AUDIT OF THE
GOLDEN GATE REGIONAL CENTER
FOR FISCAL YEARS 2012-13 AND 2013-14

Department of Developmental Services

This audit report was prepared by the
California Department of Developmental Services
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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 California Code of Regulations, Title 17 (CCR, Title 17), the California Welfare and Institutions (W&I) Code, the Home and Community-Based Services (HCBS) Waiver for the Developmentally Disabled, and the contract with DDS. Overall, the audit indicated that GGRC maintains accounting records and supporting documentation for transactions in an organized manner. This audit report identifies some areas where GGRC's administrative, 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. A follow-up review was performed to ensure GGRC has taken corrective action to resolve the finding identified in the prior DDS audit report.

Finding That Needs to be Addressed

Finding 1: **Lack of Medi-Cal Reimbursement Procedures**

During a vendor audit of College Hospital Inc. (CHI), Vendor Number HH0937, Service Code 700, it was identified that a total of $13,712 was approved for an insurance reimbursement from Anthem Blue Cross for one GGRC consumer. CHI subsequently reimbursed GGRC the $13,712 reimbursed by Anthem Blue Cross. As a result of this issue, a follow-up review was conducted at GGRC which found that GGRC does not have procedures in place to determine whether vendors have billed insurance, Medi-Cal, or both, after payments have been provided for eligible services. Since GGRC did not have procedures in place, it was unaware of amounts that should have been reimbursed by the vendor from insurance companies or Medi-Cal. In addition, GGRC did not know if the insurance companies or Medi-Cal approved or denied the payment reimbursements unless it was notified by the vendors. This is not in compliance with W&I Code, Section 14023.7.

However, GGRC has implemented, and provided DDS with procedures for monitoring the Medi-Cal reimbursements for College Hospital Inc., but did not address other vendors that provide similar services.

BACKGROUND

DDS is responsible, under the Lanterman Developmental Disabilities Services Act (Lanterman Act), for ensuring that persons with developmental disabilities (DD) receive the services and supports they need to lead more independent, productive and normal 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 (RC). 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 Branch 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 (CPA) 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 contract HD099006 (State Contract) effective July 1, 2009, through June 30, 2016. The 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 the 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 at GGRC from January 12, 2015, through February 5, 2015, and was conducted by the Audit Branch 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.

CRITERIA

The following criteria were used for this audit:

- California's W&I Code
- "Approved Application for the HCBS Waiver for the Developmentally Disabled"
- CCR, Title 17
- Federal Office of Management Budget (OMB) Circular A-133
- State Contract between DDS and GGRC, effective July 1, 2009

AUDIT PERIOD

The audit period was July 1, 2012, through June 30, 2014, with a 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 the RCs' fiscal, administrative, and program operations. The objectives of this audit are:

- To determine compliance with the W&I Code (or the Lanterman Act)
- To determine compliance with CCR, Title 17 regulations
- To determine compliance with the provisions of the HCBS Waiver Program for the Developmentally Disabled
- To determine that costs claimed were in compliance with the provisions of the State Contract

The audit was conducted in accordance with 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 Lanterman Act, CCR, Title 17, the HCBS Waiver for the Developmentally Disabled, and the State Contract.

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 accounting firm for Fiscal Years 2012-13 and 2013-14, issued on December 3, 2013 and November 18, 2014, respectively. In addition, DDS noted no management letters 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 that the rates paid were set in accordance with the provisions of CCR, Title 17, and the W&I Code of Regulations.

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

- DDS selected a sample of bank reconciliations for Operations accounts to determine if the reconciliations were properly completed on a monthly basis.

II. Regional Center Operations

DDS audited GGRC's operations and conducted tests to determine compliance with the State Contract. The tests included various expenditures claimed for administration to ensure that GGRC's accounting staff is properly inputting data, to ensure that transactions were recorded on a timely basis, and to ensure that expenditures charged to various operating areas were valid and reasonable. These tests included the following:

- A sample of the personnel files, time sheets, 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 operating 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 is the study that 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 month of March 2014, 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 it to the Case Management Time Study Forms (DS 1916) to ensure that they were properly completed and supported.

