State of California—Health and Human Services Agency
Department of Developmental Services
1215 O Street, Sacramento, CA 95814
www.dds.ca.gov

NANCY BARGMANN
DIRECTOR

GAVIN NEWSOM
GOVERNOR

October 27, 2023

Jacy Cohen, Board Chairperson
Golden Gate Regional Center, Inc.
1355 Market Street, Suite 220
San Francisco, CA 94103

Dear Ms. Cohen:

The Department of Developmental Services' (DDS) Audit Section has completed the audit of the Golden Gate Center (GGRC). The period of review was from July 1, 2018 through June 30, 2020, with follow-up as needed into prior and subsequent periods. The enclosed report discusses the areas reviewed along with the finding and recommendation. The audit report includes the response submitted by GGRC as Appendix A and DDS' reply on page 18.

If there is a disagreement with the audit finding, a written "Statement of Disputed Issues" may be filed with DDS' Audit Appeals Unit, pursuant to California Code of Regulations (CCR), Title 17, Section 50730, Request for Administrative Review (excerpt enclosed). The "Statement of Disputed Issues" must be filed and submitted within 30 days of receipt of this audit report to the address below:

Office of Legal Affairs
Department of Developmental Services
P.O. Box 944202
Sacramento, CA 94299-9974

The cooperation of GGRC's staff in completing the audit is appreciated.

If you have any questions regarding the audit report, please contact Edward Yan, Manager, Audit Section, at (916) 651-8207.

Sincerely,

DocuSigned by:
Pete Cervinka
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PETE CERVINKA
Chief Deputy Director
Data Analytics and Strategy

Enclosure(s)

cc: Eric Zigman, GGRC
Lop Hou, GGRC
Bob Sands, DHCS
Carla Castañeda, DDS
Brian Winfield, DDS
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Jonathan Hill, DDS
Edward Yan, DDS
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Staci Yasui, DDS

California Code of Regulations
Title 17, Division 2
Chapter 1 - General Provisions
Subchapter 7 - Fiscal Audit Appeals
Article 2 - Administrative Review

§**50730**. Request for Administrative Review.

a) An individual, entity, or organization which disagrees with any portion or aspect of an audit report issued by the Department or regional center may request an administrative review. The appellant's written request shall be submitted to the Department within 30 days after the receipt of the audit report. The request may be amended at any time during the 30-day period.

(b) If the appellant does not submit the written request within the 30-day period, the appeals review officer shall deny such request, and all audit exceptions or findings in the report shall be deemed final unless the appellant establishes good cause for late filing.

(c) The request shall be known as a “Statement of Disputed Issues.” It shall be in writing, signed by the appellant or his/her authorized agent, and shall state the address of the appellant and of the agent, if any agent has been designated. An appellant shall specify the name and address of the individual authorized on behalf of the appellant to receive any and all documents, including the final decision of the Director, relating to proceedings conducted pursuant to this subchapter. The Statement of Disputed Issues need not be formal, but it shall be both complete and specific as to each audit exception or finding being protested. In addition, it shall set forth all of the appellant's contentions as to those exceptions or findings, and the estimated dollar amount of each exception or finding being appealed.

(d) If the appeals review officer determines that a Statement of Disputed Issues fails to state the grounds upon which objections to the audit report are based, with sufficient completeness and specificity for full resolution of the issues presented, he/she shall notify the appellant, in writing, that it does not comply with the requirements of this subchapter.

(e) The appellant has 15 days after the date of mailing of such notice within which to file an amended Statement of Disputed Issues. If the appellant does not amend his/her appeal to correct the stated deficiencies within the time permitted, all audit exceptions or findings affected shall be dismissed from the appeal, unless good cause is shown for the noncompliance.

(f) The appellant shall attach to the Statement of Disputed Issues all documents which he/she intends to introduce into evidence in support of stated contentions. An appellant that is unable to locate, prepare, or compile such documents within the appeal period specified in Subsection (a) above, shall include a statement to this effect in the Statement of Disputed Issues. The appellant shall have an additional 30 days after the expiration of the initial 30-day period in which to submit the documents. Documents that are not submitted within this period shall not be accepted into evidence at any stage of the appeal process unless good cause is shown for the failure to present the documents within the prescribed period.

AUDIT OF THE GOLDEN GATE REGIONAL CENTER FOR FISCAL YEARS 2018-19 AND 2019-20

Department of Developmental Services

October 27, 2023

This audit report was prepared by the
California Department of Developmental Services
1215 O Street
Sacramento, CA 95814

Pete Cervinka, Chief Deputy Director, Data Analytics and Strategy
Ann Nakamura, Chief, Research, Audit, and Evaluation Branch
Edward Yan, Manager, Audit Section
Luciah Ellen Nzima, Chief, Regional Center Audit Unit
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EXECUTIVE SUMMARY

The Department of Developmental Services (DDS) conducted a fiscal compliance audit of Golden Gate Regional Center (GGRC) to ensure GGRC is compliant with the requirements set forth in the Lanterman Developmental Disabilities Services Act and Related Laws/Welfare and Institutions (W&I) Code; the Home and Community-based Services (HCBS) Waiver for the Developmentally Disabled; California Code of Regulations (CCR), Title 17; Federal Office of Management and Budget (OMB) Circulars A-122 and A-133; and the contract with DDS. Overall, the audit indicated that GGRC maintains accounting records and supporting documentation for transactions in an organized manner.

The audit period was July 1, 2018, through June 30, 2020, with follow-up, as needed, into prior and subsequent periods. This report identified an area where GGRC's administrative and operational controls could be strengthened, but the finding was not of a nature that would indicate systemic issues or constitute major concerns regarding GGRC's operations.

Finding that needs to be addressed.

Finding 1: <u>Overpayments Due to Rate Increases</u>

The sampled review of 128 POS vendor files revealed GGRC issued higher rates for three of its Family Home Agency (FHA) vendors, Service Code 904, than the Community Care Facility (CCF) rate model set by DDS. This resulted in apparent overpayments to the three vendors totaling $4,316,351.98 from July 2015 through March 2021. This would not in compliance with W&I Code, Sections 4681.1(a), 4689.1(7)(B) and CCR, Title 17, Section 56082(b)(1).

Based on further analysis of GGRC's response to the draft audit report, DDS will not seek reimbursement of these apparent overpayments.

