COMMENT LETTER 1 (CAHF 7/19/10)		
SUBJECT	**COMMENT**	**RESPONSE**
1. Finding of Emergency	The Department's Issuance of These Regulations on an "Emergency" Basis Was Neither Lawful Nor Justified Under the Circumstances In order to demonstrate the need to adopt "emergency" regulations, section 11346.1 of the Government Code requires an agency must describe specific facts demonstrating the existence of an emergency. Moreover, section 11346.1(b)(2) requires the identification of each technical, theoretical, and empirical study, report, or similar document upon with the agency relies. According to section 11346.1(b)(2) a "finding of emergency based only upon expediency, convenience, best interest, general public need, or speculation, *shall not be adequate* to demonstrate the existence of an emergency." (Emphasis added.) Finally, if the situation identified in the finding of the emergency was known to the agency adopting the emergency regulations in sufficient time to have been addressed through nonemergency regulations, the finding of emergency shall include facts explaining the failure to address the situation through nonemergency regulations. (Government Code § 11346.1(b)(2).) Against this backdrop the proposed emergency regulations from the Department must be judged. A. The Department is Not Exempt from the Requirement to Demonstrate an "Emergency by Virtue of AB 1629 or AB 1183. In its Finding of Emergency, the Department fails to provide any facts whatsoever to support a finding of an emergency situation, in direct violation of Government Code section 11346.1. Instead, the Department contends that in offering these emergency regulations the Department is exempt from any requirement to demonstrate or support a finding of an emergency. The Department contends that the implementing legislation, primarily AB 1629 and later extended through AB 1183, supports the use of the emergency regulations and deems the situation an emergency. Specifically, the Department argues that Health and Safety	The Department relies on the emergency authority provided through the enactment of Assembly Bill (AB) 1629 (Chapter 875, Statutes of 2004) that established the Quality Assurance Fee (QAF) Program and the Medi-Cal Long-Term (LTC) Reimbursement Act. Specifically, Health and Safety Code (H&S), Section 1324.23 provides for the Department to adopt "as emergency regulations" those requirements "as are necessary to implement the (QAF) article". Welfare and Institutions Code (W&I), Section 14126.027 authorizes the Department to adopt the Medi-Cal LTC rate methodology regulations on an emergency basis, and also states that "the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action." Both of these statutes clearly provide for the Department's emergency rulemaking authority for these regulations. This is further discussed in the Department's Finding of Emergency as initially dated June 24, 2010. The Department believes that all provisions of the regulatory text fall within the authority provided in the above noted statutes. The Office of Administrative Law has confirmed the Department's authority for emergency regulations by approving the initial emergency filing on July 22, 2010 and the subsequent re-adoption of the emergency regulations on January 18, 2011.

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	Code section 1324.23 (added by AB 1629) deem regulations necessary to implement the article as emergency regulations. In addition, the Department cites Welfare and Institutions Code section 14126.027 (also added by AB 1629), which states that the adoption of regulations *is* "deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for the purposes of Sections 11346.1 and 11349.6 of the Government Code and the department is exempted from the requirement that it describe specific facts showing the need for immediate action." Finally, the Department cites Welfare and Institutions Code section 14105, which provides for the use of emergency regulations "within one month after the enactment of the Budget Act and of any other appropriation which changes the level of funding for Medi-Cal services." (Welfare & Institutions Code § 14105(a).) This final rationale can be dispensed with quickly as the proposed emergency regulations do not follow a budget act nor do they change the level of funding for Medi-Cal services. Although the regulations involve fees paid by long-term care facilities and the methods used to calculate facility rates, they do not address the level of funding or any specific changes thereto. Therefore, Welfare and Institutions Code section 14105 cannot be used to excuse the Department's failure to demonstrate or support a finding of an emergency. With regard to Health and Safety Code section 1324.23 and Welfare and Institutions Code section 14126.027, some additional explanation is required. As described by the Department, the proposed emergency regulations deal with two distinct, but related, topics: (1) a quality assurance fee; and (2) the methodology utilized to calculate facility specific reimbursement rates and methodology. The quality assurance fee was authorized in 2004 by Health and Safety Code section 1324.23. The facility specific reimbursement rates and methodology was authorized in 2004 by Welfare and Institutions Code section 14126.027. Of the proposed regulations 52000 (definitions) and 52100 through 52104 pertain to the quality assurance fee and are related to Health and Safety Code, while the remainder deal with the distinct issue of facility specific	

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	reimbursement rates and methodology. Therefore, the Department cannot rely on these two sections to support the finding of an emergency for all of its proposed regulations. In fact, the Welfare and Institutions Code provision related to the proposed regulations does not say that adoption of the regulations will be deemed an emergency. For proposed regulations 52500-52516 and 52600, the Department must still demonstrate that the adoption on an emergency basis is not based on expediency, convenience or general public need. (Government Code § 11346.1(b)(2).) B. The Department's Own Delay of Several Years is Not a Sufficient Basis for a Finding of an Emergency The Department must also provide an explanation for the failure to adopt these regulations on a nonemergency basis. (Welfare & Institutions Code § 11346.1(b)(2).) The implementing statute was passed September 1, 2004. Nearly six years have passed between the time AB 1629 passed and the Department issued "emergency" regulations. Even if one takes into account AB 1183, the Department's delay is unsupportable. AB 1183 was passed on September 30,2008, but did not change the substance of the provisions discussed above. AB 1183 merely pushed back various "sunset provisions" and deadlines related to regulations, the quality assurance fee and the facility specific reimbursement system. The Department was well aware of the July 31, 2010 deadline to implement regulations for years. There is simply no excuse for the delay and the last minute attempt to create an emergency. Finally, it appears that the only basis for the Department's attempt to adopt these regulations on an emergency basis is to meet the statutory deadline to implement regulations by July 31, 2010. Following July 31, 2010, any and all provider bulletins or other instructions issued in accordance with AB 1629 would be unenforceable. Therefore, the Department is attempting to replace its provider bulletins and/or other instructions with regulations prior to their expiration. There is no other explanation for the Department's actions. According to the	

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	Government Code, a finding of emergency based only upon expediency shall not be adequate to demonstrate the existence of an emergency. (Government Code § 11346.l(b)(2).) For all of these reasons, the Department's attempt to justify the issuance of these regulations on an emergency basis must fail.	
2. Labor Cost – Temporary Staffing (52000 & 52502)	Proposed Regulation Sections 52500 (Definitions) and 52502 (Labor Costs Category) Violates Welfare and Institutions Code Section 14126.023(e). Pursuant to the APA, "no regulation adopted is valid or effective unless consistent and not in conflict with the [authorizing] statute and reasonably necessary to effectuate the purpose of the statute." (Govt. Code § 11342.2.) Furthermore, the APA requires that these regulations be reasonable and meet the six standards of necessity, authority, clarity, consistency, reference and nonduplication. (Govt. Code § 11349.1.) "Authority" requires that the regulation fall within the authorization of the statute. (Govt. Code § 11349(b).) "Consistency" requires that the regulations be "in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law." (Govt. Code § 11349(d).) Proposed Regulation 52502 addresses the Labor Costs Category, including the Labor Driven Operating Allocation ("LDOA"). According to Welfare and Institutions Code section 14126.023(c)(3), the LDOA "shall include an amount equal to 8 percent of labor costs, minus expenditures for *temporary staffing,* which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate." In addition, the State Plan Amendment("SPA 05-005"), which was approved by CMS in September 2005 provides, in relevant part, that: Labor-driven operating allocation includes an amount equal to eight percent of direct and indirect resident care labor costs, less expenditures for *agency staffing, such as nurse registry and temporary staffing agency costs.*	The assumption has been made that this comment refers to Sections 52000 and 52502. SB 853 (Chapter 717, Statutes of 2010) removed the Labor Driven Operating Allocation (LDOA) component of the facility-specific reimbursement methodology. As a result all language in Section 52502 pertaining to the LDOA was removed as part of the re-adoption of the emergency regulations on January 18, 2011. With the removal of the LDOA component, the commenter's request for amendments to the definitions of "Direct Care Agency Costs" and "Indirect Care Agency Costs", to include contract labor costs, is no longer applicable.

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	(SPA 05-005, § V(CX1)(emphasis added).) The proposed regulations do not follow these provisions. Proposed regulation 52500 sections (m) and (w) define direct and indirect care agency costs. (m) "Direct Care Agency Costs" means expenditures for contractor staff for routine services and ancillary services included in the Medi-Cal rate including all nursing, social services and activities. (w) "Indirect Care Agency Costs" means expenditures for contractor staff for housekeeping laundry and linen, dietary, medical records, in service education, and plant operations and maintenance. According to the proposed regulation, "[t]he Department shall calculate the LDOA by combining the direct and indirect labor costs, subtracting the expenditures for *direct care agency costs* as well as the expenditures for the *indirect care agency costs* and multiplying the sum by 8 percent." (Emphasis added.) The Department is interpreting the term "temporary staffing" as used in Welfare & Institutions Code section 14126.023 to include permanent contract labor, which many facilities utilize for nursing, housekeeping, dietary and other forms of staff. The Department is attempting to expand the scope of employees that are excluded from the LDOA calculations to contract labor in contravention of the plain language of Section 14126.023 and SPA 05-005. While the term "temporary staffing" is not defined by statute, it is commonly understood in the long-term care industry to refer to the use of nurse registries, employment agencies or temporary staffing agencies utilized by facilities to cover shifts on a temporary basis. California also recognizes the related term "temporary employee" as applying to nurse registries or nursing employment agencies. (Civil Code § 1812.540 et seq.) These temporary staffing agencies provide individuals, such as nurses, to work a shift or two before working the following day at a	

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	different facility. The nature of temporary staff is transitory, rather than permanent. On the other hand, contract labor is commonly understood in the industry to refer to distinct group of workers who are more permanent in nature than temporary staff. In particular, a facility will often contract with another company to provide certain employees who are assigned to the facility on an exclusive basis and generally work at the facility indefinitely, until the contract is terminated. The Department's proposed regulation expands the scope of such exclusions to costs for contract employees, who are an entirely different class of workers and are not temporary employees. *CAHF RECOMMENDATION: The Department should limit the exclusion from the LDOA calculation to temporary staffing, such as nurse registries. The Department should revise the definitions of the Direct and Indirect Care Costs to include contract labor costs.*	
3. QAF Change of Ownership (CHOW) Successor Liability (52104)	Proposed Regulation Section 52104 (Quality Assurance Fee and Change of Ownership) Exceeds the Department's Statutory Authority Pursuant to the APA, "no regulation adopted is valid or effective unless consistent and not in conflict with the [authorizing] statute and reasonably necessary to effectuate the purpose of the statute." (Govt. Code § 11342.2.) Furthermore, the APA requires that these regulations be reasonable and meet the six standards of necessity, authority, clarity, consistency, reference and nonduplication. (Govt. Code § 11349.1.) "Authority" requires that the regulation fall within the authorization of the statute. (Govt. Code § 11349(b).) "Consistency" requires that the regulations be "in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law." (Govt. Code § 11349(d).) "Necessity" requires that the rulemaking record demonstrate by substantial evidence the need for a regulation to effectuate the purpose of the statute, taking into account the totality of the	This section was not amended based comment. Section 52104 is under the authority of H&S Code Section 1324.23(b)(1) which authorizes the Department to adopt regulations necessary to implement this article, including the proper imposition and collection of the QAF. In addition, Section 52104 is consistent with Section 1324.22(f) which was added to the H&S Code through SB 853 (Chapter 717, Statutes of 2010) and requires the Department to assess and collect the QAF, including any previously unpaid QAF, from each skilled nursing facility, irrespective of any change in ownership.

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	record. (Govt. Code § 11349(a).) Proposed Regulation Section 52104 imposes liability for a licensee's quality assurance fee on any subsequent licensee of the same facility. The proposed regulation states: The amount due shall be assessed on each FS/NF-B and FSSA/NFB irrespective of any change in ownership, change in ownership interest or control, or the transfer of any portion of the assets of a FS-NF-B and FSSA/NF-B to another owner. A new owner shall assume any and all liability for payment of the amount due, plus interest, owed by the facility. Pursuant to Health and Safety Code section 1324.21, all facilities licensed under Health and Safety Code section 1250(c) must pay a uniform QAF per resident day. Section 1324.21 and others address several elements of the QAF, including calculation, increases, payment, penalties, collection, and exemptions. However, absolutely no section of the Health and Safety Code imposes liability for licensee's unpaid QAF upon a subsequent owner of the same facility. Thus, the Department has exceeded its authority from the authorizing statute. Moreover, the Department's position is not supported by the SPA. No provision of the SPA imposes successor liability for the QAF. In addition, the Department's proposed regulation conflicts with common law principles of successor liability. Under California law, when one corporation sells or transfers all its assets to another corporation, the latter is not liable for the debts and liabilities of the transferor unless one of our exceptions applies: (I) there is an express or implied agreement of assumption, (2) the transaction amounts to a consolidation or merger of the two corporations, (3) the purchasing corporation is a mere continuation of the seller, or (4) the transfer of assets to the purchaser is for the fraudulent purpose of escaping liability for the seller's debts. *(Ray v. Alad Corp.* (1977) 19 Cal.3d 22, 28; *Butler v. Adoption Media, LLC* (2007) 486	

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	F.Supp.2d 1022, 1063). **FN1** With regard to the third exception, the "mere continuation" doctrine requires that "after the transfer of assets, only one corporation remains, and there is an identity of stock, stockholders and directors between the two corporations. *(California Dept. of Toxic Substances Control v. California-Fresno Investment Co.* 2007 WL 1345580 at 6.) Other courts have found successor liability under the "mere continuation" exception where: (I) no adequate consideration was given for the predecessor corporation's assets and made available for meeting the claims of its unsecured creditors; and, (2) one or more persons were officers, directors, or stockholders of both corporations. *(Ray, supra,* 19 Cal.3d at 29.) "The key element of a continuation is a common identity of the officers, directors, and stockholders in the selling and purchasing corporations." *(California Dept. of Toxic Substances Control, supra,* 2007 WL 1345580 at 6.) **FN1:** Federal courts have adopted this same standard in deciding whether a corporation, which acquires the assets of another corporation, may be held liable under the Comprehensive Environmental Response Compensation and Liability Act ("CERCLA") for the costs of investigating and abating hazardous substances for which the predecessor corporation is responsible. There is simply no legal basis for the imposition of liability of a QAF on a successor. The Department lacks the authority to promulgate the proposed regulation and the proposed regulation is not consistent with existing law. Finally, the proposed regulation is unnecessary to effectuate the purpose of the AB 1629. Among other things, the Department has the authority (if not a duty) to collect QAF from the facility that incurs them. For example, the Department may deduct outstanding QA F from prospective Medi-Cal payments to facilities, delay licensure, and impose penalties against noncompliant facilities. The need to impose successor liability would only arguably arise where the Department inexcusably fails to avail itself of these other remedial measures.	

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	CAHF RECOMMENDATION: The Department eliminate this proposed regulation.	
4. Definitions/liability insurance costs inconsistent with SPA (52500)	Proposed Regulation Section 52500 (Definitions) Violates the State Plan Amendment Pursuant to the APA, "no regulation adopted is valid or effective unless consistent and not in conflict with the [authorizing] statute and reasonably necessary to effectuate the purpose of the statute." (Govt. Code § 11342.2.) Furthermore, the APA requires that these regulations be reasonable and meet the six standards of necessity, authority, clarity, consistency, reference and nonduplication. (Govt. Code § 11349.1.) "Authority" requires that the regulation fall within the authorization of the statute. (Govt. Code § 11349(b).) "Consistency" requires that the regulations be "in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law," (Govt. Code § 11349(d).) Proposed Regulation Section 52500 contains definitions of, among other things, liability insurance costs. The proposed regulation states: "(q) Direct Pass-Through Costs for Liability Insurance means the reasonable cost of insurance premiums purchased from a commercial insurance carrier ...." Section	The Department assumes this comment refers to Section 52000, subsections (b) and (r) and to Section 14126.023. These subsections were amended through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010). Professional Liability Insurance (PLI) costs, including deductible costs, will no longer be reimbursed as direct pass-through costs, as specified under W&I Code Section 14126.023(a)(5)(B). SB 853 specifies that PLI costs shall be reimbursed under their own cost category, and the definition for "Direct Pass-Through Costs for Liability Insurance" was amended and re-designated. In addition, all references to liability insurance costs within the direct pass-through category, in Section 52506, were removed and the PLI requirements were placed in Section 52507(f). Subsequently, through the 15-Day Public Availability (published on February 17, 2011), the requirements under subsection (f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is

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	52500(a) defines Administrative Costs to include "liability insurance deductibles." The Department is specifically carving out liability insurance deductibles from the Direct Pass-Through Cost Category. This violates the provisions of AB 1629 and the SPA. Specifically, California's Welfare & Institutions Code § 14126.03 defines the Direct Pass-Through cost category as including the following expenses: "costs for property taxes, facility license fees, new state and federal mandates, caregiver training and liability insurance projected on the prior year's costs." (Welf. & Inst. Code § 14126.023 [emphasis added].) This section does not distinguish "premium costs" as the only allowable "liability insurance cost." The proposed regulation is creating just such a distinction. Indeed, of the five cost categories set forth in Welfare and Institutions Code section 14126.023(a), only the Direct Pass-Through cost category contemplates liability insurance costs in any form. The four other cost categories Authorized by section 14126.023(a), including the administrative cost category, contain no language pertaining to insurance whatsoever. Therefore, the proposed regulation contravenes the express language of Welfare& Institutions Code § 14126.023(a)(5). In addition, the Medicaid State Plan prohibits treating the liability insurance deductibles and other liability costs as administrative costs under AB 1629. Specifically, the Medicaid State Plan provides: The administrative cost category will include allowable property insurance costs, and *exclude* expenditures associated with caregiver training, liability insurance, facility license fees, and medical records. (State Plan Amendment, Supplement 4 to Attachment 4 19-D, § V(C)(3).) Thus, the definition of Administrative Costs directly contradicts the SPA. *CAHF RECOMMENDATION: The Department should include in the Direct Pass Through Cost category all liability insurance*	in accordance with the authority under W&I Code Section 14126.027(c).

