Received
April 22, 2011
Commission on
State Mandates

RESPONSE BY THE STATE CONTROLLER'S OFFICE (SCO) TO THE COMMISSION ON STATE MANDATES' (CSM) DRAFT STAFF ANALYSIS CONCERNING THE INCORRECT REDUCTION CLAIM BY SANTA CLARA COUNTY

For Fiscal Year (FY) 2003-04, FY 2004-05, and FY 2005-06

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

SUMMARY

The following is the SCO response to the CSM's Draft Staff Analysis relative to the Incorrect Reduction Claim (IRC) filed by Santa Clara County. The SCO reviewed the CSM's analysis of the county's IRC for the legislatively mandated Handicapped and Disabled Students Program for the period of July 1, 2003, through June 30, 2006.

We disagree with the CSM's analysis of the county's IRC. Our analysis and rebuttal follows.

I. CSM DRAFT STAFF ANALYSIS

Below is an outline of the CSM analysis of the county's IRC regarding reimbursement for rehabilitation services. For the complete analysis please refer to the draft staff analysis. For the following reasons, the CSM believes that the SCO incorrectly reduced the county's claims:

1. **Providing outpatient rehabilitation services required by a pupil's IEP is a reimbursable activity and, thus, the State Controller's Office incorrectly reduced the costs incurred by the claimant for the provision of these services in fiscal years 2003-2004 through 2005-2006.**

   The CSM identifies two primary issues in dispute. The first is whether providing outpatient rehabilitation services is a reimbursable component of the mental health services identified in the regulations and the parameters and guidelines. The CSM agrees with the county that rehabilitation services claimed by the county fall within "day services" including "day care rehabilitative services" and "day rehabilitation." Further, this position is largely based on the opinions of the county's expert witness, Margaret Rea, Ph.D., and the declaration filed by Laura Champion, Executive Director of EMQ Families First, one of the vendors that provides rehabilitation services to the county.

   The second issue is whether the county provided "socialization and vocational services" as part of the mental health treatment to these pupils, which the CSM determined were deleted from the regulatory definition of "mental health treatment services" in 1998. The CSM agrees with the SCO that socialization and vocational services are no longer mandated. However, based on the evidence in the record, the CSM concludes that the county did not design the rehabilitation services for socialization and vocational purposes. Further, the CSM finds that the county's Manual for Outpatient Mental Health Services, which defines rehabilitation services as including fringe services, is not relevant to the claim. The manual contains service definitions and descriptions of services for the purposes of tracking and reporting to federal and state agencies.

2. **The footnote in the statement of decision on reconsideration denying reimbursement for providing mental health treatment services based on section 1810.243 of the Department of Mental Health's Title 9 regulations is not relevant to this incorrect reduction claim.**

   The CSM finds that section 1810.243 is not relevant to the mandate program because it applies to Medi-Cal beneficiaries.

II. SCO REBUTTAL TO THE CSM DRAFT STAFF ANALYSIS

We maintain that the outpatient rehabilitation services, Mode 15, Service Function Code 35, are separate and distinct from day rehabilitation services, Mode 10, Service Function Codes 91-99. The county claims both of the aforementioned services on its claims separately using the designations indicated. As set forth in our response to the county's IRC, the two services differ in terms of definition, tracking, reporting, and service delivery. In addition, each service has a separate cost per unit. We allowed any day rehabilitation services claimed by the county as these services are identified in the program's parameters and guidelines.

The county prepared its claims using the cost report method, utilizing cost reports submitted to the California Department of Mental Health (DMH) as a basis for its claim. A cost report is prepared and submitted by the county and each vendor. When submitting the cost report to DMH, a certification is provided at close-out (**Tab 1**). In accordance with the program's parameters and guidelines, the cost report method is an acceptable means to claim program costs. The cost report identifies various services by mode and service function, and accumulates associated units of service relative to each service type (**Tab 2 – Sample excerpt from a county and a vendor cost report**). The costs are reported in accordance with Medi-Cal definitions because a portion of the units of service provided relative to each cost category are for Medi-Cal eligible clients. For each mental health service claimed, the county computed its direct costs by multiplying the corresponding units of service by the applicable unit rate. Further, the county also computed the corresponding offsetting revenues for each service category by identifying the portion of units of service that are Medi-Cal, multiplying the units by a unit rate, and then applying a funding percentage to determine the offsetting revenue. Medi-Cal is specifically identified as a revenue source in the program's parameters and guidelines. Consistent with the DMH guidelines, and Medi-Cal reporting, the county and its vendors identified, tracked, and reported the day rehabilitation services under Mode 10 – Day Mode of Service and rehabilitation services under Mode 15 – Outpatient Mode of Service.

The report prepared by the county's expert witness, Margaret Rea, Ph.D., and the declaration from Laura Champion, Executive Director of EMQ Families First do not address the differences between the two rehabilitation services in the context of the cost report, nor do they address the potential ramifications of their conclusions.

Dr. Rea's analysis concludes that outpatient rehabilitation services claimed by the county (Mode 15, Service Function Code 35) fall within the broad definition of day rehabilitation (Mode 10, Service Function Codes 91-99). The analysis does not address the differences concerning service definitions, units of service, cost per unit, Medi-Cal eligibility, requirements, exclusions, tracking, and reporting mechanisms. Further, Dr. Rea based these conclusions on a review of files that were limited to non-Medi-Cal clients, excluding services provided to Medi-Cal clients also claimed by the county. Based on the county's request for reconsideration dated January 15, 2010, the review was limited to 33 non-Medi-Cal client files. The nature of the additional 20 client files that were subsequently reviewed was not disclosed. If outpatient rehabilitation services are actually day rehabilitation services, the county has reported erroneous information to both federal and state agencies.

As for Ms. Champion's declaration, she discussed the general need and basis for the rehabilitation services. The vendor reports outpatient rehabilitation services in Mode 15, Service Function 35, and day services separately in Mode 10 on its cost reports. The declaration does not address the distinction between the two services in the context of how the vendor identifies, tracks, and reports the services in its cost report. Further, the declaration does not address issues concerning Medi-Cal even though a portion of the services claimed within the rehabilitation cost category include Medi-Cal clients. Again, if outpatient rehabilitation services are actually day rehabilitation services, the county has reported erroneous information to both federal and state agencies.

In the excerpt provided in the draft staff analysis, Ms. Champion indicates that the services are a cost effective alternative to out-of-home placement. However, Ms. Champion does not address potential revenues relative to the wrap-around program. Wrap-around services were established using non-federal Aid to Families with Dependent Children-Foster Care (AFDC-FC). Counties can use the AFDC-FC funding to provide children and families with family-based service alternatives to group home care. The funding provided ranges from $2,245 to $2,548 monthly per client based on a rate classification level of 12 to 14, Welfare and Institutions Code, section 11462, subsection (f) (1) (**Tab 3**), and Welfare and Institutions Code, section 15200, subsection (c) (1) (**Tab 4**). Nevertheless, the county has not responded to our inquiries regarding the relationship between the rehabilitation services provided and the wrap-around program.

We agree with the CSM in that day rehabilitation services do not include socialization and vocational services, as these are separate and distinct services in Mode 10. However, we maintain that outpatient rehabilitation services include fringe services that are not within the context of day rehabilitation services including, but not limited to, daily living skills, social and leisure skills, grooming and personal hygiene, and meal preparation skills. We have included a few additional examples of fringe services (**Tab 5**). As such, we believe that outpatient rehabilitation services are separate and distinct from day rehabilitation services.

Lastly, we disagree with the CSM concerning the relevance of the County's Manual for Outpatient Mental Health Services. The manual identifies and defines services that are provided, tracked, and reported on its cost reports submitted to the DMH. Further, the service definitions contained in the county's manual are consistent with Medi-Cal requirements and DMH guidelines. The cost report method is identified as an acceptable method in the program's parameters and guidelines. As stated earlier, the cost categories on the cost report conform to Medi-Cal guidelines and a portion of the units provided in each category are to Medi-Cal eligible clients. Medi-Cal is identified in the program's parameters and guidelines as offsetting revenue for claimed costs. The county's claims include both Medi-Cal and non-Medi-Cal clients. So, we believe that the county's manual is pertinent to this IRC.

