October 25, 2018, leading to a Presidential Disaster Declaration. While recovery efforts were initiated, a slower onset disaster was in the making.

Throughout 2018, the CNMI was sliding to the Medicaid Fiscal Cliff where temporary funding for the Medicaid Program in the Territories would end in FY 2019. In March 2019, the CNMI Medicaid program reached and fell off of the Medicaid Fiscal Cliff with the complete exhaustion of Medicaid funds from Section 1108 of Title XIX, temporary increases in Medicaid funding for the Territories provided by the Affordable Care Act, and the small amount from Section 1323 of the ACA made available because the CNMI did not elect to develop a Health Insurance Exchange. We were in a free fall toward catastrophe.

Fortunately, with the passage of HR 2157 by Congress, the CNMI, landed on a Ledge. The Ledge of the Medicaid Cliff is tenuous and will crumble on September 30 of this year; and, without intervention from the U.S. Congress, the CNMI will plunge into a humanitarian and fiscal crisis. The U.S. citizens of the

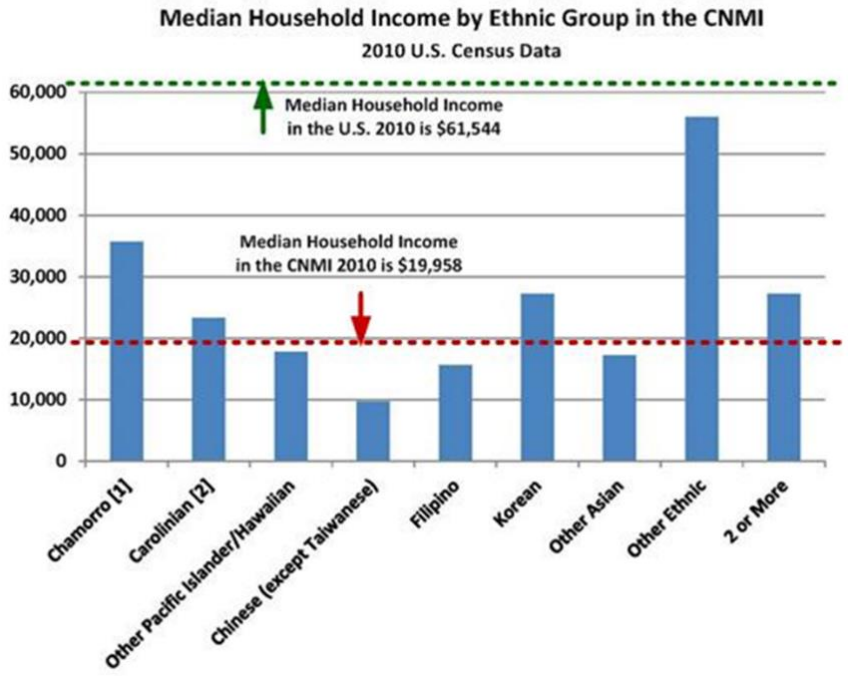
CNMI Medicaid program are huddling on the ledge today, hopeful that the U.S. Congress will reveal and provide a path up the cliff, and enable Territories to avert falling into the crisis. The CNMI Medicaid program is critical to the health of the U.S. citizen Medicaid beneficiaries and the health system of the CNMI for today and into the future.

BASIC INFORMATION ON THE CNMI AND MEDICAID

There are 16,206 U.S. citizen beneficiaries enrolled in the Medicaid and CHIP programs today. The percentage of U.S. citizens in the Territory is estimated 61.6% or 33,196 of the total population of 53,890 in the CNMI.[1] This means that Medicaid and CHIP provides critical healthcare services for about 49% of the total U.S. citizens in the CNMI today.

