

ITEM 5
INCORRECT REDUCTION CLAIM
PROPOSED DECISION

Government Code Sections 7570-7588

Statutes 1984, Chapter 1747 (AB 3632); Statutes 1985, Chapter 1274 (AB 882)

California Code of Regulations, Title 2, Sections 60000-60200 (Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed June 30, 1986, effective July 12, 1986 [Register 86, No. 28])

Handicapped and Disabled Students

Fiscal Years 1996-1997, 1997-1998, and 1998-1999

05-4282-I-03

County of San Mateo, Claimant

EXECUTIVE SUMMARY

Overview

This incorrect reduction claim (IRC) addresses reductions made by the State Controller's Office (Controller) to reimbursement claims filed by the County of San Mateo (claimant) for costs incurred during fiscal years 1996-1997 through 1998-1999 under the *Handicapped and Disabled Students* program.

The following issues are in dispute:

- Reductions based on services that claimant alleges were inadvertently miscoded in the reimbursement claim forms;
- Whether costs for medication monitoring and crisis intervention are eligible for reimbursement; and
- Whether reductions of the full amount of revenues and disbursements received by claimant under the Early Periodic Screening, Diagnosis, and Testing (EPSDT) program are correct as a matter of law and supported by evidence in the record.¹

The *Handicapped and Disabled Students* Program

The *Handicapped and Disabled Students* program was enacted by the Legislature to implement federal law that requires states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services, including psychological and other mental health services, designed to meet the pupil's unique educational

¹ The total disputed reduction over three fiscal years is \$3,323,423.

needs. The program shifted to counties the responsibility and funding to provide mental health services required by a pupil's individualized education plan (IEP).

In 1990 and 1991, the Commission on State Mandates (Commission) approved the test claim and adopted parameters and guidelines, authorizing reimbursement for mental health treatment services.

Procedural History

On December 26, 2002, the Controller issued a "final audit report," which states in its cover letter: "The SCO has established an informal review process to resolve a dispute of facts. The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report".² On February 20, 2003, claimant filed a response to the final audit report.³ On April 28, 2003, the Controller issued three remittance advice letters, one for each of the fiscal years at issue.⁴ On April 27, 2006, the claimant filed this IRC.⁵ On May 4, 2009, the Controller submitted written comments on the IRC.⁶ On March 15, 2010, the claimant submitted rebuttal comments.⁷

On May 28, 2015, Commission staff issued a draft proposed decision on the IRC setting this matter for hearing on July 24, 2015.⁸ On June 17, 2015, the claimant submitted comments on the draft and a request to postpone the matter, which was denied.⁹ Upon further review, Commission staff determined that claimant's comments raised substantial and complex legal issues that would require significant staff time to address and therefore postponed the matter to the September Commission hearing. On July 28, 2015, Commission staff issued a revised draft proposed decision setting this matter for hearing on September 25, 2015.¹⁰

On August 14, 2015, the Controller submitted a request for an extension of time to file comments, which was approved for good cause. On August 25, 2015, the claimant filed comments on the revised draft proposed decision.¹¹ On August 26, 2015, the Controller filed comments on the revised draft proposed decision.¹²

² Exhibit A, IRC 05-4282-I-03, page 71.

³ Exhibit A, IRC 05-4282-I-03, page 104.

⁴ Exhibit A, IRC 05-4282-I-03, pages 1; 373-377.

⁵ Exhibit A, IRC 05-4282-I-03, page 1.

⁶ Exhibit B, Controller's Comments on the IRC.

⁷ Exhibit C, Claimant's Rebuttal Comments.

⁸ Exhibit D, Draft Proposed Decision.

⁹ Exhibit E, Claimant's Comments on the Draft Proposed Decision and Request for Postponement.

¹⁰ Exhibit F, Revised Draft Proposed Decision.

¹¹ Exhibit G, Claimant's Comments on the Revised Draft Proposed Decision.

¹² Exhibit H, Controller's Comments on the Revised Draft Proposed Decision.

Commission Responsibilities

Government Code section 17561(b) authorizes the Controller to audit the claims filed by local agencies and school districts and to reduce any claim for reimbursement of state-mandated costs that the Controller determines is excessive or unreasonable.

Government Code Section 17551(d) requires the Commission to hear and decide a claim that the Controller has incorrectly reduced payments to the local agency or school district. If the Commission determines that a reimbursement claim has been incorrectly reduced, section 1185.9 of the Commission's regulations requires the Commission to send the decision to the Controller and request that the costs in the claim be reinstated.

The Commission must review questions of law, including interpretation of parameters and guidelines, de novo, without consideration of conclusions made by the Controller in the context of an audit. The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.¹³ The Commission must also interpret the Government Code and implementing regulations in accordance with the broader constitutional and statutory scheme. In making its decisions, the Commission must strictly construe article XIII B, section 6 and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."¹⁴

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.¹⁵

The Commission must also review the Controller's audit in light of the fact that the initial burden of providing evidence for a claim of reimbursement lies with the claimant.¹⁶ In addition, section 1185.1(f) and 1185.2(c) of the Commission's regulations requires that any assertions of fact by the parties to an IRC must be supported by documentary evidence. The Commission's ultimate findings of fact must be supported by substantial evidence in the record.¹⁷

¹³ *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 331-334; Government Code sections 17551, 17552.

¹⁴ *County of Sonoma*, supra, 84 Cal.App.4th 1264, 1280, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

¹⁵ *Johnston v. Sonoma County Agricultural* (2002) 100 Cal.App.4th 973, 983-984. See also *American Bd. of Cosmetic Surgery, Inc. v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547.

¹⁶ *Gilbert v. City of Sunnyvale* (2005) 130 Cal.App.4th 1264, 1274-1275.

¹⁷ Government Code section 17559(b), which provides that a claimant or the state may commence a proceeding in accordance with the provisions of section 1094.5 of the Code of Civil Procedure to set aside a decision of the Commission on the ground that the Commission's decision is not supported by substantial evidence in the record.

Claims

The following chart provides a brief summary of the claims and issues raised and staff's recommendation.

Issue	Description	Staff Recommendation
Was the IRC timely filed?	<p>At the time pertinent to this IRC, section 1185 of the Commission's regulations stated as follows: "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." Section 1185 further provides that an incomplete incorrect reduction claim filing may be cured within thirty days to preserve the original filing date.</p> <p>The Controller contends that this IRC was filed on May 25, 2006, the date the IRC was deemed complete, and it was therefore not timely based on the remittance advice letters issued to the claimant on April 28, 2003. Thus, the Controller asserts that the Commission does not have jurisdiction to hear and determine this IRC.</p>	<p><i>The IRC was timely filed –</i></p> <p>The IRC was filed on April 27, 2006, and after requesting additional documentation, was deemed complete on May 25, 2006. The "final audit report" issued December 26, 2002 describes the reductions that the Controller intended to take and the reasons for the reductions. However, the "final audit report" contains an express invitation for the claimant to participate in further dispute resolution, and invites the claimant to submit additional documentation to the Controller, which indicates that it was not the Controller's <i>final</i> determination on the subject claims. The remittance advice letters dated April 28, 2003, provide the Controller's final determination on the audit and the first notice of an actual adjustment to the claimant following the informal audit review of the final audit report. Since the IRC was filed on April 27, 2006, within three years of the April 28, 2003 remittance advice letters, the IRC is timely filed.</p>
Reduction of costs claimed for	The Controller reduced costs claimed for "Residential, Other" and "Skilled Nursing" by \$76,223 and \$21,708, respectively, on	<i>Incorrect</i> – Staff finds the claimant's worksheets show evidence of the validity of the

<p>“Residential, Other” and “Skilled Nursing.”</p>	<p>the ground that these service costs were ineligible for reimbursement.</p> <p>The claimant argues that these costs were simply miscoded on the claim forms, and the costs in question were actually related to eligible day treatment services for patients in residential and skilled nursing facilities. The claimant corrected the coding and submitted corrected worksheets to support the costs claimed.</p>	<p>costs claimed and satisfy the documentation requirements of the parameters and guidelines. The worksheets contain the name of the provider and identify the service provided with day treatment codes, the dates the services were provided, and the costs paid. The parameters and guidelines do not require declarations, contracts, or billing statements from the treatment provider. Therefore, this reduction is incorrect as a matter of law and arbitrary, capricious, and entirely lacking in evidentiary support.</p>
<p>Reduction of all costs to provide medication monitoring services to seriously emotionally disturbed pupils.</p>	<p>The Controller reduced all costs claimed for medication monitoring, totaling \$1,007,332, on the basis that this is not a reimbursable activity. The claimant argues that the disallowed activity is an eligible component of the mandated program, and that the Controller’s decision to reduce these costs relies on a too-narrow interpretation of the parameters and guidelines.</p>	<p><i>Correct</i> – The Commission has already decided that “medication monitoring” was not mandated by the original test claim legislation or the implementing regulations. Medication monitoring was added to the regulations for this program in 1998 and was approved in <i>Handicapped and Disabled Students II</i>, 02-TC-40/02-TC-49. The Controller’s reduction is correct as a matter of law.</p>
<p>Reduction of all costs claimed for crisis intervention.</p>	<p>The Controller reduced all costs claimed for all fiscal years for crisis intervention, totaling \$224,318, on the ground that crisis intervention is not reimbursable.</p> <p>The claimant argues that it “provided mandated . . . crisis intervention services under the authority of the California Code of Regulations – Title 2, Division 9, Joint Regulations for Handicapped Children.” The claimant cites the test claim regulations, which incorporate by reference</p>	<p><i>Partially Correct</i> –The requirement to provide crisis intervention services was expressly repealed beginning July 1, 1998, and is no longer reimbursable. Therefore the reduction for costs incurred in 1998-1999 is correct as a matter of law.</p> <p>However, the reduction of costs for fiscal years 1996-</p>

	<p>section 543 of title 9, which <i>expressly included</i> crisis intervention as a service required to be provided if the service is identified in a pupil's IEP. Claimant argues that these services were provided under the mandate, even though the parameters and guidelines did not expressly provide for them.</p>	<p>1997 and 1997-1998 is incorrect as a matter of law. The test claim decision approved the regulations that expressly included crisis intervention as a required service and found that providing psychotherapy and other mental health services required by the pupil's IEP was mandated by the state.</p>
<p>Reductions based on alleged understated offsetting state EPSDT revenues.</p>	<p>The 1991 parameters and guidelines identify the following potential offsetting revenues that must be identified and deducted from a reimbursement claim for this program: "any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc."</p> <p>Finding 3 of the Controller's final audit report states that the claimant did not account for or identify the portion of Medi-Cal funding received from the state under the EPSDT program as offsetting revenue. The auditor deducted the entire amount of state EPSDT revenues received by the claimant (\$2,069,194) during the audit period because the claimant did not provide adequate information regarding how much of these funds were actually applicable to the mandate.</p> <p>The claimant disputes the reduction and states that the Controller 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. The claimant estimates the portion of EPSDT revenue attributable to the mandate at approximately, or less than, ten percent.</p>	<p><i>Partially Correct</i> – Staff finds that the Controller's application of <i>all</i> state EPSDT funds received by claimant as an offset is not supported by the law or evidence in the record and is therefore arbitrary, capricious, and entirely lacking in evidentiary support. EPSDT services and funds are not limited to this mandated program.</p> <p>Staff also finds, based on assertions made by the claimant, that some EPSDT state matching funds were received by the claimant and applied to the program. However, staff is unable to determine from the evidence in the record the amount of state EPSDT funding received by the claimant that must be offset against the reimbursement claims at issue in this IRC. Staff recommends that the Commission remand the issue back to the Controller to determine the amount of state EPSDT funds received by the claimant and applied to this</p>

		program, which must be identified as offsetting.
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Staff Analysis

A. The Incorrect Reduction Claim Was Timely Filed.

The Controller contends that this IRC was filed on May 25, 2006, the date the IRC was deemed complete, and it was therefore not timely based on the remittance advice letters issued to the claimant on April 28, 2003. Thus, the Controller asserts that the Commission does not have jurisdiction to hear and determine this IRC. As described below, the IRC was timely filed.

The Commission received an IRC filing from the County of San Mateo on April 27, 2006, and after requesting additional documentation, determined that filing to be complete on May 25, 2006.¹⁸ Both the claimant and the Controller rely in their comments on the remittance advice letters dated April 28, 2003 as beginning the period of limitation for filing the IRC,¹⁹ and based on those documents, a claim filed on or before April 28, 2006 would be timely, being “no later than three (3) years following the date...” of the remittance advice.

Based on the date of the “final audit report,” the draft proposed decision issued May 28, 2015 concluded that the IRC was not timely filed, presuming that the “final audit report” was the first notice of adjustment.²⁰ However, upon further review, the final audit report contains an express invitation for the claimant to participate in further dispute resolution, and invites the claimant to submit additional documentation to the Controller: “The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report.”²¹ The language inviting further informal dispute resolution supports the finding that the audit report did not constitute the Controller’s *final* determination on the subject claims and thus did not provide the first notice of an actual reduction.²²

¹⁸ Exhibit I, Completeness Letter, dated June 6, 2006.

¹⁹ See Exhibit B, Controller’s Comments on the IRC, page 19; Exhibit C, Claimant’s Rebuttal Comments, page 4.

