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RECEIVED
August 26, 2016
Commission on
State Mandates

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August 26, 2016

VIA E-FILING (www.csm.ca.gov)

Commission on State Mandates
980 9th Street, Suite 300
Sacramento, CA 95814

Re: Los Angeles County's Request for Reconsideration – Handicapped and Disabled Students II, 12-0240-I-01

Dear Commission on State Mandates:

Pursuant to Government Code § 17559(a) and 2 CCR § 1187.15, the County of Los Angeles ("County") requests the Commission on State Mandates ("Commission") reconsider its adopted decision on Handicapped and Disabled Students II, 12-0240-I-01served on July 27, 2016 which denied the County's Incorrect Reduction Claim ("IRC") on the basis that the IRC was not timely filed.

Enclosed please find an explanation of the reasons for the request for reconsideration and documentations in support of the request. The adopted decision at issue is attached as Attachment A. The County requests the Commission to set aside the ruling that the County's IRC was filed untimely and that the Commission decide on the merits of County's IRC.

If you have any questions, please do not hesitate to contact me at 213-974-1857 or via email at plee@counsel.lacounty.gov.

Very truly yours,

MARY C. WICKHAM
County Counsel

By
PETER LEE
Deputy County Counsel
Government Services Division

PL

Enclosure

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County of Los Angeles (Department of Auditor-Controller; Department of Mental Health)

STATE OF CALIFORNIA

COMMISSION ON STATE MANDATES

HANDICAPPED AND DISABLED STUDENTS II, 12-0240-I-01; Fiscal Years: 2002-2003 and 2003-2004 County of Los Angeles, Claimant	CASE NO. 12-0240-I-01 **LOS ANGELES COUNTY'S REQUEST FOR RECONSIDERATION (GOVERNMENT CODE § 17559(a); 2 CCR § 1187.15)** (Decision adopted July 22, 2016) (Decision served July 27, 2016)

INTRODUCTION

The County of Los Angeles ("County") requests the Commission on State Mandates ("Commission") reconsider its adopted decision on Handicapped and Disabled Students II, 12-0240-I-01("Adopted Decision" attached hereto as Attachment A) which denied the County's Incorrect Reduction Claim ("IRC") on the basis that the IRC was not timely filed. (Government Code §17559 (a); 2 CCR § 1187.15(b).) The Commission's *sua sponte* ruling[1] on the statute of limitation is an error of law for the following two independent reasons:

[1] Unlike the County's Handicapped and Disabled Students I 13-4282-I-06) Adopted Decision attached hereto as Attachment B (p. 11, fn. 66) which was adopted on the same date as this Adopted Decision and the facts are the virtually the same as to the statute of limitation issue, this Adopted Decision does not cite to any legal authority for the Commission to *sua sponte* raise the statute of limitation defense for the State Controller. For the limited purpose of this Request for Reconsideration, the County is assuming the Commission is also relying on the same United States Supreme Court as described in the County's Handicapped and Disabled Students I 13-4282-I-06) Adopted Decision.

(1) The statute of limitation is an affirmative defense that must be raised by the opposing party, the State Controller's Office ("State Controller"), and its failure to do so waives the defense.

(2) The Commission relies on an inapplicable United States Supreme Court case for the proposition that the Commission has an obligation to *sua sponte* raise the statute of limitation defense. This is an error of law and also violates the County's rights to due process and to fair and impartial hearing.

The County requests that the Commission set aside the ruling that the County's IRC was filed untimely and that the Commission decide on the merits of County's IRC. This Request for Reconsideration does not waive any of the County's positions, including but not limited to, issues raised in the IRC, the documents the County filed with the Commission, testimony at hearing before the Commission, and the Adopted Decision for purposes of judicial review.

ARGUMENT

I. The State Controller's failure to raise the statute of limitation defense is a waiver, and it was an error of law for the Commission to rule that County's IRC was untimely filed.

Statute of limitation is an affirmative defense that must be raised by the opposing party or else it is waived. In this case, the State Controller never raised the statute of limitation in its November 25, 2014 response to the County's IRC and, therefore, waived any argument that it applied. (Attachment A at p. 8-9; State Controller's November 25, 2014 Response attached hereto as Attachment C); *Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 396 (The statute of limitations operates in an action as an affirmative defense); *Gailing v. Rose, Klein & Marias*, (1996) 43 Cal.App.4th 1570, 1577 (The statute of limitations is not jurisdictional. It is an affirmative defense); *Getz v. Wallace* (1965) 236 Cal.App.2d 213 (In civil actions, the statute of limitations is a personal defense which is waived by failure to plead it.)

The fact that the State Controller did not raise the statute of limitation defense is consistent with the State Controller's official letter, which was relied upon by the County, informing the County that an "IRC must be filed within three years following the date we notified the County of

a claim reduction. The State Controller's Office notified the county of a claim reduction…on June 12, 2010, for the HDS II program audit…" (Attachment D.) In other incorrect reduction claims, the State Controller first raised the statute of limitation defense by claiming and explaining why the IRC was filed untimely and then the Commission decided this issue. (See Handicapped and Disabled Students (County of San Mateo), 05-4282-I-03 Decision at p. 11 attached hereto as Attachment E); Collective Bargaining (Gavilan Joint Community College District), 05-4425-I-11 Decision at p. 5 attached hereto as Attachment F.) In this case, the State Controller's failure to raise the statute of limitation constitutes a waiver.

The first time the statute of limitation issue was raised was by the Commission's staff in the May 20, 2016 Draft Proposed Decision. (Attachment G.) On June 3, 2016, the State Controller responded by stating that it "supports the Commission's conclusion and recommendation. The Commission found that the claimant's IRC was untimely filed..." (Attachment H.) The State Controller's belated "support of the Commission's conclusion" does not constitute an affirmative defense that must be asserted by the opposing party and failure to invoke it is a waiver. (*Samuels v. Mix*, (1999) *22* Cal.4th 1, 10 (a defendant must prove the facts necessary to enjoy the benefits of a statute of limitations…if defendant had never pled the statute of limitations as a defense, that defense would have been forfeited); *Martin v. Van Bergen* (2012) 209 Cal.App.4th 84, 91 (a defendant who failed to plead the statute of limitations could not raise it in trial brief.) For this reason alone, the Commission should reverse its ruling and allow the County's IRC to be ruled on the merit.

II. Commission's *sua sponte* decision to assert the statute of limitation defense for the State Controller is an error of law.

The Commission appears to incorrectly rely on a United State Supreme Court decision, *John R. Sand & Gravel Co. v. United States* (2008) 552 U.S. 130, 132, for the proposition that the "Commission's limitations period is jurisdictional, and, as such, the Commission is obligated to review the limitations issue sua sponte." (Attachment B at p. 11 fn 66.)

The *John R. Sand* case involves the interpretation of a special federal court of claims' statute of limitation. (552 U.S. at 132-34.) It was decided under federal law and has no bearing on the Commission, which is a state-created quasi-judicial body. The Commission is subject to the California Constitution, laws, and regulations as interpreted by California state courts. And, as discussed above, California courts hold that the statute of limitations is an affirmative defense which must be pleaded or it is waived. Indeed, in *John R. Sand*, the Supreme Court first observed the unique jurisdictional nature of the federal court of claims statute, observing the law typically treats a limitations defense as an affirmative defense that the defendant must raise at the pleadings stage and that is subject to rules of forfeiture and waiver. (*Id.* at 133.)

The Commission does not cite to any applicable California legal authority to establish that the Commission's regulation on the statute of limitation for filing an incorrect reduction is an absolute or fundamental jurisdictional matter, establishing an exception from the general rule that the statute of limitation is an affirmative defense. The Commission's *sua sponte* decision to raise the statute of limitation defense for the State Controller without any legal basis is an error of law and also violates County's rights to due process rights and to fair and impartial hearing.

CONCLUSION

For the forgoing reasons, the County requests the Commission to set aside the ruling that the County's IRC was filed untimely and allow the Commission to decide on the merits of the County's IRC.

DATED: August 26, 2016

Respectfully submitted,

MARY C. WICKHAM
County Counsel

By _____
SANGKEE PETER LEE
Deputy County Counsel

Attorneys for County of Los Angeles (Department of Auditor-Controller; Department of Mental Health)

Attachment A

STATE of CALIFORNIA
COMMISSION ON STATE MANDATES

July 27, 2016

Dr. Robin Kay
County of Los Angeles
Department of Mental Health
550 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020

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**
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60030, 60040, 60045, 60050, 60055, 60100, 60110, 60200
(Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years: 2002-2003 and 2003-2004
County of Los Angeles, Claimant

Dear Dr. Kay and Ms. Kanemasu:

On July 22, 2016, the Commission on State Mandates adopted the Decision on the above-entitled matter.

Sincerely,

Heather Halsey
Executive Director

J:\MANDATES\IRC\2012\0240 (Handicapped II)\12-0240-I-01\correspondence\Decisiontrans.docx

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE INCORRECT REDUCTION CLAIM ON: Government Code Sections 7572.55 and 7576; Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726); California Code of Regulations, Title 2, Chapter 1, Sections 60020, 60030, 60040, 60045, 60050, 60055, 60100, 60110, 60200[1] (Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33]) Fiscal Years 2002-2003 and 2003-2004 County of Los Angeles, Claimant	Case No.: 12-0240-I-01 *Handicapped and Disabled Students II* DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (*Adopted July 22, 2016*) (*Served July 27, 2016*)

DECISION

The Commission on State Mandates (Commission) heard and decided this Incorrect Reduction Claim (IRC) during a regularly scheduled hearing on July 22, 2016. Edward Jewik and Hasmik Yaghobyan appeared on behalf of County of Los Angeles. Jim Spano and Chris Ryan 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 Proposed Decision to deny this IRC by a vote of 6-0 as follows:

[1] Note that this caption differs from the Test Claim and the Parameters and Guidelines captions in that it includes only those sections that were approved for reimbursement in the Test Claim Decision. Generally, a parameters and guidelines caption should include only the specific sections of the statutes and executive orders that were approved in the test claim decision. However, that was an oversight in the case of the Parameters and Guidelines at issue in this case.

Member	Vote
Ken Alex, Director of the Office of Planning and Research	Yes
Richard Chivaro, Representative of the State Controller	Yes
Mark Hariri, Representative of the State Treasurer, Vice Chairperson	Yes
Sarah Olsen, Public Member	Yes
Eraina Ortega, Representative of the Director of the Department of Finance, Chairperson	Yes
Carmen Ramirez, City Council Member	Yes
Don Saylor, County Supervisor	Absent

Summary of the Findings

This IRC was filed in response to an audit by the State Controller's Office (Controller) of the County of Los Angeles's (claimant's) initial reimbursement claims under the *Handicapped and Disabled Students II* program for fiscal years 2002-2003 and 2003-2004. The Controller reduced the claims because it found the claimant: (1) overstated costs by using inaccurate units of service, and (2) overstated offsetting revenues.[2] In this IRC, the claimant contends that the Controller's reductions were incorrect and requests, as a remedy, that the Commission reinstate the following cost amounts, which would then become subject to the Program's reimbursement formula:

FY2002-2003: $216,793

FY2003-2004: $231,409[3]

After a review of the record and the applicable law, the Commission finds that the IRC was untimely filed. Accordingly, the Commission denies this IRC.

I. Chronology

05/08/2006 Claimant dated the reimbursement claim for fiscal year 2002-2003.[4]

05/08/2006 Claimant dated the reimbursement claim for fiscal year 2003-2004.[5]

08/12/2008 Controller dated a letter to claimant confirming the start of the audit.[6]

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[2] See, e.g., Exhibit A, IRC, page 96 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated May 28, 2010).

[3] Exhibit A, IRC, page 1.

[4] Exhibit A, IRC, page 113 (cover letter), page 117 (Form FAM-27).

[5] Exhibit A, IRC, page 113 (cover letter), page 254 (Form FAM-27).

[6] Exhibit B, Controller's Late Comments on the IRC, page 148-149 (Letter from Christopher Ryan to Wendy L. Watanabe, dated August 12, 2008). See also Exhibit B, Controller's Late Comments on the IRC, page 19, which asserts "The SCO contacted the county by phone on July 28, 2008, to initiate the audit . . . ." However, this assertion is not supported by a declaration of a person with personal knowledge or any other evidence in the record.

03/26/2010	Controller issued the Draft Audit Report, dated March 26, 2010.[7]
04/30/2010	Claimant sent a letter to Controller dated April 30, 2010, in response to the Draft Audit Report.[8]
05/28/2010	Controller issued the Final Audit Report dated May 28, 2010.[9]
06/11/2013	Claimant filed this IRC.[10]
11/25/2014	Controller filed late comments on the IRC.[11]
12/23/2014	Claimant filed a request for extension of time to file rebuttal comments which was granted for good cause.
03/26/2015	Claimant filed rebuttal comments.[12]
05/20/2016	Commission staff issued the Draft Proposed Decision.[13]
06/06/2016	Controller filed comments on the Draft Proposed Decision.[14]
06/10/2016	Claimant filed comments on the Draft Proposed Decision.[15]

II. Background

In 1975, Congress enacted the Education for All Handicapped Children Act (EHA) with the stated purpose of assuring that "all handicapped children have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs . . . ."[16] Among other things, the EHA authorized the payment of federal funds to states which complied with specified criteria regarding the provision of special education and related services to handicapped and disabled students.[17] The EHA was ultimately renamed the Individuals with Disability Education Act (IDEA) and guarantees to disabled pupils, including those with mental health needs, the right to receive a free and appropriate public

[7] Exhibit A, IRC, page 101.

[8] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[9] Exhibit A, IRC, page 96 (cover letter), pages 95-110 (Final Audit Report).

[10] Exhibit A, IRC, pages 1, 3.

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

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

[13] Exhibit D, Draft Proposed Decision.

[14] Exhibit E, Controller's Comments on the Draft Proposed Decision, page 1.

[15] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 1.

[16] Public Law 94-142, section 1, section 3(a) (Nov. 29, 1975) 89 U.S. Statutes at Large 773, 775. See also 20 U.S.C. § 1400(d) (current version).

[17] Public Law 94-142, section 5(a) (Nov. 29, 1975) 89 U.S. Statutes at Large 773, 793. See also 20 U.S.C. 1411(a)(1) (current version).

education, including psychological and other mental health services, designed to meet the pupil's unique educational needs.[18]

The *Handicapped and Disabled Students* Mandate

In California, the responsibility of providing both "special education" and "related services" was initially shared by local education agencies (broadly defined) and by the state government.[19] However, in 1984, the Legislature enacted AB 3632, which amended Government Code chapter 26.5 relating to "interagency responsibilities for providing services to handicapped children" which created separate spheres of responsibility.[20] And, in 1985, the Legislature further amended chapter 26.5.[21]

The impact of the 1984 and 1985 amendments — sometimes referred to collectively as "Chapter 26.5 services" — was to transfer the responsibility to provide mental health services for disabled pupils from school districts to county mental health departments.[22]

In 1990 and 1991, the Commission adopted the Statement of Decision and the Parameters and Guidelines approving the Test Claim *Handicapped and Disabled Students,* CSM 4282, as a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution.[23] The Commission found that the activities of providing mental health assessments; participation in the individualized education plan (IEP) process; and providing psychotherapy and other mental health treatment services were reimbursable and that providing mental health treatment services was funded as part of the Short-Doyle Act, based on a cost-sharing formula with the state.[24] Beginning July 1, 2001, however, the cost-sharing ratio for providing psychotherapy and other mental health treatment services no longer applied, and

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[18] Public Law 101-476, section 901(a)(1) (October 30, 1999) 104 U.S. Statutes at Large 1103, 1141-1142.

[19] *California School Boards Ass'n v. Brown* (2011) 192 Cal.App.4th 1507, 1514.

[20] Statutes of 1984, chapter 1747.

[21] Statutes of 1985, chapter 1274.

[22] "With the passage of AB 3632 (fn.), California's approach to mental health services was restructured with the intent to address the increasing number of emotionally disabled students who were in need of mental health services. Instead of relying on LEAs [local education agencies] to acquire qualified staff to handle the needs of these students, the state sought to have CMH [county mental health] agencies — who were already in the business of providing mental health services to emotionally disturbed youth and adults — assume the responsibility for providing needed mental health services to children who qualified for special education." Stanford Law School Youth and Education Law Clinic, *Challenge and Opportunity: An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California*, May 2004, page 12.

[23] "As local mental health agencies had not previously been required to provide Chapter 26.5 services to special education students, local mental health agencies argued that these requirements constituted a reimbursable state mandate." (*California School Boards Ass'n v. Brown* (2011) 192 Cal.App.4th 1507, 1515.)

[24] Former Welfare and Institutions Code sections 5600 et seq.

counties were entitled to receive reimbursement for 100 percent of the costs to perform these services.[25]

In 2004, the Legislature directed the Commission to reconsider *Handicapped and Disabled Students*, CSM 4282.[26] In May 2005, the Commission adopted the Statement of Decision on Reconsideration, 04-RL-4282-10, and determined that the original Statement of Decision correctly concluded that the test claim statutes and regulations 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. Thus, for costs incurred beginning July 1, 2004, the Commission identified the activities expressly required by the test claim statutes and regulations that were reimbursable, identified the offsetting revenue applicable to the program, and updated the new funding provisions enacted in 2002 that required 100 percent reimbursement for mental health treatment services.

The *Handicapped and Disabled Students II* Mandate

In May 2005, the Commission also adopted the Statement of Decision on *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, a Test Claim addressing statutory amendments enacted between the years 1986 and 2002 to Government Code sections 7570 et seq., and 1998 amendments to the joint regulations adopted by the Departments of Education and Mental Health.[27]

The Controller's Audit and Reduction of Costs

The Controller issued a Draft Audit Report dated March 26, 2010, and provided a copy to the claimant for comment.[28]

In a three-page letter dated April 30, 2016, the claimant responded to the Draft Audit Report, agreeing with the audit's findings and accepting its recommendations.[29] The first page of this three-page letter contains the following statement:

> *The County's response, which is attached, indicates agreement with the audit findings* and the actions that the County will take to implement policies and

[25] Statutes 2002, chapter 1167 (AB 2781, §§ 38, 41).

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

[27] Statutes 2011, chapter 43 (AB 114) eliminated the mandated programs for *Handicapped and Disabled Students* (4282, 04-RL-4282-10) and *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) by transferring responsibility for providing mental health services under IDEA back to school districts, effective July 1, 2011. On September 28, 2012, the Commission adopted an amendment to the parameters and guidelines ending reimbursement effective July 1, 2011.

[28] Exhibit A, IRC, page 101.

[29] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

> procedures to ensure that the costs claimed under HDSII are eligible, mandate related, and supported.[30]

The following two pages of the three-page letter contain further statements of agreement with the Controller's findings and recommendations.

In response to the Controller's Finding No. 1 that the claimant overstated medication support costs by more than $1.1 million, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that only actual units of service for eligible clients are claimed in accordance with the mandate program.[31]

In response to the Controller's Finding No. 2 that the claimant overstated indirect costs by more than $80,000, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that indirect cost rates are applied to eligible and supported direct costs.[32]

In response to the Controller's Finding No. 3 that the claimant overstated offsetting reimbursements by more than $500,000, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that revenues are applied to valid program costs, appropriate SD/MC and EPSDT reimbursement percentage rates are applied to eligible costs, and supporting documentation for applicable offsetting revenues are maintained.[33]

In a separate two-page letter also dated April 30, 2010, the claimant addressed its compliance with the audit and the status of any remaining reimbursement claims.[34] Material statements in the two-page letter include:

> • "We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO."[35]

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[30] Exhibit A, IRC, page 107 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010) (emphasis added).

[31] Exhibit A, IRC, page 108 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[32] Exhibit A, IRC, page 108 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[33] Exhibit A, IRC, page 109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[34] Exhibit B, Controller's Late Comments on the IRC, pages 152-153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010).

[35] Exhibit B, Controller's Late Comments on the IRC, pages 152-153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 1).

• "We designed and implemented the County's accounting system to ensure accurate and timely records."[36]

• "We claimed mandated costs based on actual expenditures allowable per the Handicapped and Disabled Students II Program's parameters and guidelines."[37]

• "We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims."[38]

• "We are not aware of any . . . Relevant, material transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims."[39]

• "There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims."[40]

• "We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims."[41]

On May 28, 2010, the Controller issued the Final Audit Report.[42] The Controller reduced the claims because the claimant: (1) overstated costs by using inaccurate units of service, (2) and overstated offsetting revenues.[43]

On June 11, 2013, the claimant filed this IRC with the Commission.[44]

III. Positions of the Parties

A. County of Los Angeles

[36] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 2).

[37] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 4).

[38] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 5).

[39] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 7(d)).

[40] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 8).

[41] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 9).

[42] Exhibit A, IRC, page 96 (cover letter), pages 95-110 (Final Audit Report).

[43] See, e.g., Exhibit A, IRC, page 96 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated May 28, 2010).

[44] Exhibit A, IRC, pages 1, 3.

The claimant objects to reductions totaling $448,202 to the claimant's reimbursement claims for fiscal years 2002-2003 and 2003-2004.

The claimant takes the following principal positions:

1. The Controller reviewed and utilized incomplete and inaccurate data and documentation when it conducted its audit.[45]
2. The claimant's claims were timely filed.[46]
3. Under the principle of equitable offset, the claimant may submit new claims for reimbursement supported by previously un-submitted documentation.[47]

On June 10, 2016, the claimant filed comments on the Draft Proposed Decision, arguing that the IRC should be considered timely filed because the claimant relied upon statements made by the Controller that it had three years to file an IRC from the notices dated June 12, 2010, as follows:

> The County relied upon the statements and the actions of the SCO in making its determinations. In its cover letter to the County accompanying the audit report, the SCO states that the County must file an IRC within three years of the SCO notifying the County of a claim reduction. The SCO then refers to the notices as notices of claim reduction. The SCO then specifically referred to the dates of the notices upon which the County relied as the dates they notified the County of a claim reduction.[48]

The claimant also argued that the limitations period should be reset or suspended because the Controller engaged in a reconsideration of the audit results.[49]

B. State Controller's Office

The Controller contends that it acted according to the law when it made $448,202 in reductions to the claimant's fiscal year 2002-2003 and 2003-2004 reimbursement claims.

The Controller takes the following principal positions:

1. The claimant failed to provide support for its claims in a format which could be verified.[50]
2. The claimant agreed to the findings of the audit.[51]

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[45] Exhibit A, IRC, pages 6-8, 10-12.

[46] Exhibit A, IRC, pages 13-17 (the "Notice of Claim Adjustment" dated June 12, 2010, filed as a supplement to this IRC to establish alleged timeliness).

[47] Exhibit A, IRC, pages 8-10.

[48] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3. The letter the claimant is referring to is the letter at Exhibit A, IRC, pages 485-486, from Jim Spano to Robin C. Kay, dated May 7, 2013.

[49] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3.

[50] Exhibit B, Controller's Late Comments on the IRC, pages 20-22.

[51] Exhibit B, Controller's Late Comments on the IRC, pages 19, 22.

3. The claimant may not, under the principle of equitable offset, submit new claims for reimbursement supported by previously un-submitted documentation.[52]

On June 6, 2016, the Controller filed comments agreeing with the Draft Proposed Decision.[53]

IV. Discussion

Government Code section 17561(d) 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, of the California Constitution.[54] 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."[55]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.[56] 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

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[52] Exhibit B, Controller's Late Comments on the IRC, page 19, 21-22.

[53] Exhibit E, Controller's Comments on the Draft Proposed Decision, page 1.

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

[55] *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1281, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[56] *Johnston v. Sonoma County Agricultural Preservation and Open Space Dist.* (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.

> considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." [Citation.]' "[57]

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.[58] In addition, sections 1185.1(f)(3) 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.[59]

A. The IRC Was Untimely Filed.

At the time the reimbursement claims were audited and when this IRC was filed, the regulation containing the limitations period read:

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[60]

Applying the plain language of the limitations regulation — that the IRC must have been filed no later than three years after "the date" of the Final Audit Report — the IRC was untimely. The Controller's Final Audit Report is dated May 28, 2010.[61] Three years later was Tuesday, May 28, 2013. Instead of filing this IRC by the deadline of Tuesday, May 28, 2013, the claimant filed this IRC with the Commission on Tuesday, June 11, 2013 — 14 days later.[62]

The claimant attempts to save its IRC by calculating the commencement of the limitations period from June 12, 2010, the date of two documents sent by the Controller which the claimant dubs a "Notice of Claim Adjustment."[63] In the Written Narrative portion of the IRC, the claimant writes, "The SCO issued its audit report on May 28, 2010. The report was followed by a Notice

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[57] *American Bd. of Cosmetic Surgery, Inc., v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547-548.

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

[59] 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.

[60] Former Code of California Regulations, title 2, section 1185(b), which was renumbered section 1185(c) as of January 1, 2011. Effective July 1, 2014, the regulation was amended to state as follows: "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." Code of California Regulations, title 2, section 1185.1(c).

[61] Exhibit A, IRC, pages 96 (cover letter), 95-110 (Final Audit Report).

[62] Exhibit A, IRC, page 1.

[63] See Exhibit A, IRC, pages 13-17 ("Notice of Claim Adjustment").

of Claim Adjustment dated June 12, 2010."[64] Although the claimant reads the document dated June 12, 2010, as a single document, the Commission reads it as two documents — specifically, two letters each containing a separate "Dear Claimant" salutation, of which the main text of the second letter is reproduced twice.[65]

The claimant's argument fails because: (1) the two documents were not notices of claim adjustment; and (2) even if they were, the limitations period commenced upon the date of the Final Audit Report and did not re-commence upon the receipt of the later two documents.

1. The Two Documents Dated June 12, 2010, Are Not Notices of Claim Adjustment.

For purposes of state mandates law, the Legislature has enacted a statutory definition of what constitutes a notice of claim adjustment.

Government Code section 17558.5(c) reads in relevant 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.

In other words, a notice of claim adjustment is a document which contains four elements: (1) a specification of the claim components adjusted, (2) the amounts adjusted, (3) interest charges, and (4) the reason for the adjustment.

Both of the two documents which the claimant dubs a "Notice of Claim Adjustment" contain the amount adjusted, but the other three required elements are absent. Neither of the two documents specifies the claim components adjusted; each provides merely a lump-sum total of all *Handicapped and Disabled Students II* program costs adjusted for the entirety of the relevant fiscal year. Neither of the two documents contains interest charges. Perhaps most importantly, neither of the two documents enunciates any reason for the adjustment.[66]

In addition to their failure to satisfy the statutory definition, the two documents cannot be notices of claim adjustment because neither of the documents adjusts anything. The two documents restate, in the most cursory fashion, the bottom-line findings contained in the Controller's Final Audit Report.[67] The claimant asserts that if the documents dated August 6, 2010 do not

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[64] Exhibit A, IRC, page 5.

[65] The two "Dear Claimant" salutations appear at Exhibit A, IRC, pages 13 and 15. The main text of Exhibit A, IRC, page 17, appears to be identical to the main text of Exhibit A, IRC, pages 15 and 16.

[66] Exhibit A, IRC, pages 13-17 ("Notice of Claim Adjustment").

[67] Compare Exhibit A, IRC, pages 13-17 (the "Notice of Claim Adjustment") with Exhibit A, IRC, page 102 ("Schedule 1 — Summary of Program Costs" in the Final Audit Report). The bottom-line totals are identical.

constitute notices of claim adjustment, then the Controller never provided notice.[68] The Final Audit Report provides abundant notice.

Neither of the two documents provides the claimant with notice of any new finding. The Final Audit Report contained the dollar amounts which would not be reimbursed.[69] The two later documents merely repeat information which was already contained in the Final Audit Report. The two documents do not provide any new and material information nor do they contain any previously unannounced adjustments.[70]

For these reasons, the two documents are not notices of adjustment within the meaning of Government Code section 17558.5(c).

2. The Limitations Period Begins to Run Upon the Occurrence of the Earliest Event Which Would Have Allowed the Claimant to File a Claim.

The Commission's regulation setting out the limitation period lists several events which could potentially trigger the running of the limitations period. Specifically, the limitations regulation lists, as potentially triggering events, the date of a final audit report, the date of a letter, the date of a remittance advice, and the date of a written notice of adjustment. The claimant argues that, if more than one of these events occurred, then the limitations period should begin to run upon the occurrence of the event which occurred last in time.[71] The Commission reaches (and has, many times in the past, reached) the opposite conclusion; the limitations period begins to run from the occurrence of the earliest event which would have allowed the claimant to file a claim. Subsequent events do not reset the limitations clock.

At the time the reimbursement claims were audited and when this IRC was filed, the Commission's regulation containing the limitations period read:

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[72]

Under a legal doctrine with the potentially confusing name of the "last essential element" rule, a limitations period begins to run upon the occurrence of the *earliest* event in time which creates a

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[68] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3.

[69] The Final Audit Report is dated May 28, 2010. (Exhibit A, IRC, pages 96, 101.)

[70] Moreover, the governing statute provides that a remittance advice or a document which merely provides notice of a payment action is not a notice of adjustment. (Government Code section 17558.5(c) ["Remittance advices and other notices of payment action shall not constitute notice of adjustment from an audit or review."].) Whatever term may accurately be used to characterize the two documents identified by the claimant, the two documents are not "notices of claim adjustment" under state mandate law.

[71] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

[72] Former Code of California Regulations, title 2, section 1185(b), effective May 8, 2007, renumbered as 1185(c) effective January 1, 2011.

complete claim. Under this rule, a right accrues — and the limitations period begins to run — from the earliest point in time when the claim can be filed and maintained.

As recently summarized by the California Supreme Court:

> The limitations period, the period in which a plaintiff must bring suit or be barred, runs from the moment a claim accrues. (See Code Civ. Proc., § 312 [an action must "be commenced within the periods prescribed in this title, after the cause of action shall have accrued"]; (Citations.). Traditionally at common law, a "cause of action accrues 'when [it] is complete with all of its elements' — those elements being wrongdoing, harm, and causation." (Citations.) This is the "last element" accrual rule: ordinarily, the statute of limitations runs from "the occurrence of the last element essential to the cause of action." (Citations.)[73]

In determining when a limitations period begins to run, the California Supreme Court looks to the earliest point in time when a litigant could have filed and maintained the claim:

> Generally, a cause of action accrues and the statute of limitation begins to run when a suit may be maintained. [Citations.] "Ordinarily this is when the wrongful act is done and the obligation or the liability arises, but it does not 'accrue until the party owning it is entitled to begin and prosecute an action thereon.' " [Citation.] In other words, "[a] cause of action accrues 'upon the occurrence of the last element essential to the cause of action.' " [Citations.][74]

Under these principles, the claimant's three-year limitations period began to run from the date of the Final Audit Report. As of that day, the claimant could have filed an IRC, because, as of that day, the claimant had been, from its perspective, harmed by a claim reduction. The Controller's subsequent issuance of a letter or other notice that does not change the reason for the reduction does not start a new limitations clock; the limitations period starts to run from the earliest point in time when the claimant could have filed an IRC — and the limitations period expires three years after that earliest point in time.

This finding is consistent with two recent Commission decisions regarding the three-year period in which a claimant can file an IRC.

In the *Collective Bargaining* Program IRC Decision adopted on December 5, 2014, the claimant argued that the limitations period should begin to run from the date of the *last* notice of claim adjustment in the record.[75] This argument parallels that of the claimant in this instant IRC, who argues that between the Final Audit Report dated May 28, 2010, and the two letters dated June 12, 2010, the *later* event should commence the running of the limitations period.

In the *Collective Bargaining* Decision, the Commission rejected the argument. The Commission held that the limitations period began to run on the *earliest* applicable event because that was when the claim was complete as to all of its elements.[76] "Accordingly, the claimant cannot

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[73] *Aryeh v. Canon Business Solutions, Inc.* (2013) 55 Cal.4th 1185, 1191.

[74] *Howard Jarvis Taxpayers Ass'n v. City of La Habra* (2001) 25 Cal. 4th 809, 815.

[75] Decision, *Collective Bargaining*, 05-4425-I-11 (adopted December 5, 2014), pages 20-22.

[76] Decision, *Collective Bargaining*, 05-4425-I-11 (adopted December 5, 2014), pages 20-22.

allege that the earliest notice did not provide sufficient information to initiate the IRC, and the later adjustment notices that the claimant proffers do not toll or suspend the operation of the period of limitation," the Commission held.[77]

In the *Domestic Violence Treatment Services — Authorization and Case Management* program IRC Decision adopted on March 25, 2016, the Commission held, "For IRCs, the 'last element essential to the cause of action' which begins the running of the period of limitations . . . is a notice to the claimant of the adjustment that includes the reason for the adjustment."[78] In the instant IRC, the limitations period therefore began to run from the Final Audit Report, which is the notice that informed the claimant of the adjustment and of the reasons for the adjustment.

Furthermore, the Commission's finding in the instant IRC is not inconsistent with a recent Commission ruling regarding the timeliness of filing an IRC.

In the *Handicapped and Disabled Students* Program IRC Decision adopted September 25, 2015, the Commission found that an IRC filed by a claimant was timely because the limitations period began to run from the date of a remittance advice letter which was issued after the Controller's Final Audit Report.[79] The Decision is distinguishable because the Controller's cover letter accompanying the audit report to the claimant in that case requested additional information and implied that the attached audit report was not final.[80] In the instant IRC, by contrast, the Controller's cover letter contained no such statement or implication; rather, the Controller's cover letter stated that, if the claimant disagreed with the attached Final Audit Report, the claimant would need to file an IRC within three years.[81]

The finding in this instant IRC is therefore consistent with recent Commission rulings regarding the three-year IRC limitations period.[82]

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[77] Decision, *Collective Bargaining*, 05-4425-I-11 (adopted December 5, 2014), page 21.

[78] Decision, *Domestic Violence Treatment Services — Authorization and Case Management*, 07-9628101-I-01 (adopted March 25, 2016), page 16.

[79] Decision, *Handicapped and Disabled Students*, 05-4282-I-03 (adopted September 25, 2015), pages 11-14.

[80] Decision, *Handicapped and Disabled Students*, 05-4282-I-03 (adopted September 25, 2015), pages 11-14. In the proceeding which resulted in this 2015 Decision, the cover letter from the Controller to the claimant is reproduced at Page 71 of the administrative record. In that letter, the Controller stated, "The SCO has established an informal audit review process to resolve a dispute of facts. The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report." The Controller's cover letter in the instant IRC contains no such language. Exhibit A, IRC, page 96 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated May 28, 2010).

[81] Exhibit A, IRC, page 96.

[82] All that being said, an administrative agency's adjudications need not be consistent so long as they are not arbitrary. See, e.g., *Weiss v. State Board of Equalization* (1953) 40 Cal.2d 772, 777 ("The administrator is expected to treat experience not as a jailer but as a teacher."); *California Employment Commission v. Black-Foxe Military Institute* (1941) 43 Cal.App.2d Supp. 868, 876

In comments on the Draft Proposed Decision, the claimant argues that the Commission should not apply the "last essential element" rule because Regulation 1185 used the disjunctive "or" when listing the events which triggered the running of the limitations period.[83] The claimant provides no legal authority for its argument or evidence that Regulation 1185 was intended to be read in such a manner. The Commission therefore rejects the argument.

The Commission also notes that the claimant's interpretation would yield the absurd result of repeatedly resetting the limitations period. Under the claimant's theory, a statute of limitations containing a disjunctive "or" restarts whenever one of the other events in the list occurs. In other words, if a regulation states that a three-year limitations period begins to run upon the occurrence of X, Y, or Z, then (under the claimant's theory), X can occur, a decade can elapse, and then the belated occurrence of Y or Z restarts the limitations clock. This interpretation cannot be correct, particularly in the context of monetary claims against the State's treasury. The "last essential element" rule provides the claimant with the opportunity to timely file a claim while protecting the State from reanimated liability.

Consequently, the Commission concludes that the limitations period begins to run from the occurrence of the earliest event which would have allowed the claimant to file a claim. That event, in this case, was the date of the Final Audit Report. Since more than three years elapsed between that date and filing of the IRC, the IRC was untimely.

3. The Controller's Misstatement of Law (Specifically, the Controller's Erroneous Statement That the Limitations Period Began to Run as of the Three Documents Dated June 12, 2010) Does Not Result in an Equitable Estoppel That Makes the IRC Timely.

In its comments on the Draft Proposed Decision, the claimant argues that the IRC should be considered timely because the claimant relied upon statements made by the Controller. "The County relied upon the statements and the actions of the SCO in making its determinations. In its cover letter to the County accompanying the audit report, the SCO states that the County must file an IRC within three years of the SCO notifying the County of a claim reduction. The SCO then refers to the notices as notices of claim reduction. The SCO then specifically referred to the dates of the notices upon which the County relied as the dates they notified the County of a claim reduction."[84]

Although the claimant does not use the precise term (and does not conduct the requisite legal analysis), the claimant is arguing that the Controller should be equitably estopped from benefiting from the statute of limitations, and that the Commission should find the IRC timely. The claimant is arguing that, if the filing deadline provided by the Controller was erroneous, then

("even were the plaintiff guilty of occupying inconsistent positions, we know of no rule of statute or constitution which prevents such an administrative board from doing so.").

[83] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3.

[84] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3. The letter the claimant is referring to is the letter at Exhibit A, IRC, pages 20-21 from Jim Spano to Robin C. Kay, dated May 7, 2013.

the claimant should be forgiven for filing late because the claimant was relying upon the Controller's statements.

A state administrative agency may possess[85] — but does not necessarily possess[86] — the authority to adjudicate claims of equitable estoppel. The Commission possesses the authority to adjudicate claims of equitable estoppel because, without limitation, the Commission is vested with exclusive and original jurisdiction and the Commission is obligated to create a full record for the Superior Court to review in the event that a party seeks a writ of administrative mandamus.[87]

The general elements of estoppel are well-established. "Whenever a party has, by his own statement or conduct, intentionally and deliberately led another to believe a particular thing true and to act upon such belief, he is not, in any litigation arising out of such statement or conduct, permitted to contradict it."[88] "Generally speaking, four elements must be present in order to apply the doctrine of equitable estoppel: (1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury."[89]

"The doctrine of estoppel is available against the government '"where justice and right require it."' (Citation.)"[90] However, "estoppel will not be applied against the government if to do so would nullify a strong rule of policy adopted for the benefit of the public."[91] Estoppel against the government is to be limited to "exceptional conditions," "special cases," an "exceptional case," or applied in a manner which creates an "extremely narrow precedent."[92]

Furthermore, the party to be estopped must have engaged in some quantum of turpitude. "We have in fact indicated that some element of turpitude on the part of the party to be estopped is requisite even in cases not involving title to land," the California Supreme Court noted.[93] In the

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[85] *Lentz v. McMahon* (1989) 49 Cal.3d 393, 406.

[86] *Foster v. Snyder* (1999) 76 Cal.App.4th 264, 268 ("The holding in *Lentz* does not stand for the all-encompassing conclusion that equitable principles apply to all administrative proceedings.").

[87] *Lentz v. McMahon* (1989) 49 Cal.3d 393, 404 (regarding exclusive jurisdiction) & fn. 8 (regarding duty to create full record for review). See also Government Code section 17552 (exclusive jurisdiction); Government Code section 17559(b) (aggrieved party may seek writ of administrative mandamus).

[88] Evidence Code section 623.

[89] *Driscoll v. City of Los Angeles* (1967) 67 Cal.2d 297, 305.

[90] *Robinson v. Fair Employment and Housing Commission* (1992) 2 Cal.4th 226, 244, quoting *Lentz v. McMahon* (1989) 49 Cal.3d 393, 399, quoting *City of Los Angeles v. Cohn* (1894) 101 Cal. 373, 377.

[91] *Lusardi Construction Co. v. Aubry* (1992) 1 Cal.4th 976, 994–995.

[92] *City of Long Beach v. Mansell* (1970) 3 Cal.3d 462, 496 & fn. 30, 500.

[93] *City of Long Beach v. Mansell* (1970) 3 Cal.3d 462, 490 fn. 24.

federal courts, equitable estoppel against the government "must rest upon affirmative misconduct going beyond mere negligence."[94]

Upon a consideration of all of the facts and argument in the record, the Commission concludes for the following reasons that the Controller is not equitably estopped from benefiting from the statute of limitations.

The Commission interprets the evidence in the record as presenting a mutual mistake of law by both the Controller and the claimant. On the date of the Controller's erroneous letter (May 7, 2013), the three-year limitations period had been in effect and had been published since at least May 2007.[95] Despite the fact that the limitations period had been in effect for several years, both the claimant and the Controller incorrectly calculated the IRC filing deadline as starting from the date of the two documents dated June 12, 2010, when, for the reasons explained in this Decision, the filing deadline started to run as of the date of the Final Audit Report.

A situation in which a government agency and a third party both misinterpret the law does not allow for an estoppel against the government — because the third party should have taken the time to learn what the law actually said. "Acts or conduct performed under a mutual mistake of law do not constitute grounds for estoppel. (Citation.) It is presumed the party claiming estoppel had an equal opportunity to discover the law."[96] "Where the facts and law are known to both parties, there can be no estoppel. (Citation.) Even an expression as to a matter of law, in the absence of a confidential relationship, is not a basis for an estoppel."[97] "Persons dealing with the government are charged with knowing government statutes and regulations, and they assume the risk that government agents may exceed their authority and provide misinformation."[98]

In point of fact, the Controller had earlier provided the claimant with general IRC filing information and had admonished the claimant to visit the Commission's website. In the cover letter dated May 28, 2010, the Controller summarized the audit findings and then stated, "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 Web site at www.csm.ca.gov/docs/IRCform.pdf."[99] In other words, as of May or June 2010, the claimant had been informed in general terms of the filing deadline and had been directed to the Commission's website. The fact that the claimant failed to do so and the fact that the Controller made an erroneous statement more than two years later does not somehow make the claimant's IRC timely.

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[94] *Morgan v. Heckler* (1985) 779 F.2d 544, 545 (Kennedy, J.). See also *Mukherjee v. I.N.S.* (9th Cir. 1986) 793 F.2d 1006, 1009 (defining affirmative misconduct as "a deliberate lie . . . or a pattern of false promises").

[95] Title 2, California Code of Regulations section 1185; California Regulatory Code Supplement, Register 2007, No. 19 (May 11, 2007), page 212.1 [version operative May 8, 2007].

[96] *Adams v. County of Sacramento* (1991) 235 Cal.App.3d 872, 883-884.

[97] *People v. Stuyvesant Ins. Co.* (1968) 261 Cal.App.2d 773, 784.

[98] *Lavin v. Marsh* (9th Cir. 1981) 644 F.2d 1378, 1383.

[99] Exhibit A, IRC, page 96.

Separately and independently, the record does not indicate that the Controller engaged in some quantum of turpitude. There is no evidence, for example, that the Controller acted with an intent to mislead.

Finally, the finding of an estoppel under this situation would nullify a strong rule of policy adopted for the benefit of the public, specifically, the policy that limitations periods exist "to encourage the timely presentation of claims and prevent windfall benefits."[100]

For each of these reasons, the claimant's argument of equitable estoppel is denied.

The Commission is also unpersuaded that the events which the claimant characterizes as the Controller's reconsideration of the audit act to extend, reset, suspend or otherwise affect the limitations period.[101] While the claimant contends that the Controller reconsidered the audit findings and then withdrew from the reconsideration,[102] the Controller contends that it did not engage in a reconsideration, but instead denied the claimant's request for a reconsideration.[103] On this point, the factual evidence in the record, within the letter from the Controller dated May 7, 2013, provides, "This letter confirms that we denied the county's reconsideration request . . . ."[104] The limitations period cannot be affected by a reconsideration which did not occur. Separately, the process which the claimant characterizes as a reconsideration did not commence until a June 2012 delivery of documents,[105] by which time the limitations period had been running for about two years. The claimant does not cite to legal authority or otherwise persuasively explain how the Controller's alleged reconsideration stopped or reset the already-ticking limitations clock.

Accordingly, the IRC is denied as untimely filed.

V. Conclusion

The Commission finds that claimant's IRC was untimely filed. The Commission therefore denies this IRC.

[100] *Lentz v. McMahon* (1989) 49 Cal.3d 393, 401.

[101] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

[102] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

[103] Exhibit A, IRC, page 20.

[104] Exhibit A, IRC, page 20.

[105] Exhibit A, IRC, page 20.

RE: **Decision**

Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60030, 60040, 60045, 60050, 60055, 60100, 60110, 60200
(Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years: 2002-2003 and 2003-2004
County of Los Angeles, Claimant

On July 22, 2016, the foregoing Decision of the Commission on State Mandates was adopted on the above-entitled matter.

Dated: July 27, 2016

Heather Halsey, Executive Director

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 July 27, 2016, I served the:

Decision
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60030, 60040, 60045, 60050, 60055, 60100, 60110, 60200
(Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years: 2002-2003 and 2003-2004
County of Los Angeles, 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 July 27, 2016 at Sacramento, California.

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

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 7/5/16

Claim Number: 12-0240-I-01

Matter: Handicapped and Disabled Students II

Claimant: County of Los Angeles

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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Attachment B

STATE of CALIFORNIA
COMMISSION ON STATE MANDATES

July 27, 2016

Dr. Robin Kay
County of Los Angeles
Department of Mental Health
550 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020

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**
Handicapped and Disabled Students, 13-4282-I-06
Government Code Sections 7572 and 7572.5
Statutes 1984, Chapter 1747 (AB 3632); Statutes 1985, Chapter 1274 (AB 882);
California Code of Regulations, Title 2, Division 9, Chapter 1, Section 60040
(Emergency regulations filed December 31, 1985, designated effective
January 1, 1986 [Register 86, No. 1] and refiled June 30, 1986, designated effective
July 12, 1986 [Register 86, No. 28])
Fiscal Years: 2003-2004, 2004-2005, and 2005-2006
County of Los Angeles, Claimant

Dear Dr. Kay and Ms. Kanemasu:

On July 22, 2016, the Commission on State Mandates adopted the Decision on the above-entitled matter.

Sincerely,

Heather Halsey
Executive Director

Commission on State Mandates
980 9th Street, Suite 300 Sacramento, CA 95814 | www.csm.ca.gov | tel (916) 323-3562 | email: csminfo@csm.ca.gov

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE INCORRECT REDUCTION CLAIM ON: Government Code Sections 7572 and 7572.5; Statutes 1984, Chapter 1747 (AB 3632); Statutes 1985, Chapter 1274 (AB 882); California Code of Regulations, Title 2, Division 9, Chapter 1, Section 60040 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 [Register 86, No. 1] and refiled June 30, 1986, designated effective July 12, 1986 [Register 86, No. 28])[1] Fiscal Years 2003-2004, 2004-2005, and 2005-2006 County of Los Angeles, Claimant	Case No.: 13-4282-I-06 *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 July 22, 2016*) (*Served July 27, 2016*)

DECISION

The Commission on State Mandates (Commission) heard and decided this Incorrect Reduction Claim (IRC) during a regularly scheduled hearing on July 22, 2016. Edward Jewik and Hasmik Yaghobyan appeared on behalf of the County of Los Angeles. Jim Spano and Chris Ryan 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 Proposed Decision to deny this IRC by a vote of 6-0 as follows:

[1] Note that this caption differs from the Test Claim and the Parameters and Guidelines captions in that it includes only those sections that were approved for reimbursement in the Test Claim Decision. Generally, a parameters and guidelines caption should include only the specific sections of the statutes and executive orders that were approved in the underlying test claim decision. However, that was an oversight in the case of the Parameters and Guidelines at issue in this case.

Member	Vote
Ken Alex, Director of the Office of Planning and Research	Yes
Richard Chivaro, Representative of the State Controller	Yes
Mark Hariri, Representative of the State Treasurer, Vice Chairperson	Yes
Sarah Olsen, Public Member	Yes
Eraina Ortega, Representative of the Director of the Department of Finance, Chairperson	Yes
Carmen Ramirez, City Council Member	Yes
Don Saylor, County Supervisor	Absent

Summary of the Findings

This IRC was filed in response to an audit by the State Controller's Office (Controller) of the County of Los Angeles's (claimant's) initial reimbursement claims under the *Handicapped and Disabled Students* program for fiscal years 2003-2004, 2004-2005, and 2005-2006. The Controller reduced the claims because it found that the claimant: (1) claimed ineligible, unsupported, and duplicate services related to assessment and treatment costs and administrative costs; (2) overstated indirect costs by applying indirect cost rates toward ineligible direct costs; and (3) overstated offsetting revenues by using inaccurate Medi-Cal units, by applying incorrect funding percentages for Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) for fiscal year (FY) 2005-06, including unsupported revenues, and by applying revenue to ineligible direct and indirect costs.[2] In this IRC, the claimant contends that the Controller's reductions were incorrect and requests, as a remedy, that the Commission reinstate the following cost amounts (which would then become subject to the program's reimbursement formula):

FY2003-2004: $5,247,918

FY2004-2005: $6,396,075

FY2005-2006: $6,536,836[3]

After a review of the record and the applicable law, the Commission found that the IRC was untimely filed.

Accordingly, the Commission denies this IRC.

I. Chronology

01/05/2005 Claimant dated the reimbursement claim for fiscal year 2003-2004.[4]

[2] See, e.g., Exhibit A, IRC, page 542 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated June 30, 2010).

[3] Exhibit A, IRC, page 1. In footnotes 1 to 4, inclusive, of the Written Narrative portion of the IRC, the claimant explains why it is requesting reinstatement of cost amounts which are greater than the amounts that the Controller reduced. Exhibit A, IRC, page 4.

[4] Exhibit A, IRC, page 564 (cover letter), page 571 (Form FAM-27).

01/10/2006	Claimant dated the reimbursement claim for fiscal year 2004-2005.[5]
04/05/2007	Claimant dated the amended reimbursement claim for fiscal year 2005-2006.[6]
08/12/2008	Controller sent a letter to claimant dated August 12, 2008 confirming the start of the audit.[7]
05/19/2010	Controller issued the Draft Audit Report dated May 19, 2010.[8]
06/16/2010	Claimant sent a letter to Controller dated June 16, 2010 in response to the Draft Audit Report.[9]
06/16/2010	Claimant sent a letter to Controller dated June 16, 2010, with regard to the claims and audit procedure.[10]
06/30/2010	Controller issued the Final Audit Report dated June 30, 2010.[11]
08/02/2013	Claimant filed this IRC.[12]
11/25/2014	Controller filed late comments on the IRC.[13]
12/23/2014	Claimant filed a request for extension of time to file rebuttal comments which was granted for good cause.
03/26/2015	Claimant filed rebuttal comments.[14]
05/20/2016	Commission staff issued the Draft Proposed Decision.[15]

[5] Exhibit A, IRC, page 859 (cover letter), page 862 (Form FAM-27). The cover letter is dated one day before the date of the Form FAM-27; the discrepancy is immaterial, and this Decision will utilize the date of the cover letter (January 10, 2006) as the relevant date.

[6] Exhibit A, IRC, page 1047 (cover letter), page 1050 (Form FAM-27).

[7] Exhibit B, Controller's Late Comments on the IRC, page 181 (Letter from Christopher Ryan to Wendy L. Watanabe, dated August 12, 2008). The Controller also asserts on page 25 of its comments that "The SCO contacted the county by phone on July 28, 2008, to initiate the audit…." However, this assertion of fact is not supported by a declaration of a person with personal knowledge or any other evidence in the record.

[8] Exhibit A, IRC, page 547.

[9] Exhibit A, IRC, pages 558-561 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated June 16, 2010).

[10] Exhibit B, Controller's Late Comments on the IRC, pages 185-186 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010).

[11] Exhibit A, IRC, page 542 (cover letter), pages 541-562 (Final Audit Report).

[12] Exhibit A, IRC, pages 1, 3.

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

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

[15] Exhibit D, Draft Proposed Decision, pages 1, 34.