In 2010, the U.S. Census provided data on the per-family median income in the United States. Figure 1, below, shows that the median income for a family of four in the CNMI was $19,958, in comparison to the median family income of $61,544 for the United States.[2] Figure 1 also shows the income disparities among the ethnic groups in the CNMI. The income disparities among the indigenous Chamorros, Carolinians, and "Other," principally Caucasian populations, when compared to the Asian populations are even more stark but important to note since they are principally non-U.S. and because of their income levels, constitute the vast majority of the uninsured population in the CNMI.

Figure 1 – Median Household Income from the U.S. Census from the CNMI State Innovation Model Plan



As a result of the low-income levels in the CNMI, there should be no surprise that 49% of the eligible U.S. Citizens in the CNMI are enrolled in the Medicaid program. In 2016, the overall uninsured rate was

[1] 2016 CNMI CSD Household Income and Expenditures Survey. http://commerce.gov.mp/hies-2016-population
[2] 2010 U.S. Census.

estimated to be 34% of adults.[3] The 20% of the population that have private health insurance include the government employees which account for about 10% of the population.[4]

Further, the CNMI Medicaid program foresees that more will soon be huddled on the ledge. Just this month, following the losses of Government revenue given Typhoon Yutu, the CNMI Government instituted "austerity" measures. Specifically, government employees have been placed on a 4-day work week. The CNMI Government further restricted funding allocations of the Public School System (PSS). The PSS, in turn, is rolling back salaries and benefits. Given the pay scale of many of the employees that are affected, the Medicaid program foresees enrollment increases, the full extent cannot be known today.

THE MEDICAID FISCAL CLIFF IN THE CNMI

For many years since becoming a U.S. Territory in 1978 and participant in the Medicaid program since 1979, the CNMI has had to struggle with artificial Section 1108 budget caps under Title XIX and an artificial Federal Medical Assistance Percentage (FMAP). The Section 1108 budget cap for the CNMI Medical Assistance Program rose to only *$4.964 million for FY 2012* and the FMAP was statutorily adjusted through the ACA to 55%.

In 2010, Section 2005 of the Affordable Care Act (ACA) recognized the inadequacy of the funds to improve health care for the Medicaid beneficiaries and provided some much-needed relief by temporarily adding to the Section 1108 budget cap an additional amount of $100.14 million to be used from 2011 to 2019 for the CNMI and an additional $9.11 million under Section 1323 that would be available only after the Section 1108 budget caps and Section 2005 ACA increases were expended.[5] Additionally, as noted, the Federal Medical Assistance Percentage (FMAP) for the Territories was also permanently increased to 55% through the ACA in 2012.

The Base Section 1108 funding for the CNMI in 2012 was $4.964 million. Hence, the Medicaid Program was limited in Eligibility and Benefits. The increase provided under the ACA enabled the CNMI Medicaid Program to increase eligibility, deliver on Mandatory Medicaid services throughout these years, and to implement additional "Optional" services under the Medicaid program. The temporary funds under the ACA will end for the Territories on September 30, 2019.

For the CNMI, the temporary increases under the ACA were exhausted at the end of March 2019 and did not last to September 30, 2019. At the end of March, all Medicaid Medical Assistance Program (MAP) and temporary increases under Section 2005 of the ACA were completely exhausted, including the Section 1323 funding of the ACA made available because the CNMI elected not to implement a Health Insurance Exchange (HIE).

THE GAP BETWEEN EXPENSES AND THE SECTION 1108 BUDGET CAPS IN FY 2020

The CNMI will fall off of the Ledge of the Medicaid Fiscal Cliff for FY 2020 without Congressional action. For FY 2020, the Centers for Medicare and Medicaid Services (CMS) has informed the CNMI that the Section 1108 Budget cap for FY 2020 will be $6.85 million, the Children's Health Insurance Program will be $11.2 million, and the amount of the Enhanced Allotment Program will be $195,318. These amounts are completely inadequate to support the current Medicaid Program services in FY 2020.

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[3] 2016 Non-Communicable Diseases Risk Factor and Hybrid Survey. In 2016, the CHCC NCD Bureau conducted the Non-Communicable Diseases Risk Factor and Hybrid Survey was the first population-based, household survey to measure prevalence of non-communicable diseases and related risk factors in the CNMI.