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	costs, including deductible costs. The Department should revise the definition of Administrative Costs to exclude liability insurance deductibles. **Conclusion –** **The proposed emergency regulations do not comply with the APA in that many of the provisions are not authorized by statute, conflict with existing law or are unnecessary to effectuate AB 1629. Moreover, the Department failed to establish the appropriate basis for issuing these proposed regulations on an emergency basis. The only way to remedy the problems in these regulations is to substantially revise and re-issue these regulations in a manner consistent with AB 1629, the SPA and other existing laws. CAHF is ready, able and willing to be involved in stakeholder discussions to move this process forward to create an appropriate regulatory package.**	

COMMENT LETTER 2 (CAHF 9/27/10 – Oral Testimony)		
SUBJECT	**COMMENT**	**RESPONSE**
1. Finding of Emergency	As outlined in our letter dated July 19, 2010, to the Department, the Department's issuance of these regulations on an "emergency" basis was neither lawful nor justified under the circumstances.	The Department relies on the emergency authority provided through the enactment of AB 1629 (Chapter 875, Statutes of 2004) that established the QAF and the Medi-Cal LTC Reimbursement Act. Specifically, H&S Code, Section 1324.23 provides for the Department to adopt "as emergency regulations" those requirements "as are necessary to implement the QAF article". W&I Code, Section 14126.027 authorizes the Department to adopt the Medi-Cal LTC rate methodology regulations on an emergency basis, and also states that "the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action." Both of these statutes clearly provide for the Department's emergency rulemaking authority for these regulations. This is further discussed in the Department's Finding of Emergency as initially dated June 24, 2010. The Department believes that all provisions of the regulatory text fall within the authority provided in the above noted statutes. The Office of Administrative Law has confirmed the Department's authority for emergency regulations by approving the initial emergency filing on July 22, 2010 and the subsequent re-adoption of the emergency regulations, which were effective on January 18, 2011.
2. No stakeholder consultation	This emergency regulation package was crafted by the Department without any stakeholder involvement. This is clearly at odds with the legislative intent to have stakeholder involvement in the ongoing implementation of AB 1629, including the development of regulations and similar instructions as required by Welfare and Institutions Code section 14126.027 (a) (2). CAHF was first given notice of these regulations on June 24, 2010, by Vanessa Baird, Deputy Director of Health Care Policy. She provided an advance copy to CAHF CEO/President, Jim Gomez. CAHF inquired within 2 hours of receipt if there was an opportunity for input and was informed by Ms. Baird that the regulations had been submitted and were on the way to printing.	The implementation of AB 1629 (Chapter 875, Statutes of 2004), the QAF Program and Medi-Cal LTC Reimbursement Act, began with the development and release of provider bulletins, as authorized by H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c). Through the development and implementation of these bulletins the Department met with stakeholders on numerous occasions, which was followed by ongoing informal discussions with stakeholders. In accordance with H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c) the Department transitioned the bulletin provisions into regulatory language, meeting the standards of the Administrative Procedure Act (APA). During this time the Department also collaborated with stakeholders regarding proposed SB 853 (Chapter 717, Statutes of 2010). This emergency regulatory proposal was initially adopted on July 22,

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	When the regulations were transmitted to CAHF, the Department stated that: "These regulations reflect current provider bulletins and practices and they are also consistent with the proposed trailer bill." These emergency regulations cover specific matters and subject areas that were not covered in any AB 1629 provider bulletin and are not consistent with the current trailer bill language.	2010, and was followed by public proceedings (including a public hearing). The regulations were amended in accordance with SB 853 (Chapter 717, Statutes of 2010) and re-adopted on an emergency basis on January 18, 2011. Prior to the publication of the 15-Day Public Availability, the Department convened a stakeholder meeting to discuss any additional changes.
3. LDOA elimination (52502)	The regulations provide for a labor-driven operating allocation which is eliminated in TBL.	Same Response as Comment Letter 1, Comment 2.
4. PLI Deductibles (52000)	The regulations include liability insurance deductibles as administrative costs. The TBL provides that deductibles be categorized as liability insurance pass-through costs.	"Liability insurance deductibles" were excluded from the definition of Administrative Costs through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 835 (Chapter 717, Statutes of 2010). Also as a result of the re-adoption of the regulations, liability Insurance deductible costs are under a new cost category. These costs are not considered to be "direct pass-through costs" as highlighted within this comment, instead the liability insurance cost deductibles will be reimbursed within the new professional liability insurance (PLI) costs category at the 75th percentile, unless providers fail to submit the required supplemental data to the Department. Otherwise these costs will be reimbursed within the Administrative Costs Category (at the 50th percentile) as specified in W&I Code Section 14126.023(a)(5)(B).
5. MLRC exemption (52102 & 52103)	The regulations will exempt multi-level retirement communities from paying the quality assurance fee – the TBL removes this exemption.	Section 52103 "Request for Exemption from the QAF" and the related definitions (Assisted Living Services, Business Practice, Certificate of Authority, Corporate Structure, Independent Living Services, Multi-Level Retirement Community and Residential Care Facility for the Elderly) were removed from the regulations through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
6. Labor costs category (52000 & 52502)	The proposed regulation sections 52000 (Definitions) and 52502 (Labor Costs Category) violate Welfare and Institutions Code section 14126.023(c).	This comment is vague. These two sections contain a lot of information. The Department is unable to provide a specific response. However, see response to Comment Letter 1, Comment 2 for related information.

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7. QAF & CHOW (52104)	The proposed regulation Section 52104 (Quality Assurance Fee and Change of Ownership) exceeds the Department's statutory authority.	Please see response to Comment Letter 1, Comment 3.
8. Definitions (52000)	The proposed regulation section 52500 (Definitions) violates the State Plan Amendment.	The Department assumes this comment is referring to Section 52000. This comment is vague. The State Plan Amendment (SPA) contains a substantial amount of information, as does Section 52000. The Department is unable to provide a specific response. However, please refer to Comment Letter 1, Comment 4 for related information.
9. Captive insurance policies 52506	The proposed regulation section 52506 in the area of the liability insurance pass through is contrary to Medicare reimbursement principles in the Provider Reimbursement Manual (the "PRM"). The provisions related to captive insurance policies are critically flawed and if not changed, eliminate the reimbursement of liability cost for providers who insure through a captive. The regulation erroneously applies self insurance provisions contained in the Medicare PRM to captive insurance coverage. Captive arrangements will not meet these provisions. It is absolutely clear from the Initial Statement of Reasons, that the Department's intent is to equate providers with liability insurance through captive insurance arrangements as one and the same as providers who self insure liability insurance costs. This is a critical flaw which must be rectified by the Department's need to research and understand that self-insurance and captive insurance arrangements are two very different modes of coverage and regulations should reflect this basic premise. **Conclusion** – **The proposed emergency regulations do not comply with the Administrative Procedure Act in that many of the provisions are not authorized by statute, conflict with existing law or are unnecessary to implement AB 1629. Moreover, the Department failed to establish the appropriate basis for issuing these proposed regulations on an emergency basis.** **The only way to remedy the problems in these regulations is to substantially revise and re-issue them in a manner**	Through the re-adoption of the emergency regulations on January 18, 2011, provisions related to professional liability insurance costs under Section 52506 were amended and moved to new Section 52507 to be consistent with SB 853 (Chapter 717, Statutes of 2010). Subsequently, through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).

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	consistent with AB 1629 statutory requirements, the State Plan Amendment and Medicare reimbursement principles. **CAHF is ready, able, and willing to be involved in stakeholder discussions to move this process forward to create an appropriate regulatory package.**	

COMMENT LETTER 3 (SEIU 9/29/10)		
SUBJECT	**COMMENT**	**RESPONSE**
1. TBL Changes	It is unclear why the Department is moving to adopt regulations that could potentially conflict with the proposed changes to the methodology included in the AB 1629 Reauthorization Budget Trailer Bill Language (TBL). We suggest that the Department wait to consider the adoption of regulations until after the budget discussions have settled and the proposed changes are adopted. If the Department moves ahead now, our concern is that it would be premature and we run the risk of adopting regulations that are inconsistent with the final changes to the AB 1629 Reauthorization TBL. We suggest that the expiration date of the emergency regulations be extended beyond January 18, 2011 for a period of 90 days so the Department can modify these proposed regulations to reflect the adopted budget trailer bill language.	Through the re-adoption of the emergency regulations on January 18, 2011 (with an extension to April 18, 2011), the Department incorporated all of the AB 1629 programmatic/methodology changes in relation to SB 853 (Chapter 717, Statutes of 2010).
2. Caregiver Training (52000)	SEIU suggests broadening the definition of "Direct Pass-Through Costs for Care Giver Training" in Section 52000 (p). The definition should be expanded to include nursing facility contributions to nonprofit employer-employee training funds. "Direct Pass-Through Cost for Care Giver Training" means costs for a formal program of education that is organized to train students to enter a care giver licensed or certified occupational specialty, which includes salaries, wages and benefits of the instructor and expenses for related training materials or supplies; or the cost of a contracted instructor if services are performed within the facility; or contributions to a non-profit employer-employee training fund to provide caregiver training services. Currently the direct pass-through costs for care giver training is underutilized. During the 2009-10 rate year only 5.7% of nursing facilities were compensated under the program." **FN1** SEIU believes that broadening the definition would encourage nursing facilities to invest in the education of caregivers. **FN1: California Department of Health Care Services, Long Term Care Reimbursement, 2009-2010 Final Rates downloaded March 23, 2010 from http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx; 56 of 986 nursing facilities received**	This section was not amended based on comment. The definition as written is consistent with Section 1141 of the Office of Statewide Health Planning and Development (OSHPD) Accounting and Reporting Manual for California Long-Term Care Facilities and meets the criteria for care giver training that was established as part of the facility-specific rate methodology. The proposal to include contributions would require new statutory authority because contributions are not considered an allowable expense per CMS Publication 15-1, Section 2105.7.

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	reimbursement for care giver training.	
3. Labor Inflation Index (52000)	SEIU encourages the Department of Health Care Services to include a more thorough definition and methodology of the Labor Inflation Index in the proposed regulations. SEIU suggests the Department creates two Labor Inflation Indices: 1) One for higher-labor cost facilities that provide employer paid health insurance and 2) Another for lower-labor cost facilities. Higher labor-cost facilities, especially those that offer employer paid health insurance, often encounter higher inflation year after year due to health insurance premium rate hikes and offering higher annual wage increases. These facilities should not be penalized by the time lag between when costs are incurred and when reimbursement rates are determined.	The definition of "Labor Inflation Index" was revised through the 15-Day Public Availability to more accurately reflect the variables and methods used to develop this index, based upon the "Study to Develop Labor Index For Long-Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010). The Department appreciates the suggestion to create two separate labor inflation indices, used for higher and lower cost counties, which may be taken into consideration for future rate years.
4. Peer Groups (52000 & 52508)	SEIU suggests the peer group definition be modified in Section 52000(cc) to the following: (cc) "Peer Group" means a group of geographic areas (such as health service areas or health facility planning areas for larger HSA areas) that are categorized and clustered together by means of the following factors: median/average direct care per diem costs and frequency of provider facilities within each geography. Geographically contiguous areas are preferred. SEIU suggests that section 52508(a) should not contain the specific counties in each peer group until a reevaluation of the peer group methodology can be conducted. SEIU encourages the Department to include a process to review Peer Group designations every five years. The language should also specify how Peer Groups are determined and how they can be re-evaluated. We suggest the following language: (a) The Department shall place FS/NF-Bs in peer groups. At least once every 5 years the peer group designations shall be evaluated to ensure that the geographic regions are clustered	This section was not amended based on comment. The peer groups (including the definition) were established by the professional consulting company in the context of the development of the facility-specific rate methodology, in accordance with W&I Code Sections 14126.02(c) and 14126.023(b). The consulting company conducted a peer group analysis using a statistical cluster of historical median direct care costs, labor markets and the cost of living as indicative sources. There is no statutory mandate that "established" peer groups be reconfigured. There are currently no plans to re-evaluate the peer-group methodology or designation for the current rate year. However, a re-evaluation of the peer group methodology may be taken into consideration in future years. W&I Code Section 14126.023(b), specifies that rates (methodology) shall be calculated based on a specific geographic peer-group basis. There is no mandate within the W&I Code that peer grouping be based on counties that are contiguous or based on contiguous geographic areas.

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	appropriately to reflect the most recent audited cost reports. SEIU believes that use of the term "geographic" in AB 1629 clearly implies that each peer group will be comprised of contiguous counties or other contiguous geographic areas. We believe that the Department's current policy and proposed regulations which creates peer groups solely through cluster analysis of counties, regardless of location or regional market variation is directly contrary to the legislative intent of AB 1629. SEIU disagrees with using county boundaries as the geographic definition to determine peer groups given the wide variation of the number of nursing facilities in each county (range of 0 to 350+), and the relevance of an urban/rural county designation, especially when the methodology of determining how a county is considered urban or rural is not defined. The Department's current 7 peer group vary in size from 19 facilities to 380, which is not a balanced approach. The peer group configurations have not been reviewed since they were created in early 2005 based on 2003 OSHPD cost report data, and it is time that the peer group configurations be reevaluated given how much costs have changed under this new reimbursement methodology. SEIU would like to note that Los Angeles County (the largest Peer Group) should be split into at least two peer groups. Los Angeles County is geographically and economically diverse and these factors should be reflected by separating the County into separate Peer Groups. The current LA county peer group contains facilities which significantly vary in costs, the purpose of the percentile limits for each cost component is lost, as some facilities are over-compensated and some are under-compensated. Allowing disparity among labor costs within a peer group may have a direct impact on resident care and staffing; facilities spending more on staffing and resident care may see their reimbursement capped at lower levels due to being inappropriately included in a peer group with lower-spending facilities.	

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5. Cost reports (52500)	Cost Reports, Section 52500(b), Page 14 SEIU supports the most efficient process for determining reimbursement rates. To this end, SEIU proposes the following language change in the regulation: (b) The per diem rate shall be calculated prospectively on a facility-specific basis using the most recent audited facility-specific cost report data as specified in Health and Safety Code Section 128730. FN2 SEIU believes that the above language better reflects the intent of AB 1629. AB 1629 does not include a mandatory time lag of two years when looking at cost reports and such language should not become regulation. It is understood that this two year time lag is current practice and SEIU encourages that Department to consider reducing this time lag. FN2: Current proposed language: "The per diem rate shall be calculated prospectively on a facility-specific basis using facility-specific cost report data as specified in Health and Safety Code Section 128730 with a fiscal period end date two years prior to the **rate year."**	Through the re-adoption of these emergency regulations on January 18, 2011, the Department did make amendments similar to those proposed through this comment. Specifically the "two year time lag" was removed and the term "audited" was included in the description of "cost report data," based on W&I Code Section 14126.023(i)(2).
6. TBL changes	AB 1629 Reauthorization Trailer Bill Language Proposed Changes Section 52100, 52101, 52102, 52103, Quality Assurance Fee; Section 52506, Direct Pass-Through Cost Categories; Section 52502(d), Labor Driven Operating Allocation There are many proposed changes to AB 1629 in the 2010-2011 Budget Trailer Bill Language (especially to the Quality Assurance Fee and Liability Insurance Pass-Through). SEIU suggests that the Department wait to consider the adoption of regulations until after the AB 1629 reauthorization discussions have settled and the proposed changes are adopted.	These emergency regulations were re-adopted effective on January 18, 2011 and included amendments that incorporated recently enacted provisions from SB 853 (Chapter 717, Statutes of 2010).
7. Audit specificity (52516)	**Audits and Audit Adjustments, Section 52516(a), Page 40** SEIU supports the Department's commitment to conduct audits; however the language for section 52516(a) is unclear and appears inconsistent with the intent of W&1 Code 14126.023(h).	Section 52516(a) was amended, as suggested, through the 15-Day Public Availability (published on February 17, 2011). However, an additional amendment was also included to remove the phrase "or review," to be consistent with W&I Code Section 14126.023(j) and the term "at" remains instead of the

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	The regulation needs to clearly state that a full scope field audit needs to happen at least once every three years with a limited scope audit annually. **We suggest the language be modified to the following:** **(a) The Department shall conduct full-scope field audits of all *FS/NF-Bs* facilities and home offices participating in the Medi-Cal program a minimum of once every three years. Limited scope reviews shall be conducted during intervening periods. All *FSSA/NF-Bs* shall be subject to audit or review on an annual basis.**	suggested term “during.”