Conclusion

The rehabilitation services are not identified in the Handicapped and Disabled Students and Handicapped and Disabled Students II program's parameters and guidelines. We maintain that day rehabilitation services are separate and distinct from outpatient rehabilitation services in terms of definition, tracking, reporting and service delivery. The review performed by Dr. Rea and the declaration by Ms. Champion do not address these distinctions. Further, they do not address potential ramifications arising from the possible misreporting of services to federal and state agencies. The lack of reference in the program's parameters and guidelines concerning outpatient rehabilitation services is the basis by which Los Angeles County attempted to incorporate these services in the reconsidered parameters and guidelines. Further, the CSM considered outpatient rehabilitation services in the reconsideration of the Handicapped and Disabled Students program's parameters and guidelines, stating that the services are not required by the test claim legislation. The county accumulates and reports outpatient rehabilitation costs in accordance with the same Medi-Cal specialty definition that CSM considered in the reconsideration. Day rehabilitation services are

separate and distinct from rehabilitation services in terms of definition, tracking, reporting and service delivery. As such, rehabilitation services are not eligible for reimbursement under the state-mandated cost program.

SCO's Rebuttal Comment

The following is our brief response to the CSM's two primary points raised in its analysis:

CSM's Response

1. **Providing outpatient rehabilitation services required by a pupil's IEP is a reimbursable activity and, thus, the State Controller's Office incorrectly reduced the costs incurred by the claimant for the provision of these services in fiscal years 2003-2004 through 2005-2006.**

SCO's Comment

We disagree with CSM and maintain that outpatient rehabilitation services are separate and distinct from day rehabilitation services. Further, the report by Dr. Rea and the declaration by Ms. Champion do not address the differences of each service in the context of the cost report submitted to the DMH and Medi-Cal guidelines. Dr. Rea's review was limited to only non-Medi-Cal clients, however, the county's claim includes both Medi-Cal and non-Medi-Cal clients. Outpatient rehabilitation services include fringe services that are not included in day rehabilitation services.

CSM's Response

2. **The footnote in the statement of decision on reconsideration denying reimbursement for providing mental health treatment services based on section 1810.243 of the Department of Mental Health's Title 9 regulations is not relevant to this incorrect reduction claim.**

We disagree with the CSM in that the county uses the cost report method and reports services provided in accordance with Medi-Cal guidelines. Both the cost report method and application of Medi-Cal revenues are identified within the program's parameters and guidelines. Further, the county identifies, tracks, and reports outpatient rehabilitation services in accordance the Medi-Cal definition, the same definition that the CSM excluded from the reconsidered parameters and guidelines.

III. CONCLUSION

The SCO reviewed the CSM's Draft Staff Analysis of Santa Clara County's IRC concerning claims for costs of the legislatively mandated Handicapped and Disabled Students (Chapter 1747, Statutes of 1984; and Chapter 1274, Statutes of 1985) for the period of July 1, 2003, through June 30, 2006. The county claimed unallowable costs totaling $8,658,336. The costs are unallowable because the county claimed ineligible rehabilitation services.

In conclusion, the CSM should reconsider its analysis and find that: (1) the SCO correctly reduced the county's FY 2003-04 claim by $3,172,403; (2) the SCO correctly reduced the county's FY 2004-05 claim by $2,791,393; and (3) the SCO correctly reduced the county's FY 2005-06 claim by $2,694,540.

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IV. CERTIFICATION

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

Executed on April 11, 2011, at Sacramento, California, by:

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

Tab 1

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law.

Date: 1/23/06 Signature: Manuel Peña, Ph.D.
Local Mental Health Director

Executed at Santa Clara, California

I CERTIFY under penalty of perjury that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts.

Date: 1/19/06 Signature: Kim K Roberts

Title: CPO
(County Auditor-Controller or City Finance Officer)

Executed at San Jose, California

Date Uploaded: 1/17/2006

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Upload File Name: CFRS_20032004_43_F_147930_UPLOAD.ZIP

FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

1.	County Claim for Reimbursement		$ 0.00
2.	Adjustment		0.00
	a. Rollover of Unexpended Funds	0.00	
	b. Managed Care FFS Inpatient	0.00	
	c. Managed Care Additional Funds	0.00	
	d.	0.00	
	e.	0.00	
3.	Less Claims Paid to Date		0.00
4.	Net County Costs Subject to Reimbursement		$ 0.00

Date: _____ Signature: _____

FOR DMH ACCOUNTING USE ONLY

5.	Special Adjustments	$ _____
	(A) State Hospitals Changes	_____
	(B) Audit Adjustment	_____
	(C) Other	_____
6.	**NET REIMBURSEMENT DUE COUNTY (STATE)**	$ _____

Date: _____ Signature: _____

Tab 2

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
INFORMATION SHEET
MH 1900 (08/04)

DEPARTMENT OF MENTAL HEALTH

FISCAL YEAR 2003 - 2004

SECTION I: ALL LEGAL ENTITIES:

All Legal Entities are to complete Section I.

Name of Preparer:	Amy Woo
Date:	2/23/2005
Legal Entity Name:	Santa Clara County MH
Legal Entity Number:	00043
County:	Santa Clara County
County Code:	43
Is this a County Legal Entity Report? (Y or N)	Yes
Are you reporting SD/MC? (Y or N)	Yes

SECTION II: COUNTY LEGAL ENTITY ONLY:

Only County Legal Entities are to Complete Section II.

Address:	2325 Enborg Lane, Ste 360
	San Jose, CA 95128
Phone Number:	408-885-6892
County Population: Over 125,000? (Y or N):	Yes

Contract Provider Medi-Cal Direct Service Gross Reimbursement (Used to populate MH1979 Line 2)

Inpatient Services	$	2,005,590
Outpatient Services	$	41,166,910

Contract Provider Healthy Families Direct Service Gross Reimbursement (Used to populate MH1979 Line 7)

Inpatient Services		
Outpatient Services	$	32,717

Total State Share of FFP:	$	15,017,269

Fee For Service - Mental Health Specialty Provider Numbers For Individual and Group *Mode&SF -->*

Legal Entity Number (FFS):	00043
Psychiatrist:	8396
Psychologist:	8397
MH Specialty Group:	43AB
RN:	
LCSW:	8398
MFCC (MFT):	8399

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
SCHEDULE OF NEGOTIATED RATES AND PUBLISHED CHARGES
MH 1901 SCHEDULE A (08/04)

DEPARTMENT OF MENTAL HEALTH MENTAL HEALTH

FISCAL YEAR 2003 - 2004

Entity Name: Santa Clara County MH

Entity Number: 00043

Fiscal Year: 2003 - 2004

		A	B	C	D	E	F	G
	SERVICE FUNCTION	MODE	SERVICE FUNCTION CODE	SMA	STATE APPROVED (NR)	PUBLISHED CHARGE	COUNTY NON M/C CONTRACT RATE	RATE FOR ALLOCATION
	A. 24 - HOUR SERVICES							
1	Hospital Inpatient	05	10 - 18	$873.40	$873.40	$1,056.00		$873.40
2	Hospital Administrative Day	05	19	$236.78		$1,056.00		$0.00
3	Psychiatric Health Facility (PHF)	05	20 - 29	$489.48				$0.00
4	SNF Intensive	06	30 -34					$0.00
5	IMD Basic (No Patch)	05	35					$0.00
6	IMD (With Patch)	05	36 - 39					$0.00
7	Adult Crisis Residential	05	40 - 49	$276.02		$317.73		$0.00
8	Jail Inpatient	06	50 - 59					$0.00
9	Residential Other	05	60 - 64					$0.00
10	Adult Residential	05	65 - 79	$134.63		$154.98		$0.00
11	Semi - Supervised Living	05	80 - 84					$0.00
12	Independent Living	05	85 - 89					$0.00
13	MH Rehab Centers	05	90 - 94					$0.00
	B. DAY SERVICES							
14	Crisis Stabilization Emergency Room	10	20 - 24	$85.68	$85.68	$98.62		$85.68
15	Urgent Care	10	25 - 29	$85.68		$98.62		$0.00
16	Vocational Services	10	30 - 39					$0.00
17	Socialization	10	40 - 49					$0.00
18	SNF Augmentation	10	60 - 89					$0.00
19	Day Treatment Intensive Half Day	10	81 - 84	$130.63		$150.37		$0.00
20	Full Day	10	85 - 89	$183.46		$211.18		$0.00
21	Day Rehabilitation Half Day	10	91 - 94	$76.20		$87.72		$0.00
22	Full Day	10	95 - 99	$118.94		$136.91		$0.00
	C. OUTPATIENT SERVICES							
23	Case Management, Brokerage	15	01 - 09	$1.83	$1.83	$2.10		$1.83
24	Mental Health Services	15	10 - 19	$2.36	$2.36	$2.71		$2.36
25	Mental Health Services	15	30 - 59	$2.36	$2.36	$2.71		$2.36
26	Medication Support	15	60 - 69	$4.37	$4.37	$5.03		$4.37
27	Crisis Intervention	16	70 - 79	$3.52	$3.52	$4.05		$3.52
	D. OUTREACH SERVICES							
28	Mental Health Promotion	45	10 - 19					$0.00
29	Community Client Services	45	20 - 29					$0.00
	E. MEDI-CAL ADMINISTRATIVE ACTIVITIES				**MEDI-CAL ELIGIBILITY FACTOR**			
30	Medi-Cal Outreach	55	01 - 03					
31	Medi-Cal Eligibility Intake	55	04 - 06		Quarter 1	50.02%		
32	Medi-Cal Contract Administration	55	07 - 08		Quarter 2	50.10%		
33	MAA Coordination and Claims Administration	55	09		Quarter 3	49.30%		
34	Referral - Crisis, Non-Open Case	55	11 - 13		Quarter 4	49.75%		
35	MH Services Contract Administration	55	14 - 16		Average	52.29%		
36	Discounted Mental Health Outreach	55	17 - 19					
37	SPMP Case Management, Non-Open Case	55	21 - 23					
38	SPMP Program Planning and Development	55	24 - 26					
39	SPMP MAA Training	55	27 - 29					
40	Non-SPMP Case Management, Non-Open Case	55	31 - 34					
41	Non-SPMP Program Planning and Development	55	35 - 39					
	F. SUPPORT SERVICES							
42	Conservatorship Investigation	60	20 - 29					$0.00
43	Administration	60	30 - 39					$0.00
44	Life Support/Board & Care	60	40 - 49					$0.00
45	Case Management Support	60	60 - 69					$0.00

