Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands

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United States House Committee on Natural Resources
"The Insular Areas Medicaid Cliff"
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Testimony of

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Chairman Grijalva, Vice Chairman Kilili, and distinguished Committee members, thank you for the opportunity to appear before you today to discuss an issue of significant importance to the Commonwealth of the Northern Mariana Islands (CNMI). On the heels of Super Typhoon Yutu, which devastated the CNMI economy and its people, we face another crisis-- our Medicaid program is unable to sustain its operations with the low statutory cap on federal contributions.[1] Low federal contributions, coupled with the exhaustion of PPACA funds this year, creates a fiscal cliff for our Medicaid program. This fiscal cliff threatens to unweave our substantial improvements over the past ten years in the delivery of health care, further erode our economy, and threaten the health and well-being of our people.

CNMI Medicaid Financing

The framework for Medicaid financing in the CNMI resembles that of the fifty states: the cost of the program (up to a point) is shared between the federal governmental and the Territory and the federal government pays a fixed percentage of CNMI Medicaid costs. For CNMI, that fixed percentage is 55 percent. However, unlike the 50 states, the federal government pays a *fixed* percentage of the CNMI Medicaid costs within a *fixed* amount of federal funding. Should CNMI Medicaid expenditures exceed the territory's federal Medicaid cap, the CNMI becomes responsible for 100 percent of Medicaid costs going forward.

Moreover, the CNMI receive a relatively low fixed percentage, which is known as the Federal Medical Assistance Percentage or FMAP.[1]

The FMAP rate for the CNMI is, and has been, lower than most of the 50 states. The formula by which FMAP is calculated for the 50 states is based on the average per capita income for each state relative to the national average. Thus, the poorer the state, the higher the FMAP is for that jurisdiction in a given year. However, due to statutory restrictions on Medicaid financing for the CNMI, the FMAP we receive is not based on per capita income of residents; subsequently, the territories' FMAP does not reflect the financial need of the CNMI in the same way as the states' financial need is reflected, and the FMAP rate for our territory remains largely stagnant.

[1] Section 1108 of the Social Security Act

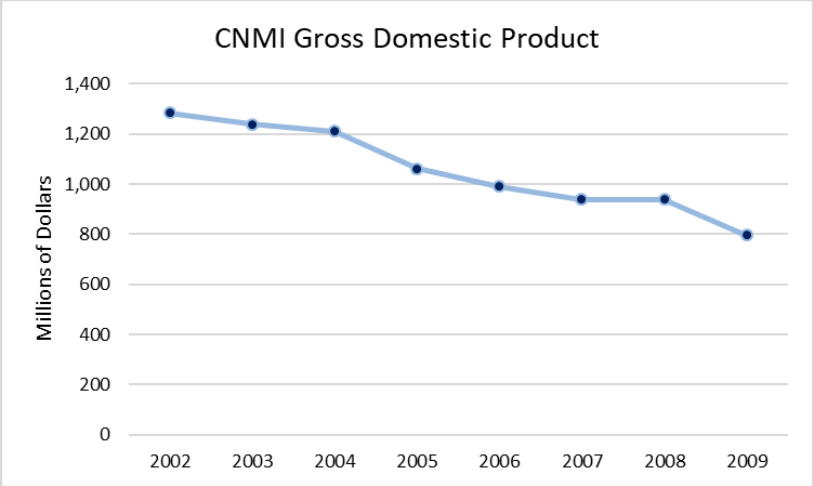
Thus, the CNMI is at a disadvantage in their Medicaid financings in two ways; 1) a low FMAP requires a territory to contribute more local funds than a state is required to provide in order to run a Medicaid program; and 2) a cap on federal Medicaid contributions stifles the overall ability of CNMI Medicaid to function.