06/06/2016 Controller filed comments on the Draft Proposed Decision.[16]

06/10/2016 Claimant filed comments on the Draft Proposed Decision.[17]

II. Background

In 1975, Congress enacted the Education for All Handicapped Children Act (EHA) with the stated purpose of assuring that "all handicapped children have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs . . . ."[18] Among other things, the EHA authorized the payment of federal funds to states which complied with specified criteria regarding the provision of special education and related services to handicapped and disabled students.[19] The EHA was ultimately renamed the Individuals with Disability Education Act (IDEA) and guarantees to disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education, including psychological and other mental health services, designed to meet the pupil's unique educational needs.[20]

In California, the responsibility of providing both "special education" and "related services" was initially shared by local education agencies (broadly defined) and by the state government.[21] However, in 1984, the Legislature enacted AB 3632, which amended Government Code chapter 26.5 relating to "interagency responsibilities for providing services to handicapped children" which created separate spheres of responsibility.[22] And, in 1985, the Legislature further amended chapter 26.5.[23]

The impact of the 1984 and 1985 amendments — sometimes referred to collectively as "Chapter 26.5 services" — was to transfer the responsibility to provide mental health services for disabled pupils from school districts to county mental health departments.[24]

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[16] Exhibit E, Controller's Comments on the Draft Proposed Decision, page 1.

[17] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 1.

[18] Public Law 94-142, section 1, section 3(a) (Nov. 29, 1975) 89 U.S. Statutes at Large 773, 775. See also 20 U.S.C. § 1400(d) [current version].

[19] Public Law 94-142, section 5(a) (Nov. 29, 1975) 89 U.S. Statutes at Large 773, 793. See also 20 U.S.C. 1411(a)(1) [current version].

[20] Public Law 101-476, section 901(a)(1) (October 30, 1999) 104 U.S. Statutes at Large 1103, 1141-1142.

[21] *California School Boards Ass'n v. Brown* (2011) 192 Cal.App.4th 1507, 1514.

[22] Statutes 1984, chapter 1747.

[23] Statutes 1985, chapter 1274.

[24] "With the passage of AB 3632 (fn.), California's approach to mental health services was restructured with the intent to address the increasing number of emotionally disabled students who were in need of mental health services. Instead of relying on LEAs [local education agencies] to acquire qualified staff to handle the needs of these students, the state sought to have CMH [county mental health] agencies — who were already in the business of providing mental health services to emotionally disturbed youth and adults — assume the responsibility for

In 1990 and 1991, the Commission adopted the Test Claim Statement of Decision and the Parameters and Guidelines, approving *Handicapped and Disabled Students*, CSM 4282, as a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution.[25] The Commission found that the activities of providing mental health assessments; participation in the IEP process; and providing psychotherapy and other mental health treatment services were reimbursable and that providing mental health treatment services was funded as part of the Short-Doyle Act, based on a cost-sharing formula with the state.[26] Beginning July 1, 2001, however, the cost-sharing ratio for providing psychotherapy and other mental health treatment services no longer applied, and counties were entitled to receive reimbursement for 100 percent of the costs to perform these services.[27]

In 2004, the Legislature directed the Commission to reconsider *Handicapped and Disabled Students*, CSM 4282.[28] In May 2005, the Commission adopted the Statement of Decision on Reconsideration, 04-RL-4282-10, and determined that the original Statement of Decision correctly concluded that the test claim statutes and regulations 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. Thus, for costs incurred beginning July 1, 2004, the Commission identified the activities expressly required by the test claim statutes and regulations that were reimbursable, identified the offsetting revenue applicable to the program, and updated the new funding provisions enacted in 2002 that required 100 percent reimbursement for mental health treatment services.[29]

Statutes 2011, chapter 43 (AB 114) eliminated the mandated programs for *Handicapped and Disabled Students*, 04-RL-4282-10 and 02-TC-40/02-TC-49, by transferring responsibility for

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providing needed mental health services to children who qualified for special education." Stanford Law School Youth and Education Law Clinic, *Challenge and Opportunity: An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California*, May 2004, page 12.

[25] "As local mental health agencies had not previously been required to provide Chapter 26.5 services to special education students, local mental health agencies argued that these requirements constituted a reimbursable state mandate." (*California School Boards Ass'n v. Brown* (2011) 192 Cal.App.4th 1507, 1515.)

[26] Former Welfare and Institutions Code sections 5600 et seq.

[27] Statutes 2002, chapter 1167 (AB 2781, §§ 38, 41).

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

[29] In May 2005, the Commission also adopted a Statement of Decision on *Handicapped and Disabled Students II* (02-TC-40/02-TC-49), a test claim addressing statutory amendments enacted between the years 1986 and 2002 to Government Code sections 7570 et seq., and 1998 amendments to the joint regulations adopted by the Departments of Education and Mental Health. The period of reimbursement for *Handicapped and Disabled Students II* (02-TC-40/ 02-TC-49) began July 1, 2001.

providing mental health services under IDEA back to school districts, effective July 1, 2011.[30] On September 28, 2012, the Commission adopted an amendment to the Parameters and Guidelines ending reimbursement effective July 1, 2011.

The Controller's Audit and Reduction of Costs

The Controller issued the Draft Audit Report dated May 19, 2010, and provided a copy to the claimant for comment.[31]

In a four-page letter dated June 16, 2010, the claimant responded directly to the Draft Audit Report, agreed with its findings, and accepted its recommendations.[32] The first page of this four-page letter contains the following statement:

> *The County's attached response indicates agreement with the audit findings* and the actions that the County will take to implement policies and procedures to ensure that the costs claimed under HDS are eligible, mandate related, and supported.[33]

The following three pages of the four-page letter contain further statements of agreement with the Controller's findings and recommendations.

In response to the Controller's Finding No. 1, that the claimant overstated assessment and treatment costs by more than $27 million, the claimant responded in relevant part:

> We agree with the recommendation. The County will strengthen the policies and procedures to ensure that only actual units of service for eligible clients are claimed in accordance with the mandated program. The County will ensure all staff members are trained on the applicable policies and procedures. . . . . .
>
> The County has agreed to the audit disallowances for Case Management Support Costs.[34]

In response to the Controller's Finding No. 2, that the claimant overstated administrative costs by more than $5 million, the claimant responded in relevant part:

> We agree with the recommendation. As stated in the County's Response for Finding 1, the County will strengthen the policies and procedures to ensure that only actual units of service for eligible clients are claimed in accordance with the mandated program and will ensure the administrative cost rates are applied appropriately. At the time of claim preparation, it was the County's understanding that the administrative cost rates were applied to eligible and supported direct

[30] Assembly Bill No. 114 (2011-2012 Reg. Sess.), approved by Governor, June 30, 2011.

[31] Exhibit A, IRC, page 547.

[32] Exhibit A, IRC, pages 558-561 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated June 16, 2010).

[33] Exhibit A, IRC, page 558 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated June 16, 2010) (emphasis added).

[34] Exhibit A, IRC, pages 559-560 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated June 16, 2010).

costs. The State auditor's discovery of ineligible units of service resulted in the ineligibility of the administrative costs.[35]

In response to the Controller's Finding No. 3, that the claimant overstated offsetting revenues by more than $13 million, the claimant responded in relevant part:

> We agree with the recommendation. It is always the County's intent to apply the applicable offsetting revenues (including federal, state, and local reimbursements) to eligible costs, which are supported by source documentation.[36]

In a separate two-page letter also dated June 16, 2010, the claimant addressed its compliance with the audit and the status of any remaining reimbursement claims.[37] Material statements in the two-page letter include:

- "We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO."[38]
- "We designed and implemented the County's accounting system to ensure accurate and timely records."[39]
- "We claimed mandated costs based on actual expenditures allowable per the Handicapped and Disabled Students Program's parameters and guidelines."[40]
- "We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims."[41]
- "We are not aware of any . . . . Relevant, material transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims."[42]

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[35] Exhibit A, IRC, page 560 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated June 16, 2010).

[36] Exhibit A, IRC, page 561 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated June 16, 2010).

[37] Exhibit B, Controller's Late Comments on the IRC, pages 185-186 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010).

[38] Exhibit B, Controller's Late Comments on the IRC, pages 185 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 1).

[39] Exhibit B, Controller's Late Comments on the IRC, pages 185 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 2).

[40] Exhibit B, Controller's Late Comments on the IRC, pages 185 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 4).

[41] Exhibit B, Controller's Late Comments on the IRC, pages 185 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 5).

[42] Exhibit B, Controller's Late Comments on the IRC, pages 186 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 7).

- "There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims."[43]
- "We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims."[44]

On June 30, 2010, the Controller issued the Final Audit Report.[45] The Controller reduced the claims because the claimant: (1) claimed ineligible, unsupported, and duplicate services related to assessment and treatment costs and administrative costs; (2) overstated indirect costs by applying indirect cost rates toward ineligible direct costs; and (3) overstated offsetting revenues by using inaccurate Medi-Cal units, by applying incorrect funding percentages for Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) for FY 2005-2006, including unsupported revenues, and by applying revenue to ineligible direct and indirect costs.[46]

On August 2, 2013, the claimant filed this IRC with the Commission.[47]

III. Positions of the Parties

A. County of Los Angeles

The claimant objects to $18,180,829 in reductions. The claimant asserts that the Controller audited the claim as if the claimant used the actual increased cost method to prepare the reimbursement claim, instead of the cost report method the claimant states it used. Thus, the claimant takes the following principal positions:

1. The Controller lacked the legal authority to audit the claimant's reimbursement claims because the claimant used the cost report method for claiming costs. The cost report method is a reasonable reimbursement methodology (RRM) based on approximations of local costs and, thus, the Controller has no authority to audit RRMs. The Controller's authority to audit is limited to actual cost claims.[48]
2. Even if the Controller has the authority to audit the reimbursement claims, the Controller was limited to reviewing only the documents required by the California Department of

[43] Exhibit B, Controller's Late Comments on the IRC, pages 186 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 8).

[44] Exhibit B, Controller's Late Comments on the IRC, pages 186 (Letter from Wendy L. Watanabe to Jim L. Spano, dated June 16, 2010, paragraph 9).

[45] Exhibit B, Controller's Late Comments on the IRC, page 6 (Declaration of Jim L. Spano, dated Nov. 17, 2014, paragraph 7); Exhibit A, IRC, page 542 (cover letter), pages 541-562 (Final Audit Report).

[46] See, e.g., Exhibit A, IRC, page 542 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated June 30, 2010).

[47] Exhibit A, IRC, pages 1, 3.

[48] Exhibit A, IRC, pages 10-11.

Mental Health's cost report instructions, and not request supporting data from the county's Mental Health Management Information System.[49]

3. The Controller also has the obligation to permit the actual costs incurred on review of the claimant's supporting documentation. However, the data set used by the Controller to determine allowable costs was incomplete and did not accurately capture the costs of services rendered.[50]

4. Under the principle of equitable offset, the claimant may submit new claims for reimbursement supported by previously un-submitted documentation.[51]

The claimant also asserts that the Controller improperly shifted IDEA funds and double-counted certain assessment costs.[52]

On June 10, 2016, the claimant filed comments on the Draft Proposed Decision, arguing that the IRC should be considered timely filed because the claimant relied upon statements made by the Controller that it had three years to file an IRC from the notices dated August 6, 2010, as follows:

> The County relied upon the statements and the actions of the SCO in making its determinations. In its cover letter to the County accompanying the audit report, the SCO states that the County must file an IRC within three years of the SCO notifying the County of a claim reduction. The SCO then refers to the notices as notices of claim reduction. The SCO then specifically referred to the dates of the notices upon which the County relied as the dates they notified the County of a claim reduction.[53]

The claimant also argued that the limitations period should be reset or suspended because the Controller engaged in a reconsideration of the audit results.[54]

B. State Controller's Office

The Controller contends that it acted according to the law when it made $18,180,829 in reductions to the claimant's reimbursement claims for fiscal years 2003-2004, 2004-2005, and 2005-2006.

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[49] Exhibit A, IRC, pages 11-12.

[50] Exhibit A, IRC, pages 12-15, 17-18.

[51] Exhibit A, IRC, pages 15-17.

[52] Exhibit A, IRC, page 4 fn. 1 through 4 ("The amounts are further offset because the SCO, in calculating the County's claimed amount, added the amounts associated with refiling of claims based on the CSM's Reconsideration Decision to the original claims submitted for Fiscal Years 2004-05 and 2005-06, thus double-counting certain assessment costs for those fiscal years.").

[53] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3. The letter the claimant is referring to is the letter at Exhibit A, IRC, pages 485-486, from Jim Spano to Robin C. Kay, dated May 7, 2013.

[54] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3.

The Controller takes the following principal positions:

1. The Controller possesses the legal authority to audit the claimant's reimbursement claims, even if the claims were made using a cost report method as opposed to an actual cost method.[55]
2. The documentation provided by the claimant did not verify the claimed costs.[56]
3. The claimant provided a management representation letter stating that the claimant had provided to the Controller all pertinent information in support of its claims.[57]
4. The claimant may not, under the principle of equitable offset, submit new claims for reimbursement supported by previously un-submitted documentation.[58]

On June 6, 2016, the Controller filed comments agreeing with the Draft Proposed Decision.[59]

IV. Discussion

Government Code section 17561(d) 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, of the California Constitution.[60] 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

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[55] Exhibit B, Controller's Late Comments on the IRC, page 27. But see Exhibit C, Claimant's Rebuttal Comments, page 2 ("The SCO states it disagrees with the County's contention that the SCO did not have the legal authority to audit the program during these three fiscal years. However, it offers no argument or support for its position."). The Commission is not aided by the Controller's failure to substantively address a legal issue raised by the IRC.

[56] Exhibit B, Controller's Late Comments on the IRC, pages 27-29.

[57] Exhibit B, Controller's Late Comments on the IRC, page 29.

[58] Exhibit B, Controller's Late Comments on the IRC, page 28.

[59] Exhibit E, Controller's Comments on the Draft Proposed Decision.

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

apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."[61]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.[62] Under this standard, the courts have found:

> 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.]' "[63]

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.[64] In addition, sections 1185.1(f)(3) 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.[65]

A. The IRC Was Untimely Filed.

The threshold issue is whether this IRC was timely filed.[66]

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[61] *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1281, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[62] *Johnston v. Sonoma County Agricultural Preservation and Open Space Dist.* (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.

[63] *American Bd. of Cosmetic Surgery, Inc. v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547-548.

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

[65] 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.

[66] In its comments on the IRC (Exhibit B), the Controller did not raise the issue of whether the IRC was timely filed. However, the Commission's limitations period is jurisdictional, and, as such, the Commission is obligated to review the limitations issue sua sponte. (See *John R. Sand & Gravel Co. v. United States* (2008) 552 U.S. 130, 132 [128 S. Ct. 750, 752].)

"The statute of limitations is an affirmative defense" (*Ladd v. Warner Bros. Entertainment, Inc.* (2010) 184 Cal.App.4th 1298, 1309), and, in civil cases, an affirmative defense must be

At the time the reimbursement claims were audited and when this IRC was filed, the Commission's regulation containing the limitations period read:

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[67]

Thus, the applicable limitations period is "three (3) years following the date of the Office of State Controller's final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction."[68]

Applying the plain language of the limitations regulation — that the IRC must have been filed no later than three years after "the date" of the Final Audit Report — the IRC was untimely. The Controller's Final Audit Report is dated June 30, 2010.[69] Three years later was June 30, 2013. Since June 30, 2013, was a Sunday, the claimant's deadline to file this IRC moved to Monday, July 1, 2013.[70] Instead of filing this IRC by the deadline of Monday, July 1, 2013, the claimant filed this IRC with the Commission on Friday, August 2, 2013 — 32 days later.[71]

The claimant attempts to save its IRC by calculating the commencement of the limitations period from the date of three documents which bear the date August 6, 2010, and which were issued by the Controller; the claimant refers to these three documents as "Notices of Claim Adjustment."[72]

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established by a preponderance of the evidence (31 Cal.Jur.3d, Evidence, section 97 [collecting cases]; *People ex. rel. Dept. of Public Works v. Lagiss* (1963) 223 Cal.App.2d 23, 37). See also Evidence Code section 115 ("Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence.").

[67] Former Code of California Regulations, title 2, section 1185(b), which was renumbered section 1185(c) effective January 1, 2011. Effective July 1, 2014, the regulation was amended to state the following: "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." Code of California Regulations, title 2, section 1185.1(c).

[68] Former Code of California Regulations, title 2, section 1185(b).

[69] Exhibit A, IRC, page 547 (Final Audit Report).

[70] See California Code of Regulations, title 2, section 1183.18(a)(1); Code of Civil Procedure section 12a(a) ("If the last day for the performance of any act provided or required by law to be performed within a specified period of time is a holiday, then that period is hereby extended to and including the next day that is not a holiday."); Government Code section 6700(a)(1) ("The holidays in this state are: Every Sunday…."); and Code of Civil Procedure section 12a(b) ("This section applies . . . to all other provisions of law providing or requiring an act to be performed on a particular day or within a specified period of time, whether expressed in this or any other code or statute, ordinance, rule, or regulation.").

[71] Exhibit A, IRC, page 1.

[72] Exhibit A, IRC, pages 21-27.

In the Written Narrative portion of the IRC, the claimant writes, "The SCO issued its audit report on June 30, 2010. The report was followed by Notices of Claim Adjustment dated August 6, 2010 (see Exhibit A)."[73] The claimant further argues that the Commission should find that the IRC was timely filed based on statements made by the Controller's Office that an IRC could be filed three years from the August 6, 2010, notices.[74]

The claimant's argument fails because: (1) the three documents dated August 6, 2010, were not notices of claim adjustment; (2) the limitations period commences to run upon the earliest event in time which would have allowed the claimant to file a claim; and (3) the Controller's misstatement of law (specifically, the Controller's erroneous statement that the limitations period for filing an IRC began to run as of the three documents dated August 6, 2010) does not result in an equitable estoppel that makes the IRC timely.

1. The Three Documents Dated August 6, 2010, Are Not Notices of Adjustment.

For purposes of state mandate law, the Legislature has enacted a statutory definition of what constitutes a "notice of adjustment."

Government Code section 17558.5(c) reads in relevant 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."

In other words, a notice of adjustment is a document which contains four elements: (1) a specification of the claim components adjusted, (2) the amounts adjusted, (3) interest charges, and (4) the reason for the adjustment.

Each of the three documents which the claimant dubs "Notices of Claim Adjustment" contains the amount adjusted, but the other three required elements are absent. None of the three documents specifies the claim components adjusted; each provides merely a lump-sum total of all *Handicapped and Disabled Students* program costs adjusted for the entirety of the relevant fiscal year. None of the three documents contains interest charges. Perhaps most importantly, none of the three documents enunciates a reason for the adjustment.[75]

In addition to their failure to satisfy the statutory definition, the three documents cannot be notices of adjustment because none of the documents adjusts anything. The three documents restate, in the most cursory fashion, the bottom-line findings contained in the Controller's Final

[73] Exhibit A, IRC, page 6.

[74] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

[75] Exhibit A, IRC, pages 21-27 (the "Notices of Claim Adjustment"). See also Decision, *Domestic Violence Treatment Services — Authorization and Case Management*, Commission on State Mandates Case No. 07-9628101-I-01, adopted March 25, 2016, page 16 ("For IRCs, the 'last element essential to the cause of action' which begins the running of the period of limitations . . . is a notice to the claimant of the adjustment that includes the reason for the adjustment.").

Audit Report.[76] The claimant asserts that, if the documents dated August 6, 2010, do not constitute notices of claim adjustment, then the Controller never provided notice.[77] The Final Audit Report provides abundant notice.

None of the three documents provides the claimant with notice of any new finding. The Final Audit Report informed the claimant of the dollar amounts which would not be reimbursed and the dollar amounts which the Controller contended that the claimant owed the State.[78] The Final Audit Report informed the claimant that the Controller would offset unpaid amounts from future mandate reimbursements if payment was not remitted.[79] The three documents merely repeat this information. The three documents do not provide notice of any new and material information, and the three documents do not contain any previously unannounced adjustments.[80]

For these reasons, the three documents are not notices of adjustment within the meaning of Government Code section 17558.5(c).

2. The Limitations Period Begins to Run Upon the Occurrence of the Earliest Event Which Would Have Allowed the Claimant to File a Claim.

The Commission's regulation setting out the limitation period lists several events which could potentially trigger the running of the limitations period. Specifically, the limitations regulation lists, as potentially triggering events, the date of a final audit report, the date of a letter, the date of a remittance advice, and the date of a written notice of adjustment. The claimant argues that, if more than one of these events occurred, then the limitations period should begin to run upon the occurrence of the event which occurred last in time.[81] The Commission reaches (and has, many times in the past, reached) the opposite conclusion; the limitations period begins to run from the occurrence of the earliest event which would have allowed the claimant to file a claim. Subsequent events do not reset the limitations clock.

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[76] Compare Exhibit A, IRC, pages 21-27 (the "Notices of Claim Adjustment") with Exhibit A, IRC, pages 548-550 ("Schedule 1 — Summary of Program Costs" in the Final Audit Report). The bottom-line totals are identical.

[77] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3.

[78] The Final Audit Report and the Controller's cover letter to the Final Audit Report are each dated June 30, 2010. Exhibit A, IRC, pages 542, 547. In addition, the claimant has admitted that the Controller issued the Final Audit Report on June 30, 2010, and that the three documents dated August 6, 2010 "followed" the Final Audit Report. Exhibit A, IRC, page 6.

[79] Exhibit A, IRC, page 547.

[80] Moreover, the governing statute provides that a remittance advice or a document which merely provides notice of a payment action is not a notice of adjustment. Government Code section 17558.5(c) ("Remittance advices and other notices of payment action shall not constitute notice of adjustment from an audit or review."). Whatever term may accurately be used to characterize the three documents identified by the claimant, the three documents are not "notices of adjustment" under state mandate law.

[81] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

At the time the reimbursement claims were audited and when this IRC was filed, the Commission's regulation containing the limitations period read:

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[82]

Under a legal doctrine with the somewhat confusing name of the "last essential element" rule, a limitations period begins to run upon the occurrence of the *earliest* event in time which creates a claim. Under this rule, a right accrues — and the limitations period begins to run — from the earliest point in time when the claim could have been filed and maintained.

As recently summarized by the California Supreme Court:

> The limitations period, the period in which a plaintiff must bring suit or be barred, runs from the moment a claim accrues. (See Code Civ. Proc., § 312 [an action must "be commenced within the periods prescribed in this title, after the cause of action shall have accrued"]; (Citations.). Traditionally at common law, a "cause of action accrues 'when [it] is complete with all of its elements' — those elements being wrongdoing, harm, and causation." (Citations.) This is the "last element" accrual rule: ordinarily, the statute of limitations runs from "the occurrence of the last element essential to the cause of action." (Citations.)[83]

In determining when a limitations period begins to run, the California Supreme Court looks to the earliest point in time when a litigant could have filed and maintained the claim:

> Generally, a cause of action accrues and the statute of limitation begins to run when a suit may be maintained. [Citations.] "Ordinarily this is when the wrongful act is done and the obligation or the liability arises, but it does not 'accrue until the party owning it is entitled to begin and prosecute an action thereon.' " [Citation.] In other words, "[a] cause of action accrues 'upon the occurrence of the last element essential to the cause of action.' " [Citations.][84]

Under these principles, the claimant's three-year limitations period began to run from the date of the Final Audit Report. As of that date, the claimant could have filed an IRC pursuant to Government Code sections 17551 and 17558.7, because, as of that date, the claimant had been (from its perspective) harmed by a claim reduction. The Controller's subsequent issuance of a letter or other notice that does not change the reason for the reduction does not start a new limitations clock. The limitations period starts to run from the earliest point in time when the

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[82] Former Code of California Regulations, title 2, section 1185(b) (Regulation 1185), which was renumbered section 1185(c) effective January 1, 2011. Effective July 1, 2014, the regulation was amended to state the following: "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." Code of California Regulations, title 2, section 1185.1(c).

[83] *Aryeh v. Canon Business Solutions, Inc.* (2013) 55 Cal.4th 1185, 1191.

[84] *Howard Jarvis Taxpayers Ass'n v. City of La Habra* (2001) 25 Cal.4th 809, 815.

claimant could have filed an IRC — and the limitations period expires three years after that earliest point in time.

This finding is consistent with two recent Commission decisions regarding the three-year period in which a claimant can file an IRC.

In the *Collective Bargaining* program IRC Decision adopted on December 5, 2014, the claimant argued that the limitations period should begin to run from the date of the *last* notice of adjustment in the record.[85] This argument parallels that of the claimant in this instant IRC, who argues that between the Final Audit Report dated June 30, 2010, and the three documents dated August 6, 2010, the *later* event should commence the running of the limitations period.

In the *Collective Bargaining* Decision, the Commission rejected the argument. The Commission held that the limitations period began to run on the *earliest* applicable event because that was when the claim was complete as to all of its elements.[86] "Accordingly, the claimant cannot allege that the earliest notice did not provide sufficient information to initiate the IRC, and the later adjustment notices that the claimant proffers do not toll or suspend the operation of the period of limitation," the Commission held.[87]

In the *Domestic Violence Treatment Services — Authorization and Case Management* program IRC Decision adopted on March 25, 2016, the Commission held, "For IRCs, the 'last element essential to the cause of action' which begins the running of the period of limitations . . . is a notice to the claimant of the adjustment that includes the reason for the adjustment."[88] In the instant IRC, the limitations period therefore began to run from the Final Audit Report, which is the notice that informed the claimant of the adjustment and of the reasons for the adjustment.

Furthermore, the Commission's finding in the instant IRC is not inconsistent with a recent Commission ruling regarding the timeliness of filing an IRC.

In the *Handicapped and Disabled Students* IRC Decision adopted September 25, 2015, the Commission found that an IRC filed by a claimant was timely because the limitations period began to run from the date of a remittance advice letter which was sent after the Controller's Final Audit Report.[89] This Decision is distinguishable because, in that claim, the Controller's cover letter (accompanying the audit report) to the claimant requested additional information and implied that the attached audit report was not final.[90] In the instant IRC, by contrast, the

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[85] Decision, *Collective Bargaining*, 05-4425-I-11 (adopted December 5, 2014), pages 20-22.

[86] Decision, *Collective Bargaining*, 05-4425-I-11 (adopted December 5, 2014), pages 20-22.

[87] Decision, *Collective Bargaining*, 05-4425-I-11 (adopted December 5, 2014), page 21.

[88] Decision, *Domestic Violence Treatment Services — Authorization and Case Management*, 07-9628101-I-01 (adopted March 25, 2016), page 16.

[89] Decision, *Handicapped and Disabled Students*, 05-4282-I-03 (adopted September 25, 2015), pages 11-14.

[90] Decision, *Handicapped and Disabled Students*, 05-4282-I-03 (adopted September 25, 2015), pages 11-14. In the proceeding which resulted in this 2015 Decision, the cover letter from the Controller to the claimant is reproduced at Page 71 of the administrative record. In that letter, the Controller stated, "The SCO has established an informal audit review process to resolve a dispute of facts. The auditee should submit, in writing, a request for a review and all information

Controller's cover letter contained no such statement or implication; rather, the Controller's cover letter stated that, if the claimant disagreed with the attached Final Audit Report, the claimant would need to file an IRC within three years.[91]

The finding in this instant IRC is therefore consistent with recent Commission rulings regarding the three-year IRC limitations period.[92]

In comments on the Draft Proposed Decision, the claimant argues that the Commission should not apply the "last essential element" rule because Regulation 1185 used the disjunctive "or" when listing the events which triggered the running of the limitations period.[93] The claimant provides no legal authority for its argument or evidence that Regulation 1185 was intended to be read in such a manner. The Commission therefore rejects the argument.

The Commission also notes that the claimant's interpretation would yield the absurd result of repeatedly resetting the limitations period. Under the claimant's theory, a statute of limitations containing a disjunctive "or" restarts whenever one of the other events in the list occurs. In other words, if a regulation states that a three-year limitations period begins to run upon the occurrence of X, Y, or Z, then (under the claimant's theory), X can occur, a decade can elapse, and then the belated occurrence of Y or Z restarts the limitations clock. This interpretation cannot be correct, particularly in the context of monetary claims against the State's treasury. The "last essential element" rule provides the claimant with the opportunity to timely file a claim while protecting the State from reanimated liability.

Consequently, the Commission concludes that the limitations period begins to run from the occurrence of the earliest event which would have allowed the claimant to file a claim. That event, in this case, was the date of the Final Audit Report. Since more than three years elapsed between that date and filing of the IRC, the IRC was untimely.

3. The Controller's Misstatement of Law (Specifically, the Controller's Erroneous Statement That the Limitations Period Began to Run as of the Three Documents Dated August 6, 2010) Does Not Result in an Equitable Estoppel That Makes the IRC Timely.

In its comments on the Draft Proposed Decision, the claimant argues that the IRC should be considered timely because the claimant relied upon statements made by the Controller. "The County relied upon the statements and the actions of the SCO in making its determinations. In

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pertinent to the disputed issues within 60 days after receiving the final report." The Controller's cover letter in the instant IRC contains no such language. Exhibit A, IRC, page 542 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated June 30, 2010).

[91] Exhibit A, IRC, page 542.

[92] All that being said, an administrative agency's adjudications need not be consistent. See, e.g., *Weiss v. State Board of Equalization* (1953) 40 Cal.2d 772, 777 ("The administrator is expected to treat experience not as a jailer but as a teacher."); *California Employment Commission v. Black-Foxe Military Institute* (1941) 43 Cal.App.2d Supp. 868, 876 ("even were the plaintiff guilty of occupying inconsistent positions, we know of no rule of statute or constitution which prevents such an administrative board from doing so.").

[93] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3.

its cover letter to the County accompanying the audit report, the SCO states that the County must file an IRC within three years of the SCO notifying the County of a claim reduction. The SCO then refers to the notices as notices of claim reduction. The SCO then specifically referred to the dates of the notices upon which the County relied as the dates they notified the County of a claim reduction."[94]

Although the claimant does not use the precise term (and does not conduct the requisite legal analysis), the claimant is arguing that the Controller should be equitably estopped from benefiting from the statute of limitations, and that the Commission should find the IRC timely. The claimant is arguing that, if the filing deadline provided by the Controller was erroneous, then the claimant should be forgiven for filing late because the claimant was relying upon the Controller's statements.

A state administrative agency may possess[95] — but does not necessarily possess[96] — the authority to adjudicate claims of equitable estoppel. The Commission possesses the authority to adjudicate claims of equitable estoppel because, without limitation, the Commission is vested with exclusive and original jurisdiction and the Commission is obligated to create a full record for the Superior Court to review in the event that a party seeks a writ of administrative mandamus.[97]

The general elements of estoppel are well-established. "Whenever a party has, by his own statement or conduct, intentionally and deliberately led another to believe a particular thing true and to act upon such belief, he is not, in any litigation arising out of such statement or conduct, permitted to contradict it."[98] "Generally speaking, four elements must be present in order to apply the doctrine of equitable estoppel: (1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury."[99]

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[94] Exhibit F, Claimant's Comments on the Draft Proposed Decision, page 3. The letter the claimant is referring to is the letter at Exhibit A, IRC, pages 485-486 from Jim Spano to Robin C. Kay, dated May 7, 2013.

[95] *Lentz v. McMahon* (1989) 49 Cal.3d 393, 406.

[96] *Foster v. Snyder* (1999) 76 Cal.App.4th 264, 268 ("The holding in *Lentz* does not stand for the all-encompassing conclusion that equitable principles apply to all administrative proceedings.").

[97] *Lentz v. McMahon* (1989) 49 Cal.3d 393, 404 (regarding exclusive jurisdiction) & fn. 8 (regarding duty to create full record for review). See also Government Code section 17552 (exclusive jurisdiction); Government Code section 17559(b) (aggrieved party may seek writ of administrative mandamus).

[98] Evidence Code section 623.

[99] *Driscoll v. City of Los Angeles* (1967) 67 Cal.2d 297, 305.

"The doctrine of estoppel is available against the government '"where justice and right require it."' (Citation.)"[100] However, "estoppel will not be applied against the government if to do so would nullify a strong rule of policy adopted for the benefit of the public."[101] Estoppel against the government is to be limited to "exceptional conditions," "special cases," an "exceptional case," or applied in a manner which creates an "extremely narrow precedent."[102]

Furthermore, the party to be estopped must have engaged in some quantum of turpitude. "We have in fact indicated that some element of turpitude on the part of the party to be estopped is requisite even in cases not involving title to land," the California Supreme Court noted.[103] In the federal courts, equitable estoppel against the government "must rest upon affirmative misconduct going beyond mere negligence."[104]

Upon a consideration of all of the facts and argument in the record, the Commission concludes for the following reasons that the Controller is not equitably estopped from benefiting from the statute of limitations.

The Commission interprets the evidence in the record as presenting a mutual mistake of law by both the Controller and the claimant. On the date of the Controller's erroneous letter (May 7, 2013), Regulation 1185's three-year limitations period had been in effect and had been published since at least May 2007.[105] Despite the fact that the limitations period had been in effect for several years, both the claimant and the Controller incorrectly calculated the IRC filing deadline as starting from the date of the three documents dated August 6, 2010, when, for the reasons explained in this Decision, the filing deadline started to run as of the date of the Final Audit Report.

A situation in which a government agency and a third party both misinterpret the law does not allow for an estoppel against the government — because the third party should have taken the time to learn what the law actually said. "Acts or conduct performed under a mutual mistake of law do not constitute grounds for estoppel. (Citation.) It is presumed the party claiming estoppel had an equal opportunity to discover the law."[106] "Where the facts and law are known to both parties, there can be no estoppel. (Citation.) Even an expression as to a matter of law, in the

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[100] *Robinson v. Fair Employment and Housing Commission* (1992) 2 Cal.4th 226, 244, quoting *Lentz v. McMahon* (1989) 49 Cal.3d 393, 399, quoting *City of Los Angeles v. Cohn* (1894) 101 Cal. 373, 377.

[101] *Lusardi Construction Co. v. Aubry* (1992) 1 Cal.4th 976, 994–995.

[102] *City of Long Beach v. Mansell* (1970) 3 Cal.3d 462, 496 & fn. 30, 500.

[103] *City of Long Beach v. Mansell* (1970) 3 Cal.3d 462, 490 fn. 24.

[104] *Morgan v. Heckler* (1985) 779 F.2d 544, 545 (Kennedy, J.). See also *Mukherjee v. I.N.S.* (9th Cir. 1986) 793 F.2d 1006, 1009 (defining affirmative misconduct as "a deliberate lie . . . or a pattern of false promises").

[105] California Regulatory Code Supplement, Register 2007, No. 19 (May 11, 2007), page 212.1 [version operative May 8, 2007].

[106] *Adams v. County of Sacramento* (1991) 235 Cal.App.3d 872, 883-884.

absence of a confidential relationship, is not a basis for an estoppel."[107] "Persons dealing with the government are charged with knowing government statutes and regulations, and they assume the risk that government agents may exceed their authority and provide misinformation."[108]

In point of fact, the Controller had earlier provided the claimant with general IRC filing information and had admonished the claimant to visit the Commission's website. In the cover letter dated June 30, 2010, the Controller summarized the audit findings and then stated, "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 Web site at www.csm.ca.gov/docs/IRCform.pdf."[109] In other words, as of June or July 2010, the claimant had been informed in general terms of the filing deadline and had been directed to the Commission. The fact that the claimant failed to do so and the fact that the Controller made an erroneous statement more than two years later does not somehow make the claimant's IRC timely.

Separately and independently, the record does not indicate that the Controller engaged in some quantum of turpitude. There is no evidence, for example, that the Controller acted with an intent to mislead.

Finally, the finding of an estoppel under this situation would nullify a strong rule of policy adopted for the benefit of the public, specifically, the policy that limitations periods exist "to encourage the timely presentation of claims and prevent windfall benefits."[110]

For each of these reasons, the claimant's argument of equitable estoppel is denied.

The Commission is also unpersuaded that the events which the claimant characterizes as the Controller's reconsideration of the audit act to extend, reset, suspend or otherwise affect the limitations period.[111] While the claimant contends that the Controller reconsidered the audit findings and then withdrew from the reconsideration,[112] the Controller contends that it did not engage in a reconsideration, but instead denied the claimant's request for a reconsideration.[113] On this point, the factual evidence in the record, within the letter from the Controller dated May 7, 2013, provides, "This letter confirms that we denied the county's reconsideration request . . . ."[114] The limitations period cannot be affected by a reconsideration which did not occur. Separately, the process which the claimant characterizes as a reconsideration did not commence

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[107] *People v. Stuyvesant Ins. Co.* (1968) 261 Cal.App.2d 773, 784.

[108] *Lavin v. Marsh* (9th Cir. 1981) 644 F.2d 1378, 1383.

[109] Exhibit A, IRC, page 542.

[110] *Lentz v. McMahon* (1989) 49 Cal.3d 393, 401.

[111] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

[112] Exhibit F, Claimant's Comments on the Draft Proposed Decision, pages 2-3.

[113] Exhibit A, IRC, page 485.

[114] Exhibit A, IRC, page 485.

until a June 2012 delivery of documents,[115] by which time the limitations period had been running for about two years. The claimant does not cite to legal authority or otherwise persuasively explain how the Controller's alleged reconsideration stopped or reset the already-ticking limitations clock.

Accordingly, the IRC is denied as untimely filed.

V. Conclusion

The Commission finds that claimant's IRC was untimely filed.

Therefore, the Commission denies this IRC.

[115] Exhibit A, IRC, page 485.

RE: **Decision**

Handicapped and Disabled Students, 13-4282-I-06
Government Code Sections 7572 and 7572.5
Statutes 1984, Chapter 1747 (AB 3632); Statutes 1985, Chapter 1274 (AB 882);
California Code of Regulations, Title 2, Division 9, Chapter 1, Section 60040
(Emergency regulations filed December 31, 1985, designated effective
January 1, 1986 [Register 86, No. 1] and refiled June 30, 1986, designated effective
July 12, 1986 [Register 86, No. 28])
Fiscal Years: 2003-2004, 2004-2005, and 2005-2006
County of Los Angeles, Claimant

On July 22, 2016, the foregoing Decision of the Commission on State Mandates was adopted on the above-entitled matter.

Dated: July 27, 2016

Heather Halsey, Executive Director

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 July 27, 2016, I served the:

Decision
Handicapped and Disabled Students, 13-4282-I-06
Government Code Sections 7572 and 7572.5
Statutes 1984, Chapter 1747 (AB 3632); Statutes 1985, Chapter 1274 (AB 882);
California Code of Regulations, Title 2, Division 9, Chapter 1, Section 60040
(Emergency regulations filed December 31, 1985, designated effective
January 1, 1986 [Register 86, No. 1] and refiled June 30, 1986, designated effective
July 12, 1986 [Register 86, No. 28])
Fiscal Years: 2003-2004, 2004-2005, and 2005-2006
County of Los Angeles, 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 July 27, 2016 at Sacramento, California.

Jill Magee

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

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 7/5/16

Claim Number: 13-4282-I-06

Matter: Handicapped and Disabled Students

Claimant: County of Los Angeles

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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Attachment C

RECEIVED
November 25, 2014
Commission on
State Mandates

LATE FILING

JOHN CHIANG
California State Controller

November 24, 2014

Heather Halsey
Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Re: **Incorrect Reduction Claim (IRC)**
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes of 1994, Chapter 1128; Statutes of 1996, Chapter 654
Fiscal Years 2002-2003 and 2003-2004
Los Angeles County, Claimant

Dear Ms. Halsey:

The State Controller's Office is transmitting our response to the above-named IRC.

If you have any questions, please contact me by telephone at (916) 323-5849.

Sincerely,

JIM L. SPANO, Chief
Mandated Cost Audits Bureau
Division of Audits

JS/kw

14663

RESPONSE BY THE STATE CONTROLLER'S OFFICE TO THE INCORRECT REDUCTION CLAIM (IRC) BY LOS ANGELES COUNTY

Handicapped and Disabled Students II

Table of Contents

Note: References to Exhibits related to county's IRC filed June 11, 2013, as follows:

- Exhibit A – PDF page 18
- Exhibit B – PDF page 73
- Exhibit C – PDF page 94
- Exhibit D – PDF page 111

Tab 1

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

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

INCORRECT REDUCTION CLAIM ON: Handicapped and Disabled Students II Program Chapter 1128, Statutes of 1994 Chapter 654, Statutes of 1996 LOS ANGELES COUNTY, Claimant	No.: CSM 12-0240-I-01 AFFIDAVIT OF BUREAU CHIEF

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

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

2) I am currently employed as a Bureau Chief, and have been so since April 21, 2000. Before that, I was employed as an audit manager for two years and three months.

3) I am a California Certified Public Accountant.

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

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

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

7) A review of the claims for fiscal year (FY) 2002-03 and FY 2003-04 was completed on May 28, 2010.

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

Date: October 31, 2014

OFFICE OF THE STATE CONTROLLER

By: _____

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

Tab 2

STATE CONTROLLER'S OFFICE ANALYSIS AND RESPONSE TO THE INCORRECT REDUCTION CLAIM BY LOS ANGELES COUNTY For Fiscal Year (FY) 2002-04 and FY 2003-04

Handicapped and Disabled Students II Program Chapter 1128, Statutes of 1994, and Chapter 654, Statutes of 1996

SUMMARY

The following is the State Controller's Office's (SCO) response to the Incorrect Reduction Claim (IRC) that Los Angeles County filed on June 11, 2013. The SCO audited the county's claims for costs of the legislatively mandated Handicapped and Disabled Students II Program for the period of July 1, 2002, through June 30, 2004. The SCO issued its final report on May 28, 2010 (**Exhibit C**).

The county submitted reimbursement claims totaling $3,276,316—$1,703,889 for fiscal year (FY) 2002-03 (**Tab 3**) and $1,572,427 for FY 2003-04 (**Tab 4**). Subsequently, the SCO audited the claims and determined that $2,558,437 is allowable and $717,879 is unallowable. The county claimed unallowable costs primarily because the county overstated costs by using inaccurate units of service, and overstated offsetting revenues. In calculating offsetting revenues, the county used inaccurate Medi-Cal units and deducted unsupported revenues for the audit period, and applied an incorrect funding percentage for Short Doyle/Medi-Cal for FY 2002-03.

The following table summarizes the audit results:

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment
July 1, 2002, through June 30, 2003			
Direct costs:			
Psychotherapy of other treatment services	$ 2,981,091	$ 2,407,966	$ (573,125)
Total direct costs	2,981,091	2,407,966	(573,125)
Indirect costs	203,322	165,995	(37,327)
Total direct and indirect	3,184,413	2,573,961	(610,452)
Less offsetting reimbursements	(1,480,524)	(1,185,536)	294,988
Total program costs	$ 1,703,889	1,388,425	$ (315,464)
Less amount paid by the State [1]		—	
Allowable costs claimed in excess of (less than) amount paid		$ 1,388,425	
July 1, 2003, through June 30, 2003			
Direct costs:			
Psychotherapy of other treatment services	$ 2,839,465	$ 2,266,155	$ (573,310)
Total direct costs	2,839,465	2,266,155	(573,310)
Indirect costs	235,416	187,972	(47,444)
Total direct and indirect	3,074,881	2,454,127	(620,754)
Less offsetting reimbursements	(1,502,454)	(1,284,115)	218,339
Total program costs	$ 1,572,427	1,170,012	$ (402,415)
Less amount paid by the State [1]		—	
Allowable costs claimed in excess of (less than) amount paid		$ 1,170,012	

Cost Elements	Actual Costs Claimed	Allowable per Audit	Audit Adjustment
Summary: July 1, 2002, through June 30, 2004			
Direct costs:			
Psychotherapy of other treatment services	$ 5,820,556	$ 4,674,121	$ (1,146,435)
Total direct costs	5,820,556	4,674,121	(1,146,435)
Indirect costs	438,738	353,967	(84,771)
Total direct and indirect	6,259,294	5,028,088	(1,231,206)
Less offsetting reimbursements	(2,982,978)	(2,469,651)	513,327
Total program costs	$ 3,276,316	2,558,437	$ (717,879)
Less amount paid by the State [1]		—	
Allowable costs claimed in excess of (less than) amount paid		$ 2,558,437	

[1] Payment information as of July 25, 2014.

The county contends that the data set used by the SCO to determine allowable costs was incorrect and did not accurately capture the actual costs of services rendered. In addition, the county contends that the SCO audit used certain assumptions in calculating offsetting reimbursements that resulted in the understatement of Federal Financial Participation and the overstatement of State General Funds related to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The county contests $448,202 for the audit period—$216,793 for FY 2002-03 ($143,443 in direct costs, $14,008 in indirect costs, and $59,342 in offsetting reimbursements) and $231,409 for FY 2003-04 ($131,570 in direct costs, $19,974 in indirect costs, and $79,865 in offsetting reimbursements).

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

Parameters and Guidelines

On May 26, 2005, the Commission on State Mandates (Commission) determined that Chapter 1128, Statutes of 1994 and Chapter 654, Statutes of 1996 imposed a state mandate reimbursable under Government Code section 17561 **(Tab 5)**. The Commission adopted the program's parameters and guidelines on December 9, 2005 **(Tab 6)**, corrected it on July 21, 2006 **(Tab 7)**, and amended it on October 26, 2006 **(Tab 8)**. The correction added language to Section V, Preparation and Submission, that allows eligible claimants to claim costs using the cost report method. The amendment relates to the closing out of the program after FY 2005-06. Beginning in FY 2006-07, the program becomes part of the consolidated parameters and guidelines that is made up of the Handicapped and Disabled Students, Handicapped and Disabled Students II, and SED Pupils: Out-of-State Mental Health Services Programs.

Following are excerpts from the Handicapped and Disabled Students II Program's parameters and guidelines that are applicable to the audit period **(Tab 8)**.

Section I, Summary of Mandate, provides a summary of the mandate. It states:

> **I. SUMMARY OF MANDATE**
>
> On May 26, 2005, the Commission on State Mandates (Commission) adopted its Statement of Decision in *Handicapped and Disabled Students II*, finding that Government Code sections

7572.55 and 7576, as added or amended in 1994 and 1996, and the joint regulations adopted by the Department of Mental Health and Education as emergency regulations in 1998 and final regulations in 1999 (Cal. Code Regs., tit. 2 §§ 60000 et seq.), impose a reimbursable state-mandated program on counties within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

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

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

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

These parameters and guidelines are effective for reimbursement claims filed for costs incurred through the 2005-06 fiscal year. Commencing with the 2006-07 fiscal year, reimbursement claims shall be filed through the consolidated parameters and guidelines for *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).

Section III, Period of Reimbursement, identifies the period of reimbursement. It states:

III. PERIOD OF REIMBURSEMENT

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

Actual costs for one fiscal year shall be included in each claim. Estimated costs for the subsequent year may be included on the same claim, if applicable. Pursuant to Government Code section 17561, subdivision (d)(1)(A), all claims for reimbursement of initial fiscal year costs shall be submitted to the State Controller within 120 days of the issuance date for the claiming instructions.

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

Section IV, Reimbursable Activities, identifies the reimbursable activities. It states:

IV. REIMBURSABLE ACTIVITIES

To be eligible for mandated cost reimbursement for any given fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities.

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

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

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[1] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

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

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

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

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

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

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

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

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

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

[1] 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, 20014, the State Controller's Office will reissue the audit reports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become

available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(When providing psychotherapy or other mental health treatment services, the activities of crisis intervention, vocational services, and socialization services are not reimbursable.)

Section V, Claim Preparation and Submission, identifies the two methods of submitting claims for reimbursement. It states:

V. CLAIM PREPARATION AND SUBMISSION

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

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

Direct Cost Reporting Method

A. Direct Cost Reporting

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

1. Salaries and Benefits

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

2. Materials and Supplies

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

3. Contracted Services

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

4. Fixed Assets and Equipment

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

B. Indirect Cost Rates

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

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

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

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

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

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

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

Cost Report Method

A. Cost Report Method

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

B. Indirect Cost Rates

To the extent that reimbursable indirect costs have not already been reimbursed, they may be claimed under this method.

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

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

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

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

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

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

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

Section VII, Offsetting Revenues and Other Reimbursements, identifies applicable offset requirements. It states:

VII. OFFSETTING REVENUES AND OTHER REIMBURSEMENTS

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

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

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

SCO Claiming Instructions

In compliance with Government Code section 17558, the SCO issues claiming instructions for mandated programs in order to assist local agencies and school districts in claiming reimbursable costs. The SCO issued claiming instructions for Chapter 1128, Statutes of 1994 and Chapter 654, Statutes of 1996 in January 2006 (**Exhibit B**). The county used this version to file its reimbursement claims (**Tabs 3 and 4**).

II. COUNTY OVERSTATED COSTS BY CLAIMING UNSUPPORTED MEDICATION MONITORING COSTS, AND MISCALCULATING THE RELATED INDIRECT COSTS AND OFFSETTING REIMBURSEMENTS

Issue

The county's IRC challenges a portion of Findings 1, 2, and 3 in the SCO's final audit report issued May 28, 2010, related to unsupported medication monitoring costs, and the related indirect costs and offsetting revenues, consisting of direct costs of $275,013, indirect costs of $33,982, and offsetting revenues of $139,207.

The SCO concluded that the county claimed unsupported medication monitoring costs and miscalculated the associated indirect costs and offsetting revenues.

The county would like the SCO to reconsider audit adjustments in light of information identified by the county subsequent to the issuance of the final audit report.

SCO Analysis

The county claimed $717,879 in unallowable costs because it claimed unsupported costs and miscalculated its related indirect costs and offsetting revenues.

As noted in the SCO's final audit report, the county initially did not have support for its claims in a testable format that we could verify. At that time, the county could not provide detailed information regarding the services provided, including the client receiving service, type of service, date of service, duration of service, etc. County staff asserted that the identifiers set up in its system were unreliable, and suggested that the county should query its database to identify detail of services provided.

The county's methodology was to identify all related services of clients who received an assessment at one of the three county-run facilities dedicated to assessing AB 3632 client eligibility. The county ran three different database queries; each query failed to support costs claimed and contained errors. The errors included names of clients who were not in the program, clients that were not eligible for the program, duplicate transactions, and partial/incomplete transactions. The county did not provide the SCO with the parameters it used for the three initial queries.

We worked with the county to develop its query parameters for a fourth query report. We suggested clarifying the parameters of the query to identify eligible clients, such as by establishing an age limit so that the query would not identify clients over 22 years old as part of the program. The county ran the fourth query and presented the results as support for its claims. The detailed unit-of-services report provided did not support claimed costs.

The program's parameters and guidelines, Reimbursable Activities, section IV, applicable to the time period, specify that only actual costs may be claimed. Further, actual costs must be traceable and supported by source documents that show the validity of such costs (**Tab 8**):

> **IV. REIMBURSABLE ACTIVITIES**
>
> To be eligible for mandated cost reimbursement for any given fiscal year, only actual costs may be claimed. Actual costs are those costs actually incurred to implement the mandated activities. Actual costs must be traceable and supported by source documents that show the validity of such costs, when they were incurred, and their relationship to the reimbursable activities. A source document is a document created at or near the same time the actual cost was incurred for the event or activity in question. Source documents may include, but are not limited to, employee time records or time logs, sign-in sheets, invoices, and receipts.
>
> Evidence corroborating the source documents may include, but is not limited to, worksheets, cost allocation reports (system generated), purchase orders, contracts, agendas, calendars, and declarations. Declarations must include a certification or declaration stating, "I certify (or declare) under penalty or perjury under the laws of the State of California that the foregoing is true and correct," and must further comply with the requirements of Code of Civil Procedure section 2015.5. Evidence corroborating the source documents may include data relevant to the reimbursable activities otherwise reported in compliance with local, state, and federal government requirements. However, corroborating documents cannot be substituted for source documents.

The county is asserting that the claim information and support it provided in the course of the audit is erroneous or incomplete. The county believes that the SCO should reconsider its audit adjustments based on the new information.

The SCO contacted the county by phone on July 28, 2008, to initiate the audit, and confirmed the entrance conference date with a start letter dated August 12, 2008 (**Tab 9**). The SCO issued the final report on May 28, 2010 (**Exhibit C**). In response to the findings, the county agreed with the audit results. Further, the county provided a management representation letter asserting that it made available to the SCO all pertinent information in support of its claims (**Tab 10**). The county provided information regarding its reconsideration request in June and August 2012 (**Exhibit A-1**).

Government Code section 17558.5 requires that an audit by the SCO shall be completed not later than two years after the date that the audit is commenced. Government Code section 17561, subdivision (d)(3), specifies that initial claims are not subject to payment if submitted more than one year after the filing deadline in the Controller's claiming instructions.