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1. Differentiate clinical admin from non-clinical admin (52000)	**Administrative Costs – CAHF recommends that changes be made to Subsection (b) for the following specific reasons:** There is a need to ensure clarity in differentiating activities between those related to general administration and clinical administration/management. CAHF suggests language be added such as the term "non-clinical" when describing certain specific administrative activities. Clearly, clinical direction and management is related to direct patient care and these costs should be allocated appropriately, which was the intent of AB 1629. *Recommended language changes are specified. (Applies to comments 1-5)*	This section was not amended based on comment. W&I Code Section 14126.023(a)(3) specifies Administrative Costs as one of the designated cost categories for the facility-specific rate methodology. As described in the FSOR, Page 5, the definition for this cost category is based on the definition of "Administration Cost Center" from the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities sections 3220.2 and 3220.3, which clearly delineates these costs as those related to the overall management and administration of the facility, which would be considered non-clinical (not direct care). Although administrative activities do support clinical direction and management, such as those provided by an attending physician, the management of these administrative activities is not clinical (direct care).
2. Move Medical Director from Admin to Direct Care and/or Non-Labor (52000)	The medical director should not be included within the definition as duties are more expansive than strictly administrative. The position should be included in direct care or direct care non-labor. The medical director's primary responsibility is to consult with Direct Care staff and provide oversight of the care and evaluation of the residents. This is obviously not an administrative function. This is further supported by the definition of Medical Director contained in Appendix B of Office of Statewide Health Planning and Development Accounting and Reporting Manual for California Long-Term Care Facilities, which provides the following definition for Medical Director: A physician who acts as a liaison between facility administration and attending physicians, reviews and evaluates facility patient care policies. The medical director also acts as a consultant to director of nursing services in patient care matters. Furthermore, federal certification requirements at F Tag 50l (implementing 42 CFR 483.75(i)) outline the responsibilities of the Medical Director. The CMS intent in establishing this requirement is that the medical director provides clinical guidance and oversight regarding resident care policies and procedures and assists in the identification, evaluation and	This section was not amended based on comment. As described in the FSOR, Page 5, the definition for this cost category (administrative costs) is based on the definition of "Administration Cost Center" from the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities sections 3220.2 and 3220.3, which clearly delineates these costs as those related to the overall management and administration of the facility, which would not be considered direct care. The medical director does provide clinical leadership and oversight for resident care policies. However, in this position the medical director does not provide direct care to residents, thus the placement of this position within this cost category definition is appropriate and consistent with the Title 42 CFR 483.75(i)), which clearly distinguishes the functions of the medical director versus an attending physician. Specifically, the medical director coordinates facility wide medical care while the attending physician provides direct care to the individual residents.

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	resolution of medical and clinical concerns and issues. As a clinician, the medical director plays a pivotal role in providing clinical leadership regarding current standards of practices and approaches to care. The 200I Institute of Medicine report, "Improving the Quality of Long Term Care", urged facilities to give medical directors greater authority for medical services and care. The report states," Nursing homes should develop structures and processes that enable and required a more focused and dedicated medical staff responsible for patient care." This report and the CMS expansive guidance to surveyors at F Tag 50I emphasize the medical director's clinical role in assuring current, relevant and effective care practices are an integral part of the skilled nursing facility care delivery system. While CAHF firmly believes that the entire cost of the Medical Director should be classified as a direct care or direct non-labor cost, at a minimum, the regulations should be rewritten to provide that only that portion of the Medical Director's position directly related to administrative functions should be allocated or assigned within the definition of the administrative category. Clearly clinical direction and management is related to direct patient care and these costs should be allocated appropriately, which was the intent of AB 1629. This clarification is necessary because DHCS's auditors have inappropriately reclassified these and similar costs as administrative costs when they should be direct care costs. *Recommended language changes are specified. (Applies to comments 1-5)*	
3. Liability Insurance Deductibles, Paid Liability Losses, Paid Claims, Claims Mgt Fees, and Taxes on PLI should be included in PLI Pass-Thru (52506)	Liability insurance deductibles, paid liability losses, paid claims and claims management fees, and taxes related to liability insurance should not be included within the definition of administrative cost. These should be included within the pass-through costs category of liability insurance costs defined under Section 52506 (a)(l). Any costs associated with obtaining liability insurance should fall within the pass-through costs category.	Section 52000(b) was amended through the re-adoption of these emergency regulations on January 18, 2011 in accordance with SB 853 (Chapter 717, Statutes of 2010). Specifically, "liability insurance deductibles" was removed. PLI costs, including deductible costs, will no longer be reimbursed as direct pass-through costs. Instead, SB 853 specifies that PLI costs shall be reimbursed under their own cost category. In addition all references to liability insurance

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	W & I Section 14126.023 uses the term "liability insurance" and these costs are all part of cost of obtaining insurance coverage. CAHF's recommendation is consistent with the State Plan. This clarification is necessary because DHCS's auditors have inappropriately reclassified these and similar costs as administrative costs when they should be liability insurance costs. *Recommended language changes are specified. (Applies to comments 1-5)*	costs within the direct pass-through category in Section 52506 were removed and the PLI requirements were placed in Section 52507(f). Subsequently, through the 15-Day Public Availability (published on February 17, 2011), the requirements under subsection (f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c). Although insurance (PLI) costs, including deductible costs, will no longer be reimbursed as direct pass-through; taxes related to liability insurance and paid liability claims will remain in the administrative costs category. The taxes related to liability insurance are not liability insurance costs, and the PLI provisions under W&I Code Section 14126.023(a)(5)(B) do not include taxes. As for paid liability claims, the first dollar losses are considered deductibles, but losses paid that are not part of a specified deductible amount will also continue to remain under the administrative costs definition.
4. MIS related to Management of Clinical Info should be moved from Admin to Non-labor (52000)(b)	There needs to be clarity in defining management information systems (MIS) such as that referred to as: "the production of indexes, abstracts, and statistics for facility management uses." This is necessary to differentiate MIS between resident care and administrative management functions. MIS related to management of clinical information, including resident care related management information, should be categorized under the definition of "Direct and Indirect Non-Labor Costs" included under subsection (O). *Recommended language changes are specified. (Applies to comments 1-5)*	This section was not amended based on comment. W&I Code Section 14126.023(a)(3) specifies Administrative Costs as one of the designated cost categories for the facility-specific rate methodology. As described in the FSOR, Page 5, the definition for this cost category (administrative costs) is based on the definition of “Administration Cost Center” from the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities sections 3220.2 and 3220.3, which clearly specifies that administration includes data processing activities (MIS).
5. Add clarifying Language similar to the OSHPD Report for Admin (52000)	Additional language similar to that contained in the Office of Statewide Health Planning and Development Accounting and Reporting Manual for California Long-Term Care Facilities, Section 6900, relating to Administration, should be added to assure consistency with established cost reporting procedures. The manual states: "Also, expenses which are not assignable to a particular cost center should be included here. However, care should be taken to ascertain that all costs included in this cost center do not properly belong in a different cost center."	This section was not amended based on comment. All the costs are allocated correctly under their appropriate cost categories, consistent with W&I Code Section 14126.023. Thus all costs are appropriately categorized and no additional clarification is necessary.

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	Recommended language changes are specified. (Applies to comments 1-5)	
6. Add Ancillary Costs definition (52000)	Add definition for "ancillary costs" – A definition of ancillary costs is required to ensure clarity and differentiation between the types of costs incurred when rendering care to residents of free-standing skilled nursing facilities (NFs) and subacute facilities. *Recommended language changes are specified.*	This section was not amended based on comment. A definition of ancillary costs (that differentiates between FS/NF-Bs and FSSA/NF-Bs) is not necessary. Existing CCR Section 51511 clearly delineates the services and supplies (ancillary costs) that are outside the scope of the reimbursement rate for FS/NF-Bs. Existing Section 51511.5 clearly specifies the services, equipment and supplies (ancillary costs) that are included within the FSSA/NF-Bs reimbursement rate.
7. Assisted Living Svc Definition clarification-to be provided in a RCFE (52000)	(c) Assisted Living Services – This definition lacks clarity. As written, NFs provide assisted living services but that is not the intent of the regulations. At a minimum, the definition should provide that assisted living services be rendered in a Residential Care Facility for the Elderly. If the 2010-20 11 Trailer Bill Language (TBL) passes, this definition won't be necessary. *Recommended language changes are specified.*	The definition of "Assisted Living Services" was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
8. Delete Business Practices definition (52000 & 51202)	(f) Business Practice - The term "business practice" is overly broad when considered in conjunction with section 51202(c). Under this definition, a minor change to a Human Resource manual would require notification to DHCS. CAHF suggests that the term be deleted. This definition is not necessary if TBL passes. *Recommendation – delete this definition and the term from 51202(c)*	The definition of "Business Practice" was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
9. Add CCPI definition-deadline of May of each year to create CCPI Import File (52000)	Add a new subsection for the California Consumer Price Index – A new subsection should be added to define the All-Urban California Consumers Price Index (CCPI) published by the California Department of Finance (DOF). It is also important to provide information on how DHCS uses these data to create an index for the rate study, and specific cut off dates for the rate study.	This section was not amended based on comment. There is no need to define the California Consumer Price Index (CPI). The CPI is a commonly understood economic indicator, which is published and described by the Department of Industrial Relations, available at http://www.dir.ca.gov/dlsr/CPI/faqs.htm#q1. The Department simply uses the CPI to adjust the applicable costs as part of the rate-setting development process. This index is further

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	Recommended language changes are specified.	described under the FSOR under each relevant cost category.
Capital Costs/FRVS: (Comments 10-13)		
10. Leased Specialty Medical Equipment included in Capital Costs (52000)	(g) Capital Costs - DHCS auditors have reclassified costs to capital costs incorrectly. This has resulted in unnecessary and expensive audit appeals. CAHF is recommending language that will clarify what is included in capital costs. This definition should be clarified to ensure that leased specialty medical equipment such as specialty beds and home office related capital costs are not included. Equipment such as specialty beds that are leased are patient care equipment and properly classified as an ancillary cost and should not be included within the definition as "leased" equipment. *Recommended language changes are specified. (Applies to comments 10-13)*	This section was not amended based on comment. "Leased specialty medical equipment" used in patient care, such as specialty beds, are not included within the capital costs portion of the facility-specific reimbursement rate. The exclusion of these costs does not need to be identified within the definition of capital costs because Department auditors are not including these costs within this portion of the audit reports. The intent of this definition is to solely specify the factors included within the costs, not to describe exclusions. These costs are reimbursed by the Medi-Cal program, but not under this facility-specific reimbursement rate system. Existing CCR Section 51511 clearly delineates the services and supplies (ancillary costs) that are outside the scope of the reimbursement rate for FS/NF-Bs. Existing Section 51511.5 clearly specifies the services, equipment and supplies (ancillary costs) that are included within the FSSA/NF-Bs reimbursement rate.
11. Home Office Capital Costs included in Capital Costs (52000)	Capital costs related to home office are "home office" costs and are not to be included within the capital cost category for a facility but are included within the administrative cost category. Home office costs were not considered as capital cost in the development of the FRVS, and the classification of such costs as capital cost does not afford the provider proper reimbursement for costs that were previously considered to be administrative. *Recommended language changes are specified. (Applies to comments 10-13)*	This section was not amended based on comment. "Home office" costs are not included within the capital cost category, they are however included within the administrative cost category. The exclusion of these costs does not need to be identified within the definition of capital costs because the Department auditors are not including these costs within this portion of the audit reports. The intent of this definition is to solely specify the factors included within the costs, not to describe exclusions.
12. Incidental Rentals included in Capital Costs (52000)	Incidental rentals, which include daily rentals of chairs for a facility functions, temporary garbage containers, etc., are excluded from capital costs. *Recommended language changes are specified. (Applies to comments 10-13)*	This section was not amended based on comment. "Incidental rentals," such as daily rentals of chairs for facility functions, temporary garbage containers, etc., are not included within the capital costs portion of the facility-specific reimbursement rate. The exclusion of these costs does not need to be identified within the definition of capital costs because the Department auditors are not including these

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		costs within this portion of the audit reports. The intent of this definition is to solely specify the factors included within the costs, not to describe exclusions.
13. Complex Equipment and DME included in Capital Costs (52000)	Complex or durable medical equipment that are directly related to the provision of patient care are excluded from Capital Costs. **These clarifications are necessary because DHCS auditors have inappropriately reclassified these and similar costs as capital costs when they are more appropriately allocated to other cost categories. (Applies to comments 10-13)** *Recommended language changes are specified. (Applies to comments 10-13)*	This section was not amended based on comment. "Durable medical equipment" used in patient care, is not included within the capital costs portion of the facility-specific reimbursement rate. The exclusion of these costs does not need to be identified within the definition of capital costs because the Department auditors are not including these costs within this portion of the audit reports. These costs are reimbursed by the Medi-Cal Program, but not under this facility-specific reimbursement rate system. The intent of this definition is to solely specify the factors included within the costs, not to describe exclusions. Existing CCR Section 51511(c), clearly specifies the items excluded from the rate, such as: specialty beds, variable height beds and specialized support surfaces.
14. New Capital Project definition (52000)	Add new subsection to define "Capital project" – Language defining this term for purposes of the Fair Rental Value System (FRVS) should be added. "Capital project" should include specificity to allow the ability to aggregate upgrades and renovations that are not specifically like in nature such as painting and new carpeting. This clarification is necessary because DHCS auditors have inappropriately excluded these types of costs when computing the FRVS amount and they should be included to encourage facilities to renovate and upgrade facilities and assure proper reimbursement. *Recommended language changes are specified.*	This section was not amended based on comment. The term "capital project" is not used within this regulatory proposal, thus it is not defined. This term is commonly understood by long-term care stakeholders. For further information please see the FSOR Page 11, which references the document relied upon "Frequently Asked Questions Regarding Capital Supplemental Schedule for 2008-2009 Rate Year".
15. Reword Captive Insurance Policy definition (52000)	(h) Captive Insurance Policy – The second sentence of the definition lacks clarity in that goes beyond the stated definition and uses other undefined terms such as "operating entity" or "captive company." Section 2162.2A of the Publication 15-1, titled The Provider Reimbursement Manual (PRM), published by the Centers for Medicare and Medicaid, includes a definition of "captive insurance companies" which is tied to "premium costs." The definition used in this section should be consistent with the PRM and link "captive insurance policies" to the payment of	This definition was removed through the 15-Day Public Availability (published on February 17, 2011), as a result of collaboration and recommendation from stakeholders and to be consistent with the removal of Section 52507(f), which also occurred through the 15-Day Public Availability.

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	premiums. This assures consistency with the State Plan Amendment (SPA), which provides that cost reporting shall be consistent with Medicare reimbursement principles. *Recommended language changes are specified.*	
16. Current Facility Value definition (52000)	(k) Current Facility Value -The term "under-depreciated" lacks clarity in that it is not a commonly used term and there is no reference to the context of use for this definition such as "for purposes of defining elements of the FRVS". *Recommended language changes are specified.*	In response to this comment and upon further review it was determined that this definition was not necessary, so it was removed through the 15-Day Public Availability (published on February 17, 2011). Section 52505(a)(4), as proposed through the 15-Day Public Availability, clearly states how the current facility is determined.
17. Direct Care Agency Costs and Contractor Staff (52000)	(m) Direct Care Agency Costs – The language is awkward and should be re-written to ensure appropriate cost reporting for routine and ancillary services. Further, there is a need for clarity on the definition of contractor staff. Costs incurred by a facility for registry/temporary staffing, including consultants utilized in direct care activities, such as nursing consultants and wound care consultants should be included in this cost category. This clarification is needed because DHCS auditors have inappropriately reclassified these and similar costs during audits. *Recommended language changes are specified.*	This section was not amended based on comment. "Direct Care Agency Costs," are considered costs of labor for services provided by contract staff, directly to residents (i.e. nursing registry). On the other hand, the costs of services provided by a "consultant" (such as a wound care consultant) would fall under "Direct and Indirect Care Non-labor Costs" because these services support the delivery of resident care but are not provided directly by the consultant.
18. Direct Care Home Office Costs (52000)	(n) Direct Care Labor Costs – A reference should be added to ensure that home office costs related to direct care are included. Such costs would include clinical oversight and quality reviews performed by a nurse that is paid from the home office. This clarification is needed because DHCS auditors have inappropriately reclassified these and similar costs during audits. *Recommended language changes are specified.*	This section was not amended based on comment. Home office costs are clearly described in the definition of "Administrative Costs," based on the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities sections 3220.2 and 3220.3, which clearly delineates these costs as those related to the overall management and administration of the facility, which would not be considered direct care. Services provided remotely from a home office can't be considered direct care labor costs since such services are not provided directly to a resident in the facility.
19. Non-labor-Non-Administrative Consultants (52000)	(0) Direct and Indirect Care Non-Labor Costs – The phrase "non-administrative consultants" should be expanded to ensure that the definition captures consultants that are not included within the definition of direct/indirect care agency costs included with subsections (m) and (w).	This section was not amended based on comment. Services provided by consultants are considered non-labor and fall under the definition of "Direct and Indirect Care Non-Labor Costs," because these services support the delivery of resident care but are not provided directly by the consultant.