CNMI Background

In 1975, voters of the Northern Mariana Islands chose to enter into a covenant that established the political union between the Northern Mariana Islands and the United States. The Covenant recognizes U.S. sovereignty but limits, in some respects, applicability of federal law. The Covenant established that the, "United States will assist the Government of the Northern Marianas to achieve a progressively higher standard of living for its people as part of the American economic community and to develop the economic resources needed to meet the financial responsibilities of local self-government.[2]"

From 2004 to 2007, the CNMI lost one-third of its economy.[3] This economic downfall was due largely to several concomitant U.S. federal and global policy shifts, including the lifting of quotas on garment exports to the US,[4] the imposition of the federal minimum wage,[5] and implementation of federal immigration authority in the territory.[6] Figure 1 demonstrates the severity of this economic spiral.

Figure 1 - CNMI Gross Domestic Product 2002-2009



Source: Bureau of Economic Analysis, U.S. Department of Commerce, Released October 17, 2018

The Inception of the Commonwealth Healthcare Corporation (CHCC)

In 1978, the CNMI Department of Public Health was formed under the executive branch of government. Over next thirty years it came to operate the sole territory hospital and emergency department, several outpatient clinics, a dialysis unit, ancillary services, behavioral health services, and all public health functions. In 2007, in the thick of the CNMI's economic collapse, the Department of Public Health began

[2] 48 U.S.C. § 1801 Article VII Section 701

[3] "Economic Impact of Federal Laws on The Commonwealth of The Northern Mariana Islands". October 2008. Malcolm D. McPhee & Associates and Dick Conway. https://marianaslabor.net/news/economic_impact.pdf

[4] The 1994 Uruguay Round Agreement on Textiles and Clothing called for the World Trade Organization (WTO) members to eliminate quotas on textiles and clothing by January of 2005. This meant the CNMI garment industry could no longer compete with cheap labor in countries such as China, Bangladesh, and the Philippines. (Source: Northern Mariana Islands Business Law Handbook: Strategic Information and Laws. International Business Publications, 2013.)

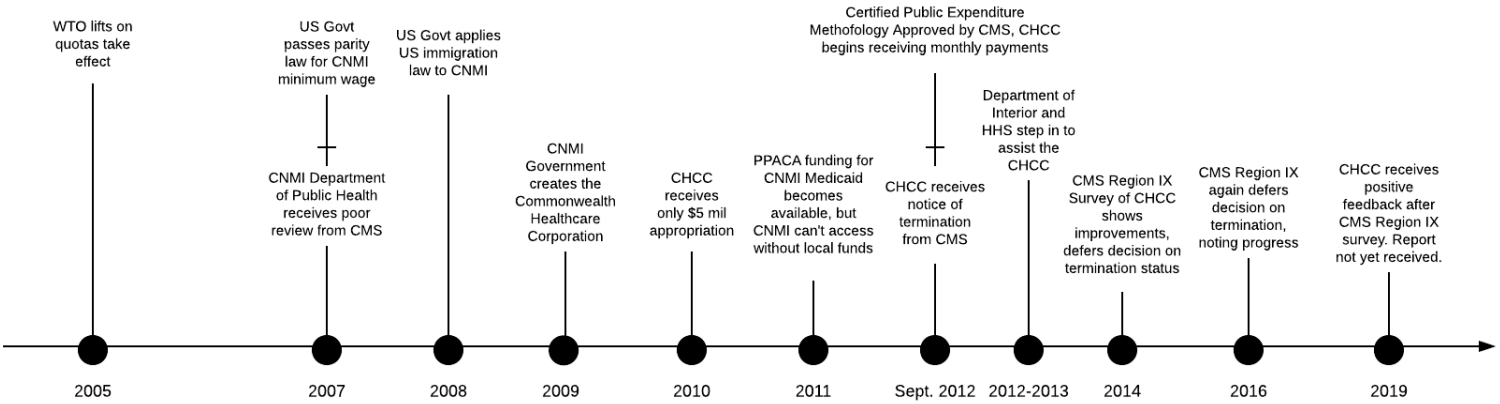
[5] On May 25, 2007, Congress enacted Public Law 110-28, increasing the minimum wage in the CNMI by fifty cents per hour. The act further increased the CNMI minimum wage by fifty cents per year until parity with the U.S. minimum wage was reached.