BACKGROUND

DDS is responsible, under the W&I Code, for ensuring that persons with developmental disabilities (DD) receive the services and supports they need to lead more independent, productive, and integrated lives. To ensure that these services and supports are available, DDS contracts with 21 private, nonprofit community agencies/corporations that provide fixed points of contact in the community for serving eligible individuals with DD and their families in California. These fixed points of contact are referred to as regional centers (RCs). The RCs are responsible under State law to help ensure that such persons receive access to the programs and services that are best suited to them throughout their lifetime.

DDS is also responsible for providing assurance to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), that services billed under California's HCBS Waiver program are provided and that criteria set forth for receiving funds have been met. As part of DDS' program for providing this assurance, the Audit Section conducts fiscal compliance audits of each RC no less than every two years, and completes follow-up reviews in alternate years. Also, DDS requires RCs to contract with independent Certified Public Accountants (CPAs) to conduct an annual financial statement audit. The DDS audit is designed to wrap around the independent CPA's audit to ensure comprehensive financial accountability.

In addition to the fiscal compliance audit, each RC will also be monitored by the DDS Federal Programs Operations Section to assess overall programmatic compliance with HCBS Waiver requirements. The HCBS Waiver compliance monitoring review has its own criteria and processes. These audits and program reviews are an essential part of an overall DDS monitoring system that provides information on RCs' fiscal, administrative, and program operations.

DDS and Golden Gate Regional Center, Inc. entered into State Contract HD099006, effective July 1, 2014, through June 30, 2021. This contract specifies that Golden Gate Regional Center, Inc., will operate an agency known as GGRC to provide services to individuals with DD and their families in Marin, San Francisco, and San Mateo Counties. The contract is funded by state and federal funds that are dependent upon GGRC performing certain tasks, providing services to eligible consumers, and submitting billings to DDS.

This audit was conducted remotely from February 22, 2021, through April 2, 2021, by the Audit Section of DDS.

AUTHORITY

The audit was conducted under the authority of the W&I Code, Section 4780.5 and Article IV, Section 3 of the State Contract between DDS and GGRC.

CRITERIA

The following criteria were used for this audit:

- W&I Code,
- “Approved Application for the HCBS Waiver for the Developmentally Disabled,”
- CCR, Title 17,
- OMB Circulars A-122 and A-133, and
- The State Contract between DDS and GGRC, effective July 1, 2014.

AUDIT PERIOD

The audit period was July 1, 2018, through June 30, 2020, with follow-up, as needed, into prior and subsequent periods.

OBJECTIVES, SCOPE, AND METHODOLOGY

This audit was conducted as part of the overall DDS monitoring system that provides information on RCs' fiscal, administrative, and program operations. The objectives of this audit were:

- To determine compliance with the W&I Code,
- To determine compliance with the provisions of the HCBS Waiver Program for the Developmentally Disabled,
- To determine compliance with CCR, Title 17 regulations,
- To determine compliance with OMB Circulars A-122 and A-133, and
- To determine that costs claimed were in compliance with the provisions of the State Contract between DDS and GGRC.

The audit was conducted in accordance with the Generally Accepted Government Auditing Standards issued by the Comptroller General of the United States. However, the procedures do not constitute an audit of GGRC's financial statements. DDS limited the scope to planning and performing audit procedures necessary to obtain reasonable assurance that GGRC was in compliance with the objectives identified above. Accordingly, DDS examined transactions on a test basis to determine whether GGRC was in compliance with the W&I Code; the HCBS Waiver for the Developmentally Disabled; CCR, Title 17; OMB Circulars A-122 and A-133; and the State Contract between DDS and GGRC.

DDS' review of GGRC's internal control structure was conducted to gain an understanding of the transaction flow and the policies and procedures, as necessary, to develop appropriate auditing procedures.

DDS reviewed the annual audit reports that were conducted by an independent CPA firm for Fiscal Years (FYs) 2018-19 and 2019-20, issued on November 26, 2019 and November 18, 2020. It was noted that no management letters were issued for GGRC. This review was performed to determine the impact, if any, upon the DDS audit and, as necessary, develop appropriate audit procedures.

The audit procedures performed included the following:

I. Purchase of Service

DDS selected a sample of Purchase of Service (POS) claims billed to DDS. The sample included consumer services and vendor rates. The sample also included consumers who were eligible for the HCBS Waiver Program. For POS claims, the following procedures were performed:

- DDS tested the sample items to determine if the payments made to service providers were properly claimed and could be supported by appropriate documentation.

- DDS selected a sample of invoices for service providers with daily and hourly rates, standard monthly rates, and mileage rates to determine if supporting attendance documentation was maintained by GGRC. The rates charged for the services provided to individual consumers were reviewed to ensure compliance with the provision of the W&I Code; the HCBS Waiver for the Developmentally Disabled; CCR, Title 17, OMB Circulars A-122 and A-133; and the State Contract between DDS and GGRC.

- DDS analyzed all of GGRC's bank accounts to determine whether DDS had signatory authority, as required by the State Contract with DDS.

- DDS selected a sample of bank reconciliations for Operations (OPS) accounts and Consumer Trust bank accounts to determine if the reconciliations were properly completed on a monthly basis.

II. Regional Center Operations

DDS selected a sample of OPS claims billed to DDS to determine compliance with the State Contract. The sample included various expenditures claimed for administration that were reviewed to ensure GGRC's accounting staff properly input data, transactions were recorded on a timely basis, and expenditures charged to various operating areas were valid and reasonable. The following procedures were performed:

- A sample of the personnel files, timesheets, payroll ledgers, and other support documents were selected to determine if there were any overpayments or errors in the payroll or the payroll deductions.

- A sample of OPS expenses, including, but not limited to, purchases of office supplies, consultant contracts, insurance expenses, and lease agreements were tested to determine compliance with CCR, Title 17, and the State Contract.

- A sample of equipment was selected and physically inspected to determine compliance with requirements of the State Contract.

- DDS reviewed GGRC's policies and procedures for compliance with the DDS Conflict of Interest regulations, and DDS selected a sample of personnel files to determine if the policies and procedures were followed.

III. Targeted Case Management (TCM) and Regional Center Rate Study

The TCM Rate Study determines the DDS rate of reimbursement from the federal government. The following procedures were performed upon the study:

- Reviewed applicable TCM records and GGRC's Rate Study. DDS examined the months of April 2019 and May 2020 and traced the reported information to source documents.

- Reviewed GGRC's TCM Time Study. DDS selected a sample of payroll timesheets for this review and compared timesheets to the Case Management Time Study Forms (DS 1916) to ensure that the forms were properly completed and supported.

