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December 28, 2015
Commission on
State Mandates

County of San Diego

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December 28, 2015

VIA E-FILING
(hhtp://csm.ca.gov/dropbox.shtml)

Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Re: Appeal of Executive Director's Notice of Untimely Filed Incorrect Reduction Claim.

To the Commission on State Mandates:

The County of San Diego submits this "Appeal of Executive Director's Notice of Untimely Filed Incorrect Reduction Claim." The County submitted an Incorrect Reduction Claim on December 10, 2015 challenging the State Controller's disallowance of costs claimed under Consolidated Handicapped and Disabled Students (HDS), HDS II, and Seriously Emotionally Disturbed Pupils Program for the time period of July 1, 2006-June 30, 2009. On December 18, 2015, the Executive Director sent a "Notice of Untimely Filed Incorrect Reduction Claim" instead of a determination of completeness.

Enclosed please find the County of San Diego's appeal of the Executive Director's decision. If you have any questions please do not hesitate to contact the undersigned at (619) 531-6296.

Sincerely,

THOMAS E. MONTGOMERY, County Counsel

By

KYLE SAND, Senior Deputy

11-01866

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STATE OF CALIFORNIA
COMMISSION ON STATE MANDATES

HANDICAPPED AND DISABLED STUDENTS, HANDICAPPED AND DISABLED STUDENTS II, SERIOUSLY EMOTIONALLY DISTURBED PUPILS: OUT-OF-STATE MENTAL HEALTH SERVICES. FY 06-07, FY 07-08, AND FY 08-09.	**APPEAL OF EXECUTIVE DIRECTOR'S NOTICE OF UNTIMELY FILED INCORRECT REDUCTION CLAIM**

I. Basis for Appeal:

Government Code section 17553, subdivision (d), requires the Commission to determine within ten days of receipt whether an incorrect reduction claim is complete. However, no such determination has yet been made. Instead, the Executive Director deemed the December 10, 2015 filing of the County's Incorrect Reduction Claim ("Claim") to be untimely despite the fact that it was filed within three years of the State Controller's Revised Final Audit Report dated December 18, 2012. (See December 18, 2015 Letter, EXHIBIT "A".)

The plain language of Title 2, Section 1185.1 (c) of the Code of Regulations states that the time to file a claim is "three years from the date of the … final state audit report." By arguing that the date of an earlier report controls, the Executive Director's ignores the plain and ordinary meaning of the word "final" in Section 1185.1 (c). Furthermore, the State Controller was clear that it's December 18, 2012 Revised Final Audit Report was the final determination in this matter and "supersedes our previous report." (EXHIBIT "B".)

The Executive Director incorrectly deemed the County's claim untimely; therefore, the Commission must proceed with the County's claim. If the Commission wishes to address the Executive Director's statute of limitations argument, it should do so at a full hearing of the Commission.

II. Requested Action:

The County of San Diego requests that the Commission find the incorrect reduction claim to be complete and timely.

III. Applicable Facts:

- In December 2012, the County of San Diego received a bound 46 page report from the California State Controller entitled *San Diego County Revised Audit Report.* (EXHIBIT "B") This report superseded a prior report entitled *San Diego County Audit Report* dated March 2012.
- The bound cover of the *Revised Audit Report* is dated "December 2012."
- The first two pages of the *Revised Audit Report* consist of a formal letter from the State Controller's Office dated December 18, 2012. The letter is addressed to the

Chairman of the San Diego County Board of Supervisors and is signed by Jeffrey V. Brownfield, Chief, Division of Audits. The letter states: "This revised final report supersedes our previous report dated March 7, 2012." (Emphasis added.)

- Included in the Revised Audit Report are the following:
  - "Revised Schedule 1"; (EXHIBIT B, Page 6, emphasis added) and
  - "Revised Findings and Recommendations." (EXHIBIT "B", Page 7, emphasis added.)
- The Revised Final Report contained contains recalculated Revenues for Early and Periodic Screening, Diagnosis and Treatment reimbursements for fiscal year 2008-2009.
- The County filed its incorrect reduction claim in this matter on December 10, 2015.
- On Friday, December 18, 2015, Commission staff served a *Notice of Untimely Filed Incorrect Reduction Claim* via email. (EXHIBIT "A".)

IV. Applicable Regulation:

The time period to file an incorrect reduction claim is found in Title 2, Section 1185.1, subdivision (c), of the California Code of Regulations. Section 1185.1 (c) states in plain and unequivocal language:

> "All incorrect reduction claims shall be filed with the Commission no later than three years following the date of the Office of State Controller's final state audit report, letter, remittance advice, or other written notice of adjustment to a reimbursement claim." (Emphasis added.)

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V. Analysis:

1. The December 2012 "Revised Audit" was the "final state audit report" for the purposes of Section 1185.1(c).

The Claim filed on December 10, 2015 was timely because it was filed "no later than three years" following the date of the final audit report. (Section 1185.1(c).) The December 18, 2012 report *was* the final audit report. The State Controller voided its prior report and stated that "[t]his revised final report supersedes our previous report." (State Controller's Letter, EXHIBIT "B", emphasis added.) "Supersede" means "to annul, make void, or repeal by taking the place of." (Black's Law Dictionary 1497 (8th ed. 2004).) The State Controller could not have been clearer that the December 2012 report was the *final* determination of the matter. The Executive Director's legal conclusion to the contrary is at odds with the undisputed facts and plain language of the Commission's own regulation.

2. Section 1185.1 does not authorize the Executive Director to disregard a superseding revised final report based on a determination that it had "no fiscal effect."

The Executive Director is not merely attempting to interpret a state regulation; she is adding a new qualification that does not presently exist. "Generally, an agency's interpretation of its own regulation is entitled to considerable judicial deference." (*Motion Picture Studio Teachers & Welfare Workers v. Millan* (1996) 51 Cal. App. 4th 1190, 1195, "*Motion Picture Studio*".) However, "the principle of deference is not without limit; it does not permit the agency to disregard the regulation's plain language." (*Ibid.*) The court in *Motion Picture Studio* further stated:

"An agency may not alter a regulation except by the APA process [citation omitted], which is similar to the procedures that govern its adoption. The procedures for adoption, amendment and repeal of a regulation parallel the law applicable to statutory changes. If a state agency believes that the regulation it adopted ought to be changed, it may only accomplish that result through the APA procedure, a process that ordinarily requires advance publication and an opportunity for public comment. (See Gov. Code, § 11346.4, 11346.5, 11346.8.) It may not do so by interpreting the regulation in a manner inconsistent with its plain language." (*Motion Picture Studio, supra*, 51 Cal. App. 4th at 1195 (Emphasis added).)

The Commission has revised Section 1185.1 (c) and its predecessor several times. If the Commission wishes to have the filing period run from the earliest report, letter, or notice that has a "fiscal effect" then the Commission presumably knows how to do so. As is stands today, the Commission promulgated a specific time period in which to file an incorrect reduction claim ("three years following the date of the ... final audit report..."). The County's claim was filed during that time period.

3. Reliance on general tort statute of limitations cases is misapplied when the Commission's own regulation sets forth a more specific time period for filing an incorrect reduction claim.

The Executive Director relies on various judicial interpretations of general tort statute of limitations provisions contained in the Code of Civil Procedure. Code of Civil Procedure Section 318 states: "Civil actions, without exception, can only be commenced within the periods prescribed in this title, after the cause of action shall have accrued, unless where, in special cases, a different limitation is prescribed by statute."

In contrast, the Commission adopted a more specific limitations period as promulgated through the Code of Regulations. "'It is well settled ... that a general provision is controlled by one that is special, the latter being treated as an exception to the former. A specific provision relating to a particular subject will govern in respect to that subject, as against a general provision, although the latter, standing alone, would be broad enough to include the subject to which the more particular provision relates.'" (*San Francisco Taxpayers Assn. v. Board of Supervisors* (1992) 2 Cal.4th 571, 577 quoting *Rose v. State of California* (1942) 19 Cal.2d 713, 723-724.)

Since the Commission has adopted very a specific limitation period (three years following the date of the ... final audit report) for incorrect reduction claims, reliance on case law interpreting general tort statute of limitation statutes is unnecessary. In addition, the Commission has never interpreted the current version of Section 1185.1 and need not do so now other than to look to the plain meaning of the regulation.

4. Prior Commission Decisions do not support the Executive Director's position.

   A. *Handicapped and Disabled Students* (*County of Orange*) (2011) (05-4282-I-02 and 09-4282-I-04). (EXHIBIT "C")

In *Handicapped and Disabled Students*, the Commission interpreted a predecessor to current Section 1185.1. This prior regulation stated:

> "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." (Code of Regulations, title 2, section 1185, subdivision (b) (as amended by Register 2003, No. 17, operative April 21, 2003)

In finding that an incorrect reduction claim was timely filed, the Commission stated: "section 1185 of the Commission's regulations does not require the running of the time period from when a claimant *first* receives notice; but simply states that the time runs from either the remittance advice *or* other notice of adjustment." (*Handicapped Disabled Students* (2011), p. 9) (Emphasis by Commission.) "Thus, when viewed in a light most favorable to the County, and based on the policy determined by the courts favoring the disposition of cases on their merits rather than on procedural grounds, staff finds that the County timely filed the incorrect reduction claim...". (*Ibid.*)

Handicapped and Disabled Students interpreted the plain language of the relevant regulation to find that nothing required the filing period to run from an earlier date; Instead the Commission found that the plain language of the regulation allowed the claim to be filed from *either* the remittance advance *or* notice of adjustment.

B. *Collective Bargaining* (05-4425-I-11). (EXHIBIT "D")

In *Collective Bargaining*, the Commission took a more narrow view of the relevant time period to submit a claim when interpreting even earlier predecessor to Section 1185.1. Former section 1185 (b) stated:

> "All incorrect reduction claims shall be submitted to the commission no later than (3) years following the date of the State Controller's remittance advance notifying the claimant of the reduction." (Code of Regulations, title 2, section 1185 (Register 1999, No. 38).)

In analyzing former Section 1185 (b), the Commission noted that the plain language stated that "notifying the claimant of the adjustment" was the triggering event. (*Collective Bargaining*, p. 19) The Commission stated: "[b]ased on the plain language of

the provision, the Commission's regulation on point is consistent with the general rule that the period of limitation to file an IRC begins to run when the claimant receives notice of a reduction." (*Ibid.*) However, unlike the current regulation, this former regulation clearly stated that "notifying the claimant of the adjustment" through a remittance advance was the triggering event. In contrast, Section 1185.1 states that a claim may be filed "no later than three years following the date of the State Controller's final state audit report, letter, remittance advice, or other written notice of adjustment to a reimbursement claim other conditions". (Section 1185.1 (c).) Therefore, *Collective Bargaining* is not factually applicable to the Claim because it was interpreting entirely different regulatory language.

C. *Handicapped and Disabled Students (County of San Mateo)*(2015) (05-4282-I-03) (EXHIBIT "E")

Recently, in *Handicapped and Disabled Students* (*San Mateo*), the Commission rejected an argument that the County of San Mateo filed an untimely claim involving the same regulation that was applicable in *Handicapped and Disabled Students* (*County of Orange*). The Commission considered the plain language of the State Controller's cover letters, final audit report, and remittance in finding when the final determination occurred. The Commission found that although an earlier audit report "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." (*Handicapped and Disabled Students* (*San Mateo*), p. 14)

The Commission further stated: "[b]ased 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 truly final based on the plain language of the cover letter." (*Ibid., emphasis added.*) In addition, both San Mateo County and the State Controller's Office relied on the date of the later document. (*Ibid.*)

Similarly here, the State Controller's Office issued subsequent new document that became the final determination on the subject claims. The plain language of the Revised Final Audit Report including its title, cover letter, Revised Schedule 1, and Revised Findings and Recommendations indicate that it was State Controller's final determination on the subject claim.

Furthermore, both the County and the State Controller appear to have relied on the date of the final report. For example, the State Controller's website indicates that the date of their report is actually "12/20/12". (Available at: <http://www.sco.ca.gov/aud_mancost_la_costrpt.html>, as of 12/24/15.) (EXHIBIT "F".) Accordingly, December 2012 is the operative date of the "final report" for the purposes of Section 1185.1.

VI. Conclusion:

The County's filed its incorrect reduction claim no later than three years from the final audit report in compliance with Section 1185.1 (c). The December 2012 final audit report was the State Controller's final determination on the subject claims. The State

Controller specifically stated that the "revised final report supersedes our previous report." The County's position is consistent with the plain language of the regulation, case law, and the Commission's prior decisions. Therefore, the Commission must direct the Executive Director to deem the County's incorrect reduction claim complete.

Dated:

Respectfully submitted,

THOMAS E. MONTGOMERY, County Counsel

By

KYLE SAND, Senior Deputy
Attorneys for the County of San Diego

EXHIBIT “A”

Sand, Kyle

Subject: FW: Handicapped and Disabled Students, Handicapped and Disabled Students II, and Seriously Emotionally Disturbed (SED) Pupils: Out of State Mental Health Services IRC Filing
Attachments: Untimely Filed Letter.pdf

From: Jill Magee [mailto:jill.magee@csm.ca.gov]
Sent: Friday, December 18, 2015 2:41 PM
To: Macchione, Lisa M
Cc: Heidi Palchik
Subject: Handicapped and Disabled Students, Handicapped and Disabled Students II, and Seriously Emotionally Disturbed (SED) Pupils: Out of State Mental Health Services IRC Filing

Good Afternoon Ms. Macchione,

Please find the attached letter regarding the incorrect reduction claim filing you submitted on behalf of the County of San Diego for the *Handicapped and Disabled Students, Handicapped and Disabled Students II, and Seriously Emotionally Disturbed (SED) Pupils: Out of State Mental Health Services* program. Commission staff has determined that this filing is untimely.

Please contact me if you have any questions.

Thank you,
Jill

Jill Magee
Program Analyst
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
www.csm.ca.gov
Phone: (916) 323-3562
Fax: (916) 445-0278

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STATE OF CALIFORNIA
COMMISSION ON STATE MANDATES
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E-mail: csminfo@csm.ca.gov

December 18, 2015

Ms. Lisa Macchione
County of San Diego, Office of County Counsel
1600 Pacific Highway, Room 355
San Diego, CA 92101

Mr. Alfredo Aguirre
County of San Diego
Behavioral Health Services
3255 Camino Del Rio South
San Diego, CA 92108

Re: Notice of Untimely Filed Incorrect Reduction Claim
Handicapped and Disabled Students, (04-RL-4282-10); *Handicapped and Disabled Students II*, (02-TC-40/02-TC-49); and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services*, (97-TC-05)
Government Code Sections 7570-7588; Statutes 1984, Chapter 1741; Statutes1985, Chapter 1274; Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654;
California Code of Regulations, Title 2, Sections 60000-60610 (Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28]; and Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No.33])
Fiscal Years 2006-2007, 2007-2008, and 2008-2009
County of San Diego, Claimant

Dear Ms. Macchione and Mr. Aguirre:

On December 10, 2015, the Commission on State Mandates (Commission) received an incorrect reduction claim (IRC) filing on the *Handicapped and Disabled Students*, (04-RL-4282-10); *Handicapped and Disabled Students II*, (02-TC-40/02-TC-49); and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services*, (97-TC-05) consolidated program on behalf of the County of San Diego (claimant). On December 16, 2015, claimant revised the filing to include the consolidated parameters and guidelines.

Commission staff has reviewed this filing and determined that it is not timely filed. Section 1185.1(c), of the Commission's regulations states: "all incorrect reduction claims shall be filed with the Commission no later than three years following the date of the Office of State Controller's final state audit report, letter, remittance advice, or other written notice of adjustment to a reimbursement claim."

The incorrect reduction claim was filed with the Commission more than three years following the State Controller's Final Audit Report, dated March 7, 2012. Although the filing includes a letter dated December 18, 2012, from the State Controller, indicating that the Revised Audit Report superseded the previous report and included a recalculation of offsetting revenue for fiscal year 2008-2009, the revision had no fiscal effect on the reductions made for fiscal year 2008-2009 and it appears that no further reductions were made by the revised audit.

The California Supreme Court has said, "Critical to applying a statute of limitations is determining the point when the limitations period begins to run."[1] Generally, "a plaintiff must

[1] *Pooshs v. Phillip Morris USA, Inc.* (2011) 51 Cal.4th 788, 797.

file suit within a designated period after the cause of action accrues."[2] The cause of action accrues, the Court said, "when [it] is complete with all of its elements."[3] Put another way, the courts have held that "[a] cause of action accrues 'upon the occurrence of the last element essential to the cause of action.'"[4] For IRCs, the "last element essential to the cause of action" which begins the running of the period of limitation pursuant to Government Code section 17558.5 and section 1185.1 of the Commission's regulations, is a written notice to the claimant of the adjustment that explains the reason for the adjustment. This interpretation is consistent with previously adopted Commission decisions.[5]

Here, the State Controller's Final Audit Report, dated March 7, 2012, provided claimant written notice of the adjustment and reasons for the adjustment, triggering the three-year limitation to file an IRC. Therefore, the IRC would have to have been filed on or before March 9, 2015 to be timely filed. A later revised audit which incorporates the prior audit findings and makes no new reductions does not trigger a new period of limitation for those earlier reductions.

Pursuant to the Commission's regulations, you may appeal to the Commission for review of the actions and decisions of the executive director. Please refer to California Code of Regulations, title 2, section 1181.1(c).

The appeal may be submitted electronically via the Commission's e-filing system pursuant to section 1181.3 of the Commission's regulations. Please see the Commission's website at http://www.csm.ca.gov/dropbox.shtml.

Sincerely,

Heather Halsey
Executive Director

---

[2] *Ibid* [citing Code of Civil Procedure section 312].

[3] *Ibid* [quoting *Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 397].

[4] *Seelenfreund v. Terminix of Northern California, Inc.* (1978) 84 Cal.App.3d 133 [citing *Neel v. Magana, Olney, Levy, Cathcart & Gelfand* (1971) 6 Cal.3d 176].

[5] See Commission on State Mandates, Decision, *Collective Bargaining*, 05-4425-I-11, adopted December 5, 2014, and Decision, *Handicapped and Disabled Students*, 05-4282-I-03 adopted September 25, 2015.

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On December 18, 2015, I served via email to lisa.macchione@sdcounty.ca.gov the:

> **Notice of Untimely Filed Incorrect Reduction Claim**
> *Handicapped and Disabled Students*, (04-RL-4282-10); *Handicapped and Disabled Students II*, (02-TC-40/02-TC-49); and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services*, (97-TC-05)
> Government Code Sections 7570-7588; Statutes 1984, Chapter 1741; Statutes1985, Chapter 1274; Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654;
> California Code of Regulations, Title 2, Sections 60000-60610 (Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28]; and Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No.33])
> Fiscal Years 2006-2007, 2007-2008, and 2008-2009
> County of San Diego, Claimant

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on December 18, 2015 at Sacramento, California.

Jill Magee
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

EXHIBIT "B"

SAN DIEGO COUNTY

Revised Audit Report

CONSOLIDATED HANDICAPPED AND DISABLED STUDENTS (HDS), HDS II, AND SEDP PROGRAM

Chapter 1747, Statutes of 1984; Chapter 1274, Statutes of 1985; Chapter 1128, Statutes of 1994; and Chapter 654 Statutes of 1996

July 1, 2006, through June 30, 2009

JOHN CHIANG
California State Controller

December 2012

JOHN CHIANG
California State Controller

December 18, 2012

Honorable Ron Roberts, Chairman
Board of Supervisors
County Administration Center
San Diego County
1600 Pacific Highway, Room 335
San Diego, CA 92101

Dear Mr. Roberts:

The State Controller's Office audited the costs claimed by San Diego County for the legislatively mandated Consolidated Handicapped and Disabled Students (HDS), HDS II, and Seriously Emotionally Disturbed Pupils (SEDP) Program (Chapter 1747, Statutes of 1984; Chapter 1274, Statutes of 1985; Chapter 1128, Statutes of 1994; and Chapter 654, Statutes of 1996) for the period of July 1, 2006, through June 30, 2009.

This revised final report supersedes our previous report dated March 7, 2012. Subsequent to the issuance of our final report, the California Department of Mental Health finalized its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) reimbursements for fiscal year (FY) 2008-09. We recalculated EPSDT revenues for FY 2008-09 and revised Finding 4 to reflect the actual funding percentages based on the final settlement. The revision has no fiscal effect on allowable total program costs for FY 2008-09.

The county claimed $14,484,766 ($14,494,766 less a $10,000 penalty for filing a late claim) for the mandated program. Our audit disclosed that $11,651,891 is allowable and $2,832,875 is unallowable. The costs are unallowable because the county overstated mental health services costs, administrative costs, and residential placement costs, duplicated due process hearing costs, and understated offsetting reimbursements. The State paid the county $4,106,959. The State will pay allowable costs claimed that exceed the amount paid, totaling $7,544,932, contingent upon available appropriations.

If you disagree with the audit findings, you may file an Incorrect Reduction Claim (IRC) with the Commission on State Mandates (CSM). The IRC must be filed within three years following the date that we notify you of a claim reduction. You may obtain IRC information at the CSM's website at www.csm.ca.gov/docs/IRCForm.pdf.

If you have any questions, please contact Jim L. Spano, Chief, Mandated Cost Audits Bureau, at (916) 323-5849.

Sincerely,

JEFFREY V. BROWNFIELD
Chief, Division of Audits

JVB/bf

cc: Jim Lardy, Finance Officer
Health and Human Services Agency
San Diego County
Alfredo Aguirre, Deputy Director
Mental Health Services
Health and Human Services Agency
San Diego County
Lisa Macchione, Senior Deputy Counsel
Finance and General Government
County Administration Center
San Diego County
Randall Ward, Principal Program Budget Analyst
Mandates Unit, Department of Finance
Carol Bingham, Director
Fiscal Policy Division
California Department of Education
Erika Cristo
Special Education Program
Department of Mental Health
Chris Essman, Manager
Special Education Division
California Department of Education
Jay Lal, Manager
Division of Accounting and Reporting
State Controller's Office

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Attachment—County's Response to Draft Audit Report

Revised Audit Report

Summary

The State Controller's Office audited the costs claimed by San Diego County for the legislatively mandated Consolidated Handicapped and Disabled Students (HDS), HDS II, and Seriously Emotionally Disturbed Pupils (SEDP) Program (Chapter 1747, Statutes of 1984; Chapter 1274, Statutes of 1985; Chapter 1128, Statutes of 1994; and Chapter 654 Statutes of 1996) for the period of July 1, 2006, through June 30, 2009.

The county claimed $14,484,766 ($14,494,766 less a $10,000 penalty for filing a late claim) for the mandated program. Our audit disclosed that $11,651,891 is allowable and $2,832,875 is unallowable. The costs are unallowable because the county overstated mental health services costs, administrative costs, and residential placement costs, duplicated due process hearing costs, and understated other reimbursements. The State paid the county $4,106,959. The State will pay allowable costs claimed that exceed the amount paid, totaling $7,544,932, contingent upon available appropriations.

Background

Handicapped and Disabled Students (HDS) Program

Chapter 26 of the Government Code, commencing with section 7570, and Welfare and Institutions Code section 5651 (added and amended by Chapter 1747, Statutes of 1984, and Chapter 1274, Statutes of 1985) require counties to participate in the mental health assessment for "individuals with exceptional needs," participate in the expanded "Individualized Education Program" (IEP) team, and provide case management services for "individuals with exceptional needs" who are designated as "seriously emotionally disturbed." These requirements impose a new program or higher level of service on counties.

On April 26, 1990, the Commission on State Mandates (CSM) adopted the statement of decision for the HDS Program and determined that this legislation imposed a state mandate reimbursable under Government Code section 17561. The CSM adopted the parameters and guidelines for the HDS Program on August 22, 1991, and last amended it on January 25, 2007.

The parameters and guidelines for the HDS Program state that only 10% of mental health treatment costs are reimbursable. However, on September 30, 2002, Assembly Bill 2781 (Chapter 1167, Statutes of 2002) changed the regulatory criteria by stating that the percentage of treatment costs claimed by counties for fiscal year (FY) 2000-01 and prior fiscal years is not subject to dispute by the SCO. Furthermore, this legislation states that, for claims filed in FY 2001-02 and thereafter, counties are not required to provide any share of these costs or to fund the cost of any part of these services with money received from the Local Revenue Fund established by Welfare and Institutions Code section 17600 et seq. (realignment funds).

Furthermore, Senate Bill 1895 (Chapter 493, Statutes of 2004) states that realignment funds used by counties for the HDS Program "are eligible for reimbursement from the state for all allowable costs to fund assessments, psychotherapy, and other mental health services" and that the finding by the Legislature is "declaratory of existing law" (emphasis added).

The CSM amended the parameters and guidelines for the HDS Program on January 26, 2006, and corrected them on July 21, 2006, allowing reimbursement for out-of-home residential placements beginning July 1, 2004.

Handicapped and Disabled Students (HDS) II Program

On May 26, 2005, the CSM adopted a statement of decision for the HDS II Program that incorporates the above legislation and further identified medication support as a reimbursable cost effective July 1, 2001. The CSM adopted the parameters and guidelines for this new program on December 9, 2005, and last amended them on October 26, 2006.

