51550 Administrative Adjustment Process

(a)

A provider may request an AA to the ARPDL or PGRPDL established for that provider if the provider's cost based allowable reimbursement for the settlement fiscal period as defined by the lower of Sections 51546(a)(1) and (a)(2), exceeds or are expected to exceed the PIRL by over $100. Expected to exceed only refers to the settlement period being issued and not any future settlement fiscal periods. The burden shall be on the provider to estimate, using the PIRL settlement information provided by the Department and any other information they may have, if they will expect to exceed the PIRL by over $100.

(b)

Items that are not subject to an AA or appeal include the following: (1) The use of Medicare standards and principles of reimbursement. (2) The reimbursement amounts determined in Section 51546(a)(1) and (a)(2). (3) The method for determining the IPI. (4) The use of all-inclusive reimbursement rates. (5) The use of a volume adjustment formula. (6) Disproportionate share payments (these are not reduced by application of the PIRL). (7) Data reported on the cost report which has been audited or reviewed by the Department are considered true and correct pursuant to W&I Code Section 14170. Data that was incorrectly transferred from the providers' Medi-Cal cost or audit report and used to calculate the MIRL is subject to appeal. (8) The methodology used to calculate the interim rate. (9) Any

prior fiscal period issues. (10) Higher costs due to low occupancy. (11) Items not reimbursed as part of the Medi-Cal cost report process as determined in Section 51546(a)(1) and (a)(2). (12) Increased costs. Only the cause for the increased costs may be appealable, and then only if it is otherwise an appealable item. (13) Any issue raised in a previous formal appeal for which a decision was made by the Department for the same provider. The only exception is to incorporate into the settlement fiscal period PIRL the prior decision in the same manner as it was previously decided by the Department. These only include decisions made for FPEs affected by Sections 51545 through 51557. This does not include issues withdrawn by the provider and thus not determined on their merits in the formal decision. (14) Increases in average length of stay. (15) Changes in the Cost-Based Reimbursement System as determined under Section 51546(a)(1) and (a)(2). (16) Increased costs incurred by entering into a contract which did not contain reasonable cost increase limitations. (17) Increases due to increased costs or charges of a related party. (18) Any issues involving labor cost increases except for those allowed in Section 51551(b). (19) New services.

(1)

The use of Medicare standards and principles of reimbursement.

(2)

The reimbursement amounts determined in Section 51546(a)(1) and (a)(2).

(3)

The method for determining the IPI.

(4)

The use of all-inclusive reimbursement rates.

(5)

The use of a volume adjustment formula.

(6)

Disproportionate share payments (these are not reduced by application of the PIRL).

(7)

Data reported on the cost report which has been audited or reviewed by the Department are considered true and correct pursuant to W&I Code Section 14170. Data that was incorrectly transferred from the providers' Medi-Cal cost or audit report and used to calculate the MIRL is subject to appeal.

(8)

The methodology used to calculate the interim rate.

(9)

Any prior fiscal period issues.

(10)

Higher costs due to low occupancy.

(11)

Items not reimbursed as part of the Medi-Cal cost report process as determined in Section 51546(a)(1) and (a)(2).

(12)

Increased costs. Only the cause for the increased costs may be appealable, and then only if it is otherwise an appealable item.

(13)

Any issue raised in a previous formal appeal for which a decision was made by the Department for the same provider. The only exception is to incorporate into the settlement fiscal period PIRL the prior decision in the same manner as it was previously decided by the Department. These only include decisions made for FPEs affected by Sections 51545 through 51557. This does not include issues withdrawn by the provider and thus not determined on their merits in the formal decision.

(14)

Increases in average length of stay.

(15)

Changes in the Cost-Based Reimbursement System as determined under Section 51546(a)(1) and (a)(2).

(16)

Increased costs incurred by entering into a contract which did not contain reasonable cost increase limitations.

(17)

Increases due to increased costs or charges of a related party.

(18)

Any issues involving labor cost increases except for those allowed in Section 51551(b).

(19)

New services.

