JOHN CHIANG
California State Controller

May 1, 2009

Nancy Patton, Asst. Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Patrick J. Dyer
Public Resource Management Group, LLC
1380 Lead Hill Boulevard, Suite 106
Roseville, CA 95661

Re: **Incorrect Reduction Claim**
Handicapped and Disabled Students, 05-4282-I-03
County of San Mateo, Claimant
Statutes 1984, Chapter 1747; Statutes 1985, Chapter 1274
Fiscal Years 1996-97, 1997-98, and 1998-99

Dear Ms. Patton and Mr. Dyer:

This letter is in response to the above-entitled Incorrect Reduction Claim. The subject claims were reduced because the Claimant included costs for services that were not reimbursable under the Parameters & Guidelines in effect during the audited years. In addition, the Claimant failed to document to what degree AB3632 students were also Medi-Cal beneficiaries, requiring that EPSDT revenues be offset. The reductions were appropriate and in accordance with law.

The Controller's Office is empowered to audit claims for mandated costs and to reduce those that are "excessive or unreasonable."[1] This power has been affirmed in recent cases, such as the Incorrect Reductions Claims (IRCs) for the *Graduation Requirements* mandate.[2] If the claimant disputes the adjustments made by the Controller pursuant to that power, the burden is upon them to demonstrate that they are entitled to the full amount of the claim. This principle likewise has been upheld in the *Graduation Requirements* line of IRCs.[3] See also Evidence Code section 500.[4] In this case, the audit

[1] See Government Code section 17561, subdivisions (d)(1)(C) and (d)(2), and section 17564.
[2] See for example, the Statement of Decision in the Incorrect Reduction Claim of San Diego Unified School District [No. CSM 4435-I-01 and 4435-I-37], adopted September 28, 2000, at page 9.
[3] See for example, the Statement of Decision in the Incorrect Reduction Claim of San Diego Unified School District [No. CSM 4435-I-01 and 4435-I-37], adopted September 28, 2000, at page 16.

determined that the Claimant was claiming costs for medication monitoring and crisis intervention, which were not identified reimbursable activities in the Parameters & Guidelines as amended in 1996, and effective for the fiscal years that were the subject of this audit. Therefore, these claimed costs are unsupportable and thus, disallowed.

The Claimant points to subsequent amendments of the Parameters & Guidelines adopted in 2005 and 2006, which refer to medication monitoring, to support their claim that it is a reimbursable cost. However, amendments to Parameters & Guidelines are not retroactive, and the amendments in question were only effective from July 1, 2001, forward; therefore, they did not apply to the fiscal years audited. In fact, the addition of medication monitoring as a reimbursable activity supports the Controller's position in this case; it does not contradict it, as the Claimant asserts. If medication monitoring had been covered in the prior Parameters & Guidelines, there would have been no need to add an explicit reference to the activity in the amendments. Therefore, medication monitoring was not a reimbursable activity prior to July 1, 2001.

Enclosed please find a complete detailed analysis from our Division of Audits, exhibits, and supporting documentation with declaration.

Sincerely,

Shawn D. Silva

SHAWN D. SILVA
Staff Counsel

SDS/ac

Enclosure

cc: Tom Huening, Auditor-Controller, San Mateo County
Ginny Brummels, Div. of Acctg. & Rptg., State Controller's Office (w/o encl.)
Jim Spano, Division of Audits, State Controller's Office (w/o encl.)

[4] "Except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."

PROOF OF SERVICE

I am employed in the County of Sacramento, State of California. At the time of service, I was at least 18 years of age, a United States citizen employed in the county where the mailing occurred, and not a party to the within action. My business address is 300 Capitol Mall, Suite 1850, Sacramento, CA 95814.

On May 1, 2009, I served the foregoing document entitled:

SCO'S RESPONSE TO THE INCORRECT REDUCTION CLAIM FOR COUNTY OF SAN MATEO, CSM 05-4282-I-03

on all interested parties in this action by placing a true and correct copy thereof enclosed in a sealed envelope, addressed as follows:

Nancy Patton *(original)*
Assistant Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Tom Huening, Auditor-Controller
San Mateo County
555 County Center, 4th Floor
Redwood City, CA 94063

Patrick J. Dyer
Public Resource Management Group, LLC
1380 Lead Hill Boulevard, Suite 106
Roseville, CA 95661

[X] BY MAIL
I placed the envelope for collection and processing for mailing following this business's ordinary practice with which I am readily familiar. On the same day correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service.

[ ] BY PERSONAL SERVICE
I caused to be delivered by hand to the above-listed addressees.

[ ] BY OVERNIGHT MAIL/COURIER
To expedite the delivery of the above-named document, said document was sent via overnight courier for next day delivery to the above-listed party.

[ ] BY FACSIMILE TRANSMISSION
In addition to the manner of service indicated above, a copy was sent by facsimile transmission to the above-listed party.

I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made. I declare under penalty of perjury under the laws of California that the foregoing is true and correct.

Executed on May 1, 2009, at Sacramento, California.

Amber A. Camarena

RESPONSE BY THE STATE CONTROLLER'S OFFICE TO THE INCORRECT REDUCTION CLAIM BY SAN MATEO COUNTY
Handicapped and Disabled Students Program

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RESPONSE BY THE STATE CONTROLLER'S OFFICE TO THE INCORRECT REDUCTION CLAIM BY SAN MATEO COUNTY
Handicapped and Disabled Students Program

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OFFICE OF THE STATE CONTROLLER
300 Capitol Mall, Suite 1850
Sacramento, CA 94250
Telephone No.: (916) 445-6854

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

INCORRECT REDUCTION CLAIM ON: *Handicapped and Disabled Students Program* Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985 SAN MATEO COUNTY, Claimant	No.: CSM 05-4282-I-03 AFFIDAVIT OF BUREAU CHIEF

I, Jim L. Spano, make the following declarations:

1) I am an employee of the State Controller's Office (SCO) and am over the age of 18 years.

2) I am currently employed as a bureau chief, and have been so since April 21, 2000.

3) I am a California Certified Public Accountant.

4) I reviewed the work performed by the SCO auditor.

5) Any attached copies of records are true copies of records, as provided by San Mateo County or retained at our place of business.

6) The records include claims for reimbursement, with attached supporting documentation, explanatory letters, or other documents relating to the above-entitled Incorrect Reduction Claim.

7) A field audit of the claims for fiscal year (FY) 1996-97, FY 1997-98, and FY 1998-99 commenced on November 20, 2000, and ended on November 9, 2001.

I do declare that the above declarations are made under penalty of perjury and are true and correct to the best of my knowledge, and that such knowledge is based on personal observation, information, or belief.

