

# 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).<sup>1</sup> 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).<sup>2</sup> 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 \$1,762.5 for a couple (SSA 2020). The Commonwealth allows a medically needy spend down for residents whose income is in excess of the established limits (CMS 2017).<sup>3</sup>

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 June 2019, 16,336 people were enrolled in Medicaid, or approximately one-quarter of the population (MACPAC 2021).



## 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 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 Medicare 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 in the states through Medicare Savings Programs because these programs are not available in CNMI (CMS 2013a).<sup>4</sup> 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.<sup>5</sup> The allotment is separate from the Section 1108 allotment described below 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 and its affiliated clinics (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 (§ 1108(g)). 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.<sup>6</sup> However, Congress has provided time-limited supplemental federal Medicaid funds to CNMI and other territories on several occasions; most recently, through the FY 2020 appropriations package, signed into law on December 20, 2019 (P.L. 116-94) and the Families First Coronavirus Response Act, signed into law on March 18, 2020 (FFCRA, P.L. 116-127). These actions raised CNMI's FY 2020 allotment from \$6.9 million to \$63.1 million and its FY 2021 allotment from approximately \$7.1 million to \$62.3 million (CMS 2019a).<sup>7,8</sup>

Additionally, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided the territories with a total of \$7.3 billion in additional federal funds for their Medicaid programs (i.e., on top of their annual Section 1108 allotments). ACA Section 2005 provided \$100.1 million to CNMI, which was available to be drawn down between July 2011 and September 2019. ACA Section 1323 provided an additional \$9.1 million.<sup>9</sup> 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).

Congress has not made additional funding available after FY 2021 (i.e., September 30, 2021), which means that for FY 2022 and future years, CNMI's Section 1108 allotment will revert back to pre-P.L. 116-94 levels (approximately \$7.2 million in FY 2022).

## Federal medical assistance percentage

The FMAP for CNMI and the other territories is set statutorily at 55 percent, unlike that of the states, where the FMAP is set using a formula based on state per capita income (§ 1905(b) of the Act). For FYs 2020 and 2021, CNMI has a temporary FMAP of 83 percent. During the national emergency declared in response to the COVID-19 outbreak, effective January 1, 2020 CNMI will receive the 6.2 percentage point increase FFCRA provided to all states and territories. This brings CNMI's FMAP to 89.2 percent during the emergency period. CNMI will also receive a 100 percent CHIP enhanced FMAP during the emergency period (CMS 2020a, b).<sup>10</sup> 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).

CNMI is eligible for enhanced matching rates for certain expenditures. 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 90 percent in calendar year 2019 (§ 1905(z)(2) of the Act). However, CNMI had not claimed expenditures under this FMAP. 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 are certified public expenditures (CMS 2016c). CNMI has often experienced difficulty generating the non-federal share it needs to draw down federal funds.

In response to these difficulties and to natural disasters affecting CNMI in 2018 and 2019, Congress provided CNMI with a temporary 100 percent federal matching rate for most of calendar year 2019. Funds provided under P.L. 116-20 were available at a 100 percent matching rate for the period between January 1, 2019 and September 30, 2019. Additionally, through the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59); and the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69), Congress provided CNMI a temporary 100 percent matching rate for expenditures occurring from October 1, 2019 to December 20, 2019.

## Total spending

In FY 2020, federal Medicaid spending in CNMI was \$39.1 million, or 1.4 percent of total federal Medicaid spending in the territories. Federal CHIP spending totaled \$16.3 million, or 9.4 percent of total federal CHIP spending in the territories.

As noted above, additional funds provided to CNMI by P.L. 116-94 and FFCRA were structured as part of CNMI's FYs 2020 and 2021 Section 1108 allotments. As a result, federal spending in FY 2020 did not exceed the allotment and is unlikely do so in FY 2021.

In FYs 2011–2019, federal spending for Medicaid in CNMI exceeded the annual Section 1108 allotment every year, because additional federal funds were structured as separate allotments.. For FYs 2011 – 2018, 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 primarily reflects use of the funds provided by P.L. 116-20. Higher federal spending in FY 2019 than in previous years is a result of the 100 percent federal matching rate available to CNMI for most of the fiscal year. Federal spending decreased in FY 2020 (Table 1).



**TABLE 1.** Medicaid and CHIP Funding and Spending in CNMI FYs 2011–2020, by Source of Funds (millions)

Year	Medicaid				CHIP			
	Section 1108 allotment	Federal spending	CNMI spending	Total spending	Federal allotment	Federal spending	CNMI spending	Total spending
FY 2020	\$63.1	\$39.1	\$3.6	<b>\$42.7</b>	\$11.8	\$16.3	\$0.0	<b>\$16.3</b>
FY 2019	6.7	49.8	10.4	<b>60.2</b>	11.2	5.6	0.3	<b>5.9</b>
FY 2018	6.6	25.0	20.0	<b>45.0</b>	7.1	10.6	0.8	<b>11.4</b>
FY 2017	6.3	17.0	13.4	<b>30.4</b>	6.7	9.6	0.7	<b>10.3</b>
FY 2016	6.1	20.6	16.0	<b>36.6</b>	1.0	6.4	0.6	<b>6.4</b>
FY 2015	6.0	16.2	12.2	<b>28.4</b>	1.2	0.9	0.3	<b>1.2</b>
FY 2014	5.9	19.7	15.7	<b>35.4</b>	1.0	1.0	0.4	<b>1.4</b>
FY 2013	5.6	16.4	13.4	<b>29.8</b>	0.9	0.9	0.4	<b>1.3</b>
FY 2012	5.5	13.8	11.3	<b>25.1</b>	0.9	0.9	0.4	<b>1.3</b>
FY 2011	6.5	14.3	12.6	<b>26.9</b>	0.9	0.9	0.4	<b>1.3</b>

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

**Sources:** MACPAC 2021 analysis of CMS-64 financial management report net expenditure data as of February 3, 2021; MACPAC 2020; CMS 2019b; MACPAC 2019 analysis of CMS regional office narrative reports for FYs 2011–2018.

