STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Office of Accountability and Management Reporting
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DATE: June 30, 2018

TO: Medicaid Certified Nursing Facilities
(Please give a copy of this memo to your cost report preparer)

FROM: Kelley Johnson, Program Manager for LTC Facilities

RE: Financial and Statistical Reports ended June 30, 2018

The current nursing facility rates are in effect through September 30, 2018. The 6/30/18 cost reports are DUE (postmarked) on Wednesday, August 29, 2018.

AREAS HIGHLIGHTED ARE NEW REPORTING REQUIREMENTS OR REMINDERS

The Department of Health and Human Resources Financial and Statistical Report for the six-month period ending June 30, 2018 must be submitted (postmarked) no later than Wednesday, August 29, 2018. Recent desk reviews and rate setting cycles have identified a few recurring problems regarding cost report information submitted to the Department of Health and Human Resources (DHHR) for rate determination. As a result, the following are requirements that **MUST** be adhered to by each nursing facility seeking a rate for Medicaid participation:

- On **WV1, WV2, and WV3**, the following information **MUST** be correct the facility name, address, phone number, cost report preparer, and ownership information. **The facility addresses on the cost report will be used to mail the rate letters. If you do not include the correct mailing address on WV1, you may not receive your rate letter.**

- Beginning with the 6/30/17 cost report period we switched from Medicaid provider numbers to NPI numbers (National Provider Identifier). Medicaid is no longer issuing provider numbers making the switch mandatory. On the cost report where you would normally put your Medicaid number please replace it with your NPI number. Our system will no longer be able to properly compute your rate without your NPI number. Last period some reports had an invalid number instead of the NPI number. It MUST be included on this cost report. If you are unsure of this number, please refer to your October 1, 2017 rate sheet.

- Due to scanning, the submitted paper copy of the Medicaid Cost Report, Medicaid Grouping Report, Facility Trial Balance, Trial Balance by Medicaid Chart of Accounts, Schedule of Adjusting Entries and attachments **MUST** be **one-sided** copies only. Please do not staple reports or other supporting schedules.

- The Medicaid Grouping Report, the Facility Trial Balance, the Trial Balance by Medicaid Chart of Accounts, the Schedule of Adjusting Entries and the 8 dbf files (all generated by the cost report software) **MUST** be included with the facility cost report. Also, please include the **e-mail address of the cost report preparer. The 8 dbf files should be submitted on a CD. Do not put the dbf files inside a folder on the disk. A paper copy is required for all documentation.**

- **Please make sure all insurance is properly categorized on WV22 (Line 21 - Property Insurance, Line 22 - Liability Insurance, Line 23 - Malpractice Insurance and Line 24 - Other Insurance). According to Chapter 514.13.32, effective January 1, 2013, Damage Awards and Negotiated Settlements:** Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, as well as the associated legal deductibles or legal costs is non-allowable.

- Total assets on WV10 **MUST** equal total equity/liabilities on WV12. The cost report will be deemed incomplete and returned if it is not in balance. A rounding difference of less than $10.00 will be considered acceptable.

- **ALL** "Other" accounts (including Central Office) **MUST** be described in detail on a separate accompanying schedule unless the account description on the Medicaid Grouping Report is sufficient to identify the contents of the account ("purchased services" **IS NOT SUFFICIENT**).

- **ALL** "Purchased Services" accounts listed on the cost report and grouping report **MUST** be described in detail on a separate accompanying schedule. Please include vendor name, amount and purpose of service.

- **ALL** "Consulting Services" accounts listed on the cost report and grouping report **MUST** be described in detail on a separate accompanying schedule. Please include vendor name, amount and description of service.

- **ALL** items posted to Medicaid account #8790 – Public Relations **MUST** be described in detail on a separate accompanying schedule. Allowable are promotional expenses such as brochures, pens, mugs and resident funeral flowers but **NOT** TV, radio, newspaper advertising (#8632); family/resident activities (#7420), employee flowers (#9950). You must document that you received some type of public recognition (ex. name in program, on signs, radio announcement) for contributions to groups and charities or it will be considered a donation and moved to non-allowable (#9950).