[6] On May 8, 2008, the president signed PL 110-229 applying the US immigration law to the CNMI.

experiencing financial shortfalls due to reduced government revenues, and struggled to stock adequate medical supplies, and recruit health care workers. At the CMS Region IX visit in 2007, surveyors identified many problems with the delivery of health care at the hospital, and cited several cases where harm and injury to patients was found to be imminent if immediate corrective actions were not implemented.

In FY 2009, the CNMI government appropriated roughly $31 million of local government resources (about 20% of the total budgetary resources identified for appropriation that year) to the CNMI Department of Public Health. In January of 2009, to conserve stagnant public funding improve efficiency, the CNMI government reformed its Department of Public Health into an autonomous government corporation, the Commonwealth Healthcare Corporation (CHCC).[7] The CHCC took over operations of the sole hospital, primary care services, dialysis services, disease surveillance, substance abuse, mental health, and all public health services. In 2010, in the face of dwindling revenues, the CNMI government slashed the budget for public health and health care service delivery. Only $5 million was appropriated to the newly established CHCC, and even this was not made available all at once.[8] For an operation that normally received a local government appropriation of $30-$40 million annually, with only $5 million for the newly established CHCC, it became known as the "baby born with no blanket". Figure 2 below demonstrates the series of events which have significantly impacted the delivery of health care in the CNMI.

Figure 2 – Factors Affecting the CNMI Public Health Care System 2005 to 2019



Several more visits were made by CMS surveyors, and it was clear that due to inadequate funding, the CHCC, was not meeting medical care standards, and was not meeting the needs of CNMI residents.

In July 2011, the federal government awarded a total of $7.3 billion in additional funds available across all five territory Medicaid programs under the Patient Protection and Affordable Care Act (PPACA), including an additional $100.1 million for the CNMI[9] from July 2011- September 2019. This meant the CNMI Medicaid program could receive an average of $11 million of federal funds beyond its statutory cap every year until the funds were scheduled to expire in September 2019. With the statutory federal cap for the CNMI Medicaid program typically around $6 to $7 million each year, these additional funds

[7] CNMI Public Law 16-51

[8] Special to the Saipan Tribune by former CHCC CEO Juan Nekai Babauta. August 07, 2018. https://www.saipantribune.com/index.php/the-struggles-of-chcc/

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

created an unprecedented opportunity to make improvements to delivery of health care services in the CNMI. This extra funding opportunity meant that the CHCC could rely on receiving reimbursement for seeing a higher volume of patients, and could expand services sustainably with improved financing streams through Medicaid. However, the local government still needed to come up with a local match of roughly $10 million each year to take full advantage of this opportunity and turn around the CNMI's failing system. In FY 2012, on the heels of deep economic recession, roughly $2.7 million was appropriated from local funds to cover the expenses of the CNMI Medicaid program, which meant the CNMI Medicaid Agency didn't have enough local funds to draw down the federal contribution in full. This meant the Medicaid Agency was not able to fulfill its obligations to the CHCC and to private medical providers, so payments to private providers were prioritized.

CHCC and the CNMI Medicaid program proposed a Certified Public Expenditure reimbursement methodology to CMS, otherwise known as CPE. The CPE methodology meant that the CHCC's expenditures, as a public entity, would contribute to the local government's match. This meant that although the CHCC would not receive a 100% reimbursement on claims submitted to Medicaid, it would at least receive the federal share of the reimbursement at 55%. The CPE methodology is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider (e.g., public hospital), incurs an expenditure eligible for Federal Financial Participation (FFP) under the state's approved Medicaid state plan. The governmental entity (CHCC) certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service. The CPE methodology was approved by CMS in 2012; the federal match that the CPE permitted improved financial stressors at CHCC almost immediately.

However, the same month this new funding methodology was implemented, in September 2012, CMS issued a notice of termination to the CHCC for not meeting the standards of care required as conditions of participation in the Medicare. This meant the CHCC was at serious risk of losing all Medicaid and Medicare funding.