The parameters and guidelines for the HDS II Program state that "Some costs disallowed by the State Controller's Office in prior years are now reimbursable beginning July 1, 2001 (e.g., medication monitoring). Rather than claimants re-filing claims for those costs incurred beginning July 1, 2001, the State Controller's Office will reissue the audit reports." Consequently, we are allowing medication support costs commencing on July 1, 2001.

Seriously Emotionally Disturbed Pupils (SEDP) Program

Government Code section 7576 (added and amended by Chapter 654, Statutes of 1996) allows new fiscal and programmatic responsibilities for counties to provide mental health services to seriously emotionally disturbed pupils placed in out-of-state residential programs. Counties' fiscal and programmatic responsibilities include those set forth in California Code of Regulations section 60100, which provide that residential placements may be made out of state only when no in-state facility can meet the pupil's needs.

On May 25, 2000, the CSM adopted the statement of decision for the SEDP Program and determined that Chapter 654, Statutes of 1996, imposed a state mandate reimbursable under Government Code section 17561. The CSM adopted the parameters and guidelines for the SEDP Program on October 26, 2000. The CSM determined that the following activities are reimbursable:

- Payment of out-of-state residential placements;
- Case management of out-of-state residential placements (case management includes supervision of mental health treatment and monitoring of psychotropic medications);

- Travel to conduct quarterly face-to-face contacts at the residential facility to monitor level of care, supervision, and the provision of mental health services as required in the pupil's IEP; and
- Program management, which includes parent notifications as required; payment facilitation; and all other activities necessary to ensure that a county's out-of-state residential placement program meets the requirements of Government Code section 7576.

The CSM consolidated the parameters and guidelines for the HDS, HDS II, and SEDP Programs for costs incurred commencing with FY 2006-07 on October 26, 2006, and last amended them on September 28, 2012. On September 28, 2012, the CSM stated that Statutes of 2011, Chapter 43, "eliminated the mandated programs for counties and transferred responsibility to school districts, effective July 1, 2011. Thus, beginning July 1, 2011, these programs no longer constitute reimbursable state-mandated programs for counties." The consolidated program replaced the prior HDS, HDS II, and SEDP mandated programs. The parameters and guidelines establish the state mandate and define reimbursable criteria. In compliance with Government Code section 17558, the SCO issues claiming instructions to assist local agencies and school districts in claiming mandated program reimbursable costs.

Objective, Scope, and Methodology

We conducted the audit to determine whether costs claimed represent increased costs resulting from the Consolidated HDS, HDS II, and SEDP Program for the period of July 1, 2006, through June 30, 2009.

Our audit scope included, but was not limited to, determining whether costs claimed were supported by appropriate source documents, were not funded by another source, and were not unreasonable and/or excessive.

We conducted this performance audit under the authority of Government Code sections 12410, 17558.5, and 17561. We did not audit the county's financial statements. We conducted the audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We limited our review of the county's internal controls to gaining an understanding of the transaction flow and claim preparation process as necessary to develop appropriate auditing procedures.

Conclusion

Our audit disclosed instances of noncompliance with the requirements outlined above. These instances are described in the accompanying Summary of Program Costs (Schedule 1) and in the Findings and Recommendations section of this report.

For the audit period, San Diego County claimed $14,484,766 ($14,494,766 less a $10,000 penalty for filing a late claim) for costs of the Consolidated HDS, HDS II, and SEDP Program. Our audit disclosed that $11,651,891 is allowable and $2,832,875 is unallowable.

For the FY 2006-07 claim, the State paid the county $4,106,959. Our audit disclosed that $5,687,326 is allowable. The State will pay allowable costs claimed that exceed the amount paid, totaling $1,580,367, contingent upon available appropriations.

For the FY 2007-08 claim, the State made no payment to the county. Our audit disclosed that $5,964,565 is allowable. The State will pay allowable costs claimed that exceed the amount paid, totaling $5,964,565, contingent upon available appropriations.

For the FY 2008-09 claim, the State made no payment to the county. Our audit disclosed that claimed costs are unallowable.

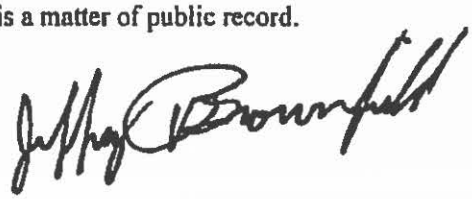
Views of Responsible Officials

We issued a draft audit report on February 6, 2012. Lisa Macchione, Senior Deputy County Counsel, responded by letter dated February 29, 2012 (Attachment), disagreeing with the audit results for Finding 2. The county did not respond to Findings 1, 3, and 4. We issued the final report on March 7, 2012.

Subsequently, we revised our audit report based on finalized Early and Periodic, Screening, Diagnosis and Treatment revenues for FY 2008-09. We recalculated offsetting reimbursements and revised Finding 4. The revision has no effect on allowable total program costs for FY 2008-09. On October 30, 2012, we advised Chona Penalba, Principal Accountant, Fiscal Services Division, of the revisions. This revised final report includes the county's response to our March 7, 2012, final report.

Restricted Use

This report is solely for the information and use of San Diego County, the California Department of Finance, and the SCO; it is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit distribution of this report, which is a matter of public record.



JEFFREY V. BROWNFIELD
Chief, Division of Audits

December 20, 2012

Revised Schedule 1—
Summary of Program Costs
July 1, 2006, through June 30, 2009

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment	Reference[1]
July 1 2006, through June 30, 2007				
Direct and indirect costs:[2]				
Referral and mental health assessments	$ 884,162	$ 880,170	$ (3,992)	Finding 1
Transfers and interim placements	1,923,625	1,890,217	(33,408)	Findings 1, 2
Authorize/issue payments to providers	5,802,928	4,741,441	(1,061,487)	Finding 2
Psychotherapy/other mental health services	7,868,926	7,837,430	(31,496)	Finding 1
Participation in due process hearings	5,330	-	(5,330)	Finding 3
Total direct and indirect costs	16,484,971	15,349,258	(1,135,713)	
Less offsetting reimbursements	(9,887,542)	(9,651,932)	235,610	Finding 4
Total claimed amount	6,597,429	5,697,326	(900,103)	
Less late claim penalty	(10,000)	(10,000)	-	
Total program cost	$ 6,587,429	5,687,326	$ (900,103)	
Less amount paid by State[3]		(4,106,959)		
Allowable costs claimed in excess of (less than) amount paid		$ 1,580,367		
July 1 2007, through June 30, 2008				
Direct and indirect costs:[2]				
Referral and mental health assessments	$ 1,040,292	$ 1,032,856	$ (7,436)	Finding 1
Transfers and interim placements	1,827,332	1,822,587	(4,745)	Findings 1, 2
Authorize/issue payments to providers	6,738,212	6,257,153	(481,059)	Finding 2
Psychotherapy/other mental health services	8,565,332	8,514,338	(50,994)	Finding 1
Participation in due process hearings	10,071	-	(10,071)	Finding 3
Total direct and indirect costs	18,181,239	17,626,934	(554,305)	
Less offsetting reimbursements	(11,589,942)	(11,662,369)	(72,427)	Finding 4
Total claimed amount	6,591,297	5,964,565	(626,732)	
Total program cost	$ 6,591,297	5,964,565	$ (626,732)	
Less amount paid by State[3]		-		
Allowable costs claimed in excess of (less than) amount paid		$ 5,964,565		
July 1 2008, through June 30, 2009				
Direct and indirect costs:[2]				
Referral and mental health assessments	$ 1,625,079	$ 1,207,589	$ (417,490)	Finding 1
Transfers and interim placements	722,633	548,944	(173,689)	Findings 1, 2
Authorize/issue payments to providers	6,224,038	6,125,362	(98,676)	Finding 2
Psychotherapy/other mental health services	9,749,679	9,198,502	(551,177)	Finding 1
Participation in due process hearings	46,636	46,636	-	
Total direct and indirect costs	18,368,065	17,127,033	(1,241,032)	
Less offsetting reimbursements	(17,062,025)	(17,382,168)	(320,143)	Finding 4
Total claimed amount	1,306,040	(255,135)	(1,561,175)	
Adjustment to eliminate negative balance	-	255,135	255,135	
Total program cost	$ 1,306,040	-	$(1,306,040)	
Less amount paid by State[3]		-		
Allowable costs claimed in excess of (less than) amount paid		$ -		

Revised Schedule 1 (continued)

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment	Reference[1]
Summary: July 1 2006 through June 30, 2009				
Direct and indirect costs:[2]				
Referral and mental health assessments	$ 3,549,533	$ 3,120,615	$ (428,918)	
Transfers and interim placements	4,473,590	4,261,748	(211,842)	
Authorize/issue payments to providers	18,765,178	17,123,956	(1,641,222)	
Psychotherapy/other mental health services	26,183,937	25,550,270	(633,667)	
Participation in due process hearings	62,037	46,636	(15,401)	
Total direct and indirect costs	53,034,275	50,103,225	(2,931,050)	
Less offsetting reimbursements	(38,539,509)	(38,696,469)	(156,960)	
Total claimed amount	14,494,766	11,406,756	(3,088,010)	
Adjustment to eliminate negative balance	-	255,135	255,135	
Less late claim penalty	(10,000)	(10,000)	-	
Total program cost	$ 14,484,766	11,651,891	$ (2,832,875)	
Less amount paid by State[3]		(4,106,959)		
Allowable costs claimed in excess of (less than) amount paid		$ 7,544,932		

[1] See the Findings and Recommendations section.

[2] The county incorrectly claimed indirect costs associated with each cost component under the direct cost component.

[3] County received Categorical payment from the California Department of Mental Health from FY 2009-10 budget.

Revised Findings and Recommendations

FINDING 1— Overstated mental health services unit costs and indirect (administrative) costs

The county overstated mental health services unit costs and indirect (administrative) costs by $1,261,745 for the audit period.

The county claimed mental health services costs to implement the mandated program that were not fully based on actual costs. The county determined its service costs based on preliminary units and rates. The county ran unit-of-service reports to support its claims. These reports did not fully support the units of service claimed and contained duplicated units and unallowable costs including crisis intervention, individual rehabilitation, group rehabilitation, family rehabilitation, and rehabilitation evaluation services.

The county claimed rehabilitation costs for individual rehabilitation, group rehabilitation, family rehabilitation, and rehabilitation evaluation services. The services are provided in accordance with a definition that includes a broad range of services, including certain fringe services such as social skills, daily living skills, meal preparation skills, personal hygiene, and grooming. Based on the Commission on State Mandate's (CSM) statement of decision dated May 26, 2011, the portions of rehabilitation services related to socialization are not reimbursable under the parameters and guidelines. The statement of decision relates to an incorrect reduction claim filed by Santa Clara County for the Handicapped and Disabled Students (HDS) Program. In light of the CSM decision, the county must separate the ineligible portions of the service. To date, the county has not provided our office with sufficient documentation to identify the eligible portion of claimed rehabilitation services.

We recalculated mental health services unit costs based on actual, supportable units of service provided to eligible clients using the appropriate unit rates that represented actual cost to the county. We excluded duplicated units and ineligible crisis intervention, individual rehabilitation, group rehabilitation, family rehabilitation, and rehabilitation evaluation services.

The county incorrectly capped its administrative rates at 15% and applied the rates to costs based on preliminary units and rates. For fiscal year (FY) 2007-08 and FY 2008-09 the county understated its administrative rate by incorrectly capping it at 15%. Additionally, the county incorrectly used FY 2007-08 data when computing its FY 2008-09 administrative rate.

We recalculated administrative cost rates using a method that is consistent with the cost reports submitted to the California Department of Mental Health (DMH) and by not capping the rates at 15%. We applied the rates to eligible direct costs.

The following table summarizes the overstated mental health services unit costs and indirect (administrative) costs claimed:

	Fiscal Year			
	2006-07	2007-08	2008-09	Total
Referral and mental health assessments				
Units of service/unit rates	$ (3,406)	$ (10,025)	$ (423,591)	$ (437,022)
Administrative costs	(586)	2,589	6,101	8,104
Total referral and mental health assessments	(3,992)	(7,436)	(417,490)	(428,918)
Transfers and interim placements				
Units of service/unit rates	(18,165)	(9,455)	(178,999)	(206,619)
Administrative costs	(2,561)	4,710	5,310	7,459
Total transfers and interim placements	(20,726)	(4,745)	(173,689)	(199,160)
Psychotherapy/other mental health services				
Rehabilitation costs	-	-	(129,585)	(129,585)
Units of service/unit rates	(27,089)	(52,308)	(425,730)	(505,127)
Administrative costs	(4,407)	1,314	4,138	1,045
Total psychotherapy/other mental health services	(31,496)	(50,994)	(551,177)	(633,667)
Audit adjustment	$ (56,214)	$ (63,175)	$ (1,142,356)	$ (1,261,745)

The program's parameters and guidelines specify that the State will reimburse only actual increased costs incurred to implement the mandated activities that are supported by source documents that show the validity of such costs. The parameters and guidelines do not identify crisis intervention as an eligible service.

The parameters and guidelines (section IV.H.) reference Title 2, *California Code of Regulations* (CCR), section 60020, subdivision (i), for reimbursable psychotherapy or other mental health treatment services. This regulation does not include socialization services. The CSM's May 26, 2011 statement of decision also states that the portion of the services provided that relate to socialization are not reimbursable.

The parameters and guidelines further specify that to the extent the DMH has not already compensated reimbursable administrative costs from categorical funding sources, the costs may be claimed.

Recommendation

In our previous final report dated March 7, 2012, we recommended the following:

- Ensure that only actual and supported costs for program-eligible clients are claimed in accordance with the mandate program.
- Compute indirect cost rates using a method that is consistent with the cost allocations in the cost report submitted to the DMH and apply administrative cost rates to eligible and supported direct costs.
- Apply all relevant administrative revenues to valid administrative costs.

No recommendation is applicable for this revised report as the consolidated program no longer is mandated.

County's Response

The county did not respond to the audit finding.

FINDING 2— Overstated residential placement costs

The county overstated residential placement costs by $1,653,904 for the audit period.

The county claimed board-and-care costs and mental health treatment "patch" costs for residential placements in out-of-state facilities that are operated on a for-profit basis. Only placements in facilities that are operated on a not-for-profit basis are eligible for reimbursement.

The county claimed board-and-care costs for clients incurred outside of the clients' authorization period. Only payments made for clients with a valid authorization for placement in a residential facility are eligible for reimbursement.

The county claimed board-and-care costs net of the California Department of Social Services reimbursement (40% state share). However, the county did not consider Local Revenue Funds applied to SED costs when computing its net costs.

We adjusted costs claimed for residential placements in out-of-state facilities that are operated on a for-profit basis, as well as costs associated with board-and-care costs for clients incurred outside of the clients' authorization period. Additionally, we applied Local Revenue Funds to eligible board-and-care costs in order to arrive at the county's net cost.

The following table summarizes the overstated residential placement costs claimed:

	Fiscal Year			
	2006-07	2007-08	2008-09	Total
Transfers and interim placements				
Local revenue funds	$ (12,682)	$ -	$ -	$ (12,682)
Total transfers and interim placements	(12,682)	-	-	$ (12,682)
Authorize/issue payments to providers				
Ineligible placements				
Board and care	(451,719)	(251,128)	(50,777)	(753,624)
Treatment	(373,380)	(215,136)	(44,955)	(633,471)
Local revenue funds	(217,649)	-	-	(217,649)
Unauthorized payments	(18,739)	(14,795)	(2,944)	(36,478)
Total authorize/issue payments to providers	(1,061,487)	(481,059)	(98,676)	(1,641,222)
Audit adjustment	$(1,074,169)	$(481,059)	$ (98,676)	$(1,653,904)

The parameters and guidelines (section IV.C.1) specify that the mandate is to reimburse counties for payments to vendors providing mental health services to pupils in out-of-state residential placements as specified in Government Code section 7576, and Title 2, CCR, sections 60100 and 60110.

Title 2, CCR, section 60100, subdivision (h), specifies that out-of-state residential placements shall be made only in residential programs that meet the requirements of Welfare and Institutions Code section 11460, subdivision (c)(2) through (3). Welfare and Institutions Code section 11460, subdivision (c)(3), states that reimbursement shall be paid only to a group home, organized, and operated on a nonprofit basis.

The parameters and guidelines (section IV.G.) reference Welfare and Institutions Code (WIC), section 18355.5, which prohibits a county from claiming reimbursement for its 60% share of the total residential and non-educational costs of a seriously emotionally disturbed child placed in an out-of-home residential facility if the county claims reimbursement for these costs from the Local Revenue Fund identified in WIC section 17600 and receives these funds.

Recommendation

In our previous final report dated March 7, 2012, we recommended the following:

> We recommend that the county take steps to ensure that:
>
> - Only actual and supported costs for program eligible clients are claimed in accordance with the mandate program.
> - It only claims out-of-state residential placements that are in agencies owned and operated on a non-profit basis.
> - Each residential placement has a valid authorization for placement.
> - Costs claimed are reduced by the portion funded with Local Revenue Funds.

No recommendation is applicable for this revised report as the consolidated program no longer is mandated.

County's Response

> The State's position is that the County overstated residential placement costs by $1,653,904 for the audit period; and the County disputes this finding. The County specifically disputes the finding that it claimed ineligible vendor payments of $1,387,095 (board and care costs of $753,624 and treatment costs of $633,471) for out-of-state residential placement of SED pupils owned and operated for profit [*sic*]. In support of its position, the State cites the California Code of Regulations, Title 2, section 60100, subdivision (h), which provides that out-of-state residential placements will be made only in residential programs that meet the requirements of Welfare and Institutions Code section 11460(c)(2) through (3). Welfare and Institutions Code section 11460(c)(3) provides that reimbursement will only be paid to a group home organized and operated on a nonprofit basis. The State also cites the parameters and guidelines in support of their position.

The County asserts that it is entitled to the entire amount claimed less the sum already paid by the State. Please see Summary of Program Costs for Out-of-State Residential Placements for Profit facilities for July 1, 2006 – June 30, 2009 attached hereto as Exhibit A-4. In support of its position, the County provides the following arguments and Exhibits A through C attached hereto.

1. California Law Prohibiting For-Profit Placements is Inconsistent with Both Federal Law, Which No Longer Has Such a Limitation, and With IDEA's "Most Appropriate Placement" Requirement.

In 1990, Congress enacted IDEA (20 U.S.C.S. § 1400-1487) pursuant to the Spending Clause (U.S. Const., art. I, § 8, cl. 1). According to Congress, the statutory purpose of IDEA is ". . . to assure that all children with disabilities have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs. . . ." 20 U.S.C. § 1400(d)(1)(A); *County of San Diego v. Cal. Special Educ. Hearing*, 93 F.3d 1458, 1461 (9th Cir. 1996).

To accomplish the purposes and goals of IDEA, the statute "provides federal funds to assist state and local agencies in educating children with disabilities but conditions such funding on compliance with certain goals and procedures." *Ojai Unified School Dist. v. Jackson*, 4 F.3d 1467, 1469 (9th Cir. 1993); see *Ciresoli v. M.S.A.D. No. 22*, 901 F. Supp. 378, 281 (D.Me. 1995). All 50 states currently receive IDEA funding and therefore must comply with IDEA. *County of L.A. v. Smith*, 74 Cal. App. 4th 500, 508 (1999).

IDEA defines "special education" to include instruction conducted in hospitals and institutions. If placement in a public or private residential program is necessary to provide special education, regulations require that the program must be provided at no cost to the parents of the child. 34 C.F.R. § 300.302 (2000). Thus, IDEA requires that a state pay for a disabled student's residential placement when necessary. *Indep. Schl. Dist. No. 284 v. A.C.*, 258 F. 3d 769 (8th Cir. 2001). Local educational agencies (LEA) initially were responsible for providing all the necessary services to special education children (including mental health services), but Assembly Bill 3632/882 shifted responsibility for providing special education mental health services to the counties.

Federal law initially required residential placements to be in nonprofit facilities. In 1997, however, the federal requirements changed to remove any reference to the tax identification (profit/nonprofit) status of an appropriate residential placement as follows: Section 501 of the Personal Responsibility and Work Opportunity Responsibility Act of 1996 states, Section 472(c)(2) of the Social Security Act (42 U.S.C. 672(c)(2) is amended by striking "nonprofit." That section currently states:

"The term 'child-care institution' means a private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the

standards established for such licensing, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent."

The California Code of Regulations, title 2, section 60100, subdivision (h) and Welfare and Institutions Code section 11460(c)(2) through (3) are therefore inconsistent with the Social Security Act as referenced above, as well as inconsistent with a primary principle of IDEA as described below.

IDEA "was intended to ensure that children with disabilities receive an education that is both appropriate and free." *Florence County School District Four v. Carter*, 510 U.S. 7, 13, 126 L. Ed. 2d 284, 114 S. Ct. 361 (1993). A "free appropriate public education" (FAPE) includes both instruction and "related services" as may be required to assist a child with a disability. 20 U.S.C. § 1401 (22). Both instruction and related services, including residential placement, must be specially designed to suit the needs of the individual child. 20 U.S.C. §1401(25). The most appropriate residential placement specially designed to meet the needs of an individual child may not necessarily be one that is operated on a nonprofit basis. Consequently, to limit the field of appropriate placements for a special education student would be contrary to the FAPE requirement referenced above. Counties and students cannot be limited by such restrictions because the most appropriate placement for a student may not have a nonprofit status. This need for flexibility becomes most pronounced when a county is seeking to place a student in an out-of-state facility which is the most restrictive level of care. Such students have typically failed California programs and require a more specialized program that may not necessarily be nonprofit.

In contrast to the restrictions placed on counties with respect to placement in nonprofits, LEAs are not limited to accessing only nonprofit educational programs for special education students. When special education students are placed in residential programs, out-of-state LEAs may utilize the services provided by certified nonpublic, nonsectarian schools and agencies that are for profit. See Educ. Code § 56366.1. These nonpublic schools become certified by the state of California because they meet the requirements set forth in Education Code sections 56365 *et seq*. Theses [sic] requirements do not include nonprofit status, but rather, among other things, the ability to provide special education and designated instruction to individuals with exceptional needs which includes having qualified licensed and credentialed staff. LEAs monitor the out-of-state nonpublic schools through the Individualized Education Program process and are also required to monitor these schools annually which may include a site visit. Consequently, counties and LEAs should not be subject to different criteria when seeking a placement in out-of-state facilities for a special education student. Consistent with federal law, counties must have the ability to place students in the most appropriate educational environment out-of-state and not be constrained by nonprofit status.

2. Parents Can be Reimbursed When Placing Students in Appropriate For-Profit Out-of-State Facilities. County Mental Health Agencies Are Subject to Increased Litigation Without the Same Ability to Place Seriously Emotionally Disturbed Students in Appropriate For-Profit Out-of-State Facilities.

In *Florence County School District Four, et al. v. Shannon Carter*, 510 U.S. 7, 114 S.Ct. 361 (1993), the U.S. Supreme Court found that although the parents placed their child in a private school that did not meet state education standards and was not state approved, they were entitled to reimbursement because the placement was found to be appropriate under IDEA. The parents in *Carter* placed their child in a private school because the public school she was attending provided an inappropriate education under IDEA.

In California, if counties are unable to access for profit out-of-state programs, they may not be able to offer an appropriate placement for a child that has a high level of unique mental health needs that may only be treated by a specialized program. If that program is for profit, that county will therefore be subject to potential litigation from parents who through litigation may access the appropriate program for their child regardless of for profit or nonprofit status.

County Mental Health Agencies recommend out-of-state residential programs for special education students only after in state alternatives have been considered and are not found to meet the child's needs. See Covet Code §§ 7572.5 and 7572.55. As described in Sections 7572.5 and 7275.55, such decisions are not made hastily and require levels of documented review, including consensus from the special education student's individualized education program team. Further, when students require the most restrictive educational environment, their needs are great and unique. Consistent with IDEA, counties should be able to place special education students in the most appropriate program that meets their unique needs without consideration for the programs for profit or nonprofit status so that students are placed appropriately and counties are not subject to needless litigation.

3. The State of California Office of Administrative Hearings Special Education Division (OAH) has Ordered a County Mental Health Agency to Fund an Out-of-State For-Profit Residential Facility When no Other Appropriate Residential Placement is Available to Provide Student a FAPE.

In *Student v. Riverside Unified School District and Riverside County Department of Mental Health*, OAH Case No. N 2007090403, OAH ordered the Riverside County Department of Mental Health (RCDMH) and the Riverside Unified School District to fund the placement of a student with a primary disability of emotional disturbance with a secondary disability of deafness in an out-of-state for-profit residential facility because there was no other appropriate facility available to provide the Student a FAPE. A copy of *Student v. Riverside Unified School District and Riverside County Department of Mental Health*, OAH Case No. N 2007090403 is attached hereto as Exhibit B for your convenience. In the *Riverside* case, the Administrative Law Judge (ALJ) concluded that Section 60100 subdivision (h) of title 2 of the California Code of Regulations is "inconsistent with the federal statutory and regulatory law by which California has chosen to abide." The ALJ further concluded in her opinion that:

"California education law itself mandates a contrary response to Welfare and Institutions code section 11460, subdivision (c) (3), where no other placement exists for a child. Specifically, "It is the further intent of the legislature that this part does not abrogate any rights provided to individuals with exceptional needs and their parents or guardians under the federal Individuals with Disabilities Education

Act." (Ed.Code § 56000, subd. (e) (Feb. 2007).) A contrary result would frustrate the core purpose of the IDEA and the companion state law, and would prevent student from accessing educational opportunities."