- Restating the description from the Grouping Report as detail on the supporting schedules is **NOT** sufficient or acceptable. The total for the detail must also match the total on the grouping report. Any cost reports that have schedules that do not have proper descriptions or traceable totals will be considered incomplete and will not be reviewed until the schedules are corrected.

- **For hospitals, it is acceptable that your detail ties to the per books total. However, it is necessary that you include the allocation % used. If items have been reclassified before the allocation, please label each reclassified item with the account it was moved to.**

- Bed holds are reported on the Census Report on WV6. Please submit a schedule with the following information (a sample schedule is attached for your use):

  1. Reported bed holds by payer type (Medicaid or Other)
  2. Midnight census and occupancy percentage for only Medicaid reported bed holds
  3. Resident identifier with discharge and re-admit dates for only Medicaid bed holds
  4. List whether or not the Medicaid bed hold was billed and payment was received (Only paid bed holds should be included on WV6)

  When reconciling a Molina bed reservation report to the bed holds on the cost report, we noticed some problem areas. Please let your billing staff know that the same rules that apply to reporting bed hold days on the cost report also apply to billing bed hold days. It is **very** important to use the correct rev codes when billing bed holds. ***Please use rev code 183 for therapeutic leave, 185 for medical leave or 189 for other/no payment.*** Please **DO NOT** use 183 or 185 with a $0.00 charge. **Only 189 should be used with a $0.00 charge.** If that occurs, it requires more analysis and causes problems with the reconciliation.

- Nursing home administrator salaries are reviewed for reasonableness. Please refer to Section 514.31.1 of the Medicaid Provider Manual for the calculation. For the cost report period January 1, 2018 – June 30, 2018, the administrator salary CAP is $75.26/hr for the small bed group and $89.00/hr for the large bed group. The facility is allowed the lesser of their actual expense (total compensation of the administrator) or the CAP.

- For the cost report period January 1, 2018 to June 30, 2018 the standard mileage rate is **$0.545/mile** (set by

the U.S. General Services Administration). Please report **BOTH** facility vehicle mileage and employee reimbursement mileage on WV8. Logs must be kept for both types of mileage. Please use account #8750 for all vehicle expenses such as, but not limited to, employee mileage reimbursement, rental or lease payments, fuel, interest, repairs, routine maintenance, inspections, licenses, insurance and depreciation.

- To ensure that all expenses are mapped properly, please put employee background checks on WV 21/16 (#9070), copier rental and maintenance on WV 20/24 (#8660), shredding service on WV 20/42 (#8820) and hazardous waste disposal on WV 22/6 (#9250).

- A portion of AHCA and WVHCA dues are non-allowable and should be mapped to WV24/23 (#9950). The non-allowable portion for 2018 is 28% for AHCA and 11% for WVHCA. Medicaid account #9950 should be used with "Non-Allowable Dues" as the account description.

- According to Medicaid Regulation 514.10 Ancillary Services, the nursing facility must have formal arrangements for the provision of ancillary services which are necessary to support the primary activities of the nursing facility; however, they are not included in the per-diem rate.

    - Prescription Drugs
    - Prosthetics and Orthotics
    - Dental Services
    - Vision Care Services
    - Podiatry Services
    - Laboratory, X-Ray, and Other Diagnostic Services
    - Ambulance Services

  Because these services are billed directly to the Bureau, they are **NOT** included in the per diem rate and, therefore, should **ONLY** appear on WV24 of the cost report. Any of the above expenses found on the cost report during desk review without written description and supporting documentation submitted to justify the departure from Medicaid Regulation 514.10 will be moved to non-allowable.

  Please send all cost reports to:

  Jeanne Snow
  WV DHHR Office of Accountability & Management Reporting
  One Davis Square, Suite 304
  Charleston, WV 25301

Any cost report which does not comply with the DHHR regulations will be considered unacceptable and subject to the penalty for delinquent reporting of costs in accordance with the state plan.

Extensions will be granted for extenuating circumstances and only for 15 days. Written requests for extensions should be addressed to Jeanne Snow and must be received by close of business on Wednesday, August 29, 2018.

For any questions concerning the cost report, please contact Jeanne Snow, Director of Rate Setting at (304) 558-8334 or Jeanne.L.Snow@wv.gov.