COMMENT LETTER 1 (SEIU - 3/3/11)		
SUBJECT	**COMMENT**	**RESPONSE**
1. § 52508 – Peer Groups	Will there be an opportunity to reassess the peer groups in the regulations? If so, SEIU suggests that the Department of Health Care Services restructures the Los Angeles peer group (p. 31 of the regulation text) into multiple peer groups due to the large area, economic variance, etc. covered by Los Angeles County.	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to Peer Groups please refer to the Responses to 45-Day Comments, Comment Letter 3, Comment 4.

COMMENT LETTER 2 (CAHF - 3/4/11)		
SUBJECT	**COMMENT**	**RESPONSE**
§ 52000 – Definitions		
1. Administrator Compensation	**Subsection (a)** -There is a need to clarify what can be included in fringe benefits; for example, health insurance etc. and clarity to ensure the employer portion of payroll taxes and workers' compensation are not included in the definition of fringe benefits.	This section was not amended through the 15-Day Public Availability, published 2-17-11.
2. Administrative Costs	**Subsection (b) (2)** -Taxes related to liability insurance should be deleted from the definition of "Administrative Costs" and should be included in the definition of "Liability Insurance Costs" in subsection (s). Similarly, paid liability claims should likewise be deleted from the definition of "Administrative Costs" and should be included in	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to professional liability insurance taxes and paid liability claims included in Administrative Costs please refer to the Responses to 45-Day Comments, Comment Letter 4, Comment 3.

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	the definition of "Liability Insurance Costs" in subsection (s).	
3. Medical Director Costs	**Subsection (b) (2)** - Additionally, CAHF continues to object to the premise that the cost of the medical director be included within the definition of administrative because the duties of the Medical Director are more expansive than strictly administrative. See prior comments and additional documents provided. 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.	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to Medical Director costs included in Administrative Costs please refer to the Responses to 45-Day Comments, Comment Letter 4, Comment 2.

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4. Capital Costs	**Subsection (e)** - Definition should be expanded to include "all leases and rental expenses related to building, equipment and leasehold improvements except patient-specific equipment rental generating charges thus considered ancillary….	This section was not amended through the 15-Day Public Availability, published 2-17-11.
5. Direct Care Labor Costs	**Subsection (h)** - Need to add language at the end of the definition as follows: "...costs of services provided to the facility by a related entity, including home office costs directly allocated to direct care in a specific facility."	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to home office costs included in Direct Care Labor Costs please refer to the Responses to 45-Day Comments, Comment Letter 4, Comment 18.
6. Direct Pass-Through Costs for Care Giver Training	**Subsection (j)** - Need to add language at the end of the definition as follows: "...within the facility or in an offsite training facility, where appropriate, as long as students are coming from a facility licensed to train."	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to Direct Pass-Through Care Giver Training please refer to the Responses to 45-Day Comments, Comment Letter 4, Comment 20.
7. Indirect Care Labor Costs	**Subsection (p)** - At the end of the definition, add language as follows: "...by a related entity or by a home office when such costs can be directly allocated to the facility."	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to home office costs included in Indirect Care Labor Costs please refer to the Responses to 45-Day Comments, Comment Letter 4, Comment 25.
8. § 52502 – Labor Costs Category	**Subsection (c)(2)** - should read as indirect, not direct.	The use of the term "direct," through the 15-Day Public Availability, was simply a typographical error that was corrected as part

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		of the certificate of compliance filing. The accurate term “indirect” was included in the original emergency filing, approved 7-22-10, and with the subsequent readoption of the emergency regulations, effective 1-18-11.
9. § 52507 – Professional Liability Insurance Costs	CAHF agrees with the deletions of the previous subsections of 52507 that were designed to determine allowable "liability insurance costs" for self-insurance and captive liability insurance programs under the AB 1629 methodology. The subsections were incomplete and at times conflicted with the provisions of the Medicare Provider Reimbursement Manual ("PRM") which are utilized for cost-finding programs in California's State Medicaid Plan implementing AB 1629. Based on CAHF's discussions with the Department, CAHF understands that the Department will utilize the provider bulletin authority provided under AB 1629 to fully incorporate the applicable provisions of the PRM for self-insured and captive liability insurance programs in order to determine "liability insurance costs" for the purposes of AB 1629 with respect to these types of programs. See, e.g., Memorandum from Mark Reagan to Vicki Orlich dated February 28, 2011. In that regard, CAHF fully expects that the Department will comply with its responsibilities under AB 1629 for the development of the	The Department will comply with the statutory provisions of W&I Code Sections 14126.023(a)(5)(B), 14126.025(b) and 14126.027(c) for the development of the provider bulletin. For further information in regard to Professional Liability Insurance Costs please refer to the Responses to 45-Day Comments, Comment Letter 2, Comment 9.