²⁰ The Commission has previously found that the earliest notice of an adjustment which also provides a reason for the adjustment triggers the period of limitation to run. See Adopted Decision, *Collective Bargaining*, 05-4425-I-11, December 5, 2014 [The claimant in that IRC argued that the *last* notice of a reduction should control the regulatory period of limitation for filing its IRC, but the Commission found that the earliest notice in the record which also contains a reason for the reduction, controls the period of limitation. The claimant, in that case, received multiple notices of reduction for the subject claims between January 24, 1996 and August 8, 2001, but none of those contained an adequate explanation of the reasons for the reduction. Finally, on July 10, 2002, the claimant received remittance advice that included a notation that the claim was being denied due to a lack of supporting documentation; based on that date, a timely IRC would have to be filed by July 10, 2005, and the claimant’s December 16, 2005 filing was not timely.].

²¹ Exhibit A, IRC 05-4282-I-03, page 71.

²² Code of Regulations, title 2, section 1185 (Register 2003, No. 17).

Based on the evidence in the record, the remittance advice letters provide the Controller's final determination on the audit and the first notice of an adjustment to the claimant following the informal audit review of the final audit report. Thus, based on the April 28, 2003 date of the remittance advice letter, an IRC filed by April 28, 2006 is timely.

B. Some of the Controller's Reductions Based on Ineligible Activities Are Partially Correct.

Finding 2 of the Controller's audit report reduced reimbursement by \$1,329,581 for skilled nursing, "Residential, Other," medication monitoring, and crisis intervention, which the Controller determined are not reimbursable under the parameters and guidelines.²³

The claimant states in the audit report that it does not concur with the Controller's findings with respect to \$76,223 reduced for "Residential, Other" services; and \$21,708 reduced for "Skilled Nursing" services, which the claimant asserts were in fact "eligible, allowable day treatment service costs that were miscoded."²⁴ More importantly, the claimant disputes the Controller's reductions of \$1,007,332 for "Medication Monitoring," and \$224,318 for "Crisis Intervention," which the claimant states are mandated activities within the scope of the approved regulations, and an essential part of "mental health services" provided to handicapped and disabled students under the applicable statutes and regulations.²⁵

1. *The Controller's reductions for "Residential, Other" and "Skilled Nursing," totaling \$91,132 for the audit period, are incorrect as a matter of law, and arbitrary, capricious, and entirely lacking in evidentiary support.*

The Controller reduced costs claimed for "Residential, Other" and "Skilled Nursing" services by \$76,223 and \$21,708, respectively, because these services were ineligible for reimbursement. The claimant, in response to the draft audit report, and in a letter responding to the final audit report that requested informal review, argued that \$91,132 of these costs were simply miscoded on the claim forms, and the costs in question were actually related to eligible day treatment services and those costs should be reinstated.²⁶

Exhibit A attached to claimant's letter shows the original coding and the corrected coding, with notes to indicate that rehabilitative day treatment and mental health services were provided, and also breaks down the miscoded amounts, the units of service associated with the dollar amounts, the provider of services, and dates of service.²⁷ It is not clear why the Controller was not satisfied with the additional documentation. Staff finds that the claimant's worksheets provided show evidence of the validity of the costs claimed and, thus, satisfy the documentation requirements of the parameters and guidelines.²⁸ The documentation contains the name of the provider, identifies the service provided with day treatment codes, the dates the services were

²³ Exhibit A, IRC 05-4282-I-03, page 78 [Final Audit Report].

²⁴ Exhibit A, IRC 05-4282-I-03, page 78 [Final Audit Report].

²⁵ Exhibit A, IRC 05-4282-I-03, pages 11; 78-79 [Final Audit Report].

²⁶ Exhibit A, IRC 05-4282-I-03, pages 112-114.

²⁷ Exhibit A, IRC 05-4282-I-03, pages 118-130.

²⁸ See Exhibit A, IRC 05-4282-I-03, page 165.

provided, and the costs paid. The parameters and guidelines do not require declarations, contracts, or billing statements from the treatment provider.

Based on the foregoing, staff finds that the Controller's reduction of \$91,132 in costs claimed for allowable day treatment services, as reflected in the corrected documentation submitted by the claimant, is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support, and should be reinstated, adjusted for the appropriate offset amount for Medi-Cal funding attributable to the reinstated treatment service costs.²⁹

2. *The Controller's reduction of costs to provide medication monitoring services to seriously emotionally disturbed pupils under the Handicapped and Disabled Students program is correct as a matter of law.*

The Controller reduced all costs claimed for medication monitoring (\$1,007,332) for the audit period.³⁰ The claimant argues that the disallowed activity is an eligible component of the mandated program, and that the Controller's decision to reduce these costs relies on a too-narrow interpretation of the parameters and guidelines.³¹

The *Handicapped and Disabled Students*, CSM-4282 decision addressed Government Code section 7576³² and the implementing regulations as they were *originally adopted* in 1986.³³ *Handicapped and Disabled Students II* was filed in 2003 on subsequent statutory and regulatory changes to the program, including the 1998 amendments to the regulation that defined "mental health services." On May 26, 2005, the Commission adopted a statement of decision finding that the activity of "medication monitoring," as defined in the 1998 amendment of section 60020, constituted a new program or higher level of service *beginning July 1, 2001*.

In 2001, the Counties of Los Angeles and Stanislaus filed separate requests to amend the parameters and guidelines for the original program in *Handicapped and Disabled Students*, CSM-4282. As part of the requests, the Counties wanted the Commission to apply the 1998 regulations, including the provision of medication monitoring services, to the original parameters and guidelines. On December 4, 2006, the Commission denied the request, finding that the 1998 regulations were not pled in original test claim, and cannot by law be applied retroactively to the original parameters and guidelines in *Handicapped and Disabled Students*, CSM-4282.

These decisions of the Commission are final, binding decisions and were never challenged by the parties. Once "the Commission's decisions are final, whether after judicial review or without

²⁹ In Finding 4 of the audit report, the Controller adjusted, in the claimant's favor, the amount of Medi-Cal offsetting revenue reported, based on the Controller's disallowance of certain treatment services claimed for which Medi-Cal revenues were received and reported by the claimant. Based on the reinstatement of \$91,132 in eligible services, at least some of which are Medi-Cal eligible services, the amount of the offset must be further adjusted to take account of Medi-Cal revenues received by the claimant for the services reinstated. (See Exhibit A, IRC 05-4282-I-03, pages 14; 81.)

³⁰ Exhibit A, IRC 05-4282-I-03, pages 78-79.

³¹ Exhibit A, IRC 05-4282-I-03, pages 11-13.

³² Added, Statutes 1984, chapter 1747; amended Statutes 1985, chapter 1274.

³³ Register 87, No. 30.

judicial review, they are binding, just as judicial decisions.”³⁴ Accordingly, based on these decisions, counties are not eligible for reimbursement for medication monitoring until July 1, 2001, in accordance with the decisions on *Handicapped and Disabled Students II*.³⁵

Based on the foregoing, staff finds that the Controller correctly reduced the reimbursement claims of the County of San Mateo for costs incurred in fiscal years 1996-1997, 1997-1998, and 1998-1999 to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

3. *The Controller’s reduction of costs claimed for crisis intervention, for fiscal years 1996-1997 and 1997-1998 only, is incorrect as a matter of law.*

The Controller reduced all costs claimed during the audit period for crisis intervention (\$224,318) on the ground that crisis intervention is not a reimbursable service.³⁶ The claimant argues that it “provided mandated . . . crisis intervention services under the authority of the California Code of Regulations – Title 2, Division 9, Joint Regulations for Handicapped Children.”³⁷ The claimant cites the test claim regulations, which incorporate by reference section 543 of title 9, which *expressly included* crisis intervention as a service required to be provided if the service is identified in a pupil’s IEP. Claimant argues that these services were provided under the mandate, even though the parameters and guidelines did not expressly provide for them.³⁸

Former section 60020 of the regulations, approved in the original 1990 test claim decision defined “mental health services” to include those services identified in sections 542 and 543 of the Department of Mental Health’s (DMH’s) Title 9 regulations.³⁹ Section 543 defined “Crisis Intervention,” as “immediate therapeutic response which must include a face-to-face contact with a patient exhibiting acute psychiatric symptoms to alleviate problems which, if untreated, present an imminent threat to the patient or others.”⁴⁰

The Commission’s 1990 decision approved the test claim with respect to section 60020 and found that providing psychotherapy and other mental health services required by the pupil’s IEP was mandated by the state.⁴¹ The parameters and guidelines adopted in 1991 caption all of sections 60000 through 60200 of the title 2 regulations, and specify in the “Summary of Mandate” that the reimbursable services “include psychotherapy and other mental health services

³⁴ *California School Boards Assoc. v. State of California* (2009) 171 Cal.App.4th 1183, 1200.

³⁵ See Statement of Decision, *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, pages 37-39; Statement of Decision, 00-PGA-03/04.

³⁶ Exhibit A, IRC 05-4282-I-03, page 78.

³⁷ Exhibit C, Claimant’s Rebuttal Comments, page 2.

³⁸ Exhibit A, IRC 05-4282-I-03, page 12.

³⁹ Former Cal. Code Regs., tit. 2, § 60020(a) (Register 87, No. 30).

⁴⁰ California Code of Regulations, title 9, section 543 (Reg. 83, No. 53; Reg. 84, No. 15; Reg. 84, No. 28; Reg. 84, No. 39).

⁴¹ Statement of Decision, Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 26.

provided to ‘individuals with exceptional needs,’ including those designated as ‘seriously emotionally disturbed,’ and required in such individual’s IEP.”⁴²

Therefore, even if the parameters and guidelines adopted in 1991 were vague and non-specific with respect to the reimbursable activities, crisis intervention was within the scope of the mandate approved by the Commission. Moreover, on reconsideration, the Commission found that the original decision correctly approved the program, as pled, as a reimbursable state-mandated program, but that the original decision did not fully identify all of the activities mandated by the state.⁴³

As the reconsideration decision and parameters and guidelines note, however, crisis intervention was repealed from the regulations on July 1, 1998.⁴⁴ For that reason this activity was not approved in the reconsideration decision, which had a period of reimbursement beginning July 1, 2004, or in *Handicapped and Disabled Students II*, which had a period of reimbursement beginning July 1, 2001.⁴⁵ Here, because the requirement was expressly repealed as of July 1, 1998; it is no longer a reimbursable mandated activity, and thus the costs for crisis intervention are reimbursable under the prior mandate finding only through June 30, 1998.

Based on the foregoing, staff finds that crisis intervention is within the scope of reimbursable activities approved by the Commission until July 1, 1998, and the Controller’s reduction of costs for fiscal years 1996-1997 and 1997-1998 for crisis intervention is incorrect as a matter of law. Staff therefore recommends that the Commission request that the Controller reinstate costs claimed for crisis intervention for fiscal years 1996-1997 and 1997-1998 only, adjusted for Medi-Cal offsetting revenues attributable to this mandated activity.⁴⁶

C. The Controller’s Reductions Based on Understated Offsetting State EPSDT Revenues Are Partially Correct, But the Reduction Based on the Full Amount of EPSDT Revenues Received Is Arbitrary, Capricious, and Entirely Lacking in Evidentiary Support.

The 1991 parameters and guidelines identify the following potential offsetting revenues that must be identified and deducted from a reimbursement claim for this program: “any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc.”⁴⁷

⁴² Exhibit A, IRC 05-4282-I-03, page 160.

⁴³ Statement of Decision, Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 26.

⁴⁴ Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 41.

⁴⁵ Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 42; *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, page 37.

⁴⁶ As noted above, Finding 4 of the audit report adjusted the Medi-Cal offsetting revenues claimed based on treatment services disallowed. To the extent crisis intervention is a Medi-Cal eligible service for which the claimant received state Medi-Cal funds, the reinstatement of costs must also result in an adjustment to the Medi-Cal offsetting revenues reported by the claimant.

⁴⁷ Exhibit A, IRC 05-4282-I-03, page 163.

Finding 3 of the Controller's final audit report states that the claimant did not account for or identify the portion of Medi-Cal funding received from the state under the EPSDT program as offsetting revenue. The auditor deducted the entire amount of state EPSDT revenues received (\$2,069,194) by the claimant during the audit period because the claimant did not provide adequate information regarding how much of these funds were actually applicable to the mandate."⁴⁸ The claimant disputes the reduction and states that the Controller "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."⁴⁹ The claimant estimates the portion of EPSDT revenue attributable to the mandate at approximately, or less than, ten percent.⁵⁰

The scope of EPSDT program services includes vision services, dental services, and "treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures."⁵¹ EPSDT mental health services include individual therapy, crisis counseling, case management, special day programs, and "medication for your mental health." Counseling and therapy services provided under EPSDT may be provided in the home, in the community, or in another location.⁵² Since state and federal funding under the EPSDT program may, by definition, be used for mental health treatment services for children under the age of 21, the funding received can be applied to the treatment of pupils under the *Handicapped and Disabled Students* mandate and reduce county costs under the mandate.

In this case, the claimant identified as an offset the federal share of EPSDT funding it claimed was attributable to this mandated program, and the audit did not make adjustments to that offset. But the claimant failed to identify any state matching EPSDT funds in its reimbursement claims.⁵³ The final audit report states that the claimant then estimated state EPSDT offsetting revenue for this program during the audit period at \$166,352, but the Controller rejected that estimate because it lacked "an accounting of the number of Medi-Cal units of service applicable to the mandate."⁵⁴ In response to the final audit report, the claimant explained that it "spent considerable time analyzing and refining the EPSDT units of service." The claimant now asserts, in rebuttal comments on the IRC, that "[t]he State SB90 auditor, utilizing a different methodology, then calculated the offset separately, and came to a three-year total for the offset of \$665,975."⁵⁵ And finally, the claimant states that it recalculated the offset again at \$524,389,

⁴⁸ Exhibit A, IRC 05-4282-I-03, page 79.