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	Recommended language changes are specified.	
20. Caregiver Training definition – Include CNA's, Restorative Nurses Aides, etc...(52000)	(p) Direct Pass-Through Costs for Care Giver Training – The definition should be expanded and clarified to include examples such as Certified Nurse Assistant Training Programs and to include other formal certification programs generally recognized within the long-term care profession such as Restorative Nurse Aide and other similar programs. Also need to clarify that costs for program coordinator and use of training facilities should be included within the definition. *Recommended language changes are specified.*	This section was not amended based on comment. The existing definition clearly describes the overall umbrella of caregiver education, including those for a "certified occupational specialty," under which Certified Nurse Assistant and Restorative Nurses Aide would fall. The language as suggested does not provide further clarity, and is thus not necessary. Caregiver training is provided by an "instructor," thus these costs clearly fall under "Direct Pass-Through Costs for Care Giver Training." A "Program Coordinator" on the other hand does not provide direct training, thus these costs would fall under the Administrative Cost Category. All "facility costs," including those related to care giver training, fall under the FRVS, as described under Section 52505, and explained in the FSOR Pages 29-33.
21. PLI definition – in conflict w/ TBL, should include Self-Insured and Captive Ins, remove Reasonableness Test (52000)	(r) Direct Pass-Through Costs for Liability Insurance – The definition includes the "cost of premiums purchased from a commercial insurance carrier, including the related brokerage fees," "self insurance costs" and "costs of insurance purchased from a captive insurance company" and modifies each of those elements by the term "reasonable." There are several problems with the definition. First, while the definition reflects the current state of the law that liability insurance is a "direct pass-through cost:' the TBL would reduce the recognition of this cost center for ratemaking purposes to the 75th percentile and clarify that deductibles are included in the pass-through costs. To the extent that the TBL is passed by the Legislature and signed by the Governor, this provision would conflict with the law and its promulgation would be unlawful. Second, the definition does not recognize all of the various costs that are allowable under the PRM for self-insured programs and for captive insurance programs. For example, the costs associated with the claims and risk management programs are allowable under Section 2162.2 for captive insurance programs	The definition of "Direct Pass-Through Costs for Liability Insurance" was amended and re-designated (as "liability insurance costs") through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010). Subsequently, through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c). For further explanation for the definition of "liability insurance costs" please see FSOR Page 9.

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	and the costs associated with the establishment and maintenance of the insurance reserve fund along with any number of other costs are recognized as allowable under Section 2162.8 for self-insured programs. These should be all recognized in the definition of this provision. Third, while it is certainly appropriate to take reasonableness into account, CAHF is of the view that the Department has historically abused its discretion in issuing and applying through an unlawful Provider Bulletin (on a retroactive and selective basis) a so-called "reasonableness test." In a pending audit appeal associated with a captive insurance company, representatives from the Department admitted that the data utilized in such test was inaccurate and incomplete and was not consistently applied. In addition, the testimony was clear that the bulletin had not been prepared "in consultation with representatives of the long-term care industry," as required by W & I Sections 14126.027(a)(2) and 14126.025(b). As a result, to the extent that the Department seeks to implement this flawed "reasonableness test" through this regulation, the regulation is arbitrary and capricious. Assuming that the TBL is passed by the Legislature and signed by the Governor, the costs and premiums associated with liability programs will be determined at the 75th percentile. The use of this percentile will itself establish a "reasonableness test" for this cost center and CAHF proposes that the Department should accept the reported costs and apply the 75th percentile and not seek to make a second "reasonableness" determination. *Recommended language changes are specified.*	
22. FRVS Definition – cite SPA (52000)	Subsection (s) Fair Rental Value System – This subsection needs to be defined more clearly and specifically referenced to the SPA. *Recommended language changes are specified.*	This section was not amended based on comment. The existing definition of "Fair Rental Value System" clearly describes the use of this phrase as it is further detailed under Section 52505. This definition as well as the provisions under Section 52505 are consistent with the State Plan Supplement 4 to Attachment 4.19-D Pages 9-14, thus a reference to this document is not necessary. Also, see the FSOR Page 8, for further information about the definition and Pages 29-33 of the

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		FSOR for an explanation regarding the regulatory provisions.
23. Clarify Independent Living Services definition (52000)	(v) Independent Living Services (ILS) – This definition lacks clarity. Under this definition a nursing facility could provide ILS, which is not the intent of the regulations. The definition should be clarified to identify that services must be provided on a single campus that includes an RCFE and a skilled nursing facility. *Recommended language changes are specified.*	Section 52000(v), "Independent Living Services" was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
24. Indirect Care Agency Costs definition (52000)	(w) Indirect Care Agency Costs – The definition should be clarified to define "contractor staff." Included staff should not be limited to purchased services needed to operate the department, but should also include replacement staff, consistent with the definition of direct care. Replacement staff consists of individuals coming from registry/agency that replace employees, for example, registered dietitians. There is also a need to clarify that indirect care services are performed within the facility. This clarification is needed because DHCS auditor have inappropriately reclassified these and similar costs during audits. *Recommended language changes are specified.*	This section was not amended based on comment. Indirect Care Agency Costs pertain to expenditures of labor for services provided in the facility by contract or temporary replacement staff for indirect services within the facility. These provisions are clear and no further clarification is needed. For further explanation please refer to the FSOR Pages 8-9.
25. Include Home Office in Indirect Care Labor Costs definition (52000)	(x) Indirect Care Labor Costs – The definition needs to be clarified to add that services provided by a related entity include home office costs that can be directly associated facility are included within the definition. This clarification is needed because DHCS auditor have inappropriately reclassified these and similar costs during audits. *Recommended language changes are specified.*	This section was not amended based on comment. The treatment of services provided by a related agency is clearly described in CMS Publication 15-1, Chapter 10, Section 1005 as further described in the FSOR Pages 8-9.
26. In-Service Education definition clarified to exclude Care Giver Training (52000)	(y) In-Service Education – Definition needs to be clarified by adding language to ensure there is a clear distinction between In-Service Education and Care Giver Training. This can be done by indicating that In-Service Education Costs are other than those leading to a formal license or certification. *Recommended language changes are specified.*	This section was not amended based on comment. The description of the definition of "In-Service Education" is described under the FSOR Page 9, and the description of the definition of "Direct Pass-Through Costs for Care Giver Training" is described under the FSOR Page 7.

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27. Labor Inflation Index definition clarification (52000)	(z) Labor inflation index – The definition lacks clarity. The term "normalized average mean" does not accurately describe the labor inflation index. *Recommended language changes are specified.*	In consideration of this comment and upon further review, the definition of "Labor Inflation Index" was revised through the 15-Day Public Availability (published on February 17, 2011). This definition as revised more accurately reflects the variables and methods used to develop this index, and is based on the "Study to Develop Labor Index For Long-Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010). The amended definition did not include a cut-off time period in which to obtain the data, (as specified in this comment) because the index is updated regularly on a prospective basis (once the data is submitted to OSHPD).
28. Minor Equipment (52000)	(aa) Minor Equipment – The regulations are not consistent with PRM section 108.1 and should be corrected to ensure those items with either a useful life of less than 2 years or an actual cost of less than $5000 are classified as minor equipment. This regulation is not necessary because cost reporting is required to be consistent with Medicare reimbursement principles as set forth in the PRM; however, CAHF does not strongly object to this language because DHCS auditors failed to follow Medicare principles when the Medicare depreciation threshold changed from $500 to $5000. *Recommended language changes are specified.*	An amendment was included in the 15-Day Public Availability (published on February 17, 2011). This amendment corrected a typographical error; the term "and" was replaced with the accurate term "or."
29. MLRC definition clarification (52000)	(bb) Multi-Level Retirement Community (MLRC) – This definition lacks clarity because independent livings services and assisted living services are not adequately defined. In addition, a reference to the Health and Safety Code (H & S) Section 1771.3 should be added to be consistent with H & S Section 1324.20(a). Finally, subsection is not necessary if TBL is enacted. *Recommended language changes are specified.*	Section 52000(bb) "Multi-Level Retirement Community" was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
30. Peer group definition clarification (52000)	Subsection (cc) "Peer Group" – Definition needs to be clarified to better explain the purpose for establishing peer groups. Further, descriptive process language needs to be deleted and general language to allow the Department to establish peer groups without specificity in process should be added.	This section was not amended based on comment. The peer groups (including the definition) were established by the professional consulting company in the context of the development of the facility-specific rate methodology, in accordance with W&I Code Sections 14126.02(c) and

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	Recommended language changes are specified.	14126.023(b). The consulting company conducted a peer group analysis using a statistical cluster of historical median direct care costs, labor markets and the cost of living as indicative sources.
31. New PRM definition (52000)	Add a new subsection defining the PRM – CAHF has suggested regulations changes that refer to the Provider Reimbursement Manual (PRM). A definition should be added to assure consistent definition is applied throughout these regulations. *Recommended language changes are specified.*	This section was not amended based on comment. The CMS Provider Reimbursement Manual Part 1, Publication 15-1 (accessible at: www.cms.gov/manuals/pbm/list.asp) and the CMS Publication 13, Part 2, Audits Reimbursements/ Program Administration (accessible at: www.cms.gov/manuals/pbm/list.asp) are part of the CMS Manual System which is used by CMS program components, partners, contractors, and State Survey Agencies to administer CMS programs. These manuals offer day-to-day operating instructions, policies, and procedures based on federal statutes and regulations, guidelines, models, and directives and are clearly accessible and understood by the affected public, thus a definition is not necessary.
32. Replacement Project definition clarification (52000)	Subsection (ff) Replacement Project – This subsection needs to be more clearly defined consistent with the SPA and definition of capital project. *Recommended language changes are specified.*	In consideration of this comment and upon further review, a more comprehensive and commonly understood definition was developed and was included as part of the 15-Day Public Availability (published on February 17, 2011). This new definition is based upon consultation between the Department and the professional consulting company, which resulted in the "Capital Supplement Schedule, Frequently Asked Questions, 2008-09," which is available at http://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/2008%2009%20Capital%20Sup%20Sch%20FAQ.pdf.
33. Residential Care Facility for the Elderly - refer to DSS Lic Req. (52000)	(gg) Residential Care Facility for the Elderly – This definition lacks specificity and clarity. Under this definition a NF could qualify as a RCFE. It would be better to leave out the language about the intensity and level of care and refer to Department of Social Services licensing regulations Title 22, section 87100 et seq. *Recommended language changes are specified.*	Section 52000(gg) "Residential Care Facility for the Elderly" was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
34. New Routine Services	Add definition of "Routine Services Costs" – CAHF recommends	This section was not amended based on comment.

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Costs Definition (52000)	that a definition of routine services costs be added to ensure clarity and differentiation between the types of costs incurred when rendering care to residents of free-standing skilled nursing and subacute facilities. *Recommended language changes are specified.*	Medi-Cal routine services are defined by other sections within Division 3 of Title 22 and an additional definition is unnecessary. A definition of routine costs (that differentiates between FS/NF-Bs and FSSA/NF-Bs) is not necessary. Existing CCR Section 51511 clearly delineates the services and supplies (routine costs) that are within the scope of the reimbursement rate for FS/NF-Bs. Existing Section 51511.5 clearly specifies the services, equipment and supplies (routine costs) that are included within the FSSA/NF-Bs reimbursement rate.
35. QAF Resident Days – quarterly vs. monthly (52100)	Section 52100 Quality Assurance Fee – (b) – The determination of the amount due references use of resident days for the preceding quarter. CAHF believes that this reference is in error as the amount is determined monthly and should reference the preceding month as opposed to quarter. This may be confused with provisions contained in H & S Section 1324.22 which also has a quarterly report requirement. The language needs to be consistent with Section 52101(3)(a) as noted on page 8 of the regulations. *Recommended language changes are specified.*	Pursuant to H&S Code Section 1324.21(b), each FS/NF-B and FSSA/NF determines the amount due by multiplying the QAF by the total resident days for the preceding month. This regulatory provision was amended (corrected) through the re-adoption of the emergency regulations on January 18, 2011.
36. Facilities not req to pay new QAF rate until DHCS pays new Rate. Interest Rate changed for outstanding QAF (52101)	Section 52101 Payment of the Quality Assurance Fee – Language should be added to ensure that providers are not required to pay the incremental amount for an increase in the annual Quality Assurance Fee (QAF) until such time as rates are adjusted tor rate year and are paid by DHCS. This requirement is consistent with current provisions contained in Health and Safety Code 1324.21(e)(1). Additionally, a new subsection should be added to ensure that before the DHCS takes collection action against a facility tor nonpayment of quality assurance fees, that resident care will not be adversely impacted. Further, use of a specified interest rate of seven (7) percent as stated in subsection (c) is arbitrary. Consistent with W & I section 14171, would be to cite and use the interest rate of the State's Surplus Money Investment Fund. Lastly, to ensure protection of due process rights for providers, any collection action should be subject to an appellate right as prescribed in	H&S Code Section 1324.28 and more specifically Section 1324.21(e)(1) clearly identifies the requirements for payment of the QAF, thus further interpretation of these statutes is not necessary in the regulations. H&S Code Section 1324.22 and CCR Section 52101 specify the requirements and processes that pertain to payment and collection of the amount due to the Department, pursuant to H&S Code Section 1324.22. Pursuant to Article XV, Section 1 of the California Constitution and Civil Code Sections 3281 and 3287, the Department is authorized to assess 7 percent interest on accounts after payment is delinquent and a demand for payment has been sent.

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	the Welfare and Institutions Code. *Recommended language changes are specified.*	The Department issues three invoices every quarter to facilities requesting payment of the QAF. If the facility fails to pay the fee, the Department sends out a delinquent notice (payment demand), which is also the Department's written notice of intent to offset. If the fee is not paid, the Department reserves the right to withhold the facility's Medi-Cal reimbursements. The collection procedures described in the W&I Code do not apply to the QAF, which is imposed by the H&S Code Section 1324.22. Under the current collection process, a facility's due process is protected and is not subject to an appellate right.
37. TBL changes QAF exemption for MLRC's (52102 & 52103)	Section 52102 and 52103 – While these provisions are consistent with the current law and process concerning exemptions for Multi Level Retirement Communities ("MLRCs") associated with the payment of Quality Assurance Fees ("QAFs") and requests associated there with, the TBL would eliminate the exemption for MLRCs. To the extent that the TBL is passed by the Legislature and signed by the Governor, these provisions would conflict with the law and their promulgation would be unlawful. *Recommended language changes are specified.*	Section 52102 was amended and Section 52103 was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010).
38. QAF and CHOW's – no successor liability. (52104)	Section 52104 Quality Assurance Fee and Change of Ownership – Proposed Regulation Section 52104 imposes liability for a licensee's quality assurance fee on any subsequent licensee of the same facility. The proposed regulation states: The amount due shall be assessed on each FS/NF-B and FSSA/NF-B irrespective of any change in ownership, change in ownership interest or control, or the transfer of any portion of the assets of a FS/NF-B and FSSA/NF-B to another owner. A new owner shall assume any and all liability or payment of the amount due, plus interest, owed by the facility. Pursuant to Health and Safety Code (H & S) Section 1324.21, all facilities licensed under H & S Section 1250(c) must pay a uniform QAF per resident day. Section 1324.21 and others address several elements of the QAF, including calculation,	The inclusion of Section 52104 within this regulatory action, falls under the authority of H&S Code Section 1324.23(b)(1), which authorizes the Department to adopt regulations necessary to implement this article, including the proper imposition and collections of the QAF. In addition, Section 52104 is consistent with Section 1324.22(f) which was added to the H&S Code through SB 853 (Chapter 717, Statutes of 2010) and requires the Department to assess and collect the QAF, including any previously unpaid QAF, from each skilled nursing facility, irrespective of any change in ownership.

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	increases, payment, penalties, collection, and exemptions. However, absolutely no section of the Health and Safety Code imposes liability for licensee's unpaid QAF upon a subsequent owner of the same facility. Thus, the Department has exceeded its authority from the authorizing statute. Moreover, the Department's position is not supported by the SPA. No provision of the SPA imposes successor liability for the QAF. In addition, the Department's proposed regulation conflicts with common law principles of successor liability. Under California law, when one corporation sells or transfers all its assets to another corporation, the latter is not liable for the debts and liabilities of the transfer or unless one of four exceptions applies: (1) there is an express or implied agreement of assumption, (2) the transaction amounts to a consolidation or merger of the two corporations, (3) the purchasing corporation is a mere continuation of the seller, or (4) the transfer of assets to the purchaser is for the fraudulent purpose of escaping liability for the seller's debts. *(Ray v. Alad Corp.* (1977) 19 Ca1.3d 22, 28; *Butler v. Adoption Media, LLC* (2007) 486 F.Supp.2d 1022, 1063). **FN1** With regard to the third exception, the "mere continuation" doctrine requires that "after the transfer of assets, only one corporation remains, and there is an identity of stock, stockholders and directors between the two corporations. *(California Dept. of Toxic Substances Control v. California-Fresno Investment Co.* 2007 WL 1345580 at 6.) Other courts have found successor liability under the "mere continuation" exception where: (1) no adequate consideration was given for the predecessor corporation 's assets and made available for meeting the claims of its unsecured creditors; and, (2) one or more persons were officers, directors, or stockholders of both corporations. *(Ray, supra,* 19Ca1.3dat29.) The key element of a continuation is a common identity of the directors, and stockholders in the selling and purchasing corporations." *(California Dept. of Toxic Substances Control, supra,* 2007 WL 1345580 at 6.) There is simply no legal basis for the imposition of liability of a	

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	QAF on a successor. The Department lacks the authority to promulgate the proposed regulation and the proposed regulation is not consistent with existing law. Finally, the proposed regulation is unnecessary to effectuate the purpose of the AB 1629. Among other things, the Department has the authority (if not a duty) to collect QAF from the facility that incurs them. For example, the Department may deduct outstanding QAF from prospective Medi-Cal payments to facilities, delay licensure, and impose penalties against non compliant facilities. The need to impose successor liability would only arguably arise where the Department inexcusably fails to avail itself of these other remedial measures. We understand that the TBL revises the Health and Safety Code to provide for successor liability for the QAF. If the TBL passes, there is no need for this regulation. Conversely, if it does not pass, this regulation is unlawful for the reasons described above. As a result, this regulation should not be adopted. **FNI:** Federal courts have adopted this same standard in deciding whether a corporation, which acquires the assets of another corporation, may be held liable under the Comprehensive Environmental Response Compensation and Liability Act ("CERCLA") for the costs of investigating and abating hazardous substances for which the predecessor corporation is responsible. *Recommendation: This proposed regulation should be withdrawn and deleted.*	
39. Use most recent cost report (even if unaudited and/or amended) (52500)	Section 52500 Facilities Subject to Facility-Specific Rate-Setting System (Subsection (b)) – This provision is inconsistent with the SPA and also goes beyond current law contained in W & I Section 14126.023(g) that references "the most recent reporting period available". The reference to the most recent cost report data available is also used elsewhere within these regulations and should be consistent throughout. Subsection (b)(2) provides that only audited cost data will be used to compute reimbursement rates. This is contrary to W & I Section 14126.023, which provides that unaudited cost reports can be used to set rates. The regulations should address the rate-	Through the re-adoption of the emergency regulations on January 18, 2011, and in accordance with SB 853 (Chapter 717, Statutes of 2010), specifically (W&I code 14126.023(i)(2)), Section 52500(b) was amended. The term “audited” was included in reference to cost report data, meaning only audited cost report data is used in establishing facility-specific rates. Also in accordance with W&I Code Section 14126.023(i)(2), the phrase “with a fiscal period end date two years prior to the rate year” was removed. Lastly, the suggestion to have the Department audit or review