Consequently, it is clear the ALJ agrees that there is a conflict that exists between state and federal law when there are no appropriate residential placements for a student that are nonprofit and that the right of the student to access a FAPE must prevail.

4. County Contracted with Nonprofit Out-of-State Residential Program for SED Pupils.

During the audit period, the County contracted with Mental Health Systems, Inc. (Provo Canyon School) the provider of the out-of-state residential services that are the subject of the proposed disallowance that the county disputes in this Response. As referenced in the April 28, 2007 letter from the Internal Revenue Service (attached hereto as Exhibit C) Mental Health Systems, Inc. (Provo Canyon School) is a nonprofit entity. The County contracted with this provider in a manner consistent with the requirements of the California Code of Regulations and Welfare and Institutions Code referenced above. The State never provided any guidance to counties as to how to access or contract with appropriate out-of-state facilities that meet State criteria or qualifications. The State never provided counties a list of appropriate out-of-state facilities that meet State requirements. County should not be penalized now for fulfilling the requirements of the law with little or no guidance from the State.

5. There are no Requirements in Federal or State Law Regarding the Tax Identification Status of Mental Health Treatment Services Providers. Thus, There are No Grounds to Disallow the County's Treatment Costs.

Government Code section 7572 (c) provides that "Psychotherapy and other mental health assessments shall be conducted by qualified mental health professionals as specified in regulations developed by the State Department of Mental Health in consultation with the State Department of Education. . . ." The California Code of Regulations, title 2, division 9, chapter 1, article 1, section 60020 (i) and (j) further describe the type of mental health services to be provided in the program as well as who shall provide those services to special education pupils. There is no mention that the providers have a nonprofit or for profit status. The requirements are that the services "shall be provided directly or by contract at the discretion of the community mental health service of the county of origin" and that the services are provided by "qualified mental health professionals." Qualified mental health professionals include licensed practitioners of the healing arts such as: psychiatrists, psychologists, clinical social workers, marriage, family and child counselors, registered nurses, mental health rehabilitation specialists and others who have been waivered under Section 5751.2 of the Welfare and Institutions Code. The County has complied with all these requirements. Consequently, because there is no legal requirement that treatment services be provided by nonprofit entities the State cannot and shall not disallow the treatment costs.

SCO's Comment

The finding remains unchanged. The residential placement issue is not unique to this county; other counties are concerned about it as well. In 2008 the proponents of Assembly Bill (AB) 1805 sought to change the California regulations and allow payments to for-profit facilities for placement of SED pupils. This legislation would have permitted retroactive application, so that any prior unallowable claimed costs identified by the SCO would be reinstated. However, the Governor vetoed this legislation on September 30, 2008. In the next legislative session, AB 421, a bill similar to AB 1805, was introduced to change the regulations and allow payments to for-profit facilities for placement of SED pupils. On January 31, 2010, AB 421 failed passage in the Assembly. Absent any legislative resolution, counties must continue to comply with the governing regulations cited in the SED Pupils: Out-of-State Mental Health Services Program's parameters and guidelines. Our response addresses each of the five arguments set forth by the county in the order identified above.

1. **California law prohibiting for-profit placements is inconsistent with both federal law, which no longer has such a limitation, and with IDEA's "most appropriate placement" requirement.**

   The parameters and guidelines (section IV.C.1.) specify that the mandate is to reimburse counties for payments to service vendors providing mental health services to SED pupils in out-of-state residential placements as specified in Government Code section 7576 and Title 2, *California Code of Regulations* (CCR), sections 60100 and 60110. Title 2, CCR, section 60100, subdivision (h), specifies that out-of-state residential placements shall be made only in residential programs that meet the requirements of Welfare and Institutions Code section 11460, subdivision (c)(2) through (3). Welfare and Institutions Code section 11460, subdivision (c)(3), states that reimbursement shall only be paid to a group home organized and operated on a nonprofit basis. The program's parameters and guidelines do not provide reimbursement for out-of-state residential placements made outside of the regulation.

   We agree that there is inconsistency between the California law and federal law related to IDEA funds. Furthermore, we do not dispute the assertion that California law is more restrictive than federal law in terms of out-of-state residential placement of SED pupils; however, the fact remains that this is a State-mandated cost program and the county filed a claim seeking reimbursement from the State under the provisions of Title 2, CCR, section 60100.

   We also agree that Education Code sections 56366.1 and 56365 do not restrict local educational agencies (LEAs) from contracting with for-profit schools for educational services. These sections specify that educational services must be provided by a school certified by the California Department of Education.

2. **Parents can be reimbursed when placing students in appropriate for-profit out-of-state facilities. County mental health agencies will be subject to increased litigation without the same ability to place seriously emotionally disturbed students in appropriate for-profit out-of-state facilities.**

   Refer to previous comment.

3. **The State of California Office of Administrative Hearings Special Education Division (OAH) has ordered a county mental health agency to fund an out-of-state for-profit residential facility when no other appropriate residential placement is available to provide student a FAPE.**

   Office of Administrative Hearings (OAH) Case No. N 2007090403 is not precedent-setting and has no legal bearing. In this case, the administrative law judge found that not placing the student in an appropriate facility (for-profit) was to deny the student a free appropriate public education (FAPE) under federal regulations. The issue of funding residential placements made outside of the regulation was not specifically addressed in the case. Nevertheless, the fact remains that this is a State-mandated cost program and the county filed a claim seeking reimbursement from the State under the provisions of Title 2, CCR, section 60100, and Welfare and Institutions Code section 11460, subdivision (c)(3). Residential placements made outside of the regulation are not reimbursable under the State-mandated cost program.

4. **County contracted with nonprofit out-of-state residential program for SED pupils.**

   As noted in the finding, the mandate reimburses counties for payments to service vendors (group homes) providing mental health services to SED pupils in out-of-state residential placements that are organized and operated on a nonprofit basis. Based on documents the county provided us in the course of the audit, we determined that Mental Health Systems, Inc., a California nonprofit corporation, contracted with Charter Provo Canyon School, a Delaware for-profit limited liability company, to provide out-of-state residential placement services. The referenced Provo Canyon, Utah residential facility was not organized and operated on a nonprofit basis until its Articles of Incorporation as a nonprofit entity in the state of Utah were approved on January 6, 2009. We only allowed costs incurred by the county for residential placements made at the Provo Canyon facility when it became a nonprofit.

5. **There are no requirements in federal or state law regarding the tax identification status of mental health treatment services providers. Thus, there are no grounds to disallow the county's treatment costs.**

   We do not dispute that Government Code section 7572 requires mental health services to be provided by qualified mental health professionals. As noted in the finding and our previous response, the

mandate reimburses counties for payments to service vendors (group homes) providing mental health services to SED pupils in out-of-state residential placements that are organized and operated on a nonprofit basis. The unallowable treatment and board-and-care vendor payments claimed result from the county placement of clients in non-reimbursable out-of-state residential facilities. The program's parameters and guidelines do not include a provision for the county to be reimbursed for vendor payments made to out-of-state residential placements outside of the regulation.

FINDING 3— Duplicate due process hearing costs

The county claimed $15,401 in duplicate due process hearing costs for the audit period.

The county claimed allowable due process hearing costs. For FY 2006-07 and FY 2007-08 the county included these costs in the pool of direct costs used to compute the unit rates in the county's cost reports submitted to the DMH. Consequently, due process hearing costs claimed for FY 2006-07 and FY 2007-08 were also allocated through the unit rates to various mental health programs, including the Consolidated HDS, HDS II, and SEDP Program claims. Allowing the FY 2006-07 and FY 2007-08 due process hearing costs would result in duplicate reimbursement.

We did not allow the claimed FY 2006-07 and FY 2007-08 due process hearing costs because they resulted in a duplication of claimed costs.

The following table summarizes the duplicated due process hearing costs claimed:

	Fiscal Year			
	2006-07	2007-08	2008-09	Total
Participation in due process hearings	$ (5,330)	$ (10,071)	$ -	$ (15,401)
Audit adjustment	$ (5,330)	$ (10,071)	$ -	$ (15,401)

The parameters and guidelines specify that the State will reimburse only actual increased costs incurred to implement the mandated activities and supported by source documents that show the validity of such costs.

Recommendation

In our previous final report dated March 7, 2012, we recommended the following:

> We recommend that the county ensure that only actual and supported costs for program-eligible clients are claimed in accordance with the mandate program. Furthermore, we recommend that the county only claim reimbursement for allowable direct costs that are not included as a part of its total cost used to compute the unit rates.

No recommendation is applicable for this revised report as the consolidated program no longer is mandated.

County's Response

The county did not respond to the audit finding.

FINDING 4— Understated offsetting reimbursements

The county understated other reimbursements by $156,960 for the audit period.

The county understated Individuals with Disabilities Education Act (IDEA) grant reimbursements for the audit period, and DMH Categorical grant reimbursements for FY 2008-09, by claiming preliminary grant amounts.

The county overstated Short-Doyle/Medi-Cal Federal Financing Participation Funds (SD/MC FFP), and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) reimbursements by applying the funding shares to service costs not fully based on actual costs. The county determined its service costs based on preliminary units and rates. The county ran unit-of-service reports to support its claims. These reports did not fully support the units of service claimed and contained duplicate units and unallowable costs including crisis intervention, individual rehabilitation, group rehabilitation, family rehabilitation, and rehabilitation-evaluation services.

The county claimed costs for individual rehabilitation, group rehabilitation, family rehabilitation, and rehabilitation-evaluation services that may include ineligible socialization services that are not reimbursable under the parameters and guidelines. Based on the CSM's statement of decision dated May 26, 2011, the portions of rehabilitation services related to socialization are not reimbursable under the parameters and guidelines. The county must separate the ineligible portions of the rehabilitation service. To date, the county has not provided our office with any documentation to identify the eligible portion of claimed rehabilitation services. Therefore, we are excluding the portion of reimbursements that relate to claimed rehabilitation services.

The following table summarizes the overstated offsetting reimbursements claimed:

	Fiscal Year			
	2006-07	2007-08	2008-09	Total
IDEA	$ 202,469	$ (90,847)	$ (487,781)	$ (376,159)
DMH Categorical payment	-	-	(406,984)	(406,984)
SD/MC FFP:				
Rehabilitation costs			48,090	48,090
Units of service/unit rates	(11,373)	(17,438)	11,132	(17,679)
EPSDT:				
Rehabilitation costs			24,326	24,326
Units of service/unit rates	44,514	35,858	491,074	571,446
Total other reimbursements	$ 235,610	$ (72,427)	$ (320,143)	$ (156,960)

The parameters and guidelines specify that any direct payments (Categorical funds, SD/MC FFP, EPSDT, IDEA, and other offsets such as private insurance) received from the State that are specifically allocated to the program, and/or any other reimbursement received as a result of the mandate, must be deducted from the claim.

Recommendation

In our previous final report dated March 7, 2012, we recommended the following:

> We recommend that the county ensure that appropriate revenues are identified and applied to valid costs.

No recommendation is applicable for this revised report as the consolidated program no longer is mandated.

County's Response

The county did not respond to the audit finding.

SCO's Comment

Subsequent to the issuance of our final report on March 7, 2012, the DMH issued its EPSDT settlement for FY 2008-09. We recalculated offsetting reimbursements and revised Finding 4 to reflect the actual funding percentage. As a result, the finding was reduced by $184,731.

Attachment—
County's Response to
Draft Audit Report

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February 29, 2012

Jim L. Spano, Chief, Mandated Cost Audits Bureau
California State Controller's Office
Division of Audits
Post Office Box 942850
Sacramento, California 94250-5874

Re: Response to Consolidated Handicapped and Disabled Students (HDS), HDS II, and SEDP Program Audit for the Period of July 1, 2006 through June 30, 2009

Dear Mr. Spano:

The County of San Diego (County) is in receipt of the State Controller's Office draft audit report of the costs claimed by County for the legislatively mandated Consolidated Handicapped and Disabled Students (HDS), HDS II, and SEDP Program Audit for the Period of July 1, 2006 through June 30, 2009. The County received the report on February 7, 2012 and received an extension from Mr. Jim L. Spano, Chief, Mandated Audits Bureau to submit its response to the report on or before February 29, 2012. The County is submitting this response and its management representation letter in compliance with that extension on February 29, 2012.

As directed in the draft report, the County's response will address the accuracy of the audit findings. There were four Findings in the above-referenced Draft Report and the County disputes Finding 2 – Overstated Residential Placement Costs. The County claimed $14,484,766 for the mandated programs for the audit period and $4,106,959 has already been paid by the State. The State Controller's Office's audit found that $11,651,891 is allowable and $2,832,875 is unallowable. The unallowable costs as determined by State Controller's Office occurred primarily because the State alleges the County overstated residential placement costs by $1,653,904 (the County disputes

$1,387,095) for the audit period. As stated above, the County disputes Finding 2 and asserts that $1,387,095 are allowable costs that are due the County for the audit period.

If you have any questions please contact Lisa Macchione, Senior Deputy County Counsel at (619) 531-6296.

Very truly yours,

THOMAS E. MONTGOMERY, County Counsel

By L. M. Macchione
LISA M. MACCHIONE, Senior Deputy

LMM:vf
11-01866
Encs.

COUNTY OF SAN DIEGO'S RESPONSE TO LEGISLATIVELY MANDATED CONSOLIDATED HANDICAPPED AND DISABLED STUDENTS (HDS), HDS II, AND SERIOUSLY EMOTIONALLY DISTURBED PUPILS (SEDP) PROGRAM AUDIT FOR THE PERIOD OF JULY 1, 2006 THROUGH JUNE 30, 2009

Summary

The State Controller's Office audited the costs claimed by County for the legislatively mandated Consolidated handicapped and Disabled Students (HDS), HDS II, and Seriously Emotionally Disturbed Pupils (SEDP) Program for the period of July 1, 2006 through June 30, 2009. The County claimed $14,484,766 for the mandated program, and the State found $11,651,891 is allowable and $2,832,875 is unallowable. The State alleges that the unallowable costs occurred because the County overstated mental health services costs, administrative costs, and residential placement costs, duplicated due process hearing costs, and understated other reimbursements. The State has broken down the unallowable costs claimed into four findings. The County disputes the second finding regarding the alleged overstated residential placement costs and does not dispute the first finding relating to overstated mental health services unit costs and indirect (administrative) costs, the third finding relating to duplicate due process hearing costs or the fourth finding relating to understated other reimbursements.

The County disputes Finding 2 – overstated residential placement costs - because the California Code of Regulations section 60100(h) and Welfare and Institutions Code section 11460(c)(3) cited by the State are in conflict with provisions of federal law, including the Individuals with Disabilities Education Act (IDEA) and Section 472(c)(2) of the Social Security Act (42 U.S.C.672 (c)(2).

Response To Finding 2 – Overstated Residential Placement Costs

The State's position is that the County overstated residential placement costs by $1,653,904 for the audit period; and the County disputes this finding. The County specifically disputes the finding that it claimed ineligible vendor payments of $1,387,095.00 (board and care costs of $753,624 and treatment costs of $633,471) for out-of-state residential placement of SED pupils owned and operated for profit. In support of its position, the State cites the California Code of Regulations, Title 2, section 60100, subdivision (h), which provides that out-of-state residential placements will be made only in residential programs that meet the requirements of Welfare and Institutions Code section 11460(c)(2) through (3). Welfare and Institutions Code section 11460(c) (3) provides that reimbursement will only be paid to a group home organized and operated on a nonprofit basis. The State also cites the parameters and guidelines in support of their position.

The County asserts that it is entitled to the entire amount claimed less the sum already paid by the State. Please see Summary of Program Costs for Out-of-State Residential Placements for Profit facilities for July 1, 2006 - June 30, 2009 attached hereto as Exhibit A-4.

In support of its position, the County provides the following arguments and Exhibits A through C attached hereto.[1]

1. California Law Prohibiting For-Profit Placements is Inconsistent with Both Federal Law, Which Does Not Have Such a Limitation, and With IDEA's "Most Appropriate Placement" Requirement.

In 1990, Congress enacted IDEA (20 U.S.C.S. § 1400-1487) pursuant to the Spending Clause (U.S. Const., art. I, § 8, cl. 1). According to Congress, the statutory purpose of IDEA is ". . . to assure that all children with disabilities have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs. . . ." 20 U.S.C. § 1400(d)(1)(A); *County of San Diego v. Cal. Special Educ. Hearing*, 93 F.3d 1458, 1461 (9th Cir. 1996).

To accomplish the purposes and goals of IDEA, the statute "provides federal funds to assist state and local agencies in educating children with disabilities but conditions such funding on compliance with certain goals and procedures." *Ojai Unified School Dist. v. Jackson*, 4 F.3d 1467, 1469 (9th Cir. 1993); see *Ciresoli v. M.S.A.D. No. 22*, 901 F. Supp. 378, 381 (D.Me. 1995). All 50 states currently receive IDEA funding and therefore must comply with IDEA. *County of L.A. v. Smith*, 74 Cal. App. 4th 500, 508 (1999).

IDEA defines "special education" to include instruction conducted in hospitals and institutions. If placement in a public or private residential program is necessary to provide special education, regulations require that the program must be provided at no cost to the parents of the child. 34 C.F.R. § 300.302 (2000). Thus, IDEA requires that a state pay for a disabled student's residential placement when necessary. *Indep. Schl. Dist. No. 284 v. A.C.*, 258 F. 3d 769 (8th Cir. 2001). Local educational agencies (LEA) initially were responsible for providing all the necessary services to special education children (including mental health services), but Assembly Bill 3632/882 shifted responsibility for providing special education mental health services to the counties.

Federal law initially required residential placements to be in nonprofit facilities. In 1997, however, the federal requirements changed to remove any reference to the tax identification (profit/nonprofit) status of an appropriate residential placement as follows: Section 501 of the Personal Responsibility and Work Opportunity Responsibility Act of 1996 states, Section 472(c)(2) of the Social Security Act (42 U.S.C. 672(c)(2) is amended by striking "nonprofit." That section currently states:

---

[1] County acknowledges that as of July 1, 2011 the various sections of the Government Code, Welfare and Institutions Code, Education Code and Family Code mandating that counties provide educationally related mental health services to students on individualized education plans ("IEP") became inoperative and as of January 1, 2012 these sections were repealed. It should be made clear, however, that counties were still mandated to provide educationally related mental health services to eligible students on IEPs during the audit period and therefore, all arguments made within this audit response are relevant and valid for the audit period.

> "The term 'child-care institution' means a private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent."

The California Code of Regulations, title 2, section 60100, subdivision (h) and Welfare and Institutions Code section 11460(o)(2) through (3) are therefore inconsistent with the Social Security Act as referenced above, as well as inconsistent with a primary principle of IDEA as described below.

IDEA "was intended to ensure that children with disabilities receive an education that is both appropriate and free." *Florence County School District Four* v. Carter, 510 U.S. 7, 13, 126 L. Ed. 2d 284, 114 S. Ct. 361 (1993). A "free appropriate public education" (FAPE) includes both instruction and "related services" as may be required to assist a child with a disability. 20 U.S.C. § 1401 (22). Both instruction and related services, including residential placement, must be specially designed to suit the needs of the individual child. 20 U.S.C. § 1401(25). The most appropriate residential placement specially designed to meet the needs of an individual child may not necessarily be one that is operated on a nonprofit basis. Consequently, to limit the field of appropriate placements for a special education student would be contrary to the FAPE requirement referenced above. Counties and students cannot be limited by such restrictions because the most appropriate placement for a student may not have a nonprofit status. This need for flexibility becomes most pronounced when a county is seeking to place a student in an out-of-state facility which is the most restrictive level of care. Such students have typically failed California programs and require a more specialized program that may not necessarily be nonprofit.

In contrast to the restrictions placed on counties with respect to placement in nonprofits, LEAs are not limited to accessing only nonprofit educational programs for special education students. When special education students are placed in residential programs, out-of-state LEAs may utilize the services provided by certified nonpublic, nonsectarian schools and agencies that are for profit. See Educ. Code § 56366.1. These nonpublic schools become certified by the state of California because they meet the requirements set forth in Education Code sections 56365 *et seq*. Theses requirements do not include nonprofit status, but rather, among other things, the ability to provide special education and designated instruction to individuals with exceptional needs which includes having qualified licensed and credentialed staff. LEAs monitor the out-of-state nonpublic schools through the Individualized Education Program process and are also required to monitor these schools annually which may include a site visit. Consequently, counties and LEAs should not be subject to different criteria when seeking a placement in out-of state facilities for a special education student. Consistent with federal law, counties must have the ability to place students in the most appropriate educational environment out-of state and not be constrained by nonprofit status.

2. **Parents Can be Reimbursed When Placing Students in Appropriate For-Profit Out-of-State Facilities. County Mental Health Agencies Are Subject to Increased Litigation Without the Same Ability to Place Seriously Emotionally Disturbed Students in Appropriate For-Profit Out-of-State Facilities.**

In *Florence County School District Four, et al. v. Shannon Carter*, 510 U.S. 7, 114 S.Ct. 361 (1993), the U.S. Supreme Court found that although the parents placed their child in a private school that did not meet state education standards and was not state approved, they were entitled to reimbursement because the placement was found to be appropriate under IDEA. The parents in *Carter* placed their child in a private school because the public school she was attending provided an inappropriate education under IDEA.

In California, if counties are unable to access for profit out-of-state programs, they may not be able to offer an appropriate placement for a child that has a high level of unique mental health needs that may only be treated by a specialized program. If that program is for profit, that county is therefore subject to potential litigation from parents who through litigation may access the appropriate program for their child regardless of for profit or nonprofit status.

County Mental Health Agencies recommend out-of state residential programs for special education students only after in state alternatives have been considered and are not found to meet the child's needs. See Gov't Code §§ 7572.5 and 7572.55. As described in Sections 7572.5 and 7275.55, such decisions are not made hastily and require levels of documented review, including consensus from the special education student's individualized education program team. Further, when students require the most restrictive educational environment, their needs are great and unique. Consistent with IDEA, counties should be able to place special education students in the most appropriate program that meets their unique needs without consideration for the programs for profit or nonprofit status so that students are placed appropriately and counties are not subject to needless litigation.

3. **The State of California Office of Administrative Hearings Special Education Division (OAH) has Ordered a County Mental Health Agency to Fund an Out-of-State For-Profit Residential Facility When no Other Appropriate Residential Placement is Available to Provide Student a FAPE.**

In Student *v. Riverside Unified School District and Riverside County Department of Mental Health*, OAH Case No. N 2007090403, OAH ordered the Riverside County Department of Mental Health (RCDMH) and the Riverside Unified School District to fund the placement of a student with a primary disability of emotional disturbance with a secondary disability of deafness in an out-of-state for-profit residential facility because there was no other appropriate facility available to provide the Student a FAPE. A copy of *Student v. Riverside Unified School District and Riverside County Department of Mental Health*, OAH Case No. N 2007090403 is attached hereto as Exhibit B for your convenience. In the *Riverside* case, the Administrative Law Judge (ALJ) concluded that Section 60100 subdivision (h) of title 2 of the California Code

of Regulations is "inconsistent with the federal statutory and regulatory law by which California has chosen to abide." The ALJ further concluded in her opinion that:

> "California education law itself mandates a contrary response to Welfare and Institutions code section 11460, subdivision (c) (3), where no other placement exists for a child. Specifically, "It is the further intent of the legislature that this part does not abrogate any rights provided to individuals with exceptional needs and their parents or guardians under the federal Individuals with Disabilities Education Act." (Ed.Code § 56000, subd. (e) (Feb. 2007).) A contrary result would frustrate the core purpose of the IDEA and the companion state law, and would prevent student from accessing educational opportunities."

Consequently, it is clear the ALJ agrees that there is a conflict that exists between state and federal law when there are no appropriate residential placements for a student that are nonprofit and that the right of the student to access a FAPE must prevail.

4. County Contracted with Nonprofit Out-of-State Residential Program for SED Pupils.

During the audit period, the County contracted with Mental Health Systems, Inc. (Provo Canyon School) the provider of the out-of-state residential services that are the subject of the proposed disallowance that the County disputes in this Response. As referenced in the April 28, 2007 letter from the Internal Revenue Service (attached hereto as Exhibit C) Mental Health Systems, Inc. (Provo Canyon School) is a nonprofit entity. The County contracted with this provider in a manner consistent with the requirements of the California Code of Regulations and Welfare and Institutions Code referenced above. The State never provided any guidance to counties as to how to access or contract with appropriate out-of-state facilities that meet State criteria or qualifications. The State never provided counties a list of appropriate out-of-state facilities that meet State requirements. County should not be penalized now for fulfilling the requirements of the law with little or no guidance from the State.