⁴⁹ Exhibit A, IRC 05-4282-I-03, page 13.

⁵⁰ Exhibit A, IRC 05-4282-I-03, pages 13-14; 81.

⁵¹ Exhibit I, Early and Periodic Screening, Diagnostic, and Treatment, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>, accessed July, 14, 2015.

⁵² Exhibit I, EPSDT Mental Health Services Brochure, published by Department of Health Care Services.

⁵³ Exhibit A, IRC 05-4282-I-03, page 80.

⁵⁴ Exhibit A, IRC 05-4282-I-03, page 81.

⁵⁵ Exhibit C, Claimant's Rebuttal Comments, page 2.

based on a Department of Mental Health methodology developed in 2003-2004.⁵⁶ The Controller has not acknowledged these proposed offsets, and maintains that the claimant still has not provided an adequate accounting of actual offsetting revenue attributable to this program.⁵⁷

In response to the revised draft proposed decision, the parties still dispute how the EPSDT offset is to be calculated, and there is some question whether the claimant has provided any evidence to support its calculation. In addition, the claimant alleges, without evidence in support, that DMH has issued guidance for calculating these offsets, and that its calculations have been accepted for purposes of the broader program by state and federal authorities.

Staff finds that the Controller's application of *all* state EPSDT funds received by claimant as an offset is not supported by the law or evidence in the record. There is no evidence in the record, and the Controller has made no finding or assertion, that *all* EPSDT funds received by the claimant are for services provided to pupils within the *Handicapped and Disabled Students* program. As noted above, the scope of EPSDT program services includes vision services, dental services, and "treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures" for all "full-scope" Medi-Cal beneficiaries.⁵⁸

Staff also finds, based on assertions made by the claimant, that some EPSDT state matching funds were received by the claimant and applied to the program. In this respect, the claimant agrees that it did not identify the state general fund EPSDT match as an offset. Referring to the population served by this mandated program, the claimant asserts that "[o]nly 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."⁵⁹

However, the Commission is unable to determine, based on evidence in the record, the amount of state EPSDT funding received by the claimant that must be offset against the reimbursement claims at issue in this IRC. No evidence has been submitted by the parties to show the number of EPSDT eligible pupils receiving mental health treatment services under the *Handicapped and Disabled Students* program during the audit years, or how much EPSDT funds were applied to the program. As indicated above, four different estimates have been offered as the correct offset amount for the state matching EPSDT funds, based on methodologies allegedly developed by the claimant, the Controller, and DMH. In this respect, the claimant has asserted that the offset for

⁵⁶ Exhibit C, Claimant's Rebuttal Comments, page 2.

⁵⁷ Exhibit B, Controller's Comments on the IRC, pages 18-19.

⁵⁸ Exhibit I, Early and Periodic Screening, Diagnostic, and Treatment, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>, accessed July, 14, 2015.

⁵⁹ Exhibit A, IRC 05-4282-I-03, page 13.

state EPSDT funding should be anywhere from \$55,407,⁶⁰ to \$166,352,⁶¹ to \$524,389,⁶² to \$665,975.⁶³

Accordingly, staff finds that the Controller's reduction of the full amount of state EPSDT funding received by the claimant during the audit period is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support. Staff recommends that the Commission remand the issue back to the Controller to determine the amount of state EPSDT funds received by the claimant and applied to services received by pupils within the *Handicapped and Disabled Students* program during the audit period.

Conclusion

Based on the foregoing, staff finds that the IRC was timely filed and partially approves this IRC. Staff further finds that the Controller's reduction of costs claimed for medication monitoring is correct as a matter of law, and not arbitrary, capricious, or entirely in evidentiary support.

However, the reductions listed below are incorrect as a matter of law, or are arbitrary, capricious, and entirely lacking in evidentiary support. Staff recommends that the Commission request that the Controller reinstate the costs reduced as follows:

- \$91,132 originally claimed as "skilled nursing" or "residential, other," costs which have been correctly stated in supplemental documentation, adjusted for state Medi-Cal revenues received and attributable to the reinstated services.
- That portion of \$224,318 reduced for crisis intervention services which is attributable to fiscal years 1996-1997 and 1997-1998, adjusted for state Medi-Cal revenues received and attributable to the reinstated services.
- Recalculate EPSDT offsetting revenues based on the amount of EPSDT state share funding actually received and attributable to the services provided to pupils under this mandated program during the audit period and reinstate the portion of the EPSDT funds which exceed those actually applied to the mandated services.

Staff Recommendation

Staff recommends that the Commission adopt the proposed decision to partially approve the IRC, and, pursuant to Government Code section 17551(d) and section 1185.9 of the Commission's regulations, request that the Controller reinstate the costs as indicated above. Staff further recommends that the Commission authorize staff to make any technical, non-substantive changes following the hearing.

⁶⁰ Exhibit A, IRC 05-4282-I-03, page 115 [Claimant's response to audit report].

⁶¹ Exhibit A, IRC 05-4282-I-03, page 80 [Final Audit Report].

⁶² Exhibit C, Claimant's Rebuttal Comments, page 7 [Claimant's recalculation using "new methodology developed by DMH"].

⁶³ Exhibit C, Claimant's Rebuttal Comments, page 7 ["Rosemary's" (the auditor) recalculation].

BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

IN RE INCORRECT REDUCTION CLAIM
ON:

Government Code Sections 7570-7588

Statutes 1984, Chapter 1747 (AB 3632);
Statutes 1985, Chapter 1274 (AB 882)

California Code of Regulations, Title 2,
Sections 60000-60200 (Emergency regulations
effective January 1, 1986 [Register 86, No. 1],
and re-filed June 30, 1986, effective
July 12, 1986 [Register 86, No. 28])

Fiscal Years 1996-1997, 1997-1998, and
1998-1999

County of San Mateo, Claimant

Case No.: 05-4282-I-03

Handicapped and Disabled Students

DECISION PURSUANT TO
GOVERNMENT CODE SECTION 17500 ET
SEQ.; CALIFORNIA CODE OF
REGULATIONS, TITLE 2, DIVISION 2,
CHAPTER 2.5. ARTICLE 7

(Adopted September 25, 2015)

DECISION

The Commission on State Mandates (Commission) heard and decided this incorrect reduction claim (IRC) during a regularly scheduled hearing on September 25, 2015. [Witness list will be included in the adopted decision.]

The law applicable to the Commission's determination of a reimbursable state-mandated program is article XIII B, section 6 of the California Constitution, Government Code section 17500 et seq., and related case law.

The Commission [adopted/modified] the proposed decision to [approve/partially approve/deny] the IRC at the hearing by a vote of [vote count will be included in the adopted decision].

Summary of the Findings

This analysis addresses reductions made by the State Controller's Office (Controller) to reimbursement claims filed by the County of San Mateo (claimant) for costs incurred during fiscal years 1996-1997 through 1998-1999 for the *Handicapped and Disabled Students* program. Over the three fiscal years in question, reductions totaling \$3,940,249 were made, based on alleged unallowable services claimed and understated offsetting revenues.

The Commission partially approves this IRC, finding that reductions for medication monitoring in all three fiscal years, and for crisis intervention in fiscal year 1998-1999 were correct as a matter of law, but that reductions for eligible day treatment services inadvertently miscoded as "skilled nursing" and "residential, other" are incorrect, and reductions for fiscal years 1996-1997 and 1997-1998 for crisis intervention are incorrect. And, the Commission finds that reduction of the entire amount of Early and Periodic Screening, Diagnosis, and Testing (EPSDT) program funds is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in

evidentiary support. The Commission requests the Controller to reinstate costs reduced for services and offsetting revenues as follows:

- \$91,132 originally claimed as “Skilled Nursing” or “Residential, Other,” costs which have been correctly stated in supplemental documentation, adjusted for state Medi-Cal revenues received and attributable to the reinstated services.
- That portion of \$224,318 reduced for crisis intervention services which is attributable to fiscal years 1996-1997 and 1997-1998, adjusted for state Medi-Cal revenues received and attributable to the reinstated services.
- Recalculate EPSDT offsetting revenues based on the amount of EPSDT state share funding actually received and attributable to the services provided to pupils under this mandated program during the audit period.

COMMISSION FINDINGS

I. Chronology

12/26/2002	Controller issued the final audit report. ⁶⁴
04/28/2003	Controller issued remittance advice letters for each of the three fiscal years. ⁶⁵
04/27/2006	Claimant filed the IRC. ⁶⁶
05/04/2009	Controller submitted written comments on the IRC. ⁶⁷
03/15/2010	Claimant submitted rebuttal comments. ⁶⁸
05/28/2015	Commission staff issued the draft proposed decision. ⁶⁹
06/17/2015	Claimant submitted comments on the draft proposed decision and a request for postponement, which was denied. ⁷⁰
07/9/2015	Upon further review, Commission staff postponed the hearing to September 25, 2015.
07/28/2015	Commission staff issued the revised draft proposed decision. ⁷¹
08/14/2015	Controller requested an extension of time to file comments on the revised draft proposed decision, which was approved for good cause.

⁶⁴ Exhibit A, IRC 05-4282-I-03, page 71.

⁶⁵ Exhibit A, IRC 05-4282-I-03, pages 1; 373-377.

⁶⁶ Exhibit A, IRC 05-4282-I-03, page 1.

⁶⁷ Exhibit B, Controller’s Comments on the IRC.

⁶⁸ Exhibit C, Claimant’s Rebuttal Comments.

⁶⁹ Exhibit D, Draft Proposed Decision.

⁷⁰ Exhibit E, Claimant’s Comments on the Draft Proposed Decision and Request for Postponement.

⁷¹ Exhibit F, Revised Draft Proposed Decision.

08/25/2015 Claimant filed comments on the revised draft proposed decision.⁷²

08/26/2015 Controller filed comments on the revised draft proposed decision.⁷³

II. Background

The *Handicapped and Disabled Students* program was enacted by the Legislature to implement federal law requiring states to guarantee to disabled pupils the right to receive a free and appropriate public education that emphasizes special education and related services, including psychological and other mental health services, designed to meet the pupil's unique educational needs. The program shifted to counties the responsibility and costs to provide mental health services required by a pupil's individualized education plan (IEP).

The *Handicapped and Disabled Students* test claim was filed on Government Code section 7570 et seq., as added by Statutes 1984, chapter 1747 (AB 3632) and amended by Statutes 1985, chapter 1274 (AB 882); and on the initial emergency regulations adopted in 1986 by the Departments of Mental Health and Education to implement this program.⁷⁴ Government Code section 7576 required the county to provide psychotherapy or other mental health services when required by a pupil's IEP. Former section 60020 of the Title 2 regulations defined "mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health's (DMH's) Title 9 regulations.⁷⁵ In 1990 and 1991, the Commission approved the test claim and adopted parameters and guidelines, authorizing reimbursement for the mental health treatment services identified in the test claim regulations.⁷⁶

In 2004, the Legislature directed the Commission to reconsider *Handicapped and Disabled Students*, CSM-4282.⁷⁷ In May 2005, the Commission adopted a statement of decision on reconsideration (04-RL-4282-10), and determined that the original statement of decision correctly concluded that the 1984 and 1985 test claim statutes and the original regulations adopted by the Departments of Mental Health and Education impose a reimbursable state-mandated program on counties pursuant to article XIII B, section 6. The Commission concluded, however, that the 1990 statement of decision did not fully identify all of the activities mandated by the state or the offsetting revenue applicable to the program. On reconsideration, the Commission agreed with its earlier decision that Government Code section 7576 and the initial regulations adopted by the Departments of Mental Health and Education required counties to provide psychotherapy or other mental health treatment services to a pupil, either directly or by contract, when required by the pupil's IEP. The Commission further found that the

⁷² Exhibit G, Claimant's Comments on Revised Draft Proposed Decision.

⁷³ Exhibit H, Controller's Comments on Revised Draft Proposed Decision.

⁷⁴ California Code of Regulations, title 2, division 9, sections 60000-60200 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and re-filed June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

⁷⁵ Former California Code of Regulations, title 2, section 60020(a).

⁷⁶ *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49 was filed in 2003 on subsequent statutory and regulatory changes to the program, including 1998 amendments to the regulation that defined "mental health services" but those changes are not relevant to this IRC.

⁷⁷ Statutes 2004, chapter 493 (SB 1895).

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 title 9 regulations. These services included day care 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.

Controller’s Audit and Summary of the Issues

The Controller issued its “final audit report” on December 26, 2002, which proposed reductions to claimed costs for fiscal years 1996-1997 through 1998-1999 by \$3,940,249, subject to “an informal review process to resolve a dispute of facts.” Though claimant did participate in the informal review process, the Controller made no changes to its findings in the “final audit report” and thereafter issued remittances, reducing claimed costs consistently with the audit findings. The Controller’s audit report made the following findings.

In Finding 1, the Controller determined that \$518,337 in costs were claimed in excess of amounts paid to its contract providers. The claimant does not dispute this finding.