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	setting methodology when the most recent cost report has not been audited and should be consistent with W & I Section 14126.023. Further, facilities may file amended cost reports with OSHPD in order to correct data reported in error. In some instances, the Department does not receive the amended cost report from OSHPD and, on a discretionary basis, may or may not utilize the most current and correct information reported by the facility. If an amended cost report is presented at or prior to audit, it should be used in the audit. *Recommended language changes are specified.*	amended cost report data when presented by the facility at the time of the audit will not be adopted since it is contrary to Title 22, CCR Section 51019, which specifies that amended cost report data is only accepted in relation to the Provider Audit Appeals Process (specified in W&I Code Section 14171, and Title 22, CCR Sections 51016 through 51048).
40. Reimbursement is for routine services – excluding ancillary services (52501)	Section 52501 Facility-Specific Rate Methodology – Modify this section to clarify that reimbursement is for routine services and not ancillary services; items are not considered to be included in the facility-specific rate unless they are actually recorded and/or reported in routine costs and included within the calculation and cost categories outlined under Section 52501. The regulations should be changed to include that projected rates may be adjusted under W & I Section 14126.033. *Recommended language changes are specified.*	This section was not amended based on comment. The suggested language would not add clarity to this section. A definition of ancillary costs (that differentiates between FS/NF-Bs and FSSA/NF-Bs) is not necessary. Existing CCR Section 51511 clearly delineates the services and supplies (ancillary costs) that are outside the scope of the reimbursement rate for FS/NF-Bs. Existing Section 51511.5 clearly specifies the services, equipment and supplies (ancillary costs) that are included within the FSSA/NF-Bs reimbursement rate.
41. Delete LDOA (52502)	Section 52502 Labor Costs Category – (Comments 41-44) Sections 52502(a) and (d) – These provisions reference the labor driven operating allocation (LDOA) as part of the overall labor costs of a facility and the manner in which the LDOA is calculated. While these accurately depict the current methodology, the TBL would eliminate the LDOA from the ratemaking process. To the extent that the TBL is passed by the Legislature and signed by the Governor, the inclusion of the LDOA would conflict with law and the promulgation of these aspects of the regulation would be unlawful. *Recommended language changes are specified. (Applies to comments 41-44)*	SB 853 (Chapter 717, Statutes of 2010) removed the LDOA component of the facility-specific reimbursement methodology. As a result all language in Section 52502 pertaining to the LDOA was removed as part of the re-adoption of the emergency regulations on January 18, 2011.
42. Direct Care/ Indirect	Subsections (b)(1) and (2) – The reference to reimbursement	Based on this comment and suggested language,

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Care Benchmark – clarify that Ratcheting reduces Rate in each Cost Category further (52502)	needs to be clarified as the "benchmark" is used to determine the rate component for each daily direct care labor rate component but may not be reimbursed when the global budget CAP is exceeded and all rates are reduced proportionately. As written, this regulation fails to recognize that this cost component may be reduced when the global budget CAP is exceeded and all rates are reduced proportionately. In addition, CAHF recommends that the word "each" be changed to "the" because of clarity. As written, the regulations could be interpreted to allow DHCS to apply benchmarks to individual components within the cost category, such housekeeping, dietary, etc. *Recommended language changes are specified. (Applies to comments 41-44)*	amendments were made to Sections 52502(b)(1) and (2); and (c)(2) and (3) through the 15-Day Public Availability (published on February 17, 2011). These amendments take into consideration the inflation in relation to the global budget CAP.
43. Labor Index – eliminate 52502(b)(3)	Subsection (b)(3) – This subsection should be eliminated and subsection (4) retained and renumbered as (3) to reference the department's labor index. Similarly, this should be mirrored under subsection (c) (4) as well. *Recommended language changes are specified. (Applies to comments 41-44)*	Based on public comment, amendments were made through the 15-Day Public Availability (published on February 17, 2011). Specifically, Sections 52502(b)(3) and (c)(4) were removed and the definition of “Labor Inflation Index” was revised to more accurately reflect the variables and methods used to develop this index, based upon the “Study to Develop Labor Index For Long-Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010).
44. Percentages used for Indirect Care Agency Costs if Facility is unable to substantiate Costs (52502)	Subsection (c) – This subsection involves the allowability of indirect care labor costs when facilities contract with an agency to perform certain tasks. It is a common practice in the nursing home profession for facilities to contract with agencies to perform certain indirect care services such as laundry and linen, plant operations and maintenance, housekeeping, and dietary. Section 52502(c) formalizes a policy previously implemented by the Department through a Provider Bulletin. The Department determined that only the agency's "labor" costs would be included in the facility's rate calculation. However, where a facility is unable to substantiate the agency's labor costs, Section 52502(c) establishes percentages that shall be utilized for reimbursement purposes.	This section was not amended based on comment. Subsection (c) insures that when a facility is unable to determine the labor portion of a contract for department services, that only the portion of the contractor’s labor is included as agency costs. Other indirect non-labor costs from these contracted departments must be properly categorized in the non-labor cost category. Please see the FSOR Page 23 for further information.

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	For example, if a facility contracts with an agency to provide plant operations and maintenance and is unable to substantiate what percentage of the fee it pays to the agency constitutes the agency's labor costs, the Department shall use 31%. So, if a facility pays $100,000 to an agency for plant operations and maintenance, the Department shall include only $31,000 of such costs in the facility's indirect care labor category. This results in a reclassification of $69,000 of cost to the indirect non-labor component based on the Department's assumption that only 31% of plant operations and maintenance agency costs are related to labor. The percentages implemented by Section 52502(c) have not been supported by any published cost analysis. These percentages appear to be arbitrary and may not reflect the actual labor costs incurred by facilities. CAHF requests that DHCS produce their study as part of the evidentiary basis for promulgating this provision in regulations. **The subsections have been reordered to clarify that the inflated costs will be used to determine the rate component. Also, the term "inflated" has been added to assure that the rate component is computed correctly.** *Recommended language changes are specified. (Applies to comments 41-44)*	
45. Non-labor Benchmark-clarify that Ratcheting reduces Rate in each cost category further (52503)	Section 52503 Direct and Indirect Non-Labor Costs Category – As written, this regulation fails to recognize that this cost component may be reduced when the global budget CAP is exceeded and all rates are reduced proportionately. The recommended language clarifies this issue. CAHF recommends that subsection (c) be modified to assure consistency with the addition of the California Consumer Price Index to the definitions. The subsections have been reordered to clarify that the inflated costs will be used to determine the rate component. Also, the term inflated has been added to assure that the rate component is computed correctly. *Recommended language changes are specified.*	Re-ordering of the subsections under 52503 was not necessary because the current organization does not present clarity issues with the CPI use as applied. Based on this comment and suggested language, amendments were made to Sections 52503(a) and (b) through the 15-Day Public Availability (published on February 17, 2011). These amendments take into consideration the inflation in relation to the global budget CAP.

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46. Eliminate Admin Reasonableness Test from Survey (52504)	Section 52504 Administrative Costs Category – (Comments 46-57) CAHF strongly objects to the Department's policy of using a survey to determine the reasonableness of non-owner administrator compensation. The PRM, Chapter 9, pertains to "Compensation of Owners" and should not be applied to administrator compensation for non-owners. Furthermore, with the implementation of AB 1629, the use of the 50 percentile benchmark for administrative costs itself establishes a "reasonableness test" for this cost center. There is no incentive for nursing facilities to pay non-owner administrators more than market value of his/her services. There no economic incentives to "overpay" non-owner administrators. At a minimum, this provision should not be applicable to non-owner administrators. CAHF proposes that the Department should accept the reported costs for administrator compensation for both owners and non-owners and apply the 50th percentile. The Department should not seek to make a second "reasonableness" determination for administrator compensation. This is an example where the Department has failed to recognize that the rationale for audits is no longer to "reduce" rates to save the State money, but to assure that costs are reported accurately. In the past, the Department has failed to conduct administrator surveys in a timely manner and has merely updated antiquated survey data, which was not statistically valid when collected. While CAHF continues to object to the use of surveys, CAHF recommends safeguards be adopted through regulation to assure that the Department does not fail to update survey data in the future by adding a subsection that provides that the limitation on administrator compensation be suspended if surveys are not completed at a minimum of every three years. The subsections have been reordered to clarify that the inflated costs will be used to determine the rate component. Also, the term inflated has been added to assure that the rate component	This section was not amended based on comment. The provisions pertaining to administrator compensation in Section 52504 are consistent with the State Plan Supplement 4 to Attachment 4.19-D that was approved by CMS, and with CMS Publication 15-1, Chapter 9.

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	is computed correctly. *Recommended language changes are specified.*	
47. Admin Benchmark – clarify that Ratcheting reduces Rate in each Cost Category further (52504(b))	Subsection (b) – As written, this regulations fails to recognize that that this cost component may be reduced when the global budget CAP is exceeded and all rate are reduced proportionately. The recommended change clarifies this issue. Subsection (b) has been re-lettered subsection (c). *Recommended language changes are specified. (Applies to comments 47-57)*	Based on this comment and suggested language, amendments were made to Sections 52504(a) and (b), through the 15-Day Public Availability (published on February 17, 2011). These amendments take into consideration the inflation in relation to the global budget CAP.
48. Admin-CCPI (52504(c))	Subsection (c) – This subsection should be modified to assure consistency with the addition of the California Consumer Price Index to the definitions. Subsection (c) has been re-lettered to subsection (a). *Recommended language changes are specified. (Applies to comments 47-57)*	As specified above, in regard to Comment 4, there is no need to define the California Consumer Price Index (CPI). The CPI is a commonly understood economic indicator, which is published and described by the Department of Industrial Relations, available at http://www.dir.ca.gov/dlsr/CPI/faqs.htm#q1. The Department simply uses the CPI to adjust the applicable costs as part of the rate-setting development process. This index is further described under the FSOR under each relevant cost category. A definition of CPI is not included, thus the amendments proposed through this comment are not applicable.
49. Admin Compensation – distinguish between Owner Admin and Non-Owner Admin (52504(d))	Subsection (d) – In the event that the Department does not accept CAHF's recommendation to eliminate limitation on administrator compensation, subsection (d) needs to be clarified as it relates to administrator compensation to ensure there is a clear distinction between owner administrators and non-owner administrators. *Recommended language changes are specified. (Applies to comments 47-57)*	This section was not amended based on comment. The provisions pertaining to administrator compensation in Section 52504 are consistent with the State Plan Supplement 4 to Attachment 4.19-D that was approved by CMS. The administrator's compensation guidelines have been determined by CMS to be applicable to both owner and non-owner administrators. See the FSOR Pages 27-28 for further information.
50. Assistant Administrators "augment" Admin Duties (52504(e))	Subsection (e) – In the event that the Department does not accept CAHF's recommendation to eliminate limitation on administrator compensation, language should be added to indicate that an assistant administrator augments the duties of the administrator as opposed to "performs."	This section was not amended based on comment. As specified in the FSOR, Page 28, this subsection is consistent with CMS Publication 15-1, Chapter 9, Section 904.2 C. 2.

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	Recommended language changes are specified. (Applies to comments 47-57)	
51. Full Time Employees average 40 hrs a week (52504(f))	Subsection (f) – In the event that the Department does not accept CAHF's recommendation to eliminate limitation on administrator compensation, language should be added to clarify that a full-time base employee is expected to average at least 40 hours per week. *Recommended language changes are specified. (Applies to comments 47-57)*	This section was not amended based on comment. As specified in the FSOR, Page 28, this subsection is based on CMS Publication 15-1, Chapter 9, Section 904.2 C. 1.
52. Admin Comp Survey be performed by Peer Group instead of Geographic Areas (52504(h))	Subsection (h) – In the event that the Department does not accept CAHF's recommendation to eliminate limitation on administrator compensation, CAHF suggests recommending language that surveys are performed using the current rate-setting peer groups as opposed to language that simply states like geographic areas. *Recommended language changes are specified. (Applies to comments 47-57)*	This section was not amended based on comment. The industry response to the latest survey was not large enough to create a statistically valid range for each of the seven peer groups.
53. Admin Comp Survey-Peer Groups, evaluate reasonable Administrator (52504(h)(1))	Subsection (h)(l) – In the event that the Department does not accept CAHF's recommendation to eliminate limitation on administrator compensation, CAHF suggests consistent reference with *use* of peer groups and adding the term "reasonable" between evaluate and administrator. *Recommended language changes are specified. (Applies to comments 47-57)*	This section was not amended based on comment. As specified in the FSOR Page 28, this subsection is consistent with CMS Publication 15-1, Chapter 9, Section 905.2 that pertains to non-owner administrators. The corresponding section for administrator compensation in the State Plan Supplement 4 to Attachment 4.19-D, pg. 4, effective on August 1, 2005, also cross references the CMS Publication 15-1, Chapter 9 and requires the Department's adherence to these CMS standards.
54. Clarify exclude extreme values and other data anomalies (52504(h)(2))	Subsection (h)(2) – The terms "exclude extreme values and other data anomalies" lacks clarity and specificity. They should be removed or defined in specific statistical terms. *Recommended language changes are specified. (Applies to comments 47-57)*	In response to this comment this phrase was removed through the 15-Day Public Availability (published on February 17, 2011).
55. Use Labor Study Inflation instead of CMS data. (52504(h)(3))	Subsection (h)(3) – The regulations specify that the survey data should be updated by a CMS inflation index. The use of CMS data is not appropriate when a better measure of inflation is available that is specific to the economic conditions of California,	This section was not amended based on comment. As specified in the FSOR Page 29, the use of such a survey is consistent with the inflation factor described under CMS

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	which is the Labor Inflation Index specified in these regulations. This use of the inflation update would assure consistency in the regulations. *Recommended language changes are specified. (Applies to comments 47-57)*	Publication 15-1, Chapter 9, Section 905.6.
56. Admin Comp Survey done w/I 3 yrs or the Survey Results are not used (52504(h)(4))	Add Subsection (h)(4) – If a survey is not done within a 3-year period of time, then this practice should be suspended and not applied to compensation. *Recommended language changes are specified. (Applies to comments 47-57)*	This section was not amended based on comment. As specified in the FSOR, Page 28, subsection (h) is based on CMS Publication 15-1, Chapter 9, Section 905.2. The corresponding section for administrator compensation in the State Plan Supplement 4 to Attachment 4.19-D, pg. 4, effective on August 1, 2005, also cross references the CMS Publication 15-1, Chapter 9 and requires the Department's adherence to these CMS standards. No further amendments to this subsection are necessary.
57. Correct reference (52504(i))	Subsection (i) **–** The reference to subsection (a) is incorrect and should be (d). *Recommended language changes are specified. (Applies to comments 47-57)*	This cross reference was corrected through the re-adoption of the emergency regulations on January 18, 2011.
58. Capital Costs – eliminate most of the language; replace Return Value with Fair Rental Value; clarify Under-Appreciated (52505)	Section 52505 Capital Costs Category – The majority of the language in this section is unnecessary as it simply restates the current provisions related to the Fair Rental Value System (FRYS) as contained and specified in the SPA. CAHF recommends limiting the language to simply reference the FRYS without restating the specificity of the process which is already thoroughly outlined in the SPA. The regulations as written are redundant and problematic because the Department has failed to exactly restate the language contained in the SPA. The Department inserts the terms "return value" instead of "fair rental value" as used in the SPA. In addition, the regulations at *(C)(* 1) and *(C)(2)* are not consistent with V(C)(4)(c)(iii) of the SPA. The term "under-depreciated" is not a common accounting term and lacks clarity. *Recommended language changes are specified.*	In response to comments received during the 45-Day Comment Period and additional stakeholder input, this section was redeveloped through the 15-Day Public Availability (published on February 17, 2011), to incorporate necessary provisions of the State Plan and to further explain how the Department develops the fair rental value.
59. PLI-Captive and self-	Section 52506 Direct Pass-Through Costs Category –	PLI, as a direct pass-through, was removed from Section

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insured are separate and distinct. Rewrite whole section. (52506)	CAHF's principal concern with Section 52506 is that the Department impermissibly attempts to combine the PRM's requirements involving captive and self-insured programs for liability insurance when they are clearly separate and distinct (See, PRM, Sees, 2162.2 and 2162.7). The Department further compounds this problem by including self-insurance provisions from PRM section 2161B as the centerpiece for regulatory adherence when these provisions, by their own terms, do not even apply to liability insurance programs. At best, this section (and the corresponding discussion in the Initial Statement of Reasons) hopelessly confuses the distinctions between these types of programs. At worst, this provision reflects the Department's intent to collapse these separate and distinct modes of insurance arrangements under Medicare reimbursement principles into one set of requirements that are neither lawful nor rational. Regardless of the Department's motives surrounding this section, the section is fatally flawed, should be withdrawn and re-issued in a manner that is consistent with Medicare principles of reimbursement and the PRM. *Recommended language changes are specified. (Applies to comments 59-71)*	52506 during the re-adoption of the emergency regulations on January 18, 2011, which was consistent with the SB 853 (Chapter 717, Statutes of 2010). Also through the emergency re-adoption of the regulations, the requirements for self-insurance and captive insurance were relocated to Section 52507. Subsequently, through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
60. Need Liability Insurance Costs definition. Proportional Costs term unnecessary (52506(a)(1))	Subsection (a)(I) - Liability insurance costs need to be clearly defined. Additionally, use of the term "proportional costs" is not necessary and is inconsistent with language for all other cost categories. The cost methodology itself calculates the "proportional costs" and any use of that term should be eliminated. *Recommended language changes are specified. (Applies to comments 59-71)*	PLI, as a direct pass-through, was removed from Section 52506 during the re-adoption of the emergency regulations on January 18, 2011, which was consistent with the SB 853 (Chapter 717, Statutes of 2010). Also through the emergency re-adoption of the regulations, the requirements for self-insurance and captive insurance were relocated to Section 52507. In addition the Department has added a definition for Liability Insurance in Section 52000. Subsequently, through the 15-Day Public Availability (published on February 17, 2011), the definition for Liability Insurance Costs (Section 52000(s)) was amended and the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).