[4] *Note*. Data sources are disparate and much of the data is extrapolated from multiple data sources.

[5] MACPAC. *When will the Territories Exhaust Federal Medicaid Funding?* (May 2019) https://www.macpac.gov/wp-content/uploads/2019/05/When-will-the-territories-exhaust-federal-Medicaid-funding.pdf

To show the *magnitude of the inadequacy*, Table 1, below, shows the Medicaid program expenditures and Accounts Payables at the end of FY 2018 and illustrates the FY 2019 estimated spending and shortfalls. This shortfall includes the $36 million to be received in Medicaid Disaster Assistance.

Table 1 – Summary of FY 2018 Expenditures and Accounts Payables 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	$6.17
FY 2019 CHIP Program Allocation	$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
FY 2019 Enhanced Allotment Program	$0.18
Total Federal and CNMI Medicaid Funds for 2019	**$29.02**
FY 2019 Projected Shortfall Given 2018 Expenditures and APs or Disaster Assistance Needed Based on 2018 Actual Expenditures and Unbooked IBNR	**$42.40**
Amount appropriated under HR 2157 signed into law	$36.00
Estimated FY 2019 Shortfall with $36 Million provided for Disaster Assistance and does not include additional AP accumulating.	$6.40

*Note numbers may not add up due to rounding.

Table 1 clearly shows the gap between the Section 1108 and CHIP funding when compared to 2018 Medicaid expenditures and Accounts Payable Incurred But Not Reported (IBNR). Further, for FY 2019, even with the additional funding provided by the much welcomed and needed HR 2157 disaster relief for FY 2019, the CNMI Medicaid will carry forward into FY 2020 an additional balance that cannot be estimated at this time.

There is much to be learned from this comparison. One lesson is that CMS provided to Congress the estimate of $36 million that was needed for the remainder of the current FY 2019. The CMS is very knowledgeable of the financial situation because the financial reporting required of the CNMI and because CMS releases the allotments for all Medicaid funding sources. The Disaster Assistance was provided at 100% FMAP. However, even if the additional amount of $36 million were to be provided at the current 55% FMAP or $19.8 million then, the total difference for the FY2019 would be $19.8 million plus the already expended amounts of $13.8 million or a total of $33.6 million as of September 30, 2019.

The FY 2020 Fall Off the Ledge of the Medicaid Fiscal Cliff

The CMS has informed the CNMI that for FY 2020, the Section 1108 Cap will be $6.85 million, CHIP budget will be $11.20 million, and the Enhanced Allotment Plan (EAP) will be $195,318 for a total of $18.24 million.

Table 2 projects the FY 2020 shortfall through a comparison of the FY 2018 Medicaid Expenses and Accounts Payables. The Table shows the shortfall to be approximately $42.40 million, even with a commitment of CNMI share at $5.46 million, the amount currently under consideration by the CNMI Legislature due to the financial shortfalls following Typhoon Yutu.

Table 2 – Summary of FY 2018 Expenditures and Accounts Payables and FY 2020 Shortfall Given the End of Additional Funding under the ACA

FY 2020 Allocation Provided by CMS	In Millions*
FY 2020 Section 1108 Allocation	$6.85
FY 2020 CHIP Allocation	$11.20
FY 2020 Enhanced Allotment Plan	$0.19
Total FY 2020 Allocation by CMS	**$18.24**

FY 2020 CNMI Proposed Budget Currently Under Consideration	**$5.46**
Total Federal MAP and CNMI Medicaid Funds for 2019	**$29.02**
FY 2018 Expenditures and Accounts Payables (AP) Incurred But Not Booked (IBNR)	**$71.42**
FY 2020 Medicaid Shortfall	**$42.40**

*Note: the numbers may not add up due to rounding.