5. There are no Requirements in Federal or State Law Regarding the Tax Identification Status of Mental Health Treatment Services Providers. Thus, There are No Grounds to Disallow the County's Treatment Costs.

Government Code section 7572 (c) provides that "Psychotherapy and other mental health assessments shall be conducted by qualified mental health professionals as specified in regulations developed by the State Department of Mental Health in consultation with the State Department of Education. . . ." The California Code of Regulations, title 2, division 9, chapter 1, article 1, section 60020 (i) and (j) further describe the type of mental health services to be provided in the program as well as who shall provide those services to special education pupils. There is no mention that the providers have a nonprofit or for profit status. The requirements are that the services "shall be provided directly or by contract at the discretion of the community mental health service of the county of origin" and that the services are provided by "qualified

mental health professionals." Qualified mental health professionals include licensed practitioners of the healing arts such as: psychiatrists, psychologists, clinical social workers, marriage, family and child counselors, registered nurses, mental health rehabilitation specialists and others who have been waivered under Section 5751.2 of the Welfare and Institutions Code. The County has complied with all these requirements. Consequently, because there is no legal requirement that treatment services be provided by nonprofit entities the State cannot and shall not disallow the treatment costs.

Conclusion

In conclusion, the County asserts that the costs of $1,387,095.00 as set forth in Exhibits A-1 through A-4 should be allowed.

Dated: February 29, 2012

Respectfully submitted,

THOMAS E. MONTGOMERY, County Counsel

By

LISA M. MACCHIONE, Senior Deputy
Attorneys for the County of San Diego

Summary of July 01 2006- June 30 2007	Actual Costs Claimed	Allowable	Adjustments
Direct and Indirect Costs:			
Referral and mental health assessments	$ 884,162	$ 880,170	$ (3,992)
Transfers and interim placements	$ 1,923,825	$ 1,890,217	$ (33,408)
Psychotherapy /other mental health services	$ 7,868,926	$ 7,837,430	$ (31,496)
Authorize/else payments to providers:			$ -
Vendor Reimbursement	$ 5,768,131	[redacted]	$ (1,081,487)
Travel	$ 14,797	$ 14,797	$ -
Participation in due process hearings	$ 6,330	$ -	$ (6,330)
Sub-Total program costs	$ 16,464,971	$ 15,349,258.00	$ (1,135,713)
Less: Other reimbursements	$ (9,887,542)	$ (9,651,932)	$ 235,610
Total claimed amount	$ 6,597,429	$ 5,697,326	$ (900,103)
Less: Late filing penalty	$ (10,000)	$ (10,000)	$ -
Total Program Costs	$ 6,587,429	$ 5,687,326	$ (900,103)
Less: Amount paid by the State		$ (4,106,959)	
Allowable costs claimed in excess of amount paid		$ 1,580,367	
Allowable per State Audit (Residential Placement Costs)		[redacted]	
Amount being appealed (Payments to Profit Facility)		[redacted]	
Breakdown:			
Out of State Residential Placement (Treatment Cost) Provo Canyon PO#506325		$ 373,380.00	
Out of State Residential Placement (Room and Board) Provo Canyon PO#506325		$ 481,719.00	
Total		[redacted]	

Exh. A-1

Summary of July 01 2007- June 30 2008	Actual Costs Claimed	Allowable	Adjustments
Direct and Indirect Costs:			
Referral and mental health assessments	$ 1,040,292	$ 1,032,858	$ (7,438)
Transfers and interim placements	$ 1,827,532	$ 1,822,587	$ (4,745)
Psychotherapy /other mental health services	$ 8,565,332	$ 8,514,338	$ (50,994)
Authorize/issue payments to providers:			$ -
Vendor Reimbursement	$ 8,724,027	[redacted]	$ (481,059)
Travel	$ 14,185	$ 14,185	$ -
Participation in due process hearings	$ 10,071	$ -	$ (10,071)
Sub-Total program costs	$ 18,181,239	$ 17,626,934	$ (554,305)
Less: Other reimbursements	$ (11,689,942)	$ (11,962,369)	$ (72,427)
Total claimed amount	$ 6,691,297	$ 6,964,566	$ (626,732)
Total Program Costs	$ 6,691,297	$ 6,964,566	$ (626,732)
Less: Amount paid by the State		$ -	
Allowable costs claimed in excess of amount paid		$ 6,964,566	
Allowable per State Audit (Residential Placement Costs)		[redacted]	
Amount being appealed (Payments to Profit Facility)		[redacted]	
Breakdown:			
Out of State Residential Placement (Treatment Cost) Provo Canyon PO#506325		$ 218,136.00	
Out of State Residential Placement (Room and Board) Provo Canyon PO#506325		$ 251,128.00	
Total		[redacted]	

Exh. A-2

Summary of July 01 2008- June 30 2009	Actual Costs Claimed	Allowable	Adjustments
Direct and Indirect Costs:			
Referral and mental health assessments	$ 1,625,079	$ 1,207,589	$ (417,490)
Transfers and interim placements	$ 722,833	$ 546,944	$ (175,889)
Psychotherapy /other mental health services	$ 9,749,679	$ 9,198,502	$ (551,177)
Authorize/issue payments to providers:			$ -
Vendor Reimbursement	$ 8,211,566	[redacted]	$ (98,676)
Travel	$ 12,472	$ 12,472	$ -
Participation in due process hearings	$ 46,536	$ 46,536	$ -
Sub-Total program costs	$ 18,368,086	$ 17,127,053	$ (1,241,032)
Less: Other reimbursements	$ (17,062,025)	$ (17,666,899)	$ (604,874)
Total claimed amount	$ 1,306,040	$ (439,866)	$ (1,745,906)
Adjustment to eliminate negative balance	$ -	$ 439,866	$ 439,866
Total Program Costs	$ 1,306,040	$ -	$ (1,306,040)
Less: Amount paid by the State		$ -	
Allowable costs claimed in excess of amount paid		$ -	
Allowable per State Audit (Residential Placement Costs)		[redacted]	
Amount being appealed (Payments to Profit Facility)		[redacted]	
Breakdown:			
Out of State Residential Placement (Treatment Cost) Provo Canyon PO#508325		$ 44,966.00	
Out of State Residential Placement (Room and Board) Provo Canyon PO#508325		$ 50,777.00	
Total		[redacted]	

Exh. A-3

Summary of July 01 2006- June 30 2009	Actual Costs Claimed	Allowable	Adjustments
Direct and Indirect Costs:			
Referral and mental health assessments	$ 3,549,533	$ 3,120,815	$ (428,018)
Transfers and interim placements	$ 4,473,590	$ 4,261,748	$ (211,842)
Psychotherapy /other mental health services	$ 26,183,937	$ 25,550,270	$ (633,667)
Authorize/Issue payments to providers:			
Vendor Reimbursement	$ 18,723,724	$ 17,082,502	$ (1,641,222)
Travel	$ 41,454	$ 41,454	$ -
Participation in due process hearings	$ 82,037	$ 66,636	$ (15,401)
Sub-Total program costs	$ 53,034,275	$ 50,103,225	$ (2,931,050)
Less: Other reimbursements	$ (38,539,509)	$ (38,881,200)	$ (341,691)
Total claimed amount	$ 14,494,766	$ 11,222,025	$ (3,272,741)
Adjustment to eliminate negative balance		439,866	439,866
Less: Late filing penalty	$ (10,000)	$ (10,000)	
Total Program Costs	$ 14,484,766	$ 11,661,891	$ (2,832,876)
Less: Amount paid by the State		$ (4,108,959)	
Allowable costs claimed in excess of amount paid		$ 7,544,932	

Allowable per State Audit (Residential Placement Costs)	$ 17,082,502.00
Total amount being appealed (Payments to Profit Facility)	$ 1,387,095.00
Breakdown:	
Out of State Residential Placement (Treatment Cost) Provo Canyon PO#506325	$ 633,471.00
Out of State Residential Placement (Room and Board) Provo Canyon PO#506325	$ 753,624.00
Grand Total	$ 1,387,095.00

Administration

MAY 0 7 2007

Internal Revenue Service

Date: April 28, 2007

MENTAL HEALTH SYSTEMS INC
9465 FARNHAM ST
SAN DIEGO CA 92123

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

Person to Contact:
T. Buckingham 29-70700
Customer Service Representative
Toll Free Telephone Number:
877-829-5500
Federal Identification Number:

Dear Sir or Madam:

This is in response to your request of April 28, 2007, regarding your organization's tax-exempt status.

In November 1982 we issued a determination letter that recognized your organization as exempt from federal income tax. Our records indicate that your organization is currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records indicate that your organization is also classified as a public charity under section 509(a)(2) of the Internal Revenue Code

Our records indicate that contributions to your organization are deductible under section 170 of the Code, and that you are qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Internal Revenue Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

Michele M. Sullivan

Michele M. Sullivan, Oper. Mgr.
Accounts Management Operations 1

EXHIBIT B

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
SPECIAL EDUCATION DIVSION
STATE OF CALIFORNIA

In the Matter of: STUDENT, Petitioner, v. RIVERSIDE UNIFIED SCHOOL DISTRICT and RIVERSIDE COUNTY DEPARTMENT of MENTAL HEALTH, Respondents.	OAH CASE NO. N 2007090403

DECISION

Administrative Law Judge Judith L. Pasewark, Office of Administrative Hearings, Special Education Division, State of California (OAH), heard this matter by written stipulation and joint statement of facts presented by the parties, along with written argument and closing briefs submitted by each party.

Heather D. McGunigle, Esq., of Disability Rights Legal Center, and Kristelia Garcia, Esq., of Quinn Emanuel Urquhart Oliver & Hedges, represented Student (Student).

Ricardo Soto, Esq., of Best Best & Krieger, represented Riverside Unified School District (District).

Sharon Watt, Esq., of Filarsky & Watt, represented Riverside County Department of Mental Health (CMH).

Student filed his first amended Request for Due Process Hearing on September 25, 2007. At the pre-hearing conference on December 7, 2007, the parties agreed to submit the matter on a written Joint Stipulation of Facts, and individual written closing arguments. The documents were received, the record closed, and matter was submitted for decision on December 31, 2007.

ISSUE

May the educational and mental health agencies place Student in an out-of-state for-profit residential center under California Code of Regulations section 60100, subdivision (h), and California Welfare and Institutions Code section 11460, subdivision (c)(2) and (3), when no other appropriate residential placement is available to provide Student a FAPE?

CONTENTIONS

All parties agree that Student requires a therapeutic residential placement which will meet his mental health and communication needs pursuant to his October 9, 2007 Individual Educational Plan (IEP). The District and CMH have conducted a nation-wide search and have been unable to locate an appropriate non-profit residential placement for Student.

Student contends that, as the District and CMH's searches for an appropriate non-profit residential placement have been exhausted, the District and CMH are obligated to place Student in an appropriate out-of-state for-profit residential program in order to provide Student with a free and appropriate public education (FAPE).

Both the District and CMH contend that they do not have the authority to place Student at an out-of-state for-profit residential program.

JOINT STIPULATION OF FACTS[1]

1. Student is 17 years old and resides with his Mother (Mother) within the District in Riverside County, California. Student's family is low-income and meets Medi-Cal eligibility requirements.

2. Student is deaf, has impaired vision and an orthopedic condition known as legg-perthes. Student has been assessed as having borderline cognitive ability. His only effective mode of communication is American Sign Language (ASL). Student also has a long history of social and behavioral difficulties. As a result, Student is eligible for special education and related services and mental health services through AB2726/3632 under the category of emotional disturbance (ED), with a secondary disability of deafness.

3. Student requires an educational environment in which he has the opportunity to interact with peers and adults who are fluent in ASL. Student attended the California

[1] The parties submitted a Stipulated Statement of Undisputed Facts and Evidence which is admitted into evidence as Exhibit 67, and incorporated herein. The stipulated facts have been consolidated and renumbered for clarity in this decision. As part of the same document, the parties stipulated to the entry of the joint Exhibits 1 through 66, which are admitted into evidence.

School for the Deaf, Riverside (CSDR) between January 2005 and September 2006, while a resident of the Monrovia Unified School District.

4. CSDR does not specialize in therapeutic behavior interventions. In January 2005, CSDR terminated Student's initial review period due to his behaviors. CSDR removed Student from school as suicide prevention because Student physically harmed himself. At that time, both CSDR and Monrovia USD believed Student to be a danger to himself and others. They, therefore, placed him in home-hospital instruction.

5. Between June 2005 and October 2005, Student's behaviors continued to escalate. Student was placed on several 72-hour psychiatric holds for which he missed numerous days of school. On one occasion, Student was hospitalized for approximately two weeks. On another occasion, he was hospitalized at least a week.

6. Pursuant to a mental health referral, on September 14, 2006, Monrovia USD and Los Angeles County Department of Mental Health (LACDMH) met, and determined that Student had a mental disturbance for which they recommended residential placement.[2] At that time, Amy Kay, Student's ASL-fluent therapist through LACDMH's AB2726 program, recommended a residential placement at the National Deaf Academy (NDA). Ms. Kay specifically recommended that Student be placed in a residential placement at NDA due to his need for a higher level of care to address his continuing aggressive and self-injurious behaviors. Additionally, the rehabilitation of these behaviors would be unsuccessful without the ability for Student to interact with deaf peers and adults. Ms. Kay further indicated that the use of an interpreter did not provide an effective method for Student to learn due to his special needs.

7. On August 5, 2006, NDA sent Student a letter of acceptance into its program. Monrovia USD and LACDMH, however, placed Student at Willow Creek/North Valley Non-public School. This placement failed as of March 2007, at which time both Monrovia USD and LACDMH indicated they were unable to find a residential placement for Student that could meet his mental health and communication needs. They did not pursue the residential treatment center at NDA because of its for-profit status.

8. Student and his mother moved to the District and Riverside County in April 2007.

9. On April 20, 2007, the District convened an IEP meeting to develop Student's educational program. The District staff, CMH staff, staff from CSDR, Student, his mother and attorney attended and participated in the IEP meeting. The IEP team changed Student's primary disability classification from emotional disturbance to deafness with social-emotional overlay. The parties agreed to this change in eligibility as CSDR required that

[2] As noted in Student's prior IEP, Student also required an educational environment which provided instruction in his natural language and which facilitated language development in ASL.

deafness be listed as a student's primary disability in order to be admitted and no other appropriate placements were offered. The IEP team offered placement at CSDR for a 60-day assessment period, individual counseling, speech and language services through CSDR, and individual counseling through CMH. The IEP team also proposed to conduct an assessment to determine Student's current functioning and to make recommendations concerning his academic programming based upon his educational needs.

10. CSDR suspended Student within its 60-day assessment period. CSDR subsequently terminated Student when, during his suspension, Student was found in the girl's dormitory following an altercation with the staff.

11. On May 23, 2007, the District convened another IEP meeting to discuss Student's removal from CSDR. The IEP team recommended Student's placement at Oak Grove Institute/Jack Weaver School (Oak Grove) in Murrieta, California, with support from a deaf interpreter pending the assessment agreed to at the April 2007 IEP meeting. CMH also proposed conducting an assessment for treatment and residential placement for Student.

12. On August 3, 2007, the District convened an IEP meeting to develop Student's annual IEP, and to review the assessments from CSDR and CMH. District staff, Oak Grove staff, CMH staff, Student's mother and attorney attended the IEP meeting. Based upon the information reviewed at the meeting, the IEP team proposed placement at Oak Grove with a signing interpreter, deaf and hard of hearing consultation and support services from the District, and individual counseling with a signing therapist through CMH. Mother and her attorney agreed to implementation of the proposed IEP, but disagreed that the offer constituted an offer of FAPE due to its lack of staff, teachers and peers who used ASL.

13. On October 9, 2007, the District convened another IEP meeting to review Student's primary disability. District staff, Oak Grove staff, CMH staff, Student's mother and attorney attended the IEP meeting. At this meeting, the IEP team once again determined Student's primary special education eligibility category as emotional disturbance with deafness as a secondary condition. The IEP team recommended placement in a residential treatment program, as recommended by CMH. Placement would remain at Oak Grove with a signing interpreter pending a residential placement search by CMH. Mother consented to the change in eligibility and the search for a residential placement. Mother also requested that Student be placed at NDA.

14. CMH made inquiries and pursued several leads to obtain a therapeutic residential placement for Student. CMH sought placements in California, Florida, Wyoming, Ohio and Illinois. All inquiries have been unsuccessful, and Student has not been accepted in any non-profit residential treatment center. At present CMH has exhausted all leads for placement of Student in a non-profit, in-state or out-of-state residential treatment center.

15. Student, his mother and attorney have identified NDA as an appropriate placement for Student. NDA, located in Mount Dora, Florida, is a residential treatment center for the treatment of deaf and hard-of-hearing children with the staff and facilities to

accommodate Student's emotional and physical disability needs. NDA also accepts students with borderline cognitive abilities. In addition, nearly all of the service providers, including teachers, therapists and psychiatrists are fluent in ASL. The residential treatment center at NDA is a privately owned limited liability corporation, and is operated on a for-profit basis. The Charter School at NDA is a California certified non-public school. All parties agree that NDA is an appropriate placement which would provide Student a FAPE.

16. Student currently exhibits behaviors that continue to demonstrate a need for a residential treatment center. Student has missed numerous school days due to behaviors at home. As recently as December 11, 2007, Student was placed in an emergency psychiatric hold because of uncontrollable emotions and violence to himself and others.

LEGAL CONCLUSIONS

1. Under *Schaffer v. Weast* (2005) 546 U.S. 49 [126 S.Ct. 528], the party who files the request for due process has the burden of persuasion at the due process hearing. Student filed this due process request and bears the burden of persuasion.

2. A child with a disability has the right to a free appropriate public education (FAPE) under the Individuals with Disabilities Education Act (IDEA or the Act) and California law. (20 U.S.C. § 1412(a)(1)(A); Ed. Code, § 56000.) The Individuals with Disabilities Education Improvement Act of 2004 (IDEIA), effective July 1, 2005, amended and reauthorized the IDEA. The California Education Code was amended, effective October 7, 2005, in response to the IDEIA. Special education is defined as specially designed instruction provided at no cost to parents and calculated to meet the unique needs of a child with a disability. (20 U.S.C. § 1401(29); Ed. Code, § 56031.)

3. In *Board of Education of the Hendrick Hudson Central School District, et. al. v. Rowley* (1982) 458 U.S. 176, 201 [102 S.Ct. 3034, 73 L. Ed.2d 690] (*Rowley*), the Supreme Court held that "the 'basic floor of opportunity' provided by the IDEA consists of access to specialized instruction and related services which are individually designed to provide educational benefit to a child with special needs." *Rowley* expressly rejected an interpretation of the IDEA that would require a school district to "maximize the potential" of each special needs child "commensurate with the opportunity provided" to typically developing peers. (*Id.* at p. 200.) Instead, *Rowley* interpreted the FAPE requirement of the IDEA as being met when a child receives access to an education that is "sufficient to confer some educational benefit" upon the child. (*Id.* at pp. 200, 203-204.) The Court concluded that the standard for determining whether a local educational agency's provision of services substantively provided a FAPE involves a determination of three factors: (1) were the services designed to address the student's unique needs, (2) were the services calculated to provide educational benefit to the student, and (3) did the services conform to the IEP. (*Id.* at p.176; *Gregory K. v. Longview Sch. Dist.* (9th Cir. 1987) 811 F. 2d 1307, 1314.) Although the IDEA does not require that a student be provided with the best available education or services or that the services maximize each child's potential, the "basic floor of opportunity"

of specialized instruction and related services must be individually designed to provide some educational benefit to the child. De minimus benefit or trivial advancement is insufficient to satisfy the *Rowley* standard of "some" benefit. (*Walczak v. Florida Union Free School District* (2d Cir. 1998) 142 F.3d at 130.)

4. Under California law, "special education" is defined as specially designed instruction, provided at no cost to parents, that meets the unique needs of the child. (Ed. Code, § 56031.) "Related services" include transportation and other developmental, corrective, and supportive services as may be required to assist a child to benefit from special education. State law refers to related services as "designated instruction and services" (DIS) and, like federal law, provides that DIS services shall be provided "when the instruction and services are necessary for the pupil to benefit educationally from his or her instructional program." (Ed. Code, § 56363, subd. (a).) Included in the list of possible related services are psychological services other than for assessment and development of the IEP, parent counseling and training, health and nursing services, and counseling and guidance. (Ed. Code, § 56363, subd. (b).) Further, if placement in a public or private residential program is necessary to provide special education and related services to a child with a disability, the program, including non-medical care and room and board, must be at no cost to the parent of the child. (34 C.F.R § 300.104.) Thus, the therapeutic residential placement and services that Student requests are related services/DIS that must be provided if they are necessary for Student to benefit from special education. (20 U.S.C. § 1401(22); Ed. Code, § 56363, subd. (a).) Failure to provide such services may result in a denial of a FAPE.

5. A "local educational agency" is generally responsible for providing a FAPE to those students with disabilities residing within its jurisdictional boundaries. (Ed. Code, § 48200.)

6. Federal law provides that a local educational agency is not required to pay for the cost of education, including special education and related services, of a child with a disability at a private school or facility if that agency made a free appropriate public education available to the child and the parents elected to place the child in such private school or facility. (20 U.S.C. § 1412(a)(10)(C)(i).)

7. Under California law, a residential placement for a student with a disability who is seriously emotionally disturbed may be made outside of California only when no in-state facility can meet the student's needs and only when the requirements of subsections (d) and (e) have been met. (Cal. Code Regs., tit. 2, § 60100, subd. (h).) An out-of-state placement shall be made only in residential programs that meet the requirements of Welfare and Institutions Code sections 11460, subdivisions (c)(2) through (c)(3).

8. When a school district denies a child with a disability a FAPE, the child is entitled to relief that is "appropriate" in light of the purposes of the IDEA. (*School Comm. of the Town of Burlington v. Dept. of Educ.* (1985) 471 U.S. 359, 374 [105 S.Ct. 1996].) Based on the principle set forth in *Burlington*, federal courts have held that compensatory education is a form of equitable relief which may be granted for the denial of appropriate

special education services to help overcome lost educational opportunity. (*See e.g. Parents of Student W. v. Puyallup Sch. Dist.* (9th Cir. 1994) 31 F.3d 1489, 1496.) The purpose of compensatory education is to "ensure that the student is appropriately educated within the meaning of the IDEA." (*Id.* at p. 1497.) The ruling in *Burlington* is not so narrow as to permit reimbursement only when the placement or services chosen by the parent are found to be the exact proper placement or services required under the IDEA. (*Alamo Heights Independent Sch. Dist. v. State Bd. of Educ.* (6th Cir. 1986) 790 F.2d 1153, 1161.) However, the parents' placement still must meet certain basic requirement of the IDEA, such as the requirement that the placement address the child's needs and provide him educational benefit. (*Florence County Sch. Dist. Four v. Carter* (1993) 510 U.S. 7, 13-14 [114 S.Ct. 361].)

Determination of Issues

9. In summary, based upon Factual Findings 2, 3, and 6 through 16, all parties agree that the placement in the day program at Oak Grove NPS with an interpreter cannot meet Student's unique educational needs because it does not sufficiently address his mental health and communication needs and does not comport with his current IEP. All parties agree that Student requires a therapeutic residential placement in order to benefit from his education program. Further, all parties agree that the nationwide search by the District and CMH for an appropriate non-profit residential placement with a capacity to serve deaf students has been exhausted, and Student remains without a residential placement. Lastly, all parties agree that the National Deaf Academy can meet both Student's mental health and communication needs. Further, the charter school at NDA is a California certified NPS.

10. The District and CMH rely upon Legal Conclusion 7 to support their contentions that they are prohibited from placing Student in an out-of-state for-profit residential placement, even if it represents the only means of providing Student with a FAPE.

11. As administrative law precedent, CMH cites *Yucaipa-Calimesa Joint Unified School District and San Bernardino County Department of Behavioral Health (Yucaipa)*, OAH Case No. N2005070683 (2005), which determined that the District and County Mental Health were statutorily prohibited from funding an out-of-state for-profit placement. The *Yucaipa* case can be distinguished from the one at hand. Clearly, the ruling in *Yucaipa*, emphasized that the regulation language used the mandatory term "shall," and consequently there was an absolute prohibition from funding a for-profit placement. The ALJ, however, did not face a resulting denial of FAPE for Student. In *Yucaipa*, several non-profit placement options were suggested, including residential placement in California, however, the parent would not consider any placement other than the out-of-state for-profit placement. In denying Student's requested for-profit placement, the ALJ ordered that the parties continue to engage in the IEP process and diligently pursue alternate placements. In the current matter, however, pursuant to Factual Findings 12 through 14, CMH has conducted an extensive multi-state search, and all other placement possibilities for Student have been exhausted. Pursuant to Factual Finding 15, NDA is the only therapeutic residential placement remaining, capable of providing a FAPE for Student.