Date: October 9, 2007

OFFICE OF THE STATE CONTROLLER

By: _____
Jim L. Spano, Chief
Mandated Cost Audits Bureau
Division of Audits
State Controller's Office

STATE CONTROLLER'S OFFICE ANALYSIS AND RESPONSE TO THE INCORRECT REDUCTION CLAIM BY SAN MATEO COUNTY
For Fiscal Year (FY) 1996-97, FY 1997-98, and FY 1998-99

Handicapped and Disabled Students Program
Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985

SUMMARY

The following is the State Controller's Office's (SCO's) response to the Incorrect Reduction Claim (IRC) that San Mateo County filed with the Commission on State Mandates (CSM) on May 25, 2006. The SCO audited the county's claims for costs of the legislatively mandated Handicapped and Disabled Students Program for the period of July 1, 1996, through June 30, 1999. The SCO issued its final report on December 26, 2002 **(Exhibit 4)**.

The county submitted reimbursement claims totaling $7,767,163 for FY 1996-97, FY 1997-98, and FY 1998-99 as follows:

- FY 1996-97—$2,297,163 **(Exhibit 1)**
- FY 1997-98—$2,429,787 **(Exhibit 2)**
- FY 1998-99—$3,040,213 **(Exhibit 3)**

The SCO determined that $3,826,914 is allowable and $3,940,249 is unallowable. The unallowable costs occurred because the district claimed ineligible and unsupported costs, and understated offsetting revenues. The State paid the district $7,767,163. The amount paid exceeded allowable costs claimed by $3,940,249. The following table summarizes the audit results.

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments
July 1, 1996, through June 30, 1997			
Assessment/case management costs	$ 253,922	$ 253,699	$ (223)
Offsetting revenues:			
State categorical funds	—	(80,701)	(80,701)
Short-Doyle/Medi-Cal funds	(65,344)	(65,344)	—
Net assessment/case management costs	188,578	107,654	(80,924)
Treatment costs	3,906,295	3,261,226	(645,069)
Offsetting revenues:			
State categorical funds	(568,934)	(1,027,414)	(458,480)
Short-Doyle/Medi-Cal funds	(1,228,776)	(1,083,266)	145,510
Net treatment costs	2,108,585	1,150,546	(958,039)
Total program costs	$ 2,297,163	1,258,200	$ (1,038,963)
Amount paid by the State		(2,297,163)[1]	
Amount paid in excess of allowable costs claimed		$ 1,038,963	

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustments
July 1, 1997, through June 30, 1998			
Assessment/case management costs	$ 302,231	$ 301,702	$ (529)
Offsetting revenues:			
State categorical funds	—	(114,455)	(114,455)
Short-Doyle/Medi-Cal funds	(79,662)	(79,662)	—
Net assessment/case management costs	222,569	107,585	(114,984)
Treatment costs	3,914,536	3,287,107	(627,429)
Offsetting revenues:			
State categorical funds	(568,934)	(1,281,318)	(712,384)
Short-Doyle/Medi-Cal funds	(1,138,384)	(1,034,991)	103,393
Net treatment costs	2,207,218	970,798	(1,236,420)
Total program costs	$ 2,429,787	1,078,383	$ (1,351,404)
Amount paid by the State		(2,429,787)[1]	
Amount paid in excess of allowable costs claimed		$ 1,351,404	
July 1, 1998, through June 30, 1999			
Assessment/case management costs	$ 332,334	$ 331,301	$ (1,033)
Offsetting revenues:			
State categorical funds	—	(128,024)	(128,024)
Short-Doyle/Medi-Cal funds	(85,532)	(85,532)	—
Net assessment/case management costs	246,802	117,745	(129,057)
Treatment costs	4,248,335	3,632,555	(615,780)
Offsetting revenues:			
State categorical funds	(568,934)	(1,520,570)	(951,636)
Short-Doyle/Medi-Cal funds	(884,990)	(738,399)	146,591
Net treatment costs	2,794,411	1,373,586	(1,420,825)
Subtotal	3,041,213	1,491,331	(1,549,882)
Less late penalty	(1,000)	(1,000)	—
Total program costs	$ 3,040,213	1,490,331	$ (1,549,882)
Less amount paid by the State		(3,040,213)[1]	
Amount paid in excess of allowable costs claimed		$ 1,549,882	
Summary: July 1, 1996, through June 30, 1999			
Assessment/case management costs	$ 888,487	$ 886,702	$ (1,785)
Offsetting revenues:			
State categorical funds	—	(323,180)	(323,180)
Short-Doyle/Medi-Cal funds	(230,538)	(230,538)	—
Net assessment/case management costs	657,949	332,984	(324,965)
Treatment costs	12,069,166	10,180,888	(1,888,278)
Offsetting revenues:			
State categorical funds	(1,706,802)	(3,829,302)	(2,122,500)
Short-Doyle/Medi-Cal funds	(3,252,150)	(2,856,656)	395,494
Net treatment costs	7,110,214	3,494,930	(3,615,284)
Subtotal	7,768,163	3,827,914	(3,940,249)
Less late penalty	(1,000)	(1,000)	—
Total program costs	$ 7,767,163	3,826,914	$ (3,940,249)
Less amount paid by the State		(7,767,163)[1]	
Amount paid in excess of allowable costs claimed		$ 3,940,249	

[1] Payment information is based on amount paid when the final report was issued.

The county's IRC contests audit adjustment relating to ineligible Medication Monitoring and Crisis Intervention costs claimed during the audit period. The county also believes that only a small portion of the SCO's Early Periodic Screening, Diagnosis, and Treatment program audit adjustment relates to claimed AB 3632 students.

I. SCO REBUTTAL TO STATEMENT OF DISPUTE— CLARIFICATION OF REIMBURSABLE ACTIVITIES, CLAIM CRITERIA, AND DOCUMENTATION REQUIREMENTS

Parameters and Guidelines

On April 26, 1990, the Commission on State Mandates (CSM) determined that Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985 imposed a state mandate reimbursable under Government Code section 17561. The CSM adopted the program's parameters and guidelines on August 22, 1991, and amended them on August 29, 1996. On May 26, 2005, the CSM adopted a statement of decision on reconsideration of the program pursuant to Senate Bill 1895 (Statutes of 2004, Chapter 493). The CSM determined that the 1990 statement of decision does not fully identify all of the activities mandated by the statutes and regulations. Subsequently, the CSM amended the parameters and guidelines on January 26, 2006, and again, on January 25, 2007.

Following are excerpts from the amended parameters and guidelines, adopted on August 29, 1996, that are applicable for the audit period of FY 1996-97, FY 1997-98, and FY 1998-99.