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	provider bulletin. Finally, CAHF believes that facilities reporting zero or a *de minimus* amount for "liability insurance costs" should be considered as outliers and excluded when determining the 75th percentile benchmark for the professional liability insurance cost rate component.	
10. § 52508 – Peer Groups	**Subsection (c)** - The word “seven” should be deleted.	This section was not amended through the 15-Day Public Availability, published 2-17-11.
11. § 52600 – Provider Bulletin Authority	CAHF continues to believe that any invalid provider bulletin cannot be “validated” by the adoption of this regulation.	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to Provider Bulletin Authority please refer to the Responses to 45-Day Comments, Comment Letter 4, Comment 79.

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1.§ 52507 – Professional Liability Insurance Costs	We strongly oppose the Department's plan to rescind all of its standards for self-insurance or captive insurance policies that are found in Section 52507. This abrupt shift in Department policy will only serve the interest of the nursing home operators who misuse self-insurance at Medi-Cal and taxpayer expense. The Department proposes to change the emergency regulations by deleting all of the following requirements on self-insurance: • Insurance reserve fund must be sufficient to meet any actual losses sustained • Documentation to the Department on assets covered by the insurance reserve fund • Insurance reserve fund shall be maintained in a segregated account • Insurance reserve fund shall be sufficient to meet losses of the type and to the extent that would ordinarily be covered by insurance • Annual or more frequent contributions to the insurance reserve fund • Offset of income from invested insurance reserve funds • Income earned from insurance reserve fund becomes part of the fund • Facility must demonstrate the ability to	The Department has made the determination to utilize the authority under W&I Code Section 14126.027(c) to implement the provisions for self-insurance and captive insurance policies via provider bulletin. This avenue was determined to be the most effective way to implement all the applicable provisions of CMS Pub. 15-1, Sections 2160 – 2162.10. The establishment of these provisions via provider bulletin instead of through these regulations does not affect the compliance standards for professional liability insurance. For further information in regard to Professional Liability Insurance Costs please refer to the Responses to 45-Day Comments, Comment Letter 2, Comment 9.

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	effectively replace the inspection services, the loss handling service, and the legal defense service of insurance companies • Restrictions on casualty losses Most importantly, the Department is deleting the existing requirement at Section 52507(f)(10) that it exclude reimbursement of unreasonable insurance costs. The Department's written information on this change offers almost no explanation. It states that the requirements were removed based on stakeholder input and authority under W&I Code Section 14126.027. Contrary to the Department's representation, W&I Code Section 14126.027 requires that regulations and other instructions on this matter be developed in consultation with consumer representatives and other stakeholders. CANHR opposed this change and we know of no consumer or labor representative who supported it. The Department is ignoring the public's interest and defying the law by the extraordinary deference it is giving to the nursing home industry on these regulations and other AB 1629-related policies. The only verbal explanation the Department has offered to us for rescinding these requirements is that Medi-Cal does not need regulations	

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	governing reimbursement of liability insurance because it follows CMS guidelines. Federal guidelines are no substitute for California regulations on this subject. On January 21, 2011, just weeks ago, the Department issued draft regulations that would have considerably strengthened Medi-Cal's requirements on liability insurance coverage. In now reversing itself, the Department is essentially deregulating liability insurance coverage requirements, damaging its ability to hold nursing home operators accountable in this area. We strongly recommend that the Department adopt its January 2011 draft liability insurance regulations because they would serve the interests of nursing home residents and the public. Medi-Cal should not pay nursing home operators for liability insurance unless they are properly insured. California regulations should spell out the reimbursement requirements for liability insurance and the consequences of noncompliance to ensure accountability. The regulations should serve the public's interest, not solely the interests of nursing home operators.	
2. Reimbursement of Facility Legal Fees	Although the Department is updating the regulations to comply with other changes required by SB 853, it has not included the new restriction on reimbursement of nursing home legal costs established at Welfare & Institutions	This section was not amended through the 15-Day Public Availability, published 2-17-11. However, for further information in regard to changes in relation to SB 853 (Chapter 717, Statutes of 2010) please refer to the