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY **DEPARTMENT OF MENTAL HEALTH**

ALLOCATION OF COSTS TO MODES OF SERVICE
MH 1964 (08/04)

FISCAL YEAR 2003 - 2004

County: Santa Clara County
County Code: 43

	Legal Entity: Santa Clara County MH	A
Legal Entity Number: 00043		Total Costs
1	Mode Costs (Direct Service and MAA) from MH 1960	70,581,678
	Modes	
2	Hospital Inpatient Services (Mode 05-SFC 10-19)	21,354,530
3	Other 24 Hour Services (Mode 05-All Other SFC)	7,337,767
4	Day Services (Mode 10)	10,490,210
5	Outpatient Services (Mode 15 Program 1 + Program 2)	30,556,298
6	Outreach Services (Mode 45)	114,758
7	Medi-Cal Administrative Activities (Mode 55)	728,115
8	Support Services (Mode 60)	
9	Total - Lines 2 through 8	70,581,678

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF MENTAL HEALTH
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ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL
MH 1966 (08/04)

DETAIL COST REPORT

FISCAL YEAR 2003 - 2004

County: Santa Clara County
County Code: 43

NR

			A	B	C	D	E	F	G
Legal Entity: Santa Clara County MH									
Legal Entity Number: 00043			Mode Total	Service Function	Service Function	Service Function	Service Function	Service Function	Service Function
Mode: 10 - Day Services									
				20					
1	Allocation Percentage		100.00%	100.00%					
2	Total Units			106,736					
3	Gross Cost		10,490,210	10,490,210					
4	Cost per Unit			98.28					
5	SMA per Unit			85.68					
6	Published Charge per Unit			98.52					
7	Negotiated Rate / Cost per Unit			85.68					
8	Medi-Cal Units	07/01/03 - 09/30/03		7,757					
8A		10/01/03 - 06/30/04		21,274					
9	Medicare/Medi-Cal Crossover Units	07/01/03 - 09/30/03		2,356					
9A		10/01/03 - 06/30/04		12,067					
10	Enhanced SD/MC (Children) Units	07/01/03 - 09/30/03		30					
10A		10/01/03 - 06/30/04							
10B	Enhanced SD/MC (Refugees) Units	07/01/03 - 06/30/04							
11	Healthy Families (SED) Units	07/01/03 - 09/30/03							
11A		10/01/03 - 06/30/04							
12	Non-Medi-Cal Units			63,252					
13	Medi-Cal Costs	07/01/03 - 09/30/03	762,372	762,372					
13A		10/01/03 - 06/30/04	2,090,848	2,090,848					
14	Medi-Cal SMA Upper Limits	07/01/03 - 09/30/03	664,620	664,620					
14A		10/01/03 - 06/30/04	1,822,756	1,822,756					
15	Medi-Cal Published Charges	07/01/03 - 09/30/03	764,995	764,995					
15A		10/01/03 - 06/30/04	2,098,042	2,098,042					
16	Medi-Cal Negotiated Rates	07/01/03 - 06/30/03	664,620	664,620					
16A		10/01/03 - 06/30/04	1,822,756	1,822,756					
17	Medicare/Medi-Cal Crossover Costs	07/01/03 - 09/30/03	231,552	231,552					
17A		10/01/03 - 06/30/04	1,185,967	1,185,967					
18	Medicare/Medi-Cal Crossover SMA Upper Limits	07/01/03 - 09/30/03	201,862	201,862					
18A		10/01/03 - 06/30/04	1,033,901	1,033,901					
19	Medicare/Medi-Cal Crossover Published Charges	07/01/03 - 09/30/03	232,349	232,349					
19A		10/01/03 - 06/30/04	1,190,048	1,190,048					
20	Medicare/Medi-Cal Crossover Negotiated Rates	07/01/03 - 09/30/03	201,862	201,862					
20A		10/01/03 - 06/30/04	1,033,901	1,033,901					
21	Enhanced SD/MC Costs	07/01/03 - 09/30/03	2,848	2,848					
21A		10/01/03 - 06/30/04							
22	Enhanced SD/MC SMA Upper Limits	07/01/03 - 09/30/03	2,570	2,570					
22A		10/01/03 - 06/30/04							
23	Enhanced SD/MC Published Charges	07/01/03 - 09/30/03	2,959	2,959					
23A		10/01/03 - 06/30/04							
24	Enhanced SD/MC Negotiated Rates	07/01/03 - 09/30/03	2,570	2,570					
24A		10/01/03 - 06/30/04							
25	Enhanced SD/MC (Refugees) Costs	07/01/03 - 06/30/04							
26	Enhanced SD/MC (Refugees) SMA Upper Limits	07/01/03 - 06/30/04							
27	Enhanced SD/MC (Refugees) Published Charges	07/01/03 - 06/30/04							
28	Enhanced SD/MC (Refugees) Negotiated Rates	07/01/03 - 06/30/04							
29	Healthy Families Costs	07/01/03 - 09/30/03							
29A		10/01/03 - 06/30/04							
30	Healthy Families SMA Upper Limits	07/01/03 - 09/30/03							
30A		10/01/03 - 06/30/04							
31	Healthy Families Published Charges	07/01/03 - 09/30/03							
31A		10/01/03 - 06/30/04							
32	Healthy Families Negotiated Rates	07/01/03 - 09/30/03							
32A		10/01/03 - 06/30/04							
33	Non-Medi-Cal Costs		6,216,523	6,216,523					

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MH1966_MODE10

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL
MH 1968 (08/04)

DETAIL COST REPORT

DEPARTMENT OF MENTAL HEALTH
PAGE 1 OF 1

FISCAL YEAR 2003 - 2004

County: Santa Clara County
County Code: 43

Legal Entity: Santa Clara County MH
Legal Entity Number: 00043
Mode: 15 - Outpatient (Program 1)