The 2012 notice of termination prompted the Department of Interior and the U.S. Department of Health & Human Services to deploy several U.S.P.H.S. Commissioned Corps Personnel with expertise in internal medicine, pharmacy, pediatric medicine, laboratory services and nursing to assist the hospital in complying with the standards of care.

The federal reimbursement opportunities available due to the newly established CPE methodology coupled with support received from HHS in response to the CHCC's notice of termination from CMS, enabled the CHCC to make the corrections necessary to meet the standards of care required as conditions of participation by CMS regulations. A 2014 CMS survey found numerous improvements; and another survey which took place just a few months ago demonstrated maintenance of these corrections and even further advancement.

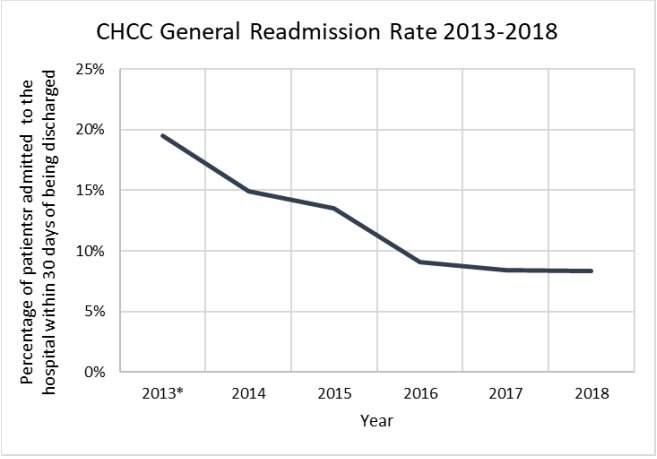
Exceeding Expectations

In 2008, the CNMI Department of Public Health generated roughly $15 million in revenue.[10] In 2018, the CHCC generated nearly four times that amount at $56 million. Since 2011, we've implemented an electronic health records system, a quality assurance unit, an outpatient pharmacy, sustainable telemedicine services, have tripled our medical staff, added specialty services such as podiatry, ENT,

[10] "Finance: Public Health Generates only $15M Annually". August 13, 2008. Marianas Variety. http://www.mvariety.com/cnmi/cnmi-news/local/9257-finance-public-health-generates-only-15m-annually-

orthopedic surgery, and, as of this month, oncology. We have maintained the only CLIA-certified laboratory in the territory, and renovated our inpatient pharmacy to be compliant with new compounding standards more than a year ahead of schedule[11]. Clinic visits have nearly doubled since 2013, and earlier this year, clinic hours were expanded to accommodate a greater volume of patients. We have improved patient care outcomes and significantly reduced hospital readmission rates by developing a discharge planning process which includes the unpaid caregivers of patients (See figure 3). During this same period, we weathered two of the worst storms in US history,[12] avoiding any interruption to our inpatient and emergency departments, and getting other services such as dialysis, primary care up and running within 48 hours of each storm. Beyond maintaining services through these disasters, the CHCC was also able to provide medical outreach, disease surveillance of local shelters, and conduct post-disaster rapid community health assessments. Providing these services was possible because of the reliable monthly reimbursements from Medicaid which protected the CHCC's cashflow.

Figure 3 – CHCC Readmission Improvement



*Data is only available for October through December of 2013
Source: CHCC Corporate Quality and Performance Management (CQPM)

Dependence on Medicaid Funds

In FY 2018, Medicaid reimbursements made up almost one half (49%) of all third-party payor reimbursements to the CHCC and about thirty percent of CHCC's total revenues (about $17.3 million). This high proportion exists even though the CHCC only receives a fifty-five percent reimbursement[13] from Medicaid, and is not eligible for supplemental Medicaid payments, such as Disproportionate Share Hospital (DSH) payments or Critical Access Hospital designation on the remote islands because of its location in a U.S. territory.[14] Furthermore, because the CHCC is located in a U.S territory, the CHCC's hospital is not eligible for other programs designed to assist rural hospitals serving low-income populations, such as the Medicare EHR incentive program, and the 340B drug discount program.[15] As the

[11] USP 797 and USP 800 are updated standards for the compounding intravenous drugs. The deadline to meet these standards

[12] Typhoon Soudelor in August 2015 was a category 4 typhoon, while typhoon Yutu in October of 2018 was classified as a category 5 super typhoon.