THE UNDERLYING CAUSES OF THE MEDICAID FISCAL CLIFF

The Medicaid Fiscal Cliff for the U.S. Territories exists because of the differences in the financing of the Medicaid program between the States and Territories and requires Congress to resolve the inequities.

The two primary statutory inequities between the States and Territories: are the Section 1108 Budget caps under Title XIX and the Federal Medical Assistance Percentage (FMAP). The nature of these differences and impact on the Medicaid program in the Territories is well understood by agencies of the U.S Government and the nonprofit organizations that study health care such as the Medicaid and CHIP Payment and Access Commission (MACPAC), Congressional Research Service (CRS), and Kaiser Family Foundation (KFF), among many others.

The following is a brief summary of these two issues and examples of how this impacts the Medicaid Program in the CNMI and other Territories.

1. Section 1108 of Title XIX

The Section 1108 of Title XIX *establishes budgetary caps* for the Medicaid program for the Territories. In contrast, the States are provided federal funds based on the cost of Medicaid mandatory and optional benefits that are statutorily enabled, proposed by States and Territories through a Medicaid State Plan (Amendment), and reviewed and approved by the Centers for Medicare and Medicaid Services (CMS).

The Section 1108 budget caps were established decades ago and as described by MACPAC are tied to the Consumer Price Index (CPI).[5] MACPAC observes that the CPI has not kept up with Medicaid spending. More important, the amounts were established when the program only provided assistance for the aged, blind, disabled, and Aid for Families with Dependent Children. This is completely inadequate as demonstrated by estimated requirements of an additional $36 million for the Medicaid Disaster Assistance for the last six (6) months of FY 2019.

So, how does this impact the Medicaid Program in the Territories?

Example of an Optional Service under Medicaid

The Medicaid Program has a Mandatory and Optional set of services. Now, if a State wanted to elect providing an Optional service, subject to CMS approval, the State would get an automatic increase in the funding and the State would have to finance the increased State share.

However, if the CNMI, as a Territory, wanted to implement an "Optional" Medicaid service, the cost of the Optional service would need to be accommodated within the existing Section 1108 budget cap. There would be no increase in Federal funding under the Section 1108 Budget caps under Title XIX, even though the Optional Services exists in law and regulation for all States and Territories.

Medications – An Optional Service

The following is an example. Under the Medicaid program, "Medications" for beneficiaries are an "Optional" and not "Mandatory" program service.

Everyone understands the importance of medications in health care and the continuously increasing and high costs of drugs. Further, we all understand, the importance of medications and the severe detriment for low-income beneficiaries with chronic diseases such as diabetes who are unable to get insulin and other medications. The same is true for Medicaid beneficiaries with or at risk of cardiovascular disease who are unable to obtain medications such as statins that are well-proven to lessen the risk of heart attacks and stroke.

Without medication these beneficiaries are left in vulnerable situations in the short and long-run for the health of these individuals; and, ultimately it will cost the health system even more in health care spending.

The good news is that all States provide for Medicaid drug coverage in their programs and so does the CNMI, today. However, the bad news is that the CNMI Medicaid program has been, and will continue to be, deliberating whether medications will be covered in FY 2020 if the CNMI has to live with only the Section 1108 budget caps. The reason is that the CNMI will have to prioritize the services provided by the Commonwealth Healthcare Corporation, a public safety-net health care system or the many mandatory services. The CNMI CHCC health system includes a sole community hospital, ancillary clinics, ancillary services (e.g., pharmacy, laboratory, radiology), and clinics on the remote islands of Tinian and Rota. There are also private providers, including many off-island providers. However, if the CNMI Medicaid program prioritizes payments to the CHCC, then, there will not be sufficient funding for private providers or medication benefits. The short and long-term consequences are clear and do not need further description here.

CNMI was able to support some important Optional benefits such as medications because of the increased funding under the ACA. However, the increase has been exhausted and no further amounts are available today for FY 2020 that starts on October 1 of this year, a few months from now.