In Finding 2, the Controller determined that the claimant had claimed ineligible costs for treatment services, represented in the claim forms by “mode and service function code” as follows: 05/10 Hospital Inpatient (\$38,894); 05/60 Residential, Other (\$76,223); 10/20 Crisis Stabilization (\$3,251); 10/60 Skilled Nursing (\$21,708); 15/60 Medication [Monitoring] (\$1,007,332); and 15/70 Crisis Intervention (\$224,318). The claimant concurred with the findings regarding Hospital Inpatient and Crisis Stabilization and, thus, those reductions are not addressed in this decision. However, the claimant disputes the reductions with respect to “skilled nursing” and “residential, other,” “medication monitoring,” and “crisis intervention.” The Controller’s audit rejected costs claimed for “skilled nursing” and “residential, other” based on the service function codes recorded on the reimbursement claim forms, because those services are ineligible for reimbursement. Additionally, the Controller determined that medication monitoring and crisis intervention were not reimbursable activities because they were not included in the original test claim decision or parameters and guidelines. The Controller’s audit reasons that while several other treatment services are defined in title 9, section 543 of the Code of Regulations, including medication monitoring and crisis intervention, and some are expressly named in the parameters and guidelines, medication monitoring and crisis intervention were excluded from the parameters and guidelines, which the Controller concludes must have been intentional.⁷⁸

In Finding 3, the Controller determined that the claimant failed to report state matching funds received under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to reimburse for services provided to Medi-Cal clients, as well as funding received from the State Board of Education for school expenses (referred to as AB 599 funds); and that the claimant incorrectly deducted Special Education Pupil funds (also called AB 3632 funds). The adjustment to the claimant’s offsetting revenues totaled \$2,445,680. The claimant does not dispute the adjustment for AB 599 funds, and does not address the correction of the allocation of Special Education Pupil funds, but does dispute the Controller’s reduction of the entire amount received

⁷⁸ Exhibit A, IRC 05-4282-I-03, page 79.

under the EPSDT program as offsetting revenue since EPSDT funds may be allocated to a wide range of services, in addition to the mandated program, and many of the students receiving services under the mandated program were not Medi-Cal clients.

Finally, in Finding 4, the Controller determined that the claimant's offsetting revenue reported from Medi-Cal funds required adjustment based on the disallowances of certain ineligible services for which offsetting revenues were claimed. The claimant requests that if any of the costs for the disallowed services are reinstated as a result of this IRC, the offsetting Medi-Cal revenues would need to be further adjusted.

Accordingly, based on the claimant's response to the audit report and its IRC filing, the following issues are in dispute:

- Reductions based on services claimant alleges were inadvertently miscoded as "skilled nursing" and "residential, other" on its original reimbursement claim forms;
- Whether costs for medication monitoring and crisis intervention are eligible for reimbursement; and
- Whether reductions of the full amount of revenues and disbursements received by claimant under the EPSDT program are correct as a matter of law and supported by evidence in the record.

III. Positions of the Parties

County of San Mateo

First, with respect to the Controller's assertion that the IRC was not timely filed, the claimant argues that "[i]n fact, our IRC was initially received by the Commission on April 26, 2006."⁷⁹ The claimant states that "[w]e were then requested to add documentation solely to establish the final date by which the IRC must have been submitted in order to avoid the [statute of limitations] issue." The claimant points out that "[t]he SCO asserts that the basis of the [statute of limitations] issue is that the IRC was not submitted by the deadline of April 28, 2006." The claimant continues: "The confirmation of this deadline by the SCO supports the timeliness of the initial presentation of our IRC to the Commission."⁸⁰

The draft proposed decision recommended denial of the entire IRC based on the three year limitation period to file an IRC with the Commission, applied to the December 26, 2002 audit report; based on that date, the IRC filed April 27, 2006 was not timely. In response, the claimant submitted written comments requesting that the matter be continued to a later hearing and the decision be revised. Specifically, the claimant argued that the IRC was timely filed based on the plain language of the Commission's regulations, and based on the interpretation of those regulations in the Commission's "Guide to State Mandate Process", a public information document available for a time on the Commission's web site. The claimant argued that while the IRC was filed "within three years of issuance of the...remittance advice..." the "Commission [staff] now asserts, though, that the IRC should have been filed within three years of the issuance

⁷⁹ Exhibit C, Claimant's Rebuttal Comments, pages 3-4. The IRC is in fact stamped received on April 27, 2006. (See Exhibit A, page 3.)

⁸⁰ Exhibit C, Claimant's Rebuttal Comments, pages 3-4.

of the SCO's final audit report because, based on the Commission's *present* interpretation, the final audit report constitutes 'other notice of adjustment' notifying the County of a reduction of its claim."⁸¹ The claimant argued that this "is contrary to both well-settled practice and understanding and the Commission's own precedents." The claimant further pointed out that neither party has raised the issue of whether the IRC was timely filed based on the audit report, and that both the claimant and the Controller relied on the remittance advice to determine the regulatory period of limitation.

In addition, the claimant argues that "even after issuance of the SCO's final audit report, the County may submit further materials and argument to the SCO with respect to its claim..." The claimant characterizes this process as "the ongoing administrative process after the preparation of the SCO's final audit report..." and argues that "it is inappropriate to conclude that the report constitutes a 'notice of adjustment' as that term is used in Section 1185."⁸²

Furthermore, the claimant argues that denying this IRC based on the regulatory period of limitation applied to the December 26, 2002 audit report is inconsistent with a prior Commission decision on the same program. The claimant argues that "the Commission, construing the same regulatory text at issue here, under remarkably similar circumstances, rejected a claim that a county's IRC was untimely."⁸³ The claimant argues that while statutes of limitation do provide putative defendants repose, and encourage diligent prosecution of claims: "A countervailing factor...is the policy favoring disposition of cases on the merits rather than on procedural grounds."⁸⁴ Therefore, the claimant concludes that the period of limitation must be calculated from the later remittance advice, rather than the audit report, and the Commission should decide this IRC on its merits.

With regard to the merits, claimant asserts that the Controller incorrectly reduced claimed costs totaling \$3,232,423 for the audit period.⁸⁵

The claimant asserts that disallowed costs for "skilled nursing" and "residential, other" were merely miscoded on the reimbursement claim forms, and in fact were eligible day treatment services that should have been reimbursed, totaling \$91,132.⁸⁶

⁸¹ Exhibit E, Claimant's Comments on the Draft Proposed Decision and Request for Postponement, page 2 [emphasis in original].

⁸² Exhibit E, Claimant's Comments on the Draft Proposed Decision and Request for Postponement, page 2.

⁸³ Exhibit E, Claimant's Comments on the Draft Proposed Decision and Request for Postponement, page 3.

⁸⁴ Exhibit E, Claimant's Comments on the Draft Proposed Decision and Request for Postponement, page 4 [citing *Fox v. Ethicon Endo-Surgery, Inc.* (2005) 35 Cal.4th 797, 806.).

⁸⁵ Exhibit A, IRC 05-4282-I-03, pages 2; 8.

⁸⁶ Exhibit A, IRC 05-4282-I-03, page 115. [However, as noted below, the claimant concedes that of the \$97,931 in miscoded services, only \$91,132 "should have been approved..." and the claimant disputes only that amount of the disallowance. (See Exhibit A, IRC 05-4282-I-03, page 114.)]

Referring to “medication monitoring” and “crisis intervention,” the claimant argues that the Controller “arbitrarily excluded eligible activities for all three fiscal years...” (incorrectly reducing costs claimed by a total of \$1,231,650)⁸⁷ based on an “overly restrictive Parameters and Guidelines interpretation...” The claimant maintains:

The activities in question were clearly a part of the original test claim, statement of decision and are based on changes made to Title 2, Division 9, Chapter 1 of the California Code of Regulations, Section 60020, Government Code 7576 and Interagency Code of Regulations, and part of the activities included in the Parameters and guidelines. [*sic*]⁸⁸

The disallowance, the claimant argues, “is based on an errant assumption that these activities were intentionally excluded.” Rather, the claimant argues, “the Parameters and Guidelines for this program, like many other programs of the day, were intended to guide locals to broad general areas of activity within a mandate without being the overly restrictive litigious documents as they have become today.”⁸⁹

The claimant therefore concludes that medication monitoring and crisis intervention activities are reimbursable, when necessary under an IEP, because these are defined in the regulations and not specifically excluded in the parameters and guidelines.⁹⁰

In addition, with regard to offsets, the claimant asserts that EPSDT revenues “only impact 10% of the County’s costs for this mandate.” However, the Controller “deducted 100% of the EPSDT revenue from the claim.” Therefore, the claimant “disagrees with the SCO and asks that \$1,902,842 be reinstated.”⁹¹

The claimant explains the issue involving the EPSDT offset as follows:

In the SCO’s audit report, the SCO stated “...if the County can provide an accurate accounting of the number of Medi-Cal units of services applicable to the mandate, the SCO auditor will review the information and adjust the audit finding as appropriate.” We have provided this data as requested by the SCO. The State auditor also recalculated the data, but no audit adjustments were made.

Here is a brief chronology of the calculation of the offset amount:

- The County initially estimated the offset for the three-year total to be \$166,352.
- The State SB 90 auditor, utilizing a different methodology, then calculated the offset separately, and came to a three-year total for the offset of \$665,975.

⁸⁷ This amount includes \$1,007,332 for medication monitoring and \$224,318 for crisis intervention. (See Exhibit A, IRC 05-4282-I-03, pages 8; 78-79.)

⁸⁸ Exhibit A, IRC 05-4282-I-03, page 7.

⁸⁹ Exhibit A, IRC 05-4282-I-03, page 7.

⁹⁰ Exhibit A, IRC 05-4282-I-03, page 8.

⁹¹ Exhibit A, IRC 05-4282-I-03, page 12.

- Subsequently, in FY 2003-04 the Department of Mental Health (DMH) developed a standard methodology for calculating EPSDT offset for SB90 claims. Applying this approved methodology the EPSDT offset is \$524,389, resulting in \$1,544,805 being due to the County. This methodology is supported by the State and should be accepted as the final calculation of the accurate EPSDT offset and resulting reimbursement due to the County.⁹²

In comments filed on the revised draft proposed decision, the claimant further explains that the Controller's calculation of the EPSDT offset conflicts with DMH guidance, and does not reflect the intent of the Legislature to provide EPSDT revenue for growth above the baseline year. In addition, the claimant stresses that the Controller has asked for documentation to audit the baseline calculations made by the County, but those figures have been accepted by the state and federal government, and based on the passage of time, should be deemed true and correct, and not revisited at this time.⁹³

State Controller's Office

As a threshold issue, the Controller asserts that the IRC was not timely filed, in accordance with the Commission's regulations. The Controller argues that section 1185 requires an IRC to be filed no later than three years following the date of the Controller's remittance advice or other notice of adjustment. The Controller states that this IRC was filed on May 25, 2006, and is not timely based on the remittance advice letters issued to the claimant on April 28, 2003.

The Controller further maintains that "[t]he subject claims were reduced because the Claimant included costs for services that were not reimbursable under the Parameters and Guidelines in effect during the audited years." In addition, the Controller asserts that "the Claimant failed to document to what degree AB3632 students were also Medi-Cal beneficiaries, requiring that EPSDT revenues be offset." The Controller holds that the reductions "were appropriate and in accordance with law."⁹⁴

Specifically, the Controller asserts that the "county did not furnish any documentation to show that ["skilled nursing" and "residential, other"] services represented eligible day treatment services that had been miscoded."⁹⁵

The Controller further argues that while medication monitoring and crisis intervention "were defined in regulation...at the time the parameters and guidelines on the Handicapped and Disabled Students (HDS) program were adopted..." those activities "were not included in the adoption of the parameters and guidelines as reimbursable costs."⁹⁶ The Controller asserts that medication monitoring costs were not reimbursable until the Commission made findings on the regulatory amendments and adopted revised parameters and guidelines for the *Handicapped and Disabled Students II* program on May 26, 2005 (test claim decision) and December 9, 2005

⁹² Exhibit C, Claimant's Rebuttal Comments, pages 1-2.

⁹³ Exhibit G, Claimant's Comments on Revised Draft Proposed Decision, page 2.

⁹⁴ Exhibit B, Controller's Comments on the IRC, page 1.

⁹⁵ Exhibit A, IRC 05-4282-I-03, page 79.

⁹⁶ Exhibit B, Controller's Comments on the IRC, page 17.

(parameters and guidelines decision). The Commission, the Controller notes, “defined the period of reimbursement for the amended portions beginning July 1, 2001.” Therefore, the Controller concludes, “medication monitoring costs claimed prior July 1, 2001 [*sic*] are not reimbursable.”⁹⁷

In addition, the Controller notes that “[i]n 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 Controller concludes, “the regulation no longer includes crisis intervention activities as a mental health service.”⁹⁸

With respect to offsetting revenues, the Controller argues that the claimant “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 Controller states that its 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.” The Controller states that “if the county can provide an accurate accounting of the number of Medi-Cal units of service applicable to the mandate, the SCO auditor will review the information and adjust the audit finding as appropriate.”⁹⁹

In response to the revised draft proposed decision, the Controller argues that the Commission should not analyze the alleged miscoded costs for “Residential, Other” and “Skilled Nursing” services, because these costs were not alleged specifically in the IRC narrative. The Controller argues that “the Commission’s regulations require the claimant to request a determination that the SCO incorrectly reduced a reimbursement claim...”¹⁰⁰ In addition, the Controller disagrees with the finding in the decision to remand the EPSDT offset question to the Controller. The Controller states that because the claimant did not sufficiently support its estimate of EPSDT offsetting revenue applied to the mandate, “we believe that the only reasonable course of action is to apply the mental health related EPSDT revenues received by the county, totaling \$2,069,194, as an offset.”¹⁰¹

IV. Discussion

Government Code section 17561(b) authorizes the Controller to audit the claims filed by local agencies and school districts and to reduce any claim for reimbursement of state mandated costs that the Controller determines is excessive or unreasonable.