(c)

Issues involving the following MIRL (or ARPDL but not PGRPDL) items may be resolved through an AA under the procedures in Section 51551: (1) Changes in Medi-Cal case mix and outliers. (2) Inappropriate calculation of fixed and variable costs. (3) An error in the calculations. (4) Determination of whether or not a provider is exempt from the ARPDL. (5) Extraordinary and unusual events. (6) Labor costs as allowed under Section 51551(b). (7) Other causes of cost increases for costs which were economically and efficiently incurred for the necessary care of Medi-Cal inpatients, that are an increase on a per-discharge basis over the prior fiscal period and are not listed under (b) as not being subject to an AAR. (8) The interim rate as it may be affected by changes resulting from items appealed under (1) through (7) above.

(1)

Changes in Medi-Cal case mix and outliers.

(2)

Inappropriate calculation of fixed and variable costs.

(3)

An error in the calculations.

(4)

Determination of whether or not a provider is exempt from the ARPDL.

(5)

Extraordinary and unusual events.

(6)

Labor costs as allowed under Section 51551(b).

(7)

Other causes of cost increases for costs which were economically and efficiently incurred for the necessary care of Medi-Cal inpatients, that are an increase on a per-discharge basis over the prior fiscal period and are not listed under (b) as not being subject to an AAR.

(8)

The interim rate as it may be affected by changes resulting from items appealed under (1) through (7) above.

(d)

If a provider's cost based reimbursement (lower of Section 51546(a)(1) and (a)(2)) exceeds both the ARPDL and the PGRPDL, the providers' AAR and any subsequent appeal of the AA, must address both limitations in order to obtain relief for both limitations. If only the ARPDL is appealed, no further appeal rights will exist for the PGRPDL at any later date, except for an AAR on a tentative PIRL

settlement that is issued later as a final PIRL settlement.

(e)

The procedures for requesting an AA of an ARPDL shall be as follows:(1) A request for an AA of the ARPDL or PGRPDL, which the Department deems acceptable, shall be submitted within 90 days after notification of that limitation. These AARs must be postmarked or hand delivered on or before the 90th day after the postmark on the settlement notification letter. No extensions shall be granted. If a settlement letter from the Department contains settlements for more than one fiscal period, 120 days shall be allowed to file the AAR. (2) The AAR shall be submitted in writing to the Department and shall specifically and clearly identify each issue, the total dollar amount involved for each issue and the dollar amount of overlap among each issue. If the Department determines that additional data are needed, the provider shall have 60 days after notification of the Department's request to supply it to the Department. No extension shall be granted. (3) The AAR need not be formal, but it shall be in writing and specific as to each issue in dispute, setting forth the provider's specific contentions as to those issues and the estimated amount each issue involves. If the Department determines that the request for any issue fails to state the specific grounds upon which objection to the specific issue is based, including the estimated dollar amount involved, the provider shall be notified that is does not comply with the requirements of this regulation and the issue cannot be accepted. If an issue is not accepted on this basis, the provider may not submit this issue as a formal appeal. (4) All AARs must be signed by an employee of the provider authorized by the provider to do so or by an authorized representative.(A) If the AAR is signed by an authorized representative, a signed statement of such authorization for each FPE must accompany the AAR signed by an appropriate employee of the provider. (B) Each AAR must have a declaration

attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative. (5) For each issue other than those covered by one of the specific formulas in this section the provider must demonstrate either (A), (B) or all parts of (C) below:(A) Data that was incorrectly transferred as specified in Section 51550(b)(7). (B) An error was made in the rate calculation. (C) All costs for which additional reimbursement are being requested were: 1. Economically and efficiently provided for the necessary care of Medi-Cal inpatients. 2. Not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed. 3. Not overlapped with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted. (6) The request shall contain all the appropriate data to allow the Department to determine if relief is needed and to do the relief calculation. (A) This may include, but is not limited to: 1. All internal/external reports concerning each issue; 2. All material presented to the hospitals' Governing Board concerning this issue; 3. Medical records for Medi-Cal patients; 4. Bank statements and canceled checks; 5. All financial statements; 6. Copies of contracts. 7. Copies of proposed and/or actual budgets. 8. The provider's suggested calculation for relief (for each issue specifically listed under Section 51551 below, the formula in regulation must be used). (B) All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than one statement may be required if more than one data source is utilized. (C) All data submitted may be audited by the Department. (7) One-time relief may be granted for extraordinary and unusual events. (A) The criteria for one-time relief is any item which occurred in one FPE and is not normally expected to apply to all future FPEs and therefore