Section 1, Summary of the Mandate, states:

> Chapter 1747 of the Statutes of 1984 added Chapter 26, commencing with section 7570, to Division 7 of Title 1 of the Government code (Gov. Code).
>
> Chapter 1274 of the Statutes of 1985 amended sections 7572, 7572.5, 7575, 7576, 7579, 7582, and 7587 of, amended and repealed 7583 of, added section 7586.5 and 7586.7 to, and repealed 7574 of, the Gov. Code, and amended section 5651 of the Welfare and Institutions Code.
>
> To the extent that Gov. Code section 7572 and section 60040, Title 2, Code of California Regulations, require county participation in the mental health assessment for "individuals with exceptional needs, " such legislation and regulations impose a new program or higher level of service upon a county. Furthermore, any related county participation on the expanded "Individualized Education Program" (IEP) team and case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed, " pursuant to subdivisions (a), (b), and (c) of Gov. Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county.
>
> The aforementioned mandatory county participation in the IEP process is not subject to the Short-Doyle Act, and accordingly, such costs related thereto are costs mandated by the state and are fully reimbursable within the meaning of section 6, article XIIIB of the California Constitution.
>
> The provisions of Welfare and Institutions Code section 565 1, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health

services, pursuant to Gov. Code sections 757 1 and 7576 and their implementing regulations,

must be included in the county Short-Doyle annual plan. Such services include psychotherapy and other mental health services provided to "individuals with exceptional needs, " including those designated as "seriously emotionally disturbed, "and required in such individual's IEP.

Such mental health services are subject to the current cost sharing formula of the Short-Doyle Act, through which the state provides ninety (90) percent of the total costs of the Short-Doyle program, and the county is required to provide the remaining ten (10) percent of the funds. Accordingly, only ten (10) percent of such program costs are reimbursable within the meaning of section 6, article XIIIB of the California Constitution as costs mandated by the state, because the Short-Doyle Act currently provides counties ninety (90) percent of the costs of furnishing those mental health services set forth in Gov. Code section 757 1 and 7576 and their implementing regulations, and described in the county's Short-Doyle annual plan pursuant to Welfare and Institutions Code section 565 1, subdivision (g).

Section III identifies eligible claimants as follows.

All counties.

Section V identifies reimbursable activities as follows.

A. One Hundred (100) percent of any costs related to IEP Participation, Assessment, and Case Management:

1. The scope of the mandate is one hundred (100) percent reimbursement, except that for individuals billed to Medi-Cal only, the Federal Financing Participation portion (FFP) for these activities should be deducted from reimbursable activities not subject to the Short-Doyle Act.

2. For each eligible claimant, the following cost items are one hundred (100) percent reimbursable (Gov. Code, section 7572, subd. (d)(1)):

   a. Whenever an LEA refers an individual suspected of being an 'individual with exceptional needs' to the local mental health department, mental health assessment and recommendation by qualified mental health professionals in conformance with assessment procedures set forth in Article 2 (commencing with section 56320) of Chapter 4 of part 30 of Division 4 of the Education Code, and regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, including but not limited to the following mandated services:

      i. interview with the child and family,

      ii. collateral interviews, as necessary,

      iii. review of the records,

      iv. observation of the child at school, and

      v. psychological testing and/or psychiatric assessment, as necessary.

b. Review and discussion of mental health assessment and recommendation with parent and appropriate IEP team members. (Government Code section 7572, subd. (d)(1)).

c. Attendance by the mental health professional who conducted the assessment at IEP meetings, when requested. (Government Code section 7572, subd. (d)(l)) *

d. Review by claimant's mental health professional of any independent assessment(s) submitted by the IEP team. (Government Code section 7572, subd. (d)(2)).

e. When the written mental health assessment report provided by the local mental health program determines that an 'individual with special needs' is 'seriously emotionally disturbed', and any member of the IEP team recommends residential placement based upon relevant assessment information, inclusion of the claimant's mental health professional on that individual's expanded IEP team.

f. When the IEP prescribes residential placement for an 'individual with exceptional needs' who is 'seriously emotionally disturbed,' claimant's mental health personnel's identification of out-of-home placement, case management, six month review of IEP, and expanded IEP responsibilities. (Government Code section 7572.5).

g. Required participation in due process procedures, including but not limited to due process hearings.

3. One hundred (100) percent of any administrative costs related to IEP Participation, Assessment, and Case Management, whether direct or indirect.

B. Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:

1. The scope of the mandate is ten (10) percent reimbursement.

2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Government Code 7576):

a. Individual therapy,

b. Collateral therapy and contacts,

c. Group therapy,

d. Day treatment, and

e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.

3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

Section VI describes the claim preparation process as follows.

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate:

A. Actual Increased Costs Method. To claim under the Actual Increased Costs Method, report actual increased costs incurred for each of the following expense categories in the format specified by the State Controller's claiming instructions. Attach supporting schedules as necessary:

1 Employee Salaries and Benefits: Show the classification of the employees involved, mandated functions performed, number of hours devoted to the function, and hourly rates and benefits.

2 Services and supplies: Include only expenditures which can be identified as a direct cost resulting from the mandate. List cost of materials acquired which have been consumed or expended specifically for the purpose of this mandate.

3 Direct Administrative Costs:

a. One hundred (100) percent of any direct administrative costs related to IEP Participation, Assessment, and Case Management.

b. Ten (10) percent of any direct administrative costs related to mental health treatment rendered under the Short-Doyle Act.

4 Indirect Administrative and Overhead Costs: To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions:

a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SC0 for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SC0 sources must not exceed the total for those items as computed in the ICRP(s).

B. Cost Report Method. Under this claiming method the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with the claiming instructions. A complete copy of the annual cost report including all supporting schedules attached to the cost report as filed with DMH must also be filed with the claim forms submitted to the State Controller.

1 To the extent that reimbursable indirect costs have not already been reimbursed by DMH from categorical funding sources, they may be claimed under this method in either of the two following ways prescribed in the State Controller's claiming instructions :

a. Ten (10) percent of related direct labor, excluding fringe benefits. This method may not result in a total combined reimbursement from DMH and SCO for program indirect costs which exceeds ten (10) percent of total program direct labor costs, excluding fringe benefits.

OR if an indirect cost rate greater than ten (10) percent is being claimed,

b. By preparation of an "Indirect Cost Rate Proposal" (ICRP) in full compliance with Office of Management and Budget Circular No. A-87 (OMB A-87). Note that OMB A-87 was revised as of May 17, 1995, and that while OMB A-87 is based on the concept of full allocation of indirect costs, it recognizes that in addition to its restrictions, there may be state laws or state regulations which further restrict allowability of costs. Additionally, if more than one department is involved in the mandated program; each department must have its own ICRP. Under this method, total reimbursement for program indirect costs from combined DMH and SCO sources must not exceed the total for those items as computed in the ICRP(s).