Government Code Section 17551(d) requires the Commission to hear and decide a claim that the Controller has incorrectly reduced payments to the local agency or school district. If the Commission determines that a reimbursement claim has been incorrectly reduced, section 1185.9

⁹⁷ Exhibit B, Controller’s Comments on the IRC, page 17.

⁹⁸ Exhibit B, Controller’s Comments on the IRC, page 17.

⁹⁹ Exhibit B, Controller’s Comments on the IRC, page 18.

¹⁰⁰ Exhibit H, Controller’s Comments on Revised Draft Proposed Decision, page 2.

¹⁰¹ Exhibit H, Controller’s Comments on Revised Draft Proposed Decision, page 4.

of the Commission's regulations requires the Commission to send the decision to the Controller and request that the costs in the claim be reinstated.

The Commission must review questions of law, including interpretation of the parameters and guidelines, de novo, without consideration of legal conclusions made by the Controller in the context of an audit. The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.¹⁰² The Commission must also interpret the Government Code and implementing regulations in accordance with the broader constitutional and statutory scheme. In making its decisions, the Commission must strictly construe article XIII B, section 6 and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."¹⁰³

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.¹⁰⁴ Under this standard, the courts have found that:

When reviewing the exercise of discretion, "[t]he scope of review is limited, out of deference to the agency's authority and presumed expertise: 'The court may not reweigh the evidence or substitute its judgment for that of the agency. [Citation.]'" ... "In general ... the inquiry is limited to whether the decision was arbitrary, capricious, or entirely lacking in evidentiary support. . . ." [Citations.] When making that inquiry, the " "court must ensure that an agency has adequately considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." [Citation.]' "¹⁰⁵

The Commission must review the Controller's audit in light of the fact that the initial burden of providing evidence for a claim of reimbursement lies with the claimant.¹⁰⁶ In addition, section 1185.1(f) and 1185.2(c) of the Commission's regulations require that any assertions of fact by the parties to an IRC must be supported by documentary evidence. The Commission's ultimate findings of fact must be supported by substantial evidence in the record.¹⁰⁷

¹⁰² *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 331-334; Government Code sections 17551, 17552.

¹⁰³ *County of Sonoma, supra*, 84 Cal.App.4th 1264, 1280, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

¹⁰⁴ *Johnston v. Sonoma County Agricultural* (2002) 100 Cal.App.4th 973, 983-984. See also *American Bd. of Cosmetic Surgery, Inc. v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547.

¹⁰⁵ *American Bd. of Cosmetic Surgery, Inc, supra*, 162 Cal.App.4th 534, 547-548.

¹⁰⁶ *Gilbert v. City of Sunnyvale* (2005) 130 Cal.App.4th 1264, 1274-1275.

¹⁰⁷ Government Code section 17559(b), which provides that a claimant or the state may commence a proceeding in accordance with the provisions of section 1094.5 of the Code of Civil

A. The Incorrect Reduction Claim Was Timely Filed.

The Controller contends that this IRC was filed on May 25, 2006, the date the IRC was deemed complete, and it was therefore not timely based on the remittance advice letters issued to the claimant on April 28, 2003. Thus, the Controller asserts that the Commission does not have jurisdiction to hear and determine this IRC. As described below, the Commission finds that the IRC was timely filed.

At the time pertinent to this IRC, section 1185 of the Commission's regulations stated as follows: "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."¹⁰⁸

Based on the date of the "final audit report", the draft proposed decision issued May 28, 2015 concluded that the IRC was not timely filed, presuming that the "final audit report" was the first notice of adjustment.¹⁰⁹ However, upon further review, the final audit report contains an express invitation for the claimant to participate in further dispute resolution, and invites the claimant to submit additional documentation to the Controller: "The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report."¹¹⁰ The language inviting further informal dispute resolution supports the finding that the audit report did not constitute the Controller's *final* determination on the subject claims and thus did not provide the first notice of an actual reduction.¹¹¹

The County of San Mateo filed its IRC on April 27, 2006, and, after requesting additional documentation, Commission staff determined that filing to be complete on May 25, 2006.¹¹²

Procedure to set aside a decision of the Commission on the ground that the Commission's decision is not supported by substantial evidence in the record.

¹⁰⁸ Code of Regulations, title 2, section 1185 (as amended by Register 2003, No. 17, operative April 21, 2003). This section has since been renumbered 1185.1.

¹⁰⁹ The Commission has previously found that the earliest notice of an adjustment which also provides a reason for the adjustment triggers the period of limitation to run. See Adopted Decision, *Collective Bargaining*, 05-4425-I-11, December 5, 2014 [The claimant in that IRC argued that the *last* notice of a reduction should control the regulatory period of limitation for filing its IRC, but the Commission found that the earliest notice in the record which also contains a reason for the reduction, controls the period of limitation. The claimant, in that case, received multiple notices of reduction for the subject claims between January 24, 1996 and August 8, 2001, but none of those contained an adequate explanation of the reasons for the reduction. Finally, on July 10, 2002, the claimant received remittance advice that included a notation that the claim was being denied due to a lack of supporting documentation; based on that date, a timely IRC would have to be filed by July 10, 2005, and the claimant's December 16, 2005 filing was not timely.].

¹¹⁰ Exhibit A, IRC 05-4282-I-03, page 71.

¹¹¹ Code of Regulations, title 2, section 1185 (Register 2003, No. 17).

¹¹² Exhibit I, Completeness Letter, dated June 6, 2006.

Both the claimant and the Controller rely on the remittance advice letters dated April 28, 2003¹¹³ as beginning the period of limitation for filing the IRC.¹¹⁴ Based on the date of the remittance advice letters, a claim filed on or before April 28, 2006 would be timely, being “no later than three (3) years following the date...” of the remittance advice.

However, based on the date of the “final audit report”, the draft proposed decision issued May 28, 2015 concluded that the IRC was not timely filed, presuming that the “final audit report” was the first notice of adjustment.¹¹⁵ The general rule in applying and enforcing a statute of limitations is that a period of limitation for initiating an action begins to run when the last essential element of the cause of action or claim occurs, and no later.^{116,117} In the context of an IRC, the last essential element of the claim is the notice to the claimant of a reduction, as defined by the Government Code and the Commission’s regulations. Government Code section 17558.5 requires that the Controller notify a claimant in writing of an adjustment resulting from an audit, and requires that the notice “shall specify the claim components adjusted, the amounts adjusted...and the reason for the adjustment.”¹¹⁸ Generally, a final audit report, which provides

¹¹³ Exhibit A, IRC 05-4282-I-03, pages 373-377; Exhibit B, Controller’s Comments on the IRC, page 19.

¹¹⁴ See Exhibit B, Controller’s Comments on the IRC, page 19; Exhibit C, Claimant’s Rebuttal Comments, page 4.

¹¹⁵ The Commission has previously found that the earliest notice of an adjustment which also provides a reason for the adjustment triggers the period of limitation to run. See Adopted Decision, *Collective Bargaining*, 05-4425-I-11, December 5, 2014 [The claimant in that IRC argued that the *last* notice of a reduction should control the regulatory period of limitation for filing its IRC, but the Commission found that the earliest notice in the record which also contains a reason for the reduction, controls the period of limitation. The claimant, in that case, received multiple notices of reduction for the subject claims between January 24, 1996 and August 8, 2001, but none of those contained an adequate explanation of the reasons for the reduction. Finally, on July 10, 2002, the claimant received remittance advice that included a notation that the claim was being denied due to a lack of supporting documentation; based on that date, a timely IRC would have to be filed by July 10, 2005, and the claimant’s December 16, 2005 filing was not timely.].

¹¹⁶ See, e.g., *Osborn v. Hopkins* (1911) 160 Cal. 501, 506 [“[F]or it is elementary law that the statute of limitations begins to run upon the accrual of the right of action, that is, when a suit may be maintained, and not until that time.”]; *Dillon v. Board of Pension Commissioners* (1941) 18 Cal.2d 427, 430 [“A cause of action accrues when a suit may be maintained thereon, and the statute of limitations therefore begins to run at that time.”].

¹¹⁷ *Seelenfreund v. Terminix of Northern California, Inc.* (1978) 84 Cal.App.3d 133 [“A cause of action accrues ‘upon the occurrence of the last element essential to the cause of action.’”] [citing *Neel v. Magana, Olney, Levy, Cathcart & Gelfand* (1971) 6 Cal.3d 176].

¹¹⁸ Government Code section 17558.5.

the claim components adjusted, the amounts, and the reasons for the adjustments, satisfies the notice requirements of section 17558.5, since it provides the first notice of an actual reduction.¹¹⁹

However, here, as the claimant points out, the final audit report, issued December 26, 2002, contains an express invitation for the claimant to participate in further dispute resolution: “The SCO has established an informal audit review process to resolve a dispute of facts.” The letter further invites the claimant to submit additional documentation to the Controller: “The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report.”¹²⁰ Accordingly, the claimant submitted its response to the final audit report on February 20, 2003, along with additional documentation and argument.¹²¹ Therefore, although the audit report issued on December 26, 2002, identifies the claim components adjusted, the amounts, and the reasons for adjustment, and constitutes “other notice of adjustment notifying the claimant of a reduction,” the language inviting further informal dispute resolution supports the finding that the audit report did not constitute the Controller’s *final* determination on the subject claims.¹²²

Based on the evidence in the record, the remittance advice letters could be interpreted as “the last essential element”, and the audit report could be interpreted as not being final based on the plain language of the cover letter. Based on their statements in the record, both the claimant and the Controller relied on the April 28, 2003 remittance advice letters, which provide the Controller’s final determination on the audit and the first notice of an adjustment to the claimant following the informal audit review of the final audit report. Thus, based on the April 28, 2003 date of the remittance advice letter, an IRC filed by April 28, 2006 is timely.

The parties dispute, however, when the IRC in this case was actually considered filed. The claimant asserts that the IRC was actually received, and therefore filed with the Commission on April 27, 2006, and that additional documentation requested by Commission staff before completeness is certified does not affect the filing date. The Controller argues that the May 25, 2006 completeness date of the IRC establishes the filing date, which would mean the filing was not timely.

Pursuant to former section 1185 of the Commission’s regulations, an incomplete incorrect reduction claim filing may be cured within thirty days to preserve the original filing date. Thus, even though the IRC in this case was originally deemed incomplete, the filing was cured by the claimant and the IRC is considered filed on April 27, 2006, within the three year limitation period for filing IRCs.

Based on the evidence in the record, the remittance advice letters issued April 28, 2003 began the period of limitation, and this claim, filed April 27, 2006, was timely.

¹¹⁹ See former Code of Regulations, title 2, section 1185(c) (Register 2003, No. 17). Thus, the draft proposed decision issued on May 28, 2015, found that the final audit report dated December 26, 2002, triggered period of limitation for filing the IRC and that the IRC filing on April 27, 2006, was not therefore not timely. (Exhibit D.)

¹²⁰ Exhibit A, IRC 05-4282-I-03, page 71.

¹²¹ Exhibit A, IRC 05-4282-I-03, pages 107-140.

¹²² Code of Regulations, title 2, section 1185 (Register 2003, No. 17).

B. Some of the Controller's Reductions Based on Ineligible Activities Are Partially Correct.

Finding 2 of the Controller's audit report reduced reimbursement by \$1,329,581 for skilled nursing, "residential, other", medication monitoring, and crisis intervention, which the Controller determined are not reimbursable under program guidelines.¹²³

The claimant states in the audit report that it does not concur with the Controller's findings with respect to \$76,223 reduced for "Residential, Other" services; and \$21,708 reduced for "Skilled Nursing" services, which the claimant asserts were in fact "eligible, allowable day treatment service costs that were miscoded."¹²⁴ More importantly, the claimant disputes the Controller's reductions of \$1,007,332 for "Medication Monitoring," and \$224,318 for "Crisis Intervention," which the claimant states are mandated activities within the scope of the approved regulations, and an essential part of "mental health services" provided to handicapped and disabled students under the applicable statutes and regulations.¹²⁵

1. *The Controller's reductions for "Residential, Other" and "Skilled Nursing," totaling \$91,132 for the audit period, are incorrect as a matter of law, and are arbitrary, capricious, and entirely lacking in evidentiary support.*

The Controller reduced costs claimed for "Residential, Other" and "Skilled Nursing" services by \$76,223 and \$21,708, respectively, on the ground that these services were ineligible for reimbursement, and the claim forms reflected units of service and costs claimed for these ineligible activities. The claimant, in response to the draft audit report, and in a letter responding to the final audit report that requested informal review, argued that these costs were simply miscoded on the claim forms, and the costs in question were actually related to eligible day treatment services. As a result, the claimant requested the Controller to reinstate \$91,132, which the claimant alleged "should have been approved claims for services recoded to reflect provided service."¹²⁶

The claimant did not expressly raise these reductions in its IRC narrative. However, the claimant continues to seek reimbursement for disallowed activities and costs in the amount of \$1,329,581, which necessarily includes not only \$1,007,332 for medication monitoring and \$224,318 for crisis intervention; it also includes \$97,931, which is the combined total of \$76,223 for "Residential, Other" and \$21,708 for "Skilled Nursing."¹²⁷ The Controller challenges the Commission's entire analysis of these cost reductions as "a cause of action that is not before the Commission to resolve and, thus, beyond the Commission's responsibility to address..."¹²⁸ However, based on the dollar amount identified in the IRC that the claimant has alleged to be

¹²³ Exhibit A, IRC 05-4282-I-03, page 78 [Final Audit Report].