			A	B	C	D	E	F	G
				NR	NR	NR	NR		
			Mode Total	Service Function	Service Function	Service Function	Service Function	Service Function	Service Function
1	Allocation Percentage			01	10	60	70		
2	Total Units		100.00%	19.94%	45.50%	32.81%	1.74%		
3	Gross Cost			3,424,296	8,059,233	1,393,545	155,650		
4	Cost per Unit		29,368,881	5,660,364	13,373,139	9,642,974	512,384		
5	SMA per Unit			1.71	2.21	6.92	3.29		
6	Published Charge per Unit			1.83	2.36	4.37	3.52		
7	Negotiated Rate / Cost per Unit			2.10	2.71	5.03	4.05		
				1.83	2.36	4.37	3.52		
8	Medi-Cal Units	07/01/03 - 09/30/03		427,318	568,761	120,031	12,077		
8A		10/01/03 - 06/30/04		1,198,844	1,386,085	340,530	26,009		
9	Medicare/Medi-Cal Crossover Units	07/01/03 - 09/30/03			2,864	42,833			
9A		10/01/03 - 06/30/04		1,008	5,019	40,720			
10	Enhanced SD/MC (Children) Units	07/01/03 - 09/30/03		1,812	4,932	255			
10A		10/01/03 - 06/30/04		3,985	13,217	1,418	120		
10B	Enhanced SD/MC (Refugees) Units	07/01/03 - 06/30/04							
11	Healthy Families (SED) Units	07/01/03 - 09/30/03							
11A		10/01/03 - 06/30/04		760	414	60			
12	Non-Medi-Cal Units			1,790,549	4,057,941	847,698	117,444		
13	Medi-Cal Costs	07/01/03 - 09/30/03	2,901,093	731,318	1,299,436	830,684	39,758		
13A		10/01/03 - 06/30/04	7,552,900	2,051,717	3,059,184	2,358,380	85,619		
14	Medi-Cal SMA Upper Limits	07/01/03 - 09/30/03	2,736,514	781,992	1,389,476	524,535	42,511		
14A		10/01/03 - 06/30/04	7,044,713	2,193,855	3,271,161	1,488,116	91,552		
15	Medi-Cal Published Charges	07/01/03 - 09/30/03	3,145,578	897,368	1,595,642	603,756	48,912		
15A		10/01/03 - 06/30/04	8,092,065	2,517,572	3,756,290	1,712,866	105,338		
16	Medi-Cal Negotiated Rates	07/01/03 - 09/30/03	2,736,514	781,992	1,389,476	524,535	42,511		
16A		10/01/03 - 06/30/04	7,044,713	2,193,855	3,271,161	1,488,116	91,552		
17	Medicare/Medi-Cal Crossover Costs	07/01/03 - 09/30/03	302,714		6,321	296,393			
17A		10/01/03 - 06/30/04	294,574	1,725	11,077	281,772			
18	Medicare/Medi-Cal Crossover SMA Upper Limits	07/01/03 - 09/30/03	183,939		6,759	187,180			
18A		10/01/03 - 06/30/04	181,636	1,845	11,845	177,946			
19	Medicare/Medi-Cal Crossover Published Charges	07/01/03 - 09/30/03	223,211		7,761	215,450			
19A		10/01/03 - 06/30/04	220,540	2,117	13,601	204,822			
20	Medicare/Medi-Cal Crossover Negotiated Rates	07/01/03 - 09/30/03	193,939		6,759	187,180			
20A		10/01/03 - 06/30/04	191,638	1,845	11,845	177,946			
21	Enhanced SD/MC Costs	07/01/03 - 09/30/03	15,751	3,101	10,885	1,765			
21A		10/01/03 - 06/30/04	46,198	6,620	29,171	9,812	395		
22	Enhanced SD/MC SMA Upper Limits	07/01/03 - 09/30/03	16,070	3,318	11,840	1,114			
22A		10/01/03 - 06/30/04	45,104	7,293	31,192	6,197	422		
23	Enhanced SD/MC Published Charges	07/01/03 - 09/30/03	18,454	3,805	13,366	1,283			
23A		10/01/03 - 06/30/04	51,805	8,389	36,818	7,133	486		
24	Enhanced SD/MC Negotiated Rates	07/01/03 - 09/30/03	16,070	3,318	11,840	1,114			
24A		10/01/03 - 06/30/04	45,104	7,293	31,192	6,197	422		
25	Enhanced SD/MC (Refugees) Costs	07/01/03 - 06/30/04							
26	Enhanced SD/MC (Refugees) SMA Upper Limits	07/01/03 - 06/30/04							
27	Enhanced SD/MC (Refugees) Published Charges	07/01/03 - 06/30/04							
28	Enhanced SD/MC (Refugees) Negotiated Rates	07/01/03 - 06/30/04							
29	Healthy Families Costs	07/01/03 - 09/30/03							
29A		10/01/03 - 06/30/04	2,664	1,335	914	415			
30	Healthy Families SMA Upper Limits	07/01/03 - 09/30/03							
30A		10/01/03 - 06/30/04	2,867	1,427	977	262			
31	Healthy Families Published Charges	07/01/03 - 09/30/03							
31A		10/01/03 - 06/30/04	3,062	1,838	1,122	302			
32	Healthy Families Negotiated Rates	07/01/03 - 09/30/03							
32A		10/01/03 - 06/30/04	2,867	1,427	977	262			
33	Non-Medi-Cal Costs		16,272,987	3,064,369	8,956,152	5,865,853	386,614		

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
INFORMATION SHEET
MH 1900 (08/04)

DEPARTMENT OF MENTAL HEALTH

FISCAL YEAR 2003 - 2004

SECTION I: ALL LEGAL ENTITIES:

All Legal Entities are to complete Section I.

Name of Preparer:	Susan Le
Date:	1/6/2005
Legal Entity Name:	Eastfield Ming Quong, Inc.
Legal Entity Number:	00156
County:	Santa Clara
County Code:	43
Is this a County Legal Entity Report? (Y or N)	No
Are you reporting SD/MC? (Y or N)	Yes

SECTION II: COUNTY LEGAL ENTITY ONLY:

Only County Legal Entities are to Complete Section II.

Address:	
Phone Number:	
County Population Over 125,000? (Y or N):	Yes

Contract Provider Medi-Cal Direct Service Gross Reimbursement (Used to populate MH1979 Line 2)

Inpatient Services	
Outpatient Services	

Contract Provider Healthy Families Direct Service Gross Reimbursement (Used to populate MH1979 Line 7)

Inpatient Services	
Outpatient Services	

Total State Share of FFP:	$ 5,453,449

Fee For Service - Mental Health Specialty Provider Numbers For Individual and Group ***Mode&SF -->***

Legal Entity Number (FFS):	
Psychiatrist:	
Psychologist:	
Mixed Specialty Group:	
RN:	
LCSW:	
MFCC (MFT):	

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF MENTAL HEALTH

ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL
MH 1966 (08/04)

DETAIL COST REPORT

FISCAL YEAR 2003 - 2004

County: Santa Clara
County Code: 43
Legal Entity: Eastfield Ming Quong, Inc.
Legal Entity Number: 00156
Mode: 15 - Outpatient (Program 1)

			A	CR B	CR C	CR D	CR E	CR F	G
			Mode Total	Service Function	Service Function	Service Function	Service Function	Service Function	Service Function
1	Allocation Percentage		100.00%	3.56%	82.76%	4.36%	8.23%	3.08%	
2	Total Units			356,434	6,382,385	181,416	322,193	236,237	
3	Gross Cost		16,115,805	577,599	13,338,009	702,026	1,004,280	493,692	
4	Cost per Unit			1.62	2.08	3.87	3.12	2.09	
5	SMA per Unit			1.63	2.36	4.37	3.52	2.36	
6	Published Charge per Unit			2.10	2.71	5.03	4.05	2.71	
7	Negotiated Rate / Cost per Unit								
8	Medi-Cal Units	07/01/03 - 09/30/03		78,933	1,087,128	39,585	39,763	41,842	
8A		10/01/03 - 06/30/04		232,479	2,884,859	106,827	87,855	185,609	
9	Medicare/Medi-Cal Crossover Units	07/01/03 - 09/30/03							
9A		10/01/03 - 06/30/04							
10	Enhanced SD/MC (Children) Units	07/01/03 - 09/30/03		774	3,333		960		
10A		10/01/03 - 06/30/04		656	31,383	80	2,145	5,146	
10B	Enhanced SD/MC (Refugees) Units	07/01/03 - 09/30/04							
11	Healthy Families (SED) Units	07/01/03 - 09/30/03		157	1,743	90			
11A		10/01/03 - 06/30/04			280				
12	Non-Medi-Cal Units			43,436	2,373,859	34,734	191,470	22,640	
13	Medi-Cal Costs	07/01/03 - 09/30/03	2,764,761	127,810	2,271,697	153,568	123,942	87,442	
13A		10/01/03 - 06/30/04	7,436,463	376,731	6,028,406	413,389	273,845	346,092	
14	Medi-Cal SMA Upper Limits	07/01/03 - 09/30/03	3,122,206	144,447	2,565,622	173,423	139,969	98,747	
14A		10/01/03 - 06/30/04	8,400,163	425,437	6,807,795	466,834	309,250	390,837	
15	Medi-Cal Published Charges	07/01/03 - 09/30/03	3,585,924	165,759	2,946,117	199,816	161,040	113,992	
15A		10/01/03 - 06/30/04	9,647,585	488,206	7,817,426	537,340	355,813	448,800	
16	Medi-Cal Negotiated Rates	07/01/03 - 09/30/03							
16A		10/01/03 - 06/30/04							
17	Medicare/Medi-Cal Crossover Costs	07/01/03 - 09/30/03							
17A		10/01/03 - 06/30/04							
18	Medicare/Medi-Cal Crossover SMA Upper Limits	07/01/03 - 09/30/03							
18A		10/01/03 - 06/30/04							
19	Medicare/Medi-Cal Crossover Published Charges	07/01/03 - 09/30/03							
19A		10/01/03 - 06/30/04							
20	Medicare/Medi-Cal Crossover Negotiated Rates	07/01/03 - 09/30/03							
20A		10/01/03 - 06/30/04							
21	Enhanced SD/MC Costs	07/01/03 - 09/30/03	11,212	1,254	6,965		2,992		
21A		10/01/03 - 06/30/04	66,487	1,063	55,685	310	5,586	12,844	
22	Enhanced SD/MC SMA Upper Limits	07/01/03 - 09/30/03	12,862	1,416	7,866		3,379		
22A		10/01/03 - 06/30/04	87,669	1,290	74,084	350	7,550	14,505	
23	Enhanced SD/MC Published Charges	07/01/03 - 09/30/03	14,548	1,625	9,032		3,886		
23A		10/01/03 - 06/30/04	112,171	1,378	85,048	402	8,687	16,656	
24	Enhanced SD/MC Negotiated Rates	07/01/03 - 09/30/03							
24A		10/01/03 - 06/30/04							
25	Enhanced SD/MC (Refugees) Costs	07/01/03 - 06/30/04							
26	Enhanced SD/MC (Refugees) SMA Upper Limits	07/01/03 - 06/30/04							
27	Enhanced SD/MC (Refugees) Published Charges	07/01/03 - 06/30/04							
28	Enhanced SD/MC (Refugees) Negotiated Rates	07/01/03 - 06/30/04							
29	Healthy Families Costs	07/01/03 - 09/30/03	4,245	254	3,643	348			
29A		10/01/03 - 06/30/04	585		585				
30	Healthy Families SMA Upper Limits	07/01/03 - 09/30/03	4,794	287	4,118	393			
30A		10/01/03 - 06/30/04	661		661				
31	Healthy Families Published Charges	07/01/03 - 09/30/03	5,506	330	4,724	453			
31A		10/01/03 - 06/30/04	759		759				
32	Healthy Families Negotiated Rates	07/01/03 - 09/30/03							
32A		10/01/03 - 06/30/04							
33	Non-Medi-Cal Costs		5,809,852	70,386	4,960,928	134,410	596,815	47,313	