Section VII describes the supporting data that must be maintained as follows.

For auditing purposes, all costs claimed must be traceable to source documents and/or worksheets that show evidence of the validity of such costs. Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district is subject to audit by the State Controller no later than two years after the end of the calendar year in which the reimbursement claim is filed or last amended. However, if no funds are appropriated for the program for the fiscal year for which the claim is made, the time for the State Controller to initiate an audit shall commence to run from the date of initial payment of the claim.

SCO Claiming Instructions

In compliance with Government Code section 17558, the SCO issues claiming instructions for mandated programs, to assist local agencies and school districts in claiming reimbursable costs. The SCO issued revised claiming instructions for Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985 in March 1997 **(Exhibit 8)**. The county used this version to file its FY 1996-97, FY 1997-98, and FY 1998-99 reimbursement claims **(Exhibit 1, Exhibit 2, and Exhibit 3)**.

II. THE COUNTY CLAIMED COSTS THAT EXCEEDED AMOUNTS PAID UNDER THE MANDATE PROGRAM

Issue

The county claimed costs for assessment and treatment services to handicapped and disabled students that exceeded by $518,337 the amounts it paid to the contract providers of those mandated services.

SCO Analysis:

The program's parameters and guidelines specify that only actual increased costs incurred in the performance of the mandated activities and adequately documented are reimbursable.

County's Response

The county does not dispute this adjustment.

III. THE COUNTY CLAIMED INELIGBLE TREATMENT COSTS UNDER THE MANDATE PROGRAM

Issue

The county claimed costs for medication support, crisis intervention, and other services (skilled nursing and other residential services), totaling $1,371,726, that are not reimbursable under program guidelines. Of that amount, $1,007,332 relates to Medication Monitoring and $224,318 relates to Crisis Intervention activities. The county believes that Medication Monitoring and Crisis Intervention activities are eligible during the audit period. The county did not dispute the SCO adjustment related to Other Services claimed.

The following table summaries activities claimed.

	Fiscal Year			
	1996-97	1997-98	1998-99	Total
Medication Monitoring	$331,014	$267,479	$408,839	$1,007,332
Crisis Intervention	76,320	83,294	64,704	224,318
Subtotal	407,334	350,773	473,543	1,231,650
Other Services	66,527	57,770	15,779	140,076
Total	$473,861	$408,543	$489,322	$1,371,726

The following table summarizes the Other Services activites.

	Fiscal Year			
	1996-97	1997-98	1998-99	Total
Hospital Inpatient	$ 24,848	$ 14,046	$ -	$ 38,894
Crisis Stabilization/ Emergency Room	3,251	-	-	3,251
Residential Other	16,720	43,724	15,779	76,223
Skilled Nursing Augmentation	21,708	-	-	21,708
Total	$ 66,527	$ 57,770	$ 15,779	$ 140,076

SCO Analysis:

Parameters and guidelines allow reimbursement of increased costs incurred for the mandate program. The parameters and guidelines in effect during the audit period specify that the following treatment services are reimbursable:

- Individual therapy;
- Collateral therapy and contacts;
- Group therapy;
- Day treatment; and
- Mental health portion of residential treatment in excess of the California Department of Social Services' payments for residential placement.

County's Response

The incorrect reduction in Finding #2 of the SCO's final audit report centers on the two activities of medication monitoring and crisis intervention:

- **15/60 Medication Monitoring/Visits**

The California code of Regulations in Section 60020(i) defines Mental health services as such: "Mental Health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code; psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. "Medication monitoring" is clearly defined in 60020(f) as including all medication support services including prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. The cost of the medications is not a covered service and has not been billed by the County in the claiming process.

By citing the above code sections that clearly mandate medication monitoring as a service provided under Chapter 26.5, the Parameters and Guidelines includes medication monitoring by direct reference.

- **15/70 Crisis Intervention**

It was the intent of AB 3632 and later amendments not ~~to~~ include mental health services designed in to response to "psychiatric emergencies or other situations requiring an immediate response" (Article 2, section 60040(e)). This language was related primarily to inpatient hospitalization. The services currently in dispute were not provided as psychiatric emergency services leading to hospitalization or other emergency care but rather were provided in the normal course of mental health treatment. These services were provided as defined in the California Code of Regulations, Title 9, Section 543, and designed to alleviate problems, which if left untreated, presented imminent threat to the pupil.

The State Controller's auditor claimed that treatment costs associated with mediation monitoring and crisis interventions are ineligible, stating that these costs are not specified in the Parameters and Guidelines . . . .

...Given the broad and general construction of the Parameters and Guidelines, which were passed during the late 1980's and early 1990's, it's not surprising that medication monitoring and crisis intervention were not specifically mentioned as reimbursable components. During this era, the Commission on State Mandates consciously crafted Parameters and Guidelines that were neither exhaustive nor complete. Rather, it was generally understood by the Commission on, State Mandates, as well as State and local agencies, that the mandate would be implemented differently in virtually every county in the state. The Parameters and Guidelines were meant to be an inclusive document, not exclusive.

In short, if the activity fell into the referenced mandate regulations or statutes, all parties understood that the associated costs would be eligible to claim and would be subject to State audit for reasonability...

...Over time, Parameters and Guidelines have become much more detailed, lengthy, legalistic and exhaustive. Looking at all Parameters and Guidelines from earlier eras, they appear overly broad, general and almost quaint in their lack of detail by today's standards, however, those were the rules set in place by the State of California. Neither format is inherently superior, however, the difference reflects the paradigm shift at the Commission on State Mandates and SCO over the past decade.

- The County is compelled by the California Code of Regulations, Section 60020 (f and i) to provide medication monitoring and crisis intervention services. The County was compelled to provide these services.
- The governing Parameters and Guidelines allow the activities and costs included in the County's claim. The SCO claiming instructions clearly allow the costs and their implementing regulations.
- The SCO arbitrarily disallowed costs of Medication Monitoring and Crisis Intervention. Clarification of those activities in a recent Commission reconsideration, confirm the county's argument that the costs disallowed are eligible for reimbursement. These activities are not new and have always been a part of the original test claim legislation.

SCO's Comment

The SCO concurs that medication monitoring and crisis intervention were defined in regulation (California Code of Regulations, Title 2 section 60020, subdivision (i)) at the time the parameters and guidelines on the Handicapped and Disabled Students (HDS) program were adopted. However, these activities were not included in the adoption of the parameters and guidelines as reimbursable costs. Therefore, the SCO did not "arbitrarily disallow costs of Medication Monitoring and Crisis Intervention."