[13] CHCC services, including outpatient pharmacy, dental clinic, Tinian Health Center, and Rota Health Center are billed outside of the CPE methodology and reimbursed at the regular Medicaid Assistance Program. The 55% reimbursement represents the federal share of the CNMI Medicaid program funding.

[14] Section 1886(d) of the Social Security defines eligible hospitals as being located in one of the fifty States or District of Columbia.

[15] Although several public health programs in the CNMI are able to use the 340B drug discount program tied to their grant funding, the CNMI hospital and its outpatient clinics are not eligible because of the territories' exclusion from section 1886 of the Social Security Act. In April 2019, Governor Torres requested assistance from Secretary Alex Azar to consider including rural health systems of the territories in designations such as sole community hospital and disproportionate share hospital. This request letter is attached to this testimony.

sole hospital service provider, the CHCC provides one hundred percent of on-island inpatient and emergency care to CNMI Medicaid beneficiaries, and provides far more outpatient visits to Medicaid beneficiaries than any other provider in the CNMI.

Therefore, the operation of the CHCC is highly dependent on Medicaid's ability to pay for services, especially given that 28% of the CNMI population relies on Medicaid[16] to access health care services, approximately 34% of the total population were uninsured in 2010,[17] and an estimated forty-six (46%) percent of CNMI adults didn't have any form of health insurance coverage in 2016.[18]

Fifty-two percent of CNMI residents, it must be noted, live on incomes at or below the Federal Poverty Level[19], and the median household income for CNMI families was less than half of the U.S. nationwide median household income in 2010. Despite the high poverty rate, many CNMI residents don't qualify for Medicaid coverage because they do not hold the necessary permanent resident status to be eligible.[12]

Employer-sponsored insurance is not a requirement for any class of employee in the CNMI, and individual health insurance plans are not available from private insurance companies operating in the CNMI.[20]

Impact of Additional ACA Funding on CMNI and CHCC

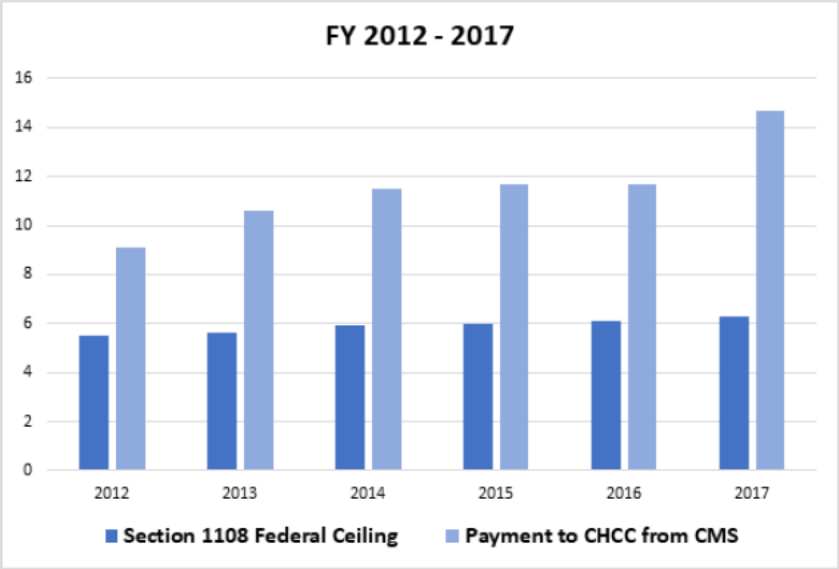
We are deeply grateful that Congress took the steps to provide additional resources to the CMNI Medicaid program through the ACA. This funding has been critical to expand services on the island such as enabled to expanding services, establish new ones such as ENT, podiatry, orthopedic surgery, and oncology, reducing patient readmissions, and increasing access to primary care. Outpatient visits at the CHCC's Saipan clinics have steadily increased by more than 50% in just three years from 2013 to 2017 (See Figure 5). Earlier this year, the adult clinic hours needed to be expanded to evenings and Saturdays to accommodate the growing patient demand. In 2018 alone, the adult clinic added psychiatry, podiatry and otolaryngologist services, further improving access to on-island care, but also increasing the number of patient visits.