IV. Service Coordinator Caseload Survey

Under the W&I Code, Section 4640.6(e), RCs are required to provide service coordinator caseload data to DDS. The following average service coordinator-to-consumer ratios apply per W&I Code Section 4640.6(c)(1)(2)(3)(A)(B)(C):

"(c) Contracts between the department and regional centers shall require regional centers to have service coordinator-to-consumer ratios, as follows:

(1) An average service coordinator-to-consumer ratio of 1 to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.

(2) An average service coordinator-to-consumer ratio of 1 to 45 for all consumers who have moved from a developmental center to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 59 consumers for more than 60 days.

(3) Commencing January 1, 2004, the following coordinator-to-consumer ratios shall apply:

(A) All consumers three years of age and younger and for

consumers enrolled in the Home and Community-based Services Waiver program for persons with developmental disabilities, an average service coordinator-to-consumer ratio of 1 to 62.

(B) All consumers who have moved from a developmental center to the community since April 14, 1993, and have lived continuously in the community for at least 12 months, an average service coordinator-to-consumer ratio of 1 to 62.

(C) All consumers who have not moved from the developmental centers to the community since April 14, 1993, and who are not described in subparagraph (A), an average service coordinator-to-consumer ratio of 1 to 66."

DDS also reviewed the Service Coordinator Caseload Survey methodology used in calculating the caseload ratios to determine reasonableness and that supporting documentation is maintained to support the survey and the ratios as required by W&I Code, Section 4640.6(e).

V. Early Intervention Program (EIP; Part C Funding)

For the EIP, there are several sections contained in the Early Start Plan. However, only the Part C section was applicable for this review.

VI. Family Cost Participation Program (FCPP)

The FCPP was created for the purpose of assessing consumer costs to parents based on income level and dependents. The family cost participation assessments are only applied to respite, day care, and camping services that are included in the child's Individual Program Plan (IPP)/Individualized Family Services Plan (IFSP). To determine whether GGRC was in compliance with CCR, Title 17, and the W&I Code, Section 4783, DDS performed the following procedures during the audit review:

- Reviewed the list of consumers who received respite, day care, and camping services, for ages 0 through 17 years who live with their parents and are not Medi-Cal eligible, to determine their contribution for the FCPP.

- Reviewed the parents' income documentation to verify their level of participation based on the FCPP Schedule.

- Reviewed copies of the notification letters to verify that the parents were notified of their assessed cost participation within 10 working days of receipt of the parents' income documentation.

- Reviewed vendor payments to verify that GGRC was paying for only its assessed share of cost.

VII. Annual Family Program Fee (AFPF)

The AFPF was created for the purpose of assessing an annual fee of up to $200 based on the income level of families with children between the ages of 0 through 17 years receiving qualifying services through the RC. The AFPF fee shall not be assessed or collected if the child receives only respite, day care, or camping services from the RC and a cost for participation was assessed to the parents under FCPP. To determine whether GGRC was in compliance with the W&I Code, Section 4785, DDS requested a list of AFPF assessments and verified the following:

- The adjusted gross family income is at or above 400 percent of the federal poverty level based upon family size.

- The child has a DD or is eligible for services under the California Early Intervention Services Act.

- The child is less than 18 years of age and lives with his or her parent.

- The child or family receives services beyond eligibility determination, needs assessment, and service coordination.

- The child does not receive services through the Medi-Cal program.

- Documentation was maintained by the RC to support reduced assessments.

VIII. Parental Fee Program (PFP)

The PFP was created for the purpose of prescribing financial responsibility to parents of children under the age of 18 years who are receiving 24-hour, out-of-home care services through an RC or who are residents of a state hospital or on leave from a state hospital. Parents shall be required to pay a fee depending upon their ability to pay, but not to exceed (1) the cost of caring for a child without DD at home, as determined by the Director of DDS, or (2) the cost of services provided, whichever is less. To determine whether GGRC is in compliance with the W&I Code, Section 4782, DDS requested a list of PFP assessments and verified the following:

- Identified all children with DD who are receiving the following services:

    (a) All 24-hour, out-of-home community care received through an RC for children under the age of 18 years;

(b) 24-hour care for such minor children in state hospitals. Provided, however, that no ability to pay determination shall be made for services required by state or federal law, or both, to be provided to children without charge to their parents.

- Provided DDS with a listing of new placements, terminated cases, and client deaths for those clients. Such listings shall be provided not later than the 20th day of the month following the month of such occurrence.

- Informed parents of children who will be receiving services that DDS is required to determine parents' ability to pay and to assess, bill, and collect parental fees.

- Provided parents a package containing an informational letter, a Family Financial Statement (FFS), and a return envelope within 10 working days after placement of a minor child.

- Provided DDS a copy of each informational letter given or sent to parents, indicating the addressee and the date given or mailed.

IX. Procurement

The Request for Proposal (RFP) process was implemented to ensure RCs outline the vendor selection process when using the RFP process to address consumer service needs. As of January 1, 2011, DDS requires RCs to document their contracting practices, as well as how particular vendors are selected to provide consumer services. By implementing a procurement process, RCs will ensure that the most cost-effective service providers, amongst comparable service providers, are selected, as required by the Lanterman Act and the State Contract. To determine whether GGRC implemented the required RFP process, DDS performed the following procedures during the audit review:

- Reviewed GGRC's contracting process to ensure the existence of a Board-approved procurement policy and to verify that the RFP process ensures competitive bidding, as required by Article II of the State Contract, as amended.

- Reviewed the RFP contracting policy to determine whether the protocols in place included applicable dollar thresholds and comply with Article II of the State Contract, as amended.

- Reviewed the RFP notification process to verify that it is open to the public and clearly communicated to all vendors. All submitted proposals are evaluated by a team of individuals to determine whether proposals are properly documented, recorded, and authorized by appropriate officials at GGRC. The process was reviewed to ensure that the vendor selection

process is transparent and impartial and avoids the appearance of favoritism. Additionally, DDS verified that supporting documentation is retained for the selection process and, in instances where a vendor with a higher bid is selected, written documentation is retained as justification for such a selection.

DDS performed the following procedures to determine compliance with Article II of the State Contract for contracts in place as of January 1, 2011:

- Selected a sample of Operations, Community Placement Plan (CPP), and negotiated POS contracts subject to competitive bidding to ensure GGRC notified the vendor community and the public of contracting opportunities available.
- Reviewed the contracts to ensure that GGRC has adequate and detailed documentation for the selection and evaluation process of vendor proposals and written justification for final vendor selection decisions and that those contracts were properly signed and executed by both parties to the contract.

In addition, DDS performed the following procedures:

- To determine compliance with the W&I Code, Section 4625.5 for contracts in place as of March 24, 2011: Reviewed to ensure GGRC has a written policy requiring the Board to review and approve any of its contracts of two hundred fifty thousand dollars ($250,000) or more before entering into a contract with the vendor.