12. "When Congress passed in 1975 the statute now known as the Individuals with Disabilities Act (IDEA or Act), it sought primarily to make public education available to handicapped children. Indeed, Congress specifically declared that the Act was intended to assure that all children with disabilities have available to them. . . appropriate public education and related services designed to meet their unique needs, to assure the rights of children with disabilities and their parents or guardians are protected. . . and to assess and assure the effectiveness of efforts to educate children with disabilities." (*Hacienda La Puente Unified School District v. Honig* (1992) 976 F.2d 487, 490.) The Court further noted that the United States Supreme Court has observed that "in responding to these programs, Congress did not content itself with passage of a simple funding statute...Instead, the IDEA confers upon disabled students an enforceable substantive right to public education in participating States, and conditions federal financial assistance upon a State's compliance with the substantive and procedural goals of the Act." (*Id.* at p. 491.)

13. California maintains a policy of complying with IDEA requirements in the Education Codes, sections 56000, et seq. With regard to the special education portion of the Education Code, the Legislature intended, in relevant part, that every disabled child receive a FAPE. Specifically, "It is the further intent of the Legislature to ensure that all individuals with exceptional needs are provided their rights to appropriate programs and services which are designed to meet their unique needs under the Individuals with Disabilities Education Act." (Ed. Code, § 56000.)

14. California case law explains further, "although the Education Code does not explicitly set forth its overall purpose, the code's primary aim is to benefit students, and in interpreting legislation dealing with our educational systems, it must be remembered that the fundamental purpose of such legislation is the welfare of the children." (*Katz v. Los Gatos-Saratoga Joint Union High School Dist.* (2004) 117 Cal.App. 4th 47, 63.)

15. Pursuant to Legal Conclusion 6, a district is not required to pay for the cost of education, including special education and related services, of a child with a disability at a private school or facility if the district made a free appropriate public education available to the child. All parties concur, in Factual Findings 12 through 15, that the District has been unable to provide a FAPE to Student because no appropriate placement exists except in an out-of-state for-profit residential program.

16. Assuming the District's interpretation of section 60100, subdivision (h) of Title 2 of the California Code of Regulations is correct, it is inconsistent with the federal statutory and regulatory law by which California has chosen to abide. California education law itself mandates a contrary response to Welfare and Institutions Code section 11460, subdivision (c)(3), where no other placement exists for a child. Specifically, "It is the further intent of the Legislature that this part does not abrogate any rights provided to individuals with exceptional needs and their parents or guardians under the federal Individuals with Disabilities Education Act." (Ed. Code, § 56000, subd. (e) (Feb. 2007).) A contrary result

would frustrate the core purpose of the IDEA and the companion state law, and would prevent Student from accessing educational opportunities.[1]

17. Regardless of whether the District and CMH properly interpreted Legal Conclusion 7, Student has ultimately been denied a FAPE since May 23, 2007, when he was terminated from attending CSDR, as indicated in Factual Findings 10 through 16. Pursuant to Factual Findings 6 and 16, Student's need for therapeutic residential placement with ASL services continues. As a result of this denial of FAPE, Student is entitled to compensatory education consisting of immediate placement at the National Deaf Academy through the 2008-2009 school years. The obligation for this compensatory education shall terminate forthwith in the event Student voluntarily terminates his attendance at NDA after his 18th birthday, or Student's placement is terminated by NDA.

ORDER

The District has denied Student a free appropriate public education as of May 23, 2007. The District and CMH are to provide Student with compensatory education consisting of immediate placement at the National Deaf Academy and through the 2008-2009 school year. The obligation for this compensatory education shall terminate forthwith in the event Student voluntarily terminates his attendance at NDA after his 18th birthday, or Student's placement is terminated by NDA.

PREVAILING PARTY

Pursuant to California Education Code section 56507, subdivision (d), the hearing decision must indicate the extent to which each party has prevailed on each issue heard and decided. Student has prevailed on the single issue presented in this case.

[1] Further, there appears to be no argument that had Mother completely rejected the District's IEP offer, and privately placed Student at NDA, she would be entitled to reimbursement of her costs from the District, if determined that the District's offer of placement did not constitute a FAPE. By all accounts, Student's low income status prevented placement at NDA, and therefore precluded Student from receiving a FAPE via reimbursement by the District.

RIGHT TO APPEAL THIS DECISION

The parties to this case have the right to appeal this Decision to a court of competent jurisdiction. If an appeal is made, it must be made within 90 days of receipt of this Decision. (Ed. Code, § 56505, subd. (k).)

Dated: January 15, 2008

Judith L. Pasewark

JUDITH L. PASEWARK
Administrative Law Judge
Special Education Division
Office of Administrative Hearings.

EXHIBIT "C"

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 60000-60610 (Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28 Fiscal Years 1997-1998, 1998-1999, 2000-2001 County of Orange, Claimant.	Case Nos.: 05-4282-I-02 and 09-4282-I-04 *Handicapped and Disabled Students* STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; TITLE 2, CALIFORNIA CODE OF REGULATIONS, DIVISION 2, CHAPTER 2.5. ARTICLE 7 *(Adopted July 28, 2011)*

STATEMENT OF DECISION

The attached Statement of Decision of the Commission on State Mandates is hereby adopted in the above-entitled matter.

Dated: August 1, 2011

DREW BOHAN
Executive Director

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 60000-60610 (Emergency regulations effective January 1, 1986 [Register 86, No. 1], and re-filed June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28 Fiscal Years 1997-1998, 1998-1999, 2000-2001 County of Orange, Claimant.	Case Nos.: 05-4282-I-02 and 09-4282-I-04 *Handicapped and Disabled Students* STATEMENT OF DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; TITLE 2, CALIFORNIA CODE OF REGULATIONS, DIVISION 2, CHAPTER 2.5. ARTICLE 7 *(Adopted July 28, 2011)*

STATEMENT OF DECISION

The Commission on State Mandates (Commission) heard and decided this incorrect reduction claim during a regularly scheduled hearing on July 28, 2011. The claimant did not make an appearance and submitted the case on the record. Mr. Jim Spano appeared for the State Controller's Office.

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 the staff analysis at the hearing by a vote of 6 to 0 to deny this incorrect reduction claim.

Summary of Findings

This is an incorrect reduction claim filed by the County of Orange regarding reductions made by the State Controller's Office to reimbursement claims for costs incurred in three fiscal years (1997-1998, 1998-1999, and 2000-2001), in the total amount of $2,676,659 to provide medication monitoring services to seriously emotionally disturbed pupils under 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 needs. The program shifted to counties the responsibility and funding to provide mental health services required by a pupil's individualized education plan (IEP).

The State Controller's Office contends that medication monitoring is not a reimbursable activity during the audit period, and did not become reimbursable until fiscal year 2001-2002. The State Controller's Office also argues that the County's first incorrect reduction claim filed for fiscal years 1997-1998 and 1998-1999 was not timely filed.

The County disagrees with the State Controller's Office. The County seeks a determination from the Commission pursuant to Government Code section 17551(d), that the State Controller's Office incorrectly reduced the claim, and requests that the Controller reinstate the $2,676,659 reduced for fiscal years 1997-1998 through 2000-2001.

The Commission finds that the County timely filed the first incorrect reduction claim for the 1997-1998 and 1998-1999 fiscal year costs.

The Commission further finds that the State Controller's Office correctly reduced the County's reimbursement claims for medication monitoring costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001. The *Handicapped and Disabled Students* program has a long and complicated history. However, the substantive issue presented in this claim relates to the sole issue of whether providing medication monitoring services is reimbursable in fiscal years 1997-1998, 1998-1999, and 2000-2001. As described in the analysis, the Commission has previously addressed the issue of medication monitoring and decisions have been adopted on the issue. These decisions are now final and must be followed here. Thus, the Commission finds that the County is not eligible for reimbursement for providing medication monitoring services until July 1, 2001.

BACKGROUND

This is an incorrect reduction claim filed by the County of Orange for costs incurred in three fiscal years (1997-1998, 1998-1999, and 2000-2001) to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.[1] The State Controller's Office reduced the County's reimbursement claims in the amount of $2,676,659, arguing that medication monitoring is not a reimbursable activity during the audit period, and did not become reimbursable until fiscal year 2001-2002.

Position of the Parties

Position of the State Controller's Office

The State Controller's Office contends that medication monitoring is not a reimbursable activity under the parameters and guidelines in effect during the audited years. The State Controller's Office further argues that the County's incorrect reduction claim filed for the fiscal year

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[1] The reduction of costs for medication monitoring for these fiscal years are as follows:

Fiscal year	Amount of Reduction
1997-1998	$ 759,114
1998-1999	$ 870,701
2000-2001	$1,046,844
Total	$2,676,659

1997-1998 and 1998-1999 costs (05-4282-I-02) was filed after the time required in the Commission's regulations, and should therefore not be considered by the Commission.

Claimant's Position

The County disagrees with the reduction of costs by the State Controller's Office and contends that medication monitoring is a reimbursable activity during the audit period in question. The County argues that the parameters and guidelines state that "any" costs related to the mental health treatment services rendered under the Short-Doyle Act are reimbursable and, while "medication monitoring" is not specifically identified, it is not excluded either. The County asserts that "medication monitoring" has always been part of the treatment services rendered under the Short-Doyle Act. The County further asserts that the Commission clarified this point when it adopted the parameters and guidelines in *Handicapped and Disabled Students II*, specifically listing "medication monitoring" as a reimbursable activity.

The County further argues that its first incorrect reduction claim on this issue (05-4282-I-02) was filed within the statute of limitations.

The County seeks a determination from the Commission pursuant to Government Code section 17551(d), that the State Controller's Office incorrectly reduced the claim, and requests that the Controller reinstate the $2,676,659 reduced for fiscal years 1997-1998, 1998-1999, and 2000-2001.

II. COMMISSION FINDINGS

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

Government Code Section 17551(d) requires the Commission to hear and decide a claim that the State Controller's Office has incorrectly reduced payments to the local agency or school district. That section states the following:

> The commission, pursuant to the provisions of this chapter, shall hear and decide upon a claim by a local agency or school district filed on or after January 1, 1985, that the Controller has incorrectly reduced payments to the local agency or school district pursuant to paragraph (2) of subdivision (b) of Section 17561.

If the Commission determines that a reimbursement claim has been incorrectly reduced, section 1185.7 of the Commission's regulations requires the Commission to send the statement of decision to the State Controller's Office and request that the costs in the claim be reinstated.

A. The State Controller's Office correctly reduced the County's reimbursement claims for the costs incurred to provide medication monitoring services in fiscal years 1997-1998, 1998-1999, and 2000-2001.

Costs incurred for this program in fiscal years 1997-1998, 1998-1999, and 2000-2001 are eligible for reimbursement under the parameters and guidelines for *Handicapped and Disabled Students* (CSM 4282). The test claim in *Handicapped and Disabled Students* was filed on Government Code section 7570 et seq., as added and amended by Statutes 1984 and 1985, and on the initial emergency regulations adopted in 1986 by the Departments of Mental Health and

Education to implement this program.[2] In 1990 and 1991, the Commission approved the test claim and adopted parameters and guidelines, authorizing reimbursement for mental health treatment services as follows:

> Ten (10) percent of any costs related to mental health treatment services rendered under the Short-Doyle Act:
>
> 1. The scope of the mandate is ten (10) percent reimbursement.
> 2. For each eligible claimant, the following cost items, for the provision of mental health services when required by a child's individualized education program, are ten (10) percent reimbursable (Gov. Code, § 7576):
>   a. Individual therapy;
>   b. Collateral therapy and contacts;
>   c. Group therapy;
>   d. Day treatment; and
>   e. Mental health portion of residential treatment in excess of the State Department of Social Services payment for the residential placement.
> 3. Ten (10) percent of any administrative costs related to mental health treatment services rendered under the Short-Doyle Act, whether direct or indirect.

While the County acknowledges that medication monitoring is not expressly listed as a reimbursable activity in the parameters and guidelines, the County argues that medication monitoring is a reimbursable activity and that the parameters and guidelines authorize reimbursement for "any costs related to mental health treatment services rendered …."

The County's interpretation of the issue, however, conflicts with prior final decisions of the Commission on the issue of medication monitoring.

The *Handicapped and Disabled Students* (CSM 4282) decision addressed Government Code section 7576 and the implementing regulations as they were originally adopted in 1986. 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 Title 9 regulations. (Former Cal. Code Regs., tit. 2, § 60020(a).) Section 543 defined outpatient services to include "medication." "Medication" 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."

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

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[2] 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)).

monitoring" was not included in the original test claim legislation. "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 and 02-TC-49), and will not be specifically analyzed here.[3]

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*. The Commission's decision in *Handicapped and Disabled Students II* states the following:

> The Department of Finance argues that "medication monitoring" does not increase the level of service provided by counties. The Department states the following:
>
> > It is our interpretation that there is no meaningful difference between the medication requirements under the prior regulations and the new regulations of the test claim. The existing activities of "dispensing of medications, and the evaluation of side effects and results of medication" are in fact activities of medication monitoring and seem representative of all aspects of medication monitoring. To the extent that counties are already required to evaluate the "side effects and results of medication," it is not clear that the new requirement of "medication monitoring" imposes a new or higher level of service. [footnote omitted.]
>
> The Commission disagrees with the Department's interpretation of section 60020, subdivisions (i) and (f), of the regulations, and finds that "medication monitoring" as defined in the regulation increases the level of service required of counties.
>
> The same rules of construction applicable to statutes govern the interpretation of administrative regulations. [Footnote omitted.] Under the rules of statutory construction, it is presumed that the Legislature or the administrative agency intends to change the meaning of a law or regulation when it materially alters the language used. [Footnote omitted.] The courts will not infer that the intent was

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[3] Statement of decision, *Reconsideration of Handicapped and Disabled Students* (04-RL-4282-10), page 42.

only to clarify the law when a statute or regulation is amended unless the nature of the amendment clearly demonstrates the case. [Footnote omitted.]

In the present case, the test claim regulations, as replaced in 1998, materially altered the language regarding the provision of medication. The activity of "dispensing" medications was deleted from the definition of mental health services. In addition, the test claim regulations deleted the phrase "evaluating the side effects and results of the medication," and replaced the phrase with "monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness." The definitions of "evaluating" and "monitoring" are different. To "evaluate" means to "to examine carefully; appraise."[4] To "monitor" means to "to keep watch over; supervise."[5] The definition of "monitor" and the regulatory language to monitor the "psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness" indicate that the activity of "monitoring" is an ongoing activity necessary to ensure that the pupil receives a free and appropriate education under federal law. This interpretation is supported by the final statement of reasons for the adoption of the language in section 60020, subdivision (f), which state that the regulation was intended to make it clear that "medication monitoring" is an educational service that is provided pursuant to an IEP, rather than a medical service that is not allowable under the program.[6]

Neither the Department of Mental Health nor the Department of Education, agencies that adopted the regulations, filed substantive comments on this test claim. Thus, there is no evidence in the record to contradict the finding, based on the rules of statutory construction, that "medication monitoring" increases the level of service on counties.

Therefore, the Commission finds that the activity of "medication monitoring," as defined in section 60020, subdivisions (f) and (i), constitutes a new program or higher level of service.[7]

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). The analysis adopted by the Commission on the issue states the following:

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[4] Webster's II New College Dictionary (1999) page 388.

[5] *Id.* at page 708.

[6] Final Statement of Reasons, page 7.

[7] Statement of decision, *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), pages 37-39.

The counties request that the Commission amend the provision in the parameters and guidelines for mental health services to include the current regulatory definition of "mental health services," medication monitoring, and crisis intervention. The counties request the following language be added to the parameters and guidelines:

> For each eligible claimant, the following cost items, for the provision of services when required by a child's individualized education program in accordance with Section 7572(d) of the Government Code: psychotherapy (including outpatient crisis-intervention psychotherapy provided in the normal course of IEP services when a pupil exhibits acute psychiatric symptoms, which, if untreated, presents an imminent threat to the pupil) as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management are reimbursable (Government Code 7576). "Medication monitoring" includes medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness. [Footnote omitted.]

The counties' proposed language, however, is based on regulations amended by the Departments of Mental Health and Education effective July 1, 1998. (Cal. Code Regs., tit. 2, § 60020, subds. (i) and (f).) The 1998 regulations were considered by the Commission in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), and approved for the following activities beginning July 1, 2001:

- Provide individual or group psychotherapy services, as defined in Business and Professions Code section 2903, when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
- Provide medication monitoring services when required by the pupil's IEP. "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, and monitoring of psychiatric medications or biologicals as necessary to alleviate the symptoms of mental illness. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subds. (f) and (i).)

The Commission's findings in *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), approving reimbursement for medication monitoring and psychotherapy services as currently defined in the regulations were not included in the original test claim (CSM 4282) and, thus, cannot be applied retroactively to the original parameters and guidelines. Based on Government Code section 17557, subdivision (e), the reimbursement period for the activities

approved by the Commission in *Handicapped and Disabled II* begins July 1, 2001.

Therefore, the proposed amendment to add language based on the current definition of "mental health services," including medication monitoring, is inconsistent with, and not supported by the Commission's original 1990 Statement of Decision in *Handicapped and Disabled Students* (CSM 4282).[8]

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 judicial review, they are binding, just as judicial decisions."[9] Accordingly, based on these decisions, counties are not eligible for reimbursement for medication monitoring until July 1, 2001.

Therefore, the State Controller's Office correctly reduced the reimbursement claims of the County of Orange for costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001 to provide medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

B. The County's first incorrect reduction claim (05-4282-I-02) was filed within the time required by the Commission's regulations and, thus, the Commission has jurisdiction to determine the claim.

The State Controller's Office argues that the County failed to file the incorrect reduction claim for fiscal years 1997-1998 and 1998-1999 (05-4282-I-02) within the time required by the Commission's regulations. The Controller's Office states the following:

> Section 1185, subdivision (b) states that "[a]ll 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." In this case, the remittance advice and accompanying letter were dated April 28, 2003 (See pages 2-5 of Exhibit C of the Claimant's IRC). Therefore, the last date to file an IRC was April 28, 2003. However, the Claimant did not file its claim until May 1, 2003, outside the time frame provided, and thus, the IRC is precluded by the limitations provision of Section 1185.

Using the date of the remittance advice, the County's filing is timely. Section 1181.1(g) of the Commission's regulations defines "filing date" as follows:

> . . . the date of delivery to the commission office during normal business hours. For purposes of meeting the filing deadlines required by statute, the filing is timely if:
>
> (1) The filing is submitted by certified or express mail or a common carrier promising overnight delivery, and

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[8] Analysis adopted by Commission on December 4, 2006, in 00-PGA-03/04.

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

(2) The time for its filing had not expired on the date of its mailing by certified or express mail as shown on the postal receipt or postmark, or the date of its delivery to a common carrier promising overnight deliver as shown on the carrier's receipt.

Section 1181.2 further states that "service by mail is complete when the document is deposited in the mail."

In this case, the County mailed the incorrect reduction claim (05-4282-I-02) by express mail with a postmark of April 28, 2006, three years to the day of the remittance advice. Although the Commission received the filing on May 1, 2006, the claim would still be considered timely, when using the date of the remittance advice. The time for filing had not expired when the claim was deposited in the mail on April 28, 2006.

However, at the time the County filed its incorrect reduction claim, section 1185 of the Commission's regulations provided that the three year deadline to file an incorrect reduction claim starts to run from "the date of the Office of State Controller's remittance advice *or other notice of adjustment notifying the claimant of a reduction*." The audit report for the County's reimbursement claims filed for fiscal years 1997-1998 and 1998-1999 identifies the Controller's intention to reduce the County's claims for medication monitoring and is dated December 26, 2002, four months earlier than the remittance advice. Three years from the date of the audit report would be December 26, 2005 (more than four months before the County filed its claim).

The Controller's Office does not base its statute of limitations argument on the date of the audit report, however. Moreover, section 1185 of the Commission's regulations does not require the running of the time period from when a claimant *first* receives notice; but simply states that the time runs from either the remittance advice *or* other notice of adjustment.

Thus, when viewed in a light most favorable to the County, and based on the policy determined by the courts favoring the disposition of cases on their merits rather than on procedural grounds,[10] staff finds that the County timely filed the incorrect reduction claim for the fiscal year 1997-1998 and 1998-1999 costs.

III. CONCLUSION

The Commission concludes that the State Controller's Office correctly reduced the County's reimbursement claims for costs incurred in fiscal years 1997-1998, 1998-1999, and 2000-2001, for providing medication monitoring services to seriously emotionally disturbed pupils under the *Handicapped and Disabled Students* program.

[10] *O'Riordan v. Federal Kemper Life Assurance* (2005) 36 Cal.4th 281, 284; *California Department of Corrections and Rehabilitation v. State Personnel Board* (2007) 147 Cal.App.4th 797, 805.

EXHIBIT "D"

STATE OF CALIFORNIA
COMMISSION ON STATE MANDATES
980 NINTH STREET, SUITE 300
SACRAMENTO, CA 95814
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December 11, 2014

Mr. Keith B. Petersen
SixTen & Associates
P.O. Box 340430
Sacramento, CA 95834-0430

Ms. Jill Kanemasu
State Controller's Office
Accounting and Reporting
3301 C Street, Suite 700
Sacramento, CA 95816

And Parties, Interested Parties, and Interested Persons (See Mailing List)

Re: **Decision**
Collective Bargaining, 05-4425-I-11
Government Code Sections 3540-3549.9
Statutes 1975, Chapter 961
Fiscal Year 1995-1996
Gavilan Joint Community College District, Claimant

Dear Mr. Petersen and Ms. Kanemasu:

On December 5, 2014, the Commission on State Mandates adopted the decision on the above-entitled matter.

Sincerely,

Heather Halsey
Executive Director

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE INCORRECT REDUCTION CLAIM ON: Government Code Sections 3540-3549.9 Statutes 1975, Chapter 961 Fiscal Year 1995-1996 Gavilan Joint Community College District, Claimant.	Case No.: 05-4425-I-11 *Collective Bargaining* DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5. ARTICLE 7 (*Adopted December 5, 2014*) (*Served December 11, 2014*)

DECISION

The Commission on State Mandates (Commission) heard and decided this incorrect reduction claim (IRC) during a regularly scheduled hearing on December 5, 2014. Keith Petersen appeared on behalf of the claimant. Jim Spano and Jim Venneman appeared on behalf of the Controller.

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 the proposed decision to deny the IRC at the hearing by a vote of six to zero.

Summary of the Findings

This IRC was filed in response to two letters received by Gavilan Joint Community College District (claimant) from the State Controller's Office (Controller), notifying the claimant of an adjustment to the claimant's fiscal year 1995-1996 reimbursement claim; one on July 30, 1998, which notified the claimant that $126,146 was due the state, and a second on July 10, 2002, notifying the claimant that $60,597 was now due to the claimant as a result of the Controller's review of the claim and "prior collections."

The Commission finds that this IRC was not timely filed. The time for filing an IRC, in accordance with the Commission's regulations, is "no later than three (3) years following the date of the State Controller's remittance advice notifying the claimant of a reduction."[1] Government Code section 17558.5 requires the Controller's notice to the claimant of a reduction to identify the claim components adjusted and the reason(s) for adjustment.[2] Here, the claimant

[1] Code of Regulations, title 2, section 1185 (Register 1999, No. 38).

[2] Government Code section 17558.5 (Stats. 1995, ch. 945 (SB 11)).

first received notice of the adjustment to its 1995-1996 reimbursement claim on July 30, 1998, and received a second notice dated July 10, 2002, and did not file this IRC until December 16, 2005. Though the parties dispute which notice triggers the running of the limitation, that issue need not be resolved here since this claim was filed beyond the limitation in either case. Therefore, the IRC is denied.

COMMISSION FINDINGS

I. Chronology

01/24/1996	Controller notified claimant of a $275,000 payment toward estimated reimbursement for the 1995-1996 fiscal year.[3]
11/25/1996	Claimant submitted its fiscal year 1995-1996 reimbursement claim for $348, 966.[4]
01/30/1997	Controller notified claimant that it would remit an additional $15,270 for a total payment of $290,270 for fiscal year 1995-1996.[5]
07/30/1998	Controller notified claimant of reduction to the fiscal year 1995-1996 reimbursement claim of $184,842, resulting in $126,146 due the state.[6]
08/05/1998	Claimant notified Controller that it was appealing the reduction.[7]
08/08/2001	Controller notified claimant that it was reducing payments for the *Open Meetings Act* mandate in partial satisfaction of the reduction for the 1995-1996 fiscal year reimbursement claim for the *Collective Bargaining* mandate.[8]
07/10/2002	Controller notified claimant of its review of the 1995-1996 reimbursement claim for the *Collective Bargaining* mandate, and its findings that the claim was properly reduced by $124,245, rather than $184,842, and that $60, 597 was now due the claimant.[9]
12/16/2005	Claimant filed this IRC.[10]
12/27/2005	Commission staff notified claimant that the claim was not timely, and deemed it incomplete.[11]

[3] Exhibit A, Incorrect Reduction Claim page 14.

[4] Exhibit A, Incorrect Reduction Claim pages 4-5.

[5] Exhibit A, Incorrect Reduction Claim page 5.

[6] Exhibit A, Incorrect Reduction Claim pages 5; 15.