2. The Federal Medical Assistance Percentage or FMAP

The second major problem is the FMAP, the federal share of the Federal-State or Federal-Territory amounts for the Medicaid Mandatory and Optional benefits.[6] The calculation of the FMAP of expenditures for States is determined through a formula, as described by Congressional Research Service, "designed so that the federal government pays a larger portion of Medicaid costs in States with lower per capita incomes relative to the national average (and vice versa for States with higher per capita incomes)."[7]

Given the major income differences identified in Figure 1, it is intuitively clear that the FMAP for the CNMI, if calculated in the same way as the FMAP is calculated for States, would be closer to the statutory

[6] MACPAC. *Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands (March 2019).* https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Commonwealth-of-the-Northern-Mariana-Islands.pdf

[7] Congressional Research Service. *Medicaid's Federal Medical Assistance Percentage (FMAP) (April 2018).*

cap of 83% for the FMAP. Instead, the FMAP for the Territories is currently statutorily set to 55% Federal and 45% Territory share of Medicaid expenses.[8]

Impacts of the Artificial and Inequitable FMAP

Table 3, below, illustrates how the artificial FMAP of 55% requires the CNMI, as a Territory, to fund a substantially higher Territory Share than if the FMAP were to be calculated in the same way as States. Table 3 uses a total Medicaid Program expense of $50 million, a hypothetical round number close to the FY 2018 Actual Expenditures in Table 1.

Example 1 in Table 3 shows the current statutory FMAP for CNMI and all U.S. Territories. Example 2 uses an FMAP of 75% Federal and 25% State Share. The 75-25% share is very realistic given the CNMI income levels shown in Table 3.

Table 3 shows that for every $50 million in total Medicaid expenditures, the difference between the FMAP at 55% and 75% results in a $10 million difference.

Table 3 – Application of the FMAP and Implications for Federal-Territory Share

Federal Medical Assistance Percentage (FMAP) and CNMI Share		
Example 1 – Artificial FMAP	**FMAP**	**CNMI Share**
Statutory FMAP Set for Territories	**55%**	**45%**
2018 Medicaid Expenditures of $50,000,000	$27,500,000	$22,500,000
Example 2 – FMAP under State Formulas	**FMAP**	**CNMI Share**
FMAP Using Formula for States	**75%**	**25%**
2018 Medicaid Expenditures of $50,000,000	$37,500,000	$12,500,000

A $10 million difference represents 20% of the total hypothetical expense and highlight the substantial difference in the amount that the CNMI would have to fund. Hence, even with the lifting of the Section 1108 budget caps and applying the State Share FMAP formula to the CNMI, the CNMI will be challenged to meet the Territory Share. Nonetheless, it is equitable but would not remove the responsibility of a Territory from having to finance its fair State/Territory share. The CNMI actual direct expenditure for FY 2018 was $10.44 million. So, the CNMI would still need to find additional funding even if the FMAP were calculated the same as States.

Clearly, the FMAP for the Territories should be calculated the same as the States. Doing so would appropriately reflect the relative income and poverty levels equally between the States and Territories. Not doing so would place an unfair burden on the Territories that are more impoverished than all States.

Impacts on the U.S. Citizens in the Commonwealth of the Northern Mariana Islands

I have worked in the CNMI Medicaid Program since 1986, over 32 years ago. In 1998, I served as the Acting Medicaid Administrator and since 2000, as the Medicaid Administrator/Director for the CNMI Government. In all these years, I have never been more emotionally affected than I have been in the past year.

With the end of the additional funding provided under the Affordable Care Act, the inequitable Section 1108 budget caps under Title XIX, the inequitable FMAP, the chronic lack of local funding, the added financial challenges created by Typhoons Mangkut and Yutu, some of the very highest rates of Medicaid

[8] Section 2005 of the Patient Protection and Affordable Care Act.

and uninsured in the United States, and the many other challenges of distance, time, and costly air travel, I have had to lead an organization that is planning and executing Medicaid program cuts that will have both short and long-term harsh and life-threatening impacts on our U.S. citizen beneficiaries.