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61. TBL will cap PLI and deductible at 75th percentile.	Subsection (e) – The TBL would reduce the recognition of this cost center for ratemaking purposes to the 75th percentile and clarify that deductibles are included in the pass-through costs. To the extent that the TBL is passed by the Legislature and signed by the Governor, these provisions would conflict with the law and their promulgation would be unlawful. *Recommended language changes are specified. (Applies to comments 59-71)*	In accordance with SB 853 (Chapter 717, Statutes of 2010), Section 52506(e) was amended through the re-adoption of the emergency regulations on January 18, 2011. PLI was established as its own cost category capped at the 75th percentile provided the facilities meet conditions set forth in W&I Code Section 14126.023(a)(5)(B).
62. Insurance Reserve Funds and Captive Insurance (52506(e)(3))	Subsection (e)(3) – This regulation seeks to establish a number of requirements concerning the facility's establishment and maintenance of an "insurance reserve fund" and to apply such requirements to both self-insured and captive insurance programs. See, Section 52506(e)(3)(A)-(H) and (J). While the governing authority in the Provider Reimbursement Manual ("PRM") requires the establishment of an insurance reserve fund for self-insurance purposes (PRM, Sec. 2162.7), there are no such requirements for captive insurance programs. Captive insurance companies charge premiums to each facility covered by the program and such companies maintain reserves in accordance with the laws of their domicile and as described in Section 2162.2 of the PRM. As a result, the defined term "Captive Insurance Policies" should be eliminated from Section 52506(e)(3). **FN2** Moreover, even as explicitly applied to self-insured programs, with a single exception, the provisions of Section 52506(e)(3) are unlawful in that they conflict with the PRM's provisions concerning liability programs. In fact, the entirety of Section (e)(3)(A)-(I) appears to have been "lifted" directly from Section 2161B of the PRM – a section that by its terms applies only to "self-insurance program[s] for other than malpractice and comprehensive general liability coverage in conjunction with malpractice coverage." (Emphasis added.) **FN3** Section 2162.7B of the PRM requires that the provider establish a fund "with a recognized independent fiduciary such as a bank, a trust company, or a private benefit administrator." Further, Section 2162.7B2 of the PRM requires that the fiduciary must	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).

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	have control of the fund. Notwithstanding the above, Section 52506(e)(3)(A) of the regulations appears to require the facility itself to maintain such a fund. As a result, this section conflicts with the existing provisions of the PRM relating to liability programs. **FN2** The discussion at page 38 of the Initial Statement of Reasons ("ISOR") concerning Section 52506(e)(3) is also incorrect, impermissibly blurs the distinctions between captive insurance and self-insurance programs and directly conflicts with the provisions of the PRM as to liability insurance programs. As described herein, none of the sections of the regulations sought to be adopted as to captive insurance programs are consistent with the PRM. There is nothing in the PRM that requires the establishment and maintenance of a separate "insurance reserve fund "by the facility or any of the subsequent related requirements for captive insurance programs. Similarly, with one exception, all of the proposed sections as applied to self-insurance programs conflict with the provisions of the PRM relating to liability programs. **FN3** Section 2161B likewise does not apply to self-insurance programs for unemployment compensation, workers' compensation, or employee health coverage. *Recommended language changes are specified. (Applies to comments 59-71)*	
63. Facility's obligation for Documentation about Specific Assets covered by Insurance Fund. (52506(e)(3)(B))	Subsection(e)(3)(B) – This subsection references a facility obligation to provide documentation "about the specific assets that are covered by the insurance fund." Beyond lacking clarity, this section implies that the facility maintains the fund when it is the fiduciary's responsibility to do so. In addition, the PRM contemplates that the fund maintained by the fiduciary contain monies paid by the provider. There would not be "specific assets" other than such monies placed into the fund. Again, this conflicts with the PRM provisions relating to liability programs. *Recommended language changes are specified. (Applies to comments 59-71)*	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
64. Insurance Reserve Funds maintained in a segregated account –	Subsection (e)(3)(C) – This subsection requires that the fund "be maintained in a segregated account and the funds shall not be commingled with any other funds." If this section is intended to	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes

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multiple facilities under common ownership (52506(e)(3)(C))	not permit a fiduciary to manage a fund for multiple facilities under common ownership, it is inconsistent with the PRM in that there is no requirement in Section 2162.7 that the fiduciary must maintain a separate fund for each facility. Again, this provision conflicts with the provisions of the PRM relating to liability programs. *Recommended language changes are specified. (Applies to comments 59-71)*	of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
65. Funds be sufficient to meet losses – needs clarification (52506(e)(3)(D))	Subsection (e)(3)(D) – This subsection requires that the fund "should be sufficient to meet the losses of the type and to the extent that they would ordinarily be covered by insurance." This section lacks clarity as to what is intended by this section. However, Section 2162.783 requires that the agreement between the provider and the fiduciary "must provide that withdrawals [from the fund] must be for malpractice and comprehensive general liability ... and those expenses listed in Section 2162.8." Again, this provision conflicts with the PRM provisions governing liability programs. *Recommended language changes are specified. (Applies to comments 59-71)*	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
66. Timing of contributions to fund (52506(e)(3)(E))	Subsection (e)(3)(E) – This subsection requires that contributions to the fund "shall be made not less frequently than annually." However, Section 2162.9A of the PRM permits payments to be made into the fund "within 75 days after the end of the provider's cost report period." Section 52506(e)(3)(E) similarly conflicts with the PRM provisions governing liability programs. *Recommended language changes are specified. (Applies to comments 59-71)*	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
67. Total Allowable Interest Expense (52506(e)(3)(F))	Subsection (e)(3)(F) – This subsection requires that a facility's "total allowable interest expense under the Medi-Cal program shall be offset by income earned by invested insurance reserve funds." There is no basis for this provision. Section 2162.786	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010).

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	requires that "any income earned by the fund must become part of the fund and used in establishing adequate fund levels." There is no rational relationship between allowable interest expense and income earned by the fund. Under the PRM, the income earned will be used to establish that the fund has appropriate reserve. Earnings from the fund should not be used to punish the provider. Again, this conflicts with the PRM provisions governing liability programs. *Recommended language changes are specified. (Applies to comments 59-71)*	Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
68. (52506(e)(3)(G))	Subsection (e)(3)(G) – This subsection is consistent with Section 2162.786 of the PRM. *Recommended language changes are specified. (Applies to comments 59-71)*	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
69. Inspection Svc, Loss – handling Svc,Legal Defense Svc of Insurance Co in Self-Insurance (52506(e)(3)(H))	Subsection (e)(3)(H) – This subsection lacks clarity in all respects. It is unclear as to what is meant by "the inspection service, the loss-handling service, and the legal defense service of the insurance companies." There are no "insurance companies" present in self-insured programs. It is likewise unclear what is intended by a "demonstration of the ability to effectively replace" such services. Finally, it is unclear when such demonstration would be "appropriate." While the PRM requires self-insured and captive insurance programs to have adequate claims and risk management programs (Section2162.70 and 2162.2A), it contains no provisions requiring the replacement of these programs. There is no rational basis for this provision and it conflicts with the PRM provisions governing liability programs. *Recommended language changes are specified. (Applies to*	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).

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	comments 59-71)	
70. Treatment of Casualty Losses Sustained by the Insurance Reserve Fund (52506(e)(3)(I))	Subsection (e)(3)(I) – This subsection limits "the treatment of casualty losses sustained by the insurance reserve fund" to the "balance of the insurance reserve fund at the date of loss. This section lacks clarity in all respects. The term "casualty losses" has no meaning for malpractice and comprehensive general liability purposes. It is likewise unclear what import such treatment will have on allowable costs. Under Section 2162.7C of the PRM, an actuary, insurance company or broker is "to determine the amount necessary to be paid into the fund" and that this amount (except for any "excess") are what represents allowable costs. This provision impermissibly conflicts with the PRM provisions governing liability programs. *Recommended language changes are specified. (Applies to comments 59-71)*	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
71. Eliminate Reasonableness – check for Self-insurance and Captive Insurance. (52506(e)(3)(J))	Subsection (e)(3)(J) – This subsection states that the Department "shall determine the reasonable cost of self-insurance or insurance purchased from a related captive insurance company based on the cost reports filed with the Department." While it is certainly appropriate to take reasonableness into account, CAHF is of the view that the Department has historically abused its discretion in issuing and applying through an unlawful Provider Bulletin (on a retroactive and selective basis) a so-called "reasonableness test." In a pending audit appeal associated with a captive insurance company, representatives from the Department admitted that the data utilized in such test was inaccurate and incomplete and was not consistently applied. In addition, the testimony was clear that the bulletin had not been prepared "in consultation with representatives of the long-term care industry," as required by Welfare and Institutions Code Sections 14I26.027(a)(2) and 14126.025(b). As a result, to the extent that the Department seeks to implement this flawed "reasonableness test" through this regulation, the regulation is arbitrary and capricious. Assuming that the TBL is passed by the Legislature and signed by the Governor, the costs and premiums associated with liability insurance programs will be determined at the 75th percentile. The use of this percentile will itself establish a "reasonableness test" for this cost center and CAHF proposes	Through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).

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	that it should adjust the reported costs using the 75th percentile and not seek to make a second "reasonableness" determination. This subsection is entirely unnecessary. The PRM allows costs based on reasonable cost standards. See 42 U.S.C. Section I395x(v)(I). This subsection gives DHCS the ability to impose an arbitrary and inconsistently applied cap with a cap. *Recommended language changes are specified. (Applies to comments 59-71)*	
72. Peer Groups – eliminate most of the language, perform review every 5 years, rewrite 7 counties (52508)	Section 52508 Peer Groups – CAHF recommends that the majority of this language be stricken as it is unnecessary and merely restates language in the current SPA. Further, publishing the peer groups as stated within the current language also limits the departments' ability to re-align peer groups in the future without having to go through the regulatory process. Additionally, CAHF recommends that language to require the department to perform a review and analysis process every 5 years. Lastly, subsection (c) specifies "seven counties" should be eliminated. This subsection re-written to state: "Counties in California that have no Medi-Cal skilled nursing days shall be excluded from the peer groups identified by the department." *Recommended language changes are specified.*	Please see the FSOR, Pages 36-37, for an explanation of the necessity for Section 52508. Provisions related to peer groups, which are also under the State Plan, are an integral part of the facility-specific rate methodology, thus are included in this regulatory proposal. The peer groups (including the definition) were established by the professional consulting company in the context of the development of the facility-specific rate methodology, in accordance with W&I Code Sections 14126.02(c) and 14126.023(b). The consulting company conducted a peer group analysis using a statistical cluster of historical median direct care costs, labor markets and the cost of living as indicative sources. There is no statutory mandate that “established” peer groups be reconfigured. There are currently no plans to re-evaluate the peer-group methodology or designation for the current rate year. However, a re-evaluation of the peer group methodology may be taken into consideration in future years. Existing subsection (c) is clear as written and relays the same information as the comment suggests. No further amendments are necessary.
73. Newly Cert, De-Cert, & CHOW’s – should not be limited to 6 mo. of Medi-Cal Cost Data. (52510-1)	Sections 52510, 52511, and 52512 Rate-Setting for Newly Certified Facilities, De-Certified Facilities, and Changes of Ownership – Sections 52510, 52511 and 52512 – The California State Medicaid Plan (the "State Plan") governs the determination of	Sections 52510, 52511, and 52512 are consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(c)(1-4), which applies to newly certified facilities, de-certified facilities and facilities that undergo a change of ownership and states “the Department shall calculate the FS/NF-B facility-specific rate when a minimum of

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	reimbursement rates for newly certified facilities, de-certified facilities and facilities that undergo a change of ownership. According to the State Plan, in cases of newly certified facilities, "once the FS/NF-B has submitted six months of cost and/or supplemental data, its facility-specific rate will be calculated according to the methodology set forth in this Supplement." Sections 52510 and 52511 change this process in three critical ways. First, these sections require that a cost report contain "Medi-Cal" cost data rather than just "cost and/or supplemental data." Under California law, each and every licensed nursing facility is required to submit a cost report to the Office of Statewide Health Planning and Development (H & S Section 128735 and Title 22, California Code of Regulations, Section 97040.) Thus, even before a provider is enrolled in the Medi-Cal program, it is submitting comprehensive cost data from which the Department could easily determine a facility specific rate. Once a provider submits an application for enrollment into the Medi-Cal program, it could be several months before a provider number is issued. Therefore, a facility could be in operation for several months (or even years) prior to enrollment. Under these regulations, it would appear that a provider must be enrolled in the Medi-Cal program and then submit six months or more of cost data in order to receive a facility specific rate. There is no rational basis for distinguishing between costs incurred and reported prior to entering the Medi-Cal program to those incurred and reported after entering the program. Both are subject to audit under the same rules and regulations. As a result, these regulations should not limit the "cost data" to "Medi-Cal cost data." To limit it in such a manner violates the State Plan. *Recommended language changes are specified. (Applies to comments 73-76)*	six months of Medi-Cal cost data has been audited." The State Plan is amended on a regular basis to ensure its consistency with state law.
74. New Rate should be retro to submission of Cost Data not when data is audited (52510 & 51511)	Second, Sections 51510 and 51511 state that the facility – specific rate shall be calculated once the cost data "has been audited." The language in the State Plan ties the calculation of the facility specific rate to the "submission" of the cost data, not	The assumption has been made that this comment refers to Sections 52510 and 52511. Sections 52510 and 52511 are consistent with SB 853

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	the auditing. This change places the timing of the calculation of the rate entirely within the discretion of the Department. For example, if the Department continues to experience the staffing and other shortages it has recently experienced, a provider could submit the necessary cost data and it could be several months before an audit is completed. This would violate the terms of the State Plan. These regulations should be revised to specify that the rate will be effective retrospectively to the submission of the cost data, including the cost report period. *Recommended language changes are specified. (Applies to comments 73-76)*	(Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(c)(1-3), which applies to newly certified facilities and de-certified facilities and states "the Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year pursuant to Section 14126.021." The State Plan is amended on a regular basis to ensure its consistency with state law.
75. Rate calculations should be as soon as Sufficient Data is available, not until August of the next Rate year. (52510-1)	Finally, Sections 51510 and 51511 state that the facility-specific rate shall be effective beginning on August 1st of each year. Similar to the timing issue discussed above, the State Plan contemplates the calculation of a facility-specific rate as soon as sufficient data exists to make such a calculation. Under these regulations, a provider could submit six months of cost data in September, but not receive a facility-specific rate until August of the following year. These regulations should be revised to specify that the rate will be effective retrospectively to the submission of the cost data, including the cost report period. *Recommended language changes are specified. (Applies to comments 73-76)*	The assumption has been made that this comment refers to Sections 52510 and 52511. Sections 52510 and 52511 are consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(c)(1-3), which applies to newly certified facilities and de-certified facilities and states "the Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year pursuant to Section 14126.021." The State Plan is amended on a regular basis to ensure its consistency with state law.
76. CHOW's – new Rate should be retro to when 6-mo. of data is available, not just Medi-Cal data. (52512)	Section 52512 involves rate-setting for facilities that undergo a change of ownership. This regulation provides that a facility that undergoes a change of ownership will receive the reimbursement rate of the prior owner until a minimum of six months of Medi-Cal cost data has been audited. This regulation suffers from same problems discussed above. There is no basis for the requirement that the cost data be "Medi-Cal cost data." However, given that the facility undergoing the change of ownership will likely be in the Medi-Cal program, this will not likely be a practical problem. Nevertheless, for consistency, the word "Medi-Cal" should be removed. Furthermore, any facility-specific rate should be effective retroactive to submission of the necessary cost data.	Section 52512 is consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(c)(4), which applies to facilities that undergo a change of ownership and states "the Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year pursuant to Section 14126.021." Language pertaining to discretion in the establishment of an interim rate, when a facility is taken over temporarily, or a change of ownership occurs (related to a request from the