- Reviewed GGRC Board-approved Operations, Start-Up, and POS vendor contracts of $250,000 or more, to ensure the inclusion of a provision for fair and equitable recoupment of funds for vendors that cease to provide services to consumers; verified that the funds provided were specifically used to establish new or additional services to consumers, the usage of funds is of direct benefit to consumers, and the contracts are supported with sufficiently detailed and measurable performance expectations and results.

The process above was conducted in order to assess GGRC's current RFP process and Board approval for contracts of $250,000 or more, as well as to determine whether the process in place satisfies the W&I Code and GGRC's State Contract requirements, as amended.

X. Statewide/Regional Center Median Rates

The Statewide and RC Median Rates were implemented on July 1, 2008, and amended on December 15, 2011 and July 1, 2016, to ensure that RCs are not negotiating rates higher than the set median rates for services. Despite the

median rate requirement, rate increases could be obtained from DDS under health and safety exemptions where RCs demonstrate the exemption is necessary for the health and safety of the consumers.

To determine whether GGRC was in compliance with the Lanterman Act, DDS performed the following procedures during the audit review:

- Reviewed sample vendor files to determine whether GGRC is using appropriately vendorized service providers and correct service codes, and that GGRC is paying authorized contract rates and complying with the median rate requirements of W&I Code, Section 4691.9.

- Reviewed vendor contracts to ensure that GGRC is reimbursing vendors using authorized contract median rates and verified that rates paid represented the lower of the statewide or RC median rate set after June 30, 2008. Additionally, DDS verified that providers vendorized before June 30, 2008, did not receive any unauthorized rate increases, except in situations where required by regulation, or health and safety exemptions were granted by DDS.

- Reviewed vendor contracts to ensure that GGRC did not negotiate rates with new service providers for services which are higher than the RC's median rate for the same service code and unit of service, or the statewide median rate for the same service code and unit of service, whichever is lower. DDS also ensured that units of service designations conformed with existing RC designations or, if none exists, ensured that units of service conformed to a designation used to calculate the statewide median rate for the same service code.

XI. Other Sources of Funding from DDS

RCs may receive other sources of funding from DDS. DDS performed sample tests on identified sources of funds from DDS to ensure GGRC's accounting staff were inputting data properly, and that transactions were properly recorded and claimed. In addition, tests were performed to determine if the expenditures were reasonable and supported by documentation. The sources of funding from DDS identified in this audit are:

- CPP;

- Part C – Early Start Program;

- Self Determination; and

- CalFresh.

XII. Follow-up Review on Prior DDS Audit Findings

A follow-up review was not conducted since DDS did not identify any findings in the prior audit report.

CONCLUSIONS

Based upon the audit procedures performed, DDS has determined that except for the item identified in the Finding and Recommendation section, GGRC was in compliance with applicable sections of the W&I Code; the HCBS Waiver for the Developmentally Disabled; CCR, Title 17; OMB Circulars A-122 and A-133; and the State Contract between DDS and GGRC for the audit period, July 1, 2018, through June 30, 2020.

The costs claimed during the audit period were for program purposes and adequately supported.

VIEWS OF RESPONSIBLE OFFICIALS

DDS issued the draft audit report on January 27, 2023. The finding in the draft audit report were discussed at a formal exit conference with GGRC on February 2, 2023. The views of GGRC's responsible officials are included in this final audit report.

RESTRICTED USE

This audit report is solely for the information and use of DDS, CMS, Department of Health Care Services, and GGRC. This restriction does not limit distribution of this audit report, which is a matter of public record.

FINDING AND RECOMMENDATION

Finding that needs to be addressed.

Finding 1: <u>Overpayments Due to Rate Increases</u>

The sampled review of 128 POS vendor payments revealed GGRC issued higher rates for three of its FHA vendors (California Mentor Family, Golden State Residential and Leveraging Equal Access, Vendor Numbers PG1548, H89124, and HG0039, respectively) for Service Code 904 than the CCF rate set by DDS. This resulted in apparent overpayments to the three vendors totaling $4,316,351.98 from July 2015 through March 2021. GGRC explained that, based on its interpretation of the regulations, it was allowed to utilize rates that exceeded those of the CCFs to protect the consumers' health and safety, because "not all individuals served by the regional centers and the department have needs that may be met by the Level 1 to 4I homes." (See Attachment A)

Based on further analysis of GGRC's response to the draft audit report, DDS will not seek reimbursement of the apparent overpayments.

W&I Code, Section 4689.1(7)(B) states:

> "Regional center reimbursement to family home agencies for services in a family home shall not exceed rates for similar individuals when residing in other types of out-of-home care established pursuant to Section 4681.1."

W&I Code, Section 4681.1(a) states:

> "The department shall adopt regulations that specify rates for community care facilities serving persons with developmental disabilities. The implementation of the regulations shall be contingent upon an appropriation in the annual Budget Act for this purpose. These rates shall be calculated on the basis of a cost model designed by the department that ensures that aggregate facility payments support the provision of services to each person in accordance with his or her individual program plan and applicable program requirements."

CCR, Title 17, Section 56082 (b) also states:

> "Regional center reimbursement to FHAs shall not exceed rates for similar individuals when residing in other types of out-of-home care established pursuant to Welfare and Institutions Code Section 4681.1.
>
> (1) The FHA shall ensure that family homes receive a sufficient portion of the rate of reimbursement to provide the services and supports specified in a consumer's IPP."

Recommendation:

GGRC must follow W&I Code Section 4681.5, or seek approval from DDS for any rate increase that may be required in the future. DDS notes that recent rate increases have mooted this particular issue relative to the three vendors.

EVALUATION OF RESPONSE

As part of the audit report process, GGRC was provided with a draft audit report and requested to provide a response to the finding. GGRC's response dated March 1, 2023, is provided as Appendix A.

DDS' Audit Section has evaluated GGRC's response and will confirm the appropriate corrective actions have been taken during the next scheduled audit.

Finding 1: <u>Overpayments Due to Rate Increases</u>

GGRC stated in its response that as of August 2018, all its FHAs had rates established for up to seven tiers. The first five tiers were tied to the ARM rates, while FHA Tiers six and seven rates are based on the 2016 median rate cap for Miscellaneous Service Code 113. In implementing this structure, GGRC indicated that it reimbursed the three FHAs for amounts that exceeded the Level 4I ARM rates, but did not exceed negotiated rates for residential care under Service Code 113. In addition, GGRC stated that it determined the rates of payment to the FHAs by adopting the same rates for similar individuals who resided in CCFs. GGRC also stated that these rates are justified and sustainable for the applicable consumers' level of behavioral, health and wellness support, whose needs cannot be met with lower tiers.