IV. Service Coordinator Caseload Survey

Under 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 in accordance to W&I Code, Section 4640.6(c)(3):

A. For all consumers that are three years of age and younger and for consumers enrolled in the Waiver, the required average ratio shall be 1:62.

B. For 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, the required average ratio shall be 1:62. The required average ratio shall be 1:45 for consumers who have moved within the first year.

C. For all consumers who have not moved from the developmental centers to the community since April 14, 1993, and who are not covered under A above, the required average ratio shall be 1:66. The 1:66 ratio was lifted in February 2009, upon imposition of the 3 percent operations reduction to regional centers as required per W&I Code, Section 4640.6(i) and (j). The ratio continued to be suspended from July 2010 until July 2013 with imposition of the subsequent 4.25 percent and 1.25 percent payment reductions.

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 (Part C Funding)

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

For this program, DDS reviewed the Early Intervention Program, including the Early Start Plan, and Federal Part C funding to determine if the funds were properly accounted for in the RC's accounting records.

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). To determine whether GGRC is in compliance with CCR, Title 17, and the W&I Code, 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 is 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 income level of families of children between the ages of 0 through 17 receiving qualifying services through a 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 is assessed to the parents under FCPP. To determine whether GGRC is in compliance with the W&I Code, 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 developmental disability 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. 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 as amended.

To determine whether GGRC implemented the required RFP process by January 1, 2011, DDS performed the following procedures during our 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 include 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 communicates 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, 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, there is written documentation retained as justification for such a selection.

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

- Selected a sample of Operational, Start-Up, 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, written justification for final vendor selection decisions, and 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 new contracts in place as of March 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's Board approved POS, Start-Up and Operational 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 and that the usage of funds is of direct benefit to consumers, and that 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 of 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.

IX. Statewide/Regional Center Median Rates

The Statewide or Regional Center Median Rates were implemented on July 1, 2008, and amended on December 15, 2011, to ensure 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 medium rate requirements of the W&I Code, Section 4691.9.

- Reviewed vendor contracts to verify 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 health and safety exemptions were granted by DDS.

X. 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:

- Start-Up Funds
- Community and Placement Program
- Part C
- First Five

XI. Follow-up Review on Prior DDS Audit Finding

As an essential part of the overall DDS monitoring system, a follow-up review of the prior DDS audit finding was conducted. DDS identified one prior audit finding that was reported to GGRC and reviewed supporting documentation to determine the degree and completeness of GGRC's implementation of corrective action.

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 CCR, Title 17, the HCBS Waiver, and the State Contract with DDS for the audit period, July 1, 2012, through June 30, 2014.

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

From the review of prior audit issue, it has been determined that GGRC has taken appropriate corrective action to resolve the prior audit issue.

VIEWS OF RESPONSIBLE OFFICIALS

DDS issued the draft audit report on September 9, 2015. The finding in the draft audit report were discussed at a formal exit conference with GGRC on September 10, 2015. The views of the responsible officials are included in the final audit report.

RESTRICTED USE

This audit report is solely for the information and use of DDS, Department of Health Care Services, CMS, 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: **Lack of Policies for Eligible Consumer Reimbursements**

During a vendor audit of CHI, Vendor Number HH0937, Service Code 700, it was identified that a total of $13,712 was approved for an insurance reimbursement from Anthem Blue Cross for one GGRC consumer for services provided from July 2, 2012, through July 17, 2012. CHI subsequently reimbursed GGRC the $13,712 reimbursed by Anthem Blue Cross. As a result of this issue, a follow-up review was conducted at GGRC which found that GGRC does not have procedures in place to determine whether vendors have billed insurance, Medi-Cal, or both, after payments have been provided for eligible services. Since GGRC did not have procedures in place, it was unaware of amounts that should have been reimbursed by the vendor from insurance companies or Medi-Cal. In addition, GGRC did not know if the insurance companies or Medi-Cal approved or denied the payment reimbursements unless it was notified by the vendors.