The CNMI Medicaid Program is in the process of ***severely curtailing services, limiting choice of providers in the program,*** and are making decisions knowing full well the adverse short and long-term consequences this will have on the U.S. citizens in the CNMI. It has been a very emotional and difficult time for our office to plan and implement decisions because we recognize and understand the impacts that this will have on the health of some of the most-needy people in the United States. Alternatively, the CNMI Medicaid Program may have to limit eligibility leaving those eliminated to become uninsured and further strain the CHCC public healthcare system.

I am frightened and saddened at each step in our undertaking because I understand the effects on our people and our health system. While we are doing our very best to determine what might be an intellectual exercise to balance the so-called "best interests" with "limited resources" – decisions regarding what services should be continued, what should be curtailed or dropped, and what providers can be paid, are and will continue to be made - we very clearly understand the consequences each decision will have on the health of the people that we serve and I am frightened for the short and long-term impacts that will occur. There is no escaping the fact that the CNMI is facing a humanitarian and fiscal crisis.

It is even more of an emotional toll because in our small Territory, we know many people that are Medicaid beneficiaries. We have relatives and friends through extended familial or community connections that are Medicaid beneficiaries. It is unavoidable that we, the Medicaid program, not see them at the grocery store, at churches, or the checkout clerk or the restaurant server, the laborer fixing roads, and everywhere else in the community. It is difficult not to know, as I see them, that decisions we are making in the Medicaid program are directly affecting their access to healthcare and the impacts that the lack of care will have on them, if not immediately, then, very certainly over the long-run.

It is very hard to explain to those that come to our office asking whether the health services that they are receiving will be cut. It is very hard to listen to their stories. What should we do with the patient that has been in an off-island hospital in another State that may be dying? How do we tell a patient, parents, and loved ones that we are sorry, but we will no longer help with their medical bills? It is impossible for me, not to see the faces of the people behind the numbers and the impacts that each decision will have.

The Impacts of the Medicaid Fiscal Cliff on the Health of U.S. Citizen Beneficiaries and the Health System in the CNMI

The additional temporary funding provided under the ACA enabled the CNMI to improve its Mandatory and Optional benefits and arrived in time to enable much needed improvements to the health care system in the CNMI. The additional funds that were provided under the ACA will end on September 30, 2019 for all of the Territories and are essential to the health care of the 16,206 Medicaid beneficiaries currently enrolled in the CNMI.

If Congress does not act, we believe that the 49% of the U.S. citizen population in the CNMI will become essentially <u>uninsured</u> shortly after the first quarter of FY 2020, unless the CNMI Medicaid program reserves all funds for the CHCC public corporation. The CNMI Medicaid Program has not made decisions on how the limited funds will be used and is consulting with CMS, the CHCC, Medicaid providers, and Medicaid beneficiaries. Any decision will have both short and long-term dire and devastating consequences for the health of the Medicaid beneficiaries and <u>have equally serious consequences for the health system</u> in the CNMI.

The situation is dire and desperate, and simply and directly a function of the fact that the Medicaid programs in the Territories are not treated the same as the States as well as the limited budgetary resources of the Territory; and, as a result, the U.S. citizens of CNMI will fall off the Medicaid Fiscal Health Cliff if the inequities are not addressed.

Impacts on the CNMI Government and the Safety Net Health System

The U.S. Government Accountability Office (GAO), about three months ago, had a teleconference with the CNMI Government and the Medicaid program. Specifically, they asked questions and requested information and insight into the impacts of the Medicaid Fiscal Cliff and its impacts on the general fiscal conditions of the CNMI government especially following the typhoons.