Both the Government Code and the California Constitution prohibit the gift of public funds to any individual, corporation, or another government agency. Government Code section 8314, subdivision (a), provides that it is unlawful for any elected state officer to use public resources for purposes that are not authorized by law. The California Constitution article 16, section 6, specifies that the Legislature shall have no power to make a gift of public funds.

The SCO completed the audit and issued the final audit report within the two-year statutory period. In June 2012 and August 2012, the county requested that the SCO consider costs based on information that was not provided in the course of the audit. The deadline to file an amended claim for FY 2002-03 and FY 2003-04 was May 2008.

Consequently, the county is requesting that the SCO consider costs not previously provided after the statutory period to file an amended claim, which is approximately four years after the filing deadline for the FY 202-03 and FY 2003-04 claims. The county's request for the SCO to consider such costs is also two years after the statutory period for the SCO to issue the final audit report.

The SCO is prohibited from making a gift of public funds. Therefore, the SCO has no authority to consider costs based on information that was not provided during the course of the audit, the statutory period to file an amended claim, or the statutory period for the SCO to issue the final report.

County's Response

The County contends that the data used by the SCO to determine allowable costs was incorrect and did not accurately capture the actual costs of services rendered. In addition, the SCO audit used certain assumptions in calculating off-setting reimbursements, which resulted in the understatement of off-setting Federal Financial Participation and the overstatement of off-setting State General Funds related to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Therefore, this IRC seeks to have the following amounts of the $717,879 disallowed by the SCO reinstated:

- Fiscal Year 2002-03: $216,793
- Fiscal Year 2003-04: $231,409

SCO's Comment

Our objective was to determine whether the costs of the county-filed claims are reimbursable under the program's parameters and guidelines adopted by the Commission. This includes tracing costs of county-filed claims to source documentation to ascertain the validity and accuracy of the costs.

The county's IRC submission contains an incomplete filing, inaccurate calculation of allowable indirect costs, miscategorization of the questioned costs, and other items we will address in our response to the county's arguments.

The county's IRC filing does not include the reimbursement claims filed with the SCO. The exhibit in the IRC filing includes the claims prepared by the county's mental health department that were submitted to its auditor-controller (**Exhibit D**). We have included the actual claim forms filed with the SCO as part of our response (**Tabs 3 and 4**). These forms were signed by the county's auditor-controller and submitted to the SCO for reimbursement of state-mandated program costs.

The indirect cost calculations presented by the county (**Exhibit A-8**) are not the calculations the SCO used in our final audit report. We have included the actual calculations from the working papers as part of our response (**Tab 11**). The SCO calculations are consistent with the allocations of indirect costs used by the county in its claims. The reduction in indirect costs is primarily due to the reduction in direct costs.

Concerning the challenged costs, the county did not identify its proposed adjustments to the correct category. For example, the county's direct and indirect costs adjustments are shown net of offsetting revenues. Further, the offsetting revenues adjustment proposed by the county does not include the audits adjustments made to direct and indirect costs. Placing the county's adjustments in the correct category results in a $2,354 difference in the net adjustment for FY 2003-04. We could not determine why our revised amounts do not reconcile to the county's proposed adjustments. A comparison of the challenged amounts is shown in the table below.

	Fiscal Year	
	2002-03	2003-04
County's IRC calculation		
Direct costs	$ 143,443	$ 131,570
Indirect costs	14,008	19,974
Offsetting reimbursements	59,342	79,865
Total	$ 216,793	$ 231,409
Revised SCO IRC calculation[1]		
Direct costs	$ 323,629	$ 411,076
Indirect costs	20,404	32,778
Offsetting reimbursements	(127,240)	(210,091)
Total	$ 216,793	$ 233,763
Difference		
Direct costs	$ 180,186	$ 279,506
Indirect costs	6,396	12,804
Offsetting reimbursements	(186,582)	(289,956)
Total	$ -	$ 2,354

[1]SCO recalculated amounts are based on information provided in the county's IRC (**Tab 12**).

A summary of the county's arguments are presented in bold below and our response follows:

1. **The SCO's audit findings do not represent the actual amount of mandated costs for medication support services and related indirect costs. The SCO incorrectly reduced medication support services costs because the data it relied on for its audit findings erroneously excluded actual allowable costs. The SCO should also consider certain contractor costs that were not included in the original claims because the costs were not correctly identified in the county's systems.**

   As previously noted, the county did not provide support for its claims when the audit was initiated in a format that could be verified. When the audit was initiated, the county had difficulty identifying the individual services that make up the total claimed mental health services; the service-related information includes client, type, duration, units, Medi-Cal eligibility, etc.

   The county has identifiers set up in its system to capture and track mandate-related costs; these identifiers include unique service function codes and plan identification codes (**Tab 13**). County staff informed the SCO that identifiers in its system are unreliable due to inconsistencies in use (**Tabs 14 and 15**). For example, clients of the state-mandated program are coded as individuals in other programs, and clients of other program are coded as part of the state-mandated program.

   As in the prior audit, the county proposed using a database query to identify the mandated-related services; the query would identify clients that went through the assessment process (**Tab 14**). The county ran three generations of query parameters and results; each query failed to support claimed costs and highlighted concerns. The first and second queries did not support claimed costs and contained partial transactions (**Tab 14**). Partial transactions are unfinalized transactions that are in various stages of completion; the county information-technology staff termed these transactions as invalid or incomplete. The results of the third query did not include information regarding Medi-Cal clients, and all of fiscal years were commingled in one file (**Tab 16**). The county performed a limited, non-statistical review of the third query results. The third query included services for clients that were ineligible and who were part of other programs; county staff believed that the identifiers were used inconsistently (**Tab 15**). For the three prior queries, the county did not provide the query parameters for our review. Therefore, the SCO cannot comment on the design of the queries; we can only address the results. We continued to work with the county to identify its costs and related revenues. The county presented the fourth query results as the support for its claims. We reviewed the query parameters and corresponding results and determined them to be reasonable; we then computed costs and the associated offsetting revenues.

   As noted above, the audit was initiated with a telephone contact on July 28, 2008, and the final audit report was issued on May 28, 2010. In June 2012 and August 2012, four years after audit initiation date and over two years after the final audit report was issued, the county asserted that the information it provided in support of its claims did not identify all eligible costs and that it presented incomplete or erroneous information to the SCO. In essence, the county argues that the fourth query results did not capture all eligible costs.

   The regulations for the reimbursement of state-mandated costs do not provide for the consideration of claims outside of the statutory period. Both the Government Code and the California Constitution prohibit the gift of public funds to any individual, corporation or another government agency. Therefore, the SCO has no authority to consider claims made outside of the statutory period and is prohibited from making a gift of public funds.

If the SCO is directed by the Commission to consider the new costs and associated revenues, we would need to perform additional testing and review. The new costs were not included in the support provided by the county in the course of the audit and, therefore, were not considered in the scope of audit work performed. The county has not provided in its IRC the query parameters or underlying basis for the identification of the new costs and associated revenues. We would need to perform further analysis and testing to validate the new costs. The new costs also raise other concerns, in that the county is asserting that services related to other programs should be considered. Also, it is not clear to what extent the county has validated the information provided—that is, what steps it performed to ensure that costs result from services provided to children and youth in special education receiving mental health services pursuant to an IEP. As noted above, we do not believe it is appropriate to revisit the new costs.

2. **The SCO miscalculated offsetting revenues because some the Medi-Cal units of service provided by the county were actually other enhancements of Medi-Cal Federal Financial Participation funds, namely Healthy Families. Further, the SCO applied Early and Periodic Screening, Diagnosis and Treatment (EPSDT) revenues to all Medi-Cal units even though some of the clients were not full scope Medi-Cal.**

   As previously stated, the county did not provide support for its claims when the audit was initiated in a format that could be verified. The SCO worked with the county to identify its costs and related revenues. The county identified the fourth query results as the support for its claims. We computed costs and the associated offsetting revenues based on the county's support provided in the course of the audit. The support provided by the county did not identify any units of service as Healthy Families, an enhancement of Medi-Cal. Further, the county did not identify a portion of the Medi-Cal units as Medi-Cal only, meaning some clients were not full-scope Medi-Cal and should not have had EPSDT revenues applied. The county provided a management representation letter asserting that it made available to the SCO all pertinent information in support of its claims (**Tab 10**). The SCO's offsetting revenues calculations are consistent with the information provided by the county in support of its claims.

   Again, the regulations for the reimbursement of state-mandated costs do not provide for the consideration of claims outside of the statutory period. Both the Government Code and the California Constitution prohibit the gift of public funds to any individual, corporation, or another government agency. Therefore, the SCO has no authority to consider claims made outside of the statutory period and is prohibited from making a gift of public funds. As noted previously, we do not believe it is appropriate to revisit the new costs.

3. **The SCO miscalculated offsetting revenues for the related indirect costs because it allocated a portion of EPSDT revenues to administrative (indirect) costs.**

   In course of the audit, the county asserted that it used a portion of EPSDT revenues to support administrative costs. The county computed and applied an EPSDT administrative offset in its filed claims (**Tab 17**). Based on information provided by county staff, we computed the EPSDT administrative offset consistent with county allocations (**Tab 18**). In the SCO's calculations, the revenues were reduced based on adjustments to the direct costs and indirect cost rates. These adjustments were based on information provided by the county. As previously noted, the county provided a management representation letter asserting that it made available to the SCO all pertinent information in support of its claims (**Tab 10**). The SCO's offsetting revenues calculations are consistent with the methodology used by the county in preparation of its claims.

III. CONCLUSION

The SCO audited Los Angeles County's claims for costs of the legislatively mandated Handicapped and Disabled Students II Program (Chapter 1128, Statutes of 1994, and Chapter 654, Statutes of 1996) for the period of July 1, 2002, through June 30, 2004. The county claimed $3,276,316 for the mandated program. Our audit disclosed that $2,558,437 is allowable and $717,879 is unallowable. The costs are unallowable because the county overstated costs by using inaccurate units of service, and overstated offsetting revenues. In calculating offsetting revenues, the county used inaccurate Medi-Cal units and deducted unsupported revenues for the audit period, and applied an incorrect funding percentage for Short Doyle/Medi-Cal for FY 2002-03.

The county is challenging the SCO's adjustment totaling $448,202 because it claims that the SCO relied on incorrect information and assumptions for its adjustments impacting claimed direct and indirect costs and offsetting reimbursements.

The county is not eligible to receive reimbursement for the reconsidered amounts. The underlying regulations prevent the SCO from considering costs claimed outside of the statutory period. To do so would violate the Government Code and California Constitutional provisions prohibiting the gift of public funds.

In conclusion, the Commission should find that: (1) the SCO correctly reduced the county's FY 2002-03 claim by $315,464, and (2) the SCO correctly reduced the county's FY 2003-04 claim by $402,415.

IV. CERTIFICATION

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

Executed on October 31, 2014, at Sacramento, California, by:

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

Tab 3

State Controller's Office **Mandated Cost Manual**

CLAIM FOR PAYMENT

Pursuant to Government Code Section 17561

SERVICES TO HANDICAPPED STUDENTS II

For State Controller Use Only
(19) Program Number 00263
(20) Date MAY 24 200
(21) LRS Input ___/___/___

LABEL HERE

(01) Claimant Identification Number: 9919

(02) Claimant Name: **Auditor-Controller**

County of Location: **County of Los Angeles**

Street Address or P.O. Box: 500 West Temple Street, Room 603

City: Los Angeles | State: CA | Zip Code: 90012

Type of Claim	Estimated Claim		Reimbursement Claim		Reimbursement Claim Data	
	(03) Estimated		(09) Reimbursement	X	(22) HDS-1, (04)(A)(1)(f)	
	(04) Combined		(10) Combined		(23) HDS-1, (04)(B)(1)(f)	
	(05) Amended		(11) Amended		(24) HDS-1, (04)(C)(1)(f)	
					(25) HDS-1, (04)(D)(1)(f)	
					(26) HDS-1, (04)(E)(1)(f)	
					(27) HDS-1, (04)(F)(1)(f)	
					(28) HDS-1, (04)(G)(1)(f)	2,839,465
					(29) HDS-1, (06)	8
Fiscal Year of Cost	(06)		(12) **2003/2004**		(30) HDS-1, (07)	235,416
Total Claimed Amount	(07)		(13) $1,572,427		(31) HDS-1, (09)	
Less: **10% Late Penalty, but not to exceed $1,000**			(14)		(32) HDS-1, (10)	1,502,454
Less: **Estimated Claim Payment Received**			(15)		(33)	
Net Claimed Amount		$0	(16)	$1,572,427	(34)	
Due from State	(08)	$0	(17)	$1,572,427	(35)	
Due to State			(18)		(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program.
All offsetting savings and reimbursements set forth in the Parameters and Guidelines are indentified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer: John Naimo FOR

Date: 5/22/06

J. Tyler McCauley
Type or Print Name

Auditor-Controller
Title

(38) Name of Contact Person for Claim: Leonard Kaye

Telephone Number (213) 974-8564 Ext.

E-mail Address lkaye@auditor.co.la.ca.us

Form FAM-27 (Revised 9/03)

No

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SB 90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II

FY 2003-2004 ACTUAL COST CLAIM

Table of Attachments

MANDATED COSTS
HANDICAPPED AND DISABLED STUDENTS II
CLAIM SUMMARY

FORM HDS-1

(01) Claimant: COUNTY OF LOS ANGELES

(02) Type of Claim: Reimbursement [X] Estimated [ ] Fiscal Year: 2003/2004

Claim Statistics

(03) Number of student referrals during the fiscal year of claim. **(Please see Attachment 6).**	2,279

Direct Costs	**Object Accounts**					
(04) Reimbursable Activities	(a) Salaries	(b) Benefits	(c) Materials and Supplies	(d) Contracted Services	(e) Fixed Assets	(f) Total
A. Interagency Agreements						
B. Referral and Mental Health Assessments						
C. Transfers and Interim Placements						
D. Membership Participation of Expanded IEP Team						
E. Case Management Duties for Pupils						
F. Payment Authorization to Care Providers						
G. Psychotherapy or Other Treatment Services (a)	2,839,465					2,839,465
(05) Total Direct Costs	2,839,465					2,839,465

Indirect Costs

(06) Indirect Cost Rate **Please see Attachment 8.**	[10% or ICRP from 2 CFR, Chapter II, formerly OMB A-87]	8.2909%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [Line (06) x {line (05)(a) + line (05)(b)}]	235,416
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]	3,074,881
Cost Reduction		
(09) Less: Offsetting Savings		0
(10) Less: Other Reimbursements **(Please see Attachment 5).**		1,502,454
(11) Total Claimed Amount	[Line (08) - {line (09) + line (10)}]	1,572,427

New 02/06

(a) The allowable costs are characterized as salary costs for purposes of computing authorized indirect costs in line (07) above.

Program 263

MANDATED COSTS

HANDICAPPED AND DISABLED STUDENTS II

ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant: COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

(02) Fiscal Year 2003/2004

(03) Reimbursable Activities: Check only one box per form to identify the activity being claimed.

- [ ] Interagency Agreements
- [ ] Referral and Mental Health Assessments
- [ ] Transfers and Interim Placements
- [ ] Member Participation of Extended IEP Team
- [ ] Case Management Duties for Pupils
- [ ] Payment Authorization to Care Providers
- [X] Psychotherapy or Other Treatment Services

(04) Description of Expenses			Object Accounts				
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Materials and Supplies	(g) Contracted Services	(h) Fixed Assets
Please see Attachment 4 for FY 2003-2004 Medication Monitoring Services Expenditures for LACDMH directly operated and non-governmental agencies. The claimed units of service are based on the AB 3632/SEP Plan identified in the LACDMH data collection system. The cost report is a unit of service based process that determines the unit cost rate.						2,839,465	
(05) Total [X] Subtotal [ ] Page: 1 of 1						2,839,465	

New 02/06

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
MEDICATION MONITORING SERVICES EXPENDITURES
FISCAL YEAR 2003-2004

1	2	3	4	5	6	7	8
Contract Type	Entity Name	Entity Number	Mode	SFC	AB 3632 UNITS	Applicable Rate	Gross AB 3632 Cost
CR	LACDMH	00019	15	61	34,224	$ 3.97	$ 135,849
CR	LACDMH	00019	15	62	7,588	3.97	30,120
NR	Aspen Health Services	00519	15	61	1,823	3.32	6,052
NR	Associated League of Mexican-America	00173	15	61	774	3.56	2,755
NR	Cedars-Sinai Medical Center	00178	15	61	2,722	4.07	11,079
NR	Child & Family Center	00210	15	61	30,786	3.60	110,830
NR	Child & Family Guidance Center	00207	15	61	173,168	3.92	678,819
NR	ChildNet Youth & Family Services	00783	15	61	907	3.89	3,528
NR	Childrens Hospital of Los Angeles	00179	15	61	7,181	4.23	30,376
NR	Childrens Hospital of Los Angeles	00179	15	62	1,564	4.23	6,616
CR	Children's Institute International	00591	15	61	1,750	4.17	7,290
NR	Community Counseling Service	00180	15	61	2,950	2.21	6,520
NR	Community Family Guidance Center	00181	15	61	11,710	1.87	21,898
NR	Devereux Foundation	00472	15	61	69	3.54	244
CR	Didi Hirsch Psychiatric Service	00183	15	61	10,568	3.60	38,072
CR	Didi Hirsch Psychiatric Service	00183	15	62	22,607	3.60	81,442
NR	Dubnoff Center	00184	15	61	12,055	4.23	50,993
CR	El Centro De Amistad, Inc.	00185	15	61	435	4.37	1,899
NR	Enki Health & Research	00188	15	61	26,144	3.09	80,785
NR	Enki Health & Research	00188	15	62	19,851	3.09	61,340
NR	Five Acres Boys' & Girls' Aid Society of	00647	15	61	2,238	2.76	6,177
NR	Foothill Family Service	00724	15	61	9,313	4.17	38,835
NR	Gateways Hospital	00190	15	61	1,308	3.00	3,924
NR	Hamburger Home, Inc.	00174	15	61	724	3.45	2,498
NR	Hathaway Children & Family Services	00192	15	61	21,266	3.40	72,304
NR	Help Group Child & Family Center	00198	15	61	50,924	4.22	214,899
NR	Hillsides	00321	15	61	9,120	3.17	28,910
NR	Institute For Redesign of Learning (The	00171	15	61	8,115	3.52	28,565
NR	Intercommunity Child Guidance Center	00195	15	61	6,341	3.38	21,433
NR	LAUSD 97th St. Mental Health	00315	15	61	1,290	4.09	5,276
NR	Los Angeles Child Guidance Clinic	00199	15	61	37,372	3.63	135,660
CR	Pacific Clinics	00203	15	61	72,898	2.92	213,099
NR	Pasadena Childrens Training	00204	15	61	47,046	3.79	178,304
NR	Penny Lane Centers	00201	15	61	3,906	4.05	15,819
CR	Saint Johns Health center	00217	15	61	8,513	4.37	37,202
CR	San Fernando Valley CMHC Inc.	00208	15	61	1,570	3.63	5,694
CR	San Gabriel Children's Center	00320	15	61	5,250	4.18	21,968
NR	South Bay Children's Health Center	00213	15	61	10,252	3.88	39,778
NR	Special Service Fro Groups	00214	15	61	1,886	3.33	6,280
NR	St. Francis Medical Center	00784	15	61	185	4.16	770
NR	Starview Adolescent Center	00543	15	61	421	3.48	1,465
NR	Stirling Academy, Inc.	00216	15	61	1,635	3.56	5,821
CR	The Guidance Center	00191	15	61	23,905	3.01	71,915
CR	Verdugo Mental Health Center	00221	15	61	21,270	3.90	82,965
NR	Vista Del Mar Child and Family Services	00196	15	61	62,741	3.72	233,397
TOTAL MEDICATION MONITORING SERVICES					**778,365**		**$ 2,839,465**

To HDS-2, Line (04), Column (g).

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
AB3632 - MEDICATION MONITORING COST SUMMARY
FY 2003-2004

COST ELEMENTS IDENTIFIED BY GROSS PROGRAM COSTS, OFFSETTING REIMBURSEMENTS/REVENUES, AND NET SB90 REIMBURSABLE COSTS

The following procedure has been followed to assure all appropriate reimbursement/revenue offsets have been applied. Total eligible cost was identified (Line 3) and all applicable reimbursements/revenues have been offset to identify the remaining balance as the eligible SB 90 Chapter 1128/94 reimbursement.

Line 1	AB3632 Program - Medication Monitoring Gross Cost	$ 2,839,465	From Attachment 5, Column (8); To HDS-2, Line (04), column (g)
Line 2	Administration Cost	235,416	From Attachment 5, Column (8); To HDS-1, Line (07)
Line 3	Gross AB 3632 Cost	$ 3,074,881	From Attachment 5, Column (8); To HDS-1, Line (08)
	Cost Reduction - Other Reimbursements		
Line 4	Final Early and Periodic Screening, Diagnosis, and Treatment State General Fund (EPSDT-SGF)	$ (590,215)	From Attachment 5, Column (9)
Line 5	EPSDT-SGF share of Administration Costs	(48,016)	From Attachment 5, Column (9)
Line 6	Final Federal Financial Participation (FFP)	(790,381)	From Attachment 5, Column (10)
Line 7	FFP share of Administration Costs	(64,611)	From Attachment 5, Column (10)
Line 8	Third Party Revenues & share of Administration Costs	(7,065)	From Attachment 5, sum of Columns (11) through (14)
Line 9	Other State and Local Funds and share of Admin Costs	(2,166)	From Attachment 5, sum of Columns (15) and (16)
Line 10	Total Cost Reduction - Other Reimbursements	$ (1,502,454)	From Attachment 5, Column (17); To HDS-1, Line (10)
Line 11	SB 90 Claimed Amount	$ 1,572,427	From Attachment 5, Column (18); To HDS-1, Line (11)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
MEDICATION MONITORING SERVICES EXPENDITURES AND REVENUES WORKSHEET
FISCAL YEAR 2003-2004

Attachment 5

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
								REVENUE OFFSETS - (OTHER REIMBURSEMENTS)									
Contract Type	Entity Name	Entity Number	Mode	SFC	AB 3632 UNITS	Applicable Rate	Gross AB 3632 Cost	Final EPSDT-SGF	Final FFP	Patient Fees	Patient Insurance	Medicare	3rd Party/ Other	State CSOC	Local Fund CalWORKs	Total Offsets (sum 9 thru 16)	SB 90 Claimed Amount (8 - 17)
CR	LACDMH	00019	15	61	34,224	$ 3.97	$ 135,849	$ 10,839	$ 21,290	$ -	$ -	$ -	$ 165	$ -	$ -	$ 32,294	$ 103,555
CR	LACDMH	00019	15	62	7,588	3.97	30,120	7,340	8,580	-	-	-	-	-	-	15,920	14,200
NR	Aspen Health Services	00519	15	61	1,823	3.32	6,052	2,278	2,464	-	-	-	-	-	-	4,742	1,310
NR	Associated League of Mexic	00173	15	61	774	3.56	2,755	1,277	1,469	-	-	-	-	-	-	2,746	9
NR	Cedars-Sinai Medical Cente	00178	15	61	2,722	4.07	11,079	-	108	-	-	-	-	-	-	108	10,971
NR	Child & Family Center	00210	15	61	30,786	3.60	110,830	16,743	20,406	78	-	-	-	-	-	37,227	73,603
NR	Child & Family Guidance Ce	00207	15	61	173,168	3.92	678,819	152,318	196,312	464	1,845	-	3,706	-	-	354,645	324,174
NR	ChildNet Youth & Family Se	00783	15	61	907	3.89	3,528	1,312	1,435	-	-	-	-	-	-	2,747	781
NR	Childrens Hospital of Los An	00179	15	61	7,181	4.23	30,376	8,154	8,874	-	-	-	-	-	1,037	18,065	12,311
NR	Childrens Hospital of Los An	00179	15	62	1,564	4.23	6,616	3,157	3,459	-	-	-	-	-	-	6,616	-
CR	Children's Institute Internatic	00591	15	61	1,750	4.17	7,290	1,006	1,054	-	-	-	-	-	-	2,060	5,230
NR	Community Counseling Serv	00180	15	61	2,950	2.21	6,520	1,507	1,664	-	-	-	-	-	-	3,171	3,349
NR	Community Family Guidance	00181	15	61	11,710	1.87	21,898	1,954	6,139	-	-	-	-	-	-	8,093	13,805
NR	Devereux Foundation	00472	15	61	69	3.54	244	51	56	-	-	-	-	-	-	107	137
CR	Didi Hirsch Psychiatric Serv	00183	15	61	10,568	3.60	38,072	8,515	12,579	-	-	-	-	-	-	21,094	16,978
CR	Didi Hirsch Psychiatric Serv	00183	15	62	22,607	3.60	81,442	2,230	2,559	-	-	-	-	-	-	4,789	76,653
NR	Dubnoff Center	00184	15	61	12,055	4.23	50,993	3,055	12,680	-	-	-	-	-	-	15,735	35,258
CR	El Centro De Amistad, Inc.	00185	15	61	435	4.37	1,899	-	-	-	-	-	-	-	-	-	1,899
NR	Enki Health & Research	00188	15	61	26,144	3.09	80,785	23,579	30,493	-	-	-	-	247	-	54,319	26,466
NR	Enki Health & Research	00188	15	62	19,851	3.09	61,340	18,309	20,563	-	-	-	-	-	-	38,872	22,468
NR	Five Acres Boys' & Girls' Aic	00647	15	61	2,238	2.76	6,177	1,837	1,991	-	-	-	-	-	-	3,828	2,349
NR	Foothill Family Service	00724	15	61	9,313	4.17	38,835	4,807	5,276	-	-	-	-	-	-	10,083	28,752
NR	Gateways Hospital	00190	15	61	1,308	3.00	3,924	1,453	1,580	-	-	-	-	-	-	3,033	891
NR	Hamburger Home, Inc.	00174	15	61	724	3.45	2,498	1,175	1,323	-	-	-	-	-	-	2,498	-
NR	Hathaway Children & Family	00192	15	61	21,266	3.40	72,304	22,028	24,863	-	-	-	-	-	-	46,891	25,413
NR	Help Group Child & Family (	00198	15	61	50,924	4.22	214,899	23,597	42,400	-	-	-	-	-	-	65,997	148,902
NR	Hillsides	00321	15	61	9,120	3.17	28,910	13,083	14,364	-	-	-	-	-	-	27,447	1,463
NR	Institute For Redesign of Le	00171	15	61	8,115	3.52	28,565	7,066	8,852	-	-	-	-	-	-	15,918	12,647
NR	Intercommunity Child Guida	00195	15	61	6,341	3.38	21,433	-	6,554	-	-	-	-	-	-	6,554	14,879
NR	LAUSD 97th St. Mental Hea	00315	15	61	1,290	4.09	5,276	2,049	2,250	-	-	-	-	-	-	4,299	977
NR	Los Angeles Child Guidance	00199	15	61	37,372	3.63	135,660	52,398	64,198	-	-	-	-	-	-	116,596	19,064
CR	Pacific Clinics	00203	15	61	72,898	2.92	213,099	55,319	74,095	38	-	203	-	-	-	129,655	83,444
NR	Pasadena Childrens Trainin	00204	15	61	47,046	3.79	178,304	56,272	72,031	-	-	-	-	-	-	128,303	50,001
NR	Penny Lane Centers	00201	15	61	3,906	4.05	15,819	3,819	5,156	-	-	-	-	-	-	8,975	6,844
CR	Saint Johns Health center	00217	15	61	8,513	4.37	37,202	4,496	4,919	-	-	-	-	-	-	9,415	27,787
CR	San Fernando Valley CMHC	00208	15	61	1,570	3.63	5,694	26	132	-	-	30	-	-	-	188	5,506
CR	San Gabriel Children's Cent	00320	15	61	5,250	4.18	21,968	7,756	8,394	-	-	-	-	-	-	16,150	5,818
NR	South Bay Children's Health	00213	15	61	10,252	3.88	39,778	-	5,013	-	-	-	-	-	-	5,013	34,765
NR	Special Service Fro Groups	00214	15	61	1,886	3.33	6,280	262	1,511	-	-	-	-	-	-	1,773	4,507
NR	St. Francis Medical Center	00784	15	61	185	4.16	770	324	356	-	-	-	-	-	-	680	90
NR	Starview Adolescent Center	00543	15	61	421	3.48	1,465	349	365	-	-	-	-	-	-	714	751
NR	Stirling Academy, Inc.	00216	15	61	1,635	3.56	5,821	-	80	2	-	-	5	-	-	87	5,734
CR	The Guidance Center	00191	15	61	23,905	3.01	71,915	11,942	15,665	-	-	-	-	-	-	27,607	44,308
CR	Verdugo Mental Health Cen	00221	15	61	21,270	3.90	82,965	1,831	16,388	-	-	-	-	-	-	18,219	64,746
NR	Vista Del Mar Child and Fan	00196	15	61	62,741	3.72	233,397	54,702	60,441	-	-	-	-	722	-	115,865	117,532
Subtotal					778,365		$2,839,465	$ 590,215	$790,381	$ 582	$ 1,845	$ 233	$ 3,676	$ 969	$ 1,037	$ 1,389,138	$ 1,450,327
Administration Costs		LACDMH		13.5837%			22,545	2,469	4,057	-	-	-	22	-	-	6,548	15,997
		NGA		7.9623%			212,871	45,547	60,554	46	147	19	295	77	83	106,768	106,103
Subtotal							235,416	48,016	64,611	46	147	19	317	77	83	113,316	122,100
Total					778,365		$3,074,881	$ 638,231	$854,992	$ 628	$ 1,992	$ 252	$ 4,193	$ 1,046	$ 1,120	$ 1,502,454	$ 1,572,427

To HDS-1, Line (10)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
FISCAL YEAR 2003-2004

FOOTNOTE TO HDS-1, Line (06) Indirect Cost Rate

	Medication Monitoring Services	Indirect Cost Rate [a]	Total Indirect Cost	
DMH directly operated	$ 165,969	13.5837%	$ 22,545	
Private contract provider	2,673,496	7.9623%	212,871	
Total	$ 2,839,465		$ 235,416	- To HDS-1, Line (07).
Average Indirect Cost Rate =			**8.2909%**	**- To HDS-1, Line (06).**

[a] Indirect Cost Rate is based on the Cost Report Actual Rates for FY 2003-2004.

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
FY 2003-2004 YEAR-END COST REPORT

INDIRECT COST RATE BY PROGRAM

See Worksheet 4 for Indirect/Direct Cost details

	(1) DMH Directly Operated Programs			(2) Life Support/Supplemental Rates		
	Indirect	Direct	Total	Indirect	Direct	Total
SALARIES AND EMPLOYEE BENEFITS						
CCAP	-		-	-		-
EXECUTIVE OFFICE	360,264		360,264	5,512		5,512
GENERAL ADMINISTRATION OPERATIONS	5,983,614		5,983,614	-		-
FISCAL SERVICES	1,705,897		1,705,897	18,038		18,038
MENTAL HEALTH BUREAU ADMINISTRATION	3,589,622		3,589,622	8,204		8,204
CONTRACTS ADMINISTRATION	-		-	13,661		13,661
MANAGEMENT INFORMATION SYSTEMS	703,351		703,351	45,231		45,231
DMH DIRECTLY OPERATED MH.PROGRAMS-GENERAL		156,199,470	156,199,470		-	-
DMH DIRECTLY OPERATED MH. PROG-SPECIAL		8,456,724	8,456,724		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES		-	-		-	-
DHS		-	-		-	-
PUBLIC GUARDIAN		-	-		-	-
TAR/OFFICE OF MANAGED CARE		-	-		-	-
FEE FOR SERVICE		-	-		-	-
STATE HOSPITAL		-	-		-	-
SD/MC UNREIMBURSABLE COSTS		-	-		-	-
IN-STATE MH CONTRACT PROVIDERS						
OTHER CONTRACT PROVIDERS		-	-		-	-
SUB-TOTAL S&EB	12,342,749	164,656,194	176,998,943	90,645	-	90,645
SRVC & SUPP / OTHER CHAR /FIX ASSETS						
CCAP	2,190,021		2,190,021	33,509		33,509
EXECUTIVE OFFICE	44,258		44,258	677		677
GENERAL ADMINISTRATION OPERATIONS	8,257,720		8,257,720	-		-
FISCAL SERVICES	111,232		111,232	1,164		1,164
MENTAL HEALTH BUREAU ADMINISTRATION	372,578		372,578	3,793		3,793
CONTRACTS ADMINISTRATION	-		-	479		479
MANAGEMENT INFORMATION SYSTEMS	3,532,183		3,532,183	152,576		152,576
DMH DIRECTLY OPERATED MH.PROGRAMS-GENERAL		28,228,542	28,228,542		-	-
DMH DIRECTLY OPERATED MH. PROG-SPECIAL		4,783,641	4,783,641		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES		-	-		3,024,446	3,024,446
DHS		-	-		-	-
PUBLIC GUARDIAN		-	-		-	-
TAR/OFFICE OF MANAGED CARE		-	-		-	-
FEE FOR SERVICE		-	-		-	-
STATE HOSPITAL		-	-		-	-
SD/MC UNREIMBURSABLE COSTS		-	-		-	-
IN-STATE MH CONTRACT PROVIDERS						
OTHER CONTRACT PROVIDERS		-	-		-	-
SUB-TOTAL SS & OTHERS	14,507,991	33,012,183	47,520,174	192,196	3,024,446	3,216,644
TOTAL EXPENDITURES						
CCAP	2,190,021	-	2,190,021	33,509	-	33,509
EXECUTIVE OFFICE	404,522	-	404,522	6,189	-	6,189
GENERAL ADMINISTRATION OPERATIONS	14,241,334	-	14,241,334	-	-	-
FISCAL SERVICES	1,817,128	-	1,817,128	19,202	-	19,202
MENTAL HEALTH BUREAU ADMINISTRATION	3,962,201	-	3,962,201	11,997	-	11,997
CONTRACTS ADMINISTRATION	-	-	-	14,140	-	14,140
MANAGEMENT INFORMATION SYSTEMS	4,235,534	-	4,235,534	197,807	-	197,807
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	184,428,012	184,428,012	-	-	-
DMH DIRECTLY OPERATED MH. PROG-SPECI	-	13,240,365	13,240,365	-	-	-
LIFE SUPPORT/SUPPLEMENTARY RATES	-	-	-	-	3,024,446	3,024,446
DHS	-	-	-	-	-	-
PUBLIC GUARDIAN	-	-	-	-	-	-
TAR/OFFICE OF MANAGED CARE	-	-	-	-	-	-
FEE FOR SERVICE	-	-	-	-	-	-
STATE HOSPITAL	-	-	-	-	-	-
SD/MC UNREIMBURSABLE COSTS	-	-	-	-	-	-
IN-STATE MH CONTRACT PROVIDERS						
OTHER CONTRACT PROVIDERS	-	-	-	-	-	-
TOTAL EXPENDITURES	26,850,740	197,668,377	224,519,117	282,844	3,024,446	3,307,290
		DMH OH	12.4758%		DMH OH	8.2440%
		CCAP	1.1079%		CCAP	1.1079%
ADMIN. OVERHEAD RATE FOR 2003/2004	26,850,740 /	197,668,377 =	13.5837%	282,844 /	3,024,446 =	9.3519%
ADMIN. OVERHEAD RATE FOR 2002/2003	29,331,116 /	189,562,900 =	15.4730%	381,248 /	2,974,725 =	12.8162%

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
FY 2003-2004 YEAR-END COST REPORT
INDIRECT COST RATE BY PROGRAM
See Worksheet 4 for Indirect/Direct Cost details

	(3a) In-State MH Contract Providers			(3b) Consulation, Out of State, & Other Contractors			(4) DHS		
	Indirect	Direct	Total	Indirect	Direct	Total	Indirect	Direct	Total
SALARIES AND EMPLOYEE BENEFITS									
CCAP	-		-	-		-	-		-
EXECUTIVE OFFICE	905,237		905,237	16,177		16,177	39,650		39,650
GENERAL ADMINISTRATION OPERATIONS	-		-	-		-	-		-
FISCAL SERVICES	4,286,409		4,286,409	72,596		72,596	187,748		187,748
MENTAL HEALTH BUREAU ADMINISTRATION	9,019,649		9,019,649	161,181		161,181	369,408		369,408
CONTRACTS ADMINISTRATION	4,397,122		4,397,122	56,815		56,815	40,995		40,995
MANAGEMENT INFORMATION SYSTEMS	2,526,231		2,526,231	-		-	78,171		78,171
DMH DIRECTLY OPERATED MH.PROGRAMS-G			-			-		-	-
DMH DIRECTLY OPERATED MH. PROG-SPEC			-			-		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES			-			-		-	-
DHS			-			-		-	-
PUBLIC GUARDIAN			-			-		-	-
TAR/OFFICE OF MANAGED CARE			-			-		-	-
FEE FOR SERVICE			-			-		-	-
STATE HOSPITAL			-			-		-	-
SD/MC UNREIMBURSABLE COSTS			-			-		-	-
IN-STATE MH CONTRACT PROVIDERS			-			-			-
OTHER CONTRACT PROVIDERS			-			-		-	-
SUB-TOTAL S&EB	21,134,647	-	21,134,647	306,769	-	306,769	715,972	-	715,972
SRVC & SUPP / OTHER CHAR /FIX ASSETS									
CCAP	5,502,868		5,502,868	98,336		98,336	241,030		241,030
EXECUTIVE OFFICE	111,206		111,206	1,987		1,987	4,871		4,871
GENERAL ADMINISTRATION OPERATIONS	-		-	-		-	-		-
FISCAL SERVICES	279,492		279,492	4,949		4,949	12,242		12,242
MENTAL HEALTH BUREAU ADMINISTRATION	936,178		936,178	16,730		16,730	40,424		40,424
CONTRACTS ADMINISTRATION	147,404		147,404	1,672		1,672	654		654
MANAGEMENT INFORMATION SYSTEMS	11,435,381		11,435,381	-		-	391,314		391,314
DMH DIRECTLY OPERATED MH.PROGRAMS-G			-			-		-	-
DMH DIRECTLY OPERATED MH. PROG-SPEC			-			-		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES			-			-		-	-
DHS			-			-		87,020,284	87,020,284
PUBLIC GUARDIAN			-			-		-	-
TAR/OFFICE OF MANAGED CARE			-			-		-	-
FEE FOR SERVICE			-			-		-	-
STATE HOSPITAL			-			-		-	-
SD/MC UNREIMBURSABLE COSTS			-			-		-	-
IN-STATE MH CONTRACT PROVIDERS		496,681,573	496,681,573			-			
OTHER CONTRACT PROVIDERS			-		8,875,704	8,875,704		-	-
SUB-TOTAL SS & OTHERS	18,412,530	496,681,573	515,094,103	123,674	8,875,704	8,999,377	690,535	87,020,284	87,710,819
TOTAL EXPENDITURES									
CCAP	5,502,868	-	5,502,868	98,336	-	98,336	241,030	-	241,030
EXECUTIVE OFFICE	1,016,443	-	1,016,443	18,164	-	18,164	44,521	-	44,521
GENERAL ADMINISTRATION OPERATIONS	-	-	-	-	-	-	-	-	-
FISCAL SERVICES	4,565,901	-	4,565,901	77,544	-	77,544	199,990	-	199,990
MENTAL HEALTH BUREAU ADMINISTRATION	9,955,826	-	9,955,826	177,911	-	177,911	409,832	-	409,832
CONTRACTS ADMINISTRATION	4,544,526	-	4,544,526	58,488	-	58,488	41,649	-	41,649
MANAGEMENT INFORMATION SYSTEMS	13,961,612	-	13,961,612	-	-	-	469,485	-	469,485
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	-	-	-	-	-	-	-	-
DMH DIRECTLY OPERATED MH. PROG-SPEC	-	-	-	-	-	-	-	-	-
LIFE SUPPORT/SUPPLEMENTARY RATES	-	-	-	-	-	-	-	-	-
DHS	-	-	-	-	-	-	-	87,020,284	87,020,284
PUBLIC GUARDIAN	-	-	-	-	-	-	-	-	-
TAR/OFFICE OF MANAGED CARE	-	-	-	-	-	-	-	-	-
FEE FOR SERVICE	-	-	-	-	-	-	-	-	-
STATE HOSPITAL	-	-	-	-	-	-	-	-	-
SD/MC UNREIMBURSABLE COSTS	-	-	-	-	-	-	-	-	-
IN-STATE MH CONTRACT PROVIDERS	-	496,681,573	496,681,573	-	-	-			
OTHER CONTRACT PROVIDERS	-	-	-	-	8,875,704	8,875,704	-	-	-
TOTAL EXPENDITURES	39,547,177	496,681,573	536,228,751	430,443	8,875,704	9,306,148	1,406,506	87,020,284	88,426,792
		DMH OH	6.8544%		DMH OH	3.7417%		DMH OH	1.3393%
		CCAP	1.1079%		CCAP	1.1079%		CCAP	0.2770%
ADMIN. OVERHEAD RATE FOR 2003/2004	39,547,177 /	496,681,573 =	7.9623%	430,443 /	8,875,704 =	4.8496%	1,406,506 /	87,020,284 =	1.6163%
ADMIN. OVERHEAD RATE FOR 2002/2003			6.3049%		=	6.3049%	1,090,720 /	81,464,004 =	1.3389%

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
FY 2003-2004 YEAR-END COST REPORT
INDIRECT COST RATE BY PROGRAM

(5) (6) (7)

[redacted] Worksheet 4 for Indirect/Direct Cost details

	Public Guardian			TAR / Office of Managed Care			Fee for Service		
	Indirect	Direct	Total	Indirect	Direct	Total	Indirect	Direct	Total
SALARIES AND EMPLOYEE BENEFITS									
CCAP	-		-	-		-	-		-
EXECUTIVE OFFICE	15,570		15,570	10,484		10,484	59,640		59,640
GENERAL ADMINISTRATION OPERATIONS	239,345		239,345	199,454		199,454	-		-
FISCAL SERVICES	50,950		50,950	34,306		34,306	209,917		209,917
MENTAL HEALTH BUREAU ADMINISTRATION	331,768		331,768	21,064		21,064	555,646		555,646
CONTRACTS ADMINISTRATION	-		-	-		-	147,805		147,805
MANAGEMENT INFORMATION SYSTEMS	6,193		6,193	-		-	333,362		333,362
DMH DIRECTLY OPERATED MH.PROGRAMS-G		-	-		-	-		-	-
DMH DIRECTLY OPERATED MH. PROG-SPECI		-	-		-	-		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES		-	-		-	-		-	-
DHS		-	-		-	-		-	-
PUBLIC GUARDIAN		5,502,949	5,502,949		-	-		-	-
TAR/OFFICE OF MANAGED CARE		-	-		5,520,842	5,520,842		-	-
FEE FOR SERVICE		-	-		-	-		-	-
STATE HOSPITAL		-	-		-	-		-	-
SD/MC UNREIMBURSABLE COSTS		-	-		-	-		-	-
IN-STATE MH CONTRACT PROVIDERS									
OTHER CONTRACT PROVIDERS		-	-		-	-		-	-
SUB-TOTAL S&EB	643,826	5,502,949	6,146,775	265,308	5,520,842	5,786,150	1,306,370	-	1,306,370
SRVC & SUPP / OTHER CHAR /FIX ASSETS									
CCAP	94,650		94,650	63,730		63,730	362,546		362,546
EXECUTIVE OFFICE	1,913		1,913	1,288		1,288	7,327		7,327
GENERAL ADMINISTRATION OPERATIONS	330,309		330,309	275,257		275,257	-		-
FISCAL SERVICES	3,289		3,289	2,215		2,215	1,044,079		1,044,079
MENTAL HEALTH BUREAU ADMINISTRATION	14,670		14,670	7,328		7,328	60,804		60,804
CONTRACTS ADMINISTRATION	-		-	-		-	5,161		5,161
MANAGEMENT INFORMATION SYSTEMS	20,889		20,889	-		-	1,316,490		1,316,490
DMH DIRECTLY OPERATED MH.PROGRAMS-G		-	-		-	-		-	-
DMH DIRECTLY OPERATED MH. PROG-SPECI		-	-		-	-		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES		-	-		-	-		-	-
DHS		-	-		-	-		-	-
PUBLIC GUARDIAN		3,040,004	3,040,004		-	-		-	-
TAR/OFFICE OF MANAGED CARE		-	-		231,345	231,345		-	-
FEE FOR SERVICE		-	-		-	-		84,538,984	84,538,984
STATE HOSPITAL		-	-		-	-		-	-
SD/MC UNREIMBURSABLE COSTS		-	-		-	-		-	-
IN-STATE MH CONTRACT PROVIDERS									
OTHER CONTRACT PROVIDERS		-	-		-	-		-	-
SUB-TOTAL SS & OTHERS	465,719	3,040,004	3,505,723	349,818	231,345	581,162	2,796,427	84,538,984	87,335,411
TOTAL EXPENDITURES									
CCAP	94,650	-	94,650	63,730	-	63,730	362,546	-	362,546
EXECUTIVE OFFICE	17,483	-	17,483	11,772	-	11,772	66,966	-	66,966
GENERAL ADMINISTRATION OPERATIONS	569,653	-	569,653	474,711	-	474,711	-	-	-
FISCAL SERVICES	54,239	-	54,239	36,521	-	36,521	1,253,996	-	1,253,996
MENTAL HEALTH BUREAU ADMINISTRATION	346,438	-	346,438	28,392	-	28,392	616,450	-	616,450
CONTRACTS ADMINISTRATION	-	-	-	-	-	-	152,966	-	152,966
MANAGEMENT INFORMATION SYSTEMS	27,082	-	27,082	-	-	-	1,649,852	-	1,649,852
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	-	-	-	-	-	-	-	-
DMH DIRECTLY OPERATED MH. PROG-SPECI	-	-	-	-	-	-	-	-	-
LIFE SUPPORT/SUPPLEMENTARY RATES	-	-	-	-	-	-	-	-	-
DHS	-	-	-	-	-	-	-	-	-
PUBLIC GUARDIAN	-	8,542,952	8,542,952	-	-	-	-	-	-
TAR/OFFICE OF MANAGED CARE	-	-	-	-	5,752,186	5,752,186	-	-	-
FEE FOR SERVICE	-	-	-	-	-	-	-	84,538,984	84,538,984
STATE HOSPITAL	-	-	-	-	-	-	-	-	-
SD/MC UNREIMBURSABLE COSTS	-	-	-	-	-	-	-	-	-
IN-STATE MH CONTRACT PROVIDERS									
OTHER CONTRACT PROVIDERS	-	-	-	-	-	-	-	-	-
TOTAL EXPENDITURES	1,109,545	8,542,952	9,652,498	615,126	5,752,186	6,367,312	4,102,796	84,538,984	88,641,781
		DMH OH	11.8799%		DMH OH	9.5858%		DMH OH	4.4243%
		CCAP	1.1079%		CCAP	1.1079%		CCAP	0.4289%
ADMIN. OVERHEAD RATE FOR 2003/2004	1,109,545 /	8,542,952 =	12.9878%	615,126 /	5,752,186 =	10.6937%	4,102,796 /	84,538,984 =	4.8531%
ADMIN. OVERHEAD RATE FOR 2002/2003	1,387,783 /	8,589,377 =	16.1570%	775,083 /	5,404,076 =	14.3426%	4,302,215 /	90,716,389 =	4.7425%

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
FY 2003-2004 YEAR-END COST REPORT

INDIRECT COST RATE BY PROGRAM

See Worksheet 4 for Indirect/Direct Cost details

	(8) SD/MC UNREIMBURSABLE COSTS			(9) STATE HOSPITAL		
	Indirect	Direct	Total	Indirect	Direct	Total
SALARIES AND EMPLOYEE BENEFITS						
CCAP	-		-	-		-
EXECUTIVE OFFICE	88,323		88,323	19,677		19,677
GENERAL ADMINISTRATION OPERATIONS	-		-	-		-
FISCAL SERVICES	289,020		289,020	64,369		64,369
MENTAL HEALTH BUREAU ADMINISTRATION	131,448		131,448	173,074		173,074
CONTRACTS ADMINISTRATION	-		-	-		-
MANAGEMENT INFORMATION SYSTEMS	-		-	65,101		65,101
DMH DIRECTLY OPERATED MH.PROGRAMS-G		-	-		-	-
DMH DIRECTLY OPERATED MH. PROG-SPEC		-	-		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES		-	-		-	-
DHS		-	-		-	-
PUBLIC GUARDIAN		-	-		-	-
TAR/OFFICE OF MANAGED CARE		-	-		-	-
FEE FOR SERVICE		-	-		-	-
STATE HOSPITAL		-	-		-	-
SD/MC UNREIMBURSABLE COSTS		336,215	336,215		-	-
IN-STATE MH CONTRACT PROVIDERS						
OTHER CONTRACT PROVIDERS		-	-		-	-
SUB-TOTAL S&EB	508,791	336,215	845,006	322,242	-	322,242
SRVC & SUPP / OTHER CHAR /FIX ASSETS						
CCAP	536,907		536,907	119,615		119,615
EXECUTIVE OFFICE	10,850		10,850	2,417		2,417
GENERAL ADMINISTRATION OPERATIONS	-		-	-		-
FISCAL SERVICES	18,657		18,657	4,157		4,157
MENTAL HEALTH BUREAU ADMINISTRATION	60,776		60,776	19,848		19,848
CONTRACTS ADMINISTRATION	-		-	-		-
MANAGEMENT INFORMATION SYSTEMS	-		-	219,605		219,605
DMH DIRECTLY OPERATED MH.PROGRAMS-G		-	-		-	-
DMH DIRECTLY OPERATED MH. PROG-SPEC		-	-		-	-
LIFE SUPPORT/SUPPLEMENTARY RATES		-	-		-	-
DHS		-	-		-	-
PUBLIC GUARDIAN		-	-		-	-
TAR/OFFICE OF MANAGED CARE		-	-		-	-
FEE FOR SERVICE		-	-		-	-
STATE HOSPITAL		-	-		43,185,230	43,185,230
SD/MC UNREIMBURSABLE COSTS		48,124,310	48,124,310		-	-
IN-STATE MH CONTRACT PROVIDERS						
OTHER CONTRACT PROVIDERS		-	-		-	-
SUB-TOTAL SS & OTHERS	627,191	48,124,310	48,751,501	365,641	43,185,230	43,550,871
TOTAL EXPENDITURES						
CCAP	536,907	-	536,907	119,615	-	119,615
EXECUTIVE OFFICE	99,173	-	99,173	22,094	-	22,094
GENERAL ADMINISTRATION OPERATIONS	-	-	-	-	-	-
FISCAL SERVICES	307,677	-	307,677	68,546	-	68,546
MENTAL HEALTH BUREAU ADMINISTRATION	192,224	-	192,224	192,922	-	192,922
CONTRACTS ADMINISTRATION	-	-	-	-	-	-
MANAGEMENT INFORMATION SYSTEMS	-	-	-	284,706	-	284,706
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	-	-	-	-	-
DMH DIRECTLY OPERATED MH. PROG-SPEC	-	-	-	-	-	-
LIFE SUPPORT/SUPPLEMENTARY RATES	-	-	-	-	-	-
DHS	-	-	-	-	-	-
PUBLIC GUARDIAN	-	-	-	-	-	-
TAR/OFFICE OF MANAGED CARE	-	-	-	-	-	-
FEE FOR SERVICE	-	-	-	-	-	-
STATE HOSPITAL	-	-	-	-	43,185,230	43,185,230
SD/MC UNREIMBURSABLE COSTS	-	48,460,526	48,460,526	-	-	-
IN-STATE MH CONTRACT PROVIDERS						
OTHER CONTRACT PROVIDERS	-	-	-	-	-	-
TOTAL EXPENDITURES	1,135,982	48,460,526	49,596,507	687,883	43,185,230	43,873,113
		DMH OH	1.2362%		DMH OH	1.3159%
		CCAP	1.1079%		CCAP	0.2770%
ADMIN. OVERHEAD RATE FOR 2003/2004	1,135,982 /	48,460,526 =	2.3441%	687,883 /	43,185,230 =	1.5929%
ADMIN. OVERHEAD RATE FOR 2002/2003	657,056 /	36,054,425 =	1.8224%	685,104 /	43,706,600 =	1.5675%

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
FY 2003-2004 YEAR-END COST REPORT

INDIRECT COST RATE BY PROGRAM

See Worksheet 4 for Indirect/Direct Cost details

	(10) Grand Total		
	Indirect	Direct	Total
SALARIES AND EMPLOYEE BENEFITS			
CCAP	-	-	-
EXECUTIVE OFFICE	1,520,534	-	1,520,534
GENERAL ADMINISTRATION OPERATIONS	6,422,413	-	6,422,413
FISCAL SERVICES	6,919,271	-	6,919,271
MENTAL HEALTH BUREAU ADMINISTRATION	14,361,065	-	14,361,065
CONTRACTS ADMINISTRATION	4,656,398	-	4,656,398
MANAGEMENT INFORMATION SYSTEMS	3,757,639	-	3,757,639
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	156,199,470	156,199,470
DMH DIRECTLY OPERATED MH. PROG-SPEC	-	8,456,724	8,456,724
LIFE SUPPORT/SUPPLEMENTARY RATES	-	-	-
DHS	-	-	-
PUBLIC GUARDIAN	-	5,502,949	5,502,949
TAR/OFFICE OF MANAGED CARE	-	5,520,842	5,520,842
FEE FOR SERVICE	-	-	-
STATE HOSPITAL	-	-	-
SD/MC UNREIMBURSABLE COSTS	-	336,215	336,215
IN-STATE MH CONTRACT PROVIDERS	-	-	-
OTHER CONTRACT PROVIDERS	-	-	-
SUB-TOTAL S&EB	37,637,319	176,016,200	213,653,519
SRVC & SUPP / OTHER CHAR /FIX ASSETS			
CCAP	9,243,213	-	9,243,213
EXECUTIVE OFFICE	186,794	-	186,794
GENERAL ADMINISTRATION OPERATIONS	8,863,286	-	8,863,286
FISCAL SERVICES	1,481,475	-	1,481,475
MENTAL HEALTH BUREAU ADMINISTRATION	1,533,128	-	1,533,128
CONTRACTS ADMINISTRATION	155,391	-	155,391
MANAGEMENT INFORMATION SYSTEMS	17,068,438	-	17,068,438
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	28,228,542	28,228,542
DMH DIRECTLY OPERATED MH. PROG-SPEC	-	4,783,641	4,783,641
LIFE SUPPORT/SUPPLEMENTARY RATES	-	3,024,446	3,024,446
DHS	-	87,020,284	87,020,284
PUBLIC GUARDIAN	-	3,040,004	3,040,004
TAR/OFFICE OF MANAGED CARE	-	231,345	231,345
FEE FOR SERVICE	-	84,538,984	84,538,984
STATE HOSPITAL	-	43,185,230	43,185,230
SD/MC UNREIMBURSABLE COSTS	-	48,124,310	48,124,310
IN-STATE MH CONTRACT PROVIDERS	-	496,681,573	496,681,573
OTHER CONTRACT PROVIDERS	-	8,875,704	8,875,704
SUB-TOTAL SS & OTHERS	38,531,724	807,734,062	846,265,787
TOTAL EXPENDITURES			
CCAP	9,243,213	-	9,243,213
EXECUTIVE OFFICE	1,707,328	-	1,707,328
GENERAL ADMINISTRATION OPERATIONS	15,285,698	-	15,285,698
FISCAL SERVICES	8,400,745	-	8,400,745
MENTAL HEALTH BUREAU ADMINISTRATION	15,894,193	-	15,894,193
CONTRACTS ADMINISTRATION	4,811,789	-	4,811,789
MANAGEMENT INFORMATION SYSTEMS	20,826,077	-	20,826,077
DMH DIRECTLY OPERATED MH.PROGRAMS-G	-	184,428,012	184,428,012
DMH DIRECTLY OPERATED MH. PROG-SPEC	-	13,240,365	13,240,365
LIFE SUPPORT/SUPPLEMENTARY RATES	-	3,024,446	3,024,446
DHS	-	87,020,284	87,020,284
PUBLIC GUARDIAN	-	8,542,952	8,542,952
TAR/OFFICE OF MANAGED CARE	-	5,752,186	5,752,186
FEE FOR SERVICE	-	84,538,984	84,538,984
STATE HOSPITAL	-	43,185,230	43,185,230
SD/MC UNREIMBURSABLE COSTS	-	48,460,526	48,460,526
IN-STATE MH CONTRACT PROVIDERS	-	496,681,573	496,681,573
OTHER CONTRACT PROVIDERS	-	8,875,704	8,875,704
TOTAL EXPENDITURES	76,169,043	983,750,262	1,059,919,306

ADMIN. OVERHEAD RATE FOR 2003/2004

ADMIN. OVERHEAD RATE FOR 2002/2003

Tab 4

State Controller's Office **Mandated Cost Manual**

CLAIM FOR PAYMENT

Pursuant to Government Code Section 17561

SERVICES TO HANDICAPPED STUDENTS II

For State Controller Use Only

(19) Program Number 00263

(20) Date F MAY 24 20

(21) LRS Input __/__/__

LABEL HERE

(01) Claimant Identification Number
9919

(02) Claimant Name
Auditor-Controller

County of Location
County of Los Angeles

Street Address or P.O. Box
500 West Temple Street, Room 603

City: Los Angeles | State: CA | Zip Code: 90012

Type of Claim	Estimated Claim		Reimbursement Claim		Reimbursement Claim Data	
	(03) Estimated		(09) Reimbursement	X	(22) HDS-1, (04)(A)(1)(f)	
	(04) Combined		(10) Combined		(23) HDS-1, (04)(B)(1)(f)	
	(05) Amended		(11) Amended		(24) HDS-1, (04)(C)(1)(f)	
					(25) HDS-1, (04)(D)(1)(f)	
					(26) HDS-1, (04)(E)(1)(f)	
					(27) HDS-1, (04)(F)(1)(f)	
					(28) HDS-1, (04)(G)(1)(f)	2,981,091
					(29) HDS-1, (06)	7
Fiscal Year of Cost	(06)		(12) **2002/2003**		(30) HDS-1, (07)	203,322
Total Claimed Amount	(07)		(13) $1,703,889		(31) HDS-1, (09)	
Less: **10% Late Penalty, but not to exceed $1,000**			(14)		(32) HDS-1, (10)	1,480,524
Less: **Estimated Claim Payment Received**			(15)		(33)	
Net Claimed Amount		$0	(16)	$1,703,889	(34)	
Due from State	(08)	$0	(17)	$1,703,889	(35)	
Due to State			(18)		(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program.
All offsetting savings and reimbursements set forth in the Parameters and Guidelines are indentified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer: John Naimo FOR

Date: 5/22/06

J. Tyler McCauley
Type or Print Name

Auditor-Controller
Title

(38) Name of Contact Person for Claim
Leonard Kaye

Telephone Number (213) 974-8564 Ext.