## 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). It does not have a



Medicaid Management Information System or report information to the Transformed Medicaid Statistical Information System (T-MSIS), but is required to demonstrate reasonable progress towards doing so by October 1, 2021 (P.L. 116-94). CNMI must report to the chair and ranking member of the House Committee on Energy and Commerce and of the Senate Committee on Finance on how it used the extra funds provided by P.L. 116-94 within 30 days of the end of FYs 2020 and 2021.

## 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).

P.L. 116-94 included new program integrity requirements for CNMI. Before the end of FY 2020, CNMI is required to designate a program integrity lead within the Medicaid agency other than the Medicaid director.<sup>11</sup> Additionally, while the territory has not historically had a Medicaid Fraud Control Unit (MFCU), it is now required to take reasonable steps towards establishing a MFCU by October 2021.<sup>12</sup>

### Endnotes

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

<sup>2</sup> CNMI is the only U.S. territory to participate in the SSI program.

<sup>3</sup> 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).

<sup>4</sup> 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.

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

<sup>6</sup> 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.

<sup>7</sup> P.L. 116-94 raised the FYs 2020 and 2021 allotments to \$60 million. Subsequently, FFCRA further raised the FY 2020 allotment to \$63.1 million and the FY 2021 allotment to \$62.3 million.

<sup>8</sup> We estimate what the FY 2021 allotment would have been without these additional funds by trending the pre-P.L. 116-94 FY 2020 allotment by 2.3 percent (percent change in the medical component of the consumer price index for urban consumers for the 12-month period ending March 2019).



<sup>9</sup> 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.

<sup>10</sup> Prior to P.L. 116-94 and FFCRA, CNMI's FY 2020 CHIP enhanced FMAP was 80 percent (§ 2101(a) of the ACA; MACPAC 2019). The 89.2 percent FMAP provided during the emergency period serves as the base for calculating the CHIP enhanced FMAP during the emergency period (CMS 2020a, b).

<sup>11</sup> CNMI will be subject to an FMAP reduction in each quarter of FY 2021. The amount of the potential reduction is 0.25 percentage points multiplied by the number of quarters the requirement is not satisfied (not to exceed 5 percentage points).

<sup>12</sup> CNMI is not required to establish MFCUs under its Section 1902(j) waiver, but P.L. 116-94 required the Secretary to periodically reevaluate whether the waiver should continue to apply to MFCU requirements.

## References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. E-mail to MACPAC, March 27.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. *Families first Coronavirus Response Act—Increased FMAP FAQs*. March 24. Baltimore, MD: CMS. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

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.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Medicaid funding for the territories. Data set provided to MACPAC by e-mail, April 26.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. Total Medicaid enrollees—VIII group breakout report, August 2017. November 2018. Baltimore, MD: CMS. <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. Northern Mariana Islands Medicaid program expenditures: Regional office narrative for quarter ending June 30, 2018. July 27, 2018.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Amendment to CNMI state plan. November 7, 2017. Baltimore, MD: CMS. <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MP/CNMI-17-001.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Commonwealth of CNMI. <http://www.medicaid.gov/medicaid-chip-program-information/by-state/cnmi.html>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. E-mail to MACPAC, March 24.



Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016c. Telephone conversation with MACPAC, January 13.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Amendment to CNMI state plan. June 4, 2013. Baltimore, MD: CMS. <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MP/MP-13-001-Att.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012a. Amendment to CNMI state plan. September 20, 2012. Baltimore, MD: CMS. <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MP/MP-13-001-Att.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012b. Amendment to CNMI state plan. June 27, 2012. Baltimore, MD: CMS. <http://www.medicaid.gov/State-Resource-Center/Downloads/MP/MP-12-001-Att.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012c. Amendment to CNMI state plan. March 27, 2012. Baltimore, MD: CMS. <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MP/MP-11-003-Att.pdf>.

Commonwealth of the Northern Mariana Islands (CNMI) State Medicaid Agency. 2016. Provider information and updates. Saipan, CNMI: CNMI State Medicaid Agency. <http://medicaid.cnmi.mp/index.php/provider-information-and-updates>. Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. MACPAC analysis of Medicaid enrollment data collected through the Medicaid Budget and Expenditure System, April – June 2019.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. Exhibit 34: Federal CHIP allotments, FYs 2018–2020. In *MACStats: Medicaid and CHIP data book*. December 2020. Washington, DC: MACPAC. <https://www.macpac.gov/publication/federal-chip-allotments/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. Exhibit 6: Federal medical assistance percentages (FMAPs) and enhanced federal medical assistance percentages (E-FMAPS) by state, FYs 2016–2020. In *MACStats: Medicaid and CHIP data book*. December 2019. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2018/05/EXHIBIT-34.-Federal-CHIP-Allotments-FYs-2017%E2%80%932019-millions.pdf>.

U.S. Government Accountability Office (GAO). 2016. Medicaid and CHIP: Increased funding in U.S. territories merits improved program integrity efforts. Report no. GAO-16-324. Washington, DC: GAO. <http://www.gao.gov/assets/680/676438.pdf>.

U.S. Social Security Administration (SSA). 2020. Fact sheet: 2020 Social Security changes. Woodlawn, MD: SSA. <https://www.ssa.gov/news/press/factsheets/colafacts2020.pdf>.