In 2001, the Counties of Los Angeles and Stanislaus filed a test claim to amend the parameters and guidelines on the original test claim decision on the Handicapped and Disabled Students (HDS) program. According to the test claim, the counties were seeking reimbursement for the activities required by statutory and regulatory amendments to the original HDS program. The amendments included treatment services such as psychotherapy, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. Upon reconsideration of the parameters and guidelines, the CSM addressed the amendments and adopted a statement of decision in HDS II on May 26, 2005. The amended parameters and guidelines were adopted December 9, 2005, and corrected on July 21, 2006 (**Tab C**). It defined the period of reimbursement for the amended portions, beginning July 1, 2001. Consequently, medication monitoring costs claimed prior July 1, 2001, are not reimbursable.

In 1998, the Department of Mental Health and Department of Education changed the definition of mental health services, pursuant to section 60020 of the regulations, which deleted the activity of crisis intervention. Therefore, the regulation no longer includes crisis intervention activities as a mental health service.

IV. THE COUNTY DID NOT PROPERLY DEDUCT STATE CATEGORICAL REVENUES

Issue

The county did not properly offset its claimed costs by certain categorical revenues received from the State, totaling $2,445,680. Of that amount, $2,069,194 related to the Early Periodic Screening Diagnosis and Treatment (EPSDT) program and $376,376 related to the AB 599 program. The county believes that only a small portion of SCO's EPSDT audit adjustments relate to claimed AB 3632 students. The county did not dispute the SCO audit adjustment related to AB 599 funds.

SCO Analysis:

The county did not report state-matching funds received from the California Department of Mental Health under the EPSDT program to reimburse the county for the cost of services provided to Medi-Cal clients. The SCO auditor deducted all such revenues received from the State because the county did not provide adequate information regarding how much of these funds were applicable to the mandate. However, if the county can provide an accurate accounting of the number of Med-Cal units of service applicable to the mandate, the SCO auditor will review the information and adjust the audit finding as appropriate.

The county also did not report state funding received from the State Board of Education under AB 599; this funding was intended to reimburse the county for program-related school expenses such as learning equipment, books, etc.

The parameters and guidelines specify that any direct payments (categorical funds) received from the State that are specifically allocated to the program, and any other reimbursement received as a result of the mandate, must be deducted from the claims.

County's Response

> The SCO claims that the County did not properly offset its matching funds received from the California Department of Mental Health under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program and Board of Education AB 599 reimbursements. The County agrees that the AB 599 revenue should have been offset from the claimed costs. However, the County does not concur with the finding that $2 million of EPSTD State Match should have reduced the allowable claim. The County has already offset the federal share of EPSDT Medi-Cal revenues, but failed to deduct the state general fund EPSDT match. The SCO incorrectly deducted all of the EPSDT state general fund revenues, even though a significant portion of that EPSDT revenue was not linked to the population served in the claim. Only a small percentage of the AB 3632 students in this claim are Medi-Cal beneficiaries, and thus, the actual state EPSDT revenue offset is quite small and less than 10% of what the SCO offset from the claim. The County disagrees with the SCO and asks that $1,902,842 be reinstated.

SCO's Comment

The county did not dispute the underreporting of state funding received from the State Board of Education under AB 599.

The county is disputing the state matching funds received from the California Department of Mental Health under the EPSDT program. As stated in the audit report, the district did not provide documentation to support how much of the funds received related to the mandate. Had the county provided accurate records of the number of Medi-Cal units of service applicable to the mandate, the SCO auditor would have reviewed the information and adjusted the audit finding as appropriate.

V. STATUTE OF LIMITATIONS

Issue

The statute of limitations for the county's IRC has expired.

SCO Analysis:

This issue was not an audit finding. The SCO reviewed the filing dates for the county's IRC for FY 1996-97, FY 1997-98, and FY 1998-99 and found the claim to be invalid, due to the expiration of the statute of limitations. Title 2, California Code of Regulations, Division 2, section 1185, subdivision (b) states that all incorrect reduction claims shall be filed with the CSM no later than three (3) years following the date of the State Controller's Office remittance advice or other notice of adjustment notifying the claimant of a reduction (**Tab D**). The SCO issued a remittance advice to the county on April 28, 2003 **(Exhibit 22)**. Therefore, the deadline for the county to file an IRC was on April 28, 2006. The county filed its IRC on May 25, 2006. Therefore, the IRC is invalid.

VI. CONCLUSION

The SCO audited the claims filed by San Mateo County for costs of the legislatively mandated Handicapped and Disabled Students Program (Chapter 1747, Statutes of 1984 and Chapter 1274, Statutes of 1985) for the period of July 1, 1996, through June 30, 1999. The district claimed ineligible and unsupported costs, and understating offsetting revenues.

Additionally, the county filed an invalid IRC for FY 1996-97, FY 1997-98, and FY 1998-99, due to the expiration of the statute of limitations.

In conclusion, the CSM should find that (1) the SCO correctly reduced the county's FY 1996-97 claim by $893,367; (2) the SCO correctly reduced the county's FY 1997-98 claim by $1,051,859; (3) the SCO correctly reduced the county's FY 1998-99 claim by $1,287,198; and (4) the county did not file an IRC within the statute of limitations.

VII. CERTIFICATION

I hereby certify by my signature below that the statements made in this document are true and correct of my own knowledge, or, as to all other matters, I believe them to be true and correct based upon information and belief.

Executed on October 9, 2007, at Sacramento, California, by:

Jim L. Spano, Chief
Mandated Cost Audits Bureau
Division of Audits
State Controller's Office

TAB C

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE PARAMETERS AND GUIDELINES ON: Government Code Sections 7572.55 and 7576 Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654, and California Code of Regulations, Title 2, Sections 60000 et seq. (Emergency Regulations Effective July 1, 1998 [Register 99, No. 33]) Filed on June 20, 2005, by County of Los Angeles, Claimant.	No. 02-TC-40, 02-TC-49 *Handicapped and Disabled Students II* ADOPTION OF PARAMETERS AND GUIDELINES PURSUANT TO GOVERNMENT CODE SECTION 17557 AND TITLE 2, CALIFORNIA CODE OF REGULATIONS, SECTION 1183.14 *(Adopted on December 9, 2005; Corrected on July 21, 2006)*

CORRECTED PARAMETERS AND GUIDELINES

On December 9, 2005, the Commission on State Mandates adopted the parameters and guidelines for this program and authorized staff to make technical corrections to the parameters and guidelines following the hearing.

On May 26, 2006, the State Controller's Office filed a letter with the Commission requesting a technical correction to the parameters and guidelines to identify and add to the parameters and guidelines language allowing eligible claimants to claim costs using the cost report method. The cost report method was included in the parameters and guidelines for the original *Handicapped and Disabled Students* program (CSM 4282) and inadvertently omitted from the parameters and guidelines for *Handicapped and Disabled Student II.* The State Controller's Office states the following:

> The majority of claimants use this method to claim costs for the mental health portion of their claims. The resulting costs represent actual costs consistent with the cost accounting methodology used to report overall mental health costs to the State Department of Mental Health. The method is also consistent with how counties contract with mental health service vendors to provide services.