However, GGRC has implemented, and provided DDS with its procedures for monitoring the Medi-Cal Reimbursements for College Hospital Inc., but did not address other vendors that provide the similar services.

W&I Code, Section 14023.7 states:

> "Any provider of service seeking payment for health care services for a person eligible for these services under this chapter shall first seek to obtain payment from any private or public health insurance coverage to which the person is entitled, where the provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to the department for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by the provider, a claim may be submitted to the department."

Good internal controls and sound business practices also dictate that RCs have written policies and procedures in place to follow-up with vendors who provide services to Medi-Cal or insurance eligible consumers. The procedures must ensure RCs are receiving copies of Medi-Cal approvals or denial letters to assist in the monitoring of Medi-Cal and insurance reimbursements, and any Medi-Cal or insurance payments received by the vendor are returned to the RC and are used to offset the claim to DDS.

Recommendation:

GGRC must follow its implemented procedures to ensure that all vendors who have consumers eligible for insurance, Medi-Cal, or both, are billing for reimbursements appropriately.

EVALUATION OF RESPONSE

As part of the audit report process, GGRC has been provided with a draft audit report and was requested to provide a response to the finding. GGRC's response dated October 12, 2015, is provided as Appendix A. This audit report includes the complete text of the finding in the Finding and Recommendation section, as well as a summary of the finding in the Executive Summary section.

DDS' Audit Branch has evaluated GGRC's response. Except as noted below, GGRC's response addressed the audit finding and provided reasonable assurance that corrective action would be taken to resolve the issue. DDS' Audit Branch will confirm GGRC's corrective action identified in the response during the follow-up review of the next scheduled audit.

Finding 1: **Lack of Policies for Eligible Consumer Reimbursements**

Although GGRC stated it does not agree with the DDS finding that it lacks policies for eligible consumer reimbursements, it has implemented, and provided DDS with its procedures for monitoring the Medi-Cal reimbursements for College Hospital Inc. The procedures state that GGRC will monitor consumers that receive services from CHI, and review quarterly reports from CHI specifying the consumers that were discharged. The quarterly reports will include the status of the Treatment Authorization Requests, and any payments that were received, and reimbursed to GGRC. However, GGRC did not address other vendors that provide similar services. A follow-up review will be conducted during the next scheduled audit to ensure Medi-Cal billings are being reviewed, not only for CHI, but also for other vendors offering a similar service.

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APPENDIX A

Golden Gate Regional Center

RESPONSE
TO AUDIT FINDING

Golden Gate Regional Center

Serving people with developmental disabilities since 1966

October 12, 2015

Mr. Edward Yan
Manager
Audit Branch
Department of Developmental Services
1600 Ninth Street, Room 230, MS-2-10
Sacramento. CA 95814

Dear Ed.

Response to DDS Draft Audit of the Golden Gate Regional Center for Fiscal Years 2012-13 and 2013-14

Reference is made to your letter or September 9, 2015, the Draft DDS Audit Report of GGRC for fiscal years 2012-13 and 2013-14 and the Audit Exit Conference call on September 10, 2015, with Oscar Perez, Supervisor, Audit Branch.

Thank you for the opportunity lo respond to the concerns raised in your report. Our response to the one finding and Recommendation is provided in Attachment A to this letter.

We wish to thank you and your audit team for their efficiency and consideration or our staff's time throughout the audit process. Should you have any questions, please do not hesitate to contact me directly.

Sincerely,

Lop Hou
Chief, Administration and Finance

Enclosure

cc: James L. Shorter, Executive Director
Julie Luu, Controller
Ellen Nzima, DDS
Oscar Perez, DDS

ATTACHMENT A

The DDS report asserts the following:

DDS Audit Finding 1: Lack of Policies for Eligible Reimbursements

During a vendor audit of CHI, Vendor Number HI-10937, Service Code 700, it was identified that a total of $13,712 was approved for an insurance reimbursement from Anthem Blue Cross for one GGRC consumer for services provided from July 2, 2012, through July 17, 2012. CHI subsequently reimbursed GGRC the $13,712 reimbursed by Anthem Blue Cross. As a result of this issue, a follow-up review was conducted at GGRC which found that GGRC does not have procedures in place to determine whether vendors have billed insurance, Medi-Cal, or both after payments have been provided for eligible services. Since GGRC did not have procedures in place, it was unaware of amounts that should have been reimbursed by the vendor from insurance companies or Medi-Cal. In addition, GGRC did not know if the insurance companies or Medi-Cal approved or denied the payment reimbursement unless it was notified by the vendors.