[7] Exhibit A, Incorrect Reduction Claim pages 5; 21.

[8] Exhibit A, Incorrect Reduction Claim pages 5; 17.

[9] Exhibit A, Incorrect Reduction Claim pages 5-6; 18.

[10] Exhibit A, Incorrect Reduction Claim page 1.

[11] See Exhibit B, Claimant Rebuttal Comments, page 1.

12/30/2005	Claimant submitted rebuttal comments seeking the full Commission's determination on the timeliness of the claim.[12]
03/09/2006	Commission staff deemed the IRC complete and issued a request for comments.
03/23/2010	Controller submitted comments on the IRC.[13]
09/25/2014	Commission staff issued the draft proposed decision.[14]
10/03/2014	The Claimant filed comments on the draft proposed decision.[15]

II. Background

On July 17, 1978, the Board of Control, predecessor to the Commission, found that Statutes 1975, chapter 961 imposed a reimbursable state mandate. On October 22, 1980, parameters and guidelines were adopted, which were amended several times.[16] The reimbursement claim at issue in this IRC was filed for the 1995-1996 fiscal year, and at the time that claim was prepared and submitted, the parameters and guidelines effective on July 22, 1993 were applicable.[17] The 1993 parameters and guidelines provided for reimbursement of costs incurred to comply with sections 3540 through 3549.1, and "regulations promulgated by the Public Employment Relations Board," including:

- Determination of appropriate bargaining units for representation and determination of the exclusive representation and determination of the exclusive representatives;
- Elections and decertification elections of unit representatives are reimbursable in the even the Public Employment Relations Board determines that a question of representation exists and orders an election held by secret ballot;
- Negotiations: Reimbursable functions include – receipt of exclusive representative's initial contract proposal, holding of public hearings, providing a reasonable number of copies of the employer's proposed contract to the public, development and presentation of the initial district contract proposal, negotiation of the contract, reproduction and distribution of the final contract agreement;

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[12] Exhibit B, Claimant Rebuttal Comments.

[13] Exhibit C, Controller's Comments.

[14] Exhibit D, Draft Proposed Decision, issued September 25, 2014.

[15] Exhibit E, Claimant's Comments on Draft Proposed Decision.

[16] Exhibit A, Incorrect Reduction Claim, Exhibit C to the IRC, pp. 3-9. On March 26, 1998, the Commission adopted a second test claim decision on Statutes 1991, chapter 1213. Parameters and guidelines for the two programs were consolidated on August 20, 1998, and have since been amended again, on January 27, 2000. However, this later decision and the consolidated parameters and guidelines are not relevant to this IRC since the IRC addressed reductions in the 1995-1996 fiscal year.

[17] Exhibit A, Incorrect Reduction Claim, Exhibit C to the IRC.

- Impasse proceedings, including mediation, fact-finding, and publication of the findings of the fact-finding panel;
- Contract administration and adjudication of contract disputes either by arbitration or litigation, including grievances and administration and enforcement of the contract;
- Unfair labor practice adjudication process and public notice complaints.[18]

III. Positions of the Parties

The issues raised in this IRC, and the comments filed in response and rebuttal, include the scope of the Controller's audit authority; the notice owed to a claimant regarding both the sufficiency of supporting documentation and the reasons for reductions; and the audit standards applied. However, the threshold issue is whether the IRC filing is timely in the first instance, with respect to which the parties maintain opposing positions.

Gavilan Joint Community College District, Claimant

The claimant argues that the Controller's reductions are not made in accordance with due process, in that the Controller "has not specified how the claim documentation was insufficient for purposes of adjudicating the claim." The letters that claimant cites "merely stated that the District's claim had 'no supporting documentation.'"[19] The claimant further argues that the adjustments made to the fiscal year 1995-1996 claim are "procedurally incorrect in that the Controller did not audit the records of the district…"[20] In addition, the claimant argues that "[t]he Controller does not assert that the claimed costs were excessive or unreasonable, which is the only mandated cost audit standard in statute." The claimant asserts that "[i]f the Controller wishes to enforce other audit standards for mandated cost reimbursement, the Controller should comply with the Administrative Procedure Act."[21]

Addressing the statute of limitations issue, the claimant states that "the incorrect reduction claim asserts as a matter of fact that the Controller's July 10, 2002 letter reports an amount payable to the claimant, which means a subsequent final payment action notice occurred or is pending from which the ultimate regulatory period of limitation is to be measured…" The claimant asserts that any "evidence regarding the date of last payment action, notice, or remittance advice, is in the possession of the Controller."[22]

In comments on the draft proposed decision, the claimant argues that "[w]ell after the incorrect reduction claim was filed, the District received a February 26, 2011, Controller's notice of adjudication of the FY 1995-96 annual claim." The claimant asserts that based on this later notice "the three year statute of limitations for the incorrect reduction claim would be moved forward to February 26, 2014, which is more than eight years after the incorrect reduction claim was filed." The claimant states: "It would seem that the Commission is now required to address

[18] Exhibit A, Incorrect Reduction Claim, Exhibit C to the IRC, pp. 3-9.

[19] Exhibit A, Incorrect Reduction Claim, page 9.

[20] Exhibit A, Incorrect Reduction Claim, page 9.

[21] Exhibit A, Incorrect Reduction Claim, page 10.

[22] Exhibit B, Claimant's Rebuttal Comments, page 2.

the first issue of what constitutes 'notice of adjustment,' that is, the Controller's adjudication of an annual claim, for purposes of the statute of limitations for filing an incorrect reduction claim."[23]

State Controller's Office

The Controller argues that it "is empowered to audit claims for mandated costs and to reduce those that are 'excessive or unreasonable.'" The Controller continues: "If the claimant disputes the adjustments made by the Controller pursuant to that power, the burden is upon them to demonstrate that they are entitled to the full amount of the claim."[24] The Controller notes that the claimant "asserts that a mere lack of documentation is an insufficient basis to reduce a claim…" but the Controller argues that "a claim that is unsupported by valid documentation is both excessive and unreasonable."[25] The Controller further asserts that the claimant "sought reimbursement for activities that are outside the scope of reimbursable activities as defined in the Parameters and Guidelines," including salary costs for expenses of school district officials.[26]

Furthermore, the Controller argues that the IRC is not timely. The Controller notes that the statute of limitations pursuant to section 1185 of the Commission's regulations is "no later than three years following the date of the Office of State Controller's final audit report, letter, remittance advice[,] or other written notice of adjustment…"[27] The Controller argues that based on the first notice sent to the claimant on July 30, 1998, "the time to file a claim would have expired on July 30, 2001."[28] Alternatively, "[e]ven if we accept the Claimant's implied argument that a subsequent letter from the Controller's Office dated July 10, 2002, started a new Statute of Limitations, the claim was still time barred."[29] The Controller concludes that "that time period would have expired on July 10, 2005, five months before this claim was actually filed."[30]

And finally, the Controller argues: "Not satisfied with two bites at the apple, Claimant asserts that the period of the Statute of Limitations 'will be measured from the date of the last payment action…'" and that there is no law to support that position.[31]

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[23] Exhibit E, Claimant's Comments on Draft Proposed Decision, page 2.

[24] Exhibit C, Controller's Comments, page 1.

[25] Exhibit C, Controller's Comments, pages 1-2.

[26] Exhibit C, Controller's Comments, page 2.

[27] Exhibit C, Controller's Comments, page 2 [citing California Code of Regulations, title 2, section 1185 (as amended, Register 2007, No. 19)].

[28] Exhibit C, Controller's Comments, page 2.

[29] Exhibit C, Controller's Comments, page 2.

[30] Exhibit C, Controller's Comments, page 2.

[31] Exhibit C, Controller's Comments, page 2.

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 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.[32] 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."[33]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This is similar to the standard used by the courts when reviewing an alleged abuse of discretion by a state agency.[34] 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.]' "[35]

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

[33] *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.

[34] *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.

[35] *American Bd. of Cosmetic Surgery, Inc, supra,* 162 Cal.App.4th at 547-548.

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. [36] In addition, section 1185.2(c) of the Commission's regulations requires that any assertion 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.[37]

This Incorrect Reduction Claim Was Not Timely Filed.

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. There are a number of recognized exceptions to the accrual rule, each of which is based in some way on the wronged party having notice of the wrong or the breach that gave rise to the action.

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, which begins the period of limitation; the same notice also defeats the application of any of the notice-based exceptions to the general rule.

Here, there is some question as to whether the reasons for the reduction were stated in the earliest notice, as required by section 17558.5 and the Commission's regulations. The evidence in the record indicates that the claimant had actual notice of the reduction and of the reason for the reduction ("no supporting documentation") as of July 30, 1998.[38] However, the July 10, 2002 letter more clearly states the Controller's reason for reduction.[39] Ultimately, whether measured from the date of the earlier notice, or the July 10, 2002 notice, the period for filing an IRC on this audit expired no later than July 10, 2005, a full seven months before the IRC was filed. The analysis herein also demonstrates that the period of limitation is not unconstitutionally retroactive, as applied to this IRC. The IRC is therefore untimely.

1. <u>The period of limitation applicable to an IRC begins to run at the time an IRC can be filed, and none of the exceptions or special rules of accrual apply.</u>

    a. *The general rule is that a statute of limitations attaches and begins to run at the time the cause of action accrues.*

The threshold issue in this IRC is when the right to file an IRC based on the Controller's reductions accrued, and consequently when the applicable period of limitation began to run against the claimant. The general rule, supported by a long line of cases, is that a statute of

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

[37] 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.

[38] Exhibit A, IRC 05-44254-I-11, pages 5; 21.

[39] Exhibit A, IRC 05-4425-I-11, page 19.

limitations attaches when a cause of action arises; when the action can be maintained.[40] The California Supreme Court has described statutes of limitations as follows:

> A statute of limitations strikes a balance among conflicting interests. If it is unfair to bar a plaintiff from recovering on a meritorious claim, it is also unfair to require a defendant to defend against possibly false allegations concerning long-forgotten events, when important evidence may no longer be available. Thus, statutes of limitations are not mere technical defenses, allowing wrongdoers to avoid accountability. Rather, they mark the point where, in the judgment of the legislature, the equities tip in favor of the defendant (who may be innocent of wrongdoing) and against the plaintiff (who failed to take prompt action): "[T]he period allowed for instituting suit inevitably reflects a value judgment concerning the point at which the interests in favor of protecting valid claims are outweighed by the interests in prohibiting the prosecution of stale ones."[41]

The Court continued: "Critical to applying a statute of limitations is determining the point when the limitations period begins to run."[42] Generally, the Court noted, "a plaintiff must file suit within a designated period after the cause of action accrues."[43] The cause of action accrues, the Court said, "when [it] is complete with all of its elements."[44] Put another way, the courts have held that "[a] cause of action accrues 'upon the occurrence of the last element essential to the cause of action.'"[45]

Here, the "last element essential to the cause of action," pursuant to Government Code section 17558.5 and former section 1185 (now 1185.1) of the Commission's regulations, is a notice to the claimant of the adjustment, which includes the reason for the adjustment. Government Code section 17558.5(c) provides, in pertinent part:

> The Controller shall notify the claimant in writing within 30 days after issuance of a remittance advice of any adjustment to a claim for reimbursement that results from an audit or review. The notification shall specify the claim components adjusted, the amounts adjusted, interest charges on claims adjusted to reduce the overall reimbursement to the local agency or school district, and the reason for the adjustment... [46]

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[40] 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."].

[41] *Pooshs v. Phillip Morris USA, Inc.* (2011) 51 Cal.4th 788, at p. 797.

[42] *Ibid.*

[43] *Ibid* [citing Code of Civil Procedure section 312].

[44] *Ibid* [quoting *Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 397].

[45] *Seelenfreund v. Terminix of Northern California, Inc.* (1978) 84 Cal.App.3d 133 [citing *Neel v. Magana, Olney, Levy, Cathcart & Gelfand* (1971) 6 Cal.3d 176].

[46] Government Code section 17558.5 (added, Stats. 1995, ch. 945 (SB 11)).

Accordingly, former section 1185 of the Commission's regulations provides that incorrect reduction claims shall be filed not later than three years following the notice of adjustment, and that the filing must include a detailed narrative describing the alleged reductions and a copy of any "written notice of adjustment from the Office of the State Controller that explains the reason(s) for the reduction or disallowance."[47] Therefore, the Commission finds that the last essential element of an IRC is the issuance by the Controller of a notice of adjustment that includes the reason for the adjustment.

b. More recent cases have relaxed the general accrual rule or recognized exceptions to the general rule based on a plaintiff's notice of facts constituting the cause of action.

Historically, the courts have interpreted the application of statutes of limitation very strictly: in a 1951 opinion, the Second District Court of Appeal declared that "[t]he courts in California have held that statutes of limitation are to be strictly construed and that if there is no express exception in a statute providing for the tolling of the time within which an action can be filed, the court cannot create one."[48] That opinion in turn cited the California Supreme Court in *Lambert v. McKenzie* (1901), in which the Court reasoned that a cause of action for negligence did not arise "upon the date of the discovery of the negligence," but rather "[i]t is the date of the act and fact which fixes the time for the running of the statute."[49] The Court continued:

> Cases of hardship may arise, and do arise, under this rule, as they arise under every statute of limitations; but this, of course, presents no reason for the modification of a principle and policy which upon the whole have been found to make largely for good... And so throughout the law, except in cases of fraud, it is the time of the act, and not the time of the discovery, which sets the statute in operation.[50]

Accordingly, the rule of *Lambert v. McKenzie* has been restated simply: "Generally, the statute of limitations begins to run against a claimant at the time the act giving rise to the injury occurs rather than at the time of discovery of the damage."[51] This historically-strict interpretation of statutes of limitation accords with the plain language of the Code of Civil Procedure, section 312, which states that "[c]ivil actions, *without exception*, can only be commenced within the period prescribed in this title, after the cause of action shall have accrued, unless where, in special cases, a different limitation is prescribed by statute."[52]

However, more recently, courts have applied a more relaxed rule in appropriate circumstances, finding that a cause of action accrues when the plaintiff has knowledge of sufficient facts to

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[47] Code of Regulations, title 2, section 1185 (Register 99, No. 38).

[48] *Marshall v. Packard-Bell Co.* (1951) 106 Cal.App.2d 770, 774.

[49] (1901) 135 Cal. 100, 103 [overruled on other grounds, *Wennerholm v. Stanford University School of Medicine* (1942) 20 Cal.2d 713, 718].

[50] *Ibid.*

[51] *Solis v. Contra Costa County* (1967) 251 Cal.App.2d 844, 846 [citing *Lambert v. McKenzie*, 135 Cal. 100, 103].

[52] Enacted, 1872; Amended, Statutes 1897, chapter 21 [emphasis added].

make out a cause of action: "there appears to be a definite trend toward the discovery rule and away from the strict rule in respect of the time for the accrual of the cause of action..."[53] For example, in *Neel v. Magana, Olney, Levy, Cathcart & Gelfand*, the court presumed "the inability of the layman to detect" an attorney's negligence or misfeasance, and therefore held that "in an action for professional malpractice against an attorney, the cause of action does not accrue until the plaintiff knows, or should know, all material facts essential to show the elements of that cause of action."[54] Similarly, in *Seelenfreund v. Terminix of Northern California, Inc.*, the court held that where the cause of action arises from a negligent termite inspection and report: "appellant, in light of the specialized knowledge required [to perform structural pest control], could, with justification, be ignorant of his right to sue at the time the termite inspection was negligently made and reported..."[55]

Also finding justification for delayed accrual in an attorney malpractice context, but on different grounds, is *Budd v. Nixen*, in which the court framed the issue as a factual question of when actual or appreciable harm occurred: "mere breach of a professional duty, causing only nominal damages, speculative harm, or the threat of future harm - not yet realized - does not suffice to create a cause of action for negligence."[56] Accordingly, in *Allred v. Bekins Wide World Van Services*, it was held that the statute of limitations applicable to a cause of action for the negligent packing and shipping of property should be "tolled until the Allreds sustained damage, and discovered or should have discovered, their cause of action against Bekins."[57]

These cases demonstrate that the plaintiff's *knowledge* of sufficient facts to make out a claim is sometimes treated as the last essential element of the cause of action. Or, alternatively, actual damage must be sustained, and knowledge of the damage, before the statute begins to run.

Here, a delayed discovery rule is inconsistent with the plain language of the Commission's regulations and of section 17558.5, and illogical in the context of an IRC filing, but notice of the reduction and the reason for it constitute the last essential element of the claim. Former section 1185 of the Commission's regulations provides for a period of limitation of three years following the date of a document from the Controller "notifying the claimant of a reduction."[58] Likewise, Government Code section 17558.5 requires the controller to notify the claimant in writing and specifies that the notice must provide "the claim components adjusted, the amounts

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[53] *Warrington v. Charles Pfizer & Co.*, (1969) 274 Cal.App.2d 564, 567 [citing delayed accrual based on discovery rule for medical, insurance broker, stock broker, legal, and certified accountant malpractice and misfeasance cases].

[54] 6 Cal.3d at p. 190.

[55] (1978) 84 Cal.App.3d 133, 138.

[56] *Budd v. Nixen* (1971) 6 Cal.3d 195, 200-201 [superseded in part by statute, Code of Civil Procedure section 340.6 (added, Stats. 1977, ch. 863) which provides for tolling the statute of limitations if the plaintiff has not sustained actual injury].

[57] (1975) 45 Cal.App.3d 984, 991 [Relying on *Neel v. Magana, Olney, Levy, Cathcart & Gelfand, supra*, 6 Cal.3d at p. 190; *Budd v. Nixen, supra*, 6 Cal.3d at pp. 200-201].

[58] Code of Regulations, title 2, section 1185 (Register 1999, No. 38).

adjusted...and the reason for the adjustment."[59] Moreover, an IRC is based on the reduction of a claimant's reimbursement during a fiscal year, and the claim could not reasonably be filed before the claimant was aware that the underlying reduction had been made. Therefore, the delayed discovery rules developed by the courts are not applicable to an IRC, because by definition, once it is possible to file the IRC, the claimant has sufficient notice of the facts constituting the claim.

c. Other recent cases have applied the statute of limitations based on the later accrual of a distinct injury or wrongful conduct.

Another line of legal reasoning, which rests not on delayed accrual of a cause of action, but on a new injury that begins a new cause of action and limitation period, is represented by cases alleging more than one legally or qualitatively distinct injury arising at a different time, or more than one injury arising on a recurring basis.

In *Pooshs v. Philip Morris USA, Inc.*, the Court held that applying the general rule of accrual "becomes rather complex when...a plaintiff is aware of both an injury and its wrongful cause but is uncertain as to how serious the resulting damages will be or whether *additional injuries* will later become manifest."[60] In *Pooshs*, the plaintiff was diagnosed with successive smoking-related illnesses between 1989 and 2003. When diagnosed with lung cancer in 2003 she sued Phillip Morris USA, and the defendant asserted a statute of limitations defense based on the initial smoking-related injury having occurred in 1989. The Ninth Circuit Court of Appeals, hearing a motion for summary judgment, certified a question to the California Supreme Court whether the later injury (assuming for purposes of the summary judgment motion that the lung cancer diagnosis was indeed a separate injury) triggered a new statute of limitations, despite being caused by the same conduct. The Court held that for statute of limitations purposes, a later physical injury "can, in some circumstances, be considered 'qualitatively different...'"[61] Relying in part on its earlier decision in *Grisham v. Philip Morris*,[62] in which a physical injury and an economic injury related to smoking addiction were treated as having separate statutes of limitation, the Court held in *Pooshs*:

> As already discussed...we emphasized in *Grisham* that it made little sense to require a plaintiff whose only known injury is economic to sue for personal injury damages based on the speculative possibility that a then latent physical injury might later become apparent. (*Grisham*, *supra*, 40 Cal.4th at pp. 644–645.) Likewise, here, no good reason appears to require plaintiff, who years ago suffered a smoking-related disease that is not lung cancer, to sue at that time for lung cancer damages based on the speculative possibility that lung cancer might later arise.[63]

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[59] Government Code section 17558.5 (added, Stats. 1995, ch. 945 (SB 11)).

[60] *Pooshs v. Philip Morris USA, Inc.* (2011) 51 Cal.4th 788, 797 [emphasis added].

[61] *Id*, at p. 792.

[62] (2007) 40 Cal.4th 623.

[63] *Pooshs*, *supra*, at p. 802.

However, the Court cautioned: "We limit our holding to latent disease cases, without deciding whether the same rule should apply in other contexts."[64] No published cases in California have sought to extend that holding. In effect, the *Pooshs* holding is not an exception to the rule of accrual of a cause of action, but a recognition that in certain limited circumstances (such as latent diseases) a new cause of action, with a new statute of limitations, can arise from the same underlying facts, such as smoking addiction or other exposure caused by a defendant.

A second, and in some ways similar exception to the general accrual rule, can occur in the context of a continuing or recurring injury or wrongful conduct, such as a nuisance or trespass. Where a nuisance or trespass is considered permanent, such as physical damage to property or a hindrance to access, the limitation period runs from the time the injury first occurs; but if the conduct is of a character that may be discontinued and repeated, each successive wrong gives rise to a new action, and begins a new limitation period.[65] The latter rule is similar to the latent physical injury cases described above, in that a continuing or recurring nuisance or trespass could have the same or similar cause but the cause of action is not stale because the injury is later-incurred or later-discovered. However, in the case of a continuing nuisance or trespass, the statute of limitations does not bar the action completely, but limits the remedy to only those injuries incurred within the statutory period; a limitation that would not be applicable to these facts, because the subsequent notice does not constitute a new injury, as explained below.

In *Phillips v. City of Pasadena*,[66] the plaintiff brought a nuisance action against the City for blocking a road leading to the plaintiff's property, which conduct was alleged to have destroyed his resort business. The period of limitation applicable to a nuisance claim against the City was six months, and the trial court dismissed the action because the road had first been blocked nine months before the claim was filed. On appeal, the court treated the obstruction as a continuing nuisance, and thus allowed the action, but limited the recovery to damages occurring six months prior to the commencement of the action, while any damages prior to that were time-barred.[67] In other words, to the extent that the city's roadblock caused injury to the plaintiff's business, Phillips was only permitted to claim monetary damages incurred during the statutory period preceding the initiation of the action.

Here, there is no indication that the "injury" suffered by the claimant is of a type that could be analogized to *Pooshs* or *Phillips*. Although the first notice of adjustment in the record of this IRC is vague as to the reasons for reduction,[68] and the Controller did alter the reduction (i.e.,

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[64] *Id*, at p. 792.

[65] See *Phillips v. City of Pasadena* (1945) 27 Cal.2d 104 ["Where a nuisance is of such a character that it will presumably continue indefinitely it is considered permanent, and the limitations period runs from the time the nuisance is created."]; *McCoy v. Gustafson* (2009) 180 Cal.App.4th 56, 84 ["When a nuisance is continuing, the injured party is entitled to bring a series of successive actions, each seeking damages for new injuries occurring within three years of the filing of the action..."].

[66] (1945) 27 Cal.2d 104.

[67] *Id*, at pp. 107-108.

[68] Exhibit A, IRC 05-4425-I-11, page 15.

reduced the reduction) in a later notice letter,[69] there is no indication that the injury to the claimant is qualitatively different, as was the case in *Pooshs*. Moreover, the later letter in the record in fact provides for a *lesser* reduction, rather than an increased or additional reduction, which would be recoverable under the reasoning of *Phillips*. It could be argued that the Controller has the authority to mitigate or retract its reduction at any time, only to impose a new or increased reduction, but no such facts emerge on this record. Moreover, in cases that apply a continuing or recurring harm theory, only the incremental or increased harm that occurred during the statutory period is recoverable, as in *Phillips*. Here, as explained above, the later notice of reduction (July 10, 2002) indicates a smaller reduction than the earlier, and therefore no incremental increase in harm can be identified during the period of limitation (i.e., three years prior to the filing date of the IRC, December 19, 2005).

d. The general rule still places the burden on the plaintiff to initiate an action even if the full extent or legal significance of the claim is not known.

Even as "[t]he strict rule…is, in various cases, relaxed for a variety of reasons, such as implicit or express representation; fraudulent concealment, fiduciary relationship, continuing tort, continuing duty, and progressive and accumulated injury, all of them excusing plaintiff's unawareness of what caused his injuries…",[70] the courts have continued to resist broadening the discovery rule to excuse a dilatory plaintiff[71] when sufficient facts to make out a claim or cause of action are apparent.[72] And, the courts have held that the statute may commence to run before *all* of the facts are available, or before the legal significance of the facts is fully understood. For example, in *Jolly v. Eli Lilly & Co.*, the Court explained that "[u]nder the discovery rule, the statute of limitations begins to run when the plaintiff suspects or should suspect that her injury was caused by wrongdoing, that someone has done something to her."[73] The Court continued:

> A plaintiff need not be aware of the specific "facts" necessary to establish the claim; that is a process contemplated by pretrial discovery. Once the plaintiff has a suspicion of wrongdoing, and therefore an incentive to sue, she must decide

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[69] Exhibit A, IRC 05-4425-I-11, pages 18-19.

[70] *Warrington v. Charles Pfizer & Co.*, (1969) 274 Cal.App.2d 564, 567.