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF MENTAL HEALTH
PAGE 1 OF 1

ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL
MH 1966 (08/04)

DETAIL COST REPORT

FISCAL YEAR 2003 - 2004

County: Santa Clara
County Code: 43

CR

Legal Entity: Eastfield Ming Quong, Inc.
Legal Entity Number: 00156
Mode: 10 - Day Services

			A	B	C	D	E	F	G
			Mode Total	Service Function	Service Function	Service Function	Service Function	Service Function	Service Function
1	Allocation Percentage		100.00%	85					
2	Total Units			100.00%					
3	Gross Cost		2,156,612	13,275					
4	Cost per Unit			2,156,612					
5	SMA per Unit			162.46					
6	Published Charge per Unit			183.46					
7	Negotiated Rate / Cost per Unit			211.18					
8	Medi-Cal Units	07/01/03 - 09/30/03		2,304					
8A		10/01/03 - 06/30/04		6,329					
9	Medicare/Medi-Cal Crossover Units	07/01/03 - 09/30/03							
9A		10/01/03 - 06/30/04							
10	Enhanced SD/MC (Children) Units	07/01/03 - 09/30/03							
10A		10/01/03 - 06/30/04							
10B	Enhanced SD/MC (Refugees) Units	07/01/03 - 06/30/04							
11	Healthy Families (SED) Units	07/01/03 - 09/30/03		18					
11A		10/01/03 - 06/30/04							
12	Non-Medi-Cal Units			4,824					
13	Medi-Cal Costs	07/01/03 - 09/30/03	374,300	374,300					
13A		10/01/03 - 06/30/04	1,028,188	1,028,188					
14	Medi-Cal SMA Upper Limits	07/01/03 - 09/30/03	422,692	422,692					
14A		10/01/03 - 06/30/04	1,181,118	1,161,118					
15	Medi-Cal Published Charges	07/01/03 - 09/30/03	466,559	466,559					
15A		10/01/03 - 06/30/04	1,336,558	1,336,558					
16	Medi-Cal Negotiated Rates	07/01/03 - 09/30/03							
16A		10/01/03 - 06/30/04							
17	Medicare/Medi-Cal Crossover Costs	07/01/03 - 09/30/03							
17A		10/01/03 - 06/30/04							
18	Medicare/Medi-Cal Crossover SMA Upper Limits	07/01/03 - 09/30/03							
18A		10/01/03 - 06/30/04							
19	Medicare/Medi-Cal Crossover Published Charges	07/01/03 - 09/30/03							
19A		10/01/03 - 06/30/04							
20	Medicare/Medi-Cal Crossover Negotiated Rates	07/01/03 - 09/30/03							
20A		10/01/03 - 06/30/04							
21	Enhanced SD/MC Costs	07/01/03 - 09/30/03							
21A		10/01/03 - 06/30/04							
22	Enhanced SD/MC SMA Upper Limits	07/01/03 - 09/30/03							
22A		10/01/03 - 06/30/04							
23	Enhanced SD/MC Published Charges	07/01/03 - 09/30/03							
23A		10/01/03 - 06/30/04							
24	Enhanced SD/MC Negotiated Rates	07/01/03 - 09/30/03							
24A		10/01/03 - 06/30/04							
25	Enhanced SD/MC (Refugees) Costs	07/01/03 - 06/30/04							
26	Enhanced SD/MC (Refugees) SMA Upper Limits	07/01/03 - 06/30/04							
27	Enhanced SD/MC (Refugees) Published Charges	07/01/03 - 06/30/04							
28	Enhanced SD/MC (Refugees) Negotiated Rates	07/01/03 - 06/30/04							
29	Healthy Families Costs	07/01/03 - 09/30/03	2,924	2,924					
29A		10/01/03 - 06/30/04							
30	Healthy Families SMA Upper Limits	07/01/03 - 09/30/03	3,302	3,302					
30A		10/01/03 - 06/30/04							
31	Healthy Families Published Charges	07/01/03 - 09/30/03	3,801	3,801					
31A		10/01/03 - 06/30/04							
32	Healthy Families Negotiated Rates	07/01/03 - 09/30/03							
32A		10/01/03 - 06/30/04							
33	Non-Medi-Cal Costs		751,199	751,199					

Tab 3

11461.1. It is the intent of the Legislature to ensure quality care for children who are placed in foster family homes. Therefore, the State Department of Social Services is directed to work with counties, foster parent associations, representatives of the community colleges, representatives of foster youth organizations, legislative staff members, and other interested parties concerning training requirements, experience, and retention of foster parents and the capacity of foster homes.

11461.5. (a) The department may establish a rate to supplement the basic rate specified in subdivision (a) of Section 11461 for the provision of additional shelter needs for AFDC-FC children who are placed in out-of-home care with their siblings.

(b) The department shall develop regulations for the rate specified in subdivision (a).

(c) The department shall amend the state plan to receive appropriate funding from the federal government, for implementation of this section, under Title IV-E of the federal Social Security Act, Part E (commencing with Section 670) of Subchapter 4 of Chapter 7 of Title 42 of the United States **Code**. The plan amendment shall be submitted within 90 days of notification that federal funds are available for the purposes of this section.

(d) Subdivisions (a) and (b) shall be implemented only if, and upon the date that, the director executes a declaration, that shall be retained by the director, stating that the director has determined that the federal government has approved the state plan amendments required by subdivision (c), and federal funding in accordance with those state plan amendments becomes available.

11462. (a) (1) Effective July 1, 1990, foster care providers licensed as group homes, as defined in departmental regulations, including public child care **institutions**, as defined in Section 11402.5, shall have rates established by classifying each group home program and applying the standardized schedule of rates. The department shall collect information from group providers beginning January 1, 1990, in order to classify each group home program.

(2) Notwithstanding paragraph (1), foster care providers licensed as group homes shall have rates established only if the group home is organized and operated on a nonprofit basis as required under subdivision (h) of Section 11400. The department shall terminate the rate effective January 1, 1993, of any group home not organized and operated on a nonprofit basis as required under subdivision (h) of Section 11400.

(3) (A) The department shall determine, consistent with the requirements of this chapter and other relevant requirements under law, the rate classification level (RCL) for each group home program on a biennial basis. Submission of the biennial rate application shall be made according to a schedule determined by the department.

(B) The department shall adopt regulations to implement this paragraph. The adoption, amendment, repeal, or readoption of a regulation authorized by this paragraph is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government **Code**, and the department is hereby exempted from the requirement to describe specific facts showing the need for immediate

action.