GGRC explained in its response that based on its legal interpretation of the regulations, it was allowed to utilize rates that exceeded those of the CCFs since "not all individuals served by the regional centers and the department have needs that may be met by the Level 1 to 4I homes and by regulation FHAs cannot accommodate more than two consumers." Therefore, GGRC is requesting DDS to fully rescind its overpayment finding. GGRC states that even if DDS disagrees with the GGRC legal rationale, it should reduce the overpayment from $4,316,351.98 to $1,439,639.50 as DDS calculated the overpayments utilizing the CCF rate for five bed facilities rates rather than the one to four bed rate. GGRC also indicated that DDS calculated the overpayments commencing in 2015, which is outside the scope of the audit.

DDS disagrees with GGRC's legal explanation provided in its response and stands by its finding that GGRC issued rates for three FHAs that were higher than the CCF rate model set by DDS. As indicated in its response, GGRC created Tier six and seven and reimbursed the FHAs even though W&I Code, Section 4689.1(7)(B), states "Regional center reimbursement to family home agencies for service in a family home shall not exceed rates for similar individuals when residing in other types of out-of-home care. . ." In addition, per W&I Code 4681.1(a), "… these rates shall be

calculated on the basis of a cost model designed by the department that ensures that aggregate facility payments support the provision of services to each person in accordance with his or her individual program plan and applicable program requirements."

However, the rates did not adhere to these requirements, and there are no regulations allowing Regional Centers to negotiate with the FHA vendors for consumers needing services in excess of the Alternative Residential Model (ARM) service levels, GGRC should have sought guidance from DDS prior to creating and implementing their new tier levels and requested Regional Center Alternatives for Service Delivery pursuant to W&I Code, Sections 4669.2 and 4669.75 (known as an "AB 637 waiver") for DDS' approval prior to implementation. This would have allowed GGRC to develop an alternative innovative means of providing the needed services, while being compliant with statute.

Alternatively, GGRC could have vendored the FHAs for the additional services separately as a supplement to the FHA services. GGRC did not choose either option therefore, DDS will not rescind the finding. Also, DDS took into consideration the new statute enacted 2023, which states, "Regional center reimbursement to family home agencies for services in a family home shall not exceed rates established pursuant to subdivision (b) of Section 4681.5 for individuals who reside in a community care facility, as defined in Section 1502 of the Health and Safety Code, vendored for four beds or fewer." Since the rates for Tiers 6 and 7 are currently lower or equivalent to the ARM Level 4I four-bed threshold amount and are no longer out of compliance, DDS will not seek the apparent overpayment totaling $4,316,351.98 paid to the vendors from July 2015 through March 2021. DDS recommends that GGRC follow W&I Code, Section 4681.5 or seek approval from DDS for any rate increase that may be required in the future.

Golden Gate Regional Center
Overpayments Due to Rate Increases
Fiscal Years 2015-16, 2016-17, 2017-18, 2018-19, 2019-20 and July 20 - March 21

No.	Vendor Number	Vendor Name	Service Code	Payment Period	Overpayment
1	PG1548	CALIFORNIA MENTOR FAMILY	904	July 15 - March 21	$ 505,352.58
2	H89124	GOLDEN STATE RESIDENTIAL		August 18 - March 21	$ 2,448,585.59
3	HG0039	LEVERAGING EQUAL ACCESS		August 18 - March 21	$ 1,362,413.82
				Total Overpayment	**$ 4,316,351.98**

APPENDIX A

GOLDEN GATE REGIONAL CENTER'S RESPONSE TO THE AUDIT FINDING

Golden Gate Regional Center

March 1, 2023

Mr. Edward Yan
Manager, Audit Section
Department of Developmental Services
1215 O Street
Sacramento, CA 95814

RE: GGRC's Response to DDS's Draft Audit of GGRC (FY 2018-2020)

Dear Mr. Yan:

Golden Gate Regional Center ("GGRC") submits this response to DDS's draft audit of GGRC for Fiscal Years 2018-19 and 2019-20 (the "Draft Audit"). This response (i) summarizes the audit finding in dispute, (ii) discusses relevant background facts, (iii) explains the legal basis for GGRC's actions and (iv) concludes with a public policy rationale for GGRC's billing practices.

1. Audit Finding in Dispute. GGRC contracts with Family Home Agencies ("FHAs") which arrange for various GGRC consumers to reside in Family Homes. During the years of the audit, the IPPs for certain consumers receiving services and supports in Family Homes mandated a level of care that exceeded the care level available under DDS's Level 4I ARM rates. Because the additional level of required care was similar to care for similar individuals residing in community care facilities ("CCFs") under Service Code 113, GGRC elected to pay FHAs for such additional level of care at the same rates as GGRC paid residential care providers under Service Code 113. This process also avoided the need for GGRC to transfer such individuals to those more restrictive settings. This letter will explain why GGRC's payments are permitted under applicable law.

2. Background Facts. Welfare and Institutions Code ("WIC") Section 4681.1 requires DDS to adopt regulations that specify rates of reimbursement for CCFs serving persons with developmental disabilities. In partial response to such mandate, DDS created rate setting procedures for residential services in Subchapter 6 of Chapter 3 of Title 17. DDS also adopted a rate model commonly known as the Alternative Residential Model ("ARM"). Residential service providers offering services within this model are vendored at levels of service that correspond to DDS's ARM rate schedule (Levels 1 - 4I), which DDS modifies annually.

However, not all individuals residing in CCFs have needs that can be met by Level 1 through 4I services. For example, after the closure of Agnews Developmental Center, hundreds of consumers in the Bay Area were relocated to CCFs, and their needs exceeded the services and supports offered under the ARM rates.

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DDS has adopted regulations for Miscellaneous Service Codes in appropriate circumstances. Specifically, 17 CCR Section 54356 provides that a "regional center shall classify a vendor as a miscellaneous service provider only if the vendor does not provide goods or services which are similar to any of the descriptions of goods or services contained within sections 54342 through 54355 of these regulations."