[71] *Regents of the University of California v. Superior Court* 20 Cal.4th 509, 533 [Declining to apply doctrine of fraudulent concealment to toll or extend the time to commence an action alleging violation of Bagley-Keene Open Meetings Act].

[72] *Scafidi v. Western Loan & Building Co.* (1946) 72 Cal.App.2d 550, 566 ["Our courts have repeatedly affirmed that mere ignorance, not induced by fraud, of the existence of the facts constituting a cause of action on the part of a plaintiff does not prevent the running of the statute of limitations."]. See also, *Royal Thrift and Loan Co v. County Escrow, Inc.* (2004) 123 Cal.App.4th 24, 43 ["Generally, statutes of limitation are triggered on the date of injury, and the plaintiff's ignorance of the injury does not toll the statute… [However,] California courts have long applied the delayed discovery rule to claims involving *difficult-to-detect injuries* or the breach of a fiduciary relationship." (Emphasis added, internal citations and quotations omitted)].

[73] (1988) 44 Cal.3d 1103, 1110.

> whether to file suit or sit on her rights. So long as a suspicion exists, it is clear that the plaintiff must go find the facts; she cannot wait for the facts to find her.[74]

Accordingly, in *Goldrich v. Natural Y Surgical Specialties, Inc.*, the court held that the statute of limitations applicable to the plaintiff's injuries for negligence and strict products liability had run, where "...Mrs. Goldrich must have suspected or certainly should have suspected that she had been harmed, and she must have suspected or certainly should have suspected that her harm was caused by the implants."[75] Therefore, even though in some contexts the statute of limitations is tolled until discovery, or in others the last element essential to the cause of action is interpreted to include notice or awareness of the facts constituting the claim, *Jolly*, *supra*, and *Goldrich*, *supra*, demonstrate that the courts have been hesitant to stray too far from the general accrual rule.[76]

Accordingly, here, the claimant argues that "[t]he Controller has not specified how the claim documentation was insufficient for purposes of adjudicating the claim..." and the Controller provides "no notice for the basis of its actions..." However, the history of California jurisprudence interpreting and applying statutes of limitation does not indicate that the claimant's lack of understanding of the "basis of [the Controller's] actions" is a sufficient reason to delay the accrual of an action and the commencement of the period of limitation. In accordance with the plain language of Government Code section 17558.5, the Controller is required to specify the claim components adjusted and the reasons for the reduction; and, former section 1185 of the Commission's regulations requires an IRC filing to include a detailed narrative and a copy of any written notice from the Controller explaining the reasons for the reduction.[77] As long as the claimant has notice of the reason for the adjustment, the underlying factual bases are not necessary for an IRC to lie. Indeed, as discussed above, the courts have held that as a general rule, a plaintiff's ignorance of the person causing the harm, or the harm itself, or the legal significance of the harm, "does not prevent the running of the statute of limitations."[78] Based on the foregoing, the claimant is not required to have knowledge of the "basis of [the Controller's] actions" for the period of limitation to run, as long as a *reason* for the reduction is stated.

e. Where the cause of action is to enforce an obligation or obtain an entitlement, the claim accrues when the party has the right to enforce the obligation.

More pertinent, and more easily analogized to the context of an IRC, are those cases in which an action is brought to enforce or resolve a claim or entitlement that is in dispute, including one administered by a governmental agency. In those cases, the applicable period of limitation attaches and begins to run when the party's right to enforce the obligation accrues.

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[74] *Id*, at p. 1111.

[75] (1994) 25 Cal.App.4th 772, 780.

[76] See *Baker v. Beech Aircraft Corp.* (1974) 39 Cal.App.3d 315, 321 ["The general rule is that the applicable statute...begins to run when the cause of action accrues even though the plaintiff is ignorant of the cause of action or of the identity of the wrongdoer."];

[77] Government Code section 17558.5 (added, Stats. 1995, ch. 945 (SB 11)). Code of Regulations, title 2, section 1185 (Register 99, No. 38).

[78] *Scafidi v. Western Loan & Building Co.* (1946) 72 Cal.App.2d 550, 566.

For example, in cases involving claims against insurance companies, the courts have held that the one-year period of limitation begins to run at the "inception of the loss," defined to mean when the insured *knew or should have known* that appreciable damage had occurred and a reasonable person would be aware of his duty under the policy to notify the insurer.[79] This line of cases does not require that the *total extent of the damage*, or the *legal significance* of the damage, is known at the time the statute commences to run.[80] Rather, the courts generally hold that where the plaintiff knows or has reason to know that damage has occurred, and a reasonable person would be aware of the duty to notify his or her insurer, the statute commences to run at that time.[81] This line of reasoning is not inconsistent with *Pooshs*, *Grisham*, and *Phillips v. City of Pasadena*, discussed above, because in each of those cases the court found (or at least presumed) a recurring injury, which was legally, qualitatively, or incrementally distinct from the earlier injury and thus gave rise to a renewed cause of action.[82]

An alternative line of cases addresses the accrual of claims for benefits or compensation from a government agency, which provides a nearer analogy to the context of an IRC. In *Dillon v. Board of Pension Commissioners of the City of Los Angeles*, the Court held that a police officer's widow failed to bring a timely action against the Board because her claim to her late husband's pension accrued at the time of his death: "At any time following the death she could demand a pension from the board and upon refusal could maintain a suit to enforce such action."[83] Later, *Phillips v. County of Fresno* clarified that "[a]lthough the cause of action accrues in pension cases when the employee first has the power to demand a pension, the limitations period is tolled or suspended during the period of time in which the claim is under consideration by the pension board."[84] In accord is *Longshore v. County of Ventura*, in which the Court declared that "claims for compensation due from a public employer may be said to accrue only when payment thereof can be legally compelled."[85] And similarly, in *California Teacher's Association v. Governing Board*, the court held that "unlike the salary which teachers were entitled to have as they earned

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[79] See *Prudential-LMI Com. Insurance v. Superior Court* (1990) 51 Cal.3d 674, 685; *Campanelli v. Allstate Life Insurance Co.* (9th Cir. 2003) 322 F.3d 1086, 1094.

[80] *Campanelli v. Allstate Life Insurance Co.* (9th Cir. 2003) 322 F.3d 1086, 1094 [Fraudulent engineering reports concealing the extent of damage did not toll the statute of limitations, nor provide equitable estoppel defense to the statute of limitations]; *Abari v. State Farm Fire & Casualty Co.* (1988) 205 Cal.App.3d 530, 534 [Absentee landlord's belated discovery of that his homeowner's policy might cover damage caused by subsidence was not sufficient reason to toll the statute]. See also *McGee v. Weinberg* (1979) 97 Cal.App.3d 798, 804 ["It is the occurrence of some ... cognizable event rather than knowledge of its legal significance that starts the running of the statute of limitations."].

[81] *Ibid.*

[82] *Pooshs v. Philip Morris USA, Inc.* (2011) 51 Cal.4th 788; *Grisham*, *supra*, 40 Cal.4th at pp. 644–645; *Phillips v. City of Pasadena* (1945) 27 Cal.2d 104.

[83] *Dillon v. Board of Pension Commissioners* (1941) 18 Cal.2d 427, 430.

[84] (1990) 225 Cal.App.3d 1240, 1251.

[85] (1979) 25 Cal.3d 14, 30-31.

it...their right to use of sick leave depended on their being sick or injured."[86] Therefore, because they "could not legally compel payment for sick leave to the extent that teachers were not sick, their claims for sick leave did not accrue."[87] This line of cases holds that a statute of limitations to compel payment begins to run when the plaintiff is entitled to demand, or legally compel, payment on a claim or obligation, but the limitation period is tolled while the agency considers that demand.

Here, an IRC cannot lie until there has been a reduction, which the claimant learns of by a notice of adjustment, and the IRC cannot reasonably be filed under the Commission's regulations until at least some reason for the adjustment can be detailed.[88] The claimant's reimbursement claim has already at that point been considered and rejected (to some extent) by the Controller. There is no analogy to the tolling of the statute, as discussed above; the period of limitation begins when the claim is reduced, by written notice, and the claimant is therefore entitled to demand payment through the IRC process.

f. Where the cause of action arises from a breach of a statutory duty, the cause of action accrues at the time of the breach.

Yet another line of cases addresses the accrual of an action on a breach of statutory duty, which is closer still to the contextual background of an IRC. In *County of Los Angeles v. State Department of Public Health*, the County brought actions for mandate and declaratory relief to compel the State to pay full subsidies to the County for the treatment of tuberculosis patients under the Tuberculosis Subsidy Law, enacted in 1915.[89] In 1946 the department adopted a regulation that required the subsidy to a county hospital to be reduced for any patients who were able to pay toward their own care and support, but the County ignored the regulation and continued to claim the full subsidy.[90] Between October 1952 and July 1953 the Controller audited the County's claims, and discovered the County's "failure to report on part-pay patients in the manner contemplated by regulation No. 5198..."[91] Accordingly, the department reduced the County's semiannual claims between July 1951 and December 1953.[92] When the County brought an action to compel repayment, the court agreed that the regulation requiring reduction for patients able to pay in part for their care was inconsistent with the governing statutes, and therefore invalid;[93] but the court was also required to consider whether the County's claim was time-barred, based on the effective date of the regulation. The court determined that the date of the *reduction*, not the effective date of the regulation, triggered the statute of limitations to run:

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[86] (1985) 169 Cal.App.3d 35, 45-46.

[87] *Ibid.*

[88] Government Code section 17558.5 (added, Stats. 1995, ch. 945 (SB 11)); Code of Regulations, title 2, section 1185 (Register 99, No. 38).

[89] (1958) 158 Cal.App.2d 425, 430.

[90] *Id*, at p. 432.

[91] *Id*, at p. 433.

[92] *Ibid.*

[93] *Id*, at p. 441.

> Appellants invoke the statute of limitations, relying on Code of Civil Procedure § 343, the four-year statute. Counsel argue [*sic*] that rule 5198 was adopted in August, 1946, and the County's suit not brought within four years and hence is barred. Respondent aptly replies: "In this case the appellants duly processed and paid all of the County's subsidy claims through the claim for the period of ending [*sic*]June 30, 1951...The first time that Section 5198 was asserted against Los Angeles County was when its subsidy claim for the period July 1, 1951, to December 31, 1951, was reduced by application of this rule of July 2, 1952...This action being for the purpose of enforcing a liability created by statute is governed by the three-year Statute of Limitations provided in Code of Civil Procedure Section 338.1. Since this action was filed May 4, 1954, it was filed well within the three-year statutory period, which commenced July 2, 1952." We agree. Neither action was barred by limitation.[94]

Similarly, in *Snyder v. California Insurance Guarantee Association (CIGA)*,[95] the accrual of an action to compel payment under the Guarantee Act was interpreted to require first the rejection of a viable claim. CIGA is the state association statutorily empowered and obligated to "protect policyholders in the event of an insurer's insolvency."[96] Based on statutory standards, "CIGA pays insurance claims of insolvent insurance companies from assessments against other insurance companies...[and] '[i]n this way the insolvency of one insurer does not impact a small segment of insurance consumers, but is spread throughout the insurance consuming public..."[97] "[I]f CIGA improperly denies coverage or refuses to defend an insured on a 'covered claim' arising under an insolvent insurer's policy, it breaches its statutory duties under the Guarantee Act."[98] Therefore, "[i]t follows that in such a case a cause of action *accrues* against CIGA when CIGA denies coverage on a submitted claim."[99] Thus, in *Snyder*, the last essential element of the action was the denial of a "covered claim" by CIGA, which is defined in statute to include obligations of an insolvent insurer that "remain unpaid despite presentation of a timely claim in the insurer's liquidation proceeding." And, the definition in the code excludes a claim "to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured."[100] Therefore a claimant is required to pursue "any other insurance" before filing a claim with CIGA, and CIGA must reject that claim, thus breaching its statutory duties, before the limitation period begins to run.

Here, an IRC may be filed once a claimant has notice that the Controller has made a determination that the claim must be reduced, and notice of the reason(s) for the reduction.

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[94] *Id*, at pp. 445-446.

[95] (2014) 229 Cal.App.4th 1196.

[96] *Id*, at p. 1203, Fn. 2.

[97] *Ibid.*

[98] *Id*, at p. 1209 [quoting *Berger v. California Insurance Guarantee Association* (2005) 128 Cal.App.4th 989, 1000].

[99] *Id*, at p. 1209 [emphasis added].

[100] *Ibid* [citing Insurance Code §1063.1].

Government Code section 17551 provides that the Commission "shall hear and decide upon" a local government's claim that the Controller incorrectly reduced payments pursuant to section 17561(d)(2), which in turn describes the Controller's audit authority.[101] Moreover, section 1185.1 (formerly section 1185) of the Commission's regulations states that "[t]o obtain a determination that the Office of State Controller incorrectly reduced a reimbursement claim, a claimant shall file an 'incorrect reduction claim' with the commission."[102] And, section 1185.1 further requires that an IRC filing include "[a] written detailed narrative that describes the alleged incorrect reduction(s)," including "a comprehensive description of the reduced or disallowed area(s) of cost(s)." And in addition, the filing must include "[a] copy of any final state audit report, letter, remittance advice, or other written notice of adjustment form the Office of State Controller that explains the reason(s) for the reduction or disallowance."[103] Therefore, the Controller's reduction of a local government's reimbursement claim is the underlying cause of an IRC, and the notice to the claimant of the reduction and the reason for the reduction is the "last element essential to the cause of action,"[104] similar to *County of Los Angeles v. State Department of Public Health*, and *Snyder v. California Insurance Guarantee Association*, discussed above.

2. As applied to this IRC, the three year period of limitation attached either to the July 30, 1998 notice of adjustment or the July 10, 2002 notice of adjustment, and therefore the IRC filed December 16, 2005 was not timely.

As discussed above, the general rule of accrual of a cause of action is that the period of limitations attaches and begins to run when the claim accrues, or in other words upon the occurrence of the last element essential to the cause of action. The above analysis demonstrates that the general rule, applied consistently with Government Code section 17558.5 and Code of Regulations, title 2, section 1185.1 (formerly 1185) means that an IRC accrues and may be filed when the claimant receives notice of a reduction and the reason(s) for the reduction. And, as discussed above, none of the established exceptions to the general accrual rule apply as a matter of law to IRCs generally. However, the claimant has here argued that later letters or notices of payment action in the record control the time "from which the ultimate regulatory period of limitation is to be measured…" The Commission finds that the claimant's argument is unsupported.

a. The general accrual rule must be applied consistently with Government Code section 17558.5(c).

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[101] Government Code section 17551 (Stats. 1985, ch. 179; Stats. 1986, ch. 879; Stats 2002, ch. 1124 (AB 3000); Stats. 2004, ch. 890 (AB 2856); Stats. 2007, ch. 329 (AB 1222)); 17561(d)(2) (Stats. 1986, ch. 879; Stats. 1988, ch. 1179; Stats. 1989, ch. 589; Stats. 1996, ch. 45 (SB 19); Stats. 1999, ch. 643 (AB 1679); Stats. 2002, ch. 1124 (AB 3000); Stats. 2004, ch. 313 (AB 2224); Stats 2004, ch. 890 (AB 2856); Stats. 2006, ch. 78 (AB 1805); Stats. 2007, ch. 179 (SB 86); Stats. 2007, ch. 329 (AB 1222); Stats. 2009, ch. 4 (SBX3 8)).

[102] Code of Regulations, title 2, section 1185.1(a) (Register 2014, No. 21.

[103] Code of Regulations, title 2, section 1185.1(f) (Register 2014, No. 21.

[104] *Seelenfreund v. Terminix of Northern California, Inc.* (1978) 84 Cal.App.3d 133 [citing *Neel v. Magana, Olney, Levy, Cathcart & Gelfand* (1971) 6 Cal.3d 176].

As noted above, the period of limitation for filing an IRC was added to the Commission's regulations effective September 13, 1999. As amended by Register 99, No. 38, section 1185(b) provided:

> All incorrect reduction claims shall be submitted to the commission no later than three (3) years following the date of the State Controller's remittance advice *notifying the claimant of a reduction.*[105]

Based on the plain language of the provision, the Commission's regulation on point is consistent with the general rule that the period of limitation to file an IRC begins to run when the claimant receives notice of a reduction.

However, Government Code section 17558.5, as explained above, provides that the Controller must issue written notice of an adjustment, which includes the claim components adjusted and the reasons for adjustment. And, accordingly, section 1185.1 (formerly 1185) requires an IRC filing to include a detailed narrative which identifies the alleged incorrect reductions, and any copies of written notices specifying the reasons for reduction.

Therefore, a written notice identifying the reason or reasons for adjustment is required to trigger the period of limitation. Here, there is some question whether the July 30, 1998 notice provided sufficient notice of the reason for the reduction. The claimant states in its IRC that the claim was "reduced by the amount of $184,842 due to 'no supporting documentation.'"[106] In addition, the claimant provided a letter addressed to the audit manager at the Controller's Office from the District, stating that "Gavilan College has all supporting documentation to validate our claim..." and "[i]t is possible you need additional information..."[107] However, the notice of adjustment included in the record, issued on July 30, 1998, does not indicate a reason for the adjustment.[108]

The July 10, 2002 letter, however, does more clearly state the reason for adjustment, as "no supporting documentation."[109] And again, the claimant states in its IRC that the later letter reduced the claim "by the amount of $124,245 due to 'no supporting documentation.'"[110]

The issue, then, is whether the claimant had actual notice as early as July 30, 1998 of the adjustment and the reason for the adjustment, or whether the Controller's failure to clearly state the reason means the period of limitation instead commenced to run on July 10, 2002. The case law described above would seem to weigh in favor of applying the period of limitation to the earlier notice of adjustment, even if the reason for the adjustment was not known at that time.[111] Additionally, the evidence in the record indicates that the claimant may have had *actual* notice of

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[105] Code of Regulations, title 2, section 1185(b) (Register 1999, No. 38) [emphasis added].

[106] Exhibit A, IRC 05-4425-I-11, page 5.

[107] Exhibit A, IRC 05-4425-I-11, page 21.

[108] Exhibit A, IRC 05-4425-I-11, page 15.

[109] Exhibit A, IRC 05-4425-I-11, page 19.

[110] Exhibit A, IRC 05-4425-I-11, pages 5-6.

[111] See *Baker v. Beech Aircraft Corp.* (1974) 39 Cal.App.3d 315, 321 ["The general rule is that the applicable statute...begins to run when the cause of action accrues even though the plaintiff is ignorant of the cause of action or of the identity of the wrongdoer."]

the reason for the reduction, even if the Controller's letter dated July 30, 1998 does not clearly state the reason.[112] However, section 17558.5 requires the Controller to specify the reasons for reduction in its notice, and section 1185.1 of the regulations requires a claimant to include a copy of any such notice in its IRC filing.

Ultimately, the Commission is not required to resolve this question here, because the period of limitation attaches *no later than* the July 10, 2002 notice, which does contain a statement of the reason for the reduction. And, pursuant to the case law discussed above, even if the reason stated is cursory or vague, the period of limitation would commence to run where the claimant knows or has reason to know that it has a claim.[113]

b. None of the exceptions to the general accrual rule apply, and therefore the later notices of adjustment in the record do not control the period of limitation.

As discussed at length above, a cause of action is generally held to accrue at the time an action may be maintained, and the applicable statute of limitations attaches at that time.[114] Here, claimant argues that the applicable period of limitation should instead attach to the *last* notice of adjustment in the record: "the incorrect reduction claim asserts as a matter of fact that the Controller's July 10, 2002 letter reports an amount payable to the claimant, which means a subsequent final payment action notice occurred or is pending from which the ultimate regulatory period of limitation is to be measured, which the claimant has so alleged."[115] In its comments on the draft, the claimant identifies a new "notice of adjustment" received by the claimant on February 26, 2011,[116] which the claimant argues "now becomes the last Controller's adjudication notice letter," and sets the applicable period of limitation.[117]

There is no support in law for the claimant's position. As discussed above, statutes of limitation attach when a claim is "complete with all its elements."[118] Exceptions have been carved out when a plaintiff is justifiably unaware of facts essential to the claim,[119] but even those exceptions are limited, and do not apply when the plaintiff has sufficient facts to be on inquiry or

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[112] Exhibit A, IRC 05-4425-I-11, pages 5-6; 15; 21.

[113] See, e.g., *Allred v. Bekins Wide World Van Services* (1975) 45 Cal.App.3d 984, 991 [Relying on *Neel v. Magana, Olney, Levy, Cathcart & Gelfand, supra*, 6 Cal.3d at p. 190; *Budd v. Nixen, supra*, 6 Cal.3d at pp. 200-201].

[114] *Lambert v. McKenzie, supra*, (1901) 135 Cal. 100, 103.

[115] Exhibit B, Claimant Comments, page 2.

[116] The notice in the record is dated February 26, 2011 but stamped received by the District on March 14, 2011.

[117] Exhibit E, Claimant Comments on Draft Proposed Decision, page 2.

[118] *Pooshs v. Phillip Morris USA, Inc.* (2011) 51 Cal.4th 788, 797 [quoting *Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 397].

[119] *Allred v. Bekins Wide World Van Services*, (1975) 45 Cal.App.3d 984, 991 [Relying on *Neel v. Magana, Olney, Levy, Cathcart & Gelfand, supra*, 6 Cal.3d at p. 190; *Budd v. Nixen, supra*, 6 Cal.3d at pp. 200-201].

constructive notice that a wrong has occurred and that he or she has been injured.[120] The courts do not accommodate a plaintiff merely because the full extent of the claim, or its legal significance, or even the identity of a defendant, may not be yet known at the time the cause of action accrues.[121] Accordingly, the claimant cannot allege that the earliest notice did not provide sufficient information to initiate an IRC, and the later adjustment notices that the claimant proffers do not toll or suspend the operation of the period of limitation.

The discussion above also explains that in certain circumstances a new statute of limitations is commenced where a new injury results, even from the same or similar conduct, and in such circumstances a plaintiff may be able to recover for the later injury even when the earlier injury is time-barred.[122] Here, the later letters in the record do not constitute either a new or a cumulative injury. The first notice stated a reduction of the claim "by the amount of $184,842..." and stated that "$126,146 was due to the State."[123] The later letters notified the claimant that funds were being offset from other programs,[124] but did not state any new reductions. And the notice dated July 10, 2002 stated that the Controller had further reviewed the claim, and now $60,597 was due the claimant, which represented a reduction of the earlier adjustment amount.[125] The letter that the claimant received on March 14, 2011,[126] states no new reductions, or new reasoning for existing reductions, with respect to the 1995-1996 annual

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[120] *Jolly v. Eli Lilly & Co.* (1988) 44 Cal.3d 1103, 1110 [belief that a cause of action for injury from DES could not be maintained against multiple manufacturers when exact identity of defendant was unknown did not toll the statute]; *Goldrich v. Natural Y Surgical Specialties, Inc.* (1994) 25 Cal.App.4th 772, 780 [belief that patient's body, and not medical devices implanted it it, was to blame for injuries did not toll the statute]; *Campanelli v. Allstate Life Insurance Co.* (9th Cir. 2003) 322 F.3d 1086, 1094 [Fraudulent engineering reports concealing the extent of damage did not toll the statute of limitations, nor provide equitable estoppel defense to the statute of limitations]; *Abari v. State Farm Fire & Casualty Co.* (1988) 205 Cal.App.3d 530, 534 [Absentee landlord's belated discovery of that his homeowner's policy might cover damage caused by subsidence was not sufficient reason to toll the statute]. See also *McGee v. Weinberg* (1979) 97 Cal.App.3d 798, 804 ["It is the occurrence of some ... cognizable event rather than knowledge of its legal significance that starts the running of the statute of limitations."].

[121] *Scafidi v. Western Loan & Building Co.* (1946) 72 Cal.App.2d 550, 566 ["Our courts have repeatedly affirmed that mere ignorance, not induced by fraud, of the existence of the facts constituting a cause of action on the part of a plaintiff does not prevent the running of the statute of limitations."]. See also, *Baker v. Beech Aircraft Corp.* (1974) 39 Cal.App.3d 315, 321 ["The general rule is that the applicable statute...begins to run when the cause of action accrues even though the plaintiff is ignorant of the cause of action or of the identity of the wrongdoer."].

[122] *Pooshs v. Phillip Morris USA, Inc.* (2011) 51 Cal.4th 788; *Phillips v. City of Pasadena* (1945) 27 Cal.2d 104.

[123] Exhibit A, IRC 05-4425-I-11, pages 5; 15.

[124] Exhibit A, IRC 05-4425-I-11, pages 5; 16-17.

[125] Exhibit A, IRC 05-4425-I-11, pages 5; 18.

[126] The claimant refers to this in Exhibit E as a February 26, 2011 letter, but the letter is stamped received by the District on March 14, 2011.

claims for the *Collective Bargaining* program; it provides exactly as the notice dated July 10, 2002: that $60,597 is due the claimant for the program.[127]

Based on the foregoing, the Commission finds none of the exceptions to the commencement or running of the period of limitation apply here to toll or renew the limitation period.

c. The three year period of limitation found in former Section 1185 of the Commission's regulations is applicable to this incorrect reduction claim, and does not constitute an unconstitutional retroactive application of the law.