E-mail Address lkaye@auditor.co.la.ca.us

Form FAM-27 (Revised 9/03)

CSM 263	MANDATED COSTS HANDICAPPED AND DISABLED STUDENTS II CLAIM SUMMARY	FORM HDS-1

(01) Claimant:	(02)		Type of Claim	Fiscal Year
COUNTY OF LOS ANGELES /	Reimbursement	X		
DEPARTMENT OF MENTAL HEALTH	Estimated			2002/2003

Claim Statistics

(03) Number of student referrals during the fiscal year of claim. **(Please see Attachment 6).**	435

Direct Costs	**Object Accounts**					
(04) Reimbursable Activities	(a) Salaries	(b) Benefits	(c) Materials and Supplies	(d) Contracted Services	(e) Fixed Assets	(f) Total
A. Interagency Agreements						
B. Referral and Mental Health Assessments						
C. Transfers and Interim Placements						
D. Membership Participation of Expanded IEP Team						
E. Case Management Duties for Pupils						
F. Payment Authorization to Care Providers						
G. Psychotherapy or Other Treatment Services (a)	2,981,091					2,981,091
(05) Total Direct Costs	2,981,091					2,981,091

Indirect Costs

(06) Indirect Cost Rate **Please see Attachment 8.**	[10% or ICRP from 2 CFR, Chapter II, formerly OMB A-87]	6.8204%
(07) Total Indirect Costs	[Line (06) x line (05)(a)] or [Line (06) x {line (05)(a) + line (05)(b)}]	203,322
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]	3,184,413

Cost Reduction

(09) Less: Offsetting Savings		0
(10) Less: Other Reimbursements	**(Please see Attachment 5).**	1,480,524
(11) Total Claimed Amount	[Line (08) - {line (09) + line (10)}]	1,703,889

New 02/06

(a) The allowable costs are characterized as salary costs for purposes of computing authorized indirect costs in line (07) above.

Program 263

MANDATED COSTS

HANDICAPPED AND DISABLED STUDENTS II

ACTIVITY COST DETAIL

FORM HDS-2

(01) Claimant: COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

(02) Fiscal Year 2002/2003

(03) Reimbursable Activities: Check only one box per form to identify the activity being claimed.

- [ ] Interagency Agreements
- [ ] Referral and Mental Health Assessments
- [ ] Transfers and Interim Placements
- [ ] Member Participation of Extended IEP Team
- [ ] Case Management Duties for Pupils
- [ ] Payment Authorization to Care Providers
- [X] Psychotherapy or Other Treatment Services

(04) Description of Expenses			Object Accounts				
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Materials and Supplies	(g) Contracted Services	(h) Fixed Assets
Please see Attachment 4 for FY 2002-2003 Medication Monitoring Services Expenditures for LACDMH directly operated and non-governmental agencies. The claimed units of service are based on the AB 3632/SEP Plan identified in the LACDMH data collection system. The cost report is a unit of service based process that determines the unit cost rate.						2,981,091	
(05) Total [X] Subtotal [ ] Page: 1 of 1						2,981,091	

New 02/06

Attachment 4

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
MEDICATION MONITORING SERVICES EXPENDITURES
FISCAL YEAR 2002-2003

1	2	3	4	5	6	7	8
Contract Type	Entity Name	Entity Number	Mode	SFC	AB 3632 UNITS	Applicable Rate	Gross AB 3632 Cost
CR	LACDMH	00019	15	61	46,896	$ 3.57	$ 167,613
NR	Aspen Health Services	00519	15	61	5,785	3.32	19,206
NR	Associated League of Mexican-American	00173	15	61	888	3.51	3,117
NR	Cedars-Sinai Medical Center	00178	15	61	705	4.09	2,883
NR	Child & Family Center	00210	15	61	19,755	3.35	66,179
NR	Child and Family Guidance Center	00207	15	61	155,575	3.92	609,854
CR	Child and Family Guidance Center	00207	15	61	430	3.92	1,686
NR	Indirect Cost Rate is based on the Cost Report Actual I	00783	15	61	2,102	3.74	7,861
NR	Children's Bureau	00668	15	61	120	2.98	358
NR	Childrens Hospital Los Angeles	00179	15	61	8,225	4.23	34,792
CR	Children's Institute International	00591	15	61	751	3.98	2,992
NR	Community Counseling Service	00180	15	61	905	2.25	2,036
NR	Community Family Guidance Center	00181	15	61	12,315	1.78	21,921
CR	Devereux Foundation	00472	15	61	3,455	3.49	12,063
CR	Didi Hirsch Psychiatric Service	00183	15	61	22,160	3.47	76,905
NR	Dubnoff Center For Child Development	00184	15	61	21,940	4.23	92,806
NR	El Centro de Amistad, Inc.	00185	15	61	150	3.87	581
NR	Enki Health & Research	00188	15	61	68,123	3.31	225,487
NR	Five Acres Boys' & Girls' Aid Society of Los Angeles	00647	15	61	661	3.84	2,538
NR	Foothill Family Service	00724	15	61	841	4.17	3,507
NR	Gateways Hosp & MHC	00190	15	61	3,340	3.00	10,020
NR	Hamburger Home, Inc	00174	15	61	1,392	3.45	4,802
NR	Hathaway Children and Family Services	00192	15	61	37,166	3.40	126,364
NR	Help Group Child & Family Center	00198	15	61	61,455	4.15	255,038
NR	Hillsides	00321	15	61	9,585	3.95	37,861
NR	Intercommunity Child Guidance Center	00195	15	61	15,634	3.38	52,843
NR	LAUSD 97th St.Mental Health	00315	15	61	435	4.09	1,779
NR	Los Angeles Child Guidance Clinic	00199	15	61	37,092	3.63	134,644
NR	Pacific Clinics	00203	15	61	79,775	3.05	243,314
NR	Pasadena Childrens Training Society dba The Sycamo	00204	15	61	36,665	3.59	131,627
NR	Penny Lane Centers	00201	15	61	667	4.05	2,701
CR	Saint Johns Health Center	00217	15	61	14,486	4.23	61,276
NR	San Fernando Valley CMHC, Inc	00208	15	61	750	3.65	2,738
NR	South Bay Children's Health Center	00213	15	61	15,190	3.88	58,937
NR	Special Service for Groups	00214	15	61	2,378	3.33	7,919
NR	St. Francis Medical Center - Children's Center	00784	15	61	370	3.48	1,288
NR	Star View	00543	15	61	900	3.48	3,132
CR	Stirling Behavioral Health Institute	00216	15	61	120	2.69	322
NR	The Almansor Center	00171	15	61	5,550	3.54	19,647
NR	The Guidance Center	00191	15	61	31,586	2.76	87,177
CR	The Guidance Center	00191	15	61	7,796	2.92	22,727
CR	Verdugo Mental Health Center	00221	15	61	29,642	3.43	101,638
NR	Vista Del Mar	00196	15	61	69,600	3.72	258,912
TOTAL MEDICATION MONITORING SERVICES					**833,356**		**$ 2,991,091**

To HDS-2, Line (04), Column (g).

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
AB3632 - MEDICATION MONITORING COST SUMMARY
FY 2002-2003

COST ELEMENTS IDENTIFIED BY GROSS PROGRAM COSTS, OFFSETTING REIMBURSEMENTS/REVENUES, AND NET SB 90 REIMBURSABLE COSTS

The following procedure has been followed to assure all appropriate reimbursement/revenue offsets have been applied. Total eligible cost was identified (Line 3) and all applicable reimbursements/revenues have been offset to identify the remaining balance as the eligible SB 90 Chapter 1128/94 reimbursement.

Line 1	AB3632 Program - Medication Monitoring Gross Cost	$ 2,981,091	From Attachment 5, Column (8); To HDS-2, Line (04), column (g).
Line 2	Administration Cost	203,322	From Attachment 5, Column (8); To HDS-1, Line (07
Line 3	Gross AB 3632 Cost	$ 3,184,413	From Attachment 5, Column (8); To HDS-1, Line (08)
	Cost Reduction - Other Reimbursements		
Line 4	Final Early and Periodic Screening, Diagnosis, and Treatment State General Fund (EPSDT-SGF)	$ (607,496)	From Attachment 5, Column (9)
Line 5	EPSDT-SGF share of Administration Costs	(40,860)	From Attachment 5, Column (9)
Line 6	Final Federal Financial Participation (FFP)	(764,552)	From Attachment 5, Column (10)
Line 7	FFP share of Administration Costs	(51,803)	From Attachment 5, Column (10)
Line 8	Federal SAMHSA Grant and share of Administration Costs	(6,400)	From Attachment 5, Column (11)
Line 9	Third Party Revenues & share of Administration Costs	(4,955)	From Attachment 5, sum of Columns (12) through (15)
Line 10	Other State and Local Funds and share of Admin Costs	(4,458)	From Attachment 5, sum of Columns (16) and (17)
	Total Cost Reduction - Other Reimbursements	$ (1,480,524)	From Attachment 5, Column (18); To HDS-1, Line (10)
Line 11	SB 90 Claimed Amount	$ 1,703,889	From Attachment 5, Column (19); To HDS-1, Line (11)

Attachment 5

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
MEDICATION MONITORING SERVICES EXPENDITURES AND REVENUES WORKSHEET
FISCAL YEAR 2002-2003

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
								REVENUE OFFSETS (OTHER REIMBURSEMENTS)										
Contract Type	Entity Name	Entity Number	Mode	SFC	AB 3632 UNITS	Applicable Rate	Gross AB 3632 Cost	Final EPSDT-SGF	Final FFP	Federal SAMHSA Grant	Patient Fees	Patient Insurance	Medicare	3rd Party/ Other	State CSOC	Local Funds DCFS	Total Offsets (sum 9 thru 17)	SB 90 Claimed Amount (8 - 18)
CR	LACDMH	00019	15	61	46,896	$ 3.57	$ 167,613	$ 27,909	$ 39,250	$ -	$ -	$ -	$ -	$ 235	$ -	$ -	$ 67,394	$ 100,219
NR	Aspen Health Services	00519	15	61	5,785	3.32	19,206	8,707	8,958	-	-	-	-	-	-	-	17,665	1,541
NR	Associated League of Mexican-Ameri	00173	15	61	888	3.51	3,117	1,499	1,575	-	-	-	-	-	-	-	3,074	43
NR	Cedars-Sinai Medical Center	00178	15	61	705	4.09	2,883	181	184	-	-	-	-	-	-	-	365	2,518
NR	Child & Family Center	00210	15	61	19,755	3.35	66,179	5,593	8,753	-	4	-	-	-	-	-	14,350	51,829
NR	Child and Family Guidance Center	00207	15	61	155,575	3.92	609,854	132,166	159,414	-	1,161	639	-	2,159	-	-	295,539	314,315
CR	Child and Family Guidance Center	00207	15	61	430	3.92	1,686	-	-	-	-	-	-	-	-	-	-	1,686
NR	Indirect Cost Rate is based on the Cc	00783	15	61	2,102	3.74	7,861	3,308	3,371	-	-	-	-	-	-	-	6,679	1,182
NR	Children's Bureau	00668	15	61	120	2.98	358	59	220	-	-	-	-	-	-	-	279	79
NR	Childrens Hospital Los Angeles	00179	15	61	8,225	4.23	34,792	10,116	10,508	-	-	-	-	-	-	-	20,624	14,168
CR	Children's Institute International	00591	15	61	751	3.98	2,992	327	338	-	-	-	-	-	-	-	665	2,327
NR	Community Counseling Service	00180	15	61	905	2.25	2,036	563	571	-	-	-	-	-	-	-	1,134	902
NR	Community Family Guidance Center	00181	15	61	12,315	1.78	21,921	1,441	5,601	-	-	-	-	-	-	-	7,042	14,879
CR	Devereux Foundation	00472	15	61	3,455	3.49	12,063	33	33	-	-	-	-	-	-	-	66	11,997
CR	Didi Hirsch Psychiatric Service	00183	15	61	22,160	3.47	76,905	16,185	20,993	-	-	-	-	-	-	-	37,178	39,727
NR	Dubnoff Center For Child Developmer	00184	15	61	21,940	4.23	92,806	18,642	25,468	-	-	-	-	-	-	-	44,110	48,696
NR	El Centro de Amistad, Inc.	00185	15	61	150	3.87	581	86	87	-	-	-	-	1	-	-	174	407
NR	Enki Health & Research	00188	15	61	68,123	3.31	225,487	66,352	75,987	-	-	-	-	-	762	-	143,101	82,386
NR	Five Acres Boys' & Girls' Aid Society	00647	15	61	661	3.84	2,538	966	981	-	-	-	-	-	-	-	1,947	591
NR	Foothill Family Service	00724	15	61	841	4.17	3,507	100	102	-	-	-	-	-	-	-	202	3,305
NR	Gateways Hosp & MHC	00190	15	61	3,340	3.00	10,020	2,882	2,925	-	-	-	-	-	-	-	5,807	4,213
NR	Hamburger Home, Inc	00174	15	61	1,392	3.45	4,802	1,355	1,413	-	-	-	-	-	-	-	2,768	2,034
NR	Hathaway Children and Family Servic	00192	15	61	37,166	3.40	126,364	33,013	36,451	-	-	-	-	-	-	-	69,464	56,900
NR	Help Group Child & Family Center	00198	15	61	61,455	4.15	255,038	44,718	62,036	-	-	-	-	-	-	-	106,754	148,284
NR	Hillsides	00321	15	61	9,585	3.95	37,861	3,545	3,627	-	-	-	-	-	-	-	7,172	30,689
NR	Intercommunity Child Guidance Cente	00195	15	61	15,634	3.38	52,843	9,193	16,883	-	-	-	-	-	304	-	26,380	26,463
NR	LAUSD 97th St.Mental Health	00315	15	61	435	4.09	1,779	756	774	-	-	-	-	-	-	-	1,530	249
NR	Los Angeles Child Guidance Clinic	00199	15	61	37,092	3.63	134,644	51,498	59,187	-	-	-	-	-	-	-	110,685	23,959
NR	Pacific Clinics	00203	15	61	79,775	3.05	243,314	59,528	71,954	-	90	3	348	1	-	-	131,924	111,390
NR	Pasadena Childrens Training Society	00204	15	61	36,665	3.59	131,627	33,689	44,261	-	-	-	-	-	-	-	77,950	53,677
NR	Penny Lane Centers	00201	15	61	667	4.05	2,701	-	933	-	-	-	-	-	-	-	933	1,768
CR	Saint Johns Health Center	00217	15	61	14,486	4.23	61,276	4,887	5,026	-	-	-	-	-	-	-	9,913	51,363
NR	San Fernando Valley CMHC, Inc	00208	15	61	750	3.65	2,738	186	547	-	-	-	-	-	-	-	733	2,005
NR	South Bay Children's Health Center	00213	15	61	15,190	3.88	58,937	-	5,576	-	-	-	-	-	-	-	5,576	53,361
NR	Special Service for Groups	00214	15	61	2,378	3.33	7,919	217	645	-	-	-	-	-	-	-	862	7,057
NR	St. Francis Medical Center - Children'	00784	15	61	370	3.48	1,288	634	647	-	-	-	-	-	-	-	1,281	7
NR	Star View	00543	15	61	900	3.48	3,132	257	261	-	-	-	-	-	-	2,234	2,752	380
CR	Stirling Behavioral Health Institute	00216	15	61	120	2.69	322	-	-	-	1	-	-	-	-	-	1	321
NR	The Almansor Center	00171	15	61	5,550	3.54	19,647	5,725	7,911	-	-	-	-	-	-	-	13,636	6,011
NR	The Guidance Center	00191	15	61	31,586	2.76	87,177	26,236	29,608	-	-	-	-	-	-	-	55,844	31,333
CR	The Guidance Center	00191	15	61	7,796	2.92	22,727	-	-	6,020	-	-	-	-	-	-	6,020	16,707
CR	Verdugo Mental Health Center	00221	15	61	29,642	3.43	101,638	1,212	15,412	-	-	-	-	-	-	-	16,624	85,014
NR	Vista Del Mar	00196	15	61	69,600	3.72	258,912	33,732	36,081	-	-	-	-	-	893	-	70,706	188,206
Subtotal					833,356		$ 2,981,091	$ 607,496	$ 764,552	$ 6,020	$ 1,256	$ 642	$ 348	$ 2,396	$ 1,959	$ 2,234	$ 1,386,903	$ 1,594,188
Administration Cost -	LACDMH			15.4730%			25,935	4,318	6,073	-	-	-	-	36	-	-	10,427	15,508
	Contractor (NGA)			6.3049%			177,387	36,542	45,730	380	79	40	22	136	124	141	83,194	94,193
Subtotal							203,322	40,860	51,803	380	79	40	22	172	124	141	93,621	109,701
TOTAL					833,356		$ 3,184,413	$ 648,356	$ 816,355	$ 6,400	$ 1,335	$ 682	$ 370	$ 2,568	$ 2,083	$ 2,375	$ 1,480,524	$ 1,703,889

To HDS-1, Line (10).

Tab 5

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE TEST CLAIM:

Government Code Sections 7570, 7571, 7572, 7572.5, 7572.55, 7573, 7576, 7579, 7582, 7584, 7585, 7586, 7586.6, 7586.7, 7587, 7588;

Statutes 1984, Chapter 1747; Statutes 1985, Chapter 107; Statutes 1985, Chapter 759; Statutes 1985, Chapter 1274; Statutes 1986, Chapter 1133; Statutes 1992, Chapter 759; Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654; Statutes 1998, Chapter 691; Statutes 2001, Chapter 745; Statutes 2002, Chapter 585; and Statutes 2002, Chapter 1167; and

California Code of Regulations, Title 2, Sections 60000-60610;

Filed on June 27, 2003 by the County of Stanislaus, Claimant; and

Filed on June 30, 2003, by the County of Los Angeles, Claimant.

Case No.: 02-TC-40/02-TC-49

Handicapped & Disabled Students II

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

(*Adopted on May 26, 2005*)

STATEMENT OF DECISION

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

_____ _____

PAULA HIGASHI, Executive Director Date

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE TEST CLAIM:

Government Code Sections 7570, 7571, 7572, 7572.5, 7572.55, 7573, 7576, 7579, 7582, 7584, 7585, 7586, 7586.6, 7586.7, 7587, 7588;

Statutes 1984, Chapter 1747; Statutes 1985, Chapter 107; Statutes 1985, Chapter 759; Statutes 1985, Chapter 1274; Statutes 1986, Chapter 1133; Statutes 1992, Chapter 759; Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654; Statutes 1998, Chapter 691; Statutes 2001, Chapter 745; Statutes 2002, Chapter 585; and Statutes 2002, Chapter 1167; and

California Code of Regulations, Title 2, Sections 60000-60610;

Filed on June 27, 2003 by the County of Stanislaus, Claimant; and

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Handicapped & Disabled Students II

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

(Adopted on May 26, 2005)

STATEMENT OF DECISION

The Commission on State Mandates ("Commission") heard and decided this test claim during a regularly scheduled hearing on May 26, 2005. Leonard Kaye and Paul McIver appeared on behalf of the County of Los Angeles. Pam Stone represented and appeared on behalf of the County of Stanislaus. Linda Downs appeared on behalf of the County of Stanislaus. Nicholas Schweizer and Jody McCoy appeared on behalf of the Department of Finance

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 4-0.

BACKGROUND

This test claim addresses amendments to the Handicapped and Disabled Students program (also known as, Assembly Bill 3632) administered by county mental health

departments. The Handicapped and Disabled Students program was initially enacted in 1984, as the state's response to federal legislation that guaranteed disabled pupils, including those with mental health needs, the right to receive a free and appropriate public education (Individuals with Disabilities Education Act, or IDEA). Before 1984, the state adopted a comprehensive statutory scheme in the Education Code to govern the special education and related services provided to disabled children.[1] Among the related services, called "designated instruction and services" in California, the following mental health services are identified: counseling and guidance, psychological services other than the assessment and development of the IEP, parent counseling and training, health and nursing services, and social worker services.[2] The state and the local educational agencies (school districts and county offices of education) provided all related services, including mental health services, to children with disabilities.

In 1984 and 1985, the Legislature enacted Assembly Bill 3632 (Stats. 1984, ch. 1747, and Stats. 1985, ch. 1274), to shift the responsibility and funding for providing mental health services for students with disabilities from local educational agencies to county mental health departments. AB 3632 added Chapter 26.5 to the Government Code (§§ 7570 et seq.), and the Departments of Mental Health and Education adopted emergency regulations (Cal. Code Regs., tit. 2, §§ 60000-60610) to require county mental health departments to:

- Renew the interagency agreement with the local educational agency every three years and, if necessary, revise the agreement.
- Perform an initial assessment of a pupil referred by the local educational agency, and discuss assessment results with the parents and IEP team.
- Participate as a member of the IEP team whenever the assessment of a pupil determines the pupil is seriously emotionally disturbed and residential placement may be necessary.
- Act as the lead case manager, as specified in statute and regulations, if the IEP calls for residential placement of a seriously emotionally disturbed pupil.
- Issue payments to providers of out-of-home residential care for the residential and non-educational costs of seriously emotionally disturbed pupils.
- Provide psychotherapy or other mental health services, as defined in regulations, when required by the IEP.
- Participate in due process hearings relating to issues involving mental health assessments or services.

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[1] Education Code section 56000 et seq. (Stats. 1980, ch. 797.)

[2] Education Code section 56363.

Past and Pending Commission Decisions on the Handicapped and Disabled Students Program

On April 26, 1990, the Commission adopted a statement of decision in *Handicapped and Disabled Students* (CSM 4282). The test claim was filed by the County of Santa Clara on Statutes 1984, chapter 1747; Statutes 1985, chapter 1274; and on California Code of Regulations, title 2, sections 60000 through 60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)). The Commission determined that the activities of providing mental health assessments, psychotherapy and other mental health treatment services, as well as assuming expanded IEP responsibilities, were reimbursable as a state-mandated program under article XIII B, section 6 of the California Constitution beginning July 1, 1986. Activities related to assessments and IEP responsibilities were found to be 100 per cent (100%) reimbursable. Psychotherapy and other mental health treatment services were found to be ten per cent (10%) reimbursable due to the cost sharing methodology in existence under the Short-Doyle Act for local mental health services. On January 11, 1993, the Sixth District Court of Appeal, in an unpublished decision, sustained the Commission's decision in CSM 4282.[3]

In May 2000, the Commission approved a second test claim relating to this program, *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (CSM 97-TC-05). The test claim on *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) was filed on Government Code section 7576, as amended by Statutes 1996, chapter 654, the corresponding regulations (Cal. Code Regs, tit. 2, §§ 60100 and 60200), and on a Department of Mental Health Information Notice Number 86-29. The test claim in *Seriously Emotionally Disturbed Pupils* addressed only the counties' responsibilities for out-of-state residential placements for seriously emotionally disturbed pupils, and has a reimbursement period beginning January 1, 1997.

In addition, there are two other matters currently pending with the Commission relating to the test claim statutes and regulations. In 2001, the Counties of Los Angeles and Stanislaus filed requests to amend the parameters and guidelines on the original test claim decision, *Handicapped and Disabled Students* (CSM 4282). The counties request that the parameters and guidelines be amended to delete all references to the Short-Doyle cost-sharing mechanism for providing psychotherapy or other mental health services; to add an activity to provide reimbursement for room and board for in-state placement of pupils in residential facilities; and to amend the language regarding the reimbursement of indirect costs. The request to amend the parameters and guidelines was scheduled on the Commission's March 2002 hearing calendar. But at the request of the counties, the item was taken off calendar, and is still pending. If the Commission approves the counties'

[3] *County of Santa Clara v. Commission on State Mandates* (Jan. 11, 1993, H009520) [nonpub. Opn.]).

request to amend the parameters and guidelines, the reimbursement period for the new amended portions of the parameters and guidelines would begin on July 1, 2000.[4]

The second matter currently pending with the Commission is the reconsideration of the *Handicapped and Disabled Students* test claim (04-RL-4282-10) that was directed by Statutes 2004, chapter 493 (Sen. Bill No. 1895).

This test claim, *Handicapped and Disabled Students II*, presents the following issues:

- Does the Commission have the jurisdiction to rehear in this test claim the statutes and regulations previously determined by the Commission to constitute a reimbursable state-mandated program in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05)?
- Are the test claim statutes and regulations subject to article XIII B, section 6 of the California Constitution?
- Do the test claim statutes and regulations impose a new program or higher level of service on local agencies within the meaning of article XIII B, section 6 of the California Constitution?
- Do the test claim statutes and regulations impose "costs mandated by the state" within the meaning of Government Code sections 17514 and 17556?

Claimants' Position

The claimants contend that the test claim statutes and regulations constitute a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514.

The County of Los Angeles, according to its test claim, is seeking reimbursement for the following activities:

- Mental health assessments and related treatment services, including psychotherapy, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management.
- Placement in a residential facility outside the child's home, including the provision of food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance with respect to the child, and reasonable travel to the child's home for visitation.
- Due process hearings, notifications, resolution requirements.
- Preparation of interagency agreements.

The County of Stanislaus is seeking reimbursement for the activities required by statutory and regulatory amendments to the original program. The County of Stanislaus takes no position on the issue of providing residential services to the child.

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[4] California Code of Regulations, title 2, section 1183.2.

The Counties of Los Angeles and Stanislaus filed comments on the draft staff analysis, which are addressed in the analysis of this claim.

Position of the Department of Finance

The Department of Finance filed comments on the test claims describing the Department's position on funding and the requested costs for residential treatment. With respect to funding, the Department contends the following:

- For claims for mental health treatment services provided before fiscal year 2000-01, eligible claimants are entitled to reimbursement for ten percent (10%) of their costs only. The Department argues that Bronzan-McCorquodale Act of 1991 was intended to replace the Short-Doyle Act, and provides ninety percent (90%) of the funding to counties for mental health treatment services for special education pupils.
- Eligible claimants are entitled to 100 per cent (100%) reimbursement for mental health treatment services beginning July 1, 2001. The Department states that section 38 of Statutes 2002, chapter 1167, increased the percentage of state reimbursement for treatment costs from ten percent (10%) to 100% for services delivered in fiscal year 2001-02 and subsequent years.

The Department of Finance states the following with respect to residential treatment costs:

> ....The [Department of Social Services (DSS)] sets reasonable board and care rates for in-state placement facilities based on specified criteria. To allow community mental health services to pay an unspecified and unregulated "patch" above and beyond the reasonable rate established by the DSS, could be extremely expensive and [would] provide no additional mental health services to the disabled child. The State would no longer be able to determine fair and reasonable placement costs. It is clear that Section 62000 [of the DSS regulations] intended that community mental health services defer to DSS when it came to board and care rate setting for in-state facilities. The state mandate process should not be used to undermine in-state rate setting for board and care in group homes.[5]

The Department of Finance filed comments on the draft staff analysis arguing that the Handicapped and Disabled Students program is federally mandated under the current federal law and that some of the activities recommended for approval do not increase the level of service required of counties and, thus, should be denied.

Position of the Department of Mental Health

The Department of Mental Health filed comments on the draft staff analysis that state in relevant part the following:

> After full review, [Department of Mental Health] wishes to state that it concurs with the comments made by the Department of Finance, but that [Department of Mental Health] has no objections, suggested

[5] Department of Finance comments filed October 7, 2003.

modifications, or other comments regarding the submission to the Claimants.

Discussion

The courts have found that article XIII B, section 6 of the California Constitution[6] recognizes the state constitutional restrictions on the powers of local government to tax and spend.[7] "Its purpose is to preclude the state from shifting financial responsibility for carrying out governmental functions to local agencies, which are 'ill equipped' to assume increased financial responsibilities because of the taxing and spending limitations that articles XIII A and XIII B impose."[8] A test claim statute or executive order may impose a reimbursable state-mandated program if it orders or commands a local agency or school district to engage in an activity or task.[9] In addition, the required activity or task must be new, constituting a "new program," or it must create a "higher level of service" over the previously required level of service.[10]

The courts have defined a "program" subject to article XIII B, section 6, of the California Constitution, as one that carries out the governmental function of providing public services, or a law that imposes unique requirements on local agencies or school districts to implement a state policy, but does not apply generally to all residents and entities in the state.[11] To determine if the program is new or imposes a higher level of service, the test claim legislation must be compared with the legal requirements in effect immediately before the enactment of the test claim legislation.[12] A "higher level of service" occurs

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[6] Article XIII B, section 6, subdivision (a), (as amended by Proposition 1A in November 2004) provides: "Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the State shall provide a subvention of funds to reimburse that local government for the costs of the program or increased level of service, except that the Legislature may, but need not, provide a subvention of funds for the following mandates: (1) Legislative mandates requested by the local agency affected. (2) Legislation defining a new crime or changing an existing definition of a crime. (3) Legislative mandates enacted prior to January 1, 1975, or executive orders or regulations initially implementing legislation enacted prior to January 1, 1975."

[7] *Department of Finance v. Commission on State Mandates (Kern High School Dist.)* (2003) 30 Cal.4th 727, 735.

[8] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 81.

[9] *Long Beach Unified School Dist. v. State of California* (1990) 225 Cal.App.3d 155, 174.

[10] *San Diego Unified School Dist. v. Commission on State Mandates* (2004) 33 Cal.4th 859, 878 (*San Diego Unified School Dist.)*; *Lucia Mar Unified School District v. Honig* (1988) 44 Cal.3d 830, 835-836 (*Lucia Mar*).

[11] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 874, (reaffirming the test set out in *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56; *Lucia Mar, supra,* 44 Cal.3d 830, 835.)

[12] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878; *Lucia Mar, supra*, 44 Cal.3d 830, 835.

when the new "requirements were intended to provide an enhanced service to the public."[13]

Finally, the newly required activity or increased level of service must impose costs mandated by the state.[14] -

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.[15] 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."[16]

Issue 1: **Does the Commission have jurisdiction to rehear in this test claim the statutes and regulations previously determined by the Commission to constitute a reimbursable state-mandated program in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05)?**

The claimants have included the following statutes and regulations in this test claim:

- Government Code sections 7570 et seq., as added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter, 107.
- Government Code section 7576, as amended by Statutes 1996, chapter 654.
- Sections 60000 through 60610 of the joint regulations adopted by the Departments of Mental Health and Education to implement the program. The claimants do not, however, identify the version of the regulations for which they are claiming reimbursement.

As indicated in the Background, the statutes and some of the regulations identified in the paragraph above were included in two prior test claims that the Commission approved as reimbursable state-mandated programs. In 1990, the Commission adopted a statement of decision in *Handicapped and Disabled Students* (CSM 4282) approving Government Code sections 7570 et seq., as added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter, 107, and sections 60000 through 60610 of the emergency regulations (filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86,

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[13] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878.

[14] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1265, 1284 (*County of Sonoma*); Government Code sections 17514 and 17556.

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

[16] *County of Sonoma, supra,* 84 Cal.App.4th 1265, 1280, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

No. 28)) as a reimbursable state-mandated program. The Legislature has directed the Commission to reconsider this decision.[17]

In 2000, the Commission adopted a statement of decision in *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) approving Government Code section 7576, as amended by Statutes 1996, chapter 654, and the corresponding regulations (Cal. Code Regs, tit. 2, §§ 60100 and 60200) as a reimbursable state-mandated program for the counties' responsibilities for out-of-state residential placements for seriously emotionally disturbed pupils.

It is a well-settled principle of law that an administrative agency, like the Commission, does not have jurisdiction to retry a question that has become final. If a prior final decision is retried by the agency, without the statutory authority to retry or reconsider the case, that decision is void.[18]

In the present case, the Commission does not have the statutory authority to rehear in this test claim the statutes and regulations previously determined by the Commission to constitute a reimbursable state-mandated program in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05).

At the time these test claims were filed, Government Code section 17521 defined a "test claim" as the first claim, including claims joined or consolidated with the first claim, filed with the Commission alleging that a particular statute or executive order imposes costs mandated by the state. The Commission's regulations allowed the filing of more than one test claim on the same statute or executive order only when (1) the subsequent test claim is filed within sixty (60) days from the date the first test claim was filed; and (2) when each test claim is filed by a different type of claimant or the issues presented in each claim require separate representation. (Cal. Code Regs., tit. 2, §§ 1183, subd. (i).) This test claim was filed more than sixty days from the date that *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) were filed. In addition, all three test claims were filed by the same type of claimant; counties. There is no evidence in the record to suggest that the same statutes already determined by the Commission to constitute a reimbursable state-mandated program in the prior test claims require separate representation here.

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[17] See reconsideration of *Handicapped and Disabled Students* (04-RL-4282-10).

[18] *Heap v. City of Los Angeles* (1936) 6 Cal.2d 405, 407, where the court held that the civil service commission had no jurisdiction to retry a question and make a different finding at a later time; *City and County of San Francisco v. Ang* (1979) 97 Cal.App.3d 673, 697, where the court held that whenever a quasi-judicial agency is vested with the authority to decide a question, such decision, when made is conclusive of the issues involved in the decision as though the adjudication had been made by the court; and *Save Oxnard Shores v. California Coastal Commission* (1986) 179 Cal.App.3d 140, 143, where the court held that in the absence of express statutory authority, an administrative agency may not change a determination made on the facts presented at a full hearing once the decision becomes final.

Finally, Government Code section 17559 grants the Commission the authority to reconsider prior final decisions only within 30 days after the Statement of Decision is issued. Since the two prior decisions in *Handicapped and Disabled Students* (CSM 4282) and *Seriously Emotionally Disturbed (SED) Pupils: Out-of-State Mental Health Services* (97-TC-05) were adopted and issued well over 30 days ago, the Commission does not have the jurisdiction in this test claim to reconsider the same statutes and regulations pled and determined in prior test claims.

As recognized by the California Supreme Court, the purpose behind the statutory scheme and procedures established by the Legislature in Government Code section 17500 et seq. was to "avoid[] multiple proceedings, judicial and administrative, addressing the same claim that a reimbursable state mandate has been created."[19]

Therefore, the Commission does not have the jurisdiction in this test claim over the following statutes and regulations:

- The Government Code sections in Chapter 26.5 considered in *Handicapped and Disabled Students* (CSM 4282) that were added and amended by Statutes 1984, chapter 1747, and Statutes 1985, chapter, 107, and that have not been amended by the remaining test claim legislation. These statutes are Government Code sections 7571, 7572.5, 7573, 7586, 7586.7, and 7588.
- Government Code section 7576, as amended by Statutes 1996, chapter 654, as it relates to out-of-state placement of seriously emotionally disturbed pupils.
- California Code of Regulations, title 2, sections 60000 through 60610 (filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)). These regulations were repealed and were superceded by new regulations, effective July 1, 1998.[20]
- California Code of Regulations, title 2, sections 60100 and 60200 (filed as emergency regulations on July 1, 1998 (Register 98, No. 26) and refiled as final regulations on August 9, 1999 (Register 99, No. 33)) as they relate to the out-of-state placement of seriously emotionally disturbed pupils.

Issue 2: Are the test claim statutes and regulations subject to article XIII B, section 6 of the California Constitution?

The activities performed by counties under the Handicapped and Disabled Students program are mandated by the state and not by federal law

[19] *Kinlaw, supra*, 54 Cal.3d at page 333.

[20] See History of the regulations (Cal. Code Regs., tit. 2, §§ 60000 et seq.), notes 8 and 9.

The test claim statutes and regulations implement the federal special education law (IDEA) 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 designed to meet the pupil's unique educational needs.

The Department of Finance argues that the activities performed by counties under the Handicapped and Disabled Students program are federally mandated and, thus, reimbursement is not required under article XIII B, section 6 of the California Constitution. The Commission disagrees.

In 1992, the Third District Court of Appeal, in *Hayes v. Commission on State Mandates*, determined that the federal law at issue in the present case, IDEA, imposes a federal mandate on the states.[21] The *Hayes* case involved test claim legislation requiring school districts to provide special education services to disabled pupils. The school districts in the *Hayes* case alleged that the activities mandated by the state that exceeded federal law were reimbursable under article XIII B, section 6 of the California Constitution.

The court in *Hayes* determined that the state's "alternatives [with respect to federal law] were to participate in the federal program and obtain federal financial assistance and the procedural protections accorded by the act, or to decline to participate and face a barrage of litigation with no real defense and ultimately be compelled to accommodate the educational needs of handicapped children in any event."[22] The court concluded that the state had no "true choice" but to participate in the federal program and, thus, there was a federal mandate on the state.[23]

Although the court concluded that the federal law was a mandate on the states, the court remanded the case to the Commission for further findings to determine if the state's response to the federal mandate constituted a state-mandated new program or higher level of service on the school districts.[24] The court held that if the state "freely chose" to impose the costs upon the local agency as a means of implementing a federal program, then the costs are the result of a reimbursable state mandate. The court's holding is as follows:

> In our view the determination whether certain costs were imposed upon the local agency by a federal mandate must focus upon the local agency which is ultimately forced to bear the costs and how those costs came to be imposed upon that agency. *If the state freely chose to impose the costs upon the local agency as a means of implementing a federal program then the costs are the result of a reimbursable state mandate regardless whether the costs were imposed upon the state by the federal government.*[25] (Emphasis added.)

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[21] *Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4th 1564, 1592.

[22] *Hayes, supra*, 11 Cal.App.4th at page 1591.

[23] *Ibid.*

[24] *Ibid.*

[25] *Id.* at page 1593-1594.

Here, pursuant to the court's holding in *Hayes*, the state "freely chose" to impose the costs upon the counties as a means of implementing the federal IDEA program.

Federal law does not require the state to impose any requirements relating to special education and related services on counties. At the time the test claim legislation was enacted, the requirements under federal law were imposed only on states and local educational agencies.[26] In 1997, Congress amended the IDEA to "strengthen the requirements on ensuring provisions of services by non-educational agencies ..." (Sen. Rep. 105-17, dated May 9, 1997.) The amendment clarified that the state or local educational agency responsible for developing a child's IEP could look to non-educational agencies to pay for or provide those services the educational agencies are otherwise responsible for. The amendment further clarified that if a non-educational agency failed to provide or pay for the special education and related services, the state or local educational agency responsible for developing the IEP remain ultimately responsible for ensuring that children receive all the services described in their IEPs in a timely fashion and the state or local educational agency shall provide or pay for the services.[27] Federal law, however, does not require states to use non-educational agencies to pay for or provide services. A state's decision regarding how to implement the IDEA is still within the discretion, or the "free choice," of the state. The Department of Finance agrees with this interpretation of federal law. The Department states the following:

> While subparagraph (A) of paragraph (11) of subdivision (a) of Sec. 612 states that the state educational agency is responsible for ensuring for the provision of IDEA services, subparagraph (B) states that "[s]ubparagraph (A) shall not limit the responsibility of agencies in the State other than the State educational agency to provide, or pay for some or all of the costs of, a free appropriate public education for any child with a disability in the State." This makes clear that Federal IDEA anticipates that agencies other than educational agencies *may be* responsible for providing services and absorbing costs related to the federal legislation. Indeed, subparagraph (A) of paragraph (12) lays out specific guidelines for the assigning of responsibility for services among various agencies.
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> DOF contends that the fact that *the state has chosen through AB 3632* and related legislation to make mental health services related to individual education plans (IEPs) the responsibility of mental health agencies does not, in and of itself, trigger mandate reimbursement through Article XIII B, section 6 as the responsibilities in question are federally mandated and

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[26] Title 34 Code of Federal Regulations section 300.2.

[27] Title 20 United States Code sections 1412 (a)(12)(A), (B), and (C), and 1401 (8); Title 34 Code of Federal Regulations section 300.142. (See also, Letters from the Department of Education dated July 28, 1998 and August 2, 2004, to all SELPAs, COEs, and LEAs on the requirements of 34 C.F.R. 300.142; and *Tri-County Special Education Local Plan Area v. County of Tuolumne* (2004) 123 Cal.App.4th 563, 578, where the court stated that "it is clear the Legislature could reassign administration of IDEA programs to a different entity if it chose to do so.".)

federal law allows the state to choose the agency or agencies responsible for service. (Emphasis added.)[28]

Accordingly, the activities performed by counties under the Handicapped and Disabled Students program are mandated by the state and not by federal law. Thus, the actual increased costs incurred as a result of the activities in the program that constitute a mandated new program or higher level of service are reimbursable within the meaning of article XIII B, section 6.

Several test claim statutes and regulations do not mandate counties to perform an activity and, thus, are not subject to article XIII B, section 6

In order for a statute or an executive order to be subject to article XIII B, section 6 of the California Constitution, the statutory language must mandate or require local governmental agencies to perform an activity or task. [29]

Here, there are several statutes included in the test claim that are helpful in understanding the Handicapped and Disabled Students program. But they do not require counties to perform an activity or task. These statutes are Government Code sections 7570, 7584, and 7587.[30]

In addition, non-substantive changes and amendments that do not affect counties were made to Government Code sections 7572, 7582, and 7585 by the test claim statutes. These amendments do not impose any state-mandated activities on counties.[31, 32]

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[28] Department of Finance comments on the draft staff analysis.

[29] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Los Angeles, supra,* 43 Cal.3d 46, 56; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1283-1284; *Department of Finance, supra,* 30 Cal.4th at page 736; Gov. Code, § 17514.

[30] Government Code section 7570 provides that ensuring a free and appropriate public education for children with disabilities under federal law and the Education Code is the joint responsibility of the Superintendent of Public Instruction and the Secretary of Health and Welfare. Government Code section 7584 defines "disabled youth," "child," and "pupil." Government Code section 7587 requires the Departments of Education and Mental Health to adopt regulations to implement the program.

[31] Government Code section 7572, as originally added in 1984 and amended in 1985, addresses the assessment of a student, including psychological and other mental health assessments performed by counties. The 1992 amendments to Government Code section 7572 substituted the word "disability" for "handicap," and made other clarifying, non-substantive amendments. Government Code section 7582 states that assessments and therapy treatment services provided under the program are exempt from financial eligibility standards and family repayment requirements. The 1992 amendment to section 7582 substituted "disabled child or youth" for "handicapped child." Government Code section 7585 addresses the notification of an agency's failure to provide a required service and reports to the Legislature. The 2001 amendments to section 7585 corrected the spelling of "administrative" and deleted the requirement for the Superintendent of

Furthermore, the Commission finds that Government Code section 7579, as amended by the test claim legislation, does not impose any state-mandated duties on county mental health departments. As originally enacted, Government Code section 7579 required courts, regional centers for the developmentally disabled, or other non-educational public agencies that engage in referring children to, or placing children in, residential facilities, to notify the administrator of the special education local plan area (SELPA) in which the residential facility is located before the pupil is placed in an out-of-home residential facility. The intent of the legislation, as stated in subdivision (c), was to "encourage communication between the courts and other public agencies that engage in referring children to, or placing children in, residential facilities, and representatives of local educational agencies."

The 2002 test claim statute (Stats. 2002, ch. 585) amended Government Code section 7579 by adding subdivision (d), to require public agencies other than educational agencies that place a child in a residential facility located out of state, without the involvement of a local educational agency, to assume responsibility for educational and non-educational costs of the child. Government Code section 7579, subdivision (d), states the following:

> Any public agency other than an educational agency that places a disabled child or child suspected of being disabled in a facility out of state without the involvement of the school district, SELPA, or COE [county office of education] in which the parent or guardian resides, shall assume financial responsibility for the child's residential placement, special education program, and related services in the other state unless the other state or its local agencies assume responsibility.

Government Code section 7579, subdivision (d), however, does not apply to county mental health departments. The duty imposed by section 7579 to pay the educational and non-educational costs of a child placed in an out-of-state residential facility is a duty imposed on a placing agency, like a court or a regional center for the developmentally

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Public Instruction and the Secretary of Health and Welfare to submit yearly reports to the Legislature on the failure of an agency to provide a required service.

[32] The County of Los Angeles, in comments to the draft staff analysis for this test claim, addresses a finding made on the reconsideration of the original *Handicapped and Disabled Students* claim (04-RL-4282-10), relating to Government Code section 7572 and the counties' attendance at IEP meetings following a mental health assessment of a pupil. The County's comments are not relevant to this test claim, however. The language in Government Code section 7572 relating to the county's attendance at an IEP meeting following an assessment was added by the Legislature in 1985. As indicated in the analysis, the Commission does not have jurisdiction in this test claim to address the statutes or activities originally added by the Legislature in 1984 and 1985. The Commission does have jurisdiction in this test claim over Government Code section 7572, as amended by Statutes 1992, chapter 759. But the 1992 amendments to section 7572 were non-substantive and do not impose any additional state-mandated activities on counties.

disabled, that fails to seek the involvement of the local educational agency. This consolidated test claim has been filed on behalf of county mental health departments.[33]

This conclusion is further supported by section 60510 of the regulations. Section 60510 of the regulations was adopted in 1998 (filed as an emergency regulation on July 1, 1998 (Register 98, No. 26) and refiled as a final regulation on August 9, 1999 (Register 99, No. 33)) to implement Government Code section 7579. The regulation requires "the court, regional center for the developmentally disabled, or public agency other than an educational agency" to notify the SELPA director before placing a child in a facility and requires the agency to provide specified information to the SELPA. Section 60510 is placed in article 7 of the regulations dealing with the exchange of information between "Education and Social Services." Article 7 is separate and apart from, and located after, the regulations addressing mental health related services. Accordingly, the Commission finds that Government Code section 7579, and section 60510 of the regulations, do not impose any state-mandated duties on county mental health departments.