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	Code §14126.023 despite our very specific recommendation to do so. During the consultation process on this regulation, CANHR submitted the following recommendation to the Department on February 7, 2011: We recommend that the regulations incorporate the new restriction on reimbursement of legal fees that SB 853 added at W&I Code §14126.023(a)(3)(B). This restriction should be included in the regulations and the regulations should identify the types of facility appeals that are subject to the restriction. Under certain circumstances, the statute states the Department shall not allow any costs associated with legal or consultation fees in connection with a fair hearing or other litigation against any governmental agency or department. The regulation should spell out the types of facility appeals that are subject to this restriction. For example, the regulation should state that the restriction applies to any appeals of state and federal enforcement actions, including, but not limited to: (1) citation review conferences and any other type of citation appeal a provider may initiate under Health and Safety Code §1428; (2)	Responses to 45-Day Comments, Comment Letter 5, Comment 1.

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	informal conferences with CDPH to challenge state or federal deficiencies issued to facilities; (3) appeals of any other enforcement actions initiated by DPH or decertification actions initiated by DHCS; (4) any appeal of federal enforcement actions imposed by CMS, including, but not limited to, civil money penalties; and (5) any appeal of actions initiated by DOJ's Bureau of Medi-Cal Fraud and Elder Abuse. As another example, the regulation should state the reimbursement restriction applies to legal and consultant fees associated with transfer, discharge or readmission hearings held by DHCS. This is not to suggest that the restriction on reimbursement of legal fees is limited to the above examples. The law applies to appeals or legal actions directed against **any** governmental agency or department, including facility appeals of Medi-Cal determinations or actions. Our recommendation is to include the restriction on reimbursement of legal fees in the regulations and to spell out the types of facility appeals that are subject to this restriction. The Department has done just the opposite. Instead of addressing this requirement through the regulations, the Department notified nursing	

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	home operators through its AB 1629 website that it had unilaterally decided to change the law by declaring it would only apply the restriction to legal fees associated with DHCS or DPH actions, rather than to "any governmental agency or department" as the law requires. The Department issued the following statement on its website. January 13, 2011 Update: NOTICE: Supplemental Schedule 3 – Revised definition of "disallowable legal and consultant fees". New definition limits those fees to those "in connection with a fair hearing or other litigation against DHCS or CDPH". The prior definition did not limit those fees to any governmental agency or department. If this new definition changes the amounts you previously submitted on a Supplemental Schedule 3, you must submit a new schedule INCLUDING any Professional Liability Insurance (PLI) Deductible you previously submitted – by (COB) January 31, 2011. The revised FAQs, instructions and form are available below and due by COB January 31, 2011. http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx	

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	Per our February 14, 2011 e-mail correspondence with Department officials, the Department does not have the authority to change the law through an underground regulation or in any other way. Given California's dire budget crisis and the newest round of devastating cuts that are underway, it is inexplicable that the Department is adding Medi-Cal costs by its subversion of this law. Taxpayers should not be subsidizing nursing home operators who engage in legal fights against the government. The Department should promptly correct this matter by amending the regulations to accurately and completely include the reimbursement restrictions on legal fees established by the Legislature through SB 853.	
3. § 52504 - Administrative Costs Category	The Department is proposing the following change to subdivision (h)(2) concerning reasonable compensation for nursing home administrators. (2) The compensation ranges shall be based on data that reflects "full time" compensation ~~and excludes extreme values and other data anomalies~~.	For information regarding Administrator Compensation in subsection (h)(2) please refer to the FSOR page 29.

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SUBJECT	**COMMENT**	**RESPONSE**
	We oppose this change because the Department should exclude extreme values and data anomalies on data it collects and uses to determine compensation ranges for administrators. The Department offers no explanation for this change except that it is based on comments it received. We recommend that the current language be retained.	
4. Stakeholder Participation	In closing, we would like to reemphasize our concern that this set of regulations and related Department policies appear to have been developed for the benefit of nursing home operators. As already noted, the Department is supposed to consult with various stakeholders, including consumers, in developing these regulations. Certainly the spirit of the law requires the Department to give more serious consideration to our comments than it has given to date.	For information regarding Stakeholder Participation please refer to the Responses to 45-Day Comments, Comment Letter 5, Comment 5.