Former section 1185[128] of the Commission's regulations, pertaining to IRCs, contained no applicable period of limitation as of July 30, 1998.[129] Neither is there any statute of limitations for IRC filings found in the Government Code.[130] Moreover, the California Supreme Court has held that "the statutes of limitations set forth in the Code of Civil Procedure...do not apply to administrative proceedings."[131] Therefore, at the time that the claimant in this IRC first received notice from the Controller of a reduction of its reimbursement claim, there was no applicable period of limitation articulated in the statute or the regulations.[132]

However, in 1999, the following was added to section 1185(b) of the Commission's regulations:

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[127] Compare Exhibit A, IRC 05-4425-I-11, pages 5; 18, with Exhibit E, Claimant Comments on Draft Proposed Decision, page 4.

[128] Section 1185 was amended and renumbered 1185.1 effective July 1, 2014. However, former section 1185, effective at the time the IRC was filed, is the provision applicable to this IRC.

[129] Code of Regulations, title 2, section 1185 (Register 1996, No. 30).

[130] See Government Code section 17500 et seq.

[131] *Coachella Valley Mosquito and Vector Control District v. Public Employees' Retirement System* (2005) 35 Cal.4th 1072, 1088 [citing *City of Oakland v. Public Employees' Retirement System* (2002) 95 Cal.App.4th 29; *Robert F. Kennedy Medical Center v. Department of Health Services* (1998) 61 Cal.App.4th 1357, 1361-1362 (finding that Code of Civil Procedure sections 337 and 338 were not applicable to an administrative action to recover overpayments made to a Medi-Cal provider); *Little Co. of Mary Hospital v. Belshe* (1997) 53 Cal.App.4th 325, 328-329 (finding that the three year audit requirement of hospital records is not a statute of limitations, and that the statutes of limitations found in the Code of Civil Procedure apply to the commencement of civil actions and civil special proceedings, "which this was not"); *Bernd v. Eu*, *supra* (finding statutes of limitations inapplicable to administrative agency disciplinary proceedings)].

[132] *City of Oakland v. Public Employees' Retirement System* (2002) 95 Cal.App.4th 29, 45 [The court held that PERS' duties to its members override the general procedural interest in limiting claims to three or four years: "[t]here is no requirement that a particular type of claim have a statute of limitation."]. See also *Bernd v. Eu* (1979) 100 Cal.App.3d 511, 516 ["There is no specific time limitation statute pertaining to the revocation or suspension of a notary's commission."].

> All incorrect reduction claims shall be submitted to the commission no later than three (3) years following the date of the State Controller's remittance advice notifying the claimant of a reduction.[133]

The courts have held that "[i]t is settled that the Legislature may enact a statute of limitations 'applicable to existing causes of action or shorten a former limitation period if the time allowed to commence the action is reasonable."[134] A limitation period is "within the jurisdictional power of the legislature of a state," and therefore may be altered or amended at the Legislature's prerogative.[135] The Commission's regulatory authority must be interpreted similarly.[136] However, "[t]here is, of course, one important qualification to the rule: where the change in remedy, as, for example, the shortening of a time limit provision, is made retroactive, there must be a reasonable time permitted for the party affected to avail himself of his remedy before the statute takes effect."[137]

The California Supreme Court has explained that "[a] party does not have a vested right in the time for the commencement of an action."[138] And neither "does he have a vested right in the running of the statute of limitations prior to its expiration."[139] If a statute "operates immediately to cut off the existing remedy, or within so short a time as to give the party no reasonable opportunity to exercise his remedy, then the retroactive application of it is unconstitutional as to such party."[140] In other words, a party has no more vested right to the time remaining on a statute of limitation than the opposing party has to the swift expiration of the statute, but if a statute is newly imposed or shortened, due process demands that a party must be granted a reasonable time to vindicate an existing claim before it is barred. The California Supreme Court has held that approximately one year is more than sufficient, but has cited to decisions in other jurisdictions providing as little as thirty days.[141]

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[133] Code of Regulations, title 2, section 1185 (Register 1999, No. 38).

[134] *Scheas v. Robertson* (1951) 38 Cal.2d 119, 126 [citing *Mercury Herald v. Moore* (1943) 22 Cal.2d 269, 275; *Security-First National Bank v. Sartori* (1939) 34 Cal.App.2d 408, 414].

[135] *Scheas, supra*, at p. 126 [citing *Saranac Land & Timber Co v. Comptroller of New York*, 177 U.S. 318, 324].

[136] *Yamaha Corp. of America v. State Board of Equalization* (1998) 19 Cal.4th 1, 10 [Regulations of an agency that has quasi-legislative power to make law are treated with equal dignity as to statutes]; *Butts v. Board of Trustees of the California State University* (2014) 225 Cal.App.4th 825, 835 ["The rules of statutory construction also govern our interpretation of regulations promulgated by administrative agencies."].

[137] *Rosefield Packing Company v. Superior Court of the City and County of San Francisco* (1935) 4 Cal.2d 120, 122.

[138] *Liptak v. Diane Apartments, Inc.* (1980) 109 Cal.App.3d 762, 773 [citing *Kerchoff-Cuzner Mill and Lumber Company v. Olmstead* (1890) 85 Cal. 80].

[139] *Liptak, supra*, at p. 773 [citing *Mudd v. McColgan* (1947) 30 Cal.2d 463, 468].

[140] *Rosefield Packing Co., supra*, at pp. 122-123.

[141] See *Rosefield Packing Co., supra*, at p. 123 ["The plaintiff, therefore, had practically an entire year to bring his case to trial..."]; *Kerchoff-Cuzner Mill and Lumber Company v. Olmstead*

Here, the regulation imposing a period of limitation was adopted and became effective on September 13, 1999.[142] As stated above, the section requires that an IRC be filed no later than three years following the date of the Controller's notice to the claimant of an adjustment. The courts have generally held that the date of accrual of the claim itself is excluded from computing time, "[e]specially where the provisions of the statute are, as in our statute, that the time shall be computed *after* the cause of action shall have accrued.[143] Here, the applicable period of limitation states that an IRC must be filed "no later than three (3) years *following* the date..."[144] The word "following" should be interpreted similarly to the word "after," and "as fractions of a day are not considered, it has been sometimes declared in the decisions that no moment of time can be said to be after a given day until that day has expired."[145] Therefore, applying the three year period of limitation to the July 30, 1998 initial notice of adjustment means the limitation period would have expired on July 31, 2001, twenty-two and one-half months after the limitation was first imposed by the regulation. In addition, if the 2002 notice is considered to be the first notice that provides a reason for the reduction, thus triggering the limitation, then the limitation is not retroactive at all. Based on the cases cited above, and those relied upon by the California Supreme Court in its reasoning, that period is more than sufficient to satisfy any due process concerns with respect to application of section 1185 of the Commission's regulations to this IRC.

Based on the foregoing, the Commission finds that the regulatory period of limitation applies from the date that it became effective, and based on the evidence in this record that application does not violate the claimant's due process rights.

V. Conclusion

Based on the foregoing, the Commission finds that this IRC is not timely filed, and is therefore denied.

(1890) 85 Cal. 80 [thirty days to file a lien on real property]. See also *Kozisek v. Brigham* (Minn. 1926) 169 Minn. 57, 61 [three months].

[142] Code of Regulations, title 2, section 1185 (Register 99, No. 38).

[143] *First National Bank of Long Beach v. Ziegler* (1914) 24 Cal.App. 503, 503-504 [Emphasis Added].

[144] Code of Regulations, title 2, section 1185 (Register 99, No. 38).

[145] *First National Bank of Long Beach v. Ziegler* (1914) 24 Cal.App., at pp. 503-504 [Emphasis Added].

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RE: **Decision**

Collective Bargaining, 05-4425-I-11
Government Code Sections 3540-3549.9
Statutes 1975, Chapter 961
Fiscal Year 1995-1996
Gavilan Joint Community College District, Claimant

On December 5, 2014, the foregoing decision of the Commission on State Mandates was adopted in the above-entitled matter.

Heather Halsey, Executive Director

Dated: December 11, 2014

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Solano and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On December 11, 2014, I served the:

Decision
Collective Bargaining, 05-4425-I-11
Government Code Sections 3540-3549.9
Statutes 1975, Chapter 961
Fiscal Year 1995-1996
Gavilan Joint Community College District, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on December 11, 2014 at Sacramento, California.

Heidi J. Palchik
Commission on State Mandates
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 11/19/14

Claim Number: 05-4425-I-11

Matter: Collective Bargaining

Claimant: Gavilan Joint Community College District

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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EXHIBIT "E"

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September 30, 2015

Mr. Patrick J. Dyer
MGT of America
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Sacramento, CA 95815

Ms. Jill Kanemasu
State Controller's Office
Division of Accounting and Reporting
3301 C Street, Suite 700
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And Parties, Interested Parties, and Interested Persons (See Mailing List)

Re: **Decision**
Handicapped and Disabled Students, 05-4282-I-03
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

Dear Mr. Dyer and Ms. Kanemasu:

On September 25, 2015, the Commission on State Mandates adopted the decision on the above-entitled matter.

Sincerely,

Heather Halsey
Executive Director

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*) (*Served September 30, 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. Patrick Dyer, John Klyver, and Glenn Kulm appeared on behalf of the claimant, the County of San Mateo (claimant). Shawn Silva and Chris Ryan appeared on behalf of the State Controller's Office (Controller).

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 the proposed decision to partially approve the IRC at the hearing by a vote of 5-1 as follows:

Member	Vote
Eraina Ortega, Representative of the Director of the Department of Finance, Chairperson	Yes
Richard Chivaro, Representative of the State Controller, Vice Chairperson	No
Mark Hariri, Representative of the State Treasurer	Yes
Scott Morgan, Representative of the Director of the Office of Planning and Research	Yes
Sarah Olsen, Public Member	Yes
Carmen Ramirez, City Council Member	Yes
Don Saylor, County Supervisor	Absent

Summary of the Findings

This analysis addresses reductions made by the Controller to reimbursement claims filed by the 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.[1]
04/28/2003	Controller issued remittance advice letters for each of the three fiscal years.[2]
04/27/2006	Claimant filed the IRC.[3]
05/04/2009	Controller submitted written comments on the IRC.[4]
03/15/2010	Claimant submitted rebuttal comments.[5]

[1] Exhibit A, IRC 05-4282-I-03, page 71.

[2] Exhibit A, IRC 05-4282-I-03, pages 1; 373-377.

[3] Exhibit A, IRC 05-4282-I-03, page 1.

[4] Exhibit B, Controller's Comments on the IRC.

[5] Exhibit C, Claimant's Rebuttal Comments.

05/28/2015	Commission staff issued the draft proposed decision.[6]
06/17/2015	Claimant submitted comments on the draft proposed decision and a request for postponement, which was denied.[7]
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.[8]
08/14/2015	Controller requested an extension of time to file comments on the revised draft proposed decision, which was approved for good cause.
08/25/2015	Claimant filed comments on the revised draft proposed decision.[9]
08/26/2015	Controller filed comments on the revised draft proposed decision.[10]

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.[11] 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.[12] In 1990 and 1991, the

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[6] Exhibit D, Draft Proposed Decision.

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

[8] Exhibit F, Revised Draft Proposed Decision.

[9] Exhibit G, Claimant's Comments on Revised Draft Proposed Decision.

[10] Exhibit H, Controller's Comments on Revised Draft Proposed Decision.

[11] 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)).

[12] Former California Code of Regulations, title 2, section 60020(a).

Commission approved the test claim and adopted parameters and guidelines, authorizing reimbursement for the mental health treatment services identified in the test claim regulations.[13]

In 2004, the Legislature directed the Commission to reconsider *Handicapped and Disabled Students*, CSM-4282.[14] 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 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

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[13] *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.

[14] Statutes 2004, chapter 493 (SB 1895).

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.[15]

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 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.

[15] Exhibit A, IRC 05-4282-I-03, page 79.

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."[16] 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."[17]

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 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."[18] 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."[19]

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

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[16] 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.)

[17] Exhibit C, Claimant's Rebuttal Comments, pages 3-4.

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

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

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."[20] 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."[21] 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.[22]

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.[23]

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)[24] 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 activities included in the Parameters and Guidelines. [*sic*][25]

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."[26]

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

[21] 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.).

[22] Exhibit A, IRC 05-4282-I-03, pages 2; 8.

[23] 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.)]

[24] 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.)

[25] Exhibit A, IRC 05-4282-I-03, page 7.

[26] Exhibit A, IRC 05-4282-I-03, page 7.

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.[27]

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."[28]

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.
> - 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.[29]

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.[30]

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[27] Exhibit A, IRC 05-4282-I-03, page 8.

[28] Exhibit A, IRC 05-4282-I-03, page 12.

[29] Exhibit C, Claimant's Rebuttal Comments, pages 1-2.

[30] Exhibit G, Claimant's Comments on Revised Draft Proposed Decision, page 2.

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."[31]

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."[32]

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."[33] 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 (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."[34]

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."[35]

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

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[31] Exhibit B, Controller's Comments on the IRC, page 1.

[32] Exhibit A, IRC 05-4282-I-03, page 79.

[33] Exhibit B, Controller's Comments on the IRC, page 17.

[34] Exhibit B, Controller's Comments on the IRC, page 17.

[35] Exhibit B, Controller's Comments on the IRC, page 17.

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."[36]

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..."[37] 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."[38]

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 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.[39] 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."[40]

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

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[36] Exhibit B, Controller's Comments on the IRC, page 18.

[37] Exhibit H, Controller's Comments on Revised Draft Proposed Decision, page 2.

[38] Exhibit H, Controller's Comments on Revised Draft Proposed Decision, page 4.

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

[40] *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.

the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.[41] 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.]' "[42]

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.[43] In addition, sections 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.[44]

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."[45]

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

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[41] *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.

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

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

[44] 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.

[45] 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.

notice of adjustment.[46] 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."[47] 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.[48]

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.[49] Both the claimant and the Controller rely on the remittance advice letters dated April 28, 2003[50] as beginning the period of limitation for filing the IRC.[51] Based 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.[52] The general rule in applying and enforcing a statute of

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[46] 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.].

[47] Exhibit A, IRC 05-4282-I-03, page 71.

[48] Code of Regulations, title 2, section 1185 (Register 2003, No. 17).

[49] Exhibit I, Completeness Letter, dated June 6, 2006.

[50] Exhibit A, IRC 05-4282-I-03, pages 373-377; Exhibit B, Controller's Comments on the IRC, page 19.

[51] See Exhibit B, Controller's Comments on the IRC, page 19; Exhibit C, Claimant's Rebuttal Comments, page 4.

[52] 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,

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.[53,54] 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."[55] Generally, a final audit report, which provides 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.[56]

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."[57] Accordingly, the claimant submitted its response to the final audit report on February 20, 2003, along with additional documentation and argument.[58] 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

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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.].

[53] 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."].

[54] *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].

[55] Government Code section 17558.5.

[56] 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.)

[57] Exhibit A, IRC 05-4282-I-03, page 71.

[58] Exhibit A, IRC 05-4282-I-03, pages 107-140.

informal dispute resolution supports the finding that the audit report did not constitute the Controller's *final* determination on the subject claims.[59]

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 truly final based on the plain language of the cover letter. Based on 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 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 determination establishes the filing date, which would mean the filing was not timely.

Pursuant to former section 1185 of the Commission's regulations, an incomplete IRC 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 in a timely manner 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.

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.[60]

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."[61] 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.[62]

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[59] Code of Regulations, title 2, section 1185 (Register 2003, No. 17).

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

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

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

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."[63]

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."[64] 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…"[65] However, based on the dollar amount identified in the IRC that the claimant has alleged to be 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."[66] 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.[67] 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.[68]

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[63] Exhibit A, IRC 05-4282-I-03, pages 112-114.

[64] 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.)

[65] Exhibit H, Controller's Comments on Revised Draft Proposed Decision, page 2.

[66] Exhibit A, IRC 05-4282-I-03, page 79.

[67] Exhibit B, Controller's Comments on the IRC, page 15.

[68] Exhibit A, IRC 05-4282-I-03, pages 6-8 and 113.

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."[69] 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."[70] The court in *Clovis Unified School District v. Chiang*[71] 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."[72]

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."[73] 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.[74] 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.

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[69] Exhibit A, IRC 05-4282-I-03, page 163.

[70] See Exhibit A, IRC 05-4282-I-03, page 165.

[71] (2010) 188 Cal.App.4th 794, 803-804.

[72] *Id*, page 804.

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

[74] 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].

> 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.[75]

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.[76] The attachment also breaks down the miscoded amounts, the units of service associated with the dollar amounts, the provider(s) of services, and dates of service.[77]

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.[78] 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.[79]

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[75] Exhibit A, IRC 05-4282-I-03, page 112, emphasis in original.

[76] Exhibit A, IRC 05-4282-I-03, page 118.

[77] Exhibit A, IRC 05-4282-I-03, pages 118-130.

[78] See Exhibit A, IRC 05-4282-I-03, page 165.

[79] 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

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.[80] 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.[81] 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 7576[82] and the implementing regulations as they were *originally adopted* in 1986.[83] 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 542 and 543 of the Department of Mental Health's Title 9 regulations.[84] 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."[85]

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

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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.)

[80] Exhibit A, IRC 05-4282-I-03, pages 78-79.

[81] Exhibit A, IRC 05-4282-I-03, pages 11-13.

[82] Added, Statutes 1984, chapter 1747; amended Statutes 1985, chapter 1274.

[83] Register 87, No. 30.

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

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

> "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.[86]

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.[87]

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 judicial review, they are binding, just as judicial decisions."[88] 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.*[89]

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."[90] 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.[91]

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

[87] Commission Decision Adopted December 4, 2006, in 00-PGA-03/04.

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

[89] 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.

[90] Exhibit C, Claimant's Rebuttal Comments, page 3.

[91] 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

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.[92] 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."[93] 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.[94]

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.

The *Handicapped and Disabled Students*, CSM-4282 decision addressed Government Code section 7576[95] and the implementing regulations as they were *originally adopted* in 1986.[96] 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.[97] 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."[98]

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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.

[92] Exhibit A, IRC 05-4282-I-03, page 78.

[93] Exhibit C, Claimant's Rebuttal Comments, page 2.

[94] Exhibit A, IRC 05-4282-I-03, page 12.

[95] Added, Statutes 1984, chapter 1747; amended Statutes 1985, chapter 1274.

[96] 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)).

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

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

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. ...*[99]

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 exceptional needs,' including those designated as 'seriously emotionally disturbed,' and required in such individual's IEP."[100]

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.[101] On reconsideration, the Commission found that the original decision correctly approved the program, as pled, as a reimbursable state-

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

[100] Exhibit A, IRC 05-4282-I-03, page 160.

[101] 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].

mandated program, but that the original decision did not fully identify all of the activities mandated by the state.[102]

As the reconsideration decision and parameters and guidelines note, however, crisis intervention was repealed from the regulations on July 1, 1998.[103] 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.[104] 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.[105]

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."[106]

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."[107] The claimant disputes the

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

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

[104] 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.

[105] 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.

[106] Exhibit A, IRC 05-4282-I-03, page 163.

[107] Exhibit A, IRC 05-4282-I-03, page 79.

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."[108] The claimant estimates the portion of EPSDT revenue attributable to the mandate at approximately, or less than, ten percent.[109] 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 "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.[110] 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 conditions, including developmental and behavioral screening and treatment.[111] 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."[112]

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.[113] However, EPSDT mental health services and funds are available to all "full-scope" Medi-Cal beneficiaries under the age of 21

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[108] Exhibit A, IRC 05-4282-I-03, page 13.

[109] Exhibit A, IRC 05-4282-I-03, pages 13-14; 81.

[110] Exhibit I, EPSDT Mental Health Services Brochure, published by Department of Health Care Services.

[111] 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.

[112] 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.

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

based on the recommendation of a doctor, clinic, or county mental health department.[114] 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.[115] 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."[116]

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 or information or belief."[117] 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

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[114] Exhibit I, EPSDT Mental Health Services Brochure, published by Department of Health Care Services.

[115] 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."].

[116] Exhibit H, Controller's Comments on Revised Draft Proposed Decision, page 4.

[117] Code of Regulations, title 2, section 1187.5 (Register 2014, No. 21).

factors."[118] 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.[119] 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."[120]

In response to the final audit report, the claimant explained that it "spent considerable time analyzing and refining the EPSDT units of service."[121] The claimant then developed a methodology to calculate the offset which determined for the "baseline" 1994-1995 year the total 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).[122] 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."[123]

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[118] Exhibit I, Legislative Analyst's Office Analysis of 2001-02 Budget, Department of Mental Health, page 3.

[119] Exhibit A, IRC 05-4282-I-03, page 80.

[120] Exhibit A, IRC 05-4282-I-03, page 81.

[121] Exhibit A, IRC 05-4282-I-03, page 115.

[122] Exhibit A, IRC 05-4282-I-03, page 115.

[123] Exhibit A, IRC 05-4282-I-03, page 115.

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."[124] 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.[125]

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.[126] 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.[127]

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."[128] 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 offset from the claim."[129] 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."[130] The claimant asserts that "[w]e have provided this data as requested by the SCO…but no audit adjustments were made."[131]

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

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[124] Exhibit C, Claimant's Rebuttal Comments, page 2.

[125] Exhibit C, Claimant's Rebuttal Comments, page 2.

[126] Exhibit B, Controller's Comments on the IRC, pages 18-19.

[127] Exhibit A, IRC 05-4282-I-03, page 80.

[128] Exhibit A, IRC 05-4282-I-03, page 114.

[129] Exhibit A, IRC 05-4282-I-03, pages 13-14.

[130] Exhibit C, Claimant's Rebuttal Comments, page 1.

[131] Exhibit C, Claimant's Rebuttal Comments, page 1.

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,[132] to $166,352,[133] to $524,389,[134] to $665,975.[135]

The Controller states that the claimant "has not provided documentation to support the calculations."[136] 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."[137] 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.[138]

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 or prejudice to the defendant resulting from the delay."[139] 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." [140] 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

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

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

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

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

[136] Exhibit H, Controller's Comments on Revised Draft Proposed Decision, page 4.

[137] Exhibit G, Claimant's Comments on Revised Draft Proposed Decision, page 2.

[138] Exhibit G, Claimant's Comments on Revised Draft Proposed Decision, page 2.

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

[140] 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."].

authority to audit state mandate claims, which is described in Government Code section 17558.5.[141]

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."[142] 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."[143]

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."[144] 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 and guidelines."[145] 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

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[141] Government Code section 17558.5 (Stats. 2004, ch. 890 (AB 2856)).

[142] 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."].

[143] 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."].

[144] Exhibit G, Claimant's Comments on Revised Draft Proposed Decision, page 2.

[145] Exhibit G, Claimant's Comments on Revised Draft Proposed Decision, page 2.

the audited years. *The DMH Short-Doyle Cost Report instructions and worksheets have also been provided to the SCO by the County.*[146]

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."[147] 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* 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.

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

[147] Exhibit H, Controller's Comments on the Revised Draft Proposed Decision, page 4.

- 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.

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RE: **Decision**

Handicapped and Disabled Students, 05-4282-I-03
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

On September 25, 2015, the foregoing decision of the Commission on State Mandates was adopted on the above-entitled matter.

Heather Halsey, Executive Director

Dated: September 30, 2015

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

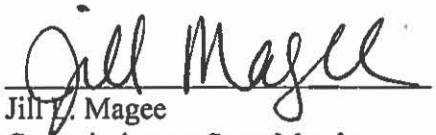
I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On September 30, 2015, I served the:

Decision
Handicapped and Disabled Students, 05-4282-I-03
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

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on September 30, 2015 at Sacramento, California.



Jill L. Magee
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

EXHIBIT "F"

Consolidated Handicapped and Disabled Students (HDS), HDSII, and SEDP Program

- Alameda County 06/13/2014
- Contra Costa County 06/02/2014
- El Dorado County 03/12/2013
- Fresno County 12/20/2012
- Kern County 12/21/2012
- Los Angeles County 06/13/2014
- Marin County 02/26/2013
- Merced County 12/20/2012
- Monterey County 04/29/2013
- Orange County 12/03/2012
- Placer County 09/11/2014
- Riverside County 08/27/2013
- San Diego County 12/20/2012
- San Francisco, City and County 06/23/2014
- San Mateo County 10/20/2014
- Santa Barbara County 08/20/2013
- Santa Clara County 10/21/2014
- Solano County 03/12/2013
- Sonoma County 08/19/2014
- Stanislaus County 08/27/2013
- Ventura County 06/09/2014

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On January 21, 2016, I served the:

Draft Proposed Decision on Appeal of Executive Director Decision and Appeal of Executive Director Decision
Appeal of Executive Director Decision, 15-AEDD-01
County of San Diego, Appellant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on January 21, 2016 at Sacramento, California.

Jill Magee

Jill L. Magee
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 1/20/16

Claim Number: 15-AEDD-01

Matter: Appeal of Executive Director Decision

Claimant: County of San Diego

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

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