Finally, the County of Stanislaus requests reimbursement for section 60400 of the regulations (filed as an emergency regulation on July 1, 1998 (Register 98, No. 26) and refiled as a final regulation on August 9, 1999 (Register 99, No. 33)). Section 60400, on its face, does not mandate any activities on counties. Rather, section 60400 of the regulations addresses the requirement imposed on the Department of Health Services to provide the services of a home health aide when the local educational agency considers a less restrictive placement from home to school for a pupil. The statutory authority and reference for this regulation is Government Code section 7575, which requires the Department of Health Services, "*or any designated local agency administering the California Children's Services*," to be responsible for occupational therapy, physical therapy, and the services of a home health aide, as required by the IEP. The claimants, however, did not plead Government Code section 7575 in their test claims. In addition, there is no evidence in the record that local agencies administering the California Children's Services program have incurred increased costs mandated by the state. Accordingly, the Commission finds that section 60400 of the regulations does not impose any state-mandated activities on county mental health departments.

Accordingly, Government Code sections 7570, 7572, 7579, 7582, 7584, 7585, and 7587, as amended by the test claim legislation, and sections 60400 and 60510 of the regulations do not impose state-mandated duties on counties and, thus, are not subject to article XIII B, section 6 of the California Constitution.

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[33] The declarations submitted by the claimants here are from the county mental health departments. (See declaration of Paul McIver, District Chief, Department of Mental Health, County of Los Angeles; and declaration of Dan Souza, Mental Health Director for the County of Stanislaus.)

The remaining test claim statutes and regulations constitute a "program" within the meaning of article XIII B, section 6

The remaining test claim statutes and regulations consist of the following:

- Government Code sections 7572.55 (as added in 1994), and 7576 and 7586.6 (as amended in 1996); and
- With the exception of sections 60400 and 60510 of the regulations, the joint regulations adopted by the Departments of Mental Health and Education (Cal. Code Regs, tit. 2, §§ 60000 et seq.), which took effect as emergency regulations on July 1, 1998 (Register 98, No. 26) and became final on August 9, 1999 (Register 99, No. 33).

In order for the test claim statutes and regulations to be subject to article XIII B, section 6 of the California Constitution, the statutes and regulations must constitute a "program." The California Supreme Court, in the case of *County of Los Angeles* v. *State of California*[34], defined the word "program" within the meaning of article XIII B, section 6 as a program that carries out the governmental function of providing a service to the public, or laws which, to implement a state policy, impose unique requirements on local governments and do not apply generally to all residents and entities in the state. Only one of these findings is necessary to trigger the applicability of article XIII B, section 6.[35]

The test claim statutes and regulations involve the special education and related services provided to pupils. In 1988, the California Supreme Court held that education of handicapped children is "clearly" a governmental function providing a service to the public.[36] Thus, the remaining test claim statutes and regulations qualify as a program that is subject to article XIII B, section 6 of the California Constitution.

Issue 3: Do the remaining test claim statutes and regulations impose a new program or higher level of service on local agencies within the meaning of article XIII B, section 6 of the California Constitution?

This test claim addresses the statutory and regulatory changes made to the existing Handicapped and Disabled Students program. The courts have defined a "higher level of service" in conjunction with the phrase "new program" to give the subvention requirement of article XIII B, section 6 meaning. "Thus read, it is apparent that the subvention requirement for increased or higher level of service is directed to state-mandated increases in the services provided by local agencies in existing programs."[37] A statute or executive order imposes a reimbursable "higher level of service" when the statute or executive order, as compared to the legal requirements in effect immediately

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[34] *County of Los Angeles, supra,* 43 Cal.3d 46, 56.

[35] *Carmel Valley Fire Protection Dist., supra*, 190 Cal.App.3d at 537.

[36] *Lucia Mar Unified School District, supra*, 44 Cal.3d at page 835.

[37] *County of Los Angeles, supra*, 43 Cal.3d at page 56; *San Diego Unified School District, supra*, 33 Cal.4th at page 874.

before the enactment of the test claim legislation, increases the actual level of governmental service provided in the existing program.[38]

As indicated above, the original statutes in Chapter 26.5 of the Government Code were added by the Legislature in 1984 and 1985. In addition, pursuant to the requirements of Government Code section 7587, the Departments of Mental Health and Education adopted the first set of emergency regulations for the program in 1986. Although the history of the regulations states that the first set of emergency regulations were repealed on June 30, 1997, by operation of Government Code section 7587, and that a new set of regulations were not operative until one year later (July 1, 1998), the Commission finds, as described below, that the initial set of emergency regulations remained operative after the June 30, 1997 deadline, until the new set of regulations became operative in 1998. Thus, for purposes of analyzing whether the remaining test claim legislation constitutes a new program or higher level of service, the initial emergency regulations, and the 1984 and 1985 statutes in Chapter 26.5 of the Government Code, constitute the existing law in effect immediately before the enactment of the test claim legislation.

Government Code section 7587 required the Departments of Mental Health and Education to adopt emergency regulations by January 1, 1986, to implement the Handicapped and Disabled Students program. The statute, as amended in 1996 (Stats. 1996, ch. 654), further states that the emergency regulations "shall not be subject to automatic repeal until the final regulations take effect on or before June 30, 1997." Section 7587 states, in relevant part, the following:

> ...For the purposes of the Administrative Procedure Act, *the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare*. These regulations shall not be subject to the review and approval of the Office of Administrative Law and *shall not be subject to automatic repeal until the final regulations take effect on or before June 30, 1997*, and the final regulations shall become effective immediately upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments. (Emphasis added.)

The final regulations were not adopted by the June 30, 1997 deadline. Nevertheless, the courts have interpreted the time limits contained in statutes similar to Government Code section 7587 as directory and not mandatory. When a deadline in a statute is deemed directory, then the action required by the statute remains valid.[39] The California Supreme Court describes the general rule of interpretation as follows:

> Time limits are usually deemed to be directory unless the Legislature clearly expresses a contrary intent. [Citation omitted.] "In ascertaining

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[38] *San Diego Unified School Dist., supra,* 33 Cal.4th 859, 878; *Lucia Mar, supra*, 44 Cal.3d 830, 835.

[39] *California Correctional Peace Officers Association v. State Personnel Board* (1995) 10 Cal.4th 1133, 1145.

> probable intent, California courts have expressed a variety of tests. In some cases focus has been directed at the likely consequences of holding a particular time limitation mandatory, in an attempt to ascertain whether those consequences would defeat or promote the purpose of the enactment. . . .Other cases have suggested that a time limitation is deemed merely directory 'unless a consequence or penalty is provided for failure to do the act within the time commanded. [Citation omitted.] As *Morris v. County of Marin* [citation omitted] held, the consequence or penalty must have the effect of invalidating the government action in question if the limit is to be characterized as "mandatory."[40]

As determined by the California Supreme Court, time limits are usually deemed directory unless a contrary intent is expressly provided by the Legislature or there is a penalty for not complying with the deadline. In the present case, the plain language of Government Code section 7587 does *not* indicate that the Legislature intended the June 30, 1997 deadline to be mandatory, thus making the regulations invalid on that date. If that was the case, the state would be acting contrary to federal law by not having procedures in place for one year regarding the assessment, special education, and related services of a child suspected of needing mental health services necessary to preserve the child's right under federal law to receive a free and appropriate public education.[41] Instead, the plain language of the statute expresses the legislative intent that the regulations are "deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." This language supports the conclusion that the Legislature intended the original regulations to remain valid until new regulations were adopted.

This conclusion is further supported by the actions of the affected parties after the June 30, 1997 deadline. In 1998, individual plaintiffs filed a lawsuit seeking a writ of mandate directing the Departments of Mental Health and Education to adopt final regulations in accordance with Government Code section 7587.[42] As indicated in the petition for writ of mandate, the plaintiffs asserted that the original emergency regulations were enforced and applied after the June 30, 1997 deadline, that the Office of

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[40] *Ibid.*

[41] The requirements of the federal special education law (the Individuals with Disabilities Education Act (IDEA)) have been determined to constitute a federal mandate on the states. (*Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4th 1564, 1592.) Under federal law, states are required to provide specially designed instruction, at no cost to the parent, to meet the unique needs of a disabled pupil, including classroom instruction and related services, according to the pupil's IEP. (U.S.C., tit. 20 §§ 1400 et seq.; 34 C.F.R. § 300.343.) Related services include psychological services. (34 C.F.R. § 300.24.) Pursuant to federal regulations on the IEP process, the pupil must be evaluated in all areas of suspected disabilities by a multidisciplinary team. (34 C.F.R. § 300.502.)

[42] *McLeish and Ryan v. State Department of Education, et al.*, Sacramento Superior Court, Case No. 96CS01380.

Administrative Law did not provide notice of repeal of the regulations, and that the original emergency regulations were never deleted from the California Code of Regulations.[43] Ultimately, the parties stipulated to a judgment and writ that subsequent emergency regulations would be filed on or before July 1, 1998, to supercede the original emergency regulations, and that on or before September 24, 1999, the final regulations would be in full force and effect.[44] Thus, the parties affected by the original emergency regulations continued to act as if the regulations were still in effect.

Therefore, the Commission finds that the initial set of emergency regulations remained operative after the June 30, 1997 deadline, until the new set of regulations became operative in 1998. Thus, for purposes of analyzing whether the remaining test claim legislation constitutes a new program or higher level of service, there is no time gap between the original emergency regulations and the subsequent regulations adopted in July 1998. The initial emergency regulations, and the 1984 and 1985 statutes in Chapter 26.5 of the Government Code, constitute the valid, existing law in effect immediately before the enactment of the test claim legislation.

Accordingly, the issue before the Commission is whether the remaining test claim legislation [Gov. Code, § 7572.55, as added in 1994, and §§ 7576 and 7586.6, as amended in 1996, and the joint regulations adopted by the Departments of Mental Health and Education (Cal. Code Regs, tit. 2, §§ 60000 et seq.), which took effect as emergency regulations on July 1, 1998 (Register 98, No. 26) and became final on August 9, 1999 (Register 99, No. 33)] imposes a new program or higher level of service when compared to the legal requirements in effect immediately before the enactment of the test claim legislation, by increasing the actual level of governmental service provided in the existing program.

A. Interagency Agreements (Gov. Code, § 7586.6; Cal. Code Regs., tit. 2, § 60030)

Government Code section 7586.6

Government Code section 7586.6 was added by the test claim legislation in 1996 to address, in part, the interagency agreements between counties and local educational agencies. Government Code section 7586.6, subdivision (b), states the following:

> It is the intent of the Legislature that the designated local agencies of the State Department of Education and the State Department of Mental Health update their interagency agreements for services specified in this chapter at the earliest possible time. It is the intent of the Legislature that the state and local interagency agreements be updated at least every three years or earlier as necessary.

The plain language of Government Code section 7586.6, subdivision (b), states the "legislative intent" that the local interagency agreements be updated at least every three years or earlier as necessary.

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[43] See Petition for Writ of Mandamus, paragraphs 42 and 43, *McLeish, supra.*

[44] See Writ of Mandamus, *McLeish, supra.*

The Commission finds that Government Code section 7586.6 does not impose a new program or higher level of service. Even if legislative intent were determined to constitute a mandated activity, updating or renewing the interagency agreements every three years is not new and the level of service required of counties is not increased. Under prior law, former section 60030, subdivision (a)(2), of the regulations adopted by the Departments of Mental Health and Education required the local mental health director[45] and the county superintendent of schools to renew, and revise if necessary, the interagency agreements every three years or at any time the parties determine a revision is necessary.

Accordingly, the Commission finds that Government Code section 7586.6 does not impose a new program or higher level of service.

California Code of Regulations, title 2, section 60030

Section 60030 of the joint regulations governs the interagency agreements between counties and local educational agencies. Under prior law, the original emergency regulations required the development of an interagency agreement that included "a delineation of the process and procedure" for the following nine (9) items:

- Interagency referrals of pupils, which minimize time line delays. This may include written parental consent on the receiving agency's forms.
- Timely exchange of pupil information in accordance with applicable procedures ensuring confidentiality.
- Participation of mental health professionals, including those contracted to provide services, at IEP team meetings pursuant to Government Code sections 7572 and 7576.
- Developing or amending the mental health related service goals and objectives, and the frequency and duration of such services indicated on the pupil's IEP.
- Transportation of individuals with exceptional needs to and from the mental health service site when such service is not provided at the school.
- Provision by the school of an assigned, appropriate space for delivery of mental health services or a combination of education and mental health services to be provided at the school.
- Continuation of mental health services during periods of school vacation when required by the IEP.
- Identification of existing public and state-certified nonpublic educational programs, treatment modalities, and location of appropriate residential placements, which may be used for placement by the expanded IEP program team.

[45] Local mental health director is defined as "the officer appointed by the governing body of a county to manage a community mental health service." (Cal. Code Regs., tit. 2, § 60020, subd. (e).)

- Out-of-home placement of seriously emotionally disturbed pupils in accordance with the educational and treatment goals on the IEP.[46]

In addition, former section 60100, subdivision (a), of the regulations required the local mental health program and the SELPA liaison to define the process and procedures for coordinating services to promote alternatives to out-of-home care of seriously emotionally disturbed pupils. These requirements remain the law.

Section 60030 of the regulations, as replaced by the test claim legislation in 1998, now requires that the interagency agreement include a "delineation of the procedures" for seventeen (17) items. In this regard, section 60030, subdivision (c), requires that the following additional eight (8) procedures be identified in the interagency agreement:

- Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)
- A host county[47] to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
- Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)
- At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

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[46] Former California Code of Regulations, title 2, section 60030, subdivision (b).

[47] A "host county" is defined to mean the county where the pupil with a disability is living when the pupil is not living in the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (d).) The "county of origin" is defined as the county in which the parent of the pupil with disability resides. If the pupil is a ward or dependent of the court, an adoptee receiving adoption assistance, or a conservatee, the county of origin is the county where this status currently exists. (Cal. Code Regs., tit. 2, § 60020, subd. (b).)

- The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

According to the final statement of reasons prepared by the Departments of Education and Mental Health for the regulations, the section on interagency agreements was "expanded because experience in the field has shown that many local interagency agreements are not effective." The final statement of reasons further states that the regulation "requires stronger interagency agreements in order to improve local agencies' ability to adhere to the timelines required by law."[48]

Since the interagency agreement must now contain additional information, the Commission finds that section 60030 of the regulations imposes a new program or higher level of service for the one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:

- Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)
- A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
- Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)
- At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)

[48] Final Statement of Reasons, pages 10-11.

- The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)[49]

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

Government Code section 7576, as amended by the 1996 test claim statute (Stats. 1996, ch. 654), and sections 60040 and 60045 of the regulations govern the referral of a pupil suspected of needing mental health services to the county for an assessment. Under prior law, Government Code section 7572 and former section 60040 of the regulations required counties to perform the following referral and assessment activities:

- Review the following educational information of a pupil referred to the county by a local education agency for an assessment: a copy of the assessment reports completed in accordance with Education Code section 56327, current and relevant behavior observations of the pupil in a variety of educational and natural settings, a report prepared by personnel that provided "specialized" counseling and guidance services to the pupil and, when appropriate, an explanation why such counseling and guidance will not meet the needs of the pupil.
- If necessary, observe the pupil in the school environment to determine if mental health assessments are needed.
- If mental health assessments are deemed necessary by the county, develop a mental health assessment plan and obtain the parent's written informed consent for the assessment.
- Assess the pupil within the time required by Education Code section 56344.

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[49] The Counties of Los Angeles and Stanislaus, in comments to the draft staff analysis, argue that revising the interagency agreement in accordance with section 60030 of the regulations is not a one-time activity. The County of Los Angeles argues "the negotiation, development, and periodic revision and review of Interagency Agreements require a variety of time consuming activities over an extended period of time." The County of Stanislaus contends that the interagency agreement is a living, breathing document. However, as indicated in the analysis, periodic renewal and revision of the agreements, which are ongoing activities, are not new. Counties were required to perform these activities every three years under the prior regulations. (Former Cal. Code Regs., tit. 2, § 60030.) Reimbursement for the ongoing activities of renewing the interagency agreements every three years and revising if necessary are addressed in the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10).

- If a mental health assessment cannot be completed within the time limits, provide notice to the IEP team administrator or designee no later than 15 days before the scheduled IEP meeting.
- Prepare and provide to the IEP team, and the parent or guardian, a written assessment report in accordance with Education Code section 56327. The report shall include the following information: whether the pupil may need special education and related services; the basis for making the determination; the relevant behavior noted during the observation of the pupil in the appropriate setting; the relationship of that behavior to the pupil's academic and social functioning; the educationally relevant health and development, and medical findings, if any; for pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services; a determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate; and the need for specialized services, materials, equipment for pupils with low incidence disabilities.
- Review and discuss the county recommendation with the parent and the appropriate members of the IEP team before the IEP team meeting.
- In cases where the local education agency refers a pupil to the county for an assessment, attend the IEP meeting if requested by the parent.
- Review independent assessments of a pupil obtained by the parent.
- Following review of the independent assessment, discuss the recommendation with the parent and with the IEP team before the meeting of the IEP team.
- In cases where the parent has obtained an independent assessment, attend the IEP team meeting if requested.

These activities are still required by law. However, the test claim legislation requires counties to perform additional activities. For example, Government Code section 7576, subdivision (b)(1), mandates a new program or higher level of service by requiring the county and the local educational agency to "work collaboratively to ensure that assessments performed *prior to referral* are as useful as possible to the community mental health service [i.e., the county] in determining the need for mental health services and the level of services needed." (Emphasis added.)

In addition, Government Code section 7576, subdivision (g), and section 60040, subdivision (g), mandate a new program or higher level of service by requiring a county that receives a referral for a pupil with a different county of origin, to forward the referral within one working day to the county of origin. The county of origin shall then have the programmatic and fiscal responsibility for providing or arranging for the provision of necessary services for the pupil.

Furthermore, section 60045 of the regulations addresses the assessment of a pupil and imposes new, required activities on counties. Under prior law, counties were required to determine if a mental health assessment of a pupil is necessary. (Former Cal. Code Regs., tit. 2, § 60040, subd. (d).) Section 60045 retains that requirement, and also

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

Section 60045, subdivision (a)(2), now requires that if the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral.

Section 60045, subdivision (b), provides that "if a mental health assessment is determined to be necessary," the community mental health service shall notify the local educational agency, develop a mental health assessment plan, and provide the plan and a consent form to the parent." Under prior law, counties were required to develop a mental health assessment plan and provide a consent form for the assessment to the parent. (Former Cal. Code Regs., tit. 2, § 60040, subd. (d).) However, the activities to notify the local educational agency when an assessment is determined necessary, and to provide the assessment plan to the parent are new activities.

Although section 60045, subdivisions (a) and (b), includes language that implies that the activities are within the discretion of the county (e.g., the activity is required "if no mental health assessment is determined necessary"), the Commission finds that these activities are mandated by the state when necessary to provide the pupil with a free and appropriate education under federal law. Under the rules of statutory construction, section 60045, subdivisions (a) and (b), must be interpreted in the context of the entire statutory scheme so that the statutory scheme may be harmonized and have effect.[50] In addition, it is presumed that the administrative agency, like the Departments of Mental Health and Education, did not adopt a regulation that alters the terms of a legislative enactment.[51] Federal law, through the IDEA, requires the state to *identify*, locate, and evaluate *all* children with disabilities, including children attending private schools, who are in need of special education and related services.[52] The state is also required by federal law to conduct a full and individual initial evaluation to determine whether a child has a qualifying disability, and the educational needs of the child.[53] In addition, Government Code section 7572, subdivision (a), requires that a child shall be assessed in all areas related to the suspected handicap by those qualified to make a determination of the child's need for the service. In cases where the pupil is suspected of needing mental health services, the state has delegated to the counties the activity of assessing the need for service. Accordingly, the Commission finds that the section 60045, subdivisions (a) and (b), mandate the following new activities that constitute a new program or higher level of service:

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[50] *Select Base Materials v. Board of Equalization* (1959) 51 Cal.2d 640, 645; *City of Merced v. State of California* (1984) 153 Cal.App.3d 777, 781-782.

[51] *Wallace v. State Personnel Board* (1959) 168 Cal.App.2d 543, 547.

[52] 20 United States Code section 1412, subdivision (a)(3).

[53] 20 United States Code section 1414, subdivision (a).

- If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and local educational agency of the county determination within one working day.
- If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral.
- Notify the local educational agency when an assessment is determined necessary.
- Provide the assessment plan to the parent.

Furthermore, section 60045, subdivision (c), requires counties to perform a new activity to "report back to the referring [local educational agency] or IEP team within 30 days from the date of the receipt of the referral . . . if no parental consent for a mental health assessment has been obtained." The Commission finds this activity constitutes a new program or higher level of service.

The Commission further finds that section 60045, subdivision (d), mandates a new program or higher level of service on counties by requiring counties to notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. This activity was not required under prior law.

The Commission also finds that section 60045, subdivision (f)(1), mandates a new program or higher level of service on counties by requiring counties to provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. As enacted before the test claim legislation, Government Code section 7572, subdivision (d)(1), requires that the parent be notified in writing of this parental right. But Government Code section 7572, subdivision (d)(1), does not specify the agency that is required to provide the written notice. Thus, section 60045, subdivision (f)(1), delegates the responsibility to the county.

Finally, section 60045, subdivision (h), mandates a new program or higher level of service by requiring the county of origin to prepare statutorily required IEP reassessments. Pursuant to federal law, yearly reassessments are required to determine the needs of the pupil.[54]

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

The Departments of Education and Mental Health adopted a new regulation in section 60055 to address the interim placement of a pupil receiving mental health services pursuant to an existing IEP following the pupil's transfer to a new school district. Section 60055 states the following:

> (a) Whenever a pupil who has been receiving mental health services, pursuant to an IEP, transfers into a school district from a school district in another county, the responsible LEA [local educational

[54] 34 Code of Federal Regulations, section 300.343.

agency] administrator or IEP team shall refer the pupil to the local community mental health service [county] to determine appropriate mental health services.

(b) The local mental health director or designee shall ensure that the pupil is provided interim mental health services, as specified in the existing IEP, pursuant to Section 56325 of the Education Code, for a period not to exceed thirty (30) days, unless the parent agrees otherwise.

(c) An IEP team, which shall include an authorized representative of the responsible community mental health service, shall be convened by the LEA to review the interim services and make a determination of services within thirty (30) days of the pupil's transfer.

According to the final statement of reasons, section 60055 "conforms with and implements Education Code section 56325 which ensures that special education pupils continue to receive services after they transfer into a new school district or SELPA. This section is intended to address implementation problems in these situations reported by the field in which eligible pupils were denied services due to an inter-county transfer."[55]

The Commission finds that section 60055 mandates a new program or higher level of service on counties, following a pupil's transfer to a new school district, by requiring them to perform the following activities:

- Provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.
- Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.

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

Under existing law, when a child is assessed as seriously emotionally disturbed and any member of the IEP team recommends residential placement, the IEP team shall be expanded to include a representative of the county. The expanded IEP team is required to review the assessment and determine whether: (1) the child's needs can reasonably be met through any combination of nonresidential services, preventing the need for out-of-home care; (2) residential care is necessary for the child to benefit from educational services; and (3) residential services are available, which address the needs identified in the assessment and which will ameliorate the conditions leading to the seriously emotionally disturbed designation. The expanded IEP team is also required to consider all possible alternatives to out-of-home placement. (Gov. Code, § 7572.5, former Cal. Code Regs, tit. 2, § 60100.) Finally, the expanded IEP team is required to document the

[55] Final Statement of Reasons, page 20.

pupil's educational and mental health treatment needs that support the recommendation for the placement. (Former Cal. Code Regs, tit. 2, § 60100, subd. (e).)

These activities remain the law and counties are currently eligible for reimbursement for their participation on the expanded IEP team.[56] However, the test claim legislation amended the law with respect to the activities performed by the expanded IEP team.

In 1994, the Legislature added section 7572.55 to the Government Code (Stats. 1994, ch. 1128). Government Code section 7572.55, subdivision (c), requires the expanded IEP team, when a recommendation is made that a child be placed in an *out-of-state* residential facility, to develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school.

In addition, section 60100 of the regulations, as adopted in 1998, requires the expanded IEP team to perform the following activities:

- The expanded IEP team shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)
- The expanded IEP team shall ensure that placement is in accordance with admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)

The Department of Finance contends that these activities performed by the expanded IEP team do not constitute a new program or higher level of service. The Department states the following:

> It is our interpretation that there is no meaningful difference between the requirements under the prior regulations and the new regulations with respect to identifying, analyzing, and documenting all alternatives to residential placement. The existing activities of considering "all possible alternatives to out-of-home placement" and documenting "the pupil's educational and mental health treatment needs that support the recommendation for the placement" would already include the development of a plan for using less restrictive and in-state alternatives and documentation of the reasons why these alternatives were rejected. It is not clear that the new requirements cited above impose a new or higher level of service.[57]

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[56] For this reason, the Commission agrees with a comments filed by the Counties of Los Angeles and Stanislaus on the draft staff analysis that the county's participation on the expanded IEP team occurs when there is a recommendation for out-of-home placement, regardless of whether the recommendation is for a facility in the state or a facility out of the state. This test claim, however, addresses only the new activities required by the Government Code sections and regulations for which the Commission has jurisdiction (i.e., Gov. Code, § 7572.55, as added by Stats. 1994, ch. 1128, and the 1998 regulations.)

[57] Department of Finance comments to the draft staff analysis.

The Commission disagrees. First, the activity required by Government Code section 7572.55, subdivision (c), to develop a plan for using less restrictive alternatives and in-state alternatives when a recommendation is made that a child be placed in an out-of-state facility, is a new requirement. Government Code section 7572.55 was *added* by the test claim legislation. Under prior law, the expanded IEP team was only required to "consider" all possible alternatives to residential placement. The express language of prior law did not require the expanded IEP team to develop a plan for using less restrictive alternatives specifically for out-of-state placements. Thus, the Commission finds that Government Code 7572.55, subdivision (c), imposes a new program or higher level of service with regard to the counties' participation on the expanded IEP team.

The Commission further finds that the two activities mandated by section 60100 are new activities, not required under prior law. Section 60100, subdivision (c), requires the expanded IEP team to document the alternatives to residential placement that were considered and the reasons why they were rejected. Under prior law, the expanded IEP team was required to "consider" all possible alternatives to residential placement. Prior law also required the expanded IEP team to document the pupil's educational and mental health treatment needs that support the final recommendation for the placement. But prior law did not require the expanded IEP team to document the alternatives to residential placement that were considered by the team and the reasons why the alternatives were rejected. Thus, the Commission finds that section 60100, subdivision (c), imposes a new program or higher level of service.

Moreover, the Commission finds that the activity required by section 60100, subdivision (j), imposes a new program or higher level of service by requiring, for the first time, that the expanded IEP team ensure that placement is in accordance with admission criteria of the facility.

Finally, when the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties are now required to ensure that: (1) the mental health services are specified in the IEP in accordance with federal law; and (2) the mental health services are provided by qualified mental health professionals.[58] (Cal. Code Regs., tit. 2, § 60100, subd. (i).) Counties were not required to perform these activities under prior law. Therefore, the Commission finds that the activities required by section 60100, subdivision (i), constitute a new program or higher level of service.

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

Under existing law, Government Code section 7572.5, subdivision (c)(1), requires the county to act as the lead case manager if the review of the expanded IEP team calls for residential placement of the seriously emotionally disturbed pupil. The statute further

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[58] Section 60020 defines "qualified mental health professional" to include the following licensed practitioners of the healing arts: a psychiatrist; psychologist; clinical social worker; marriage, family and child counselor; registered nurse, mental health rehabilitation specialist, and others who have been waivered under Welfare and Institutions Code section 5751.2.

requires that "the mental health department shall retain financial responsibility for provision of case management services." Former section 60110, subdivision (a), required the following case management duties:

- Convene parents and representatives of public and private agencies in accordance with section 60100, subdivision (f), in order to identify the appropriate residential facility.
- Complete the local mental health program payment authorization in order to initiate out of home care payments.
- Coordinate the completion of the necessary County Welfare Department, local mental health program, and responsible local education agency financial paperwork or contracts.
- Develop the plan for and assist the family and pupil in the pupil's social and emotional transition from home to the residential facility and the subsequent return to the home.
- Facilitate the enrollment of the pupil in the residential facility.
- Conduct quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services and the IEP.
- Notify the parent or legal guardian and the local education agency administrator or designee when there is a discrepancy in the level of care, supervision, provision of treatment services, and the requirements of the IEP.
- Coordinate the six-month expanded IEP team meeting with the local education agency administrator or designee.

Sections 60100 and 60110 of the regulations, as adopted in 1998, require county case managers to perform the following new activities not required under prior law:

- Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)[59]
- When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with

[59] Although the regulation requires the county case manager to plan for the educational needs of a pupil placed in a residential facility, the local educational agency is ultimately responsible for "providing or arranging for the special education and non-mental health related services needed by the pupil. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(2); Final Statement of Reasons, p. 24.)

admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)[60]

- Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).) Under prior law, the expanded IEP team identified the placement. (Former Cal. Code Regs., tit. 2, § 60100, subd. (f).)
- Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)
- Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)
- Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)[61]

The Commission finds that the new activities bulleted above constitute a new program or higher level of service.

In addition, the language for some of the case management activities required under existing law was amended by section 60110 of the test claim legislation. Thus, the issue is whether the amended language mandates an increase in the level of service provided by the county case manager.

For example, existing law required counties to "conven[e] parents and representatives of public and private agencies in accordance with subsection (f) of Section 60100 in order to identify the appropriate residential placement." (Former Cal. Code Regs., tit. 2, § 60110,

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[60] A "community treatment facility" is defined in section 60025 of the regulations to mean "any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure confinement. The facility's program components shall be subject to program standards developed and enforced by the State Department of Mental Health pursuant to Section 4094 of the Welfare and Institutions Code."

[61] Welfare and Institutions Code section 4094.5, subdivision (e)(1), states in relevant part that "[t]he child shall, prior to admission, have been determined to be in need of the level of care provided by a community treatment facility, by a county interagency placement committee ..."

subd. (c)(1).) Section 60110, subdivision (c)(1), as replaced by the test claim legislation, amended the regulation, in relevant part, by requiring the county case manager to include "educational staff" in the meeting. The Commission finds that the requirement to include "educational staff" in the meeting does not increase the level of service required by county case managers. The old regulation required county case managers to convene the meeting with "representatives of public agencies." For purposes of this program, "representatives of public agencies" includes educational staff.[62] Thus, section 60110, subdivision (c)(1), does not impose a new program or higher level of service.

Furthermore, former section 60110, subdivision (c)(8), required case managers to conduct quarterly face-to-face contacts with the pupil at the residential facility to monitor the level of care and supervision and the implementation of the treatment services as required by the IEP. That requirement remains the law. However, section 60110, subdivision (c)(8), as replaced by the test claim legislation, requires the case manager to also evaluate "the continuing stay criteria" of a pupil placed in a community treatment facility on a quarterly basis:

> In addition, for children placed in a community treatment facility, an evaluation shall be made within every 90 days of the residential placement of the pupil to determine if the pupil meets the continuing stay criteria as defined in Welfare and Institutions Code section 4094 and implementing mental health regulations.

Pursuant to Department of Mental Health regulations, the continuing stay criteria require the case manager and the community treatment facility psychiatrist to evaluate and document the continued placement of the pupil in the community treatment facility.[63]

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[62] See section 60000 of the regulations, which provides that "this chapter applies to the State Departments of Mental Health, Social Services, and their designated local agencies, and the California Department of Education, school districts, county offices, and special education local plan areas."

[63] California Code of Regulations, title 9, section 1924, defines the "continuing stay criteria" for this program as follows:

> (b) Individuals who are special education pupils identified in paragraph (4) of subdivision (c) of Section 56026 of the Education Code and who are placed in a CTF [community treatment facility] prior to age eighteen (18) pursuant to Chapter 26.5 of the Government Code may continue to receive services through age 21 provided the following conditions are met:
>
> (1) They continue to satisfy the requirements of subsection (a) [documentation by the CTF psychiatrist and the case manager supporting the continued placement of the pupil in the community treatment facility];
>
> (2) They have not graduated from high school;
>
> (3) They sign a consent for treatment and a release of information for CTF staff to communicate with education and county mental health

The Commission finds that the evaluation every 90 days of the continuing stay criteria of a pupil placed in a community treatment facility, as required by section 60110, subdivision (c)(8), constitutes a new program or higher level of service.

Finally, under prior law, the expanded IEP team was required to review the case progress, the continuing need for out-of-home placement, the extent of compliance with the IEP, and progress toward alleviating the need for out-of-home care "at least every six months." (Gov. Code, § 7572.5, subd. (c)(2).) In addition, former section 60110, subdivision (c)(10), required case managers to "coordinate the six-month expanded IEP team meeting with the local educational agency administrator or designee."

Section 60110, subdivision (c)(10), as adopted by the test claim legislation in 1998, replaced the requirement imposed on the case manager to "coordinate" the expanded six-month IEP team meeting, with the requirement to "schedule and attend" the six-month expanded IEP team meeting. Section 60110, subdivision (c)(10), states the following:

> Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement.

The Commission finds that section 60110, subdivision (c)(10), increases the level of service required of counties. Under the prior requirement, case managers were required to coordinate the expanded IEP team meeting every six months. Case managers are now required to schedule the meeting. The activities of "coordinating" and "scheduling" are different. To "coordinate" means to "to place in the same order, class, or rank; to harmonize in a common effort; to work together harmoniously." To "schedule" means "to plan or appoint for a certain date or time." [64] In addition, although a representative from the county is a member of the IEP team, there was no requirement that the case manager, who may be a different person than the IEP team member, attend the IEP team meeting.[65] Therefore, the Commission finds that section 60110, subdivision (c)(10), of the regulations constitutes a new program or higher level of service for the activity of scheduling and attending the six-month expanded IEP team meetings.

> professionals after staff have informed them of their rights as an adult;
>
> (4) A CTF obtains an exception from the California Department of Social Services to allow for the continued treatment of the young adult in a CTF... .

[64] Webster's II New College Dictionary (1999) pages 248, 987.

[65] Existing law authorizes the county to delegate the case management responsibilities to the county welfare department. (Gov. Code, § 7572.5, subd. (c)(1).)

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

Pursuant to existing law, counties are financially responsible for 60 percent of the total residential and non-educational costs of a seriously emotionally disturbed pupil placed in an out-of-home residential facility. The residential and non-educational costs include the costs for food, clothing, shelter, daily supervision, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. (Gov. Code, § 7581, former Cal. Code Regs., tit. 2, § 60200, subd. (e), Welf. & Inst. Code, § 15200, subd. (c)(1).) The counties' financial responsibility for the residential and non-educational costs of pupils placed out of the home remain the law today.

In addition, former section 60200 of the regulations required the county welfare department to issue the payments to providers of out-of-home facilities in accordance with Welfare and Institutions Code section 18351, upon receipt of authorization documents from the State Department of Mental Health *or* a designated county mental health agency. The authorization documents are required to include information sufficient to demonstrate that the child meets all eligibility criteria established in the regulations for this program. (Welf. & Inst. Code, § 18351.)

The county welfare department is still required to issue payments to the residential facilities under section 60200, subdivision (e), of the regulations, as replaced in 1998. However, the regulation now requires the county community mental health service to authorize the payment to the residential facility before the county welfare agency can issue the payment. Subdivision (e) states, "[t]he community mental health service shall be responsible for authorizing payment to the facilities listed in Section 60025 based upon rates established by the Department of Social Services in accordance with Sections 18350 through 18356 of the Welfare and Institutions Code."

The Department of Finance contends that "[a]ccording to the Department of Social Services, there is no meaningful difference between the requirements under the prior regulations and the new regulations with respect to authorizing payments to the out-of-home residential facilities." The Department further states that "the child's mental health caseworker is already required to participate in the development of the IEP, and this IEP could constitute the authorizing paperwork that is presented to the county child welfare department to initiate payment for residential treatment." Thus, the Department argues that "[i]t is not clear that the new requirement . . . would impose a new or higher level of service."[66]

The Commission disagrees with the Department's interpretation of section 60200 of the regulations. The same rules of construction applicable to statutes govern the interpretation of administrative regulations. Thus, the Commission, like a court, should attempt to ascertain the intent of the regulating agency.[67]

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[66] Department of Finance comments to the draft staff analysis.

[67] *Goleta Valley Community Hospital v. Department of Health Services* (1984) 149 Cal.App.3d 1124, 1129.

As indicated above, prior law specified that either the Department of Mental Health or a designated county mental health agency provided the authorization documents before payment to the residential facility could be issued. According to the final statement of reasons prepared by the Departments of Mental Health and Education for the 1998 regulations, section 60200, subdivision (e), now assigns the responsibility of authorizing payments to the residential facilities solely to the county community mental health service. The final statement of reasons also states that it is the responsibility of the county to determine that the residential placement meets all of the criteria established in Welfare and Institutions Code sections 18350 through 18356. The final statement of reasons for this regulation expressly provides the following:

> Subsection (e) assigns the responsibility for authorizing payment for board and care to the community mental health service. It is the responsibility of the community mental health service to determine that the residential placement meets all of the criteria established in Sections 18350 through 18356 of the Welfare and Institutions Code. These sections of code also refer to Section 11460 of the Welfare and Institutions Code which state that rates will be established by CDSS, and outline certain requirements in order for facilities to be eligible for payment."[68]

Thus, compliance with section 60200, subdivision (e), of the regulations requires the counties to determine that the residential placement meets all of the criteria established in the Welfare and Institutions Code before authorizing payment. The final statement of reasons suggests that the requirement to authorize payment to residential facilities may not be satisfied by simply providing the IEP to the county welfare department.

The Department of Social Services has not provided the Commission with any comments on this test claim. In addition, the argument asserted by the Department of Finance is not supported with documentary evidence or declarations signed under the penalty of perjury, as required by the Commission's regulations. (Cal. Code Regs., tit. 2, § 1183.02, subd. (c).)

Accordingly, the Commission finds that authorizing payments to the residential facilities in accordance with section 60200, subdivision (e), constitutes a new program or higher level of service.

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

Pursuant to existing law, counties are required to provide psychotherapy or other mental health treatment services to a pupil, either directly or by contract, when required by the pupil's IEP. (Gov. Code, § 7576; former Cal. Code Regs., tit. 2, § 60200, subd. (b).) Under the former regulations, "psychotherapy and other mental health services" were defined to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).)

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[68] Final Statement of Reasons, page 26.

The regulations adopted by the Departments of Education and Mental Health in 1998 modified these activities. For example, section 60200, subdivision (c)(1), adds new requirements when a pupil receives mental health services in a host county. Under such circumstances, the county of origin (the county where the parent resides, the pupil receives adoption assistance, or where the pupil is a ward of the court, for example) is financially responsible for the mental health services, even though the services are provided in a host county. (Cal. Code Regs., tit. 2, § 60200, subd. (c).) Section 60200, subdivision (c)(1), states the following:

> The host county shall be responsible for making its provider network available and shall provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. Counties of origin shall negotiate with host counties to obtain access to limited resources, such as intensive day treatment and day rehabilitation.

Thus, the Commission finds that section 60200, subdivision (c)(1), of the regulations mandates a new program or higher level of service for the following new activities:

- The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals.
- The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation.

In addition, section 60020, subdivision (i), changed the definition of mental health services. As indicated above, the former regulations defined "psychotherapy and other mental health services" to include the day services and outpatient services identified in sections 542 and 543 of the Department of Mental Health regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Under the prior regulations, these services included the following: day care intensive services, day care habilitative (counseling and rehabilitative) services, vocational services, socialization services, collateral services, assessment, individual therapy, group therapy, medication (including the prescribing, administration, or dispensing of medications, and the evaluation of side effects and results of the medication), and crisis intervention.

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

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

Section 60020 of the test claim regulations continues to include mental health assessments, collateral services, intensive day treatment, and day rehabilitation within the definition of "mental health services." These services are not new.[69]

However, the activities of crisis intervention, vocational services, and socialization services were deleted by the test claim regulations. The final statement of reasons, in responding to a comment that these activities remain in the definition of "mental health services," states the following:

> The provision of vocational services is assigned to the State Department of Rehabilitation by Government Code section 7577.
>
> Crisis service provision is delegated to be "from other public programs or private providers, as appropriate" by these proposed regulations in Section 60040(e) because crisis services are a medical as opposed to educational service. They are, therefore, excluded under both the Tatro and Clovis decisions. These precedents apply because "medical" specialists must deliver the services. A mental health crisis team involves specialized professionals. Because of the cost of these professional services, providing these services would be a financial burden that neither the schools nor the local mental health services are intended to address in this program.
>
> The hospital costs of crisis service provision are explicitly excluded from this program in the Clovis decision for the same reasons.
>
> Additionally, the IEP process is one that responds slowly due to the problems inherent in convening the team. It is, therefore, a poor avenue for the provision of crisis services. While the need for crisis services can be a predictable requirement over time, the particular medical requirements of the service are better delivered through the usual local mechanisms established specifically for this purpose.[70]

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

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[69] The County of Los Angeles, in comments to the draft staff analysis, argues that all activities specified in section 60020, subdivision (i), should be reimbursable under this test claim. The County of Stanislaus filed similar comments. As indicated in the analysis, however, the activities of mental health assessments, collateral services, intensive day treatment, and case management, are not new activities. Counties were required to perform these activities under the prior regulations. (Former Cal. Code Regs., tit. 2, § 60020, subd. (a).) Reimbursement for the activities of mental health assessments, collateral services, intensive day treatment, and case management, are addressed in the reconsideration of the original *Handicapped and Disabled Students* program (04-RL-4282-10).

[70] Final Statement of Reasons, pages 55-56.

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

> No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organizations or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.
>
> The application of these principles and methods includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups.
>
> Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes and behavior which are emotionally, intellectually, or socially ineffectual or maladjustive.

The Commission finds that providing the services of case management and psychotherapy, as defined in Business and Professions Code section 2903, to a pupil when required by the pupil's IEP constitutes a new program or higher level of service.

Furthermore, under prior law, mental health services included prescribing, administering, and dispensing medications, and evaluating the side effects and results of the medication. Section 60020, subdivision (i), now includes "medication monitoring" within the provision of mental health services. "Medication monitoring" is defined in section 60020, subdivision (f), as follows:

> "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.

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.[71]

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.[72] 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.[73] The courts will not infer that the intent was only to clarify the law when a statute or regulation is amended unless the nature of the amendment clearly demonstrates the case.[74]

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."[75] To "monitor" means to "to keep watch over; supervise."[76] 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

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[71] Department of Finance comments to draft staff analysis.

[72] *Goleta Valley Community Hospital v. Department of Health Services* (1984) 149 Cal.App.3d 1124, 1129.

[73] *Garrett v. Young* (2003) 109 Cal.App.4th 1393, 1404-1405.

[74] *Medina v. Board of Retirement, Los Angeles County Employees Retirement Assn.* (2003) 112 Cal.App.4th 864, 869-870.

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

[76] *Id.* at page 708.

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.[77]

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.

Finally, section 60050 was added by the test claim legislation to address the completion or termination of IEP health services. In relevant part, section 60050, subdivision (b), states the following:

> When completion or termination of IEP specified health services is mutually agreed upon by the parent and the community mental health service, or when the pupil is no longer participating in treatment, the community mental health service shall notify the parent and the LEA which shall schedule an IEP meeting to discuss and document this proposed change it if is acceptable to the IEP team.

The Commission finds that section 60050, subdivision (b), mandates a new program or higher level of service by requiring counties to notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of the service, or when the pupil is no longer participating in treatment.

H. Participation in Due Process Hearings (Cal. Code Regs., tit. 2, § 60550)

The County of Los Angeles argues that a county's participation in a due process hearing, which resolves disputes between a parent and a public agency regarding special education and related services, is reimbursable. The County further argues that reimbursement should cover the costs for "participation in mediation conferences, travel costs associated with dispute resolution, preparation of witnesses and documentary evidence, as well as participation in administrative hearings ..."[78] The Commission disagrees.

Under existing law, due process procedures are in place to resolve disputes between a parent and a public agency regarding the special education and related services, including mental health services provided to a pupil by a county under the Handicapped and Disabled Students program. Government Code section 7586, as originally enacted in 1984, requires all state departments and their designated local agencies, including counties, to be governed by the procedural due process protections required by federal law. Government Code section 7586, subdivision (a), states the following:

> All state departments, and their designated local agencies, shall be governed by the procedural safeguards required in Section 1415 of

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[77] Final Statement of Reasons, page 7.

[78] County of Los Angeles' comments to the draft staff analysis.

> Title 20 of the United States Code. A due process hearing arising over a related service or designated instruction and service shall be filed with the Superintendent of Public Instruction. Resolution of all issues shall be through the due process hearing process established in Chapter 5 (commencing with Section 56500) of Part 30 of Division 4 of the Education Code. The decision issued in the due process hearing shall be binding on the department having responsibility for the services in issue as prescribed by this chapter.

Pursuant to the former regulations, counties were required to participate in the due process hearings relating to issues involving mental health assessments or services and were required to prepare documentation and provide testimony supporting the county's position. (Former Cal. Code Regs., tit. 2, § 60550.) Counties are currently eligible for reimbursement for their participation in the due process hearings.

The test claim legislation, section 60550 of the regulations, as enacted in 1998, does not increase the level of service provided by counties with respect to the due process hearings. Counties are still subject to the due process hearing procedures as they were under prior law, and are still required to prepare documentation and provide testimony to support its position. According to the final statement of reasons, the amendments in the regulation, with respect to the county, simply reflect the deletion of the Office of Administrative Hearings from the hearing process.

Therefore, the Commission finds that section 60550 does not mandate that counties perform new activities or increase their level of service. Therefore, section 60550 of the regulations does not impose a new program or higher level of service on counties.

I. Compliance Complaints (Cal. Code Regs., tit. 2, § 60560)

The County of Stanislaus requests reimbursement for defending against an allegation that the county has not complied with the regulations for this program, in accordance with section 60560 of the regulations. Section 60560 states that "[a]llegations of failure by an LEA, Community Mental Health Services or CCS to comply with these regulations, shall be resolved pursuant to [sections 4600 et seq. of the Department of Education regulations]."

The Commission finds that the compliance complaint procedure established by section 60560 does not constitute a new program or higher level of service. The compliance complaint procedures, as they relate to the counties' participation in the Handicapped and Disabled Students program, have been in the law since 1991. Section 4650 of the Department of Education regulations (the regulation cited as the authority for section 60560 of the joint regulations in this case) addresses compliance complaints and was adopted in 1991.[79] Section 4650, subdivision (a)(viii), states in relevant part the following:

> For complaints relating to special education the following shall also be conditions for direct state intervention:

[79] California Code of Regulations, title 5, section 4650.

(A) The complainant alleges that a public agency, other than a local educational agency, as specified in Government Code section 7570 et seq., fails or refuses to comply with an applicable law or regulation relating to the provision of free appropriate public education to handicapped individuals ...

Therefore, the Commission finds that section 60560 does not constitute a new program or higher level of service.

J. Interagency Dispute Resolution (Cal. Code Regs., tit. 2, §§ 60600, 60610)

The County of Stanislaus requests reimbursement for the counties' participation in interagency dispute resolution procedures, in accordance with sections 60600 and 60610 of the regulations. These regulations implement Government Code section 7585, which was enacted in 1984. Government Code section 7585 provides that whenever any department or local agency designated by that department fails to provide a related service specified in a pupil's IEP, the parent, adult pupil, or any local educational agency shall submit a written notification of the failure to provide the service to the Superintendent of Public Instruction or the Secretary of Health and Welfare. The superintendent and the secretary, or their designees, shall meet to resolve the issue within 15 days. If the issue cannot be resolved, the matter is referred to the Office of Administrative Hearings, whose decision is binding on the parties. Under prior regulations (former section 60610), once the dispute resolution procedures have been completed, the agency determined responsible for the service shall pay for, or provide the service, and shall reimburse the other agency that provided the service, if applicable.

Sections 60600 and 60610, as adopted in 1998, do not change the prior dispute resolution procedures. The level of participation by the county under the interagency dispute resolution procedures remains the same.

Therefore, the Commission finds that sections 60600 and 60610 of the regulations do not mandate a new program or higher level of service on counties.

Issue 4: Do the test claim statutes and regulations impose costs mandated by the state within the meaning of article XIII B, section 6 and Government Code section 17514?

As indicated above, the Commission finds that the following activities mandate a new program or higher level of service on counties:

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

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

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

- A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
- Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)
- At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)
- The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

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

- Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)
- A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)
- If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)

- If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)
- Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)
- Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)
- Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)
- Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)
- Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)
- The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

3. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)
   - Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.
   - Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.
4. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)
   - When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)
   - The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)

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

5. Case Management Duties for Pupils Placed in Residential Care (Cal. Code Regs., tit. 2, §§ 60100, 60110)
   - Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)
   - When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)
   - Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)
   - Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)
   - Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)
   - Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)

- Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)
- Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

6. Authorize Payments to Out-Of-Home Residential Care Providers (Cal. Code Regs., tit. 2, § 60200, subd. (e))
   - Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356.
7. Provide Psychotherapy or Other Mental Health Treatment Services (Cal. Code Regs., tit. 2, §§ 60020, subd. (i), 60050, subd. (b), 60200, subd. (c))
   - The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
   - 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).)
   - Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

In order for the activities listed above to impose a reimbursable, state-mandated program under article XIII B, section 6 of the California Constitution, two additional elements must be satisfied. First, the activities must impose costs mandated by the state pursuant to Government Code section 17514.[80] Second, the statutory exceptions to reimbursement listed in Government Code section 17556 cannot apply.

Government Code section 17514 defines "costs mandated by the state" as any increased cost a local agency or school district is required to incur as a result of a statute that mandates a new program or higher level of service.

Government Code section 17556 states that the Commission shall not find costs mandated by the state, as defined in section 17514, in any claim submitted by a local agency or school district, if, after a hearing, the commission finds that:

> (a) The claim is submitted by a local agency or school district that requested legislative authority for that local agency or school district to implement the program specified in the statute, and that statute imposes costs upon that local agency or school district requesting the legislative authority. A resolution from the governing body or a letter from a delegated representative of the governing body of a local agency or school district that requests authorization for that local agency or school district to implement a given program shall constitute a request within the meaning of this paragraph.
>
> (b) The statute or executive order affirmed for the state a mandate that had been declared existing law or regulation by action of the courts.
>
> (c) The statute or executive order imposes a requirement that is mandated by a federal law or regulation and results in costs mandated by the federal government, unless the statute or executive order mandates costs that exceed the mandate in that federal law or regulation. This subdivision applies regardless of whether the federal law or regulation was enacted or adopted prior to or after the date on which the state statute or executive order was enacted or issued.
>
> (d) The local agency or school district has the authority to levy service charges, fees, or assessments sufficient to pay for the mandated program or increased level of service.
>
> (e) The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate.
>
> (f) The statute or executive order imposed duties that were expressly included in a ballot measure approved by the voters in a statewide or local election.

[80] See also, *Lucia Mar Unified School Dist., supra*, 44 Cal.3d 830, 835.

(g) The statute created a new crime or infraction, eliminated a crime or infraction, or changed the penalty for a crime or infraction, but only for that portion of the statute relating directly to the enforcement of the crime or infraction.

Except for Government Code section 17556, subdivision (e), the Commission finds that the exceptions listed in section 17556 are not relevant to this claim, and do not apply here. Since the Legislature has appropriated funds for this program, however, Government Code section 17556, subdivision (e), is relevant and is analyzed below.

A. Government Code section 17556, subdivision (e), does not apply to deny this claim

Government Code section 17556, subdivision (e), states the Commission shall not find costs mandated by the state if the Commission finds that:

> The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, *or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate*. (Emphasis added.)

Thus, in order for Government Code section 17556, subdivision (e), to apply to deny this claim, the plain language of the statute requires that two elements be satisfied. First, the statute must include additional revenue that was specifically intended to fund the costs of the state mandate. Second, the appropriation must be in an amount sufficient to fund the cost of the state mandate.

For the reasons provided below, the Commission finds that Government Code section 17556, subdivision (e), does not apply to deny this claim.

