Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands

The Commonwealth of the Northern Mariana Islands (CNMI) became a U.S. territory in 1978 and began participating in Medicaid in 1979 (CMS 2016a). The Medicaid program is administered by the Office of the Governor after moving from the Department of Public Health in 2012 (CMS 2012c).

For the purposes of Medicaid and the State Children’s Health Insurance Program (CHIP), CNMI is considered a state unless otherwise indicated (§ 1101(a)(1) of the Social Security Act (the Act)). However, the territory has a Section 1902(j) waiver, which allows its Medicaid and CHIP programs to operate differently than programs in the states and the District of Columbia (§ 1902(j) of the Act). Under this waiver, the Secretary of the U.S. Department of Health and Human Services may waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the federal medical assistance percentage (FMAP), and the requirement that payment can only be for services otherwise coverable by Medicaid (§ 1902(j) of the Act).

This fact sheet summarizes the main requirements and design features of CNMI’s Medicaid and CHIP programs, including eligibility and enrollment, benefits, financing and spending, data and reporting, and quality and program integrity.

**Eligibility and Enrollment**

Eligibility for Medicaid is tied to income and resource requirements for Supplemental Security Income (SSI). Individuals receiving SSI cash benefits are automatically eligible for Medicaid. Medicaid also covers individuals who meet up to 150 percent of the income and resource requirements for SSI but who are not necessarily disabled (CMS 2016a). After exemptions and deductions are applied, this translates to a monthly income of $1,735.5 and assets of $4,500 for a couple (SSA 2018). The Commonwealth allows a medically needy spend down for residents whose income is in excess of the established limits (CMS 2017).

CNMI uses CHIP funds as an additional source of funding for children in Medicaid, but does not offer coverage to children whose incomes are above the threshold for Medicaid eligibility (CMS 2016a).

As of September 2017, 15,472 people were enrolled in Medicaid, or approximately one-third of the population (CMS 2018a).
Benefits

Under its 1902(j) waiver, CNMI is exempt from providing mandatory services under Medicaid. However, it covers all mandatory Medicaid benefits except for freestanding birth center services, as there are no such facilities in CNMI (GAO 2016, CMS 2012a). In addition, CNMI covers many optional benefits such as outpatient prescription drugs and dental services (GAO 2016). Enrollees may obtain Medicaid-covered services outside of the territory in certain circumstances, including for laboratory, X-ray, or inpatient or outpatient hospital services with prior authorization, when medically necessary, and when services are not available in CNMI (CMS 2013a).

Medicaid enrollees face no cost-sharing requirements (CMS 2016a, 2012b).

CNMI provides cost-sharing assistance to dually eligible individuals who are eligible for full Medicaid benefits. There is no Medicare cost-sharing assistance to individuals who may qualify as partial dually eligible individuals through Medicare Savings Programs in the states because these programs are not available in CNMI (CMS 2013a). Medicaid covers Medicare Part B premiums for individuals dually eligible for Medicare and full Medicaid benefits (CMS 2016d).

No Medicare Part D plans are available in CNMI, but dually eligible individuals can receive subsidies under the Enhanced Allotment Plan, also referred to as 1935(e) funding (CMS 2016a). The Enhanced Allotment Plan provides additional allotments to territories to help low-income beneficiaries purchase prescription drugs. The allotment is separate from the Section 1108 allotment and can only be used for this purpose (§1935(e) of the Act) and CMS 2016a).

Delivery System

The Medicaid program is entirely fee for service. Most of the health care services in CNMI are provided at the Commonwealth Health Center, a territory-owned hospital on the island of Saipan operated by the Department of Public Health (CMS 2016a).

Financing and Spending

The federal government and the territorial government jointly finance the Medicaid program. CNMI must contribute the non-federal share of Medicaid spending in order to access federal dollars, which are matched at the designated FMAP, otherwise known as the matching rate. Unlike the states, for which federal Medicaid spending is open ended, CNMI can access federal dollars only up to an annual ceiling, referred to as the Section 1108 cap or Section 1108 allotment.

Federal funding

CNMI’s annual Section 1108 allotment was set in statute when its Medicaid program was established and grows with the medical component of the Consumer Price Index for All Urban Consumers (CPI-U) (§...
The CHIP allotment is determined by the Centers for Medicare & Medicaid Services (CMS) based on prior year spending, the same methodology used for states.