We explained how we have reached the point, where, without Medicaid Disaster Assistance or a lifting of the Section 1108 caps and an adjustment to the FMAP, the Medicaid program will add to the further debt burden of the CNMI unless the CNMI Medicaid program cuts or eliminates services including off-island care, dental services, and even drugs, and not pay the CHCC for the full amounts that the CMS has determined are appropriate to pay under the CPE methodology. We have been praying for another year of Medicaid Disaster Assistance funding and for the U.S. Government to lift the Section 1108 budget caps and let the FMAP be based on the same formula as other States.

The CNMI Medicaid program is planning severe cuts that will impact our U.S. citizens and damage our health system. However, without relief from the Section 1108 caps and an equitable FMAP, there is no other option. Further, for the record, the amounts will not be sufficient to fully pay the CHCC based on the amounts due from CMS calculations.

Impacts on the Commonwealth Healthcare Corporation

The CNMI Medicaid program is also very aware and worried with the impact the shortfalls will have on the safety-net health system of the CNMI. The CNMI has a unique public corporation that provides hospital, clinical, and public health services. It is a safety-net health system and has also been doing its best given its own challenges. Due to the chronic financial shortfalls and when the CNMI government austerity program reduced work hours for all government employees by 20% for 2 years, the Medicaid program, in 2012, proposed use of the Certified Public Expenditures (CPE) payment methodology because the CNMI Government simply did not have funds to provide the matching amounts. Unfortunately, this also means that the full Medicaid reimbursement has not been provided to the CHCC since the program took effect.

The CPE was proposed to the Centers for Medicare and Medicaid Services (CMS) as the only way that the Medicaid program could provide federal Medicaid funding because of the public expenditures by the CHCC. The CMS calculates the amounts based on its annual analysis of the Medicare Cost Reports submitted by the CHCC and conducts audits to reconcile these amounts.

Under the CPE methodology, the monthly payment for the CHCC, again, as determined by the CMS, is currently $1.64 million per month or $16.34 million per year. I point this out because the Medicaid MAP for 2019, based on the Section 1108 budgetary caps, the CNMI Medicaid program will barely compensate the CHCC public corporation for an amount that the *CMS determines should be paid*. Further, this would mean that all other expenses and services, including Medications, and many other basic Mandatory and Optional services would need to be curtailed. The CNMI Medicaid program will need to limit radiology read services (because we have no radiologist on island) or referrals for advanced MRI and CT studies, cancer care treatment, off-island surgeries that cannot be performed at the CHCC, and many others. The list is endless and dooms the U.S. citizens in the CNMI to substandard or no care. Clearly, this will lead to a humanitarian and fiscal crisis. What are we to do?

IMPROVING MEDICAID PROGRAM ADMINISTRATION

The CNMI is fully aware that the U.S. Territories of Puerto Rico and the U.S. Virgin Islands have recently implemented their Medicaid Enterprise Systems (MES) and further acknowledges that the U.S. Congress in HR 2157 requires American Samoa and Guam, two Pacific Territories, to initiate the planning for submitting data to T-MSIS and establishing a Medicaid Fraud Control Unit (MFCU). That would leave the CNMI as the only U.S. State or Territory that has not yet planned or implemented a Medicaid Management Information System (MMIS), submitting data to the Transformed Medicaid Statistical Information System (T-MSIS), and establishing a Medicaid Fraud Control Unit (MFCU).

The CNMI wishes to make clear that the Territory is well aware of and has wanted to implement an 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 has not yet initiated the planning and implementation of a full MMIS is based on the fact that if the increased funding under the Affordable Care Act ends, the CNMI Section 1108 budget cap, together with the CHIP funding, would only be around $18.24 million. Since the cost of implementing a MMIS, submitting data to T-MSIS, and initiating a data warehouse has cost the next smallest U.S. Territory $46 million, even with a partnership with another state, the question was whether committing to such an expense, given the small amounts of Section 1108 and CHIP funding of $18.24 million, made sense.