the ARPDL is not adjusted each future FPE for this issue. (B) Formula relief shall only be granted for issues which are expected to carry on to every FPE. (C) Relief for allowable increases in employee hours per discharge shall be one-time relief for the first two FPEs and then formula relief during the third FPE. (8) The following steps are required by the Department for calculating relief: (A) The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue. (B) The provider shall identify the specific cause of the increased costs. (C) The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues. (D) The Department shall review the providers' figures on (A) and make any necessary corrections. (E) The Department shall determine whether to grant one-time or formula relief. (9) If data or other items requested by the Department for evaluation of an AAR are not supplied within 60 days, the Department shall suspend further consideration of this issue. If the requested data are not supplied within 120 days, the Department shall deem the AAR rejected for all issues for which the Department requested data or other items, and the provider shall be precluded from raising the issue(s) in a formal appeal. (10) The provider shall be notified of the Department's decision in writing within 90 days of receipt of the provider's written request for an AA, or within 60 days of receipt of any additional documentation or clarification which was required by the Department, whichever is later. The request for an AA shall be deemed denied if no decision is issued within these time frames. The Department shall notify providers of such denials. (11) A change in cost based reimbursable costs as defined in Section 51546(a)(1) and (a)(2), whether or not as a result of an audit appeals process, shall result in a redetermination of the PIRL, and shall not give rise to any additional appeal rights.

(1)

A request for an AA of the ARPDL or PGRPDL, which the Department deems acceptable, shall be submitted within 90 days after notification of that limitation. These AARs must be postmarked or hand delivered on or before the 90th day after the postmark on the settlement notification letter. No extensions shall be granted. If a settlement letter from the Department contains settlements for more than one fiscal period, 120 days shall be allowed to file the AAR.

(2)

The AAR shall be submitted in writing to the Department and shall specifically and clearly identify each issue, the total dollar amount involved for each issue and the dollar amount of overlap among each issue. If the Department determines that additional data are needed, the provider shall have 60 days after notification of the Department's request to supply it to the Department. No extension shall be granted.

(3)

The AAR need not be formal, but it shall be in writing and specific as to each issue in dispute, setting forth the provider's specific contentions as to those issues and the estimated amount each issue involves. If the Department determines that the request for any issue fails to state the specific grounds upon which objection to the specific issue is based, including the estimated dollar amount involved, the provider shall be notified that is does not comply with the requirements of this regulation and the issue cannot be accepted. If an issue is not accepted on this basis, the provider may not submit this issue as a formal appeal.

(4)

All AARs must be signed by an employee of the provider authorized by the provider to do so or by an authorized representative.(A) If the AAR is signed by an authorized representative, a signed statement of such authorization for each FPE must accompany the AAR signed by an appropriate employee of the provider. (B) Each AAR must have a

declaration attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative.

(A)

If the AAR is signed by an authorized representative, a signed statement of such authorization for each FPE must accompany the AAR signed by an appropriate employee of the provider.

(B)

Each AAR must have a declaration attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative.

(5)

For each issue other than those covered by one of the specific formulas in this section the provider must demonstrate either (A), (B) or all parts of (C) below:(A) Data that was incorrectly transferred as specified in Section 51550(b)(7). (B) An error was made in the rate calculation. (C) All costs for which additional reimbursement are being requested were: 1. Economically and efficiently provided for the necessary care of Medi-Cal inpatients. 2. Not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed. 3. Not overlapped with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

(A)

Data that was incorrectly transferred as specified in Section 51550(b)(7).

(B)

An error was made in the rate calculation.

(C)

All costs for which additional reimbursement are being requested were: 1. Economically and efficiently provided for the necessary care of Medi-Cal inpatients. 2. Not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed. 3. Not overlapped with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

1.