(b) A group home program shall be initially classified, for purposes of emergency regulations, according to the level of care and services to be provided using a point system developed by the department and described in the report, "The Classification of Group Home Programs under the Standardized Schedule of Rates System," prepared by the State Department of Social Services, August 30, 1989.

(c) The rate for each RCL has been determined by the department with data from the AFDC-FC Group Home Rate Classification Pilot Study. The rates effective July 1, 1990, were developed using 1985 calendar year costs and reflect adjustments to the costs for each fiscal year, starting with the 1986-87 fiscal year, by the amount of the California Necessities Index computed pursuant to the methodology described in Section 11453. The data obtained by the department using 1985 calendar year costs shall be updated and revised by January 1, 1993.

(d) As used in this section, "standardized schedule of rates" means a listing of the 14 rate classification levels, and the single rate established for each RCL.

(e) Except as specified in paragraph (1), the department shall determine the RCL for each group home program on a prospective basis, according to the level of care and services that the group home operator projects will be provided during the period of time for which the rate is being established.

(1) (A) For new and existing providers requesting the establishment of an RCL, and for existing group home programs requesting an RCL increase, the department shall determine the RCL no later than 13 months after the effective date of the provisional rate. The determination of the RCL shall be based on a program audit of documentation and other information that verifies the level of care and supervision provided by the group home program during a period of the two full calendar months or 60 consecutive days, whichever is longer, preceding the date of the program audit, unless the group home program requests a lower RCL. The program audit shall not cover the first six months of operation under the provisional rate. Pending the department's issuance of the program audit report that determines the RCL for the group home program, the group home program shall be eligible to receive a provisional rate that shall be based on the level of care and service that the group home program proposes it will provide. The group home program shall be eligible to receive only the RCL determined by the department during the pendency of any appeal of the department's RCL determination.

(B) A group home program may apply for an increase in its RCL no earlier than two years from the date the department has determined the group home program's rate, unless the host county, the primary placing county, or a regional consortium of counties submits to the department in writing that the program is needed in that county, that the provider is capable of effectively and efficiently operating the proposed program, and that the provider is willing and able to accept AFDC-FC children for placement who are determined by the placing agency to need the level of care and services that will be provided by the program.

(C) To ensure efficient administration of the department's audit responsibilities, and to avoid the fraudulent creation of records, group home programs shall make records that are relevant to the RCL determination available to the department in a timely manner. Except as provided in this section, the department may refuse to consider, for purposes of determining the rate, any documents that are relevant to the determination of the RCL that are not made available by the group home provider by the date the group home provider requests a

hearing on the department's RCL determination. The department may refuse to consider, for purposes of determining the rate, the following records, unless the group home provider makes the records available to the department during the fieldwork portion of the department's program audit:

(i) Records of each employee's full name, home address, occupation, and social security number.

(ii) Time records showing when the employee begins and ends each work period, meal periods, split shift intervals, and total daily hours worked.

(iii) Total wages paid each payroll period.

(iv) Records required to be maintained by licensed group home providers under Title 22 of the California **Code** of Regulations that are relevant to the RCL determination.

(D) To minimize financial abuse in the startup of group home programs, when the department's RCL determination is more than three levels lower than the RCL level proposed by the group home provider, and the group home provider does not appeal the department's RCL determination, the department shall terminate the rate of a group home program 45 days after issuance of its program audit report. When the group home provider requests a hearing on the department's RCL determination, and the RCL determined by the director under subparagraph (E) is more than three levels lower than the RCL level proposed by the group home provider, the department shall terminate the rate of a group home program within 30 days of issuance of the director's decision. Notwithstanding the reapplication provisions in subparagraph (B), the department shall deny any request for a new or increased RCL from a group home provider whose RCL is terminated pursuant to this subparagraph, for a period of no greater than two years from the effective date of the RCL termination.

(E) A group home provider may request a hearing of the department's RCL determination under subparagraph (A) no later than 30 days after the date the department issues its RCL determination. The department's RCL determination shall be final if the group home provider does not request a hearing within the prescribed time. Within 60 days of receipt of the request for hearing, the department shall conduct a hearing on the RCL determination. The standard of proof shall be the preponderance of the evidence and the burden of proof shall be on the department. The hearing officer shall issue the proposed decision within 45 days of the close of the evidentiary record. The director shall adopt, reject, or modify the proposed decision, or refer the matter back to the hearing officer for additional evidence or findings within 100 days of issuance of the proposed decision. If the director takes no action on the proposed decision within the prescribed time, the proposed decision shall take effect by operation of law.

(2) Group home programs that fail to maintain at least the level of care and services associated with the RCL upon which their rate was established shall inform the department. The department shall develop regulations specifying procedures to be applied when a group home fails to maintain the level of services projected, including, but not limited to, rate reduction and recovery of overpayments.

(3) The department shall not reduce the rate, establish an overpayment, or take other actions pursuant to paragraph (2) for any period that a group home program maintains the level of care and services associated with the RCL for children actually residing in the facility. Determinations of levels of care and services shall be made in the same way as modifications of overpayments are made pursuant to paragraph (2) of subdivision (b) of Section 11466.2.

(4) A group home program that substantially changes its staffing

pattern from that reported in the group home program statement shall provide notification of this change to all counties that have placed children currently in care. This notification shall be provided whether or not the RCL for the program may change as a result of the change in staffing pattern.

(f) (1) The standardized schedule of rates for the 2002-03, 2003-04, 2004-05, 2005-06, 2006-07, and 2007-08 fiscal years is:

Rate Classification Level	Point Ranges	FY 2002-03, 2003-04, 2004-05, 2005-06, 2006-07, and 2007-08 Standard Rate
1	Under 60	$1,454
2	60- 89	1,835
3	90-119	2,210
4	120-149	2,589
5	150-179	2,966
6	180-209	3,344
7	210-239	3,723
8	240-269	4,102
9	270-299	4,479
10	300-329	4,858
11	330-359	5,234
12	360-389	5,613
13	390-419	5,994
14	420 & Up	6,371

(2) (A) For group home programs that receive AFDC-FC payments for services performed during the 2002-03, 2003-04, 2004-05, 2005-06, 2006-07, 2007-08, 2008-09, and 2009-10 fiscal years, the adjusted RCL point ranges below shall be used for establishing the biennial rates for existing programs, pursuant to paragraph (3) of subdivision (a) and in performing program audits and in determining any resulting rate reduction, overpayment assessment, or other actions pursuant to paragraph (2) of subdivision (e):

Rate Classification Level	Adjusted Point Ranges for the 2002-03, 2003-04, 2004-05, 2005-06, 2006-07, 2007-08, 2008-09, and 2009-10 Fiscal Years
1	Under 54
2	54- 81
3	82-110
4	111-138
5	139-167
6	168-195
7	196-224
8	225-253
9	254-281
10	282-310
11	311-338
12	339-367
13	368-395
14	396 & Up

(B) Notwithstanding subparagraph (A), foster care providers operating group homes during the 2002-03, 2003-04, 2004-05, 2005-06, 2006-07, 2007-08, 2008-09, and 2009-10 fiscal years shall remain responsible for ensuring the health and safety of the children placed in their programs in accordance with existing applicable provisions of the Health and Safety **Code** and community care licensing regulations, as contained in Title 22 of the **Code** of California Regulations.

(C) Subparagraph (A) shall not apply to program audits of group home programs with provisional rates established pursuant to paragraph (1) of subdivision (e). For those program audits, the RCL point ranges in paragraph (1) shall be used.

(D) Rates applicable for the 2009-10 fiscal year pursuant to the act that adds this subparagraph shall be effective October 1, 2009.

(3) (A) For group home programs that receive AFDC-FC payments for services performed during the 2009-10 fiscal year the adjusted RCL point ranges below shall be used for establishing the biennial rates for existing programs, pursuant to paragraph (3) of subdivision (a) and in performing program audits and in determining any resulting rate reduction, overpayment assessment, or other actions pursuant to paragraph (2) of subdivision (e):

Rate Classification Level	Adjusted Point Ranges for the 2009-10 Fiscal Year
1	Under 39
2	39-64
3	65-90
4	91-115
5	116-141
6	142-167
7	168-192
8	193-218
9	219-244
10	245-270
11	271-295
12	296-321
13	322-347
14	348 & Up

(B) Notwithstanding subparagraph (A), foster care providers operating group homes during the 2009-10 fiscal year shall remain responsible for ensuring the health and safety of the children placed in their programs in accordance with existing applicable provisions of the Health and Safety **Code** and community care licensing regulations as contained in Title 22 of the California **Code** of Regulations.

(C) Subparagraph (A) shall not apply to program audits of group home programs with provisional rates established pursuant to paragraph (1) of subdivision (e). For those program audits, the RCL point ranges in paragraph (1) shall be used.

