STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

CNMI Medicaid Agency will reimburse Commonwealth Health Center (CHC) at cost for Medicaid inpatient hospital services. CHC, a governmental hospital, uses the CMS-2552 cost report for its Medicare program and submits this cost report each year to the Medicare contractor. CHC will utilize the protocol outlined below to determine the allowable Medicaid hospital costs to be certified as public expenditures. CHC and CNMI use the annual period from October 1 through September 30 as their fiscal year.

I. Summary of CMS-2552-10

Worksheet A:

Worksheet A is the hospital's trial balance of total expenditures by cost center. The primary groupings of cost centers are:

i. General Service;
ii. Routine;
iii. Ancillary;
iv. Outpatient;
v. Other Reimbursable and Special Purpose; and
vi. Non-Reimbursable.

Worksheet A also includes A-6 reclassifications (which move costs from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare cost and reimbursement principles.

Worksheet B:

Worksheet B allocates overhead costs (identified in General Service Cost Centers, lines 1-23 of Worksheet A) to all cost centers, including non-reimbursable cost centers identified in lines 190-194 and their subscripts.

Worksheet C:

Worksheet C computes the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records and reported on Worksheet C. The cost-to-charge ratios are used in the Worksheet D series.

Worksheet D:

Worksheet D series apportions the total costs from Worksheet B different payers/programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Routine cost centers are apportioned based on per diem amounts, while ancillary cost centers are apportioned based on cost-to-charge ratios. Note however CHC, for Medicare cost reporting purposes, does not fully complete Worksheet C or Worksheet D of the CMS-2552, as Medicare allows for an alternative cost apportionment methodology to determine allowable program costs. Additional settlement worksheets outside of the CMS-2552 are used specifically to determine CHC's Medicare program costs.

Notes:

For purposes of utilizing the CMS-2552 cost report to determine Medicaid reimbursement described in the subsequent instructions, the following terms are defined:

- The term "finalized" refers to the cost report that is settled by the Medicare contractor with the issuance of a Notice of Program Reimbursement.
- The term "as-filed" (or "filed") refers to the cost report that is submitted by the hospital to the Medicare contractor and is typically due five months after the close of the cost reporting period.
- Any revision to the finalized CMS-2552 cost report as a result of Medicare appeal or re-openings will be incorporated into the final determination.

II. Certified Public Expenditures - Determination of Allowable Medicaid Hospital Costs

To determine CHC's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by CHC through the certified public expenditures (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

Interim Medicaid Inpatient Hospital Payment

The Territory will make interim Medicaid inpatient hospital payments to approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The process of determining the allowable Medicaid inpatient hospital costs eligible for FFP begins with the use of CHC's most recently filed Medicare 2552 cost report. The following cost protocol follows the cost methodology employed by Medicare for CHC. CNMI must submit a State plan amendment to revise this cost protocol to reflect any future changes in how Medicare computes costs for the hospital.

a. Total allowable hospital costs, consistent with Medicare cost principles, are reported by cost center in the CMS-2552-10, Worksheet B, Part I, Column 26.

b. For each hospital routine cost center (including Adults and Pediatrics, ICU, and Nursery):

- A per diem amount is computed by dividing the cost for the cost center, as reported on Worksheet B, Part I, Column 26, by the total patient day for the cost center, as reported on Worksheet S-3, Part I, Column 8.

- The per diem amount is multiplied by the number of Medicaid inpatient fee-for-service days for the cost center, excluding any days pertaining to Medicare-Medicaid dual eligible individuals. The number of Medicaid days is derived from either CNMI paid claims data or the hospital's auditable records of billed and adjudicated Medicaid claims. The Medicaid days must pertain to covered and reimbursable inpatient hospital services in accordance with the CNMI State plan. The result is the computed Medicaid inpatient hospital cost for each hospital routine cost center.