The following language is added to Section V, Claim Preparation and Submission:

Cost Report Method

A. Cost Report Method

Under this claiming method, the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with claiming instructions. A complete copy of the annual cost report, including all supporting schedules attached to the cost report as filed

with the Department of Mental Health, must also be filed with the claim forms submitted to the State Controller.

B. Indirect Cost Rates

To the extent that reimbursable indirect costs have not already been reimbursed by the Department of Mental Health from categorical funding sources, they may be claimed under this method.

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

In addition, a correction is made to Section IV(G), Reimbursable Activities, "Providing Psychotherapy or Other Mental Health Treatment Services." On May 26, 2005, the Commission adopted the Statement of Decision in the reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10), and approved as a reimbursable state-mandated activity, beginning July 1, 2004, providing mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's IEP. When adopting the parameters and guidelines on the reconsidered program, the Commission determined that it would include psychotherapy and other mental health treatment activities in the parameters and guidelines in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), since it had an earlier reimbursement period (July 1, 2001) and the definition of mental health treatment services was substantially amended. The Commission's finding is as follows:

> The Commission's Statement of Decision authorizes reimbursement for providing psychotherapy or other mental health services identified in a pupil's IEP, as defined in sections 542 and 543 of the Department of Mental Health regulations. As noted in the Statement of Decision, however, the original definition of the types of services was repealed and replaced by the Departments of Mental Health and Education in 1998. [Footnote omitted.] The Commission concluded that the new definition of psychological and other mental health services constitutes a reimbursable new program or higher level of service in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) and, in December 2005, the Commission adopted parameters and guidelines for *Handicapped and Disabled Students II.* The reimbursement period for *Handicapped and Disabled Students II* begins July 1, 2001.
>
> Therefore, costs incurred by eligible claimants for the activity of providing psychological and other mental health services may be claimed pursuant to the parameters and guidelines in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), beginning July 1, 2001. Since the proposed parameters and guidelines for the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10) has a later reimbursement period, the activity is not included in these proposed parameters and guidelines.[1]

On May 26, 2005, the Commission adopted the Statement of Decision in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) and found that section 60020 of the test claim regulations continued to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation in the definition of "mental health services." However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. The Commission also found that case management services were reimbursable. The Commission's findings are as follows:

> In addition, section 60020, subdivision (i), changed the definition of mental health services. As indicated above, the former regulations defined "psychotherapy and other mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Under the prior regulations, these services included the following: day care

[1] Staff analysis adopted by Commission on January 26, 2006.

intensive services, day care habilitative (counseling and rehabilitative) services, vocational services, socialization services, collateral services, assessment, individual therapy, group therapy, medication (including the prescribing, administration, or dispensing of medications, and the evaluation of side effects and results of the medication), and crisis intervention.

Section 60020, subdivision (i), of the regulations, now defines "mental health services" as follows:

> "Mental health services" means mental health assessment and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.

Section 60020 of the test claim regulations continues to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation within the definition of "mental health services." These services are not new. [Footnote deleted.]

However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. ...

Thus, counties are not eligible for reimbursement for providing crisis intervention, vocational services, and socialization services since these activities were repealed as of July 1, 1998.

Nevertheless, section 60020 of the regulations increases the level of service of counties providing mental health services by including case management services and "psychotherapy" within the meaning of "mental health services." The regulation defines psychotherapy to include both individual and group therapy, based on the definition in Business and Professions Code section 2903.

The parameters and guidelines for the program, however, inadvertently included in the identification of activities that were *not* reimbursable the activities of mental health assessments, collateral services, intensive day treatment, and case management. The parameters and guidelines also inadvertently did not include reimbursement for day rehabilitation services. Based on the Commission's Statements of Decision for these programs, claimants are eligible for reimbursement, beginning July 1, 2001, for case management services. Claimants are also eligible for reimbursement, beginning July 1, 2004, for mental health assessments, collateral services, intensive day treatment, and day rehabilitation services.

Thus, in order for the parameters and guidelines to conform to the findings of the Commission in the reconsideration of *Handicapped and Disabled Students* (04-RL-4292-10) and *Handicapped and Disabled Students II* (02-TC-40, 02-TC-49), Section IV(G) is corrected as follows:

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

1) The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

2) The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

3) Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

4) Provide <u>case management services and</u> individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

5) <u>*Beginning July 1, 2004*, provide mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's IEP. These services shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)</u>

6) Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

7) Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

(When providing psychotherapy or other mental health treatment services, the activities of ~~mental health assessments, collateral services, intensive day treatment, case management,~~ crisis intervention, vocational services, and socialization services are not reimbursable.)

Finally, language is added to Section III, Period of Reimbursement, to reflect the July 1, 2004 period of reimbursement for the activities of mental health assessments, collateral services, intensive day treatment, and day rehabilitation services.

Dated: _____

_____
Paula Higashi, Executive Director

Corrected: July 21, 2006
Adopted: December 9, 2005
j:mandates/2000/tc/02tc40/psgs/corrected psgs

CORRECTED
PARAMETERS AND GUIDELINES

Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654

California Code of Regulations, Title 2, Sections 60000 et seq.
(emergency regulations effective July 1, 1998 [Register 98, No. 26],
final regulations effective August 9, 1999 [Register 99, No. 33])

Handicapped and Disabled Students II (02-TC-40/02-TC-49)

Counties of Stanislaus and Los Angeles, Claimants

I. SUMMARY OF THE MANDATE

On May 26, 2005, the Commission on State Mandates (Commission) adopted its Statement of Decision in *Handicapped and Disabled Students II*, finding that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2, §§ 60000 et seq.), impose a reimbursable state-mandated program on counties within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

The Handicapped and Disabled Students program was initially enacted in 1984 and 1985 as the state's response to federal legislation (Individuals with Disabilities Education Act, or IDEA) that guaranteed to disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education. Three other Statements of Decision have been adopted by the Commission on the Handicapped and Disabled Students program. They include *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

Eligible claimants are ***not*** entitled to reimbursement under these parameters and guidelines for the activities approved by the Commission in *Handicapped and Disabled Students* (CSM 4282), *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

These parameters and guidelines address only the amendments to the *Handicapped and Disabled Students* program. The Commission found, pursuant to the court's ruling in *Hayes v. Commission on State Mandates* (1992) 11 Cal. App.4th 1564, that Government Code sections 7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Departments of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999, constitute a reimbursable state-mandated program since the state "freely chose" to impose the costs upon counties as a means of implementing the federal IDEA program.