The reimbursement period of this test claim, if approved by the Commission, would begin July 1, 2001. The Budget Act of 2001 appropriated funds to counties specifically for this program in the amounts of $12,334,000 and $46,944,000.[81] The Budget Act of 2002 appropriated $1000 to counties.[82]

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[81] Statutes 2001, chapter 106, items 4440-131-0001 and 4440-295-0001. Item 4440-295-0001, however, is an appropriation, pursuant to article XIII B, section 6, for the original program approved by the Commission in CSM 4282, *Handicapped and Disabled Students* (Stats. 1984, ch. 1747; Stats. 1985, ch. 1274; and on Cal. Code Regs., tit.2, §§ 60000 through 60610 (Emergency Regulations filed December 31, 1985, designated effective January 1, 1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

[82] Statutes 2002, chapter 379, item 4440-295-0001. Item 4440-295-0001 is an appropriation, pursuant to article XIII B, section 6, for the original program added approved by the Commission in CSM 4282, *Handicapped and Disabled Students* (Stats. 1984, ch. 1747; Stats. 1985, ch. 1274; and on Cal. Code Regs., tit.2, §§ 60000 through 60610 (Emergency Regulations filed December 31, 1985, designated effective January 1,

The Commission finds that the amount appropriated in 2001 and 2002 are not sufficient to fund the cost of the state mandate and, thus, the second element under Government Code section 17556, subdivision (e), has not been satisfied. According to the State Controller's Deficiency Report issued on May 2, 2005, the unpaid claims for fiscal year 2001-02 total $124,940,258. The unpaid claims for fiscal year 2002-03 total $124,871,698.[83]

In addition, the Budget Acts of 2003 and 2004 contain appropriations "considered offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." However, for the reasons provided below, the Commission finds that Government Code section 17556, subdivision (e), has not been satisfied with these appropriations.

The Budget Act of 2003 appropriated $69 million to counties from the federal special education fund to be used exclusively to support mental health services identified in a pupil's IEP and provided during the 2003-04 fiscal year by county mental health agencies pursuant to the test claim legislation. (Stats. 2003, ch. 157, item 6110-161-0890, provision 17.) The bill further states in relevant part that the funding shall be considered offsetting revenue pursuant to Government Code section 17556, subdivision (e):

> This funding shall be considered offsetting revenues within the meaning of subdivision (e) of section 17556 of the Government Code for any reimbursable mandated cost claim for provision of these mental health services provided in 2003-04.

The Budget Act of 2004 similarly appropriated $69 million to counties from the federal special education fund to be used exclusively to support mental health services provided during the 2004-05 fiscal year pursuant to the test claim legislation. (Stats. 2004, ch. 208, item 6110-161-0890, provision 10.) The appropriation in 2004 was made as follows:

> Pursuant to legislation enacted in the 2003-04 Regular Session, of the funds appropriated in Schedule (4) of this item, $69,000,000 shall be used exclusively to support mental health services provided during the

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1986 (Register 86, No. 1) and refiled June 30, 1986, designated effective July 12, 1986 (Register 86, No. 28)).

[83] The Deficiency Report is prepared pursuant to Government Code section 17567. Government Code section 17567 requires that in the event the amount appropriated for reimbursement of a state-mandated program is not sufficient to pay all of the claims approved by the Controller, the Controller shall prorate claims in proportion to the dollar amount of approved claims timely filed and on hand at the time of proration. The Controller shall then issue a report of the action to the Department of Finance, the Chairperson of the Joint Legislative Budget Committee, and the Chairperson of the respective committee in each house of the Legislature that considers appropriations. The Deficiency Report is, thus, an official record of a state agency and is properly subject to judicial notice by the court. (*Munoz v. State* (1995) 33 Cal.App.4th 1767, 1773, fn. 2; *Chas L. Harney, Inc. v. State of California* (1963) 217 Cal.App.2d 77, 85-87.)

2004-05 fiscal year by county mental health agencies pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of the Government Code and that are included within an individualized education program pursuant to the Federal Individuals with Disabilities Education Act (IDEA).

The Budget Act of 2004 does not expressly identify the $69 million as "offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." But the statute does contain language that the appropriation was made "[p]ursuant to legislation enacted in the 2003-04 Regular Session." As indicated above, it is the 2003-04 Budget Bill that contains the language regarding the Legislature's intent that the $69 million is considered offsetting revenue within the meaning of Government Code section 17556, subdivision (e).

The Commission finds that the Legislature intended to fund the costs of this state-mandated program for fiscal year 2004-05 based on the language used by the Legislature that the funds "shall be considered offsetting revenues within the meaning of Government Code section 17556, subdivision (e)." Under the rules of statutory construction, it is presumed that the Legislature is aware of existing laws and that it enacts new laws in light of the existing law.[84] In this case, the Legislature specifically referred to Government Code section 17556, subdivision (e), when appropriating the $69 million. Thus, it must be presumed that the Legislature was aware of the plain language of Government Code section 17556, subdivision (e), and that its application results in a denial of a test claim.

But, based on public records, the second element under Government Code section 17556, subdivision (e), requiring that the appropriation must be *in an amount sufficient* to fund the cost of the state mandate, has not been satisfied. According to the State Controller's Deficiency Report issued on May 2, 2005, the amounts appropriated for this program in fiscal years 2003-04 and 2004-05 are not sufficient to pay the claims approved by the State Controller's Office. Unpaid claims for fiscal year 2003-04 total $66,915,606. The unpaid claims for fiscal year 2004-05 total $68,958,263.[85]

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[84] *Williams v. Superior Court* (2001) 92 Cal.App.4th 612, 624.

[85] The State Controller's Deficiency Report lists the total unpaid claims for the following fiscal years as follows:

1999 and prior Local Government Claims Bills	$ 8,646
2001-02	124,940,258
2002-03	124,871,698
2003-04	66,915,606
2004-05	68,958,263

This finding is further supported by the 2004 report published by Stanford Law School, which states "$69 million represented only approximately half of the total funding necessary to maintain AB 3632 services."[86]

Accordingly, the Commission finds that Government Code section 17556, subdivision (e), does not apply to deny this claim. Eligible claimants are, however, required to identify the funds received during fiscal years 2001-02 through 2004-05 as an offset to be deducted from the costs claimed.[87]

Based on the program costs identified by the State Controller's Office, the Commission further finds that counties do incur increased costs mandated by the state pursuant to Government Code section 17514 for this program. However, as more fully discussed below, the state has amended cost-sharing mechanisms for some of the mandated activities that affect the total costs incurred by a county.

B. Increased costs mandated by the state for providing psychotherapy and other mental health services.

In *Handicapped and Disabled Students* (CSM 4282), the Commission determined that the costs incurred for providing psychotherapy or other mental health treatment services were subject to the Short-Doyle Act. Under the Short-Doyle Act, the state paid 90 percent of the total costs of mental health treatment services and the counties paid the remaining 10 percent. Thus, the Commission concluded that counties incurred increased costs mandated by the state in an amount that equaled 10 percent of the total psychotherapy or other mental health treatment costs. In 1993, the Sixth District Court of Appeal agreed with the Commission's conclusion.[88]

In 1991, the Legislature enacted realignment legislation that repealed the Short-Doyle Act and replaced the sections with the Bronzan-McCorquodale Act. (Stats. 1991, ch. 89, §§ 63 and 173.) The realignment legislation became effective on June 30, 1991. The parties have disputed whether the Bronzan-McCorquodale Act keeps the cost-sharing ratio, with the state paying 90 percent and the counties paying 10 percent, for the cost of psychotherapy or other mental health treatment services for special education pupils.

The Commission finds, however, that the Commission does not need to resolve that dispute for purposes of this test claim. Section 38 of Statutes 2002, chapter 1167 (Assem. Bill 2781) prohibits the funding provisions of the Bronzan-McCorquodale Act from affecting the responsibility of the state to fund psychotherapy and other mental health treatment services for handicapped and disabled pupils and requires the state to provide reimbursement to counties for those services for all allowable costs incurred. Section 38 also states the following:

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[86] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

[87] Government Code section 17514; California Code of Regulations, title 2, section 1183.1.

[88] *County of Santa Clara v. Commission on State Mandates*, Sixth District Court of Appeal Case No. H009520, filed January 11, 1993 (unpubl.)

> *For reimbursement claims for services delivered in the 2001-02 fiscal year and thereafter*, counties are *not* required to provide any share of those costs or to fund the cost of any part of these services with money received from the Local Revenue Fund [i.e. realignment funds]. (Emphasis added.)

In addition, Senate Bill 1895 (Stats. 2004, ch. 493, § 6) states that realignment funds used by counties for this 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.)

Therefore, beginning July 1, 2001, the 90 percent-10 percent cost-sharing ratio for the costs incurred for psychotherapy and other mental health treatment services no longer applies. Since the period of reimbursement for purposes of this reconsideration begins July 1, 2001, and section 38 of Statutes 2002, chapter 1167 is still in effect, all of the county costs for psychotherapy or other mental health treatment services are reimbursable, less any applicable offsets that are identified below.

C. Identification of offsets

Reimbursement under article XIII B, section 6 and Government Code section 17514 is required only for the increased costs mandated by the state. As determined by the California Supreme Court, the intent behind section 6 was to prevent the state from forcing new programs on local governments that require an increased expenditure by local government of their limited tax revenues.[89]

Government Code section 7576.5 states the following:

> If funds are appropriated to local educational agencies to support the costs of providing services pursuant to this chapter, the local educational agencies shall transfer those funds to the community mental health services that provide services pursuant to this chapter in order to reduce the local costs of providing these services. These funds shall be used exclusively for programs operated under this chapter and are offsetting revenues in any reimbursable mandate claim relating to special education programs and services.

Government Code section 7576.5 was added by the Legislature in 2003 (Stats. 2003, ch. 227) and became operative and effective on August 11, 2003. Thus, the Commission finds money received by counties pursuant to Government Code section 7576.5 shall be identified as an offset and deducted from the costs claimed.

In addition, any direct payments or categorical funds appropriated by the Legislature to the counties specifically for this program shall be identified as an offset and deducted from the costs claimed. This includes the appropriations made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amount of $12,334,000

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[89] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of San Diego, supra*, 15 Cal.4th at page 81.

and the $69 million appropriations in 2003 and 2004.[90] The appropriations made by the Legislature in 2001 and 2002, under Item 4440-295-0001 (appropriations of $46,944,000 and $1000, respectively), however, were expressly made pursuant to article XIII B, section 6 for purposes of reimbursing the original program approved by the Commission in CSM 4282, *Handicapped and Disabled Students*.[91] Since the Commission does not have jurisdiction in this test claim over the reimbursement of the statutes and regulations pled in the original test claim (CSM 4282), the Commission finds that the 2001 appropriation of $46,944,000 and the 2002 appropriation of $1000 are not required to be identified as an offset and deducted from the costs claimed here.

Furthermore, to the extent counties obtain private insurance proceeds with the consent of a parent for purposes of this program, such proceeds must be identified as an offset and deducted from the costs claimed. Federal law authorizes public agencies to access private insurance proceeds for services provided under the IDEA if the parent consents.[92] Thus, this finding is consistent with the California Supreme Court's decision in *County of Fresno v. State of California.* In the *County of Fresno* case, the court clarified that article XIII B, section 6 requires reimbursement by the state only for those expenses that are recoverable from tax revenues. Reimbursable costs under article XIII B, section 6, do not include reimbursement received from other non-tax sources.[93]

The Commission further finds that, to the extent counties obtain proceeds under the Medi-Cal program from either the state or federal government for purposes of this mandated program, such proceeds must be identified as an offset and deducted from the costs claimed. Federal law authorizes public agencies, with certain limitations, to use public insurance benefits, such as Medi-Cal, to provide or pay for services required under the IDEA.[94] Federal law limits this authority as follows:

> (2) With regard to services required to provide FAPE [free appropriate public education] to an eligible child under this part, the public agency-
>
> (i) May not require parents to sign up for or enroll in public insurance programs in order for their child to receive FAPE under Part B of the Act;
>
> (ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2)

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[90] Statutes 2001, chapter 106, items 4440-131-0001; Statutes 2003, chapter 157, item 6110-161-0890, provision 17; Statutes 2004, chapter 208, item 6110-161-0890, provision 10.

[91] Statutes 2001, chapter 106, item 4440-295-0001; Statutes 2002, chapter 379, item 4440-295-0001.

[92] 34 Code of Federal Regulations section 300.142, subdivision (f).

[93] *County of Fresno, supra,* 53 Cal.3d at page 487.

[94] 34 Code of Federal Regulations section 300.142, subdivision (e).

of this section, may pay the cost that the parent would be required to pay;

(iii) May not use a child's benefits under a public insurance program if that use would

(A) Decrease available lifetime coverage or any other insured benefit;

(B) Result in the family paying for services that would otherwise be covered by the public insurance program and that are required for the child outside of the time the child is in school;

(C) Increase premiums or lead to the discrimination of insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.[95]

According to the 2004 report published by Stanford Law School, 51.8 percent of the students receiving services under the test claim legislation are Medi-Cal eligible.[96] Thus, the finds to the extent counties obtain proceeds under the Medi-Cal program from the state or federal government for purposes of this mandated program, such proceeds must be identified as an offset and deducted from the costs claimed.[97]

Finally, Senate Bill 1895 (Stats. 2004, ch. 493, § 6), states that realignment funds under the Bronzan-McCorquodale Act that are used by a county for the Handicapped and Disabled Students program are not required to be deducted from the costs claimed. Section 6 of Senate Bill 1895 adds, as part of the Bronzan-McCorquodale Act, section 5701.6 to the Welfare and Institutions Code, which states in relevant part the following:

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[95] 34 Code of Federal Regulations section 300.142, subdivision (e)(2).

[96] "Challenge and Opportunity – An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California," Youth and Education Law Clinic, Stanford Law School, May 2004, page 20.

[97] In comments to the draft staff analysis, the County of Stanislaus states that counties share in the cost of Medi-Cal and, thus, the local Medi-Cal match should not be offset from the costs claimed under this program. The Commission agrees. Under the Medi-Cal program, "the state's share of costs of medical care and services, county administration, and fiscal intermediary services shall be determined pursuant to a plan approved by the Director of Finance and certified to by the director." (Welf. & Inst. Code, § 14158.5.) Thus, this analysis recommends that *to the extent* a county obtains proceeds under the Medi-Cal program from the state or federal government and that such proceeds pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program, such funds are required to be identified as an offset and deducted from the costs claimed.

> Counties may utilize money received from the Local Revenue Fund [realignment] ... to fund the costs of any part of those services provided pursuant to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code. *If money from the Local Revenue Fund is used by counties for those services, counties are eligible for reimbursement from the state for all allowable costs* to fund assessments, psychotherapy, and other mental health services allowable pursuant to Section 300.24 of Title 34 of the Code of Federal Regulations [IDEA] and required by Chapter 26.5 ... of the Government Code. (Emphasis added.)

Senate Bill 1895 was a budget trailer bill to the 2004 budget. However, for reasons provided below, the language in Welfare and Institutions Code section 5701.6, that realignment funds are not required to be identified as an offset and deducted from the costs claimed, is retroactive and applies to the reimbursement period for this test claim, beginning July 1, 2001.

Welfare and Institutions Code section 5701.6, subdivision (b), states that "[t]his section is declaratory of existing law." Although a legislative statement that an act is declaratory of existing law is not binding on the courts, the courts have interpreted such language as legislative intent that the amendment applies to all existing causes of action. The courts have given retroactive effect to such a statute when there is no constitutional objection to its retroactive application. In this regard, the California Supreme Court has stated the following:

> A subsequent expression of the Legislature as the intent of the prior statute, although not binding on the court, may properly be used in determining the effect of a prior act. [Citation omitted.] Moreover, even if the court does not accept the Legislature's assurance that an unmistakable change in the law is merely a "clarification," the declaration of intent may still effectively reflect the Legislature's purpose to achieve a retrospective change. [Citation omitted.] Whether a statute should apply retrospectively or only prospectively is, in the first instance, a policy question of the legislative body enacting the statute. [Citation omitted.] Thus, where a statute provides that it clarifies or declares existing law, "[i]t is obvious that such a provision is indicative of a legislative intent that the amendment apply to all existing causes of action from the date of its enactment. In accordance with the general rules of construction, we must give effect to this intention unless there is some constitutional objection thereto." [Citations omitted.][98]

Thus, the Commission finds that realignment funds used by a county for this mandated program are not required to be identified as an offset and deducted from the costs claimed.

Accordingly, the Commission finds that the following revenue and/or proceeds must be identified as offsets and be deducted from the costs claimed:

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[98] *Western Security Bank v. Superior Court* (1997) 15 Cal.4th 232, 244.

- Funds received by a county pursuant to Government Code section 7576.5.
- Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, item 4440-131-0001), and the $69 million appropriations in 2003 and 2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).
- Private insurance proceeds obtained with the consent of a parent for purposes of this program.
- Medi-Cal proceeds obtained from the state or federal government that pay for a portion of the county services provided to a pupil under the Handicapped and Disabled Students program in accordance with federal law.
- Any other reimbursement received from the federal or state government, or other non-local source.[99]

CONCLUSION

The Commission concludes that the test claim legislation imposes a reimbursable state-mandated program on counties pursuant to article XIII B, section 6 of the California Constitution and Government Code section 17514 for the increased costs in performing the following activities:

1. Interagency Agreements (Cal. Code Regs., tit. 2, § 60030)
    - The one-time activity of revising the interagency agreement with each local educational agency to include the following eight procedures:
        - Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code section 7575, subdivision (f). For purposes of this subdivision only, the term "appropriate" means any service identified in the pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(2).)
        - A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons. (Cal. Code Regs, tit. 2, § 60030, subd. (c)(4).)
        - Development of a mental health assessment plan and its implementation. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(5).)

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[99] *County of Fresno, supra,* 53 Cal.3d at page 487; California Code of Regulations, title 2, section 1183.1, subdivision (a)(8).

- At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(7).)
- The provision of mental health services as soon as possible following the development of the IEP pursuant to section 300.342 of Title 34 of the Code of Federal Regulations. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(9).)
- The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(14).)
- The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided. (Cal. Code Regs., tit. 2, § 60030, subd. (c)(15).)
- Mutual staff development for education and mental health staff pursuant to Government Code section 7586.6, subdivision (a). (Cal. Code Regs., tit. 2, § 60030, subd. (c)(17).)

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

- Work collaboratively with the local educational agency to ensure that assessments performed prior to referral are as useful as possible to the community mental health service in determining the need for mental health services and the level of services needed. (Gov. Code, § 7576, subd. (b)(1).)
- A county that receives a referral for a pupil with a different county of origin shall forward the referral within one working day to the county of origin. (Gov. Code, § 7576, subd. (g); Cal. Code Regs., tit. 2, § 60040, subd. (g).)
- If the county determines that a mental health assessment is not necessary, the county shall document the reasons and notify the parents and the local educational agency of the county determination within one day. (Cal Code Regs., tit. 2, § 60045, subd. (a)(1).)
- If the county determines that the referral is incomplete, the county shall document the reasons, notify the local educational agency within one working day, and return the referral. (Cal. Code Regs., tit. 2, § 60045, subd. (a)(2).)
- Notify the local educational agency when an assessment is determined necessary. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)
- Provide the assessment plan to the parent. (Cal. Code Regs., tit. 2, § 60045, subd. (b).)

- Report back to the referring local educational agency or IEP team within 30 days from the date of the receipt of the referral if no parental consent for a mental health assessment has been obtained. (Cal. Code Regs., tit. 2, § 60045, subd. (c).)
- Notify the local educational agency within one working day after receipt of the parent's written consent for the mental health assessment to establish the date of the IEP meeting. (Cal. Code Regs., tit. 2, § 60045, subd. (d).)
- Provide the parent with written notification that the parent may require the assessor to attend the IEP meeting to discuss the recommendation when the parent disagrees with the assessor's mental health service recommendation. (Cal. Code Regs., tit. 2, § 60045, subd. (f).)
- The county of origin shall prepare yearly IEP reassessments to determine the needs of a pupil. (Cal. Code Regs., tit. 2, § 60045, subd. (h).)

3. Transfers and Interim Placements (Cal. Code Regs., tit. 2, § 60055)
   - Following a pupil's transfer to a new school district, the county shall provide interim mental health services, as specified in the existing IEP, for thirty days, unless the parent agrees otherwise.
   - Participate as a member of the IEP team of a transfer pupil to review the interim services and make a determination of services.
4. Participate as a Member of the Expanded IEP Team When Residential Placement of a Pupil is Recommended (Gov. Code, § 7572.55; Cal Code Regs., tit. 2, § 60100)
   - When a recommendation is made that a child be placed in an out-of-state residential facility, the expanded IEP team, with the county as a participant, shall develop a plan for using less restrictive alternatives and in-state alternatives as soon as they become available, unless it is in the best educational interest of the child to remain in the out-of-state school. (Gov. Code, § 7572.55, subd. (c).)
   - The expanded IEP team, with the county as a participant, shall document the alternatives to residential placement that were considered and the reasons why they were rejected. (Cal. Code Regs., tit. 2, § 60100, subd. (c).)
   - The expanded IEP team, with the county as a participant, shall ensure that placement is in accordance with the admission criteria of the facility. (Cal. Code Regs., tit. 2, § 60100, subd. (j).)
   - When the expanded IEP team determines that it is necessary to place a pupil who is seriously emotionally disturbed in residential care, counties shall ensure that: (1) the mental health services are specified in the IEP in accordance with federal law, and (2) the mental health services are provided by qualified mental health professionals. (Cal. Code Regs., tit. 2, § 60100, subd. (i).)

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

   - Coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in residential placement. The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of the pupil. (Cal. Code Regs., tit, 2, § 60110, subd, (b)(1).)
   - When the IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the lead case manager shall ensure that placement is in accordance with admission, continuing stay, and discharge criteria of the community treatment facility. (Cal. Code Regs., tit. 2, § 60110, subd. (b)(3).)
   - Identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost-effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment. (Cal. Code Regs, tit. 2, §§ 60100, subd. (e), 60110, subd. (c)(2).)
   - Document the determination that no nearby placement alternative that is able to implement the IEP can be identified and seek an appropriate placement that is as close to the parents' home as possible. (Cal. Code Regs., tit. 2, § 60100, subd. (f).)
   - Notify the local educational agency that the placement has been arranged and coordinate the transportation of the pupil to the facility if needed. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(7).)
   - Facilitate placement authorization from the county's interagency placement committee pursuant to Welfare and Institutions Code section 4094.5, subdivision (e)(1), by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(11).)
   - Evaluate every 90 days the continuing stay criteria, as defined in Welfare and Institutions Code section 4094, of a pupil placed in a community treatment facility every 90 days. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(8).)
   - Schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as the pupil remains in residential placement. (Cal. Code Regs, tit. 2, § 60110, subd. (c)(10).)

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

   - Authorize payments to residential facilities based on rates established by the Department of Social Services in accordance with Welfare and Institutions Code sections 18350 and 18356.

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

   - The host county shall make its provider network available and provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - The county of origin shall negotiate with the host county to obtain access to limited resources, such as intensive day treatment and day rehabilitation. (Cal. Code Regs., tit. 2, § 60200, subd. (c)(1).)
   - Provide case management services to a pupil when required by the pupil's IEP. This service shall be provided directly or by contract at the discretion of the county of origin. (Cal. Code Regs., tit. 2, § 60020, subd. (i).)
   - 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).)
   - Notify the parent and the local educational agency when the parent and the county mutually agree upon the completion or termination of a service, or when the pupil is no longer participating in treatment. ((Cal. Code Regs., tit. 2, § 60050, subd. (b).)

The Commission further concludes that the following revenue and/or proceeds must be identified as offsets and deducted from the costs claimed:

- Funds received by a county pursuant to Government Code section 7576.5.
- Any direct payments or categorical funding received from the state that is specifically allocated to any service provided under this program. This includes the appropriation made by the Legislature in the Budget Act of 2001, which appropriated funds to counties in the amounts of $12,334,000 (Stats. 2001, ch. 106, items 4440-131-0001), and the $69 million appropriations in 2003 and

2004 (Stats. 2003, ch. 157, item 6110-161-0890, provision 17; Stats. 2004, ch. 208, item 6110-161-0890, provision 10).

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

The reimbursement period for this test claim begins July 1, 2001.[100]

Finally, any statutes and or regulations that were pled in this test claim that are not identified above do not constitute a reimbursable state-mandated program.

[100] Government Code section 17557, subdivision (e).

Tab 6

Adopted: December 9, 2005

PARAMETERS AND GUIDELINES

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

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

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

Counties of Stanislaus and Los Angeles, Claimants

I. SUMMARY OF THE MANDATE

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

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

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

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

II. ELIGIBLE CLAIMANTS

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

III. PERIOD OF REIMBURSEMENT

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

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

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

IV. REIMBURSABLE ACTIVITIES

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

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

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[1] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5) 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).)

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

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

V. CLAIM PREPARATION AND SUBMISSION

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

A. Direct Cost Reporting

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

1. Salaries and Benefits

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

2. Materials and Supplies

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

3. Contracted Services

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

4. Fixed Assets and Equipment

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

B. Indirect Cost Rates

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

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

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

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

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

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

VI. RECORDS RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter[2] is subject to the initiation of an audit by the State Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. All documents used to support the reimbursable activities, as described in Section IV, must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VII. OFFSETTING SAVINGS AND REIMBURSEMENTS

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

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

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

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

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

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

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

IX. REMEDIES BEFORE THE COMMISSION

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

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

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

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

Tab 7

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

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

CORRECTED PARAMETERS AND GUIDELINES

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

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

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

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

Cost Report Method

A. Cost Report Method

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

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

B. Indirect Cost Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: _____

_____
Paula Higashi, Executive Director

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

CORRECTED
PARAMETERS AND GUIDELINES

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

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

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

Counties of Stanislaus and Los Angeles, Claimants

I. SUMMARY OF THE MANDATE

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

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

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

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

II. ELIGIBLE CLAIMANTS

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

III. PERIOD OF REIMBURSEMENT

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

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

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

IV. REIMBURSABLE ACTIVITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. CLAIM PREPARATION AND SUBMISSION

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

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

Direct Cost Reporting Method

A. Direct Cost Reporting

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

1. Salaries and Benefits

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

2. Materials and Supplies

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

3. Contracted Services

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

4. Fixed Assets and Equipment

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

B. Indirect Cost Rates

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

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

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

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

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

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

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

Cost Report Method

A. Cost Report Method

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

B. Indirect Cost Rates

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

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

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

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

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

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

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

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

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

VI. RECORDS RETENTION

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

VII. OFFSETTING SAVINGS AND REIMBURSEMENTS

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

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

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

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

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

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

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

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

IX. REMEDIES BEFORE THE COMMISSION

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

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

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

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

Tab 8

Amendment Adopted: October 26, 2006
Corrected: July 21, 2006
Adopted: December 9, 2005
j:mandates/2000/tc/02tc40/psgs/proposedamendedpsgs-Oct 06

AMENDED PARAMETERS AND GUIDELINES
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128, Statutes 1996, Chapter 654

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

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

Counties of Stanislaus and Los Angeles, Claimants

EFFECTIVE FOR REIMBURSEMENT CLAIMS FILED FOR COSTS INCURRED THROUGH THE 2005-2006 FISCAL YEAR

I. SUMMARY OF THE MANDATE

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

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

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

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

"freely chose" to impose the costs upon counties as a means of implementing the federal IDEA program.

These parameters and guidelines are effective for reimbursement claims filed for costs incurred through the 2005-2006 fiscal year. Commencing with the 2006-2007 fiscal year, reimbursement claims shall be filed through the consolidated parameters and guidelines for *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).

II. ELIGIBLE CLAIMANTS

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

III. PERIOD OF REIMBURSEMENT

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

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

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

IV. REIMBURSABLE ACTIVITIES

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

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

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Claims should *exclude* reimbursable costs included in claims previously filed, beginning in fiscal year 2001-2002, for the Handicapped and Disabled Students program (CSM 4282).[1] Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

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

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

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

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

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

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

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

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

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

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

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[1] 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(When providing psychotherapy or other mental health treatment services, the activities of crisis intervention, vocational services, and socialization services are not reimbursable.)

V. CLAIM PREPARATION AND SUBMISSION

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

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

Direct Cost Reporting Method

A. Direct Cost Reporting

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

1. Salaries and Benefits

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

2. Materials and Supplies

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

3. Contracted Services

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

4. Fixed Assets and Equipment

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

B. Indirect Cost Rates

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

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

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

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

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

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

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

Cost Report Method

A. Cost Report Method

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

B. Indirect Cost Rates

To the extent that reimbursable indirect costs have not already been reimbursed, they may be claimed under this method.

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

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

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

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

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

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

which is used to distribute indirect costs to mandates. The rate should be expressed as a percentage which the total amount allowable indirect costs bears to the base selected; or

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

VI. RECORDS RETENTION

Pursuant to Government Code section 17558.5, subdivision (a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter[2] is subject to the initiation of an audit by the State Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. All documents used to support the reimbursable activities, as described in Section IV, must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

VII. OFFSETTING REVENUES AND OTHER REIMBURSEMENTS

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

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

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

5. Any other reimbursement received from the federal or state government, or other non-local source.

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

VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS

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

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

IX. REMEDIES BEFORE THE COMMISSION

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

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

X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES

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

Tab 9

JOHN CHIANG
California State Controller

August 12, 2008

Wendy L. Watanabe, Acting Auditor-Controller
County of Los Angeles
500 West Temple Street, Room 525
Los Angeles, CA 90012

Re: Audit of Mandated Cost Claims for Handicapped and Disabled Students Program For the Period of July 1, 2003, through June 30, 2006 and Audit of Mandated Cost Claims for Handicapped and Disabled Students II Program for period of July 1, 2002, through June 30, 2004

Dear Ms. Watanabe:

This letter confirms that Anna Pilipyuk has scheduled an audit of the County of Los Angeles' legislatively mandated Handicapped and Disabled Students Program cost claims filed for fiscal year (FY) 2003-04, FY 2004-05, and FY 2005-06 and Handicapped and Disabled Students II Program cost claims filed for FY 2002-03 and FY 2003-04. Government Code sections 12410, 17558.5, and 17561 provide the authority for this audit. The entrance conference is scheduled for Monday, September 22, 2008, at 11:00 a.m. We will begin audit fieldwork after the entrance conference.

Please furnish working accommodations for and provide the necessary records (listed on the Attachment) to the audit staff. If you have any questions, please call me at (916) 327-0696.

Sincerely,

Christopher B. Ryan

CHRISTOPHER RYAN, Audit Manager
Mandated Cost Audits Bureau
Division of Audits

6954

CR/sk

Attachment

MAILING ADDRESS P.O. Box 942850, Sacramento, CA 94250-5874
SACRAMENTO 300 Capitol Mall, Suite 518, Sacramento, CA 95814 (916) 324-8907
LOS ANGELES 600 Corporate Pointe, Suite 1000, Culver City, CA 90230 (310) 342-5656

cc: Leonard Kaye, ESQ
Certified Public Accountant
County of Los Angeles
Jim L. Spano, Chief
Mandated Cost Audits Bureau
Division of Audits, State Controller's Office
Ginny Brummels, Manager
Division of Accounting and Reporting
State Controller's Office
Anna Pilipyuk, Auditor-in-Charge
Division of Audits, State Controller's Office

COUNTY OF LOS ANGELES
Records Request for Mandated Cost Program
Handicapped and Disabled Students
FY 2003-04, FY 2004-05, and FY 2005-06
and Handicapped and Disabled Students II
FY 2002-03 and FY 2003-04

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1. Copy of claims filed for the mandated cost program and all related supporting documentations.

2. Copy of external and internal audit reports performed on the mandated cost program.

3. Copy of the single audit report performed during the period and the primary contact for the CPA firm.

4. Organization charts for the county effective during the audit period and currently, showing employee names and position titles.

5. Organization charts for the department or unit handling the mandated cost program, effective during the audit period and currently, showing employee names and position titles.

6. Chart of accounts applicable to the period under review, including service function and provider identification codes.

7. Access to cost reports submitted to the Department of Mental Health, general ledger accounts, and financial reports used to support the claims.

8. Access to supporting documentation for units charged and applicable rates, vendor invoices and payments, and client files.

9. Sample of supporting documents for units of service charged, documenting the billing process (attending mental health professional billing slips, progress notes in client file, billing logs, or summaries by providers, etc.).

10. Support for costs used to compute the indirect cost rate proposal (ICRP).

11. Support of offsetting revenues identified in the claim.

Tab 10

COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 525
LOS ANGELES, CALIFORNIA 90012-3873
PHONE: (213) 974-8301 FAX: (213) 626-5427

WENDY L. WATANABE
AUDITOR-CONTROLLER

MARIA M. OMS
CHIEF DEPUTY

ASST. AUDITOR-CONTROLLERS

ROBERT A. DAVIS
JOHN NAIMO
JUDI E. THOMAS

April 30, 2010

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

Dear Mr. Spano:

Handicapped and Disabled Students Program II
July 1, 2002, through June 30, 2004

In connection with the State Controller's Office (SCO) audit of the County's claims for the mandated program and audit period identified above, we affirm, to the best of our knowledge and belief, the following representations made to the SCO's audit staff during the audit:

1. We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO.

2. We designed and implemented the County's accounting system to ensure accurate and timely records.

3. We prepared and submitted our reimbursement claims according to the Handicapped and Disabled Students II Program's parameters and guidelines.

4. We claimed mandated costs based on actual expenditures allowable per the Handicapped and Disabled Students II Program's parameters and guidelines.

5. We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims.

6. Excluding mandated program costs, the County did not recover indirect costs from any State or federal agency during the audit period.

7. We are not aware of any:

   a. Violations or possible violations of laws and regulations involving management or employees who had significant roles in the accounting system or in preparing the mandated cost claims.

   b. Violations or possible violations of laws and regulations involving other employees that could have had a material effect on the mandated cost claims.

   c. Communications from regulatory agencies concerning noncompliance with, or deficiencies in, accounting and reporting practices that could have a material effect on the mandated cost claims.

   d. Relevant, material transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims.

8. There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims.

9. We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims.

If you have any questions, please contact Hasmik Yaghobyan at (213) 893-0792 or via e-mail at hyaghobyan@auditor.lacounty.gov

Very truly yours,

Wendy L. Watanabe
Auditor-Controller

WLW:MMO:JN:CY:hy
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Tab 11

W/P Section 3E-1 Page 3/10

Indirect Costs

Los Angeles County
Handicapped and Disabled Students II
July 1, 2002, through June 30, 2004
S09-MCC-009

Prepared by: JV
Date: 1-24-10
Reviewed by: CR
Date: 2/5/10

FY 2002-03

		W/P	Direct Costs	Indirect Rate	Indirect Costs
(1)	DMH directly operated	3E-1 p. 37	154,617	P. 5 0.15473	23,924
(2)	Private contract providers		2,253,349	P. 6 0.063049	142,071
	Total		2,407,966	WP 3F-1, p. 46	165,995
	Weigthed Average		(Rate)	6.89%	

					Indirect Costs	
2,407,966	*	6.89%	=	$	165,995	p. 2

W/P Section 3F-1 Page 4/10

Indirect Costs

Los Angeles County
Handicapped and Disabled Students II
July 1, 2002, through June 30, 2004
S09-MCC-009

Prepared by: VV
Date: 1-24-17
Reviewed by: CR
Date: 2/5/10

FY 2003-04

		W/P	Direct Costs	Indirect Rate	Indirect Costs
(1)	DMH directly operated	3F-1 p. 38	134,015	p. 7 0.135837	18,204
(2)	Private contract providers		2,132,140	p. 8 0.079623	169,767
	Total		2,266,155	2nd FP 3F-1 p. 27	187,972
	Weigthed Average		(Rate)	8.29%	

Direct Costs		Indirect Rate		Indirect Costs
2,266,155	*	8.29%	= $	187,972 p. 2

Tab 12

Direct & Indirect Costs
FY 2002-03

Entity #	Provider	Gross Costs	FFP	EPSDT	Other Revenue	Net Costs	Indirect Cost Rate	Indirect Costs	FFP Admin Offset
Providers Not Identified									
00185	El Centro De Amistad, Inc.	1,161.00	-	-	-	1,161.00	6.3049%	73.20	-
00190	Gateways Hospital	2,190.00	(558.89)	(458.21)	-	1,172.90	6.3049%	138.08	(35.24)
00204	Pasadena Childrens Training	120,663.49	(32,817.53)	(26,408.49)	-	61,437.47	6.3049%	7,607.71	(2,069.11)
00217	Saint John's Health Center	33,522.75	(2,990.25)	(2,451.59)	-	28,080.91	6.3049%	2,113.58	(188.53)
00321	Hillsides (Church Home for Children)	35,708.00	(6,821.66)	(5,592.82)	-	23,293.52	6.3049%	2,251.35	(430.10)
00519	Aspen Health Services	23,339.60	(11,116.00)	(8,951.04)	-	3,272.56	6.3049%	1,471.54	(700.85)
00591	Children's Institute International	1,755.18	(210.41)	(172.51)	-	1,372.26	6.3049%	110.66	(13.27)
00724	Foothill Family Service	6,325.89	(3,185.09)	(2,611.33)	-	529.47	6.3049%	398.84	(200.82)
00783	ChildNet Youth & Family Services	11,518.08	(4,914.95)	(3,930.32)	-	2,672.81	6.3049%	726.20	(309.88)
00784	St. Francis Medical Center	2,057.20	(1,025.24)	(815.25)	-	216.71	6.3049%	129.70	(64.64)
Sub-Total - Providers Not Identified		238,241.19	(63,640.02)	(51,391.56)	-	123,209.61		15,020.87	(4,012.44)
Clients Incorrectly Determined to be Ineligible									
00192	Hathaway Children & Family Services	612.00	(331.50)	-	-	280.50	6.3049%	38.59	(20.90)
00196	Vista Del Mar Child & Family Services	2,008.80	(730.48)	(598.89)	-	679.43	6.3049%	126.65	(46.06)
Sub-Total - Clients Incorrectly Determined		2,620.80	(1,061.98)	(598.89)	-	959.93		165.24	(66.96)
Services Not Identified as AB 3632 in MIS (Unclaimed)									
00188	Enki Health & Research	56,316.34	(26,288.31)	(19,940.78)	(1,442.40)	8,644.85	6.3049%	3,550.69	(1,748.39)
00198	Help Group Child & Family Center	9,980.75	(2,173.11)	(1,678.86)	-	6,128.78	6.3049%	629.28	(137.01)
00207	Child & Family Guidance Center	15,887.76	(6,138.27)	(5,032.53)	(585.75)	4,131.21	6.3049%	1,001.71	(423.94)
00213	South Bay Children's Health Center	582.00	(117.21)	(96.10)	-	368.69	6.3049%	36.69	(7.39)
Sub-Total - Services not Identified as AB 3632		82,766.85	(34,716.90)	(26,748.27)	(2,028.15)	19,273.53		5,218.37	(2,316.74)
TOTAL (FY 2002-03)		**323,629**	**(99,419)**	**(78,739)**	**(2,028)**	**143,443**	-	**20,404**	**(6,396)**

Offsetting Reimbursements
FY 2002-03

Legal Entity #	Medi-Cal (EPSDT) Units	Medi-Cal (Non EPSDT) Units	Health Families Units	Unit Rate	Gross Cost	Medi-Cal Revenue	EPSDT Revenue	Healthy Families Revenue	Other Revenue	Total Prior to Admin	FFP Admin Offset	Total Offsets
00019	18,180	90	280	3.57	66,223.50	32,840.23	26,791.79	649.74	-	60,281.77	5,181.90	65,463.67
00171	3,125	-	300	3.54	12,124.50	5,569.97	4,566.60	690.30	-	10,826.87	394.70	11,221.57
00178	60	-	-	4.09	245.40	123.56	101.30	-	-	224.86	7.79	232.65
00179	5,114	30	-	4.23	21,759.12	10,955.72	8,929.78	-	-	19,885.50	690.75	20,576.24
00180	515	-	-	2.25	1,158.75	583.43	478.33	-	-	1,061.76	36.78	1,098.55
00181	5,255	-	445	1.78	10,146.00	4,709.69	3,861.29	514.87	-	9,085.84	329.40	9,415.25
00183	8,951	-	948	3.47	34,349.53	15,638.69	12,821.56	2,138.21	-	30,598.46	1,120.82	31,719.28
00184	9,795	-	1,870	4.23	49,342.95	20,861.44	17,103.48	5,141.57	-	43,106.49	1,639.46	44,745.95
00188	42,148	-	2,265	3.31	147,007.03	70,243.22	57,589.68	4,873.15	-	132,706.05	4,736.01	137,442.06
00191	19,850	-	-	2.76	54,786.00	27,584.75	22,615.66	-	-	50,200.41	1,739.19	51,939.60
00192	18,969	180	435	3.40	66,585.60	32,781.17	26,623.37	961.35	-	60,365.89	2,127.43	62,493.33
00195	9,437	-	145	3.38	32,387.16	16,060.17	13,167.11	318.57	-	29,545.84	1,032.66	30,578.50
00196	16,348	465	-	3.72	62,544.36	31,491.09	25,104.25	-	-	56,595.34	1,985.48	58,580.82
00198	16,481	-	-	4.15	68,396.15	34,437.46	28,233.93	-	-	62,671.39	2,171.25	64,842.64
00199	25,374	90	354	3.63	93,719.34	46,540.68	38,022.03	835.26	-	85,397.97	2,987.01	88,384.97
00201	485	-	-	4.05	1,964.25	989.00	810.84	-	-	1,799.84	62.36	1,862.20
00203	43,178	50	886	3.05	134,547.70	66,384.16	54,362.83	1,756.50	-	122,503.48	4,296.20	126,799.68
00207	68,239	60	4,167	3.92	284,066.72	134,803.10	110,422.71	10,617.52	-	255,843.33	9,168.62	265,011.95
00210	3,810	-	1,065	3.35	16,331.25	6,426.42	5,268.77	2,319.04	-	14,014.23	551.39	14,565.63
00213	2,700	-	-	3.88	10,476.00	5,274.67	4,324.49	-	-	9,599.16	332.56	9,931.72
00214	177	-	195	3.33	1,238.76	296.77	243.31	422.08	-	962.15	45.32	1,007.48
00221	8,697	-	-	3.43	29,830.71	15,019.76	12,314.12	-	-	27,333.88	946.98	28,280.86
Total	**326,888**	**965**	**13,355**		**1,199,231**	**579,615**	**473,757**	**31,238**	**-**	**1,084,611**	**41,584**	**1,126,195**
Additional Services: See "Costs (02-03)"						**99,419**	**78,739**	**-**	**2,028**	**180,186**	**6,396**	**186,582**
Total						**679,034**	**552,496**	**31,238**	**2,028**	**1,264,797**	**47,980**	**1,312,777**
Audited Reimbursements												**1,185,536**
Rounding Difference												(1)
Increase of Offsetting Reimbursements												**127,240**

Direct & Indirect Costs
FY 2003-04

Entity #	Provider	Gross Costs	FFP	EPSDT	Other Revenue	Net Costs	Indirect Cost Rate	Indirect Costs	FFP Admin Offset
Providers Not Identified									
00185	El Centro De Amistad, Inc.	2,600.15	(826.87)	(622.40)	-	1,150.88	7.9623%	207.03	(65.84)
00190	Gateways Hospital	2,820.00	(1,359.15)	(1,023.06)	-	437.79	7.9623%	224.54	(108.22)
00204	Pasadena Childrens Training	154,673.69	(57,766.91)	(42,599.66)	-	54,307.12	7.9623%	12,315.58	(4,599.57)
00208	San Fernando Valley CMHC Inc.	5,154.60	(145.11)	(21.85)	-	4,987.64	7.9623%	410.42	(11.55)
00217	Saint Johns Health Center	28,418.11	(3,188.69)	(2,400.19)	-	22,829.23	7.9623%	2,262.74	(253.89)
00320	San Gabriel Chidren's Center	13,020.70	(5,999.84)	(4,516.20)	-	2,504.66	7.9623%	1,036.75	(477.73)
00321	Hillsides (Church Home for Children)	27,515.60	(13,761.88)	(10,358.83)	-	3,394.89	7.9623%	2,190.87	(1,095.76)
00519	Aspen Health Services	5,089.56	(2,420.76)	(1,822.15)	-	846.65	7.9623%	405.25	(192.75)
00591	Children's Institute International	1,959.90	(322.28)	(242.59)	-	1,395.03	7.9623%	156.05	(25.66)
00724	Foothill Family Service	7,576.89	(3,931.80)	(2,959.54)	-	685.55	7.9623%	603.29	(313.06)
00783	ChildNet Youth & Family Services	3,656.60	(1,478.31)	(1,112.76)	-	1,065.53	7.9623%	291.15	(117.71)
00784	St. Francis Medical Center	769.60	(376.94)	(283.73)	-	108.93	7.9623%	61.28	(30.01)
00019	Los Angeles County DMH	833.70	-	-	-	833.70	13.5837%	113.25	-
Sub-Total - Providers Not Identified		254,089.10	(91,578.54)	(67,962.96)	-	94,547.60		20,278.20	(7,291.76)
Clients Incorrectly Determined to be Ineligible									
00188	Enki Health & Research	370.80	(197.64)	(148.77)	-	24.39	7.9623%	29.52	(15.74)
00192	Hathaway Children & Family Services	680.00	-	-	-	680.00	7.9623%	54.14	-
00196	Vista Del Mar Child & Family Services	12,246.24	(5,724.22)	(4,308.75)	-	2,213.27	7.9623%	975.08	(455.78)
00203	Pacific Clinics	21,339.36	(11,373.88)	(8,561.35)	-	1,404.13	7.9623%	1,699.10	(905.62)
Sub-Total - Clients Incorrectly Determined		34,636.40	(17,295.74)	(13,018.87)	-	4,321.79		2,757.85	(1,377.14)
Services Not Identified as AB 3632 in MIS (Unclaimed)									
00183	Did Hirsch Psychiatric Service	13,935.60	(4,833.46)	(3,594.91)	(27.95)	5,479.28	7.9623%	1,109.59	(387.08)
00188	Enki Health & Research	35,646.24	(16,966.85)	(12,317.74)	(702.86)	5,658.79	7.9623%	2,838.26	(1,406.92)
00198	Help Group Child & Family Center	14,596.98	(2,669.87)	(2,009.67)	-	9,917.44	7.9623%	1,162.26	(212.58)
00199	Los Angeles Child Guidance Clinic	38,006.10	(17,480.85)	(13,158.18)	(103.90)	7,263.17	7.9623%	3,026.16	(1,400.15)
00207	Child & Family Guidance Center	19,462.80	(8,823.37)	(6,641.53)	(318.04)	3,679.86	7.9623%	1,549.69	(727.87)
00213	South Bay Children's Health Center	702.28	-	-	-	702.28	7.9623%	55.92	-
Sub-Total - Services not Identified as AB 3632		122,350.00	(50,774.40)	(37,722.03)	(1,152.75)	32,700.82		9,741.87	(4,134.60)
TOTAL (FY 2002-03)		**411,076**	**(159,649)**	**(118,704)**	**(1,153)**	**131,570**	**-**	**32,778**	**(12,803)**

Offsetting Reimbursements
FY 2003-04

Legal Entity #	Medi-Cal (EPSDT) Units	Medi-Cal (Non EPSDT) Units	Health Families Units	Unit Rate	Gross Cost	Medi-Cal Revenue	EPSDT Revenue	Healthy Families Revenue	Other Revenue	Total Prior to Admin	FFP Admin Offset	Total Offsets
00019	15,628	-	90	3.97	62,400.46	33,069.00	24,891.72	232.25	-	58,192.97	4,523.54	62,716.51
00171	3,235	60	-	3.52	11,598.40	6,181.95	4,568.54	-	-	10,750.49	492.23	11,242.72
00178	-	50	-	4.07	203.50	108.47	-	-	-	108.47	8.64	117.10
00179	8,637	-	158	4.23	37,202.85	19,472.89	14,657.65	434.42	-	34,564.96	1,585.08	36,150.04
00180	1,495	-	-	2.21	3,303.95	1,761.01	1,325.54	-	-	3,086.55	140.22	3,226.77
00181	6,025	-	235	1.87	11,706.20	6,005.18	4,520.22	285.64	-	10,811.04	500.89	11,311.93
00183	6,195	36	848	3.60	25,484.40	11,956.04	8,947.56	1,984.32	-	22,887.93	1,109.97	23,997.90
00184	4,935	150	4,380	4.23	40,036.95	11,464.59	8,375.07	12,042.81	-	31,882.47	1,871.73	33,754.20
00188	29,261	692	755	3.09	94,887.72	49,331.69	36,275.10	1,516.42	-	87,123.21	4,048.68	91,171.88
00191	10,313	-	-	3.01	31,042.13	16,545.46	12,454.10	-	-	28,999.56	1,317.40	30,316.96
00192	14,239	-	310	3.40	49,466.60	25,803.92	19,423.14	685.10	-	45,912.15	2,109.13	48,021.29
00195	3,572	45	90	3.38	12,529.66	6,516.17	4,843.83	197.73	-	11,557.73	534.58	12,092.31
00196	27,430	-	-	3.72	102,039.60	54,387.11	40,938.29	-	-	95,325.39	4,330.46	99,655.86
00198	14,005	-	-	4.22	59,101.10	31,500.89	23,711.36	-	-	55,212.25	2,508.20	57,720.44
00199	29,660	370	420	3.63	110,533.50	58,101.74	43,195.52	990.99	-	102,288.25	4,705.14	106,993.39
00201	1,556	-	-	4.05	6,301.80	3,358.86	2,528.28	-	-	5,887.14	267.44	6,154.58
00203	47,808	160	3,887	2.92	151,416.60	74,655.48	56,007.26	7,377.53	-	138,040.27	6,531.71	144,571.98
00207	84,767	145	6,474	3.92	358,233.12	177,411.74	133,313.40	16,495.75	-	327,220.89	15,439.50	342,660.38
00210	10,706	-	570	3.60	40,593.60	20,542.67	15,462.89	1,333.80	-	37,339.36	1,741.87	39,081.23
00213	2,488	-	-	3.88	9,653.44	5,145.28	3,872.96	-	-	9,018.24	409.68	9,427.93
00214	165	-	595	3.33	2,530.80	292.86	220.44	1,287.88	-	1,801.17	125.86	1,927.04
00216	45	-	-	3.56	160.20	85.39	64.27	-	-	149.66	6.80	156.46
00221	7,515	285	60	3.90	30,654.00	16,213.86	11,758.57	152.10	-	28,124.53	1,303.11	29,427.64
Total	**329,680**	**1,993**	**18,872**		**1,251,081**	**629,912**	**471,356**	**45,017**	**-**	**1,146,285**	**55,612**	**1,201,897**
Additional Services: See "Costs (03-04)"						**159,649**	**118,704**	**-**	**1,153**	**279,506**	**12,803**	**292,309**
Total						**789,561**	**590,060**	**45,017**	**1,153**	**1,425,791**	**68,415**	**1,494,206**
Audited Reimbursements												**1,284,115**
Rounding Difference												
Increase of Offsetting Reimbursements												**210,091**

Tab 13

9/23/08

Paul McIver

A Guide to Community Mental Health Rehabilitation Service Activity Codes for Clinic Service Providers

County of Los Angeles – Department of Mental Health

Marvin J. Southard, D.S.W.
Director of Mental Health
March 2002

Prepared by: Date: 9/23/08

Guide To Community Mental Health Rehabilitation Service Activity Codes
for
Clinic Service Providers

MEDICATION SUPPORT (MODE 15)

MEDICATION SUPPORT

Services include prescribing, administering, dispensing, and monitoring of psychiatric medication(s) or biologicals necessary to alleviate the symptoms of mental illness which are provided by a staff person within the scope of practice of his/her profession. Activities also include evaluation of the need for medication and the effects of the medication prescribed, obtaining informed consent, medication education. *Inclusive of travel, plan development and documentation time.*

Example: A client exhibiting major depressive symptoms is referred to a psychiatrist for evaluation and treatment. Once informed consent is obtained and medication is prescribed, a nurse explains the medication regimen and possible side effects to his/her significant other. A follow-up session is scheduled.