The routine cost centers included should only pertain to hospital inpatient services and exclude any non-hospital services such as long-term care services. CHC does not operate any hospital-based long-term care units which need to be excluded.

c. For each hospital ancillary cost center (except for Renal Dialysis and Ambulance Services):

- A cost-to-charge ratio is computed by dividing the cost for the cost center as reported on Worksheet B, Part I, Column 26, by the aggregate hospital ancillary charges. The aggregate hospital ancillary charge amount is net of renal dialysis and ambulance charges, is derived from auditable hospital records, and is the same amount used for Medicare settlement purposes.

- The cost-to-charge ratio is multiplied by the aggregate Medicaid inpatient hospital fee-for-service ancillary charges, excluding any charges pertaining to Medicare-Medicaid dual eligible individuals. The aggregate Medicaid inpatient hospital ancillary charge amount is net of renal dialysis and ambulance charges and is derived from either CNMI paid claims data or the hospital's auditable records of billed and adjudicated Medicaid claims. The Medicaid charges must pertain to covered and reimbursable inpatient hospital services in accordance with the CNMI State plan. The result is the computed Medicaid inpatient hospital cost for each hospital ancillary cost center, except for renal dialysis and ambulance services.

The ancillary cost centers included should only pertain to hospital services and exclude any non-hospital services such as clinics that are not recognized as hospital outpatient departments or FQHC/RHC clinics which are separately reimbursed as non-hospital services. Non-reimbursable cost centers from the cost report should also be excluded.

d. The Medicaid inpatient hospital cost computed above should be offset by all applicable Medicaid revenues received by the hospital for the Medicaid inpatient hospital services to arrive at net Medicaid inpatient hospital cost. Net Medicaid inpatient hospital revenues include payments by the patients or any other third party payers and, if applicable, any additional payments made to the hospital by CNMI for Medicaid inpatient hospital services.

e. The Medicaid allowable inpatient hospital costs from the latest prior period cost report will be adjusted by the hospital market basket update factor published by CMS annually in the Inpatient Prospective Payment System Final Rule to account for cost inflation and will serve as an estimate of the current service period expenditure. The allowable inpatient hospital costs may also be further adjusted to account for material changes in Medicaid utilization (both increases and decreases) and hospital operations between the prior period cost report and the current service period. Other than the application of the hospital market basket for cost inflation, the additional adjustments must be properly documented by the hospital and be prior-approved by CMS. Such adjustments, when applicable, will ensure that the interim payments will approximate final payments as closely as possible. This amount is divided by twelve and will be claimed as the interim monthly inpatient hospital payment amount. The federal share of the monthly inpatient hospital payment amount will be paid to the hospital on a monthly basis.

Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments

CHC's interim Medicaid inpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as filed to the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid inpatient hospital costs will be computed using the same methodology described in steps a-d above but using cost report data from the as-filed cost report for the respective expenditure period. Additionally the days and charges from CNMI or provider auditable sources will be based on services furnished during the expenditure period; and the revenue offsets in step d would be updated to account for revenues for services furnished during the expenditure period. The Medicaid inpatient hospital cost will be compared to the interim Medicaid inpatient hospital payments made. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The Medicare CMS-2552 is due to the Medicare contractor five months after the close of the hospital's cost reporting period. The interim reconciliation will be performed and completed within six months of the filing of the Medicare CMS-2552.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payments

CHC's final Medicaid inpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as finalized by the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid inpatient hospital costs will be computed using the same methodology described in steps a-d above but using cost data from the finalized cost report for the respective expenditure period. Additionally the days and charges from CNMI or provider auditable sources will be based on services furnished during the expenditure period, and the revenue offsets in step d would be updated to account for revenues for services furnished during the expenditure period. The Medicaid inpatient hospital cost will be compared to the interim Medicaid inpatient hospital payments made, including any interim reconciliation amounts. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The final reconciliation will be performed and completed within six months of the Medicare contractor's finalization of the Medicare CMS-2552 with the issuance of a Notice of Program Reimbursement.