(g) (1) (A) For the 1999-2000 fiscal year, the standardized rate for each RCL shall be adjusted by an amount equal to the California Necessities Index computed pursuant to the methodology described in Section 11453. The resultant amounts shall constitute the new standardized schedule of rates, subject to further adjustment pursuant to subparagraph (B).

(B) In addition to the adjustment in subparagraph (A), commencing January 1, 2000, the standardized rate for each RCL shall be

increased by 2.36 percent, rounded to the nearest dollar. The resultant amounts shall constitute the new standardized schedule of rates.

(2) Beginning with the 2000-01 fiscal year, the standardized schedule of rates shall be adjusted annually by an amount equal to the CNI computed pursuant to Section 11453, subject to the availability of funds. The resultant amounts shall constitute the new standardized schedule of rates.

(3) Effective January 1, 2001, the amount included in the standard rate for each Rate Classification Level (RCL) for the salaries, wages, and benefits for staff providing child care and supervision or performing social work activities, or both, shall be increased by 10 percent. This additional funding shall be used by group home programs solely to supplement staffing, salaries, wages, and benefit levels of staff specified in this paragraph. The standard rate for each RCL shall be recomputed using this adjusted amount and the resultant rates shall constitute the new standardized schedule of rates. The department may require a group home receiving this additional funding to certify that the funding was utilized in accordance with the provisions of this section.

(4) Effective January 1, 2008, the amount included in the standard rate for each RCL for the wages for staff providing child care and supervision or performing social work activities, or both, shall be increased by 5 percent, and the amount included for the payroll taxes and other employer-paid benefits for these staff shall be increased from 20.325 percent to 24 percent. The standard rate for each RCL shall be recomputed using these adjusted amounts, and the resulting rates shall constitute the new standardized schedule of rates.

(5) The new standardized schedule of rates as provided for in paragraph (4) shall be reduced by 10 percent, effective October 1, 2009, and the resulting rates shall constitute the new standardized schedule of rates.

(6) The rates of licensed group home providers, whose rates are not established under the standardized schedule of rates, shall be reduced by 10 percent, effective October 1, 2009.

(h) The standardized schedule of rates pursuant to subdivisions (f) and (g) shall be implemented as follows:

(1) Any group home program that received an AFDC-FC rate in the prior fiscal year at or above the standard rate for the RCL in the current fiscal year shall continue to receive that rate.

(2) Any group home program that received an AFDC-FC rate in the prior fiscal year below the standard rate for the RCL in the current fiscal year shall receive the RCL rate for the current year.

(i) (1) The department shall not establish a rate for a new program of a new or existing provider, or for an existing program at a new location of an existing provider, unless the provider submits a letter of recommendation from the host county, the primary placing county, or a regional consortium of counties that includes all of the following:

(A) That the program is needed by that county.

(B) That the provider is capable of effectively and efficiently operating the program.

(C) That the provider is willing and able to accept AFDC-FC children for placement who are determined by the placing agency to need the level of care and services that will be provided by the program.

(D) That, if the letter of recommendation is not being issued by the host county, the primary placing county has notified the host county of its intention to issue the letter and the host county was given the opportunity 30 days to respond to this notification and to

discuss options with the primary placing county.

(2) The department shall encourage the establishment of consortia of county placing agencies on a regional basis for the purpose of making decisions and recommendations about the need for, and use of, group home programs and other foster care providers within the regions.

(3) The department shall annually conduct a county-by-county survey to determine the unmet placement needs of children placed pursuant to Section 300 and Section 601 or 602, and shall publish its findings by November 1 of each year.

(j) The department shall develop regulations specifying ratesetting procedures for program expansions, reductions, or modifications, including increases or decreases in licensed capacity, or increases or decreases in level of care or services.

(k) (1) For the purpose of this subdivision, "program change" means any alteration to an existing group home program planned by a provider that will increase the RCL or AFDC-FC rate. An increase in the licensed capacity or other alteration to an existing group home program that does not increase the RCL or AFDC-FC rate shall not constitute a program change.

(2) For the 1998-99, 1999-2000, and 2000-01 fiscal years, the rate for a group home program shall not increase, as the result of a program change, from the rate established for the program effective July 1, 2000, and as adjusted pursuant to subparagraph (B) of paragraph (1) of subdivision (g), except as provided in paragraph (3).

(3) (A) For the 1998-99, 1999-2000, and 2000-01 fiscal years, the department shall not establish a rate for a new program of a new or existing provider or approve a program change for an existing provider that either increases the program's RCL or AFDC-FC rate, or increases the licensed capacity of the program as a result of decreases in another program with a lower RCL or lower AFDC-FC rate that is operated by that provider, unless both of the following conditions are met:

(i) The licensee obtains a letter of recommendation from the host county, primary placing county, or regional consortium of counties regarding the proposed program change or new program.

(ii) The county determines that there is no increased cost to the General Fund.

(B) Notwithstanding subparagraph (A), the department may grant a request for a new program or program change, not to exceed 25 beds, statewide, if both of the following conditions are met:

(i) The licensee obtains a letter of recommendation from the host county, primary placing county, or regional consortium of counties regarding the proposed program change or new program.

(ii) The department determines that the new program or program change will result in a reduction of referrals to state hospitals during the 1998-99 fiscal year.

(l) General unrestricted or undesignated private charitable donations and contributions made to charitable or nonprofit organizations shall not be deducted from the cost of providing services pursuant to this section. The donations and contributions shall not be considered in any determination of maximum expenditures made by the department.

(m) The department shall, by October 1 of each year, commencing October 1, 1992, provide the Joint Legislative Budget Committee with a list of any new departmental requirements established during the previous fiscal year concerning the operation of group homes, and of any unusual, industrywide increase in costs associated with the provision of group care that may have significant fiscal impact on

providers of group homes care. The committee may, in fiscal year 1993-94 and beyond, use the list to determine whether an appropriation for rate adjustments is needed in the subsequent fiscal year.

11462.01. (a) Commencing July 1, 1994, a group home program shall be classified at RCL 13 or RCL 14 if the program meets all of the following requirements:

(1) The group home program is providing, or has proposed to provide, the level of care and services necessary to generate sufficient points in the ratesetting process to be classified at RCL 13 if the rate application is for RCL 13 or to be classified at RCL 14 if the rate application is for RCL 14.

(2) (A) (i) The group home provider shall agree not to accept for placement into a group home program AFDC-FC funded children, including voluntary placements and seriously emotionally disturbed children placed out-of-home pursuant to an individualized education program developed under Section 7572.5 of the Government **Code**, who have not been approved for placement by an interagency placement committee, as described by Section 4096. The approval shall be in writing and shall indicate that the interagency placement committee has determined the child is seriously emotionally disturbed, as defined by Section 5600.3 and subject to Section 1502.4 of the Health and Safety **Code**, and that the child needs the level of care provided by the group home.

(ii) For purposes of clause (i), group home providers who accept seriously emotionally disturbed children who are assessed and placed out-of-home pursuant to an individualized education program developed under Section 7572.5 of the Government **Code** shall be deemed to have met the interagency placement committee approval for placement requirements of clause (i) if the individualized education program assessment indicates that the child has been determined to be seriously emotionally disturbed, as defined in Section 5600.3 and subject to Section 1502.4 of the Health and Safety **Code**, and needs the level of care described in clause (i).

(B) (i) Nothing in this subdivision shall prevent the emergency placement of a child into a group home program prior to the determination by the interagency placement committee pursuant to subclause (i) of subparagraph (A) if a licensed mental health professional, as defined in the department's AFDC-FC ratesetting regulations, has evaluated, in writing, the child within 72 hours of placement, and determined the child to be seriously emotionally disturbed and in need of the care and services provided by the group home program.

(ii) The interagency placement committee shall, within 30 days of placement pursuant to clause (i), make the determination required by clause (i) of subparagraph (A).

(iii) If, pursuant to clause (ii), the placement is determined to be appropriate, the committee shall transmit the approval, in writing, to the county placing agency and the group home provider.

(iv) If, pursuant to clause (ii) the placement is determined not to be appropriate, the child shall be removed from the group home and referred to a more appropriate placement, as specified in subdivision (f).

(C) Commencing December 15, 1992, with respect to AFDC-FC funded children, only those children who are approved for placement by an interagency placement committee may be accepted by a group home under this subdivision.