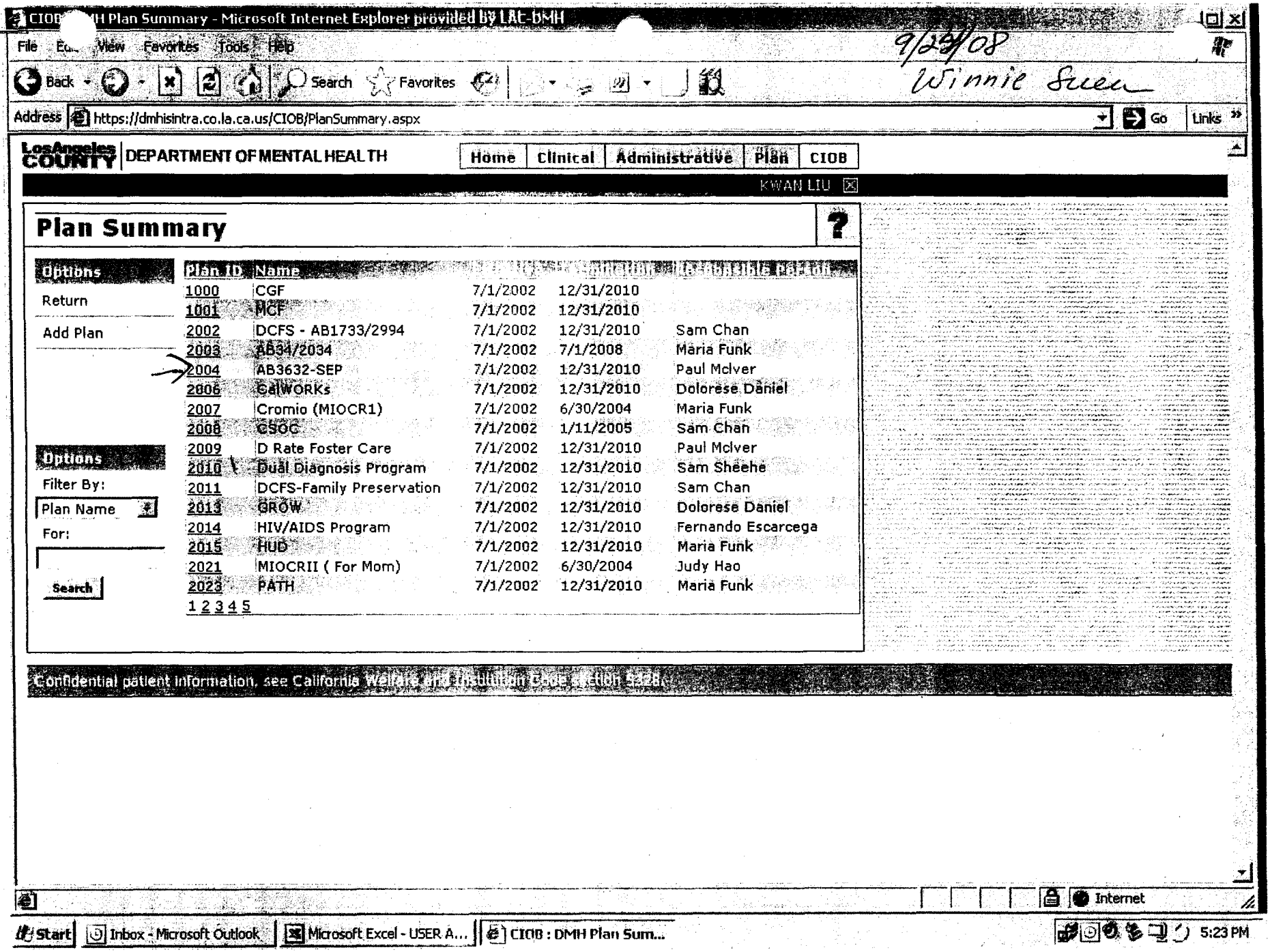
Site Location	SFC	Activity Code	Activity	Tracks To	Scope of Practice (See Legend)
☐ Office+ ☐ Field ☐ Tel. ☐ Inpt. ☐ Jail	60	1727	MED, **AB1733/2994** Medication Support, RS	AB1733/ 2994	#1+, #5, #6, #7, and #9
	61	811	MED, **SEP** Medication Support, RS	[redacted]	
	62	035	MED, Medication Support, RS	Medicare+ M/C GF	
		9116	MED, **CalWORKS/GROW** Medication Support	DPSS	
		9094	MED, **SAMHSA/ADP** Medication Support, RS (DMH Only)	SAMHSA	
	65	9008	MED, **PATH** Homeless Grant Medication Support, RS	PATH	
	67	8011	MED, **FP** Medication Support, RS	Family Pres	

Notes:

- When a physician and a nurse provide Medication Support services to a client, the time of both staff should be claimed. If one note is written covering both staff, one claim is made; if 2 notes are written, 2 claims are made. In the unusual circumstance where the client or significant other is not present, plan documentation is reimbursable without a direct contact. If a staff person ineligible to claim Medication Support participates in the contact, then a separate note must be written documenting service time as either TCM or MHS.
- Medication Support services is reimbursable up to a maximum of 4 hours a day per client.

+ Medicare reimburses only for medication support services provided in the Office to Medicare recipients by a physician.

Prepared by: [illegible] Date: 2/23/08
Reviewed by: [illegible] Date: 1/15/10



Prepared by: Date: 9/29/08
Reviewed by: Date: 9/29/08

Tab 14

Ryan, Christopher

From: Paul McIver <PMcIver@dmh.lacounty.gov>
Sent: Monday, October 06, 2008 5:36 PM
To: Ryan, Christopher; Pilipyuk, Anna; Yaghobyan, Hasmik; Winnie Suen
Cc: Johnson, John E.; Michael Boyle; Genciana Macalalad; Yee, Connie
Subject: RE: HDS and HDSII

The previous audit was before the advent of the IS, (Plans) so we were still in the MIS (Activity Codes) The basis for the inquiry was my own suspicion and also of the auditor, that some contractors and directly operated clinics were sometimes confused about he proper coding of claims. We took a small sample and found enough mistakes in the sample to warrant looking at about 1500 cases.

The key then, as it would still be now, is that all AB 3632 students are deemed eligible through the assessment process. All assessments to establish eligibility are conducted in just two reporting units: 1939 or 7437. So in the review of episode overview screens, we threw out any claims that did not link to an episode of assessment in 1939 or 7437.

From: Ryan, Christopher [mailto:cryan@sco.ca.gov]
Sent: Monday, October 06, 2008 5:14 PM
To: Paul McIver; Pilipyuk, Anna; Yaghobyan, Hasmik; Winnie Suen
Cc: Johnson, John E.; Michael Boyle; Genciana Macalalad; Yee, Connie
Subject: RE: HDS and HDSII

Paul,

In the previous case when you printed 1,500 client episode screens, was this due to a lack of a unique identifier for AB 3632?

Basically, what we are trying to get from the county is the population of clients and their units that support the units claimed. Initially, we were told that the county uses AB 3632 plan as the identifier. The AB 3632 identifier only supports a portion of the claimed units (roughly 20%-30%). Subsequently, it appears that the contractor units are commingled in EPSDT/SDMC plan identifier. Again, we need the county to identify the client population and their units of service that support the claim in order to select a sample of client files to test.

If tomorrow doesn't work maybe Wednesday would be better.

Christopher B. Ryan, CIA
Audit Manager
Mandated Costs Bureau
Division of Audits
State Controller's Office
(916) 327-0696

From: Paul McIver [mailto:PMcIver@dmh.lacounty.gov]
Sent: Monday, October 06, 2008 04:40 PM
To: Pilipyuk, Anna; Yaghobyan, Hasmik; Winnie Suen
Cc: Ryan, Christopher; Johnson, John E.; Michael Boyle; Genciana Macalalad; Yee, Connie
Subject: RE: HDS and HDSII

I am only available for a conference call tomorrow after 4:00pm.

Also, during the previous audit of this program, there were similar questions about which claims were attributable to AB 3632 students. Ultimately, we printed about 1,500 client episode overview screens, which I personally reviewed one by one, and eliminated about 15% of the claims as ineligible (miscoded) for AB 3632. We may have to do that again.

From: Pilipyuk, Anna [mailto:APilipyuk@sco.ca.gov]
Sent: Monday, October 06, 2008 4:12 PM
To: Yaghobyan, Hasmik; Winnie Suen
Cc: Paul McIver; Ryan, Christopher; Johnson, John E.; Michael Boyle; Genciana Macalalad; Yee, Connie
Subject: RE: HDS and HDSII

Winnie,
We understand that the CD that you had provided to us on 10/24/2008 includes the AB3632 units unidentified by AB 3632 Plan (Plan ID Code 2004). But the CD's units only partially support the Los Angeles claims since many of contract providers used MC/EPSDT Funding Source Plan instead of AB 3632 Funding Source Plan. Contract providers failed to identify AB 3632 population with AB 3632 Funding Source Plan. Instead, contract providers commingled AB 3632 and non-AB 3632 clients under the MC/EPSDT Funding Source Plan. Los Angeles County noted that discrepancy and required contract providers to prepare supplemental detail to MH 1901 schedule B to identify AB 3632. We received supplemental detail to MH 1901 schedule B for each contract provider for FY 2003-04, FY 2004-05, and FY 2005-06. But we still do not know how contract providers identify the AB 3632 units. You stated that "*Contract providers need to provide the back up documentation with the AB 3632 Client Name/Client Identification Number in order for us to extract the eligible AB3632 units in the MC/EPSDT plan*". Do you mean that County MH employees manually go over each client file to verify his/her eligibility?

I would like to schedule the conference call for tomorrow (10/7/08) afternoon (any time in afternoon that is suitable to Los Angeles County) so we could discuss all the outstanding issues. I also would like if Paul McIver and Hasmik Yaghobyan would be present during the conference call. My supervisor number is 916-327-0696. Please let me know if the date and time are suitable for you.

We would prepare the document request from information we had been provided so far and e-mail it to you tomorrow.

If you have any questions or concerns, please do not hesitate to contact me.

Thank you,

-Anna

Anna Pilipyuk
Auditor, Division of Audits
State Controller's Office
(916) 323-4206 - phone
(916)324-7223 - fax
apilipyuk@sco.ca.gov

From: Yaghobyan, Hasmik [mailto:HYAGHOBYAN@auditor.lacounty.gov]
Sent: Monday, October 06, 2008 02:43 PM
To: Winnie Suen; Pilipyuk, Anna

Tab 15

W/P Section SP-1.11 Page 1/5
Prepared by: XP Date: 12/18/09
Reviewed by: CR Date: 12/22/09

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

600 S. COMMONWEALTH AVE., 2nd fl., LOS ANGELES, CALIFORNIA 90005

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: Child, Youth & Family Program Admin.
Countywide Case Management / Interagency Program
Phone: (213) 739-2334
Fax: (213) 738-6521

May 11, 2009

TO: Anna Pilipyuk, Auditor
Division of Audits

FROM : Paul McIver, LCSW, District Chief
Child, Youth, and Family Program Administration

SUBJECT: **RESPONSES TO QUESTIONS OF APRIL 22, 2009**

ELIGIBILITY

Soon after our telephone conference call of March 12, 2009, I requested and received the claims data file from John Ortega of our Chief Information Office. I requested the claims data for FY 02-03, FY 03-04, FY 04-05, and FY 05-06, the entire period which is subject to your current audit. The claims data file was supposed to contain all claims for services in which "AB 3632" was identified as the " PLAN", regardless of the source of funding for the services, consistent with DMH policy and practice for claiming Units of Service in the Integrated System (IS).

Upon receipt of the data, my Administrative Assistant, Marina Taylor, reviewed the entire file and annotated each case as "YES" (eligible for AB 3632) or "NO" (ineligible for AB 3632). She did not review each claim line, but used the seven digit identifier for each client and cross referenced each client in the IS, looking for a prior episode of assessment in Provider # 1939, #7191; or #7437, the only authorized providers of AB 3632 Assessment in Los Angeles County during the past fifteen years.

Upon completion of this first round of reviews, we selected a sample of 122 clients from 20 different agencies, including some contract agencies as well as some directly operated county programs. Each of the 122 selected were from the pool of "INELIGIBLE" clients identified by Ms. Taylor's review. We sent letters to the agencies requesting "proof of eligibility", as evidenced by a copy of an Assessment Report, an IEP, or at the very least, a Letter of Referral from one of my Assessment Unit staff. (See attached sample letter)

The responses to the letter were inconsistent. Indeed, some agencies sent copies of the aforementioned "proof of eligibility", and after my review, Ms. Taylor updated the annotated data file to indicate "Yes", when eligibility was confirmed. In some cases, agencies notified me that they did not have the proof of eligibility requested, and that in

most cases the clients were also eligible for EPSDT/MediCal, which was the funding utilized for the services attributed to "AB 3632" in error. Incredibly, some agencies sent in information that clearly proved that the clients were INELIGIBLE. It is my belief that the vast majority of errors are related to inaccurate coding and are attributable to the confusion and inadequate training at the time of the implementation of the IS system.

As noted above, Ms. Taylor and I did not do any tests of the individual claim lines to validate the services. One would need to compare the claims against the clinical records and IEP documents to determine if the services delivered were appropriate and consistent with the IEP. The tasks performed by Ms. Taylor and I did not address the issues of duplicate transactions, ineligible services, and miscoded services, but rather only to verify that the clients for whom services were claimed were indeed eligible as "AB 3632" students. Approximately ten days ago, I discovered that the data files sent to me by John Ortega did not contain all of the data for the entire audit period as I had requested. The data for FY 05-06 was omitted, so the detailed review conducted by Ms. Taylor covered only FY 02-03, FY 03-04, and FY 04-05.

I will forward under separate cover the updated file that Ms. Taylor was working from, if that would be helpful. I am not sure what data John Ortega sent to you, or if he modified it after Ms. Taylor reviewed it for me.

REHABILITATION

Los Angeles County does not provide, and has never authorized rehabilitation services to any AB 3632 eligible clients. As you may know, Los Angeles County filed a test claim with the Commission on State Mandates seeking inclusion of rehabilitation services in the menu of mandated and reimbursable services under AB 3632. In 2005, the Commission ruled that such services are not mandated and not reimbursable, so we have never included recommendations for rehabilitation in our assessment reports and to the best of my knowledge it has never appeared in any student IEPs.

Even when State DMH issued DMH Information Notice # 08-15 on June 23, 2008, which indicated that rehabilitation could be provided and funded with IDEA or State General Funds, I felt that State DMH was incorrect. We maintained our position that it is neither mandated nor reimbursable, despite vehement protestations from both local and statewide mental health service providers.

To be clear, rehabilitation is a legitimate mental health service in the EPSDT/ MediCal program, and there are clients who are eligible under both programs (EPSDT/MediCal and AB 3632). If clients received rehabilitation services, it was under the EPSDT /MediCal program and was not indicative of an AB 3632 related service.

As you know, State DMH recently rescinded DMH Information Notice # 08-15, confirming my position on this issue.

MODE 60 SFC 63

To date, I have been unable to complete my evaluation and research on this issue. I am going to be out of town at a conference from May 12.through May 17. You have been very patient on this, and I assure you I will address this upon my return to give you a written response to your questions.

If you have any questions about any of the above information, please contact me. Thank you

PM:ya

Attachment

c: Hasmik Yaghobyan, Auditor-Controller
Winnie suen, DMH

Tab 16

W/P Section CD 7.11 Page 1 of 5
Prepared by: AP Date: 12/15/09
Reviewed by: CR Date: 12/22/09

Pilipyuk, Anna

From: Pilipyuk, Anna
Sent: Wednesday, April 22, 2009 02:26 PM
To: HYAGHOBYAN@auditor.lacounty.gov; Paul McIver; 'Winnie Suen'; John Ortega
Cc: Ryan, Christopher; Johnson, John E.; Read, Rebecca
Subject: HDS and HDSII audits

Importance: High

To all,
I would like to update everyone on the current audit status and follow up on some outstanding issues.

We received UOS data yesterday (4/21/2009). The file included FYs 2001-09 (we requested only FY 2002-06). We had difficulty downloading and querying the data because all years were included in data table. I an addition, the Medi-Cal units column was inadvertently deleted. I spoke to John Ortega this morning and he stated that he will post new data (broken by FYs and including Medi-Cal units) by the close of business today.

Paul,

We have some questions on how you and your staff arrived to the list of all the eligible clients:

1. What is the total population of eligible clients?
2. In terms of client eligibility, what steps did you take to verify eligibility?
3. Did you discover any ineligible clients? If so, how many?
4. What portion of the total population did you test?
5. Did you perform tests to validate the services provided? If so, what steps did you perform to verify services?
6. Do you feel that the steps performed address all of the issues noted in testing? These issues include duplicate transactions, ineligible services and miscoded services.

We also wanted to follow up with you on Mode 60 SFC 63. During our last conference call you stated that you would like to research this matter before providing a response. Specifically, you were going to respond as to why the county believes that the pre-services are eligible in accordance with the parameters and guidelines of the program. We have not heard from you on this matter.

Furthermore, we have some questions on rehabilitation services:

1. Does Los Angeles County provide any rehabilitation services? If yes, how does the county identify the services?
2. Does Los Angeles County provide any rehabilitation (Mode 15) to AB3632 clients?
3. Does the county include any rehabilitation services in the claim?

Thank you,
-Anna

Anna Pilipyuk
Auditor
State Controller's Office

Prepared by: AP Date: 12/18/09
Reviewed by: CR Date: 12/22/09

Division of Audits - Mandated Cost
(916) 323-4206 - phone
(916) 324-7223 - fax
apilipyuk@sco.ca.gov

Tab 17

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
AB3632 - MEDICATION MONITORING COST SUMMARY
FY 2002-2003

COST ELEMENTS IDENTIFIED BY GROSS PROGRAM COSTS, OFFSETTING REIMBURSEMENTS/REVENUES, AND NET SB 90 REIMBURSABLE COSTS

The following procedure has been followed to assure all appropriate reimbursement/revenue offsets have been applied. Total eligible cost was identified (Line 3) and all applicable reimbursements/revenues have been offset to identify the remaining balance as the eligible SB 90 Chapter 1128/94 reimbursement.

Line 1	AB3632 Program - Medication Monitoring Gross Cost	$ 2,981,091	From Attachment 5, Column (8); To HDS-2, Line (04), column (g).
Line 2	Administration Cost	203,322	From Attachment 5, Column (8); To HDS-1, Line (07
Line 3	Gross AB 3632 Cost	$ 3,184,413	From Attachment 5, Column (8); To HDS-1, Line (08)
	Cost Reduction - Other Reimbursements		
Line 4	Final Early and Periodic Screening, Diagnosis, and Treatment State General Fund (EPSDT-SGF)	$ (607,496)	From Attachment 5, Column (9)
Line 5	EPSDT-SGF share of Administration Costs	(40,860)	From Attachment 5, Column (9)
Line 6	Final Federal Financial Participation (FFP)	(764,552)	From Attachment 5, Column (10)
Line 7	FFP share of Administration Costs	(51,803)	From Attachment 5, Column (10)
Line 8	Federal SAMHSA Grant and share of Administration Costs	(6,400)	From Attachment 5, Column (11)
Line 9	Third Party Revenues & share of Administration Costs	(4,955)	From Attachment 5, sum of Columns (12) through (15)
Line 10	Other State and Local Funds and share of Admin Costs	(4,458)	From Attachment 5, sum of Columns (16) and (17)
	Total Cost Reduction - Other Reimbursements	$ (1,480,524)	From Attachment 5, Column (18); To HDS-1, Line (10)
Line 11	SB 90 Claimed Amount	$ 1,703,889	From Attachment 5, Column (19); To HDS-1, Line (11)

Attachment 5

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
MEDICATION MONITORING SERVICES EXPENDITURES AND REVENUES WORKSHEET
FISCAL YEAR 2002-2003

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
								REVENUE OFFSETS (OTHER REIMBURSEMENTS)										
Contract Type	Entity Name	Entity Number	Mode	SFC	AB 3632 UNITS	Applicable Rate	Gross AB 3632 Cost	Final EPSDT-SGF	Final FFP	Federal SAMHSA Grant	Patient Fees	Patient Insurance	Medicare	3rd Party/ Other	State CSOC	Local Funds DCFS	Total Offsets (sum 9 thru 17)	SB 90 Claimed Amount (8 - 18)
CR	LACDMH	00019	15	61	46,896	$ 3.57	$ 167,613	$ 27,909	$ 39,250	$ -	$ -	$ -	$ -	$ 235	$ -	$ -	$ 67,394	$ 100,219
NR	Aspen Health Services	00519	15	61	5,785	3.32	19,206	8,707	8,958	-	-	-	-	-	-	-	17,665	1,541
NR	Associated League of Mexican-Ameri	00173	15	61	888	3.51	3,117	1,499	1,575	-	-	-	-	-	-	-	3,074	43
NR	Cedars-Sinai Medical Center	00178	15	61	705	4.09	2,883	181	184	-	-	-	-	-	-	-	365	2,518
NR	Child & Family Center	00210	15	61	19,755	3.35	66,179	5,593	8,753	-	4	-	-	-	-	-	14,350	51,829
NR	Child and Family Guidance Center	00207	15	61	155,575	3.92	609,854	132,166	159,414	-	1,161	639	-	2,159	-	-	295,539	314,315
CR	Child and Family Guidance Center	00207	15	61	430	3.92	1,686	-	-	-	-	-	-	-	-	-	-	1,686
NR	Indirect Cost Rate is based on the Cc	00783	15	61	2,102	3.74	7,861	3,308	3,371	-	-	-	-	-	-	-	6,679	1,182
NR	Children's Bureau	00668	15	61	120	2.98	358	59	220	-	-	-	-	-	-	-	279	79
NR	Childrens Hospital Los Angeles	00179	15	61	8,225	4.23	34,792	10,116	10,508	-	-	-	-	-	-	-	20,624	14,168
CR	Children's Institute International	00591	15	61	751	3.98	2,992	327	338	-	-	-	-	-	-	-	665	2,327
NR	Community Counseling Service	00180	15	61	905	2.25	2,036	563	571	-	-	-	-	-	-	-	1,134	902
NR	Community Family Guidance Center	00181	15	61	12,315	1.78	21,921	1,441	5,601	-	-	-	-	-	-	-	7,042	14,879
CR	Devereux Foundation	00472	15	61	3,455	3.49	12,063	33	33	-	-	-	-	-	-	-	66	11,997
CR	Didi Hirsch Psychiatric Service	00183	15	61	22,160	3.47	76,905	16,185	20,993	-	-	-	-	-	-	-	37,178	39,727
NR	Dubnoff Center For Child Developmer	00184	15	61	21,940	4.23	92,806	18,642	25,468	-	-	-	-	-	-	-	44,110	48,696
NR	El Centro de Amistad, Inc.	00185	15	61	150	3.87	581	86	87	-	-	-	-	1	-	-	174	407
NR	Enki Health & Research	00188	15	61	68,123	3.31	225,487	66,352	75,987	-	-	-	-	-	762	-	143,101	82,386
NR	Five Acres Boys' & Girls' Aid Society	00647	15	61	661	3.84	2,538	966	981	-	-	-	-	-	-	-	1,947	591
NR	Foothill Family Service	00724	15	61	841	4.17	3,507	100	102	-	-	-	-	-	-	-	202	3,305
NR	Gateways Hosp & MHC	00190	15	61	3,340	3.00	10,020	2,882	2,925	-	-	-	-	-	-	-	5,807	4,213
NR	Hamburger Home, Inc	00174	15	61	1,392	3.45	4,802	1,355	1,413	-	-	-	-	-	-	-	2,768	2,034
NR	Hathaway Children and Family Servic	00192	15	61	37,166	3.40	126,364	33,013	36,451	-	-	-	-	-	-	-	69,464	56,900
NR	Help Group Child & Family Center	00198	15	61	61,455	4.15	255,038	44,718	62,036	-	-	-	-	-	-	-	106,754	148,284
NR	Hillsides	00321	15	61	9,585	3.95	37,861	3,545	3,627	-	-	-	-	-	-	-	7,172	30,689
NR	Intercommunity Child Guidance Cente	00195	15	61	15,634	3.38	52,843	9,193	16,883	-	-	-	-	-	304	-	26,380	26,463
NR	LAUSD 97th St.Mental Health	00315	15	61	435	4.09	1,779	756	774	-	-	-	-	-	-	-	1,530	249
NR	Los Angeles Child Guidance Clinic	00199	15	61	37,092	3.63	134,644	51,498	59,187	-	-	-	-	-	-	-	110,685	23,959
NR	Pacific Clinics	00203	15	61	79,775	3.05	243,314	59,528	71,954	-	90	3	348	1	-	-	131,924	111,390
NR	Pasadena Childrens Training Society	00204	15	61	36,665	3.59	131,627	33,689	44,261	-	-	-	-	-	-	-	77,950	53,677
NR	Penny Lane Centers	00201	15	61	667	4.05	2,701	-	933	-	-	-	-	-	-	-	933	1,768
CR	Saint Johns Health Center	00217	15	61	14,486	4.23	61,276	4,887	5,026	-	-	-	-	-	-	-	9,913	51,363
NR	San Fernando Valley CMHC, Inc	00208	15	61	750	3.65	2,738	186	547	-	-	-	-	-	-	-	733	2,005
NR	South Bay Children's Health Center	00213	15	61	15,190	3.88	58,937	-	5,576	-	-	-	-	-	-	-	5,576	53,361
NR	Special Service for Groups	00214	15	61	2,378	3.33	7,919	217	645	-	-	-	-	-	-	-	862	7,057
NR	St. Francis Medical Center - Children'	00784	15	61	370	3.48	1,288	634	647	-	-	-	-	-	-	-	1,281	7
NR	Star View	00543	15	61	900	3.48	3,132	257	261	-	-	-	-	-	-	2,234	2,752	380
CR	Stirling Behavioral Health Institute	00216	15	61	120	2.69	322	-	-	-	1	-	-	-	-	-	1	321
NR	The Almansor Center	00171	15	61	5,550	3.54	19,647	5,725	7,911	-	-	-	-	-	-	-	13,636	6,011
NR	The Guidance Center	00191	15	61	31,586	2.76	87,177	26,236	29,608	-	-	-	-	-	-	-	55,844	31,333
CR	The Guidance Center	00191	15	61	7,796	2.92	22,727	-	-	6,020	-	-	-	-	-	-	6,020	16,707
CR	Verdugo Mental Health Center	00221	15	61	29,642	3.43	101,638	1,212	15,412	-	-	-	-	-	-	-	16,624	85,014
NR	Vista Del Mar	00196	15	61	69,600	3.72	258,912	33,732	36,081	-	-	-	-	-	893	-	70,706	188,206
Subtotal					833,356		$ 2,981,091	$ 607,496	$ 764,552	$ 6,020	$ 1,256	$ 642	$ 348	$ 2,396	$ 1,959	$ 2,234	$ 1,386,903	$ 1,594,188
Administration Cost -	LACDMH			15.4730%			25,935	4,318	6,073	-	-	-	-	36	-	-	10,427	15,508
	Contractor (NGA)			6.3049%			177,387	36,542	45,730	380	79	40	22	136	124	141	83,194	94,193
Subtotal							203,322	40,860	51,803	380	79	40	22	172	124	141	93,621	109,701
TOTAL					833,356		$ 3,184,413	$ 648,356	$ 816,355	$ 6,400	$ 1,335	$ 682	$ 370	$ 2,568	$ 2,083	$ 2,375	$ 1,480,524	$ 1,703,889

To HDS-1, Line (10).

EPSDT ADMINISTRATION OFFSET CLAIMED BY COUNTY

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
AB3632 - MEDICATION MONITORING COST SUMMARY
FY 2003-2004

COST ELEMENTS IDENTIFIED BY GROSS PROGRAM COSTS, OFFSETTING REIMBURSEMENTS/REVENUES, AND NET SB90 REIMBURSABLE COSTS

The following procedure has been followed to assure all appropriate reimbursement/revenue offsets have been applied. Total eligible cost was identified (Line 3) and all applicable reimbursements/revenues have been offset to identify the remaining balance as the eligible SB 90 Chapter 1128/94 reimbursement.

Line 1	AB3632 Program - Medication Monitoring Gross Cost	$ 2,839,465	From Attachment 5, Column (8); To HDS-2, Line (04), column (g)
Line 2	Administration Cost	235,416	From Attachment 5, Column (8); To HDS-1, Line (07)
Line 3	Gross AB 3632 Cost	$ 3,074,881	From Attachment 5, Column (8); To HDS-1, Line (08)
	Cost Reduction - Other Reimbursements		
Line 4	Final Early and Periodic Screening, Diagnosis, and Treatment State General Fund (EPSDT-SGF)	$ (590,215)	From Attachment 5, Column (9)
Line 5	EPSDT-SGF share of Administration Costs	(48,016)	From Attachment 5, Column (9)
Line 6	Final Federal Financial Participation (FFP)	(790,381)	From Attachment 5, Column (10)
Line 7	FFP share of Administration Costs	(64,611)	From Attachment 5, Column (10)
Line 8	Third Party Revenues & share of Administration Costs	(7,065)	From Attachment 5, sum of Columns (11) through (14)
Line 9	Other State and Local Funds and share of Admin Costs	(2,166)	From Attachment 5, sum of Columns (15) and (16)
Line 10	Total Cost Reduction - Other Reimbursements	$ (1,502,454)	From Attachment 5, Column (17); To HDS-1, Line (10)
Line 11	SB 90 Claimed Amount	$ 1,572,427	From Attachment 5, Column (18); To HDS-1, Line (11)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
SB90 - CHAPTER 1128/94 HANDICAPPED AND DISABLED STUDENTS II
MEDICATION MONITORING SERVICES EXPENDITURES AND REVENUES WORKSHEET
FISCAL YEAR 2003-2004

Attachment 5

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
								REVENUE OFFSETS - (OTHER REIMBURSEMENTS)									
Contract Type	Entity Name	Entity Number	Mode	SFC	AB 3632 UNITS	Applicable Rate	Gross AB 3632 Cost	Final EPSDT-SGF	Final FFP	Patient Fees	Patient Insurance	Medicare	3rd Party/ Other	State CSOC	Local Fund CalWORKs	Total Offsets (sum 9 thru 16)	SB 90 Claimed Amount (8 - 17)
CR	LACDMH	00019	15	61	34,224	$ 3.97	$ 135,849	$ 10,839	$ 21,290	$ -	$ -	$ -	$ 165	$ -	$ -	$ 32,294	$ 103,555
CR	LACDMH	00019	15	62	7,588	3.97	30,120	7,340	8,580	-	-	-	-	-	-	15,920	14,200
NR	Aspen Health Services	00519	15	61	1,823	3.32	6,052	2,278	2,464	-	-	-	-	-	-	4,742	1,310
NR	Associated League of Mexic	00173	15	61	774	3.56	2,755	1,277	1,469	-	-	-	-	-	-	2,746	9
NR	Cedars-Sinai Medical Cente	00178	15	61	2,722	4.07	11,079	-	108	-	-	-	-	-	-	108	10,971
NR	Child & Family Center	00210	15	61	30,786	3.60	110,830	16,743	20,406	78	-	-	-	-	-	37,227	73,603
NR	Child & Family Guidance Ce	00207	15	61	173,168	3.92	678,819	152,318	196,312	464	1,845	-	3,706	-	-	354,645	324,174
NR	ChildNet Youth & Family Se	00783	15	61	907	3.89	3,528	1,312	1,435	-	-	-	-	-	-	2,747	781
NR	Childrens Hospital of Los An	00179	15	61	7,181	4.23	30,376	8,154	8,874	-	-	-	-	-	1,037	18,065	12,311
NR	Childrens Hospital of Los An	00179	15	62	1,564	4.23	6,616	3,157	3,459	-	-	-	-	-	-	6,616	-
CR	Children's Institute Internatio	00591	15	61	1,750	4.17	7,290	1,006	1,054	-	-	-	-	-	-	2,060	5,230
NR	Community Counseling Serv	00180	15	61	2,950	2.21	6,520	1,507	1,664	-	-	-	-	-	-	3,171	3,349
NR	Community Family Guidance	00181	15	61	11,710	1.87	21,898	1,954	6,139	-	-	-	-	-	-	8,093	13,805
NR	Devereux Foundation	00472	15	61	69	3.54	244	51	56	-	-	-	-	-	-	107	137
CR	Didi Hirsch Psychiatric Serv	00183	15	61	10,568	3.60	38,072	8,515	12,579	-	-	-	-	-	-	21,094	16,978
CR	Didi Hirsch Psychiatric Serv	00183	15	62	22,607	3.60	81,442	2,230	2,559	-	-	-	-	-	-	4,789	76,653
NR	Dubnoff Center	00184	15	61	12,055	4.23	50,993	3,055	12,680	-	-	-	-	-	-	15,735	35,258
CR	El Centro De Amistad, Inc.	00185	15	61	435	4.37	1,899	-	-	-	-	-	-	-	-	-	1,899
NR	Enki Health & Research	00188	15	61	26,144	3.09	80,785	23,579	30,493	-	-	-	-	247	-	54,319	26,466
NR	Enki Health & Research	00188	15	62	19,851	3.09	61,340	18,309	20,563	-	-	-	-	-	-	38,872	22,468
NR	Five Acres Boys' & Girls' Aic	00647	15	61	2,238	2.76	6,177	1,837	1,991	-	-	-	-	-	-	3,828	2,349
NR	Foothill Family Service	00724	15	61	9,313	4.17	38,835	4,807	5,276	-	-	-	-	-	-	10,083	28,752
NR	Gateways Hospital	00190	15	61	1,308	3.00	3,924	1,453	1,580	-	-	-	-	-	-	3,033	891
NR	Hamburger Home, Inc.	00174	15	61	724	3.45	2,498	1,175	1,323	-	-	-	-	-	-	2,498	-
NR	Hathaway Children & Family	00192	15	61	21,266	3.40	72,304	22,028	24,863	-	-	-	-	-	-	46,891	25,413
NR	Help Group Child & Family (	00198	15	61	50,924	4.22	214,899	23,597	42,400	-	-	-	-	-	-	65,997	148,902
NR	Hillsides	00321	15	61	9,120	3.17	28,910	13,083	14,364	-	-	-	-	-	-	27,447	1,463
NR	Institute For Redesign of Le	00171	15	61	8,115	3.52	28,565	7,066	8,852	-	-	-	-	-	-	15,918	12,647
NR	Intercommunity Child Guida	00195	15	61	6,341	3.38	21,433	-	6,554	-	-	-	-	-	-	6,554	14,879
NR	LAUSD 97th St. Mental Hea	00315	15	61	1,290	4.09	5,276	2,049	2,250	-	-	-	-	-	-	4,299	977
NR	Los Angeles Child Guidance	00199	15	61	37,372	3.63	135,660	52,398	64,198	-	-	-	-	-	-	116,596	19,064
CR	Pacific Clinics	00203	15	61	72,898	2.92	213,099	55,319	74,095	38	-	203	-	-	-	129,655	83,444
NR	Pasadena Childrens Trainin	00204	15	61	47,046	3.79	178,304	56,272	72,031	-	-	-	-	-	-	128,303	50,001
NR	Penny Lane Centers	00201	15	61	3,906	4.05	15,819	3,819	5,156	-	-	-	-	-	-	8,975	6,844
CR	Saint Johns Health center	00217	15	61	8,513	4.37	37,202	4,496	4,919	-	-	-	-	-	-	9,415	27,787
CR	San Fernando Valley CMHC	00208	15	61	1,570	3.63	5,694	26	132	-	-	30	-	-	-	188	5,506
CR	San Gabriel Children's Cent	00320	15	61	5,250	4.18	21,968	7,756	8,394	-	-	-	-	-	-	16,150	5,818
NR	South Bay Children's Health	00213	15	61	10,252	3.88	39,778	-	5,013	-	-	-	-	-	-	5,013	34,765
NR	Special Service Fro Groups	00214	15	61	1,886	3.33	6,280	262	1,511	-	-	-	-	-	-	1,773	4,507
NR	St. Francis Medical Center	00784	15	61	185	4.16	770	324	356	-	-	-	-	-	-	680	90
NR	Starview Adolescent Center	00543	15	61	421	3.48	1,465	349	365	-	-	-	-	-	-	714	751
NR	Stirling Academy, Inc.	00216	15	61	1,635	3.56	5,821	-	80	2	-	-	5	-	-	87	5,734
CR	The Guidance Center	00191	15	61	23,905	3.01	71,915	11,942	15,665	-	-	-	-	-	-	27,607	44,308
CR	Verdugo Mental Health Cen	00221	15	61	21,270	3.90	82,965	1,831	16,388	-	-	-	-	-	-	18,219	64,746
NR	Vista Del Mar Child and Fan	00196	15	61	62,741	3.72	233,397	54,702	60,441	-	-	-	-	722	-	115,865	117,532
Subtotal					778,365		$2,839,465	$ 590,215	$790,381	$ 582	$ 1,845	$ 233	$ 3,876	$ 969	$ 1,037	$ 1,389,138	$ 1,450,327
Administration Costs		LACDMH		13.5837%			22,545	2,469	4,057	-	-	-	22	-	-	6,548	15,997
		NGA		7.9623%			212,871	45,547	60,554	46	147	19	295	77	83	106,768	106,103
Subtotal							235,416	48,016	64,611	46	147	19	317	77	83	113,316	122,100
Total					778,365		$3,074,881	$ 638,231	$854,992	$ 628	$ 1,992	$ 252	$ 4,193	$ 1,046	$ 1,120	$ 1,502,454	$ 1,572,427

To HDS-1, Line (10)

EPSDT ADMINISTRATION OFFSET CLAIMED BY COUNTY

Tab 18

Prepared by: JV Date: 1-24-10
Reviewed by: CR Date: 2/9/10

Los Angeles County
Handicapped and Disabled Students II
July 1, 2002, through June 30, 2004
S09-MCC-009
Administrative costs offset

FY 2002-03	p. 10	p. 10		W/P 3E-1 ,p. 3
	EPSDT	FFP	OTHER*	Indirect Rate
DMH directly operated	$ 27,816 A	$ 33,928 C	$ -	E 0.15473
Private contract providers	472,201 B	575,952 D	-	F 0.063049
TOTAL	$ 500,017	$ 609,880	$ -	

	EPSDT share of admin costs *	FFP share of admin costs *	OTHER*
DMH directly operated	$ 4,304	$ 5,250	$ -
Private contract providers	29,772	36,313	-
Totals	$ 34,076	$ 41,563	$ -
	p. 6	p. 6	

Total Administrative Costs offset $ 75,639 p. 6

* Other consists of Federal SAMHSA Grant patient fees & insurance, Medicare, 3rd party/ other, state CSOC, and local funds Cal Works

* Auditor note
DMH directly Operated EPSDT share of admin = A x E
Private contract providers EPSDT share of admin = B x F

DMH directly Operated FFP share of admin = C x E
Private contract providers FFP share of admin = D x F

Prepared by: JV Date: 12-15-09
Reviewed by: MR Date: 1/5/10

Los Angeles County
Handicapped and Disabled Students II
July 1, 2002, through June 30, 2004
S09-MCC-009
Administrative costs offset

FY 2003-04	p. 11 EPSDT	p. 11 FFP	OTHER*	W/P 3E-1 ,p. 3 Indirect Rate
DMH directly operated	$ 25,636 A	$ 34,055 C	$ -	0.135837 E
Private contract providers	483,854 B	642,758 D	-	0.079623 F
TOTAL	$ 509,490	$ 676,813	$ -	

EPSDT * share of admin costs	FFP share of admin costs *	OTHER*
DMH directly operated $ 3,482	$ 4,626	$ -
Private contract providers 38,526	51,178	0
Totals $ 42,008	$ 55,804	$ -
p. 6	p. 6	

Total Administrative Costs offset $ 97,812 p.6

* Other consists of patient fees & insurance, Medicare, 3rd party/ other, state CSOC, and local funds Cal Works

* Auditor Note

DMH directly operated EPSDT share of admin = A x E
Private contract providers EPSDT share of admin = B x F
DMH directly operated FFP share of admin = C x E
Private contract providers FFP share of admin = D x F

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

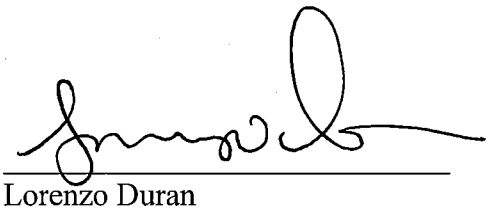
I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On November 26, 2014, I served the:

State Controller's Office (SCO) Comments
Handicapped and Disabled Students II, 12-0240-I-01
Statutes 1994, Chapter 1128; Statutes 1996, Chapter 654
County of Los Angeles, 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 November 26, 2014 at Sacramento, California.



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

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 11/26/14

Claim Number: 12-0240-I-01

Matter: Handicapped and Disabled Students II

Claimant: County of Los Angeles

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.)

Socorro Aquino, *State Controller's Office*
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Attachment D

JOHN CHIANG
California State Controller

May 7, 2013

Robin C. Kay, Ph.D.
Chief Deputy Director
Los Angeles County Department of Mental Health
550 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020

Re: Los Angeles County's Request for the State Controller's Office to Consider Additional Costs After Issuance of the Final Audit Report for the Handicapped and Disabled Students (HDS) Program Audit on June 30, 2010, and the HDS II Program Audit on May 28, 2010

Dear Dr. Kay:

This letter is in reference to Lyn Wallensak's May 3, 2013, email related to our denial of the county's request for the State Controller's Office to reconsider costs for our audits of the HDS Program for the period of July 1, 2003, through June 30, 2006, and the HDS II Program for the period of July 1, 2002, through June 30, 2004.

This letter confirms that we denied the county's reconsideration request through a telephone conference with Ed Jewik, county SB 90 Coordinator, on April 17, 2013, and a follow up telephone conference with Mr. Jewik and Ms. Wallensak on April 29, 2013. During these conference calls, we discussed the reasons for the denial and informed county representatives that we will not be reissuing the audit reports.

Based on information the county provided to us in June and August 2012, our analyses of that information, and subsequent discussions with county staff, we determined that the county did not support that it claimed costs subject to the reconsideration within the statutory period provided for in Government Code sections 17560 and 17561. Furthermore, documentation for such costs was not provided during the course of our two audits. In addition, Government Code section 17568 states that the State will not reimburse any claim that is submitted more than one year after the filing deadline specified in the SCO's claiming instructions. We have no authority to allow costs that were not claimed. Any documentation supporting claimed costs should have been provided during the course the audits. In its response to the two audits, the county agreed with the audit results and provided management representation letters indicating that it had provided our office with complete information.

MAILING ADDRESS P.O. Box 942850, Sacramento, CA 94250-5874
SACRAMENTO 3301 C Street, Suite 700, Sacramento, CA 95816 (916) 324-8907
LOS ANGELES 901 Corporate Center Drive, Suite 200, Monterey Park, CA 91754-7619 (323) 981-6802

In reference to your question on the appeal process, the State Controller's Office does not have an internal audit appeal process. Appeals are filed with the Commission on State Mandates through an incorrect reduction claim (IRC). An IRC must be filed within three years following the date that we notified the county of a claim reduction. The State Controller's Office notified the county of a claim reduction on August 6, 2010, for the HDS Program audit and on June 12, 2010, for the HDS II Program audit. Information related to filing an IRC can be found on the Commission on State Mandates' website at www.csm.ca.gov/docs/IRCForm.pdf.

I discussed your request with my supervisor, Jeffrey V. Brownfield, Chief, Division of Audits. Mr. Brownfield concurs that the proper avenue to resolve your issue is through the Commission on State Mandates.

If you have any questions, please call me at (916) 323-5849.

Sincerely,

JIM L. SPANO, Chief
Mandated Cost Audits Bureau
Division of Audits

JS/kw

12006

cc: Lyn Wallensak, Health Program Analyst III
Los Angeles County Department of Mental Health
Ed Jewik, Program Specialist V
Los Angeles County Department of Auditor-Controller
Jeffrey V. Brownfield, Chief
Division of Audits, State Controller's Office
Chris Ryan, Manager
Division of Audits, State Controller's Office

Attachment E

STATE OF CALIFORNIA
COMMISSION ON STATE MANDATES
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SACRAMENTO, CA 95814
PHONE: (916) 323-3562
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September 30, 2015

Mr. Patrick J. Dyer
MGT of America
2251 Harvard Street, Suite 134
Sacramento, CA 95815

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

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

[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

[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

[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, <u>all claimable</u> 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

[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.

[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.

Dated: September 30, 2015

Heather Halsey, Executive Director

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

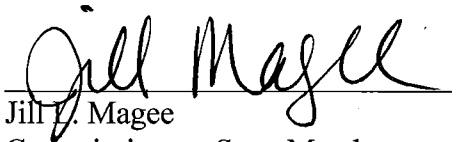
I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

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
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 7/28/15

Claim Number: 05-4282-I-03

Matter: Handicapped and Disabled Students

Claimant: County of San Mateo

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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Attachment F

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December 11, 2014

Mr. Keith B. Petersen
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Ms. Jill Kanemasu
State Controller's Office
Accounting and Reporting
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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;

[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

[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

[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. <u>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.</u>

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].

STATE OF CALIFORNIA
COMMISSION ON STATE MANDATES
980 NINTH STREET, SUITE 300
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PHONE: (916) 323-3562
FAX: (916) 445-0278
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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.

Dated: December 11, 2014

Heather Halsey, Executive Director

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
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

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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Attachment G

STATE *of* CALIFORNIA
COMMISSION ON STATE MANDATES

May 20, 2016

Dr. Robin Kay
County of Los Angeles
Department of Mental Health
550 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020

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: **Draft Proposed Decision, Schedule for Comments, and Notice of Hearing**
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60050,60030, 60040, 60045, 60055, 60100, 60110, 60200
(Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years: 2002-2003 and 2003-2004
County of Los Angeles, Claimant

Dear Dr. Kay and Ms. Kanemasu:

The draft proposed decision for the above-named matter is enclosed for your review and comment.

Written Comments

Written comments may be filed on the draft proposed decision by **June 10, 2016**. You are advised that comments filed with the Commission on State Mandates (Commission) are required to be simultaneously served on the other interested parties on the mailing list, and to be accompanied by a proof of service. However, this requirement may also be satisfied by electronically filing your documents. Refer to http://www.csm.ca.gov/dropbox_procedures.php on the Commission's website for electronic filing instructions. (Cal. Code Regs., tit. 2, § 1181.3.)

If you would like to request an extension of time to file comments, please refer to section 1187.9(a) of the Commission's regulations.

Hearing

This matter is set for hearing on **Friday, July 22, 2016**, at 10:00 a.m., State Capitol, Room 447, Sacramento, California. The proposed decision will be issued on or about July 8, 2016. Please let us know in advance if you or a representative of your agency will testify at the hearing, and if other witnesses will appear. If you would like to request postponement of the hearing, please refer to section 1187.9(b) of the Commission's regulations.

Sincerely,

Heather Halsey
Executive Director

J:\MANDATES\IRC\2012\0240 (Handicapped II)\12-0240-I-01\correspondence\draftPDtrans.docx

ITEM ___

INCORRECT REDUCTION CLAIM

DRAFT PROPOSED DECISION

Government Code Sections 7572.55 and 7576;
Statutes 1994, Chapter 1128 (AB 1892);
Statutes 1996, Chapter 654 (AB 2726);

California Code of Regulations, Title 2, Sections 60020, 60050, 60030, 60040, 60045, 60055, 60100, 60110, 60200[1]
(Emergency regulations effective July 1, 1998 [Register 98, No. 26]
final regulations effective August 9, 1999 [Register 99, No. 33])

Handicapped and Disabled Students II

Fiscal Years 2002-2003 and 2003-2004

12-0240-I-01

County of Los Angeles, Claimant

EXECUTIVE SUMMARY

Overview

This Incorrect Reduction Claim (IRC) was filed in response to an audit by the State Controller's Office (Controller) of the County of Los Angeles's (claimant's) annual reimbursement claims under the *Handicapped and Disabled Students II* program for fiscal years 2002-2003 and 2003-2004. The Controller reduced the claims because the claimant: (1) overstated costs by using inaccurate units of service, and (2) overstated offsetting revenues. In this IRC, the claimant contends that the Controller's reductions were incorrect and requests, as a remedy, that the Commission direct the Controller to reinstate $448,202.

After a review of the record and the applicable law, staff finds that:

1. The IRC was untimely filed; and
2. By clear and convincing evidence, the claimant's intention in April 2010 was to agree with the results of the Controller's audit and to waive any right to object to the audit or to add additional claims.

Accordingly, staff recommends that the Commission deny this IRC.

[1] Note that this caption differs from the Test Claim and the Parameters and Guidelines captions in that it includes only those sections that were approved for reimbursement in the Test Claim decision. Generally, a parameters and guidelines caption should include only the specific sections of the statutes and executive orders that were approved in the test claim decision. However, that was an oversight in the case of the Parameters and Guidelines at issue in this case.

Procedural History

The claimant submitted its reimbursement claims, dated May 8, 2006, for fiscal years 2002-2003 and 2003-2004.[2]

The Controller sent a letter to claimant, dated August 12, 2008, confirming the start of the audit.[3]

The Controller issued the Draft Audit Report dated March 26, 2010.[4] The claimant sent a letter to the Controller, dated April 30, 2010, regarding the Draft Audit Report.[5] The Controller issued the Final Audit Report dated May 28, 2010.[6]

On June 11, 2013, the claimant filed this IRC.[7] On November 25, 2014, the Controller filed late comments on the Incorrect Reduction Claim.[8] On December 23, 2014, the claimant filed a request for extension of time to file rebuttal comments which was granted for good cause. On March 26, 2015, the claimant filed rebuttal comments.[9]

Commission staff issued the Draft Proposed Decision on May 20, 2016.[10]

Commission Responsibilities

Government Code section 17561(d) 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.

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[2] Exhibit A, IRC, page 113 (cover letter), page 117 (Form FAM-27).

[3] Exhibit B, Controller's Late Comments on the IRC, page 148-149, (Letter from Christopher Ryan to Wendy L. Watanabe, dated August 12, 2008). See also Exhibit B, Controller's Late Comments on the IRC, page 19, which assert "The SCO contacted the county by phone on July 28, 2008, to initiate the audit, and confirmed the entrance conference date with a start letter dated August 12, 2008 . . . ."

[4] Exhibit A, IRC, page 101.

[5] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[6] Exhibit B, Controller's Late Comments on the IRC, page 6 (Declaration of Jim L. Spano, dated Oct. 31, 2014, paragraph 7); Exhibit A, IRC, page 96 (cover letter), pages 95-110 (Final Audit Report).

[7] Exhibit A, IRC, pages 1, 3.

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

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

[10] Exhibit D, Draft Proposed Decision.

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, of the California Constitution.[11] 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."[12]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.[13]

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.[14] In addition, sections 1185.1(f)(3) 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.[15]

Claims

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

Issue	Description	Staff Recommendation
Did the claimant timely file its Incorrect Reduction Claim?	The Controller issued the Final Audit Report, dated May 28, 2010. The Controller later sent two documents, dated June 12, 2010, summarizing the audit	*Deny IRC as untimely* – The claimant must file an IRC within three years of "the date of the Office of State Controller's final state audit report, letter, remittance advice, or other written notice of adjustment

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

[12] *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1281, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[13] *Johnston v. Sonoma County Agricultural Preservation and Open Space Dist.* (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.

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

[15] 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.

	findings and setting a deadline for payment. On June 11, 2013, the claimant filed this IRC.	notifying the claimant of a reduction." Former Cal. Code Regs., title 2, § 1185(b) (effective from May 8, 2007, to June 30, 2014). Letters, remittance advices, and other communications which merely re-state the findings of the Final Audit Report do not re-set the running of the three-year limitations period.
Did the claimant waive the objections it is now raising?	In two letters both dated April 30, 2010, the claimant agreed with the Controller's audit findings and made representations which contradict arguments claimant now makes in its IRC.	*Deny IRC as waived* – The record contains clear and convincing evidence that the claimant's intention in April 2010 was to agree with the results of the Controller's audit and to waive any right to object to the audit or to add additional claims.

Staff Analysis

I. The IRC Was Untimely Filed.

At the time the reimbursement claims were audited and when this IRC was filed, the regulation containing the limitations period read:

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[16]

The Controller's Final Audit Report and the cover letter to the Controller's Final Audit Report are both dated May 28, 2010.[17] Three years later was Tuesday, May 28, 2013.

Instead of filing this IRC by the deadline of Tuesday, May 28, 2013, the claimant filed this IRC with the Commission on Tuesday, June 11, 2013 — 14 days late.[18]

On its face, the IRC was untimely filed.

The claimant attempts to save its IRC by calculating the commencement of the limitations period from June 12, 2010, the date of two documents issued by the Controller, which the claimant dubs

[16] Former Code of California Regulations, title 2, section 1185(b), effective May 8, 2007, which was re-numbered section 1185(c) as of January 1, 2011, and which was in effect until June 30, 2014.