Economically and efficiently provided for the necessary care of Medi-Cal inpatients.

2.

Not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed.

3.

Not overlapped with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

(6)

The request shall contain all the appropriate data to allow the Department to determine if relief is needed and to do the relief calculation. (A) This may include, but is not limited to: 1. All internal/external reports concerning each issue; 2. All material presented to the hospitals' Governing Board concerning this issue; 3. Medical records for Medi-Cal patients; 4. Bank statements and canceled checks; 5. All financial statements; 6. Copies of contracts. 7. Copies of proposed and/or actual budgets. 8. The provider's suggested calculation for relief (for each issue specifically listed under Section 51551 below, the formula in regulation must be used). (B) All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than one statement may be required if more than one data source is utilized. (C) All data submitted may be audited by the Department.

(A)

This may include, but is not limited to: 1. All internal/external reports concerning each issue; 2. All material presented to the hospitals' Governing Board concerning this issue; 3. Medical records for Medi-Cal patients; 4. Bank statements and canceled checks; 5. All financial statements; 6. Copies of contracts. 7. Copies of proposed and/or actual budgets. 8. The provider's suggested calculation for relief (for each issue specifically listed under Section 51551 below, the formula in regulation must be used).

1.

All internal/external reports concerning each issue;

2.

All material presented to the hospitals' Governing Board concerning this issue;

3.

Medical records for Medi-Cal patients;

4.

Bank statements and canceled checks;

5.

All financial statements;

6.

Copies of contracts.

7.

Copies of proposed and/or actual budgets.

8.

The provider's suggested calculation for relief (for each issue specifically listed under Section 51551 below, the formula in regulation must be used).

(B)

All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than

one statement may be required if more than one data source is utilized.

(C)

All data submitted may be audited by the Department.

(7)

One-time relief may be granted for extraordinary and unusual events. (A) The criteria for one-time relief is any item which occurred in one FPE and is not normally expected to apply to all future FPEs and therefore the ARPDL is not adjusted each future FPE for this issue. (B) Formula relief shall only be granted for issues which are expected to carry on to every FPE. (C) Relief for allowable increases in employee hours per discharge shall be one-time relief for the first two FPEs and then formula relief during the third FPE.

(A)

The criteria for one-time relief is any item which occurred in one FPE and is not normally expected to apply to all future FPEs and therefore the ARPDL is not adjusted each future FPE for this issue.

(B)

Formula relief shall only be granted for issues which are expected to carry on to every FPE.

(C)

Relief for allowable increases in employee hours per discharge shall be one-time relief for the first two FPEs and then formula relief during the third FPE.

(8)

The following steps are required by the Department for calculating relief: (A) The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue. (B) The provider shall identify the specific cause of the increased costs. (C) The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues. (D) The

Department shall review the providers' figures on (A) and make any necessary corrections. (E) The Department shall determine whether to grant one-time or formula relief.

(A)

The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue.

(B)

The provider shall identify the specific cause of the increased costs.

(C)

The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues.

(D)

The Department shall review the providers' figures on (A) and make any necessary corrections.

(E)

The Department shall determine whether to grant one-time or formula relief.

(9)

If data or other items requested by the Department for evaluation of an AAR are not supplied within 60 days, the Department shall suspend further consideration of this issue. If the requested data are not supplied within 120 days, the Department shall deem the AAR rejected for all issues for which the Department requested data or other items, and the provider shall be precluded from raising the issue(s) in a formal appeal.

(10)

The provider shall be notified of the Department's decision in writing within 90 days of receipt of the provider's written request for an AA, or within 60 days of receipt of any additional documentation or clarification which was required by the Department,

whichever is later. The request for an AA shall be deemed denied if no decision is issued within these time frames. The Department shall notify providers of such denials.

(11)

A change in cost based reimbursable costs as defined in Section 51546(a)(1) and (a)(2), whether or not as a result of an audit appeals process, shall result in a redetermination of the PIRL, and shall not give rise to any additional appeal rights.