¹²⁴ Exhibit A, IRC 05-4282-I-03, page 78 [Final Audit Report].

¹²⁵ Exhibit A, IRC 05-4282-I-03, pages 11; 78-79 [Final Audit Report].

¹²⁶ Exhibit A, IRC 05-4282-I-03, pages 112-114.

¹²⁷ Exhibit A, IRC 05-4282-I-03, page 78 [Final Audit Report]. Note that this amount is slightly different from the \$91,132 that the claimant alleged to be properly reimbursable after the final audit report. (Exhibit A, IRC 05-4282-I-03, pages 112-114.)

¹²⁸ Exhibit H, Controller's Comments on Revised Draft Proposed Decision, page 2.

incorrectly reduced, and the evidence in the audit report and this record, the claimant has provided sufficient notice that these reductions are in dispute and have been challenged in this IRC.

The Controller did not change its audit finding in response to the claimant's letter explaining the miscoding. The audit report states that the "county did not furnish any documentation to show that these services represented eligible day treatment services that had been miscoded."¹²⁹ The Controller's comments on the IRC assert that "[t]he county did not dispute the SCO adjustment..." related to skilled nursing or residential, other activities.¹³⁰ However, the claimant's letter in response to the final audit report disputes these adjustments and offers additional documentation and evidence, and the IRC requests reinstatement of all costs reduced for claimed treatment services, including the \$91,132 reduced for "Residential, Other" and "Skilled Nursing" services.¹³¹

The Commission finds that the Controller's reductions for "Residential, Other" and "Skilled Nursing," are incorrect as a matter of law, and arbitrary, capricious, and entirely lacking in evidentiary support.

The parameters and guidelines do not authorize reimbursement for residential placement or skilled nursing, but do authorize reimbursement for the "mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement."¹³² The parameters and guidelines permit claimants to prepare their annual reimbursement claims based on actual costs, or "based on the agency's annual cost report and supporting documents...prepared based on regulations and format specified in the State of California Department of Mental Health Cost Reporting/Data Collection (CR/DC) Manual." This method relies on accounting methods and coding used to report to DMH and track services provided at the county level. Not all of the services reported to DMH in the annual cost report are reimbursable state-mandated services included within the *Handicapped and Disabled Students* mandate.

Further, the parameters and guidelines state, under "Supporting Documentation," that "all costs claimed must be traceable to source documents and/or worksheets that show evidence of the validity of such costs."¹³³ The court in *Clovis Unified School District v. Chiang*¹³⁴ found that the Controller's attempt to require additional or more specific documentation than that required by the parameters and guidelines constituted an unenforceable underground regulation, and that "certifications and average time accountings to document...mandated activities...can be deemed akin to worksheets."¹³⁵

¹²⁹ Exhibit A, IRC 05-4282-I-03, page 79.

¹³⁰ Exhibit B, Controller's Comments on the IRC, page 15.

¹³¹ Exhibit A, IRC 05-4282-I-03, pages 6-8 and 113.

¹³² Exhibit A, IRC 05-4282-I-03, page 163.

¹³³ See Exhibit A, IRC 05-4282-I-03, page 165.

¹³⁴ (2010) 188 Cal.App.4th 794, 803-804.

¹³⁵ *Id.*, page 804.

Here, the audit report indicates that the claimant used the annual cost report method, and the documentation included with the IRC filing includes certain documentation filed with the claimant's original reimbursement claims showing the providers and costs for "treatment" services, which, as in *Clovis Unified*, "can be deemed akin to worksheets."¹³⁶ The reimbursement claim forms submitted to the Controller show units of service and costs claimed and marked as "treatment services," but identify codes "05/60" and "10/85", which the parties agree represent residential and skilled nursing services not eligible for reimbursement.¹³⁷ The claimant submitted documentation in response to the final audit report stating that it mistakenly coded the treatment services as residential and skilled nursing alleging as follows:

In our earlier appeal, we mentioned that some of the disallowance of claimed amounts were due to the miscoding of services in our MIS system. This occurred in 1996-97 for Victor (provider 4194), Edgewood (provider 9215) and St. Vincent's School (provider 9224). Likewise, this occurred for Victor (provider 4194) and Quality Group Home (provider 9232) in 1997-98. This situation continued for Victor (provider 4192) in 1998-99.

Victor and St. Vincent's were erroneously coded in MIS as MOS5, service function 60 (residential, other), even though they provided SB90 billable treatment services, which is what we contracted for. Our mistake was that, since the pupils receiving these services were in a residential setting, we coded the services as residential, while they were in fact, either day treatment (Victor) or outpatient mental health services (St. Vincent's). Victor provided billable rehabilitative day treatment (10/95) on weekdays, supplemented by non-billable residential days on weekends. St. Vincent's had been also coded 05/06, residential. The actual services provided were Mental Health Services, 15/45, all claimable under SB 90.

The following table shows the correct recoding of services and the consequent reallocation of costs. Similar data are provided to show the correct service recoding for 1997-98 (Victor and Quality Group Home) and 1998-99 (Victor). Backup detail is provided in Exhibit A.¹³⁸

Exhibit A attached to the letter shows the original coding and the corrected coding, with notes to indicate that rehabilitative day treatment and mental health services were provided.¹³⁹ Exhibit A, attached to the letter, also breaks down the miscoded amounts, the units of service associated with the dollar amounts, the provider of services, and dates of service.¹⁴⁰

¹³⁶ See, e.g., Exhibit A, IRC 05-4282-I-03, pages 47-49 [Fiscal Year 1996-1997 claim].

¹³⁷ See, e.g., Exhibit A, IRC 05-4282-I-03, page 23 [Fiscal Year 1996-1997 Reimbursement Claim]. See also, Exhibit A, IRC 05-4282-I-03, pages 78 [Final Audit Report]; 112 [Claimant's response to audit report].

¹³⁸ Exhibit A, IRC 05-4282-I-03, page 112, emphasis in original.

¹³⁹ Exhibit A, IRC 05-4282-I-03, page 118.

¹⁴⁰ Exhibit A, IRC 05-4282-I-03, pages 118-130.

It is not clear why the Controller was not satisfied with the additional documentation. The Commission finds that the claimant's worksheets provided in Exhibit A to the claimant's letter show evidence of the validity of the costs claimed and, thus, satisfy the documentation requirements of the parameters and guidelines.¹⁴¹ As indicated above, the parameters and guidelines simply require supporting documentation *or* worksheets, and the documentation provided satisfies the definition of a worksheet. The documentation contains the name of the provider, identifies the service provided with day treatment codes, the dates the services were provided, and the costs paid. The parameters and guidelines do not require declarations, contracts, or billing statements from the treatment provider.

Based on the foregoing, the Commission finds that the Controller's reduction of \$91,132 in costs claimed for allowable day treatment services, as reflected in the corrected documentation submitted by the claimant, is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support, and should be reinstated, adjusted for the appropriate offset amount for Medi-Cal funding attributable to the reinstated treatment service costs.¹⁴²

2. *The Controller's reduction of costs in fiscal years to provide medication monitoring services to seriously emotionally disturbed pupils under the Handicapped and Disabled Students program is correct as a matter of law.*

The Controller reduced all costs claimed for medication monitoring (\$1,007,332) for the audit period.¹⁴³ The claimant argues that the disallowed activity is an eligible component of the mandated program, and that the Controller's decision to reduce these costs relies on a too-narrow interpretation of the parameters and guidelines.¹⁴⁴ The Commission finds, based on the analysis herein, that the claimant's interpretation of the parameters and guidelines conflicts with a prior final decision of the Commission with respect to the activity of medication monitoring, and that the Controller correctly reduced these costs.

The *Handicapped and Disabled Students*, CSM-4282 decision addressed Government Code section 7576¹⁴⁵ and the implementing regulations as they were *originally adopted* in 1986.¹⁴⁶ Government Code section 7576 required the county to provide psychotherapy or other mental health services when required by a pupil's IEP. Former section 60020 of the regulations defined "mental health services" to include the day services and outpatient services identified in sections

¹⁴¹ See Exhibit A, IRC 05-4282-I-03, page 165.

¹⁴² In Finding 4 of the audit report, the Controller adjusted, in the claimant's favor, the amount of Medi-Cal offsetting revenue reported, based on the Controller's disallowance of certain treatment services claimed for which Medi-Cal revenues were received and reported by the claimant. Based on the reinstatement of \$91,132 in eligible services, at least some of which are Medi-Cal eligible services, the amount of the offset must be further adjusted to take account of Medi-Cal revenues received by the claimant for the services reinstated. (See Exhibit A, IRC 05-4282-I-03, pages 14; 81.)

¹⁴³ Exhibit A, IRC 05-4282-I-03, pages 78-79.

¹⁴⁴ Exhibit A, IRC 05-4282-I-03, pages 11-13.

¹⁴⁵ Added, Statutes 1984, chapter 1747; amended Statutes 1985, chapter 1274.

¹⁴⁶ Register 87, No. 30.

542 and 543 of the Department of Mental Health's Title 9 regulations.¹⁴⁷ Section 543 defined outpatient services to include "medication." "Medication," in turn, was defined to include "prescribing, administration, or dispensing of medications necessary to maintain individual psychiatric stability during the treatment process," and "shall include the evaluation of side effects and results of medication."¹⁴⁸

In 2004, the Commission was directed by the Legislature to reconsider its decision in *Handicapped and Disabled Students*. On reconsideration of the program in *Handicapped and Disabled Students*, 04-RL-4282-10, the Commission found that the phrase "medication monitoring" was not included in the original test claim legislation or the implementing regulations. Medication monitoring was added to the regulations for this program in 1998 (Cal. Code Regs. tit. 2, § 60020). The Commission determined that:

"Medication monitoring" is part of the new, and current, definition of "mental health services" that was adopted by the Departments of Mental Health and Education in 1998. The current definition of "mental health services" and "medication monitoring" is the subject of the pending test claim, *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, and will not be specifically analyzed here.¹⁴⁹

Thus, the Commission did not approve reimbursement for medication monitoring in *Handicapped and Disabled Students*, CSM-4282 or on reconsideration of that program (04-RL-4282-10).

The 1998 regulations were pled in *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, however. *Handicapped and Disabled Students II* was filed in 2003 on subsequent statutory and regulatory changes to the program, including the 1998 amendments to the regulation that defined "mental health services." On May 26, 2005, the Commission adopted a statement of decision finding that the activity of "medication monitoring," as defined in the 1998 amendment of section 60020, constituted a new program or higher level of service *beginning July 1, 2001*.

In 2001, the Counties of Los Angeles and Stanislaus filed separate requests to amend the parameters and guidelines for the original program in *Handicapped and Disabled Students*, CSM-4282. As part of the requests, the Counties wanted the Commission to apply the 1998 regulations, including the provision of medication monitoring services, to the original parameters and guidelines. On December 4, 2006, the Commission denied the request, finding that the 1998 regulations were not pled in original test claim, and cannot by law be applied retroactively to the original parameters and guidelines in *Handicapped and Disabled Students*, CSM-4282.¹⁵⁰

These decisions of the Commission are final, binding decisions and were never challenged by the parties. Once "the Commission's decisions are final, whether after judicial review or without

¹⁴⁷ Former California Code of Regulations, title 2, section 60020(a) (Reg. 87, No. 30).

¹⁴⁸ California Code of Regulations, title 9, section 543 (Reg. 83, No. 53; Reg. 84, No. 15; Reg. 84, No. 28; Reg. 84, No. 39).

¹⁴⁹ Statement of Decision, Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 42.

¹⁵⁰ Commission Decision Adopted December 4, 2006, in 00-PGA-03/04.

judicial review, they are binding, just as judicial decisions.”¹⁵¹ Accordingly, based on these decisions, counties are not eligible for reimbursement for medication monitoring until July 1, 2001, in accordance with the decisions on *Handicapped and Disabled Students II*.¹⁵²

Moreover, the claimant expressly admits that “[w]e again point out that we are not claiming reimbursement under HDS II, but rather under the regulations in place at the time services were provided.”¹⁵³ However, as the above analysis indicates, the Commission has already determined that “Medication Monitoring” is only a reimbursable mandated activity under the *Handicapped and Disabled Students II* test claim and parameters and guidelines, and only on or after July 1, 2001.¹⁵⁴

Based on the foregoing, the Commission finds that the Controller correctly reduced the reimbursement claims of the County of San Mateo for costs incurred in fiscal years 1996-1997, 1997-1998, and 1998-1999 to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

3. *The Controller’s reduction of costs for crisis intervention in fiscal years 1996-1997 and 1997-1998 only is incorrect as a matter of law.*

The Controller reduced all costs claimed during the audit period for crisis intervention (\$224,318) on the ground that crisis intervention is not a reimbursable service.¹⁵⁵ The claimant argues that it “provided mandated . . . crisis intervention services under the authority of the California Code of Regulations – Title 2, Division 9, Joint Regulations for Handicapped Children.”¹⁵⁶ The claimant cites the test claim regulations, which incorporate by reference section 543 of title 9, which expressly included crisis intervention as a service required to be provided if the service is identified in a pupil’s IEP. Claimant argues that these services were provided under the mandate, even though the parameters and guidelines did not expressly provide for them.¹⁵⁷

The Commission finds that the Controller’s reduction of costs for crisis intervention, for fiscal years 1996-1997 and 1997-1998 only, is incorrect, and conflicts with the Commission’s 1990 test claim decision.