[17] Exhibit A, IRC, pages 96 (cover letter), 95-110 (Final Audit Report).

[18] Exhibit A, IRC, page 1.

a "Notice of Claim Adjustment."[19] In the Written Narrative portion of the IRC, the claimant writes, "The SCO issued its audit report on May 28, 2010. The report was followed by a Notice of Claim Adjustment dated June 12, 2010."[20]

The claimant's argument fails because: (1) the two documents were not notices of claim adjustment; and (2) even if they were, the limitations period commenced upon the Controller's issuance of the Final Audit Report and did not re-commence upon the issuance of the two documents.

For purposes of state mandate law, the Legislature has enacted a statutory definition of what constitutes a "notice of adjustment." Government Code section 17558.5(c) reads in relevant 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.

In other words, a notice of adjustment is a document which contains four elements: (1) a specification of the claim components adjusted, (2) the amounts adjusted, (3) interest charges, and (4) the reason for the adjustment.

Both of the documents which the claimant dubs a "Notice of Claim Adjustment" contain the amount adjusted, but the other three required elements are absent. Neither of the two documents specifies the claim components adjusted; each provides merely a lump-sum total of all *Handicapped and Disabled Students II* program costs adjusted for the entirety of the relevant fiscal year. Neither of the two documents contains interest charges. Perhaps most importantly, neither of the two documents enunciates a reason for the adjustment.

In addition to their failure to satisfy the statutory definition, the two documents cannot be notices of adjustment because none of the documents adjusts anything. The two documents re-state, in the most cursory fashion, the bottom-line findings contained in the Controller's Final Audit Report.[21]

The Commission's regulation states on its face that the three-year limitations period commences on "the date of" the Controller's Final Audit Report or a "letter . . . notifying the claimant of a reduction." The Controller's Final Audit Report and its cover letter are both dated May 28, 2010. Since the claimant filed its IRC more than three years after that date, the IRC was untimely filed.

The IRC was also untimely filed under the "last essential element" rule of construing statutes of limitations. Under this rule, a right accrues — and the limitations period begins to run — from

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[19] Exhibit A, IRC, pages 13-17.

[20] Exhibit A, IRC, page 5.

[21] Compare Exhibit A, IRC, pages 13-17 with Exhibit A, IRC, page 102 ("Schedule 1 — Summary of Program Costs" in the Final Audit Report). The bottom-line totals are identical.

the earliest point in time when the claim could have been filed and maintained.[22] In determining when a limitations period begins to run, the California Supreme Court looks to the earliest point in time when a litigant could have filed and maintained the claim.[23]

Under these principles, the claimant's three-year limitations period began to run on May 28, 2010, the date of the Final Audit Report and its attendant cover letter. As of that day, the claimant could have filed an IRC, because, as of that day, the claimant received or been deemed to have received detailed notice of the harm, and possessed the ability to file and maintain an IRC with the Commission.

Accordingly, the IRC should be denied as untimely filed.

II. In the Alternative, the County Waived Its Right To File An IRC.

In its comments on the IRC, the Controller stated that the claimant had agreed to the Controller's audit and findings. "In response to the findings, the county agreed with the audit results. Further, the county provided a management representation letter asserting that it made available to the SCO all pertinent information in support of its claims (Tab 10)."[24]

Courts have stated that a "waiver may be either express, based on the words of the waiving party, or implied, based on conduct indicating an intent to relinquish the right."[25] In addition, "[i]t is settled law in California that a purported 'waiver' of a statutory right is not legally effective unless it appears that the party charged with the waiver has been fully informed of the existence of that right, its meaning, the effect of the 'waiver' presented to him, and his full understanding of the explanation."[26] Waiver is a question of fact and is always based upon intent.[27] Waiver must be established by clear and convincing evidence.[28]

The Controller provided the claimant a draft copy of the audit report, dated March 26, 2010.[29] In response to the Draft Audit Report, the claimant's Auditor-Controller sent a three-page letter

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[22] *Aryeh v. Canon Business Solutions, Inc.* (2013) 55 Cal.4th 1185, 1191.

[23] *Howard Jarvis Taxpayers Ass'n v. City of La Habra* (2001) 25 Cal.4th 809, 815.

[24] Exhibit B, Controller's Late Comments on the IRC, page 19. The referenced "Tab 10" is the two-page letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010 (Exhibit B, Controller's Late Comments on the IRC, pages 152-153).

[25] *Waller v. Truck Insurance Exchange* (1995) 11 Cal.4th 1, 31.

[26] *B.W. v. Board of Medical Quality Assurance* (1985) 169 Cal.App.3d 219, 233.

[27] *Smith v. Selma Community Hospital* (2008) 164 Cal.App.4th 1478, 1506.

[28] *DRG/Beverly Hills, Ltd, supra,* 30 Cal.App.4th 54, 60. When a fact must be established by clear and convincing evidence, the substantial evidence standard of review for any appeal of the Commission's decision to the courts still applies. See Government Code section 17559(b). See also *Sheila S. v. Superior Court (Santa Clara County Dept. of Family and Children's Services)* (2000) 84 Cal.App.4th 872, 880.

[29] Exhibit A, IRC, page 101.

dated April 30, 2010: a copy of which is reproduced in the Controller's Final Audit Report.[30] The first page of this three-page letter contains the following statement:

> *The County's response, which is attached, indicates agreement with the audit findings* and the actions that the County will take to implement policies and procedures to ensure that the costs claimed under HDSII are eligible, mandate related, and supported.[31]

The claimant's written response to the Draft Audit Report — the moment when a claimant would and should proffer objections to the Controller's reductions — was to indicate "agreement with the audit findings." The Commission should note that the claimant indicated active "agreement" as opposed to passive "acceptance." In addition, the following two pages of the three-page letter contain further statements of agreement with each of the Controller's findings and recommendations.[32]

The claimant also sent a separate two-page letter dated April 30, 2010, in which the claimant contradicted several positions which the claimant now attempts to take in this IRC.

For example, in its IRC, the claimant argues that the Controller based its audit on incorrect or incomplete documentation.[33] However, neither claimant's four-page letter nor claimant's two-page letter dated April 30, 2010, objected to the audit findings on these grounds — objections which would have been known to the claimant in April 2010, since the claimant and its personnel had spent the prior two years working with the Controller's auditors. Rather, the claimant's two-page letter stated the opposite by repeatedly emphasizing the accuracy and completeness of the records provided to the Controller: "We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO."[34] "We designed and implemented the County's accounting system to ensure accurate and timely records."[35] "We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims."[36] "We are not aware of . . . . Relevant, material

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[30] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[31] Exhibit A, IRC, page 107 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010) (emphasis added).

[32] Exhibit A, IRC, pages 108-109.

[33] Exhibit A, IRC, pages 6-7, 10-12.

[34] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 1).

[35] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 2).

[36] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 5).

transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims."[37]

In the IRC, the claimant now argues that, even if the Controller correctly reduced its claims, the claimant should be allowed to submit new claims based upon previously unproduced evidence under an alleged right of equitable setoff.[38] However, in its two-page letter, the claimant stated the opposite: "There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims."[39] "We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims."[40]

The claimant's two-page letter demonstrates that, as far as the claimant was concerned in April 2010, it had maintained records of actual costs, had maintained accurate and complete records, had provided the Controller with accurate and complete records, and had acknowledged that it had no further reimbursement claims. The claimant now attempts to make the opposite arguments in this IRC.

Given the totality of the circumstances and all of the evidence in the record, staff finds by clear and convincing evidence that the claimant's intention in April 2010 was to agree with the results of the Controller's audit and to waive any right to object to the audit or to add additional claims.

Conclusion

Staff finds that claimant's IRC was untimely filed and that, even if it were timely filed, the claimant waived its arguments.

Staff Recommendation

Staff recommends that the Commission adopt the proposed decision denying the IRC and authorize staff to make any technical, non-substantive changes following the hearing.

[37] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 7(d)).

[38] Exhibit A, IRC, pages 8-10.

[39] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 8).

[40] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 16, 2010, paragraph 9).

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE INCORRECT REDUCTION CLAIM ON: Government Code Sections 7572.55 and 7576; Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726); California Code of Regulations, Title 2, Sections 60020, 60050, 60030, 60040, 60045, 60055, 60100, 60110, 60200[41] (Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33]) Fiscal Years 2002-2003 and 2003-2004 County of Los Angeles, Claimant	Case No.: 12-0240-I-01 *Handicapped and Disabled Students II* DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (*Adopted July 22, 2016*)

DECISION

The Commission on State Mandates (Commission) heard and decided this Incorrect Reduction Claim (IRC) during a regularly scheduled hearing on July 22, 2016. [Witness list will be included in the adopted decision.]

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

The Commission [adopted/modified] the proposed decision to [approve/partially approve/deny] this IRC by a vote of [vote count will be included in the adopted decision] as follows:

[41] Note that this caption differs from the Test Claim and the Parameters and Guidelines captions in that it includes only those sections that were approved for reimbursement in the Test Claim decision. Generally, a parameters and guidelines caption should include only the specific sections of the statutes and executive orders that were approved in the test claim decision. However, that was an oversight in the case of the Parameters and Guidelines at issue in this case.

Member	Vote
Ken Alex, Director of the Office of Planning and Research	
Richard Chivaro, Representative of the State Controller	
Mark Hariri, Representative of the State Treasurer, Vice Chairperson	
Sarah Olsen, Public Member	
Eraina Ortega, Representative of the Director of the Department of Finance, Chairperson	
Carmen Ramirez, City Council Member	
Don Saylor, County Supervisor	

Summary of the Findings

This IRC was filed in response to an audit by the State Controller's Office (Controller) of the County of Los Angeles's (claimant's) initial reimbursement claims under the *Handicapped and Disabled Students II* program for fiscal years 2002-2003 and 2003-2004. The Controller reduced the claims because it found the claimant: (1) overstated costs by using inaccurate units of service, and (2) overstated offsetting revenues.[42] In this IRC, the claimant contends that the Controller's reductions were incorrect and requests, as a remedy, that the Commission reinstate the following cost amounts, which would then become subject to the Program's reimbursement formula:

FY2002-2003: $216,793

FY2003-2004: $231,409[43]

After a review of the record and the applicable law:

1. The Commission finds that the IRC was untimely filed; and
2. The Commission finds, by clear and convincing evidence, that the claimant's intention in April 2010 was to agree with the results of the Controller's audit and to waive any right to object to the audit or to add additional claims.

Accordingly, the Commission denies this IRC.

I. Chronology

05/08/2006 Claimant dated the reimbursement claim for fiscal year 2002-2003[44]

05/08/2006 Claimant dated the reimbursement claim for fiscal year 2003-2004[45]

[42] See, e.g., Exhibit A, IRC, page 96 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated May 28, 2010).

[43] Exhibit A, IRC, page 1.

[44] Exhibit A, IRC, page 113 (cover letter), page 117 (Form FAM-27).

[45] Exhibit A, IRC, page 113 (cover letter), page 254 (Form FAM-27).

08/12/2008 Controller dated a letter to claimant confirming the start of the audit.[46]

03/26/2010 Controller issued the Draft Audit Report, dated March 26, 2010.[47]

04/30/2010 Claimant sent a letter to Controller dated April 30, 2010, in response to the Draft Audit Report.[48]

05/28/2010 Controller issued the Final Audit Report dated May 28, 2010.[49]

06/11/2013 Claimant filed this IRC.[50]

11/25/2014 Controller filed late comments on the IRC.[51]

12/23/2014 Claimant filed a request for extension of time to file rebuttal comments which was granted for good cause.

03/26/2015 Claimant filed rebuttal comments.[52]

05/20/2016 Commission staff issued the Draft Proposed Decision.[53]

II. Background

In 1975, Congress enacted the Education for All Handicapped Children Act ("EHA") with the stated purpose of assuring that "all handicapped children have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs . . . ."[54] Among other things, the EHA authorized the payment of federal funds to states which complied with specified criteria regarding the provision of special education and related services to handicapped and disabled students.[55] The EHA was ultimately re-named the Individuals with Disability Education Act ("IDEA") and guarantees to disabled pupils, including those with mental health needs, the right to receive a free and appropriate

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[46] Exhibit B, Controller's Late Comments on the IRC, page 148-149 (Letter from Christopher Ryan to Wendy L. Watanabe, dated August 12, 2008). See also Exhibit B, Controller's Late Comments on the IRC, page 19, which asserts "The SCO contacted the county by phone on July 28, 2008, to initiate the audit, and confirmed the entrance conference date with a start letter dated August 12, 2008 . . . ."

[47] Exhibit A, IRC, page 101.

[48] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[49] Exhibit A, IRC, page 96 (cover letter), pages 95-110 (Final Audit Report).

[50] Exhibit A, IRC, pages 1, 3.

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

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

[53] Exhibit D, Draft Proposed Decision.

[54] Public Law 94-142, section 1, section 3(a) (Nov. 29, 1975) 89 U.S. Statutes at Large 773, 775. See also 20 U.S.C. § 1400(d) (current version).

[55] Public Law 94-142, section 5(a) (Nov. 29, 1975) 89 U.S. Statutes at Large 773, 793. See also 20 U.S.C. 1411(a)(1) (current version).

public education, including psychological and other mental health services, designed to meet the pupil's unique educational needs.[56]

The *Handicapped and Disabled Students* Mandate

In California, the responsibility of providing both "special education" and "related services" was initially shared by local education agencies (broadly defined) and by the state government.[57] However, in 1984, the Legislature enacted AB 3632, which amended Government Code chapter 26.5 relating to "interagency responsibilities for providing services to handicapped children" which created separate spheres of responsibility.[58] And, in 1985, the Legislature further amended chapter 26.5.[59]

The impact of the 1984 and 1985 amendments — sometimes referred to collectively as "Chapter 26.5 services" — was to transfer the responsibility to provide mental health services for disabled pupils from school districts to county mental health departments.[60]

In 1990 and 1991, the Commission adopted the Statement of Decision and the Parameters and Guidelines approving the Test Claim *Handicapped and Disabled Students,* CSM 4282, as a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution.[61] The Commission found that the activities of providing mental health assessments; participation in the IEP process; and providing psychotherapy and other mental health treatment services were reimbursable and that providing mental health treatment services was funded as part of the Short-Doyle Act, based on a cost-sharing formula with the state.[62] Beginning July 1, 2001, however, the cost-sharing ratio for providing

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[56] Public Law 101-476, section 901(a)(1) (October 30, 1999) 104 U.S. Statutes at Large 1103, 1141-1142.

[57] *California School Boards Ass'n v. Brown* (2011) 192 Cal.App.4th 1507, 1514.

[58] Statutes of 1984, chapter 1747.

[59] Statutes of 1985, chapter 1274.

[60] "With the passage of AB 3632 (fn.), California's approach to mental health services was restructured with the intent to address the increasing number of emotionally disabled students who were in need of mental health services. Instead of relying on LEAs [local education agencies] to acquire qualified staff to handle the needs of these students, the state sought to have CMH [county mental health] agencies — who were already in the business of providing mental health services to emotionally disturbed youth and adults — assume the responsibility for providing needed mental health services to children who qualified for special education." Stanford Law School Youth and Education Law Clinic, *Challenge and Opportunity: An Analysis of Chapter 26.5 and the System for Delivering Mental Health Services to Special Education Students in California,* May 2004, page 12.

[61] "As local mental health agencies had not previously been required to provide Chapter 26.5 services to special education students, local mental health agencies argued that these requirements constituted a reimbursable state mandate." (*California School Boards Ass'n v. Brown* (2011) 192 Cal.App.4th 1507, 1515.)

[62] Former Welfare and Institutions Code sections 5600 et seq.

psychotherapy and other mental health treatment services no longer applied, and counties were entitled to receive reimbursement for 100 percent of the costs to perform these services.[63]

In 2004, the Legislature directed the Commission to reconsider *Handicapped and Disabled Students*, CSM 4282.[64] In May 2005, the Commission adopted the Statement of Decision on Reconsideration, 04-RL-4282-10, and determined that the original Statement of Decision correctly concluded that the test claim statutes and regulations 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. Thus, for costs incurred beginning July 1, 2004, the Commission identified the activities expressly required by the test claim statutes and regulations that were reimbursable, identified the offsetting revenue applicable to the program, and updated the new funding provisions enacted in 2002 that required 100 percent reimbursement for mental health treatment services.

The *Handicapped and Disabled Students II* Mandate

In May 2005, the Commission also adopted the Statement of Decision on *Handicapped and Disabled Students II*, 02-TC-40/02-TC-49, a test claim addressing statutory amendments enacted between the years 1986 and 2002 to Government Code sections 7570 et seq., and 1998 amendments to the joint regulations adopted by the Departments of Education and Mental Health.[65]

The Controller's Audit and Reduction of Costs

The Controller issued a Draft Audit Report dated March 26, 2010, and provided a copy to the claimant for comment.[66]

The claimant sent two letters to the Controller, both dated April 30, 2010. In a three-page letter, the claimant responded directly to the Draft Audit Report, agreeing with the audit's findings and accepting its recommendations.[67] In a separate two-page letter, the claimant addressed the status of its reimbursement claims and its manner of compliance with the audit.[68]

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[63] Statutes 2002, chapter 1167 (AB 2781, §§ 38, 41).

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

[65] Statutes 2011, chapter 43 (AB 114) eliminated the mandated programs for *Handicapped and Disabled Students* (4282, 04-RL-4282-10) and *Handicapped and Disabled Students II* (02-TC-40/02-TC-49) by transferring responsibility for providing mental health services under IDEA back to school districts, effective July 1, 2011. On September 28, 2012, the Commission adopted an amendment to the parameters and guidelines ending reimbursement effective July 1, 2011.

[66] Exhibit A, IRC, page 101.

[67] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[68] Exhibit B, Controller's Late Comments on the IRC, pages 152-153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010).

The Controller issued the Final Audit Report, dated June 30, 2010.[69]

In response to the Draft Audit Report, the claimant's Auditor-Controller sent a three-page letter dated April 30, 2010: a copy of which is reproduced in the Controller's Final Audit Report.[70] The first page of this three-page letter contains the following statement:

> *The County's response, which is attached, indicates agreement with the audit findings* and the actions that the County will take to implement policies and procedures to ensure that the costs claimed under HDSII are eligible, mandate related, and supported.[71]

The following two pages of the three-page letter contain further statements of agreement with the Controller's findings and recommendations.

In response to the Controller's Finding No. 1 that the claimant overstated medication support costs by more than $1.1 million, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that only actual units of service for eligible clients are claimed in accordance with the mandate program.[72]

In response to the Controller's Finding No. 2 that the claimant overstated indirect costs by more than $80,000, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that indirect cost rates are applied to eligible and supported direct costs.[73]

In response to the Controller's Finding No. 3 that the claimant overstated offsetting reimbursements by more than $500,000, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that revenues are applied to valid program costs, appropriate SD/MC and EPSDT reimbursement percentage rates are applied to

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[69] Exhibit B, Controller's Late Comments on the IRC, page 313 (Declaration of Jim L. Spano, dated Oct. 31, 2014, paragraph 7); Exhibit A, IRC, page 96 (cover letter), pages 95-110 (Final Audit Report).

[70] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[71] Exhibit A, IRC, page 107 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010) (emphasis added).

[72] Exhibit A, IRC, page 108 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[73] Exhibit A, IRC, page 108 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

eligible costs, and supporting documentation for applicable offsetting revenues are maintained.[74]

In a separate two-page letter also dated April 30, 2010, the claimant addressed its compliance with the audit and the status of any remaining reimbursement claims.[75] Material statements in the two-page letter include:

> • "We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO."[76]
>
> • "We designed and implemented the County's accounting system to ensure accurate and timely records."[77]
>
> • "We claimed mandated costs based on actual expenditures allowable per the Handicapped and Disabled Students II Program's parameters and guidelines."[78]
>
> • "We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims."[79]
>
> • "We are not aware of any . . . Relevant, material transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims."[80]
>
> • "There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims."[81]

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[74] Exhibit A, IRC, page 109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[75] Exhibit B, Controller's Late Comments on the IRC, pages 152-153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010).

[76] Exhibit B, Controller's Late Comments on the IRC, pages 152-153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 1).

[77] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 2).

[78] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 4).

[79] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 5).

[80] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 7(d)).

[81] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 8).

• "We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims."[82]

On May 28, 2010, the Controller issued the Final Audit Report.[83] The Controller reduced the claims because the claimant: (1) overstated costs by using inaccurate units of service, (2) and overstated offsetting revenues.[84]

On June 11, 2013, the claimant filed this IRC with the Commission.[85]

III. Positions of the Parties

A. County of Los Angeles

The claimant objects to reductions totaling $448,202 to the claimant's reimbursement claims for fiscal years 2002-2003 and 2003-2004.

The claimant takes the following principal positions:

1. The Controller reviewed and utilized incomplete and inaccurate data and documentation when it conducted its audit.[86]
2. The claimant's claims were timely filed.[87]
3. Under the principle of equitable offset, the claimant may submit new claims for reimbursement supported by previously un-submitted documentation.[88]

B. State Controller's Office

The Controller contends that it acted according to the law when it made $448,202 in reductions to the claimant's fiscal year 2002-2003 and 2003-2004 reimbursement claims.

The Controller takes the following principal positions:

1. The claimant failed to provide support for its claims in a format which could be verified.[89]
2. The claimant agreed to the findings of the audit.[90]

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[82] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 9).

[83] Exhibit A, IRC, page 96 (cover letter), pages 95-110 (Final Audit Report).

[84] See, e.g., Exhibit A, IRC, page 96 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated May 28, 2010).

[85] Exhibit A, IRC, pages 1, 3.

[86] Exhibit A, IRC, pages 6-8, 10-12.

[87] Exhibit A, IRC, pages 13-17 (the "Notice of Claim Adjustment" dated June 12, 2010, filed as a supplement to this IRC to establish alleged timeliness).

[88] Exhibit A, IRC, pages 8-10.

[89] Exhibit B, Controller's Late Comments on the IRC, pages 20-22.

[90] Exhibit B, Controller's Late Comments on the IRC, pages 19, 22.

3. The claimant may not, under the principle of equitable offset, submit new claims for reimbursement supported by previously un-submitted documentation.[91]

IV. Discussion

Government Code section 17561(d) 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, of the California Constitution.[92] 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."[93]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion of a state agency.[94] 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

[91] Exhibit B, Controller's Late Comments on the IRC, page 19, 21-22.

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

[93] *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1281, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[94] *Johnston v. Sonoma County Agricultural Preservation and Open Space Dist.* (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.

> between those factors, the choice made, and the purposes of the enabling statute." [Citation.]' "[95]

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. [96] In addition, sections 1185.1(f)(3) 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.[97]

A. The IRC Was Untimely Filed.

At the time the reimbursement claims were audited and when this IRC was filed, the regulation containing the limitations period read:

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[98]

The Controller's Final Audit Report and its cover letter are both dated May 28, 2010.[99] Three years later was Tuesday, May 28, 2013.

Instead of filing this IRC by the deadline of Tuesday, May 28, 2013, the claimant filed this IRC with the Commission on Tuesday, June 11, 2013 — 14 days late.[100]

On its face, the IRC was untimely filed.[101]

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[95] *American Bd. of Cosmetic Surgery, Inc. v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547-548.

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

[97] 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.

[98] Former Code of California Regulations, title 2, section 1185(b), which was re-numbered section 1185(c) as of January 1, 2011. Effective July 1, 2014, the regulation was amended to state as follows: "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." Code of California Regulations, title 2, section 1185.1(c).

[99] Exhibit A, IRC, pages 96 (cover letter), 101 (Final Audit Report).

[100] Exhibit A, IRC, page 1.

[101] "The statute of limitations is an affirmative defense" (*Ladd. v. Warner Bros. Entertainment, Inc.* (2010) 184 Cal.App.4th 1298, 1309), and, in civil cases, an affirmative defense must be established by a preponderance of the evidence (31 Cal.Jur.3d, Evidence, section 97 [collecting cases]; *People ex. rel. Dept. of Public Works v. Lagiss* (1963) 223 Cal.App.2d 23, 37). See also

The claimant attempts to save its IRC by calculating the commencement of the limitations period from June 12, 2010, the date of two documents sent by the Controller which the claimant dubs a "Notice of Claim Adjustment."[102] In the Written Narrative portion of the IRC, the claimant writes, "The SCO issued its audit report on May 28, 2010. The report was followed by a Notice of Claim Adjustment dated June 12, 2010."[103] Although the claimant reads the document dated June 12, 2010, as a single document, the Commission reads it as two documents — specifically, two letters each containing a separate "Dear Claimant" salutation, of which the main text of the second letter is reproduced twice.[104]

The claimant's argument fails because: (1) the two documents were not notices of claim adjustment; and (2) even if they were, the limitations period commenced upon the claimant's receipt of the Final Audit Report and did not re-commence upon the receipt of the later two documents.

1. The Two Documents Dated June 12, 2010, Are Not Notices Of Claim Adjustment.

For purposes of state mandates law, the Legislature has enacted a statutory definition of what constitutes a notice of claim adjustment.

Government Code section 17558.5(c) reads in relevant 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.

In other words, a notice of claim adjustment is a document which contains four elements: (1) a specification of the claim components adjusted, (2) the amounts adjusted, (3) interest charges, and (4) the reason for the adjustment.

Both of the two documents which the claimant dubs a "Notice of Claim Adjustment" contain the amount adjusted, but the other three required elements are absent. Neither of the two documents specifies the claim components adjusted; each provides merely a lump-sum total of all *Handicapped and Disabled Students II* program costs adjusted for the entirety of the relevant fiscal year. Neither of the two documents contains interest charges. Perhaps most importantly, neither of the two documents enunciates any reason for the adjustment.[105]

Evidence Code section 115 ("Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence.").

[102] See Exhibit A, IRC, pages 13-17 ("Notice of Claim Adjustment").

[103] Exhibit A, IRC, page 5.

[104] The two "Dear Claimant" salutations appear at Exhibit A, IRC, pages 13 and 15. The main text of Exhibit A, IRC, page 17, appears to be identical to the main text of Exhibit A, IRC, pages 15 and 16.

[105] Exhibit A, IRC, pages 13-17 ("Notice of Claim Adjustment").

In addition to their failure to satisfy the statutory definition, the two documents cannot be notices of claim adjustment because neither of the documents adjusts anything. The two documents re-state, in the most cursory fashion, the bottom-line findings contained in the Controller's Final Audit Report.[106]

Neither of the two documents provides the claimant with notice of any new finding. The Final Audit Report contained the dollar amounts which would not be reimbursed.[107] The two later documents merely repeat information which was already contained in the Final Audit Report. The two documents do not provide notice of any new and material information or adjustments. Moreover, Government Code section 17558.5(c) provides that a remittance advice or a document which merely provides notice of a payment action is not a notice of adjustment. Whatever term may accurately be used to characterize the two documents identified by the claimant, the two documents are not "notices of claim adjustment" under state mandate law.

The claimant might attempt to rely on a subsequent letter issued by the Controller dated May 7, 2013, which appears to state that the claimant was notified of the claim reductions on June 12, 2010, the date of the two documents. "An IRC must be filed within three years following the date that we notified the county of a claim reduction. The State Controller's Office notified the county of a claim reduction . . . on June 12, 2010, for the HDS III Program audit."[108]

However, the Controller's statement in the letter dated May 7, 2013, is not outcome-determinative for several reasons. First, the Controller's letter does not explicitly state that June 12, 2010, was the first or earliest date on which claimant was informed of the reductions. Second, to the extent that the Controller was stating its legal conclusion regarding the running of the limitations period, the Commission is not bound by the Controller's interpretation of state mandate law. Government Code section 17552 provides that the Commission has the "sole and exclusive" jurisdiction to determine such issues. Third, to the extent that the Controller was making a statement of fact, the relative vagueness of the statement in the letter dated May 7, 2013 which was sent more than two and a half years after the fact, is, on a preponderance of the evidence standard, outweighed by the evidence contained in the Final Audit Report and its cover letter.

Accordingly, the Commission finds that the two documents relied on by the claimant are not notices of claim adjustment which began or re-set the running of the limitations period.

2. <u>The Limitations Period to File This IRC Commenced on May 28, 2010, and Expired on Tuesday, May 28, 2013.</u>

When the reimbursement claims were audited and when this IRC was filed, the regulation containing the limitations period read:

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[106] Compare Exhibit A, IRC, pages 13-17 (the "Notice of Claim Adjustment") with Exhibit A, IRC, page 102 ("Schedule 1 — Summary of Program Costs" in the Final Audit Report). The bottom-line totals are identical.

[107] The Final Audit Report and its cover letter are each dated May 28, 2010. (Exhibit A, IRC, pages 96, 101.)

[108] Exhibit A, IRC, page 21 (Letter from Jim L. Spano to Robin C. Kay, dated May 7, 2013).

> 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 final state audit report, letter, remittance advice, or other written notice of adjustment notifying the claimant of a reduction.[109]

Per this regulation, the claimant's IRC was untimely filed.

The regulation states on its face that the three-year limitations period commences on "the date of" the Controller's Final Audit Report or a "letter . . . notifying the claimant of a reduction." The Controller's Final Audit Report and the cover letter forwarding the Final Audit Report to the claimant were both dated May 28, 2010. Since the claimant filed its IRC more than three years after that date, the IRC was untimely filed.

The IRC was also untimely filed under the "last essential element" rule of construing statutes of limitations. Under this rule, a right accrues — and the limitations period begins to run — from the earliest point in time when the claim can be filed and maintained.

As recently summarized by the California Supreme Court:

> The limitations period, the period in which a plaintiff must bring suit or be barred, runs from the moment a claim accrues. (See Code Civ. Proc., § 312 [an action must "be commenced within the periods prescribed in this title, after the cause of action shall have accrued"]; (Citations.). Traditionally at common law, a "cause of action accrues 'when [it] is complete with all of its elements' — those elements being wrongdoing, harm, and causation." (Citations.) This is the "last element" accrual rule: ordinarily, the statute of limitations runs from "the occurrence of the last element essential to the cause of action." (Citations.)[110]

In determining when a limitations period begins to run, the California Supreme Court looks to the earliest point in time when a litigant could have filed and maintained the claim:

> Generally, a cause of action accrues and the statute of limitation begins to run when a suit may be maintained. [Citations.] "Ordinarily this is when the wrongful act is done and the obligation or the liability arises, but it does not 'accrue until the party owning it is entitled to begin and prosecute an action thereon.' " [Citation.] In other words, "[a] cause of action accrues 'upon the occurrence of the last element essential to the cause of action.' " [Citations.][111]

Under these principles, the claimant's three-year limitations period began to run on May 28, 2010, the date of the Final Audit Report and its attendant cover letter. As of that day, the claimant could have filed an IRC, because, as of that day, the claimant had been, from its perspective, harmed by a claim reduction, had received or been deemed to have received notice of the harm, and possessed the ability to file and maintain an IRC with the Commission. The

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[109] Former Code of California Regulations, title 2, section 1185(b), effective May 8, 2007, renumbered as 1185(c) effective January 1, 2011.

[110] *Aryeh v. Canon Business Solutions, Inc.* (2013) 55 Cal.4th 1185, 1191.

[111] *Howard Jarvis Taxpayers Ass'n v. City of La Habra* (2001) 25 Cal. 4th 809, 815.

claimant could have filed its IRC one day, one month, or even three years after May 28, 2010; instead, the claimant filed its IRC three years and 14 days after — which is 14 days late.

This finding is consistent with three recent Commission Decisions regarding the three-year period in which a claimant can file an IRC.

In the *Collective Bargaining* Program IRC decision adopted on December 5, 2014, the claimant argued that the limitations period should begin to run from the date of the *last* notice of claim adjustment in the record.[112] This argument parallels that of the claimant in this instant IRC, who argues that between the Final Audit Report dated May 28, 2010, and the two letters dated June 12, 2010, the *later* event should commence the running of the limitations period.

In the *Collective Bargaining* Decision, the Commission rejected the argument. The Commission held that the limitations period began to run on the *earliest* applicable event because that was when the claim was complete as to all of its elements.[113] "Accordingly, the claimant cannot allege that the earliest notice did not provide sufficient information to initiate the IRC, and the later adjustment notices that the claimant proffers do not toll or suspend the operation of the period of limitation," the Commission held.[114]

In the *Domestic Violence Treatment Services — Authorization and Case Management* program IRC Decision adopted on March 25, 2016, the Commission held, "For IRCs, the 'last element essential to the cause of action' which begins the running of the period of limitations . . . is a notice to the claimant of the adjustment that includes the reason for the adjustment."[115] In the instant IRC, the limitations period therefore began to run when the claimant received the Final Audit Report, i.e., the notice which informed the claimant of the adjustment and of the reasons for the adjustment.

Furthermore, the Commission's finding in the instant IRC is not inconsistent with a recent Commission ruling regarding the timeliness of filing an IRC.

In the *Handicapped and Disabled Students* Program IRC decision adopted September 25, 2015, the Commission found that an IRC filed by a claimant was timely because the limitations period began to run from the date of a remittance advice letter which was issued after the Controller's Final Audit Report.[116] The Decision is distinguishable because the Controller's cover letter accompanying the audit report to the claimant in that case requested additional information and

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[112] Decision, *Collective Bargaining*, Commission Case No. 05-4425-I-11 (adopted December 5, 2014), pages 20-22.

[113] Decision, *Collective Bargaining*, Commission Case No. 05-4425-I-11 (adopted December 5, 2014), pages 20-22.

[114] Decision, *Collective Bargaining*, Commission Case No. 05-4425-I-11 (adopted December 5, 2014), page 21.

[115] Decision, *Domestic Violence Treatment Services — Authorization and Case Management*, Commission on State Mandates Case No. 07-9628101-I-01 (adopted March 25, 2016), page 16.

[116] Decision, *Handicapped and Disabled Students*, Commission Case No. 05-4282-I-03 (adopted September 25, 2015), pages 11-14.

implied that the attached audit report was not final.[117] In the instant IRC, by contrast, the Controller's cover letter contained no such statement or implication; rather, the Controller's cover letter stated that, if the claimant disagreed with the attached Final Audit Report, the claimant would need to file an IRC within three years.[118]

The finding in this instant IRC is therefore consistent with recent Commission rulings regarding the three-year IRC limitations period.[119]

Consequently, the limitations period to file this instant IRC commenced on May 28, 2010, and expired on May 28, 2013.

The IRC is denied as untimely filed.

B. In the Alternative, the County Waived Its Right To File An IRC.

Even if the claimant filed its IRC on time, which is not the case, the claimant's intention in April 2010 was to agree with the results of the Controller's audit and to waive any right to object to the audit or to add additional claims; on that separate and independent basis, the Commission hereby denies this IRC.

In its comments on the IRC, the Controller stated that the claimant had agreed to the Controller's audit and findings. "In response to the findings, the county agreed with the audit results. Further, the county provided a management representation letter asserting that it made available to the SCO all pertinent information in support of its claims (Tab 10)."[120] By stating these facts in opposition to the IRC, the Controller raises the question of whether the claimant waived its right to contest the Controller's audit findings.[121]

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[117] Decision, *Handicapped and Disabled Students*, Commission Case No. 05-4282-I-03 (adopted September 25, 2015), pages 11-14. In the proceeding which resulted in this 2015 Decision, the cover letter from the Controller to the claimant is reproduced at Page 71 of the administrative record. In that letter, the Controller stated, "The SCO has established an informal audit review process to resolve a dispute of facts. The auditee should submit, in writing, a request for a review and all information pertinent to the disputed issues within 60 days after receiving the final report." The Controller's cover letter in the instant IRC contains no such language. Exhibit A, IRC, page 96 (Letter from Jeffrey V. Brownfield to Gloria Molina, dated May 28, 2010).

[118] Exhibit A, IRC, page 96.

[119] All that being said, an administrative agency's adjudications need not be consistent so long as they are not arbitrary. See, e.g., *Weiss v. State Board of Equalization* (1953) 40 Cal.2d 772, 777 ("The administrator is expected to treat experience not as a jailer but as a teacher."); *California Employment Commission v. Black-Foxe Military Institute* (1941) 43 Cal.App.2d Supp. 868, 876 ("even were the plaintiff guilty of occupying inconsistent positions, we know of no rule of statute or constitution which prevents such an administrative board from doing so.").

[120] Exhibit B, Controller's Late Comments on the IRC, page 19. The referenced "Tab 10" is the two-page letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010 (Exhibit B, Controller's Late Comments on the IRC, pages 152-153).

[121] While the Controller's raising of the waiver issue could have been made with more precision and detail, the Controller's statements regarding the claimant's April 2010 agreement with the audit findings sufficiently raises the waiver issue under the lenient standards which apply to

The Second District of the Court of Appeal has detailed the law of waiver and how it differs from the related concept of estoppel:

> The terms "waiver" and "estoppel" are sometimes used indiscriminately. They are two distinct and different doctrines that rest upon different legal principles.
>
> Waiver refers to the act, or the consequences of the act, of one side. Waiver is the intentional relinquishment of a known right after full knowledge of the facts and depends upon the intention of one party only. Waiver does not require any act or conduct by the other party. . . . .
>
> All case law on the subject of waiver is unequivocal: " 'Waiver always rests upon intent. Waiver is the intentional relinquishment of a known right after knowledge of the facts.' [Citations]. The burden, moreover, is on the party claiming a waiver of a right to prove it by clear and convincing evidence that does not leave the matter to speculation, and 'doubtful cases will be decided against a waiver.' " (Citations.)
>
> The pivotal issue in a claim of waiver is the intention of the party who allegedly relinquished the known legal right.[122]

Courts have stated that a "waiver may be either express, based on the words of the waiving party, or implied, based on conduct indicating an intent to relinquish the right."[123] In addition, "[i]t is settled law in California that a purported 'waiver' of a statutory right is not legally effective unless it appears that the party charged with the waiver has been fully informed of the existence of that right, its meaning, the effect of the 'waiver' presented to him, and his full understanding of the explanation."[124] Waiver is a question of fact and is always based upon intent.[125] Waiver must be established by clear and convincing evidence.[126]

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administrative hearings. See, e.g., *Santa Clarita Organization for Planning the Environment v. City of Santa Clarita* (2011) 197 Cal.App.4th 1042, 1051 ("less specificity is required to preserve an issue for appeal in an administrative proceeding than in a judicial proceeding").

[122] *DRG/Beverly Hills, Ltd v. Chopstix Dim Sum Cafe & Takeout III, Ltd.* (1994) 30 Cal.App.4th 54, 59-61.

[123] *Waller v. Truck Insurance Exchange* (1995) 11 Cal.4th 1, 31.

[124] *B.W. v. Board of Medical Quality Assurance* (1985) 169 Cal.App.3d 219, 233.

[125] *Smith v. Selma Community Hospital* (2008) 164 Cal.App.4th 1478, 1506.

[126] *DRG/Beverly Hills, Ltd, supra,* 30 Cal.App.4th 54, 60. When a fact must be established by clear and convincing evidence, the substantial evidence standard of review for any appeal of the Commission's decision to the courts still applies. See Government Code section 17559(b).

"The 'clear and convincing' standard . . . is for the edification and guidance of the [trier of fact] and not a standard for appellate review. (Citations.) ' "The sufficiency of evidence to establish a given fact, where the law requires proof of the fact to be clear and convincing, is primarily a question for the [trier of fact] to determine, and if there is substantial evidence to support its conclusion, the determination is not open to review on appeal." [Citations.]' (Citations.) Thus, on appeal from a judgment required to be based upon clear and convincing evidence, 'the clear and

The Commission finds that the record of this IRC contains clear and convincing evidence that the claimant's intention in April 2010 was to accept the results of the Controller's audit and to waive any right to object to the audit or to add additional claims.

The Controller provided the claimant a draft copy of the audit report, dated March 26, 2010.[127] The record contains no evidence of the claimant objecting to the Draft Audit Report or attempting to alter the outcome of the audit before the draft report became final. Instead, the record contains substantial evidence of the claimant affirmatively agreeing with the Controller's reductions, findings and recommendations.

In response to the Draft Audit Report, the claimant's Auditor-Controller sent a three-page letter dated April 30, 2010: a copy of which is reproduced in the Controller's Final Audit Report.[128] The first page of this three-page letter[129] contains the following statement:

> *The County's response, which is attached, indicates agreement with the audit findings* and the actions that the County will take to implement policies and procedures to ensure that the costs claimed under HDSII are eligible, mandate related, and supported.[130]

The claimant's written response to the Draft Audit Report — the exact moment when a claimant would and should proffer objections to the Controller's reductions — was to indicate "agreement with the audit findings." The Commission notes that the claimant indicated active "agreement" as opposed to passive "acceptance."

The following two pages of the three-page letter contain further statements of agreement with the Controller's findings and recommendations.

In response to the Controller's Finding No. 1 that the claimant overstated medication support costs by more than $1.1 million, the claimant responded:

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convincing test disappears ... [and] the usual rule of conflicting evidence is applied, giving full effect to the respondent's evidence, however slight, and disregarding the appellant's evidence, however strong.' (Citation.)" *Sheila S. v. Superior Court (Santa Clara County Dept. of Family and Children's Services)* (2000) 84 Cal.App.4th 872, 880 (substituting "trier of fact" for "trial court" to enhance clarity).

[127] Exhibit A, IRC, page 101.

[128] Exhibit A, IRC, pages 107-109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[129] This three-page letter (which is in the record at Exhibit A, IRC, pages 107-109) will be referred to herein as the "three-page letter" to distinguish it from a separate two-page letter sent by the same author on the same date of April 30, 2010 (which is in the record at Exhibit B, Controller's Late Comments on the IRC, pages 152-153). The two-page letter is referred to herein as the "two-page letter."

[130] Exhibit A, IRC, page 107 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010) (emphasis added).

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that only actual units of service for eligible clients are claimed in accordance with the mandate program.[131]

In response to the Controller's Finding No. 2 that the claimant overstated indirect costs by more than $80,000, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that indirect cost rates are applied to eligible and supported direct costs.[132]

In response to the Controller's Finding No. 3 that the claimant overstated offsetting reimbursements by more than $500,000, the claimant responded:

> We agree with the recommendation. The County will review and establish policies and procedures to ensure that revenues are applied to valid program costs, appropriate SD/MC and EPSDT reimbursement percentage rates are applied to eligible costs, and supporting documentation for applicable offsetting revenues are maintained.[133]

Each of the claimant's responses to the Controller's three findings supports the Commission's finding that the claimant waived its right to pursue an IRC by affirmatively agreeing in writing to the Controller's audit findings. While the claimant also purported at various times in the three-page letter to reserve rights or to clarify issues,[134] the overall intention communicated in the letter is that the claimant intended to accept and be bound by the results of the Controller's audit. The fact that the claimant then waited more than three years to file the IRC is further corroboration that, at the time that the three-page letter was sent, the claimant agreed with the Controller and intended to waive its right to file an IRC.[135]

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[131] Exhibit A, IRC, page 108 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[132] Exhibit A, IRC, page 108 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[133] Exhibit A, IRC, page 109 (Letter from Wendy L. Watanabe to Jeffrey V. Brownfield, dated April 30, 2010).

[134] For example, the claimant purports to recognize, without citing legal authority or factual foundation, that the Controller would revise the Final Audit Report if the claimant subsequently provides additional information to support its claims. (Exhibit A, IRC, page 107.) The Commission finds that clear and convincing evidence of waiver in the record as a whole outweighs these sporadic, pro forma statements.

[135] In addition, the claimant waited more than two years after the issuance of the Final Audit Report to provide information to the Controller regarding a purported reconsideration request. Exhibit B, Controller's Late Comments on the IRC, page 19 ("The county provided information regarding its reconsideration request in June and August 2012 . . . .").

In addition, the Commission's finding of waiver is supported by a separate two-page letter — also dated April 10, 2010 — in which the claimant contradicted several positions which the claimant now attempts to take in this IRC.

The separate two-page letter is hereby recited in its entirety due to its materiality:

> April 30, 2010
>
> Mr. Jim L. Spano, Chief
> Mandated Costs Audits Bureau
> Division of Audits
> California State Controller's Office
> P.O. Box 942850
> Sacramento, CA 94250-5874
>
> Dear Mr. Spano:
>
> **Handicapped and Disabled Students Program II**
>
> **July 1, 2002, through June 30, 2004**
>
> In connection with the State Controller's Office (SCO) audit of the County's claims for the mandated program and audit period identified above, we affirm, to the best of our knowledge and belief, the following representations made to the SCO's audit staff during the audit:
>
> 1. We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO.
>
> 2. We designed and implemented the County's accounting system to ensure accurate and timely records.
>
> 3. We prepared and submitted our reimbursement claims according to the Handicapped and Disabled Students II Program's parameters and guidelines.
>
> 4. We claimed mandated costs based on actual expenditures allowable per the Handicapped and Disabled Students II Program's parameters and guidelines.
>
> 5. We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims.
>
> 6. Excluding mandated program costs, the County did not recover indirect cost from any State or federal agency during the audit period.
>
> 7. We are not aware of any:
>
> > a. Violations or possible violations of laws and regulations involving management or employees who had significant roles in the accounting system or in preparing the mandated cost claims.
> >
> > b. Violations or possible violations of laws and regulations involving other employees that could have had a material effect on the mandated cost claims.

c. Communications from regulatory agencies concerning noncompliance with, or deficiencies in, accounting and reporting practices that could have a material effect on the mandated cost claims.

d. Relevant, material transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims.

8. There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims.

9. We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims.

If you have any questions, please contact Hasmik Yaghobyan at (213) 893-0792 or via e-mail at hyaghobyan@auditor.lacounty.gov

Very truly yours,

Wendy L. Watanabe
Auditor-Controller[136]

The admissions made by the claimant in the two-page letter contradict arguments now made by claimant in the instant IRC.

In its IRC, the claimant argues that the Controller based its audit on incorrect or incomplete documentation.[137] For example, the claimant now contends, "It was this fourth generation data set that became the basis for the audit report. . . . . However, upon further review, this fourth generation data run actually excluded many of the units of service that had been properly used to calculate the costs of the claim."[138]

However, neither claimant's three-page letter nor claimant's two-page letter dated April 30, 2010, objected to the audit findings on these grounds — objections which would have been known to the claimant in April 2010, since the claimant and its personnel had spent the prior two years working with the Controller's auditors.

Rather, the claimant's two-page letter stated the opposite by repeatedly emphasizing the accuracy and completeness of the records provided to the Controller: "We maintain accurate financial records and data to support the mandated cost claims submitted to the SCO."[139] "We designed and implemented the County's accounting system to ensure accurate and timely

[136] Exhibit B, Controller's Late Comments on the IRC, pages 152-153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010).

[137] Exhibit A, IRC, pages 6-7.

[138] Exhibit A, IRC, page 6.

[139] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 1).

records."[140] "We made available to the SCO's audit staff all financial records, correspondence, and other data pertinent to the mandated cost claims."[141] "We are not aware of . . . . Relevant, material transactions that were not properly recorded in the accounting records that could have a material effect on the mandated cost claims."[142]

In the IRC, the claimant now argues that, even if the Controller correctly reduced its claims, the claimant should be allowed to submit new claims based upon previously unproduced evidence under a right of equitable setoff.[143]

However, in its two-page letter, the claimant stated the opposite: "There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion that would have a material effect on the mandated cost claims."[144] "We are not aware of any events that occurred after the audit period that would require us to adjust the mandated cost claims."[145]

The claimant's two-page letter demonstrates that, as far as the claimant was concerned in April 2010, it had maintained accurate and complete records, had provided the Controller with accurate and complete records, and had acknowledged that it had no further reimbursement claims. The claimant now attempts to make the opposite arguments in this IRC.

Given the totality of the circumstances and all of the evidence in the record, the Commission finds by clear and convincing evidence that the claimant's intention in April 2010 was to agree with the results of the Controller's audit and to waive any right to object to the audit or to add additional claims.

On this separate and independent ground, the Commission denies the IRC.

V. Conclusion

The Commission finds that claimant's IRC was untimely filed and that, even if it were timely filed, the claimant waived its arguments.

The Commission therefore denies this IRC.

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[140] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 2).

[141] Exhibit B, Controller's Late Comments on the IRC, page 152 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 5).

[142] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 7(d)).

[143] Exhibit A, IRC, pages 8-10.

[144] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 10, 2010, paragraph 8).

[145] Exhibit B, Controller's Late Comments on the IRC, page 153 (Letter from Wendy L. Watanabe to Jim L. Spano, dated April 30, 2010, paragraph 9).

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 May 20, 2016, I served the:

> **Draft Proposed Decision, Schedule for Comments, and Notice of Hearing**
> *Handicapped and Disabled Students II*, 12-0240-I-01
> Government Code Sections 7572.55 and 7576
> Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
> California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60050,60030, 60040, 60045, 60055, 60100, 60110, 60200
> (Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
> Fiscal Years: 2002-2003 and 2003-2004
> County of Los Angeles, 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 May 20, 2016 at Sacramento, California.

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

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 3/24/16

Claim Number: 12-0240-I-01

Matter: Handicapped and Disabled Students II

Claimant: County of Los Angeles

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

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Attachment H

BETTY T. YEE
California State Controller

June 3, 2016

Heather Halsey
Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814

Re: **Draft Proposed Decision**
Incorrect Reduction Claim
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60050, 60030, 60040, 60045, 60055, 60100, 60110, 60200
(Emergency regulations filed July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years: 2002-03 and 2003-04
Los Angeles County, Claimant

Dear Ms. Halsey:

The State Controller's Office has reviewed the Commission on State Mandates' (Commission) draft proposed decision dated May 20, 2016, for the above incorrect reduction claim (IRC) filed by Los Angeles County. We support the Commission's conclusion and recommendation. The Commission finds that the claimant's IRC was untimely filed and that, even if it were timely filed, the claimant waived its arguments when responding to the draft audit report.

If you have any questions, please contact me by telephone at (916) 323-5849.

Sincerely,

JIM L. SPANO, Chief
Mandated Cost Audits Bureau
Division of Audits

JLS/ls

17338

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901 Corporate Center Drive, Suite 200, Monterey Park, CA 91754 ♦ (323) 981-6802

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

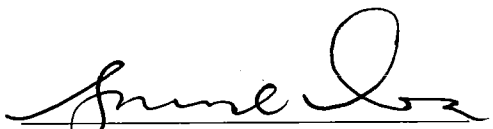
I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On June 6, 2016, I served the:

SCO Comments on the Draft Proposed Decision
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Division 9, Chapter 1, Sections 60020, 60050,60030, 60040, 60045, 60055, 60100, 60110, 60200
(Emergency regulations effective July 1, 1998 [Register 98, No. 26], final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years: 2002-2003 and 2003-2004
County of Los Angeles, 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 June 6, 2016 at Sacramento, California.



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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 3/24/16

Claim Number: 12-0240-I-01

Matter: Handicapped and Disabled Students II

Claimant: County of Los Angeles

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DSpeciale@sco.ca.gov

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 2, 2016, I served the:

Requests for Reconsideration of an Adopted Decision (Gov. Code § 17559(a); Cal. Code Regs., tit. 2, § 1187.15), Notice of Consolidation, and Notice of Hearing

16-RAD-01
Handicapped and Disabled Students II, 12-0240-I-01
Government Code Sections 7572.55 and 7576;
Statutes 1994, Chapter 1128 (AB 1892); Statutes 1996, Chapter 654 (AB 2726);
California Code of Regulations, Title 2, Sections 60020, 60050,
60030, 60040, 60045, 60055, 60100, 60110, 60200
(Emergency regulations effective July 1, 1998 [Register 98, No. 26]
final regulations effective August 9, 1999 [Register 99, No. 33])
Fiscal Years 2002-2003 and 2003-2004
County of Los Angeles, Requester

AND

16-RAD-02
Handicapped and Disabled Students, 13-4282-I-06
Government Code Sections 7572 and 7572.5;
Statutes 1984, Chapter 1747 (AB 3632); Statutes 1985, Chapter 1274 (AB 882);
California Code of Regulations, Title 2, Division 9, Section 60040
(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]
Fiscal Years 2003-2004, 2004-2005, and 2005-2006
County of Los Angeles, Requester

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 2, 2016 at Sacramento, California.

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

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 9/1/16

Claim Number: 12-0240-I-01

Matter: Handicapped and Disabled Students II

Claimant: County of Los Angeles

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