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	Language to allow discretion for the department to establish an interim rate should be added when a facility is taken over temporarily or a change of ownership occurs that is linked to a request of the California Department of Public Health (CDPH) for the purpose of protecting the health and safety of current residents. *Recommended language changes are specified. (Applies to comments 73-76)*	California Department of Public Health (CDPH)), is not consistent with W&I Code Section 14126.023(c)(4), and thus will not be adopted. W&I Code Section 14126.023(c)(4), specifies that facilities that have a change in ownership shall continue to receive the facility per diem reimbursement rate in effect with the previous owner and that the facility will continue to receive the facility per diem rate until the conditions specified under subsection (c)(4)(A) or (c)(4)(B) are met.
77. More than one Cost Report, in a CY; use most current, including amended cost reports. (52513)	Section 52513 Change in Facility Fiscal Period – This language should be clarified to state when a facility files more than one cost report in a calendar year, including an amended report covering a previously filed period, that the Department will use the most recent filed report and fiscal period available. *Recommended language changes are specified.*	This suggested language pertaining to the use of amended cost report data will not be adopted because it is not consistent with Title 22, CCR Section 51019, which specifies that an amended cost report is only considered as part of the Provider Audit Appeals process (see W&I Code Section 14171, and Title 22, CCR Sections 51016 - 51048). Therefore, unless the amended cost report reflects a data time period in relation to an audit appeal, amended cost reports are not considered part of the rate-setting process.
78. Recomps – 60-day deadline for retro payment or interest accrual, Notification to Managed Care Plans of recomped Rate (52516)	Section 52516 Audits and Audit Adjustments – Subsection (b) should be eliminated because it is redundant and subsequent subsection reordered. Section 52501 contains the provision for facility specific rate methodology. Subsection (d) is overly restricted in that facilities have the right to appeal all audit adjustments, regardless of the impact on reimbursement rates. In addition, CAHF recommends that provisions related to the timing for implementing rate adjustments upon successful appeal be added and that payment of interest be required. It is suggested that a 60 day time frame (inclusive) from the date of issuance of the Appeal Decision or Letter of Findings to DHCS retroactive payment adjustment. Interest should accrue from the date when the new rate is in effect until the date when retroactive payment is made consistent with W & I Section 14171. *Recommended language changes are specified.*	This regulatory proposal pertains specifically to the facility-specific rate-setting process, thus Section 52516 is specific to Audits and Audit Adjustments under this process. Subsection (b) delineates the type of data "audited cost data" that is used to develop these reimbursement rates and is consistent with W&I Code Section 14126.023(i)(2). Through the 15-Day Public Availability (published February 17, 2011), subsection (d) was amended based on this comment and further stakeholder input to clarify that facilities can appeal all audit findings. Proposed Section 52516(e), as written is consistent with W&I Code Section 14126.023(l), which does not specify a time frame or interest accrual provisions. In addition, W&I Code Section 14171, as referenced in this comment, refers to the Department's recoupment of overpayments, it does not pertain to retroactive payment for an appealing party.
79. Provider Bulletin	Section 52600 Provider Bulletin Authority – This section purports	The Provider Bulletins published in accordance with

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Authority shall continue prior to 2010/11 RY (52600)	to allow the Department "to continue to apply" the contents of its provider bulletins for rate years prior to the 2010-2011 rate year. This is contrary to the provisions of W & I Section 14126.027(c) which expressly provides that "no such bulletin...shall remain in effect after July 31, 2010." Moreover, CAHF is of the view that the Department has issued several unlawful Provider Bulletins in violation of W & I Sections 14126.027(a)(2) and 14125.025(b) by virtue of, among other things, its failure to prepare such bulletins "in consultation with representatives of the long-term care industry...." As a result, this provision should not be adopted. *Recommendation: Section 52600 should be deleted in its entirety*.	H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c), specified an end date for the Department's authority to regulate by means of a Provider Bulletin for the QAF and the Medi-Cal long-term care reimbursement methodology. At present, that end date is July 31, 2012. The intent of Section 52600 is simply to make clear that the standards and regulatory provisions set forth in the Provider Bulletins under the authority of W&I Code Sections 14126 through and including 14126.035, and H&S Code Sections 1324.20 through and including 1324.30, shall remain valid when applied to rate years prior to the initial emergency adoption of these regulations (July 22, 2010). The implementation of AB 1629 (Chapter 875, Statutes of 2004), the QAF Program and Medi-Cal LTC Reimbursement Act, began with the development and release of provider bulletins, as authorized by H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c). Through the development and implementation of these bulletins the Department met with stakeholders on numerous occasions, which was followed by ongoing informal discussions with stakeholders. In accordance with H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c) the Department transitioned the bulletin provisions into regulatory language, meeting the standards of the APA. During this time the Department also collaborated with stakeholders regarding proposed SB 853 (Chapter 717, Statutes of 2010).
80. Add Informal Rate Review Process	Add New Section for Rate Review and Error Correction Process – Currently there is no formal rate review process to correct an incorrect rate other than that which results from a successful audit appeal. Incorrect rates can result from a number of factors that include but are not limited to: DHCS rate calculation error; a data reporting error; an audit adjustment related to documentation; an audit adjustment that results in re-classification of a cost from one AB 1629 cost component to another; and audit adjustments resulting from a difference in interpretation of policy, regulations, or law. Currently, providers have to file an audit appeal in order to seek a correction of an incorrect rate calculation. The current audit appeals process is labor and cost intensive for both providers and DHCS. In light of	The purpose of Section 52516(d) is to specify a facility's right to appeal audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates (in relation to the facility-specific rate-setting process). Section 52516(d) is consistent with the State Plan Supplement 4 to Attachment 4.19-D, Page 5 (IV.G) and the legal citations that are specified within this section. There is no statutory authority for the creation of such an "informal rate review process." The appeal process, as described above, is the current mechanism by which a facility can pursue a correction to perceived errors in the facility-specific rate calculation.

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	the current status of national and state economies and impact to State finances and provider fiscal concerns, consideration should be given to adding regulatory provisions that would allow DHCS to implement an informal rate review process. The process would allow for DHCS to be allowed to correct rate error calculations resulting from specific circumstances. Such circumstances would be limited to issues that are easily resolved such as calculation errors on the part of DHCS; data reporting errors that can be documented; audit documentation errors; and other factual issues that can be presented and validated. Audit issues related to interpretation of policy, regulation, and law would remain within the current purview of the established DHCS Administrative Appeal Process. Consider that a process, such as a met and confer, would allow the provider and DHCS to meet informally to discuss the rate calculation error while also allowing the provider to present related justification and documentation. The DHCS could then adjudicate the outcome of the rate review considering the issue and documentation presented. Using a simplified informal process such as a meet and confer for rate corrections resulting from circumstances other than differences in policy, regulatory, and/ or legal interpretation would be more efficient and could result in significant DHCS and provider cost savings. Costs resulting from new workload requirements relating to implementation of an AB 1629 rate review process can be offset by costs savings resulting from elimination of other department workload requirements (reduction and elimination of some informal audit appeals). *Recommended language changes are specified.*	
81. Medi-Cal is the payer of last resort for ancillary services	Add a New Regulation to Assure that Medi-Cal is the Payer of Last Report – Additional regulation changes are needed to assure that Medi-Cal is the payer of last resort when an AB 1629 provider bills Medicare Part B and/or any other payers for services that may otherwise be classified as routine services. These services should be excluded from routine costs if they are separately payable ancillary services or supplies and are reimbursed by Medicare Part B and/or any other payers. The	The intent and scope of this regulatory proposal (the adoption on Division 3, Article 9 [Sections 52000 – 52600]), is the enactment of AB 1629 (Chapter 875, Statutes of 2004) that established the QAF and the Medi-Cal LTC Reimbursement Act for Freestanding Nursing Facility Level-B (FS/NF-B's) and Freestanding Subacute Nursing Facility (FSSA/NF-B's). The language proposed through this comment is outside of the scope of this regulatory proposal and would impact all Skilled

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	follow revisions are necessary to assure that Medi-Cal is the payer of last resort while at the same time assuring that AB1629 routine and ancillary costs are reported accurately. *Recommended language changes are specified.*	Nursing Facilities, Nursing Facility Level B's and Subacute Care Facilities. In addition, the Medi-Cal Program providers (including FS/NF-B's and FSSA/NF-B's) are subject to the provisions of W&I Code Section 14124.795, which clearly specifies the intent of the Legislature to comply with federal law requiring Medi-Cal be the payer of last resort.

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1. Conflict between regs and TBL	Timing of the Regulations: The Department's Notice of Emergency Rulemaking states that it has been the Department's practice to implement AB 1629 (Statutes of 2004, Chapter 875) through provider bulletins, but that it has now adopted emergency regulations because AB 1183 (Chapter 758, Statutes of 2008) directed it to do so on or before July 31, 2010. Although true, the Administration has at least twice sought and obtained legislation to extend AB 1629's original July 31, 2007 deadline for the adoption of regulations. We are concerned that the emergency regulations are virtually out-of-date due to reforms contained in the pending budget that were initiated by the Administration. For example, the regulations do not address the elimination of the Labor-Driven Operating Allocation (LDOA), the restrictions on reimbursement of facility legal fees, or the limits on liability insurance reimbursement that are part of the reform package. Given the nature and scope of these reforms, the Administration should have sought a one-year extension of the regulation deadline so that the regulations will be consistent with the law. The Department should immediately address the conflicts between the regulations and the pending budget when the changes are enacted by publishing updated regulations in accordance with administrative procedures.	Through the re-adoption of the emergency regulations on January 18, 2011 (with an extension to April 18, 2011), the Department incorporated all of the AB 1629 programmatic/methodology changes in relation to SB 853 (Chapter 717, Statutes of 2010) that required further specificity.
2. Home Office Costs component of Admin (52000(b))	Section 52000(b). Definition of Administrative Costs – The definition states that administrative costs include "the facility's portion of home office costs," without providing any explanation or definition of home office costs that are or are not included for this purpose. The regulations should define home office costs and set specific controls to ensure that nursing home chains are not reimbursed for inappropriate or disproportionate home office costs.	This section was not amended based on comment. Home office costs are described in the definition of "Administrative Costs," and are based on the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities sections 3220.2 and 3220.3. This manual clearly delineates these costs as those related to the overall management and administration of the facility, ensuring that home office costs are in the appropriate cost category.
3. Paid Liability Losses reimbursement (52000(b))	Additionally, the same section of the regulations includes "paid liability losses" as an administrative cost, raising the following questions: • Is Medi-Cal reimbursing skilled nursing facilities for liability losses in addition to reimbursing them for liability insurance	Section 52000(b) is adopted in accordance with W&I Code Section 14126.023 and as specified in Sections 52501 and 52504. This definition is the result of consultation with long-term care stakeholders and is a commonly used and understood term in the long-term care community. This definition incorporates items from the definition of "Administration Cost

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	as a pass-through cost under §52506(e)? • Is Medi-Cal reimbursing skilled nursing facilities for paid liability losses that occurred due to the facilities' failures to obtain necessary liability coverage or due to the inadequacy of liability insurance they obtained? • Is Medi-Cal subsidizing substandard care by reimbursing skilled nursing facilities for paid liability losses associated with neglect, abuse and understaffing?	Center" from the OSPHD Accounting and Reporting Manual for California Long-Term Care Facilities sections 3220.2 and 3220.3, to ensure the Department's standards/terms are consistent with those of OSHPD. In response to the three bullets under the comment: Paid liability losses are audited by the Department in a manner consistent with CMS Publication 15-1, Sections 2160-2162.10. Additionally, W&I Code Section 14126.023(a)(3)(A) limits Administrative Costs to the 50th percentile. Finally, through the re-adoption of the emergency regulations on January 18, 2011, Section 52506(e) was relocated to Section 52507, which is consistent with SB 853 (Chapter 717, Statutes of 2010). Through the 15-Day Public Availability (published on February 17, 2011), the requirements under Section 52507(f) were removed and will be addressed in a provider bulletin. This amendment was based on stakeholder input and recommendation (prior to the 15-Day Public Availability) and is in accordance with the authority under W&I Code Section 14126.027(c).
4. Paid Liability Losses either non-reimbursable of restricted (52000(b))	We recommend that paid liability losses be excluded as an administrative cost component. However, if liability losses are kept as an administrative cost, the Department should establish specific restrictions on reimbursement to ensure that Medi-Cal is not rewarding skilled nursing facilities that have failed to obtain appropriate liability insurance coverage, or providing duplicative reimbursement for liability insurance and liability losses, or subsidizing substandard care through reimbursement of paid liability losses. Additionally, paid liability losses should be defined and other pertinent laws and regulations should be cross-referenced in the regulation. The Initial Statement of Reasons discussion concerning this subsection states: "The items included in this definition are the result of consultation with long term care industry representatives and	This section was not amended based on comment. See the response to Commenter #5, Comment #3 directly above. A separate definition of "paid liability losses" is not necessary because it is clearly described in CMS Publication 15-1, Section 2162.5. This section contains the limits on paid liability losses.

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	are commonly used and understood in the long-term care community."	
5. Collaboration with Industry without accountability measures	Similar statements are repeated throughout the Initial Statement of Reasons. CANHR is very concerned by the Department's continuing practice of collaborating with the industry to develop reimbursement policies that serve operator interests at the expense of residents. The same type of catering to industry lobbyists that aided AB 1629's passage without any accountability measures is exhibited in the policies that the Department is now formalizing in these regulations.	The implementation of AB 1629 (Chapter 875, Statutes of 2004), which established the QAF Program and the Medi-Cal LTC Reimbursement Act, began with the development and release of provider bulletins, as authorized by H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c). Through the development and implementation of these bulletins the Department met with stakeholders on numerous occasions, which was followed by ongoing informal discussions with stakeholders. In accordance with H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c) the Department transitioned the bulletin provisions into regulatory language, meeting the standards of the APA. During this time the Department also collaborated with stakeholders regarding proposed SB 853 (Chapter 717, Statutes of 2010). In addition, prior to the release of the 15-Day Public Availability a stakeholder meeting was held to allow further input prior to the release of the proposed regulation amendments.
6. Use of Regs instead of TBL to add Direct Care Non-Labor to Non-Labor Cost Category (52000(o))	Section 52000(o). Definition of Direct and Indirect Care Non-Labor Costs – The Initial Statement of Reasons discussion of this subsection states that the Department, "through practical experience and consultation with long-term care industry representatives," is adding direct care non-labor costs to the cost-category for indirect care non-labor costs established by Welfare & Institutions Code §14126.023. Although we don't question the need to reimburse skilled nursing facilities for direct care non-labor costs, we do question using the regulation to correct a defect in the statute. The Administration had (and still has) the opportunity to address this issue in the pending budget trailer bill, but hasn't done so. The Department did not raise this issue during any of the stakeholder meetings it held on the pending reforms. We recommend that the Department address reimbursement of direct care non-labor costs through the AB 1629 reauthorization process. We have the same concerns with Section 52501(b), which addresses the same issue.	W&I Code, Section 14126.027(b)(2)(A) clearly specifies the Department may adopt regulations pursuant to Section 14126.027 that are necessary for the administration of the article, including the specific analytical process for the proper determination of long-term care rates; and the develop of necessary forms, details, definitions, formulas and other requirements. W&I Code Section 14126.023 established Indirect Care Non-Labor Costs as a cost category for the facility-specific rate methodology. Through practical experience and consultation with stakeholders this cost category and the items included in determining the costs were revised to also include "direct" care non-labor costs. Please also see the FSOR, Page 7.

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7. Increase staff wages/ benefits by inflation adjustment	Section 52502(b)(4). Inflation Adjustment of Labor Costs – This subparagraph states that each facility's direct care labor costs shall be adjusted by the labor inflation index from the mid-point of the cost reporting period to the mid-point of the rate year, another provision that resulted from "collaboration and agreement between the Department and long-term care representatives." Audits and Investigations officials advised us that there is no mechanism to recover inflation-adjusted labor payments from skilled nursing facilities that did not increase staff wages and benefits by the amount of the inflation adjustment. Earlier this year, California Watch reported that a large number of skilled nursing facilities responded to AB 1629 by cutting wages to staff or reducing staff. Medi-Cal should not reward nursing home operators who misuse funding intended to improve staffing and wages. One of the main purposes of AB 1629 is to advance decent wages and benefits for nursing home workers. *CANHR recommends that the Department establish a procedure in the regulations to determine if skilled nursing facilities increased staff wages and benefits by the amount of the inflation adjustment and, if not, to recover the difference.*	This section was not amended based on comment. The Department does not have control of the wages and benefits paid by a facility to its staff. The intent of the labor inflation index, as described under Section 52502(b)(4) is to adjust direct care labor costs to reflect the impact of inflation since the cost reporting period took place a significant amount of time in the past, in relation to the reimbursement that facilities will receive for the current rate year.
8. Clarification of Excessive PLI (52506(e))	Section 52506(e). Direct Pass-Through Costs of Liability Insurance – This subsection describes how the Department calculates the daily direct pass through costs for liability insurance. It is silent on how the Department will identify excessive liability insurance costs and prohibit payment of them. Until the pending budget trailer language on liability insurance payment restrictions is passed, the Department must define reasonable liability insurance costs in the regulation and prohibit payment of unreasonable costs.	Through the re-adoption of the emergency regulations on January 18, 2011, provisions related to professional liability insurance costs were amended to be consistent with SB 853 (Chapter 717, Statutes of 2010). Specifically, the Professional Liability Insurance Cost Category will be capped at the 75th percentile by peer group. Subsequently, through the 15-Day Public Availability, Section 52507 was further amended, specifically the provisions under subsection (f) pertaining to Self Insurance and Captive Insurance were removed. These amendments were based upon stakeholder input and recommendation, and are in accordance with W&I Code Section 14126.027(c), which allows the implementation of this Article by means of provider bulletin, in whole or in part, without taking regulatory action.