The additional ACA funding for the territories expires at the end of September 2019. If no action is taken by U.S. Congress to cushion the free fall from the Medicaid fiscal cliff for the CNMI, the CHCC would not be able to continue to sustain the range of services from inpatient care, primary care, dialysis, behavioral health services, laboratory, pharmacy, and many public health services that it makes available to all CNMI residents today. This would impact all health services as personnel at the CHCC may need to be drastically cut, leaving residents to either forego the care they need, or seek care off-island, possibly becoming Medicaid beneficiaries of other states or territories such as Guam. For most island residents, off-island care is not a viable option due to the cost of travel and services.

Figure 4 demonstrates how thoroughly the CNMI has utilized Section 2005 Patient Protection and Affordable Care Act (PPACA) funds. A return to the federal statutory cap would not cover even half of what is needed to deliver the health care services needed by our population.

[16] CNMI Medicaid Program Enrollment Data 2018
[17] 2010 Census
[18] 2016 CNMI Non-Communicable Disease and Risk Factor Hybrid Survey
[19] 2010 Census
[20] The majority of the Patient Protection and Affordable Care Act health insurance market reforms and health insurance mandates do not apply to the CNMI as a U.S. territory.

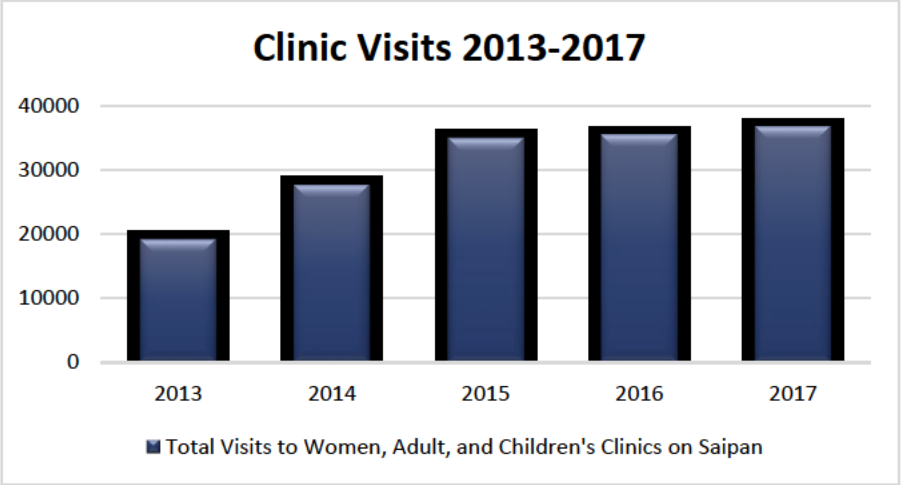
Figure 4 – CMS Payments to CHCC Compared with Section 1108 Cap on Federal Funds to the CNMI Medicaid Program



Section 1108 Federal Ceiling Amounts taken from "Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands" March 2019 document published by MACPAC found here https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-the-Commonwealth-of-the-Northern-Mariana-Islands.pdf Data on payment to CHCC from CMS is from CHCC Financial Records.