In general, once CNMI exhausts the federal Medicaid and CHIP allotments, it must fund the program with local funds. However, Section 2005 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided the territories with a total of $6.3 billion in additional federal funds for their Medicaid programs. Section 2005 funds for CNMI totaled $100.1 million, which is available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $1 billion to the territories, $9.1 million of which was directed to CNMI. These funds were available to be drawn down between January 2014 and December 2019, but were exhausted in March 2019. In response, and to help the territory respond to Super Typhoon Yutu, which struck in October 2018, Congress made an additional $36 million available through September 30, 2019 as part of the Additional Supplemental Appropriations for Disaster Relief Act of 2019 (P.L. 116-20).

Once these funds expire or are exhausted, CNMI generally will not be able to spend federal dollars beyond the annual Section 1108 allotment, which is $6.7 million in FY 2019 and $6.9 million in FY 2020 (CMS 2019a, b).

**Federal medical assistance percentage**

The FMAP for CNMI and the other territories is set statutorily at 55 percent, unlike that of the states, which are set using a formula based on states’ per capita incomes (§ 1905(b) of the Act). The CHIP enhanced FMAP is 91.5 percent (§ 2101(a) of the ACA, MACPAC 2018a). Like the states and other territories, CNMI’s federal matching rate for almost all program administration is set at 50 percent (§ 1903(a)(7) of the Act).

The territories cannot claim the newly eligible FMAP of 100 percent available to states expanding to the new adult group; they are eligible for the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the ACA, which is 93 percent in calendar year (CY) 2019 (§ 1905(z)(2) of the Act). However, CNMI had not claimed expenditures under this FMAP as of July 2018 (CMS 2018b). In addition, CNMI received a 2.2 percentage point temporary increase in its regular FMAP between January 1, 2014 and December 31, 2015 (§ 1905(z)(1) of the Act) (CMS 2016a).

CNMI finances the territorial share of Medicaid and CHIP program costs using a mix of certified public expenditures and general fund revenues, depending on the type and location of service. The major hospital where almost all health care services are provided is owned by the territory, and most of the expenses incurred there for services provided are certified public expenditures (CMS 2016c). Funds provided under P.L. 116-20 are available at a 100 percent matching rate for the period between January 1, 2019 and September 30, 2019, meaning the territory is not required to contribute local funds in order to access them.

**Total spending**

In FY 2018, federal Medicaid spending in CNMI was $25 million, or 1 percent of total federal Medicaid spending in the territories. Federal CHIP funding totaled $10.6 million, or 5 percent of total federal CHIP spending in the territories (Table 1).
**TABLE 1. Medicaid and CHIP Funding and Spending in CNMI FYs 2011–2018, by Source of Funds (millions)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid</th>
<th></th>
<th></th>
<th></th>
<th>CHIP</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section 1108 allotment</td>
<td>Federal spending</td>
<td>CNMI spending</td>
<td>Total spending</td>
<td>Federal allotment</td>
<td>Federal spending</td>
<td>CNMI spending</td>
<td>Total spending</td>
</tr>
<tr>
<td>FY 2018</td>
<td>$6.6</td>
<td>$25.0</td>
<td>$20.0</td>
<td><strong>45.0</strong></td>
<td>$7.1</td>
<td>$10.6</td>
<td>$0.8</td>
<td><strong>11.4</strong></td>
</tr>
<tr>
<td>FY 2017</td>
<td>6.3</td>
<td>17.0</td>
<td>13.4</td>
<td><strong>30.4</strong></td>
<td>6.7</td>
<td>9.6</td>
<td>0.7</td>
<td><strong>10.3</strong></td>
</tr>
<tr>
<td>FY 2016</td>
<td>6.1</td>
<td>20.6</td>
<td>16.0</td>
<td><strong>36.6</strong></td>
<td>1.0</td>
<td>6.4</td>
<td>0.6</td>
<td><strong>6.4</strong></td>
</tr>
<tr>
<td>FY 2015</td>
<td>6.0</td>
<td>16.2</td>
<td>12.2</td>
<td><strong>28.4</strong></td>
<td>1.2</td>
<td>0.9</td>
<td>0.3</td>
<td><strong>1.2</strong></td>
</tr>
<tr>
<td>FY 2014</td>
<td>5.9</td>
<td>19.7</td>
<td>15.7</td>
<td><strong>35.4</strong></td>
<td>1.0</td>
<td>1.0</td>
<td>0.4</td>
<td><strong>1.4</strong></td>
</tr>
<tr>
<td>FY 2013</td>
<td>5.6</td>
<td>16.4</td>
<td>13.4</td>
<td><strong>29.8</strong></td>
<td>0.9</td>
<td>0.9</td>
<td>0.4</td>
<td><strong>1.3</strong></td>
</tr>
<tr>
<td>FY 2012</td>
<td>5.5</td>
<td>13.8</td>
<td>11.3</td>
<td><strong>25.1</strong></td>
<td>0.9</td>
<td>0.9</td>
<td>0.4</td>
<td><strong>1.3</strong></td>
</tr>
<tr>
<td>FY 2011</td>
<td>6.5</td>
<td>14.3</td>
<td>12.6</td>
<td><strong>26.9</strong></td>
<td>0.9</td>
<td>0.9</td>
<td>0.4</td>
<td><strong>1.3</strong></td>
</tr>
</tbody>
</table>