W&I Code, Section 14023.7 states:

> "Any provider of service seeking payment for health care services for a person eligible for these services under this chapter shall first seek to obtain payment from any private or public health insurance coverage to which the person is entitled, where the provider is aware of this coverage and to the extent coverage extends to these services, prior to submitting a claim to the department for payment of any unpaid balances for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by the provider, a claim may be submitted to the department. "

Good internal controls and sound business practices also dictate that RCs have written policies and procedures in place to follow-up with vendors who provide services to Medi-Cal or insurance eligible consumers. The procedures must ensure RCs are receiving copies of Medi-Cal approvals or denial letters to assist in the monitoring of Medical and insurance reimbursements, and any Medi-Cal or insurance payments received by the vendor are returned to the RC and are used to offset the claim to DDS.

Recommendation:

GGRC must develop procedures to ensure that all vendors who have consumers' eligible for insurance, Medi-Cal, or both, are billing for reimbursements appropriately. The procedures must also include a detailed follow-up process to ensure that GGRC receives a copy of the insurance and/or Medi-Cal approval or denial letters to assist in the monitoring of reimbursement.

ATTACHMENT A

GGRC RESPONSE

Firstly, the titled finding of "Lack of Policies for Eligible Reimbursements" is misleading and incorrect. A policy cannot be lacking if no such policy was required. No such policies were ever required of Regional Centers to monitor a vendor's own internal policies and procedures to ensure they claim and are reimbursed for insured costs.

The findings in your audit of CHI pertains to deficiencies at CHI and the onus to rectify those findings fall upon CHI. As a result of those findings at CHI, other regional centers should not be penalized with added responsibilities to ensure that another organization complies with policies and procedures that it should follow. Furthermore, GGRC has no jurisdiction over CHI's operations nor does it have the resources to establish such procedures, especially as no additional funding is expected to be provided by DDS in order to facilitate the recommendation in the report.

Your finding referred to W&I Code, Section 14023.7 which states that the provider of service, in this instance, CHI, *"...shall first seek to obtain payment from any private or public health insurance coverage to which the person is entitled, where the provider is aware of this coverage and to the extent coverage extends to these services, prior to submilling a claim to the department for payment of any unpaid balances for these services. In the event that a claim submilled to a private or public health insurer has not been paid within 90 days of billing by the provider, a claim may be submilled to the department."*

This clearly states that CHI should first claim payment from private or public health insurance coverage to which the person is entitled and if after 90 days it has not received reimbursement, then to proceed to claim for reimbursement from the regional center and thus DDS.

This would suggest that CHI should not have made claims to the regional center for reimbursement and thus claims to the DDS for payment, until such time as 90 days have lapsed since submission of its claims for reimbursement from private or public health insurance providers. This finding was however not made, but is implied that regional center should not pay the provider until after the 90 days have lapsed. Clearly, such a requirement is untenable and unreasonable to expect a service provider to wait 90 days before reimbursement hence DDS does not enforce it.

As a regional center, *we* are fully aware of the need to ensure funds are not needlessly expended and certainly if funds should be reimbursed back to regional centers then this should be instigated by those responsible parties concerned.

As a conscientious regional center we are prepared to assist in ensuring CHI follows its policies and procedures, however, we cannot be expected regulate CHI's procedures. GGRC will request and monitor from CHI a list of all GGRC clients that CHI has submitted claims for reimbursement from insurers. We suggest that recommendations should be made to CHI to fully cooperate with regional centers in the monitoring of CI-II's submissions of claims to insurers for regional center clients.