Earlier this month, our Medicaid program announced that it had exhausted all federal and local funds for the program amid deep CNMI government budget cuts.[21] As a result, the CNMI Medicaid program has chosen to divert Medicaid beneficiaries to the CHCC for all outpatient care in order to maximize the savings for the local government through the CPE methodology. This means that the maximum amount of Medicaid funding will be channeled to the CHCC, the only public health care services and safety net provider. Although this will help the CHCC to maintain its operations, as Figure 4 demonstrates, even this strategy will not keep the CHCC operating at the level it is today, much less keep moving us forward.

Figure 5 – Outpatient Clinic Visits at CHCC Facility on Saipan



Source: CHCC Resource and Patient Management System (RPMS)

[21] "Starting June 1, NMI Medicaid will no longer reimburse private health providers" May 16, 2019. Lori Lyn C. Lirio. http://www.mvariety.com/cnmi/cnmi-news/local/112741-starting-june-1-nmi-medicaid-will-no-longer-reimburse-private-health-providers

Super Typhoon Yutu, which tore through the CNMI in October 2018, brought the CNMI's tourism industry to a stand-still for several months, and devastated many local businesses and residents. Two deaths were attributed to typhoon Yutu, and although fortunately there were no major disease outbreaks, many residents found it difficult to maintain their regimens for chronic disease care during the recovery months after the disaster. The CNMI government is in no position to make up the significant financing shortfall caused by the depletion of section 2005 funds. U.S. Congress must act to increase or eliminate the CNMI's section 1108 cap on federal contributions.

Without continued additional federal support of the CNMI Medicaid program, services will be eliminated, and doctors and nurses will once again leave the island thereby threatening our CMS accreditation. In order to remain compliant with CMS, ensuring patient safety and quality services while maintaining the ongoing operations of the sole hospital service on the island, we would need to make the hard decision to prioritize urgent care needs at the expense of preventive and primary care services.

Although the CHCC offers a sliding fee discount for patients who live on low incomes and don't have health insurance, this program is unfunded, and is primarily a means to reduce barriers to care. The CHCC provided roughly $18 million uncompensated care to uninsured patients in the FY 2018, and about $4 million in charity care under the sliding fee discount program. If the CNMI Medicaid program is unable to pay for services for the Medicaid beneficiaries, then, the CHCC, as the safety-net provider, will bear an even larger burden of uncompensated and charity care, making operations even more difficult to sustain. This will affect any resident of CNMI who requires any form of health care services, not only Medicaid beneficiaries. An investment in the CNMI Medicaid program is an investment in the CNMI economy.

Looking forward

The CHCC has many plans for further improvements to our health care system, but without greater certainty that Medicaid will be able to reimburse for services, these plans may need to be put on hold. Our plans for future enhancements include:

- Expanding telemedicine services, including, but not limited to, telepharmacy and teledentistry on the smaller islands of Tinian and Rota.
- Improving care efficiency by adopting the Patient-Centered Medical Home models at our outpatient clinics.
- Transforming our clinics on the islands of Tinian and Rota into Federally-Qualified Health Centers (FQHCs).
- Constructing a new 40,000+ sq. ft. outpatient facility to accommodate a greater range of services and higher patient capacity, including an outpatient chemotherapy center, and Skilled Nursing Facility.
- Expanding the sole hospital, which was built in 1986 to accommodate a population of fewer than 20,000 people. Today, the CNMI population is nearly three times this size, but the hospital has undergone very little renovation. These plans include expanding the emergency and radiology departments to more than double their current size, and expanding other units of the hospital such as the operating room, laboratory, labor and delivery ward, and intensive care units.
- Investing in photo-voltaic energy generation to improve self-sufficiency and mitigate interruption to hospital services by storm damage to the CNMI's electricity infrastructure.
- Building the first ever comprehensive cancer center in the CNMI.

- Investing in local students who pursue medicine, nursing, pharmacy, and behavioral and public health to build a strong and diverse health care workforce. We are committed to bringing health workers back home, but we need a financially stable health system to do that.
- Bringing value-based services using population health models and eliminate fee for service models that are paid by volume.
- Working with Medicaid to identify cost-saving opportunities to control costs in the program.
- Offering sustainable and innovative health care services in the CNMI.