**Notes:** CNMI is the Commonwealth of the Northern Mariana Islands. FY is fiscal year. Section 1108 allotments reflect the annual federal allotments (also referred to as caps) that territories receive under Section 1108(g) of the Social Security Act, while the actual federal spending reflects utilization of the additional allotments provided by the ACA, as well as spending not subject to the caps. Federal CHIP allotments are provided under Section 2104 of the Social Security Act. If states and territories exhaust their own available CHIP allotments, they may receive additional funding from unused state CHIP allotments. CNMI received these redistributed funds in FYs 2016–2018.

**Source:** MACPAC 2018b; MACPAC 2019 analysis of CMS-64 financial management report net expenditure data and CMS regional office narrative reports for FYs 2011-2018.

In FYs 2011–2018, federal spending for Medicaid in CNMI exceeded the annual Section 1108 allotment. This spending reflects use of the additional funds available under Sections 2005 and 1323 of the ACA. In FY 2019, federal spending over the Section 1108 allotment will primarily reflect use of the funds provided by P.L. 116-20.

**Data and Reporting**

CNMI is exempt from all Medicaid data and reporting requirements through their 1902(j) waiver. However, the program reports data on Medicaid and CHIP enrollment, budgets, and expenditures using Form CMS-37, and on aggregate and category-specific spending using Form CMS-64 (CMS 2016c).

Like the other territories, CNMI does not submit quarterly statistical and program expenditure data for CHIP. It also does not submit data on the use of early and periodic screening, diagnostic, and treatment services via Form CMS-416 or data on upper payment limit payments (CMS 2016b). Additionally, CNMI...
does not have an operational Medicaid Management Information System (MMIS) for claims processing (CMS 2016c).

**Quality and Program Integrity**

CNMI is exempt from federal quality and program integrity requirements. However, some program integrity measures are in place, including requiring providers to enroll, submit appropriate documentation, and the territory has agreed to comply with program rules (CNMI State Medicaid Agency 2016).

**Endnotes**

1 The Section 1902(j) waiver is only available to American Samoa and CNMI.

2 CNMI is the only U.S. territory to participate in the SSI program.

3 Under the medically needy eligibility pathway, people with disabilities who have higher incomes can spend down to a state-specified medically needy income level by incurring medical expenses. In CNMI, the medically needy level spend-down amount is the amount by which income exceeds the normal established limit (CMS 2017).

4 Unlike the states, CNMI is not required to establish Medicare Savings Programs under the 1902(j) waiver or under Section 1905(p)(4)(A) of the Act.

5 Like the other territories, CNMI is not eligible for the Medicare Part D low-income subsidy (§ 1935(e)(1)(A) of the Act).

6 With the funds from Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. Neither CNMI nor the other territories chose to establish an exchange.

7 Federal funds for the Enhanced Allotment Plan, electronic health record incentive program payments, and the establishment and operation of eligibility systems and Medicaid Management Information Systems (MMIS) do not count against the Section 1108 allotment.

**References**

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Calculation of territory Medicaid limits fiscal year 2020 per Sections 1108(f) and 1108(g) of the Social Security Act. Provided to MACPAC by e-mail, May 17.


---

Medicaid and CHIP Payment and Access Commission
www.mACPAC.gov


Medicaid and CHIP Payment and Access Commission
www.macpac.gov