Based on this regulation, DDS has created Miscellaneous Service Code 113 (and related Service Code 114) for CCFs. CCFs housing consumers with such greater needs are commonly referred to as Specialized Residential Facilities ("SRFs"). DDS has also published and distributed to GGRC a document entitled, "Miscellaneous Service Codes", which notes in part:

> [Service Code] 113. DSS Licensed - Specialized Residential Facility (Habilitation) – 32010 SERVICE DESCRIPTION: A regional center shall classify a vendor as a DSS Licensed-Specialized Residential Facility provider if the vendor operates a residential care facility licensed by the Department of Social Services (DSS) for individuals with developmental disabilities who require 24 hour care and supervision and whose needs cannot be appropriately met within the array of other community living options available.
>
> Primary services provided by a DSS Licensed-Specialized Residential Facility may include personal care and supervision services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law) and therapeutic social and recreational programming, provided in a home-like environment. Incidental services provided by a DSS Licensed-Specialized Residential Facility may include home health care, physical therapy, occupational therapy, speech therapy, medication administration, intermittent skilled nursing services, and/or transportation, as specified in the IPP. This vendor type provides 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and the provision of supervision and direct care support to ensure the consumers' health, safety and well-being…
>
> …Payment for services in a DSS Licensed-Specialized Residential Facility must be made [either under a U&C rate] or, pursuant to Welfare & Institutions Code, Section 4648 (a)(4), the regional center may contract for the provision of services and supports for a period of up to three years, subject to the availability of funds.

Regional centers therefore use Miscellaneous Service Code 113 (and similar Service Code 114) to compensate service providers who provide services and supports to consumers whose needs exceed those under Level 4I ARM rates. The rate of reimbursement for these homes is negotiated by the regional centers up to the applicable median rate (WIC Section 4681.6).

As with consumers in CCFs, various GGRC consumers who reside in Family Homes require a more intensive level of care than can be met under ARM Level 4I. In response to this problem, GGRC might have required such individuals to be relocated to CCFs. However, moving consumers to more institutionalized settings is contrary to a fundamental tenet of the Lanterman Act, which is to support consumers' rights to live as independently as possible in the community.

GGRC thus desired to develop an alternate approach that allowed consumers to live in a less restrictive setting while receiving the services and supports that similar consumers received in more restrictive settings, and at no additional cost to the State.

GGRC therefore created its own Family Home Agency Rate Model with a formula to assist its staff in determining appropriate rates of payment. As of August 2018, all GGRC FHAs had rates established for 7 tiers. The first five tiers were tied to the ARM rates. GGRC established FHA Tiers 6 and 7 rates at the 2016 median rate cap for Miscellaneous Service Code 113.

Under GGRC's rate model, Tier 6 rates are available for only those individuals requiring supervision and who have severe behaviors (property destruction, physical aggressiveness, socially inappropriate behavior, illegal activity/forensic). These are individuals who exhibit complex needs for intense behavioral support, medical oversight, or a combination of needs that are documented and identified as difficult to support. Tier 6 rates are for a level of care that exceeds care and supervision of a Level 4I Family Home. This tier can also support individuals with nursing/medical needs. To qualify for this Tier, GGRC requires at least 16 hours of consultation per quarter to each individual and their family.

Similarly, under GGRC's rate model, Tier 7 rates are available for only those individuals requiring a high level of need. This level of care supports individuals requiring full assistance with the completion of activities of daily living, medication management, and behavioral support. Consumers who qualify for this level of support typically have a history and presence of high severity and frequency of maladaptive behaviors that have been difficult to support, or unsuccessful to support, in other residential settings. This tier can support individuals who are non-ambulatory and require whole personal support (all areas). This Tier can be utilized for crisis placement. To qualify for this Tier, GGRC requires at least 20 hours of consultation per quarter to each individual and their family.

In implementing this structure, GGRC reimbursed three FHAs in amounts that exceeded Level 4I ARM rates, but that did not exceed negotiated rates for residential care under Service Code 113. In sum, GGRC determined the rates of payment to FHAs by adopting the same rates for similar individuals who resided in CCFs. These rates are justified and sustainable for the applicable consumers' level of behavioral, health and wellness supports, which needs cannot be met with lower tiered licensed care.

3. Legal Analysis. This section is divided into two parts: (i) first, based on the legal rationale for GGRC's billing practice, DDS should fully rescind its overpayment claim; and (ii) second, even if DDS disagrees with GGRC's legal rationale, DDS should reduce its overpayment claim from $4,316,351.98 to $1,439,639.50.

3.1 GGRC May Use Both ARM Rates and Negotiated Rates for FHAs. WIC Section 4689.1 authorizes the use of FHAs to offer services in Family Homes. FHA rates of payment are determined by WIC Section 4689.1(e)(7)(B), which provides, "Regional center reimbursement to family home agencies for services in a family home shall not exceed rates for similar individuals when residing in other types of out-of-home care established pursuant to Section 4681.1 [by which DDS has the authority to establish rates of payment for CCFs]." The FHA regulations contain similar language: "Regional center reimbursement to FHAs shall not exceed rates for similar

individuals when residing in other types of out-of-home care established pursuant to WIC Section 4681.1." 17 CCR Section 56082(b).

Therefore, for the time period covered by the Draft Audit, no statute or regulation set specific FHA rates. Rather, each regional center must determine FHA rates by comparing rates it pays for similar individuals who reside in CCFs.

As noted above, DDS is obligated under WIC Section 4681.1 to develop rates of reimbursement for all consumers in CCFs. This includes SRFs. Further, such statute requires DDS to ensure the "aggregate facility payments support the provision of services to each person in accordance with his or her individual program plan and applicable program requirements".

Under Title 17, DDS has elected to set rates of payment at CCFs under two different methodologies. If the CCF provides services at Service Levels 1 through 4I, DDS has developed ARM rates for such services pursuant to 17 CCR Section 56910 et seq. For consumers in CCFs that are SRFs, which require a higher level of care than under Service Level 4I, DDS permits regional centers to pay negotiated rates under Miscellaneous Service Codes 113 and 114. Under 17 CCR Section 54356(b), DDS must issue miscellaneous service codes for such vendors.

DDS is required by law to set rates for all consumers in CCFs, but the ARM rates only cover a subset of those consumers. DDS must therefore meet its statutory obligations by relying on Miscellaneous Service Codes 113 and 114 for those consumers residing in CCFs who require a higher level of care. Similarly, because the law instructs GGRC to set FHA rates based on CCF rates, GGRC is permitted to look to negotiated CCF rates under Service Code 113 or 114 to set FHA rates for those consumers who require more intensive services and supports than offered under ARM Rate 4I, and who are otherwise at risk for being placed in CCFs.

The above statutes and regulations therefore give GGRC the authority to set FHA rates using both the ARM rates and the rates permitted under Service Code 113 or 114 (subject to the median rate cap in WIC Section 4681.6).