II. ELIGIBLE CLAIMANTS

Any county, or city and county, that incurs increased costs as a result of this reimbursable state-mandated program is eligible to claim reimbursement of those costs.

III. PERIOD OF REIMBURSEMENT

Government Code section 17557 states that a test claim shall be submitted on or before June 30 following a given fiscal year to establish eligibility for reimbursement for that fiscal year. The test claim for this mandate was filed by the County of Stanislaus (02-TC-40) on June 27, 2003, and filed by the County of Los Angeles (02-TC-49) on June 30, 2003. Therefore, except as expressly provided in Section IV. G (5), the period of reimbursement begins July 1, 2001.

Actual costs for one fiscal year shall be included in each claim. Estimated costs for the subsequent year may be included on the same claim, if applicable. Pursuant to Government Code section 17561, subdivision (d)(l)(A), all claims for reimbursement of initial fiscal year costs shall be submitted to the State Controller within 120 days of the issuance date for the claiming instructions.

If the total costs for a given year do not exceed $1,000, no reimbursement shall be allowed, except as otherwise allowed by Government Code section 17564.

IV. REIMBURSABLE ACTIVITIES

To be eligible for mandated cost reimbursement for any given fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.

Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, calendars, and declarations. Declarations must include a certification or declaration stating, "I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of Code of Civil Procedure section 2015.5. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise reported in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[2] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

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[2] Some costs disallowed by the State Controller's Office in prior years are now reimbursable beginning July 1, 2001 (e.g., medication monitoring). Rather than claimants re-filing claims for

For each eligible claimant, the following activities are eligible for reimbursement:

A. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)

The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:

1) Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)

2) A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)

3) Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)

4) At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)

5) The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)

6) The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

7) The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)

8) Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

(The activities of updating or renewing the interagency agreements are not reimbursable.)

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those costs incurred beginning July 1, 2001, the State Controller's Office will reissue the audit reports.

B. Referral and Mental Health Assessments (Gov. Code, § 7576; Cal. Code Regs., tit. 2, §§ 60040, 60045)

1) Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)

2) A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)

3) If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)

4) If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)

5) Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

6) Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

7) Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)

8) Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)

9) Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)

10) The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

C. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)

1) Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.

2) Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.

D. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)

1) When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)

2) The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)

3) The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)

4) When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

E. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)

1) Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)

2) When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)

3) Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)

4) Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)

5) Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)

6) Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)

7) Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility every 90 days. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)

8) Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

F. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))

1) Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356. This activity requires counties to determine that the residential placement meets all the criteria established in Welfare and Institutions Code sections 18350 through 18356 before authorizing payment.

G. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))

1) The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

2) The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)

3) Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

4) Provide <u>case management services and</u> individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

5) <u>*Beginning July 1, 2004*, provide mental health assessments, collateral services, intensive day treatment, and day rehabilitation services when required by the pupil's</u>

IEP. These services shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)

6) Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

7) Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

(When providing psychotherapy or other mental health treatment services, the activities of ~~mental health assessments, collateral services, intensive day treatment, case management,~~ crisis intervention, vocational services, and socialization services are not reimbursable.)

V. CLAIM PREPARATION AND SUBMISSION

Each of the following cost elements must be identified for each reimbursable activity identified in section IV. of this document. Each claimed reimbursable cost must be supported by source documentation as described in section IV. Additionally, each reimbursement claim must be filed in a timely manner.

There are two satisfactory methods of submitting claims for reimbursement of increased costs incurred to comply with the mandate: the direct cost reporting method and the cost report method.

Direct Cost Reporting Method

A. Direct Cost Reporting

Direct costs are those costs incurred specifically for the reimbursable activities. The following direct costs are eligible for reimbursement.

1. Salaries and Benefits

Report each employee implementing the reimbursable activities by name, job classification, and productive hourly rate (total wages and related benefits divided by productive hours). Describe the specific reimbursable activities performed and the hours devoted to each reimbursable activity performed.

2. Materials and Supplies

Report the cost of materials and supplies that have been consumed or expended for the purpose of the reimbursable activities. Purchases shall be claimed at the actual price after deducting discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged on an appropriate and recognized method of costing, consistently applied.

3. Contracted Services

Report the name of the contractor and services performed to implement the reimbursable activities. If the contractor bills for time and materials, report the number of hours spent on the activities and all costs charged. If the contract is a fixed price, report the services that were performed during the period covered by the reimbursement claim. If the contract services are also used for purposes other than the reimbursable activities, only the pro-rata portion of the services used to implement the reimbursable activities can be claimed. Submit contract consultant and invoices with the claim and a description of the contract scope of services.

4. Fixed Assets and Equipment

Report the purchase price paid for fixed assets and equipment (including computers) necessary to implement the reimbursable activities. The purchase price includes taxes, delivery costs, and installation costs. If the fixed asset or equipment is also used for purposes other than the reimbursable activities, only the pro-rata portion of the purchase price used to implement the reimbursable activities can be claimed.

B. Indirect Cost Rates

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

Cost Report Method

A. Cost Report Method

Under this claiming method, the mandate reimbursement claim is still submitted on the State Controller's claiming forms in accordance with claiming instructions. A complete copy of the annual cost report, including all supporting schedules attached to the cost report as filed with the Department of Mental Health, must also be filed with the claim forms submitted to the State Controller.

B. Indirect Cost Rates

To the extent that reimbursable indirect costs have not already been reimbursed by the Department of Mental Health from categorical funding sources, they may be claimed under this method.

Indirect costs are costs that are incurred for a common or joint purpose, benefiting more than one program, and are not directly assignable to a particular department or program without efforts disproportionate to the result achieved. Indirect costs may include (1) the overhead costs of the unit performing the mandate; and (2) the costs of the central government services distributed to the other departments based on a systematic and rational basis through a cost allocation plan.

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in the Office of Management and Budget (OMB) Circular A-87. Claimants have the option of using 10% of labor, excluding fringe benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10%.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in OMB Circular A-87 Attachments A and B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in OMB A-87 Attachments A and B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

The distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution.

In calculating an ICRP, the claimant shall have the choice of one of the following methodologies:

1. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) classifying a department's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an

equitable distribution base. The result of this process is an indirect cost rate which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

2. The allocation of allowable indirect costs (as defined and described in OMB Circular A-87 Attachments A and B) shall be accomplished by (1) separating a department into groups, such as divisions or sections, and then classifying the division's or section's total costs for the base period as either direct or indirect, and (2) dividing the total allowable indirect costs (net of applicable credits) by an equitable distribution base. The result of this process is an indirect cost rate that is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected.

