Chapter 300
Provider Participation Requirements

Appendix A
Cost Reports

This appendix is a placeholder for cost report policy that originally appeared in Chapter 300 until May 16, 2018 and will be moved to Chapter 600 during the next revision. Only minor updates have been made to the original text. This policy remains continuously in effect until moved to Chapter 600.

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320.9 MEDICAID COST REPORT SUBMISSIONS AND FILING DEADLINES

Providers listed below are required to timely file their West Virginia Medicaid cost reports for Title XIX services. A timely filed report for providers that are required to submit an annual cost report must be received in accordance with the “Cost Report Due Date” outlined in the chart below, or at the end of an approved extension. Cost reports are considered to be timely filed when received on or before the applicable due date at the following address:

West Virginia Department of Health and Human Resources
Office of Accountability & Management Reporting
ATTN: Division of Audit & Rate Setting
One Davis Square, Suite 304
Charleston, WV 25301

Facility Type	Cost Report Format	Cost Report Due Date	Cost-Based Settlement
Acute Care Hospital (hospital portion and non-cost settled distinct parts)	CMS-2552-10	Last day of the fifth month after the provider's fiscal year end (FYE)	No
Acute Care Hospital-Distinct part(s) subject to cost settlement	CMS-2552-10	Last day of the fifth month after the provider's FYE	Yes
Critical Access Hospital	CMS-2552-10	Last day of the fifth month after the provider's FYE	Yes
Federally Qualified Health Center (FQHC)	CMS-224-14	Last day of the fifth month after the provider's FYE	No
Rural Health Clinic (RHC)	CMS-222-17	Last day of the fifth month after the provider's FYE	No

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Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	Financial and Statistical Report for ICF/IID)	60 days after end of annual reporting period	Settlements may occur upon audit or discovery of errors/omissions in the Financial and Statistical Report for ICF/IID
Long-Term Care Facilities	Financial and Statistical Report for Nursing Homes	60 days after end of six-month reporting period	Settlements may occur upon audit or discovery of errors/omissions in Financial and Statistical Report for Nursing Homes
Residential Child Care - Children's Residential Services	Financial and Statistical Report for Residential Child Care Providers	Last day of the second month after end of six-month reporting period	No
Inpatient Psych Facility-Acute Psych Under 21	CMS-2552-10	Last day of the fifth month after the provider's FYE	Yes
Inpatient Psychiatric Residential Treatment Facilities	CMS-2552-10	Last day of the fifth month after the provider's FYE	Yes

The DHHR will accept the CMS 2552-10, CMS 224-14, and 222-17 (Medicare) forms for Medicaid cost reporting purposes, however the cost report submitted must include an original signature on the settlement page, or the electronic signature if required by Medicare.

The provider's election to electronically file the cost report with the Medicare intermediary does not negate the requirement to file a hard copy cost report as outlined above. The DHHR will honor an extension granted by Medicare for Medicaid cost report filing purposes, however the provider must forward to the OAMR (at the above address) a copy of the Medicare granted extension prior to the original submission deadline.

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320.10 COST REPORT EXTENSIONS

The provider may request an extension of up to 30 days beyond the cost report due date for extenuating circumstances. A provider must submit a written request to the OAMR prior to the cost report due date. The request must include an explanation of the extenuating circumstances and a proposed new date for submission of the cost report to the OAMR. If approved, the provider will be notified in writing of the new cost report due date. If rejected, the provider's cost report due date will remain the originally assigned date.

The Medicare program may issue extensions in filing cost reports due to various administrative causes. Generally, these extensions are issued as blanket extensions to specified groups of providers due to software issues or late program changes. In instances where a provider files both with Medicare and with West Virginia Medicaid, the OAMR will extend the cost report due date to agree with the Medicare approved extension. A provider must notify the OAMR of the Medicare extension.

Providers may file an extension request due to extenuating circumstances any time prior to the cost report deadline for filing. Each request will be evaluated by the OAMR. The acceptance or rejection of the request will be based upon whether the late preparation of the report had been caused by circumstances within or outside of the provider's control. If the late filing is due to circumstances within the provider's control, the request will be denied.

320.11 COST REPORT EXEMPTIONS

LOW UTILIZATION EXEMPTIONS REQUIREMENTS:

Providers that have low Medicaid utilization may qualify for an exemption in filing their annual Medicaid cost report. Providers that render services to five or less Medicaid recipients during the provider's fiscal year may request an exemption in filing their annual cost report. A provider that meets the low utilization criterion must file a written request for the exemption directly to the OAMR prior to the cost report's due date. If the request for an exemption is approved by the OAMR, the provider will be notified in writing.

Providers that have no West Virginia Medicaid utilization during their fiscal year must provide a written statement to the OAMR confirming that fact prior to the cost report due date. Providers that meet the no utilization criterion will not be required to file an annual report with the West Virginia Medicaid program.

The OAMR reserves the right to approve or reject a provider's request for an exemption regardless of compliance with exemption criteria and require a complete and acceptable cost report.

320.12 COST REPORT LATE FILING PENALTIES

Failure to file a cost report timely, or failure to file a cost report, may result in suspension of future payments, assessment of interest on program overpayment, or termination from the Medicaid program.

The OAMR will notify providers, by certified mail return receipt requested, whose cost reports are not received by the cost report due date. The notification will advise the provider that their cost report is now delinquent, as well as advise them of the consequences of continued delinquency. A provider who fails to submit their delinquent cost report within 30 days following the cost report due date will have their interim payments suspended beginning on the thirty-first day of delinquency. This action results in withholding of future payments pending receipt of the provider's cost report. Payments will be reinstated after an acceptable cost report is filed with the OAMR. In addition to the full suspension of payments herein

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described, Nursing Homes and ICF/IID will be subject to a ten percent reduction in reimbursement in accordance the West Virginia State Medicaid Plan. This penalty will be assessed for each day that the cost report is delinquent. Where continued delinquency occurs with regards to submission of the required cost report, a termination action will be initiated in accordance with Medicaid guidelines, Section 310.7.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Updated Cost Report Info	Provider Participation Requirements	March 1, 2007

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