(3) The group home program is certified by the State Department of

Tab 4

CALIFORNIA CODES
WELFARE AND **INSTITUTIONS CODE**
SECTION **15200**-15207

15200. There is hereby appropriated out of any money in the State Treasury not otherwise appropriated, and after deducting federal funds available, the following sums:

(a) To each county for the support and maintenance of needy children, 95 percent of the sums specified in subdivision (a), and paragraphs (1) and (2) of subdivision (e), of Section 11450.

(b) To each county for the support and maintenance of pregnant mothers, 95 percent of the sum specified in subdivisions (b) and (c) of Section 11450.

(c) For the adequate care of each child pursuant to subdivision (d) of Section 11450, as follows:

(1) For any county that meets the performance standards or outcome measures in Section 11215, an amount equal to 40 percent of the sum necessary for the adequate care of each child.

(2) For any county that does not meet the performance standards or outcome measures in Section 11215, an amount which shall not be less than 67.5 percent of one hundred twenty dollars ($120), and multiplied by the number of children receiving foster care in the county, added to an additional twelve dollars and fifty cents ($12.50) a month per eligible child.

(3) The department shall determine the percentage of state reimbursement for those counties that fail to meet the requirements of subparagraph (1) according to the regulations required by subdivision (b) of Section 11215.

(d) Notwithstanding subdivision (c), the amount of funds appropriated from the General Fund in the annual Budget Act that equates to the amount claimed under the Emergency Assistance Program that has been included in the state's Temporary Assistance for Needy Families block grant for foster care maintenance payments shall be considered federal funds for the purposes of calculating the county share of cost, provided the expenditure of these funds contributes to the state meeting its federal maintenance of effort requirements.

(e) To each county for the support and care of hard-to-place adoptive children, 75 percent of the nonfederal share of the amount specified in Section 16121.

(f) To each county for the support and care of former dependent children who have been made wards of related guardians, an amount equal to 50 percent of the Kin-GAP payment under Article 4.5 (commencing with Section 11360) of Chapter 2 minus the federal TANF block grant contribution specified in Section 11364. This subdivision shall become inoperative on July 1, 2006.

(g) The State Department of Social Services shall not implement any change in the current funding ratios to counties as a reimbursement for out-of-home care placement until the development of a new performance standard system. The State Department of Social Services shall notify the Department of Finance when the new performance standard system is developed and ready for implementation. The Department of Finance, pursuant to the provisions of Section 28 of the Budget Act, shall notify the Joint Legislative Budget Committee in writing of its intent to implement a new performance standard that would impact the counties' funding allocation. The notification shall include the text of the draft regulations to implement the performance standards. Any adjustment in

the county funding allocation shall not be implemented sooner than 60 days after receipt and review of the new performance standard by the Joint Legislative Budget Committee and a review of the proposed changes by the Legislative Analyst.

(h) Federal funds received under Title XX of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.) and appropriated by the Legislature for the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program shall be considered part of the state share of cost and not part of the federal expenditures for purposes of subdivision (c).

15200.05. (a) Federal block grant funds received for the Temporary Assistance for Needy Families program pursuant to subtitle A (commencing with Section 401) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 601 et seq.) may be deposited in, and shall be administered through, the Temporary Assistance for Needy Families Fund, which is hereby created in the State Treasury. Upon authorization by the Director of Finance, special accounts may be established within this fund, and the fund may be used in accounting for any federal Temporary Assistance for Needy Families block grant funds received from the federal government after August 22, 1996.

(b) A fund condition statement for the federal block grant received for the Temporary Assistance for Needy Families program shall be provided to the Department of Finance with the estimates submitted pursuant to subdivision (d) of Section 10614 whether or not the Temporary Assistance for Needy Families Fund created by this section is used for the deposit and administration of those moneys.

15200.15. For purposes of Section **15200**, any reference to paragraphs (1) and (2) of subdivision (e) of Section 11450 shall mean subdivisions (e) and (f) of Section 11450.

15200.4. (a) In administering the Aid to Families with Dependent Children program provided for under Chapter 2 (commencing with Section 11200), excluding provisions relating to foster care, the director may impose sanctions as provided by this section to assure adequate county administration performance. Fiscal sanctions may be imposed against a county only if the department has conducted, within the county, a statistically reliable and valid case sample with a confidence level of at least 95 percent.

(b) The director may hold counties financially liable for aid paid to ineligible persons and aid paid to eligible persons in excess of the amount to which they are entitled as represented by a dollar error rate. There shall be established annually in the Budget Act a dollar error rate standard which shall be the basis for computing a county's liability under this section for the two subsequent quality control review periods for which error rates are generated. Counties which exceed the standard during the sanction period may be apportioned a sanction no greater than the state share of the Aid to Families with Dependent Children program payments multiplied by the amount by which the statistical measure of the lower point estimate of their error rate exceeded the standard.

(c) If a federal fiscal sanction is imposed against the state as a result of the state's dollar error rate being above the federally

Tab 5

Progress Note

SERVICE DATE	LENGTH	LOC	SERVICE	SERVICE FUNCTION
09/22/2003	140	Outside	MH = Mental Health	Rehabilitation

Progress Note Type: Daily

NOTES:

This writer from Los Gatos to Palo Alto (ttt: 55 min.) to support / with the behavorial goals of increasing his self awareness and social skills. Upon arrival at the Ester B. Clark School, for a Child and Family Team Meeting, appeared to be in a good space. He spoke to staff in an appropriate manner. Staff prompted to indicate how he was doing. / said he was fine, but a little tired. Staff acknowledged for being at school even though he was tired. / said he wanted to take part in this Child and Family Meeting since it was related to him. Staff acknowleded started telling staff a few details about his school. Staff thanked / tried to figure out what room the meeting was in. / was very polite to the adults. Staff acknowledged / for his courtesy. said thank you. Staff acted as a supportive presence during the meeting. gave his viewpoints. Staff and others acknowledged / demonstrated appropriate verbal and nonverbal behaviors. Staff will continue to support / with his behavorial goals.

Disclosure Details

No Disclosures Reported

Signature: Brenda Davis MHRS Date Completed: 10/1/03

Davis, Brenda 15233

Cosigner's Signature (if needed) / / Date Cosigner's Name - Please Print

EMQ *Children & Family Services*

Client ID /	Admission Date	11/13/2002
Individual's Name		
Date of Birth		
Program 8370-10		UPLIFT
County Client ID		
Staff Completing Reports		Davis, Brenda 15233

-Confidential W&I Code 5328-

Document ID: 346240

Regular Progress Note

SERVICE DATE	LENGTH	LOC	SERVICE	SERVICE FUNCTION
05/19/2004	215	Outside	MH = Mental Health	Rehabilitation

Progress Note Type: Daily **Service Sub-Function:**

NOTES:

Staff traveled to and from Palo Alto (TTT: 58 minutes) to assist with his behavioral goals: 1) to appropriately communicate with peers and adults, 2) to utilize effective social skills, and 3) to practice appropriate personal care and hygiene. Upon arrival, was appeared to be in a good space, as he greeted staff and had good eye contact. Staff greeted and offered non-verbal cue for to remain engaged in classroom activity. complied. Staff acknowledged for rejoining group activity and showing respect for peers and teacher through attentiveness and participation. responded well to praise. Few interventions were needed while was engaged in classroom activity. Staff offered verbal and non-verbal cues to when behavior was disruptive or inappropriate (making comments under his breath about peers, interrupting the teacher). Staff addressed concerns regarding negative peer interaction inbetween classes. Staff assisted in strategizing around how to respond to teasing, focusing on tendency to personalize comments. participated in conversation and acknowledged that sometimes he is overly sensitive to what his peers say about him. Staff acknolwedge for openly sharing thoughts and feelings and assisted him in acknowledging the talents and abilities he brings to class that others have recognized. actively particpated in discussion and appeared more aware of his peers and the level to which he allows them to dictate his behavior or mood. Staff shared observation with was receptive to feedback and appeared pleased with the results of managing his behavior more effectively. Staff acted as a supportive presence for a lengthy period of time. Staff continued to check in with regarding his behavior choices, offering encouragement, support, and feedback. was receptive to support and continued to make positive behavior choices and to self-correct inappropriate behavior. Staff used proximity when was off-task or disruptive. responded well to support. Staff will update team and continue to support with service plan goals.

Disclosure Details

No Disclosures Reported

Document Signed By: Jessica Lenneman, Jessica L P 15220 Date Completed: 5/21/04

Co-Signer/Reviewer Signature: Mona Tahsini, MHRS Tahsini, Mona 15660 Date Completed: 05,21,04

EMQ Children & Family Services

Client ID	Admission Date 11/13/2002
Individual's Name	
Date of Birth	
Program 8370-10	UPLIFT
County Client ID	
Staff Completing Reports	Lenneman, Jessica L P 15220

-Confidential W&I Code

Document ID: 476044