DDS might argue that it does not set Service Code 113 rates. That position fails to take into account DDS's actual practice, and the practical effect of the median rate cap law. As a matter of historic practice, SC 113 rates are part of DDS's overall rate-setting methodology.

GGRC's practice is also consistent with WIC Section 4648(a)(5), which provides, "In order to ensure the maximum flexibility and availability of appropriate services and supports for persons with developmental disabilities, the department shall establish and maintain an equitable system of payment to providers of services and supports identified as necessary to the implementation of a consumer's individual program plan. The system of payment shall include a provision for a rate to ensure that the provider can meet the special needs of consumers and provide quality services and supports in the least restrictive setting as required by law."

GGRC's FHA Tier 6 and 7 rates are equivalent to Service Code 113 rates for those consumers requiring additional level of care. GGRC's payments therefore do not exceed rates of equivalent licensed care payments within its catchment area. Individuals in FHA homes who have

similar needs and require similar levels of service to individuals served in CCFs are entitled by WIC Section 4689.1(e)(7)(B) to FHA rates in accordance with comparable CCF rates.

WIC Section 4648(a)(1) requires GGRC to secure needed services and supports for all of its consumers so that they can "achieve the greatest self-sufficiency possible and... exercise personal choices". That statute further provides, "The regional center shall secure services and supports that meet the needs of the consumer, as determined in the consumer's individual program plan, and... **the planning team shall give highest preference to those services and supports that would allow... adult persons with developmental disabilities to live as independently as possible in the community**...." (emphasis added). GGRC's payment structure, which allows consumers with greater support needs to remain in Family Homes rather than more restrictive settings is therefore consistent with the purpose of this statute.

Further, if GGRC is limited to the ARM rates in FHAs, and is prohibited from accessing CCF negotiated rates, GGRC could not ensure the aggregate facility payments in Family Homes support the provision of services to each person in accordance with his or her individual program plan and applicable program requirements, which is contrary to the express terms in WIC Section 4681.1(a).

In sum, WIC Section 4681.1 requires FHA rates to be set in accordance with CCF rates. Although DDS may have elected to adopt only ARM rates based on that statute, no portion of such statute limits FHA rates to ARM rates. CCF rates include both ARM rates and negotiated rates (or U&C rates) under Service Codes 113 and 114. GGRC may therefore also use both ARM rates and negotiated rates when establishing FHA rates. GGRC has fully complied with the law in establishing its rates of reimbursement for FHA homes, which are consistent with the level of consumer care in similar CCF settings.

3.2 DDS's Use of Incorrect ARM Rate; Time Barred Claims. Section 3.1 above provides legal justification for GGRC's payment procedures to its FHAs, and therefore GGRC respectfully requests DDS to remove the audit exception in the Draft Audit. However, even if DDS denies GGRC's legal authority to exceed ARM rates in FHAs, DDS's rationale for calculating the rate of overpayment is also incorrect, for the following two reasons:

3.2.1 First Reason; DDS Must Apply the 1-4 Bed ARM Rate. In analyzing the alleged overpayments, DDS compared the amount of GGRC's payments to the relevant ARM rates for facilities with five or more beds (the "5+ Bed Rate"). This resulted in an alleged overpayment of $4,316,351.98. However, the ARM rates for facilities with four or fewer beds (the "1-4 Bed Rate") are significantly higher. If DDS instead used the 1-4 Bed Rate, the alleged overpayment would instead be $1,573,443.30. GGRC has previously provided detailed documentation to DDS in support of such calculation. The legal basis for GGRC's calculation is as follows:

By law, no more than two consumers may occupy an FHA (WIC Section 4689.1; 17 CCR Section 56076(e)(5)). Therefore, based on that fact alone, DDS should have used the 1-4 Bed Rate rather than the 5+ Bed Rate. It makes no sense for DDS to apply the 5+ Bed Rate to facilities that only have one or two beds, when DDS also publishes a rate that expressly covers facilities with only one or two beds for consumers.

However, DDS has orally informed GGRC that DDS is required to use the 5+ Bed Rate because (i) DDS developed that rate under WIC Section 4681.1, which is the statute requiring DDS to set CCF rates upon which FHA rates are based and (ii) DDS developed the 1-4 Bed Rate under a different statute. Yet nothing in WIC Section 4681.1 instructs DDS to set rates in only those CCFs with five or more beds. Rather, such statute requires DDS to adopt regulations for all CCFs, which must therefore include those CCFs with four or fewer beds.

Prior to July 2016, DDS's ARM Rates did not include separate rates based on the number of beds in a facility. Under WIC Section 4681.5, by July 1, 2016, DDS was required to establish a rate schedule for CCFs vendored to provide services to a maximum of four persons with developmental disabilities. DDS has orally informed GGRC that based on this language, regional centers are precluded from relying on the 1-4 Bed Rate in setting FHA rates. It appears DDS's rationale is that (i) FHA rates must be based on CCF rates established under WIC Section 4681.1, including DDS's 5+ Bed Rate developed under that law; and (ii) because DDS developed an ARM Rate for 1-4 bed CCFs under WIC Section 4681.5, regional centers can only use the 5+ Bed Rates for FHAs.

This is a convoluted reading of the law, and contrary to the rules relating to interpretation of statutes. In determining legislative intent, the court turns first to the words used in the statute (Steilberg v. Lackner (1977) 69 Cal.App.3d 780). The words, however, must be read in context, keeping in mind the nature and obvious purpose of the statute (Johnstone v. Richardson (1951) 103 Cal. App. 2d 41, 46), and the statutory language applied must be given such interpretation as will promote rather than defeat the objective and policy of the law (City of L.A. v. Pac. Tel. & Tel. Co. (1958) 164 Cal. App. 2d 253, 256).

The primary purpose of WIC Section 4681.5 is to cap rates for residential care providers at those amounts they were receiving on June 30, 2008. The statute then added a carve out: "Notwithstanding [the rate cap] or any other law or regulation, the department shall, effective July 1, 2016, establish a rate schedule for residential community care facilities vendored to provide services to a maximum of four persons with developmental disabilities." Thus, DDS could develop rates for payment for CCFs with four or fewer persons, and those rates would be exempt from the 2008 rate cap.

WIC Section 4681.1 requires DDS to create regulations for all rates of payment for all CCFs. Thus, given the broad scope of WIC Section 4681.1, DDS has the authority under WIC Section 4681.1 to set 1-4 ARM Bed Rates. WIC Section 4681.5 <u>also</u> authorizes DDS to set 1-4 ARM Bed Rates, as a carve out to the rate cap. Nothing in WIC Section 4681.5 is contrary to, or limits DDS's rate setting rights under, WIC Section 4681.1. Further, nothing in WIC Section 4681.1 or Title 17 states that regional centers can't use 1-4 ARM Bed Rates for FHAs.