¹⁵¹ *California School Boards Assoc. v. State of California* (2009) 171 Cal.App.4th 1183, 1200.

¹⁵² See Statement of Decision, *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, pages 37-39; Statement of Decision, 00-PGA-03/04.

¹⁵³ Exhibit C, Claimant’s Rebuttal Comments, page 3.

¹⁵⁴ Finally, even if the amended regulations were reimbursable immediately upon their enactment, absent the *Handicapped and Disabled Students II* test claim, or a parameters and guidelines amendment to the *Handicapped and Disabled Students* program, the amended regulations upon which the claimant relies were effective July 1, 1998, as shown above, and therefore could only be considered mandated for the last of the three audit years.

¹⁵⁵ Exhibit A, IRC 05-4282-I-03, page 78.

¹⁵⁶ Exhibit C, Claimant’s Rebuttal Comments, page 2.

¹⁵⁷ Exhibit A, IRC 05-4282-I-03, page 12.

The *Handicapped and Disabled Students*, CSM-4282 decision addressed Government Code section 7576¹⁵⁸ and the implementing regulations as they were *originally adopted* in 1986.¹⁵⁹ Government Code section 7576 required the county to provide psychotherapy or other mental health services when required by a pupil's IEP. Former section 60020 of the regulations defined "mental health services" to include those services identified in sections 542 and 543 of the Department of Mental Health's Title 9 regulations.¹⁶⁰ Section 543 defined "Crisis Intervention," as "immediate therapeutic response which must include a face-to-face contact with a patient exhibiting acute psychiatric symptoms to alleviate problems which, if untreated, present an imminent threat to the patient or others."¹⁶¹

The Commission's 1990 decision approved the test claim with respect to section 60020 and found that providing psychotherapy and other mental health services required by the pupil's IEP was mandated by the state. The 1990 Statement of Decision states the following:

The Commission concludes that, to the extent that the provisions of Government 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. Moreover, the Commission concludes that any related participation on the expanded 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 Government Code section 7572.5 and their implementing regulations, impose a new program or higher level of service upon a county. ... The Commission concludes that the provisions of Welfare and Institutions Code section 5651, subdivision (g), result in a higher level of service within the county Short-Doyle program because the mental health services, pursuant to Government Code sections 7571 and 7576 and their implementing regulations, must be included in the county Short-Doyle annual plan. *In addition, 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.* ...¹⁶²

The parameters and guidelines adopted in 1991 caption all of sections 60000 through 60200 of the title 2 regulations, and specify in the "Summary of Mandate" that the reimbursable services "include psychotherapy and other mental health services provided to 'individuals with

¹⁵⁸ Added, Statutes 1984, chapter 1747; amended Statutes 1985, chapter 1274.

¹⁵⁹ California Code of Regulations, title 2, division 9, sections 60000-60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and re-filed June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

¹⁶⁰ Former California Code of Regulations, title 2, section 60020(a) (Reg. 87, No. 30).

¹⁶¹ California Code of Regulations, title 9, section 543 (Reg. 83, No. 53; Reg. 84, No. 15; Reg. 84, No. 28; Reg. 84, No. 39).

¹⁶² Statement of Decision, Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 26.

exceptional needs,' including those designated as 'seriously emotionally disturbed,' and required in such individual's IEP.'"¹⁶³

Therefore, even if the parameters and guidelines adopted in 1991 were vague and non-specific with respect to the reimbursable activities, crisis intervention was within the scope of the mandate approved by the Commission.

Moreover, the Legislature's direction to the Commission to reconsider the original test claim "relating to included services" is broadly worded and required the Commission to reconsider the entire test claim and parameters and guidelines to resolve a number of issues with the provision of service and funding of services to the counties.¹⁶⁴ On reconsideration, the Commission found that the original decision correctly approved the program, as pled, as a reimbursable state-mandated program, but that the original decision did not fully identify all of the activities mandated by the state.¹⁶⁵

As the reconsideration decision and parameters and guidelines note, however, crisis intervention was repealed from the regulations on July 1, 1998.¹⁶⁶ For that reason this activity was not approved in the reconsideration decision, which had a period of reimbursement beginning July 1, 2004, or in *Handicapped and Disabled Students II*, which had a period of reimbursement beginning July 1, 2001.¹⁶⁷ Here, because the requirement was expressly repealed as of July 1, 1998; it is no longer a reimbursable mandated activity, and thus the costs for crisis intervention are reimbursable under the prior mandate finding only through June 30, 1998.

Based on the foregoing, the Commission finds that crisis intervention is within the scope of reimbursable activities approved by the Commission through June 30, 1998, and the Controller's reduction of costs in fiscal years 1996-1997 and 1997-1998 for crisis intervention costs based on its strict interpretation of the parameters and guidelines is incorrect as a matter of law. The Commission therefore requests that the Controller reinstate costs claimed for crisis intervention for fiscal years 1996-1997 and 1997-1998 only, adjusted for Medi-Cal offsetting revenues attributable to this mandated activity.¹⁶⁸

¹⁶³ Exhibit A, IRC 05-4282-I-03, page 160.

¹⁶⁴ See Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, pages 7; 12; Assembly Committee on Education, Bill Analysis, SB 1895 (2004) pages 4-7 [Citing Stanford Law School, Youth and Education Law Clinic Report].

¹⁶⁵ Statement of Decision, Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 26.

¹⁶⁶ Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 41.

¹⁶⁷ Reconsideration of *Handicapped and Disabled Students*, 04-RL-4282-10, page 42; *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, page 37.

¹⁶⁸ As noted above, Finding 4 of the audit report adjusted the Medi-Cal offsetting revenues claimed based on treatment services disallowed. To the extent crisis intervention is a Medi-Cal eligible service for which the claimant received state Medi-Cal funds, the reinstatement of costs must also result in an adjustment to the Medi-Cal offsetting revenues reported by the claimant.

C. The Controller's Reductions Based on Understated Offsetting State EPSDT Revenues Are Partially Correct, But the Reduction Based on the Full Amount of EPSDT Revenues Received Is Arbitrary, Capricious, and Entirely Lacking in Evidentiary Support.

The 1991 parameters and guidelines identify the following potential offsetting revenues that must be identified and deducted from a reimbursement claim for this program: "any other reimbursement for this mandate (excluding Short-Doyle funding, private insurance payments, and Medi-Cal payments), which is received from any source, e.g. federal, state, etc."¹⁶⁹

Finding 3 of the Controller's final audit report states that the claimant did not account for or identify the portion of Medi-Cal funding received from the state under the Early Periodic Screening, Diagnosis, and Testing (EPSDT) program as offsetting revenue. The auditor deducted the entire amount of state EPSDT revenues received (\$2,069,194) by the claimant during the audit period "because the claimant did not provide adequate information regarding how much of these funds were actually applicable to the mandate."¹⁷⁰ The claimant disputes the reduction and states that the Controller "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."¹⁷¹ The claimant estimates the portion of EPSDT revenue attributable to the mandate at approximately, or less than, ten percent.¹⁷² Although the claimant agrees that it failed to identify any of the state's share of revenue received under the EPSDT program (estimated at 10 percent of the revenue), it continues to request reimbursement for the entire amount reduced.

1. *The Controller's reduction of the full amount of EPSDT state matching funds received is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support.*

EPSDT is a shared cost program between the federal, state, and local governments, providing comprehensive and preventive health care services for children under the age of 21 who are enrolled in Medicaid. According to the Department of Health Care Services, "EPSDT mental health services are Medi-Cal services that correct or improve mental health problems that your doctor or other health care provider finds, even if the health problem will not go away entirely," and that "EPSDT mental health services are provided by county mental health departments." Services include individual therapy, crisis counseling, case management, special day programs, and "medication for your mental health." Counseling and therapy services provided under EPSDT may be provided in the home, in the community, or in another location.¹⁷³ Under the federal program, states are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health

¹⁶⁹ Exhibit A, IRC 05-4282-I-03, page 163.

¹⁷⁰ Exhibit A, IRC 05-4282-I-03, page 79.

¹⁷¹ Exhibit A, IRC 05-4282-I-03, page 13.

¹⁷² Exhibit A, IRC 05-4282-I-03, pages 13-14; 81.

¹⁷³ Exhibit I, EPSDT Mental Health Services Brochure, published by Department of Health Care Services.

conditions, including developmental and behavioral screening and treatment.¹⁷⁴ The scope of EPSDT program services includes vision services, dental services, and “treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.”¹⁷⁵

Both the claimant and the Controller agree that EPSDT mental health services may overlap or include services provided to or required by special education pupils within the scope of the *Handicapped and Disabled Students* mandated program.¹⁷⁶ However, EPSDT mental health services and funds are available to all “full-scope” Medi-Cal beneficiaries under the age of 21 based on the recommendation of a doctor, clinic, or county mental health department.¹⁷⁷ This is a much broader population than the group served by this mandated program. A student need not be a Medi-Cal client, eligible for EPSDT funding, to be entitled to services under *Handicapped and Disabled Students* program.¹⁷⁸ Conversely, not all persons under 21 eligible for EPSDT program services are also so-called “AB 3632” pupils (i.e., pupils eligible for services under the *Handicapped and Disabled Students* mandated program).

The Commission finds that the Controller’s application of all state EPSDT funds received by claimant as an offset is not supported by the law or evidence in the record. There is no evidence in the record, and the Controller has made no finding or assertion, that *all* EPSDT funds received by the claimant are for services provided to pupils within the *Handicapped and Disabled Students* program. In response to the revised draft proposed decision, the Controller merely states that in the absence of evidence supporting the estimated EPSDT offset, “we believe that the only reasonable course of action is to apply the mental health related EPSDT revenues received by the county, totaling \$2,069,194, as an offset.”¹⁷⁹

As discussed above, EPSDT program services and funding are much broader than the services and requirements of the *Handicapped and Disabled Students* mandated program, and thus treating the full amount of the state EPSDT funding as a necessary offset is not supported by the law or the record. The Commission’s findings must be based on substantial evidence in the record, and the Commission’s regulations require that “[a]ll written representations of fact submitted to the Commission must be signed under penalty of perjury by persons who are authorized and competent to do so and must be based upon the declarant’s personal knowledge

¹⁷⁴ Exhibit I, Early and Periodic Screening, Diagnostic, and Treatment, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>, accessed July, 14, 2015.

¹⁷⁵ Exhibit I, Early and Periodic Screening, Diagnostic, and Treatment, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>, accessed July, 14, 2015.

¹⁷⁶ Exhibit A, IRC 05-4282-I-03, pages 13-14; 79-81.

¹⁷⁷ Exhibit I, EPSDT Mental Health Services Brochure, published by Department of Health Care Services.

¹⁷⁸ Exhibit I, Excerpt from Mental Health Medi-Cal Billing Manual, July 17, 2008, page 7 [“County mental health clients who are AB 3632-eligible may/may not be Medi-Cal eligible.”].

¹⁷⁹ Exhibit H, Controller’s Comments on Revised Draft Proposed Decision, page 4.

or information or belief.”¹⁸⁰ The Controller has not satisfied the evidentiary standard necessary for the Commission to uphold this reduction.

Based on the foregoing, the Commission finds that the Controller’s reduction of the entire amount of EPSDT funding for the audit period is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support.

2. *The Controller must exercise its audit authority to determine a reasonable amount of EPSDT state matching funds to be applied as an offset during the audit period.*

The state’s share of EPSDT funding was first made available during fiscal year 1995-1996 as a result of an agreement between the Department of Mental Health and the Department of Health Services, arising from a settlement of federal litigation. The agreement provides state matching funds for “most of the nonfederal growth in EPSDT program costs.” The counties’ share “often referred to as the county baseline – is periodically adjusted for inflation and other cost factors.”¹⁸¹ Since state and federal funding under the EPSDT program may, by definition, be used for mental health treatment services for children under the age of 21, the funding received can be applied to the treatment of pupils under the *Handicapped and Disabled Students* mandate and, when it is so applied, would reduce county costs under the mandate.

The issue in this IRC, however, is the calculation of that offset. In short, the claimant appears, based on the evidence in the record, to have no contemporaneous documentation for the Controller to audit, instead relying on its prior calculations of its baseline spending under the EPSDT program, which the claimant asserts have been accepted by DMH and the federal government for purposes of Medi-Cal reimbursement. On the other hand, the Controller has made no attempt to determine a reasonable amount for the offset, or to explain why none of the claimant’s estimates are acceptable, instead choosing to offset the entire amount of EPSDT funding, which the Commission finds, above, to be incorrect as a matter of law, and arbitrary, capricious, and entirely lacking in evidentiary support.

Based on the evidence in the record, the claimant identified as an offset the *federal* share of EPSDT funding it claimed was attributable to this mandated program, and the audit did not make adjustments to that offset. However, the claimant failed to identify any *state* matching EPSDT funds in its reimbursement claims.¹⁸² The final audit report states that the claimant then estimated state EPSDT offsetting revenue for this program during the audit period at \$166,352, but the Controller rejected that estimate because it lacked “an accounting of the number of Medi-Cal units of service applicable to the mandate.”¹⁸³

In response to the final audit report, the claimant explained that it “spent considerable time analyzing and refining the EPSDT units of service.”¹⁸⁴ The claimant then developed a methodology to calculate the offset which determined for the “baseline” 1994-1995 year the total

¹⁸⁰ Code of Regulations, title 2, section 1187.5 (Register 2014, No. 21).