In 2017, the CNMI Medicaid Program directly asked this question in a meeting with CMS Region IX. We expressed the concern that the CNMI Medicaid program would become one of the highest proportional State or Territory in MMIS spending when compared to beneficiaries or any other metric of size. Further, the ongoing administrative costs for activities, even with the federal funding support would be significant expense for a small Territory. Even the CMS team agreed that the benefit/cost and effectiveness/cost of a full system, given the 1108 budget cap of $6.85 and $11.20 million for CHIP, may be an issue for the CMS national program officers.

At the same time, to be clear, the CNMI Medicaid program is fully committed to using healthcare data to improve data collection, management, and analysis of Medicaid claims data. As evidence of this commitment, the CNMI directs attention to two important low-cost activities over the past two years.

CMS Medicaid Innovation Accelerator Program (IAP)

First, the CNMI Medicaid program took a lead role in preparing and submitting an application to the CMS to participate in a Medicaid IAP focused on Medicaid and health care data collection, management, and analytics. The Medicaid IAP was offered on a competitive basis at no charge to both States and Territories. The CNMI Medicaid Program submitted the application with the Territory of Guam and was very fortunate to have been selected by the CMS as a participant in this program.

Following the first year of participation, the CMS IAP program, recognizing the need in the Territories, approved the participation in a second year of the CMS-sponsored IAP for CNMI and Guam.

CNMI Medicaid Claims Data Warehouse

Second, and as further demonstration, the CNMI Medicaid in 2017, following the meeting with Region IX in 2017, requested funding to move forward with preliminary planning for a Medicaid Claims Data Warehouse. At a minimum, the idea was that the CNMI would be able to collect the claims data file electronically and conduct data management with the intent of getting the process to ultimately result in transmitting data to the CMS T-MSIS system.

The CMS approved that request, together with the 90-10% funding, to initiate the planning for that effort. The CNMI Medicaid program explained the importance of this activity and a law was passed for matching funds to support the effort. However, we have had to temporarily delay the project because Typhoon Yutu, a Category 5 typhoon, arrived just at the time when the contractor was on island in October 2018 and the CNMI Medicaid program had to deal with the impending Medicaid Fiscal Cliff.

These activities demonstrate CNMI's commitment to more effectively administer the Medicaid program, even with the limited resources and the major challenges we confront on a daily basis to improve the program and serve our U.S. Citizen beneficiaries.

So, should the U.S. Congress treat the CNMI equally as States and increase its federal expenditures, the CNMI is fully prepared and already committed to make reasonable and appropriate progress to implement a MMIS, submit data to T-MSIS, establish a Medicaid Fraud Control program, and use data analytics to better assess and improve health care, population health, and lessen the costs of health care. The CNMI Medicaid program further believes that the CNMI policymakers would prioritize the required matching funds for Medicaid Enterprise Systems/MMIS/T-MSIS and Medicaid Fraud Control Unit activities, especially if statutorily required.

SUMMARY

The U.S. citizen Medicaid beneficiaries in the Commonwealth of the Northern Mariana Islands are clearly "on the verge of a humanitarian and financial crisis if Congress doesn't act swiftly to increase their Medicaid funding for next year and beyond." During FY 2020, the CNMI will not be able to fully support the Mandatory services; will need to institute reductions in the Optional services, including medications, as just one example.

The CNMI is in a desperate and dire situation; and, the U.S. citizens in the Northern Mariana Islands deserve equity in healthcare. Last year, I asked myself the questions: "How can we get national attention to the plight of the CNMI? And will people hear us?" The Committees on Energy and Commerce and Natural Resources have heard us and has provided an opportunity for our Territory to discuss the Medicaid Fiscal Cliff.

We are humbly pleading for the U.S. Congress to please help the Territories and treat the U.S. citizens of the U.S. Commonwealth of the Northern Mariana Islands equitably and avert the impending humanitarian and financial crisis. We sincerely appreciate that Congress provided Medicaid Disaster Assistance. We are hopeful that Congress will hear us once more and act to mitigate the negative impacts on the health of the Medicaid beneficiaries and the Health Care System in the CNMI.

Thank you once more for taking the time to hear this issue.