Therefore, the statutes don't contradict each other, because they serve different purposes. Statutes must be harmonized if possible (Mannheim v. Superior Court (1970) 3 Cal. 3d 678, 68). GGRC's interpretation harmonizes these two statutes, and therefore should be favored. In addition, GGRC's practices are consistent with the legislative intent of the FHA billing law, which is to ensure FHAs did not spend more on residential services than licensed care.

It's highly doubtful the Legislature intended regional centers to use 5+ Bed Rates for FHAs when DDS also publishes 1-4 Bed Rates, especially in light of WIC Section 4681.1, which makes no such distinction. WIC Section 4681.1 directs DDS to establish rates of payment for CCFs. The 1-4 Bed Rate is a rate of payment for CCFs. Therefore, to the extent GGRC uses ARM Rates to set FHA rates, GGRC has the right to use DDS's 1-4 Bed Rate.

3.2.2 Second Reason: Pre-Audit Claims are Time Barred. The Draft Audit covers the service period from July 1, 2018 through June 30, 2020. However, part of DDS's overpayment claim relates to services provided by California Mentor between July 2015 and June 2018. In particular, DDS seeks repayment from GGRC of the sum of $191,081.80 that relates to claims GGRC filed with DDS for services provided prior to July 1, 2018 (the "Pre-Audit Claims").

The Pre-Audit Claims are outside of the scope of the audit period. GGRC remitted claims for some of these payments over seven years ago.

17 CCR Section 50700 et seq. addresses fiscal audit appeals relating to Regional Centers. Although an appeal is premature at this time, the terms in such regulation are instructive. In particular, 17 CCR Section 50701(g) defines an "audit report". The regulation notes that such report may contain findings, audit exceptions, audit adjustments, recommendations and other information "necessary to provide an analysis of the fiscal activities *for the period covered by the audit*" (emphasis added). In other words, DDS does not have the regulatory authority to include in its Draft Audit or final audit any fiscal activities of GGRC that arose before July 1, 2018. DDS is therefore prohibited from pursuing Pre-Audit Claims.

3.3. Conclusion. As noted in Section 3.1 above, GGRC properly paid FHAs for their services, and DDS should therefore remove the FHA overpayment audit exception from the final audit. However, even if DDS disagrees with such legal analysis, then as noted in Section 3.2 above, DDS should reduce the audit exception from $4,316,351.98 to $1,439,639.50, as summarized by the information on the following table:

DDS CALCULATIONS OF OVERPAYMENT (BASED ON 5+ BED RATE & INCLUSIVE OF "PRE-AUDIT" AMOUNTS)

	FY16	FY17	FY18	FY19	FY20	FY21	TOTAL
PG1548 (M5)	$ 91,722.80	$ 49,444.32	$ 49,914.68	$ 11,023.08	$ -	$ -	$ 202,104.88
PG1548 (T)				$ 83,044.80	$ 125,119.41	$ 95,083.49	$ 303,247.70
H89124				$ 769,541.18	$ 975,247.57	$ 703,796.84	$ 2,448,585.59
HG0039				$ 346,410.05	$ 571,187.44	$ 444,816.33	$ 1,362,413.82
Total Overpayment	$ 91,722.80	$ 49,444.32	$ 49,914.68	$ 1,210,019.11	$ 1,671,554.41	$ 1,243,696.66	$ 4,316,351.98

GGRC CALCULATIONS OF OVERPAYMENT (BASED ON 4 or LESS BED RATE & REMOVAL OF "PRE-AUDIT" AMOUNTS)

	FY16	FY17	FY18	FY19	FY20	FY21	TOTAL
PG1548 (M5)	$ -	$ -	$ -	$ 3,925.08	$ -	$ -	$ 3,925.08
PG1548 (T)				$ 19,507.13	$ 34,963.77	$ 39,726.00	$ 94,196.90
H89124				$ 332,268.38	$ 442,900.97	$ 319,370.87	$ 1,094,540.22
HG0039				$ 51,533.30	$ 100,293.24	$ 95,150.76	$ 246,977.30
Total Overpayment	$ -	$ -	$ -	$ 407,233.89	$ 578,157.98	$ 454,247.63	$ 1,439,639.50

4. Public Policy Rationale.

GGRC is dedicated to increasing the percentage of its consumer population residing in the least restrictive settings appropriate to their needs. DDS has expressed a similar commitment on its CPP webpage (https://www.dds.ca.gov/services/cpp/).

Family Homes provide a less restrictive setting for consumers than CCFs and other institutional settings. This is reflected in the FHA's required Program Design, which provides that consumers in such homes shall receive respect and support and involvement in the normal routines of family life (17 CCR Section 56084(a)(1)). Further, at noted above, no more than two consumers can occupy a Family Home, whereas most CCFs contain at least twice that number of consumers.

In light of the goal for consumers to reside in the least restrictive settings appropriate to their needs, GGRC has made an effort to retain consumers in Family Homes over more restrictive settings when possible. In 2005, 0.33% percent of GGRC's consumers resided in Family Homes. As of December 2022, 2.39% percent of GGRC's consumers reside in Family Homes.

The FHA model is supported by consumers, GGRC and DDS. As noted on DDS's website, "FHA and family home services and supports are a new option which enables adults with developmental disabilities to enter into partnerships with families that promote self-determination and interdependence." However, the FHA model has limited value if the level of care and corresponding rates of reimbursement are capped by Level 4I, five-or-more-bed ARM rates.

GGRC's Tier 6 and 7 Rates for FHAs are vital to individuals and families who receive FHA services to remain in their chosen communities. The FHA model allows consumers to have more of an independent living experience than more restrictive housing model. Without the ability to exceed the Level 4I rates, individuals from FHA homes will need to be placed in CCFs and other more restrictive settings, including possibly moving outside of their home communities to other regional center catchment areas. GGRC's FHA rate structure therefore meets the promise of the Lanterman Act – as well as the intent and letter of the FHA statutue - to ensure the consumers it serves can elect to live their most independent and productive lives possible in their community.

In sum, to the extent the rates of payment GGRC has been remitting to FHAs exceeds DDS's 5+ Bed ARM Rates, GGRC is authorized to pay such higher rates, both as a matter of applicable law and good public policy.

Sincerely,

Eric Zigman, Executive Director
Golden Gate Regional Center, Inc.