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		The provisions related to Self Insurance and Captive Insurance, which will be published via Provider Bulletin, will be consistent with CMS Publication 15-1, Sections 2160 – 2162.10.
9. Clarification of Self-Insurance requirements (52056(e)(3))	Section 52056(e)(3). Standards for Self-Insurance or Captive Insurance Policies – The Initial Statement of Reasons discussion of this item states that if a skilled nursing facility's self-insurance does not meet the criteria in paragraphs (A) through (I) of this subsection, no direct pass-through cost for liability insurance will be included in the rate calculation. We recommend that the following statement be added to the regulation because it currently fails to explain what action will be taken if a facility insurance plan fails to meet the standards: *Recommended language changes are specified.* The Initial Statement of Reasons also states that the "reasonable paid claims would instead be included in the Administrative Costs Category." We oppose this policy because it undermines the purpose of the self-insurance standards by allowing skilled nursing facilities to receive Medi-Cal payment for liability claims despite their failure to establish adequate self-insurance. The failure to define "reasonable paid claims" is an additional concern.	Through the re-adoption of the emergency regulations on January 18, 2011, provisions related to professional liability insurance costs were amended to be consistent with SB 853 (Chapter 717, Statutes of 2010). Subsequently, through the 15-Day Public Availability (published on February 17, 2011), Section 52507 was further amended, specifically the provisions under subsection (e) pertaining to Self Insurance and Captive Insurance were removed. These amendments were based upon stakeholder input and recommendation, and are in accordance with W&I Code Section 14126.027(c), which allows the implementation of this Article by means of provider bulletin, in whole or in part, without taking regulatory action. The provisions related to Self Insurance and Captive Insurance, which will be published via Provider Bulletin, will be consistent with CMS Publication 15-1, Sections 2160 – 2162.10.
10. Full Scope Audits at least every 3 years (52516(a))	Section 52516(a). Audits and Audit Adjustments – Due to poor wording, this section implies that the Department is not obligated to conduct full scope audits. The first sentence states that the Department shall conduct financial audits a minimum of once every three years. The next sentence states "these audits may be full-scope field audits or limited scope reviews." This language is inconsistent with Welfare & Institutions Code §14126.023(h), which requires full scope audits at least once every three years. *Recommended language changes are specified.*	Section 52516(a) was amended, as suggested, through the 15-Day Public Availability (published on February 17, 2011). However, an additional amendment was also included to remove the phrase "or review," to be consistent with W&I Code Section 14126.023(j) and the term "at" remains instead of the suggested term "during."
11. Overpayments due to inflated or unallowable costs must be recovered (52516 (c))	Section 52516(c). Adjustments of Overpayments – This subsection provides for the recovery of overpayments as mandated by Welfare & Institutions Code §14126.023(h)(4). Despite the clear mandate to recover overpayments, Audits & Investigations officials advised us that the Department does not	Section 52516(c) is consistent with W&I Code Section 14126.023(j)(4) and Title 22, CCR Section 51047, which specify the Department's authority and procedures for collecting overpayments made to Medi-Cal providers. Establishing additional procedures for the collection of overpayments in the

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	recover overpayments when audits determine that a facility was overpaid due to inflated or unallowable costs, and that the Department only adjusts a facility's reimbursements prospectively when costs have been overstated. The law is very clear that the Department must recover Medi-Cal overpayments to skilled nursing facilities. Although the regulatory language is consistent with the law, we are concerned that the Department may not be following the law and that the procedures required for recovering overpayments may need further development. *CANHR strongly recommends that the Department establish and implement effective procedures within these regulations to fully recover all overpayments made to skilled nursing facilities.*	regulatory proposal is not necessary.

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
1. Differentiate Clinical Admin from Non-Clinical Admin (52000)	Same as Comment Letter 4, Comment 1 *Recommended language changes are specified.* *(Applies to comments 1-5)*	Same as Response to Comment Letter 4, Comment 1
2. Move Medical Director from Admin to Direct Care and/or Non-labor (52000)	Same as Comment Letter 4, Comment 2 *Recommended language changes are specified.* *(Applies to comments 1-5)*	Same as Response to Comment Letter 4, Comment 2
3. Liability Insurance Deductibles, Paid Liability Losses, Paid Claims, Claims Mgt Fees, and Taxes on PLI should be included in PLI Pass-Thru (52506)	Same as Comment Letter 4, Comment 3 *Recommended language changes are specified.* *(Applies to comments 1-5)*	Same as Response to Comment Letter 4, Comment 3
4. MIS related to Management of Clinical Info should be moved from Admin to Non-labor (52000)	Same as Comment Letter 4, Comment 4 *Recommended language changes are specified.* *(Applies to comments 1-5)*	Same as Response to Comment Letter 4, Comment 4
5. Add clarifying Language similar to the OSHPD Report for Admin (52000)	Same as Comment Letter 4, Comment 5 *Recommended language changes are specified.* *(Applies to comments 1-5)*	Same as Response to Comment Letter 4, Comment 5
6. Add Ancillary Costs definition (52000)	Same as Comment Letter 4, Comment 6 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 6
7. Delete Business Practices definition (52000 & 51202) –	Same as Comment Letter 4, Comment 8 *Recommendation: Delete this definition and delete the term from 51202(c).*	Same as Response to Comment Letter 4, Comment 8
8. Add CCPI definition – deadline of May of each year to create CCPI Import File	Same as Comment Letter 4, Comment 9 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 9

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SUBJECT	**COMMENT**	**RESPONSE**
(52000)		
Capital Costs/FRVS:		
9. Leased Specialty Medical Equipment, Home Office Capital Costs, and Complex Equipment and DME Included in Capital Costs (52000)	Same as Comment Letter 4, Comments 10, 11 & 13 *Recommended language changes are specified.*	Same as Responses to Comment Letter 4, Comments 10, 11 & 13
10. New Capital Project definition (52000)	Same as Comment Letter 4, Comment 14 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 14
11. Reword Captive Insurance Policy definition (52000)	Same as Comment Letter 4, Comment 15 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 15
12. Current Facility Value definition (52000)	Same as Comment Letter 4, Comment 16 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 16
13. Direct Care Agency Costs and Contractor Staff (52000)	Same as Comment Letter 4, Comment 17 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 17
14. Direct Care Home Office Costs (52000)	Same as Comment Letter 4, Comment 18 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 18
15. Non-labor – Non-Administrative Consultants (52000)	Same as Comment Letter 4, Comment 19 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 19
16. Caregiver Training definition – Include CNA's, Restorative Nurses Aides, etc. (52000)	Same as Comment Letter 4, Comment 20 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 20
17. PLI definition – in conflict w/ TBL, should Include Self-	Same as Comment Letter 4, Comment 21	Same as Response to Comment Letter 4, Comment 21

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SUBJECT	**COMMENT**	**RESPONSE**
Insured and Captive Ins, Remove Reasonableness Test (52000)	Comment Letter 6 - (4th paragraph .. "Third,…." Information removed - *specific to CAHF's view of the Dept's Provider Bulletin)* *Recommended language changes are specified.*	
18. Fair Rental Value System definition (52000)	Same as Comment Letter 4, Comment 22 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 22
19. Indirect Care Agency Costs definition(52000)	Same as Comment Letter 4, Comment 24 *Comment Letter 6 also includes unit-based medical record staff and transportation staff* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 24
20. Indirect Care Labor Costs definition (52000)	Same as Comment Letter 4, Comment 25 *Comment Letter 6 also includes unit-based medical record staff and transportation staff* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 24
21. Employee Physicals (52000)	Employee Physicals: These are both a benefit to the employee and an expense related to their salaries. All employees at a facility may receive such physicals. The cost of such physicals should be included in the appropriate reimbursement category through a classification process. For example, nursing physicals should be allocated to direct care, dietary physicals should be allocated to indirect care, and administrator physicals should be allocated and compensated through administration.	Employee physicals are a benefit to the employer and a hiring cost. These costs are currently being categorized in the Administrative Cost Category and are allocated to the appropriate routine and ancillary cost centers through cost finding methods prescribed by CMS Publication 15-1, Section 2306.
22. In-Service Education definition clarified to exclude Care Giver Training (52000)	Same as Comment Letter 4, Comment 26 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 26
23. Labor Inflation Index definition clarification (52000)	Same as Comment Letter 4, Comment 27 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 27

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
24. Minor Equipment (52000)	Same as Comment Letter 4, Comment 28 *Comment Letter 6 does not include entire comment (from Comment Letter 4)* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 28
25. Peer Group definition clarification (52000)	Same as Comment Letter 4, Comment 30 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 30
26. New PRM definition (52000)	Same as Comment Letter 4, Comment 31 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 31
27. Replacement Project definition clarification (52000)	Same as Comment Letter 4, Comment 32 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 32
28. New Routine Services Costs definition (52000)	Same as Comment Letter 4, Comment 34 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 34
29. QAF resident days quarterly vs. monthly (52100)	Same as Comment Letter 4, Comment 35 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 35
30. Facilities not req to pay new QAF rate until DHCS pays new Rate. Interest Rate changed for outstanding QAF (52101)	Same as Comment Letter 4, Comment 36 *Comment Letter 4 comment more inclusive; recommended change differs – see subsections (a) and (g) (no subsection (g) in Comment Letter 6)* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 36
31. TBL changes QAF exemption for MLRC's (52102 & 52103)	Same as Comment Letter 4, Comment 37 *Comment Letter 6 recommended change differs slightly*	Same as Response to Comment Letter 4, Comment 37

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
	Recommended language changes are specified.	
32. QAF and CHOW's – no Successor Liability (52104)	Same as Comment Letter 4, Comment 38 *Recommended Change: This proposed regulation should be withdrawn and deleted.*	Same as Response to Comment Letter 4, Comment 38
33. Use most recent cost report (even if unaudited and/or amended) (52500)	Same as Comment Letter 4, Comment 39 *Comment Letter 6 recommended change differs – see (b)(2); new subsection (c) added – similar to (b)(2) (Comment Letter 4)* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 39
34. Reimbursement is for routine services - excluding ancillary services (52501)	Same as Comment Letter 4, Comment 40 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 40
35. Delete LDOA (52502)(a) & (d)	Same as Comment Letter 4, Comment 41 *Recommended language changes are specified.* *(Applies to comments 35-38)*	Same as Response to Comment Letter 4, Comment 41
36. Direct Care/ Indirect Care Benchmark – clarify that Ratcheting reduces Rate in each Cost Category further (52502)(b)(1) & (2)	Same as Comment Letter 4, Comment 42 *Comment Letter 4 more inclusive – recommended change differs slightly ((b)(3) – Comment Letter 4 & (b)(2) – Comment Letter 6)* *Recommended language changes are specified.* *(Applies to comments 35-38)*	Same as Response to Comment Letter 4, Comment 42
37. Labor Index – eliminate 52502(b)(3)	Same as Comment Letter 4, Comment 43 *Recommended language changes are specified.* *(Applies to comments 35-38)*	Same as Response to Comment Letter 4, Comment 43
38. Percentages used for	Same as Comment Letter 4, Comment 44	Same as Response to Comment Letter 4, Comment 44

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
Indirect Care Agency Costs if facility is unable to substantiate costs (52502)(c)	*Comments differ slightly* *Recommended language changes are specified.* *(Applies to comments 35-38)*	
39. Non-labor Benchmark-clarify that Ratcheting reduces Rate in each cost category further (52503)	Same as Comment Letter 4, Comment 45 *Comments differ slightly* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 45
40. Eliminate Admin Reasonableness test from survey (52504)	Same as Comment Letter 4, Comment 46 *Comment Letter 4 comment more inclusive* *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 46
41. Admin Benchmark – clarify that Ratcheting reduces Rate in each cost category further (52504(b))	Same as Comment Letter 4, Comment 47 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 47
42. Admin-CCPI (52504(c))	Same as Comment Letter 4, Comment 48 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 48
43. Admin Compensation – distinguish between Owner Admin and Non-Owner Admin (52504(d))	See Comment Letter 4, Comment 49 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 49
44. Assistant Administrators "augment" admin duties (52504(e))	Same as Comment Letter 4, Comment 50 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 50

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
45. Full Time Employees average 40 hrs a week (52504(f))	Same as Comment Letter 4, Comment 51 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 51
46. Admin Comp Survey be performed by peer group instead of geographic areas (52504(h))	Same as Comment Letter 4, Comment 52 *Comment Letter 6 adds – not statistically valid to inflate surveys each year* *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 52
47. Admin Comp Survey – Peer Groups, evaluate reasonable administrator (52504(h)(1))	Same as Comment Letter 4, Comment 53 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 53
48. Clarify exclude extreme values and other data anomalies (52504(h)(2))	Same as Comment Letter 4, Comment 54 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 54
49. Use Labor Study Inflation instead of CMS data. (52504(h)(3))	Same as Comment Letter 4, Comment 55 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 55
50. Admin Comp Survey done w/i 3 yrs or the survey results are not used (52504(h)(4))	Same as Comment Letter 4, Comment 56 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 56
51. Correct reference (52504(i)	Same as Comment Letter 4, Comment 57 *Recommended language changes are specified.* *(Applies to comments 40-51)*	Same as Response to Comment Letter 4, Comment 57
52. Capital Costs – eliminate	Same as Comment Letter 4, Comment 58	Same as Response to Comment Letter 4, Comment 58

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
most of the language; replace Return Value with Fair Rental Value; clarify Under-appreciated (52505)	*Recommended language changes are specified.*	
53. Need Liability Insurance Costs definition; Proportional Costs term unnecessary (52506(a)(1))	Same as Comment Letter 4, Comment 60 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 60
54. TBL will cap PLI and deductible at 75th percentile (52506(3))	Same as Comment Letter 4, Comment 61 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 61
55. Insurance Reserve Funds and Captive Insurance (52506(e)(3))	Same as Comment Letter 4, Comment 62 *Comment Letter 6 recommended change differs* *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 62
56. Facility's obligation for documentation about specific assets covered by insurance fund. (52506(e)(3)(B))	Same as Comment Letter 4, Comment 63 *Comment Letter 4 adds that language conflicts w/PRM provisions relating to liability programs* *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 63
57. Insurance Reserve Funds maintained in a segregated account – multiple facilities under common ownership (52506(e)(3)(C))	Same as Comment Letter 4, Comment 64 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 64
58. Funds be sufficient to meet losses – needs clarification (52506(e)(3)(D))	Same as Comment Letter 4, Comment 65 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 65

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
59. Timing of contributions to fund (52506(e)(3)(E))	See Comment Letter 4, Comment 66 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 66
60. Total Allowable Interest Expense (52506(e)(3)(F))	See Comment Letter 4, Comment 67 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 67
61. (52506(e)(3)(G))	See Comment Letter 4, Comment 68 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 68
62. Inspection Svc, Loss-handling Svc, Legal Defense Svc of Insurance Co in Self-Insurance – lacks clarity (52506(e)(3)(H))	See Comment Letter 4, Comment 69 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 69
63. Treatment of Casualty Losses sustained by the Insurance Reserve Fund (52506(e)(3)(I))	See Comment Letter 4, Comment 70 *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 70
64. Eliminate reasonableness check for Self-insurance and Captive Insurance. (52506(e)(3)(J))	See Comment Letter 4, Comment 71 *Comment Letter 4 is more inclusive* *Recommended language changes are specified.* *(Applies to comments 53-64)*	Same as Response to Comment Letter 4, Comment 71
65. Peer Groups - eliminate most of the language, perform review every 5 years, rewrite 7 counties (52508)	See Comment Letter 4 , Comment 72 *Recommended language changes are specified.* *(Applies to comments 65-69)*	Same as Response to Comment Letter 4, Comment 72
66. Newly Cert, De-Cert, &	See Comment Letter 4, Comment 73	Same as Response to Comment Letter 4, Comment 73

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
CHOW's- should not be limited to 6 mo. of Medi-Cal cost data. (52510-1)	*Recommended language changes are specified.* *(Applies to comments 65-69)*	
67. New Rate should be retro to submission of Cost Data not when data is audited (52510-1)	See Comment Letter 4, Comment 74 *Recommended language changes are specified.* *(Applies to comments 65-69)*	Same as Response to Comment Letter 4, Comment 74
68. Rate calculations should be as soon as sufficient data is available, not until August of the next rate year. (52510-1)	See Comment Letter 4, Comment 75 *Recommended language changes are specified.* *(Applies to comments 65-69)*	Same as Response to Comment Letter 4, Comment 75
69. CHOW's – new rate should be retro to when 6-mo. of data is available, not just Medi-Cal data. (52512)	See Comment Letter 4, Comment 76 *Recommended language changes are specified.* *(Applies to comments 65-69)*	Same as Response to Comment Letter 4, Comment 76
70. More than 1 Cost Report, in a CY; use most current, including amended cost reports. (52513)	See Comment Letter 4, Comment 77 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 77
71. Recomps – 60-day deadline for retro payment or interest accrual, notification to Managed Care Plans of recomped Rate (52516)	See Comment Letter 4, Comment 78 *Comment Letters differ – Comment Letter 4 suggests removing Subsection (b) & removes language from (d)* *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 78
72. Provider Bulletin Authority shall continue prior to 2010/11 RY (52600)	See Comment Letter 4, Comment 79 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 79
73. Add Informal Rate Review Process	See Comment Letter 4, Comment 80	Same as Response to Comment Letter 4, Comment 80

COMMENT LETTER 6 (Avalon 10/1/10)		
SUBJECT	**COMMENT**	**RESPONSE**
	Comment Letter 6 suggests that "an informal rate review process be held before a more costly appeal process…" – recommended language is the same *Recommended language changes are specified.*	
74. Medi-Cal is the payer of last resort for ancillary services	See Comment Letter 4, Comment 81 *Recommended language changes are specified.*	Same as Response to Comment Letter 4, Comment 81