VI. RECORDS RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter[3] is subject to the initiation of an audit by the State Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. All documents used to support the reimbursable activities, as described in Section IV, must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VII. OFFSETTING SAVINGS AND REIMBURSEMENTS

Any offsetting savings the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate received from any of the following sources shall be identified and deducted from this claim:

1. Funds received by a county pursuant to Government Code section 7576.5.
2. Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, items 4440-131-0001), and the $69 million appropriations in 2003 and 2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
3. Private insurance proceeds obtained with the consent of a parent for purposes of this program.

[3] This refers to Title 2, division 4, part 7, chapter 4 of the Government Code.

4. Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
5. Any other reimbursement received from the federal or state government, or other non-local source.

Beginning July 1, 2001, realignment funds under the Bronzan-McCorquodale Act that are used by a county for this program are not required to be deducted from the costs claimed. (Stats. 2004, ch. 493, § 6 (SB 1895).)

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

Pursuant to Government Code section 17558, subdivision (b), the Controller shall issue claiming instructions for each mandate that requires state reimbursement not later than 60 days after receiving the adopted parameters and guidelines from the Commission, to assist local agencies and school districts in claiming costs to be reimbursed. The claiming instructions shall be derived from the statute or executive order creating the mandate and the parameters and guidelines adopted by the Commission.

Pursuant to Government Code section 17561, subdivision (d)(l), issuance of the claiming instructions shall constitute a notice of the right of the local agencies and school districts to file reimbursement claims, based upon parameters and guidelines adopted by the Commission.

IX. REMEDIES BEFORE THE COMMISSION

Upon request of a local agency or school district, the Commission shall review the claiming instructions issued by the State Controller or any other authorized state agency for reimbursement of mandated costs pursuant to Government Code section 17571. If the Commission determines that the claiming instructions do not conform to the parameters and guidelines, the Commission shall direct the Controller to modify the claiming instructions to conform to the parameters and guidelines as directed by the Commission.

In addition, requests may be made to amend parameters and guidelines pursuant to Government Code section 17557, subdivision (a), and the California Code of Regulations, title 2, section 1183.2.

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

The Statement of Decision is legally binding on all parties and provides the legal and factual basis for the parameters and guidelines. The support for the legal and factual findings is found in the administrative record for the test claim. The administrative record, including the Statement of Decision, is on file with the Commission.

TAB D

2 CA ADC § 1185

Term

2 CCR s 1185

Cal. Admin. Code tit. 2, s 1185

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 2. ADMINISTRATION
DIVISION 2. FINANCIAL OPERATIONS
CHAPTER 2.5. COMMISSION ON STATE MANDATES
ARTICLE 5. INCORRECT REDUCTION CLAIMS
This database is current through 4/20/07, Register 2007, No. 16

s 1185. Incorrect Reduction Claim Filing.

(a) To obtain a determination that the Office of State Controller incorrectly reduced a reimbursement claim, a claimant shall file an "incorrect reduction claim" with the commission.

(b) All incorrect reduction claims shall be filed with the commission no later than three (3) years following the date of the Office of State Controller's remittance advice or other notice of adjustment notifying the claimant of a reduction.

(c) An incorrect reduction claim shall pertain to alleged incorrect reductions in a reimbursement claim (s) filed by one claimant. The incorrect reduction claim may be for more than one fiscal year.

(d) All incorrect reduction claims, or amendments thereto, shall be filed on a form provided by the commission.

(e) All incorrect reduction claims, or amendments thereto, shall contain at least the following elements and documents:

(1) A copy of the Office of State Controller's claiming instructions that were in effect during the fiscal year(s) of the reimbursement claim(s).

(2) A written detailed narrative that describes the alleged incorrect reduction(s). The narrative shall include a comprehensive description of the reduced or disallowed area(s) of cost(s).

(3) If the narrative describing the alleged incorrect reduction(s) involves more than discussion of statutes or regulations or legal argument and utilizes assertions or representations of fact, such assertions or representations shall be supported by testimonial

or documentary evidence and shall be submitted with the claim. All documentary evidence must be authenticated by declarations under penalty of perjury signed by persons who are authorized and competent to do so and be based upon the declarant's personal knowledge or information or belief.

(4) A copy of the final state audit report or letter or the remittance advice or other notice of adjustment from the Office of State Controller that explains the reason(s) for the reduction or disallowance.

(5) A copy of a letter sent by the claimant or the claimant's representative to the Office of State Controller explaining why the reduced area(s) of cost in dispute should be restored.

(6) A copy of the subject reimbursement claims the claimant submitted to the Office of State Controller.

(7) An incorrect reduction claim, or amendment thereto, shall be signed at the end of the document, under penalty of perjury by the claimant or its authorized representative, with the declaration that the test claim is true and complete to the best of the declarant's personal knowledge or information or belief. The date signed, the declarant's title, address, telephone number, and, if available, electronic mail address and facsimile number, shall be included.

(8) The claimant shall file one original incorrect reduction claim, or amendment thereto, and accompanying documents with commission. The original shall be unbound and single-sided, without tabs, and include a table of contents.

(9) The claimant shall also file two (2) copies of the incorrect reduction claim, or amendment thereto, and accompanying documents with the commission. The copies may be two-sided and shall not include tabs.

(f) Within ten (10) days of receipt of an incorrect reduction claim, commission staff shall notify the claimant if the incorrect reduction claim is complete or incomplete. Incorrect reduction claims will be considered incomplete if any of the elements required in subsections (d) through (f) of this section are illegible or not included. Incomplete incorrect reduction claims shall be returned to the claimant. If a complete incorrect reduction claim is not received by the commission with thirty (30) days from the date the incomplete claim was returned to the claimant, the commission shall deem the filing to be withdrawn.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Section 17527(g) and (h), Government Code. Reference: Sections 17551(b) and 17553, Government Code.

HISTORY

1. New Article 5 (Sections 1185 and 1185.1) filed 12-13-85; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 85, No.

50).

2. Amendment of Note filed 4-29-87; operative 5-29-87 (Register 87, No. 18).

3. Amendment of subsections (a), (b) and (c)(4)-(5) and Note filed 7-23-96; operative 7-23-96. Submitted to OAL for printing only (Register 96, No. 30).

4. Amendment of section and Note filed 9-13-99; operative 9-13-99. Submitted to OAL for printing only pursuant to Government Code section 17527 (Register 99, No. 38).

5. Amendment of article heading and amendment of section and Note filed 4-21-2003; operative 4-21-2003. Submitted to OAL for printing only pursuant to Government Code section 17527(g) (Register 2003, No. 17).

2 CCR s 1185, **◆2 CA ADC s 1185◆**
1CAC

◆2 CA ADC s 1185◆

END OF DOCUMENT

Term

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