¹⁸¹ Exhibit I, Legislative Analyst’s Office Analysis of 2001-02 Budget, Department of Mental Health, page 3.

¹⁸² Exhibit A, IRC 05-4282-I-03, page 80.

¹⁸³ Exhibit A, IRC 05-4282-I-03, page 81.

¹⁸⁴ Exhibit A, IRC 05-4282-I-03, page 115.

EPSDT Medi-Cal units of service for persons under 21 years of age, and the EPSDT Medi-Cal units of service attributable to the mandate: “We then calculated the increases over 1994-95 baseline units for 3632 under-21 Medi-Cal and total under-21 Medi-Cal units...” to determine a growth rate year over year for the audit period which was attributable to “3632 units” (i.e., EPSDT Medi-Cal services provided to children within the *Handicapped and Disabled Students* program).¹⁸⁵ Based on this methodology, the claimant calculated that the “amount of EPSDT [revenue] attributable to [the] 3632 [program] over the three audit years was \$55,407.” The claimant explains that “[t]his amount is due to small changes from [the 1994-1995] baseline for 3632 under-age-21 Medi-Cal services, with most increases in under-21 Medi-Cal services occurring for non-3632 youth.”¹⁸⁶

The claimant asserts, in rebuttal comments on the IRC, that “[t]he State SB90 auditor, utilizing a different methodology, then calculated the offset separately, and came to a three-year total for the offset of \$665,975.”¹⁸⁷ And finally, the claimant states that it recalculated the offset again at \$524,389, based on a Department of Mental Health methodology as follows:

Subsequently, in FY 2003-04 the Department of Mental Health (DMH) developed a standard methodology for calculating EPSDT offset for SB 90 claims. Applying this approved methodology the EPSDT offset is \$524,389, resulting in \$1,544,805 being due to the County. This methodology is supported by the State and should be accepted as the final calculation of the accurate EPSDT offset and resulting reimbursement due to the County.¹⁸⁸

The Controller has not acknowledged these proposed offsets, and maintains that the claimant still has not provided an adequate accounting of actual offsetting revenue attributable to this program.¹⁸⁹ And, although the claimant has identified four different offset amounts for the state EPSDT funds for this program, the claimant continues to request reinstatement of the entire adjustment of \$1,902,842.¹⁹⁰

The Commission finds, based on the evidence in the record, that *some* EPSDT state matching funds were received by the claimant and applied to the program, and that the claimant has acknowledged that “an appropriate amount of this revenue should be offset.”¹⁹¹ The claimant agrees that it did not identify the state general fund EPSDT match as an offset, as it should have. However, referring to the population served by this mandated program, the claimant asserts that “[o]nly 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

¹⁸⁵ Exhibit A, IRC 05-4282-I-03, page 115.

¹⁸⁶ Exhibit A, IRC 05-4282-I-03, page 115.

¹⁸⁷ Exhibit C, Claimant’s Rebuttal Comments, page 2.

¹⁸⁸ Exhibit C, Claimant’s Rebuttal Comments, page 2.

¹⁸⁹ Exhibit B, Controller’s Comments on the IRC, pages 18-19.

¹⁹⁰ Exhibit A, IRC 05-4282-I-03, page 80.

¹⁹¹ Exhibit A, IRC 05-4282-I-03, page 114.

offset from the claim.”¹⁹² In rebuttal comments, the claimant further explains that the Controller stated that if the County could provide an accurate accounting “of the number of Medi-Cal units of services applicable to the mandate, the SCO auditor will review the information and adjust the audit finding as appropriate.”¹⁹³ The claimant asserts that “[w]e have provided this data as requested by the SCO...but no audit adjustments were made.”¹⁹⁴

Based on the evidence in the record, the Commission is unable to determine the amount of state EPSDT funding received by the claimant that must be offset against the claims for this program during the audit period based on evidence in the record. No evidence has been submitted by the parties to show the number of EPSDT eligible pupils receiving mental health treatment services under the *Handicapped and Disabled Students* program during the audit years, or how much EPSDT funds were applied to the program. As indicated above, four different estimates have been offered by the claimant as the correct offset amount for the state matching EPSDT funds, based on methodologies allegedly developed by the claimant, the Controller, and DMH. In this respect, the claimant has asserted that the offset for state EPSDT funding should be anywhere from \$55,407,¹⁹⁵ to \$166,352,¹⁹⁶ to \$524,389,¹⁹⁷ to \$665,975.¹⁹⁸

The Controller states that the claimant “has not provided documentation to support the calculations.”¹⁹⁹ On the other hand, the claimant argues that the Controller’s “proposed methodology for offsetting EPSDT revenue conflicts with prior guidance issued by [DMH] on this subject.” In addition, the claimant argues that due to the passage of time, the Controller’s “attempt to audit those baseline and prior DMH reports after three years is subject to laches, as the delay in making the request is unreasonable and presumptively prejudicial to the County.”²⁰⁰ Furthermore, the claimant asserts, but provides no evidence, that “those baseline numbers (from 1994-95) as well as prior DMH cost reports for the fiscal years under SCO audit have been accepted by the state and federal government[s].” Therefore, the claimant reasons that its methodology for estimating baseline costs is no longer subject to revision.²⁰¹

The Commission rejects the claimant’s argument that laches applies. “The defense of laches requires unreasonable delay plus either acquiescence in the act about which plaintiff complains

¹⁹² Exhibit A, IRC 05-4282-I-03, pages 13-14.

¹⁹³ Exhibit C, Claimant’s Rebuttal Comments, page 1.

¹⁹⁴ Exhibit C, Claimant’s Rebuttal Comments, page 1.

¹⁹⁵ Exhibit A, IRC 05-4282-I-03, page 115 [Claimant’s response to audit report].

¹⁹⁶ Exhibit A, IRC 05-4282-I-03, page 80 [Final Audit Report].

¹⁹⁷ Exhibit C, Claimant’s Rebuttal Comments, page 7 [Claimant’s recalculation using “new methodology developed by DMH”].

¹⁹⁸ Exhibit C, Claimant’s Rebuttal Comments, page 7 [“Rosemary’s” (the auditor) recalculation].

¹⁹⁹ Exhibit H, Controller’s Comments on Revised Draft Proposed Decision, page 4.

²⁰⁰ Exhibit G, Claimant’s Comments on Revised Draft Proposed Decision, page 2.

²⁰¹ Exhibit G, Claimant’s Comments on Revised Draft Proposed Decision, page 2.

or prejudice to the defendant resulting from the delay.”²⁰² Here, the claimant has asserted that the delay is “presumptively prejudicial to the County,” but there is no showing that the delay was unreasonable in the first instance. The Controller initiated the audit within its statutory deadlines, and reasonably requested documentation to support the offsetting revenues that the claimant acknowledged it failed to properly claim. Moreover, the claimant cites Welfare and Institutions Code section 14170, in support of its assertion that “data older than three years is deemed true and correct.”²⁰³ But the Welfare and Institutions Code provisions that the claimant cites impose a three year time limit on audits by “the department” of “cost reports and other data submitted by providers...” for Medi-Cal services; the section does not limit the Controller’s authority to audit state mandate claims, which is described in Government Code section 17558.5.²⁰⁴

The Commission also takes notice of DMH’s subsequent explanation that pupils receiving special education services may or may not be Medi-Cal eligible, and that “[a] Mental Health Medi-Cal 837 transaction has no embedded information that indicates the claim specifically relates to an AB 3632-eligible child.”²⁰⁵ In other words, DMH appears to recognize that Medi-Cal cost reports or cost claims do not necessarily identify themselves as also reimbursable state-mandated costs. DMH continues: “Nevertheless, Cost Report settlement with SEP funding and California Senate Bill 90 (SB 90) claims for state-mandated reimbursements required information on AB 3632 Medi-Cal costs and receivables.” Therefore, “each county must be able to distinguish AB 3632 Medi-Cal claims from other Medi-Cal claims information.”²⁰⁶

Nevertheless, the claimant implies throughout the record that it has no documentation to prove the actual amount of EPSDT funding applied to this program in the claim years (i.e., “to distinguish AB 3632 Medi-Cal claims from other Medi-Cal claims information”). Claimant further states that documentation “to audit baseline calculations of the County” for the receipt of the state’s portion of EPSDT funding is not available, and the Controller should accept the baseline calculations that “have been accepted by the state and federal government.”²⁰⁷ The claimant argues that “[a]udit staff can verify the County methods by examining prior cost reports and should not employ a new methodology without an amendment to the program’s parameters

²⁰² *Johnson v. City of Loma Linda* (2000) 24 Cal.4th 61, 68.

²⁰³ Welfare and Institutions Code section 14170 (Stats. 2000, ch. 322) [“The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. ... the cost reports and other data for cost reporting periods beginning on January 1, 1972, and thereafter shall be considered true and correct unless audited or reviewed within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later.”].

²⁰⁴ Government Code section 17558.5 (Stats. 2004, ch. 890 (AB 2856)).

²⁰⁵ Exhibit I, Excerpt from Mental Health Medi-Cal Billing Manual, July 17, 2008, page 7 [“County mental health clients who are AB 3632-eligible may/may not be Medi-Cal eligible.”].

²⁰⁶ Exhibit I, Excerpt from Mental Health Medi-Cal Billing Manual, July 17, 2008, page 7 [“County mental health clients who are AB 3632-eligible may/may not be Medi-Cal eligible.”].

²⁰⁷ Exhibit G, Claimant’s Comments on Revised Draft Proposed Decision, page 2.

and guidelines.”²⁰⁸ The claimant argues that DMH has issued guidance on how to calculate the EPSDT baseline, which, the claimant asserts, “was to be used as the supporting documentation for SB90 State Mandate Claims,” and that the claimant has provided “worksheets” substantiating its baseline calculations:

In the Short-Doyle Medi-Cal Cost Report instructions for each of the years at issue, DMH provided a specific methodology for determining the appropriate EPSDT offset for Special Education Program (SEP) costs and included directions stating that the DMH process was to be used as the supporting documentation for SB90 State Mandate Claims. That prescribed methodology accounts for baseline program size and appropriate offset of all EPSDT revenue. Those instructions were provided to the County and are posted on the DHCS Information Technology Web Services (ITWS) website. The County used this prescribed DMH methodology to determine the EPSDT offset for SB90 claims for each of the audited years. *The DMH Short-Doyle Cost Report instructions and worksheets have also been provided to the SCO by the County.*²⁰⁹

However, the claimant does not cite to those worksheets in the record, nor provide them in its comments on the revised draft proposed decision. In addition, the claimant argues that its baseline EPSDT calculations have been accepted by DMH and the federal government, for purposes of its Medi-Cal cost reports, and have been audited by DMH and the Department of Health Care Services. The claimant states that the audited reports “have been provided to SCO staff to confirm that there were no findings related to baseline or EPSDT revenues, methods or calculations...”

The claimant has not provided any documentation to substantiate these assertions, and the Controller has not acknowledged any such documentation being provided. Indeed, despite the fact that the EPSDT program is far broader than the *Handicapped and Disabled Students* mandated program, the Controller insists that “we believe that the only reasonable course of action is to apply the [entire] mental health related EPSDT revenues received by the county, totaling \$2,069,194, as an offset.”²¹⁰ However, if the claimant’s assertions are true, that its baseline calculation has already been accepted by the state and federal governments, and if DMH has developed a methodology to estimate the amount applied this mandated program, then the Controller could take official notice of DMH’s guidance and methodology; and, the worksheets provided to the Controller might satisfy the Commission’s evidentiary standards for a finding on the proper amount of the EPSDT offsets.

Based on the foregoing, the Commission finds that some amount of EPSDT funding is applicable to the mandates. Therefore the Commission remands the issue back to the Controller to determine the most accurate amount of state EPSDT funds received by the claimant and attributable to services received by pupils within the *Handicapped and Disabled Students*

²⁰⁸ Exhibit G, Claimant’s Comments on Revised Draft Proposed Decision, page 2.

²⁰⁹ Exhibit G, Claimant’s Comments on the Revised Draft Proposed Decision, page 2 [emphasis added].

²¹⁰ Exhibit H, Controller’s Comments on the Revised Draft Proposed Decision, page 4.

program during the audit period, based on the information that is currently available, which must be offset against the costs claimed for those years.

V. Conclusion

Based on the foregoing, the Commission finds that the IRC was timely filed and partially approves this IRC. The Commission finds that the Controller's reduction of costs claimed for medication monitoring is correct as a matter of law.

However, the reductions listed below are not correct as a matter of law, or are arbitrary, capricious, and entirely lacking in evidentiary support. As a result, pursuant to Government Code section 17551(d) and section 1185.9 of the Commission's regulations, the Commission requests that the Controller reinstate the costs reduced as follows:

- \$91,132 originally claimed as "Skilled nursing" or "Residential, other," costs which have been correctly stated in supplemental documentation, adjusted for state Medi-Cal revenues received and attributable to the reinstated services.
- That portion of \$224,318 reduced for crisis intervention services which is attributable to fiscal years 1996-1997 and 1997-1998, adjusted for state Medi-Cal revenues received and attributable to the reinstated services.
- Recalculate EPSDT offsetting revenues based on the amount of EPSDT state share funding actually received and attributable to the services provided to pupils under this mandated program during the audit period and reinstate the portion of the EPSDT funds which exceed those actually applied to the mandated services.