

Item 11

**PROPOSED STATEWIDE COST ESTIMATE**

**\$27,469**

**(Approximate Prospective Cost of \$5,428 Annually)**

Welfare and Institutions Code Section 14029.5

Statutes 2006, Chapter 657

*Medi-Cal Eligibility of Juvenile Offenders*

08-TC-04

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BEFORE THE  
COMMISSION ON STATE MANDATES  
STATE OF CALIFORNIA

IN RE TEST CLAIM ON:  
Welfare and Institutions Code section 14029.5  
Statutes 2006, chapter 657  
  
Filed on January 29, 2009  
By County of Alameda, Claimant.

Case No.: 08-TC-04  
*Medi-Cal Eligibility of Juvenile Offenders*  
STATEMENT OF DECISION PURSUANT  
TO GOVERNMENT CODE SECTION  
17500 ET SEQ.; CALIFORNIA CODE OF  
REGULATIONS, TITLE 2, DIVISION 2,  
CHAPTER 2.5, ARTICLE 7.  
*(Adopted December 6, 2013)*  
*(Served December 16, 2013)*

**STATEMENT OF DECISION**

The Commission on State Mandates (Commission) heard and decided this test claim during a regularly scheduled hearing on December 6, 2013. Nicole Wordelman, Legislative Advocate of Platinum Advisors, appeared on behalf of the claimant. Lee Scott, Michael Byrne, and Kathy Lynch appeared on behalf of the Department of Finance. Eduardo Cavazos appeared on behalf of the Department of Health Care Services.

The law applicable to the Commission’s determination of a reimbursable state-mandated program is article XIII B, section 6 of the California Constitution, Government Code sections 17500 et seq., and related case law.

The Commission adopted the proposed statement of decision to partially approve the test claim by a vote of 7-0.

**Summary of the Findings**

This test claim seeks reimbursement for counties to help juveniles whose Medi-Cal coverage is terminated as a result of incarceration in a juvenile detention facility for 30 days or more to obtain Medi-Cal or other health coverage immediately upon release from custody.

The Commission finds that Welfare and Institutions Code section 14029.5 (Stats. 2006, ch. 657) constitutes a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution and requires county juvenile detention facilities to provide specified information regarding Medi-Cal eligibility to county welfare departments (CWD) and, if the ward is a minor, provide notice to the ward’s parent or guardian beginning January 1, 2008.

The CWD is then required to perform specified mandated activities related to initiating an application for Medi-Cal benefits for the ward. The CWD is also required to determine the ward’s Medi-Cal eligibility; however, this requirement does not impose a reimbursable mandate since it is not new.

## COMMISSION FINDINGS

### I. Chronology

01/29/2009	Claimant, County of Alameda, filed the test claim with the Commission.
03/12/2009	Department of Health Care Services (DHCS) filed a request for extension of time to file comments on the test claim.
06/22/2009	DHCS filed comments on the test claim.
08/12/2009	Department of Finance (Finance) filed comments on the test claim.
10/27/2010	DHCS filed rebuttal comments.
07/16/2013	Commission staff issued the draft staff analysis.
08/06/2013	DHCS filed comments on the draft staff analysis.
08/06/2013	Finance requested an extension of time to file comments until September 5, 2013, and to postpone the hearing on the test claim to December 6, 2013.
08/07/2013	Finance's request for extension of time and postponement of hearing was granted for good cause.
09/05/2013	Finance filed comments on the draft staff analysis.

### II. Background

This test claim seeks reimbursement for counties to help juveniles, whose Medi-Cal coverage is terminated as a result of incarceration in a juvenile detention facility for 30 days or more, obtain Medi-Cal or other health coverage immediately upon release from custody.

#### A. Preexisting Law

Medi-Cal is the state's system for administering the federal government's Medicaid program.<sup>1</sup> The Medicaid program provides financial assistance to states to furnish health care to low-income persons based on a cost sharing formula with the states. States that participate in the Medicaid program are required to comply with certain requirements, including having procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.<sup>2</sup> Federal law also requires that if the agency has information about anticipated changes in a recipient's circumstances, the agency must re-determine eligibility at the appropriate time based on those changes.<sup>3</sup> Otherwise, re-determination of eligibility is required every 12 months.

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<sup>1</sup> Medi-Cal family income eligibility for children ages 0 to 1 extends up to 200% of the federal poverty level (FPL), children ages 1 to 5 with family incomes up to 133% FPL, and children ages 6 to 19 with family incomes up to 100% FPL.

<sup>2</sup> Under federal law, the state may delegate the authority to determine eligibility for the program to local agencies. (42 USC § 1396a (a)(5), 42 CFR § 431.11(d).)

<sup>3</sup> 42 CFR section 435.916.

Generally, Medicaid benefits are not paid for health care services for incarcerated individuals. Incarceration is considered a change in circumstances that affects eligibility. No federal matching funds are provided to the state during the recipient's incarceration. Federal law does not require states to terminate eligibility for aid during incarceration, but allows states to suspend their eligibility during incarceration.<sup>4</sup>

California participates in the federal Medicaid program through the California Medical Assistance Program, or Medi-Cal, enacted in Welfare and Institutions Code section 14000, *et seq.* Under the Medi-Cal program, anyone serving a sentence in a facility that is part of the criminal justice system is ineligible for aid until permanent release, bail, probation, or parole.<sup>5</sup>

Prior to the enactment of the test claim statute, inmates of public institutions, including minors in juvenile detention facilities, who received Medi-Cal before incarceration had their eligibility terminated at the time of custody.<sup>6</sup> Under prior state law, the juvenile's eligibility for Medi-Cal had to then be re-determined with a new application filed by the juvenile, or the juvenile's parents or guardians, following release from custody. This gap in time after incarceration until the new Medi-Cal application was approved often left the juvenile with no Medi-Cal or other health care benefits for mental health or substance abuse issues following incarceration. As stated in the Assembly Health Committee's analysis of the bill that enacted the test claim statute:

There are huge rates of recidivism among the juvenile population. Often, the reason for a ward's return to custody is the result of his or her failure to receive treatment for a mental health or substance abuse disorder. The author reports that a recent study conducted at the University of California, Irvine found that harmful alcohol and drug use by adolescents in juvenile detention facilities is at a 70% level, or roughly 70,000 of the 100,000 admissions to juvenile halls across California counties in 2004.<sup>7</sup>

### **B. The Test Claim Statute**

The test claim statute enacted Welfare and Institutions Code section 14029.5 in 2006 to ensure that the Medi-Cal application process is initiated before juvenile wards are released from custody so that eligibility can be established immediately upon the ward's release.<sup>8</sup> Beginning January 1, 2008, the statute requires county juvenile detention facilities, immediately following the issuance of an order of the juvenile court committing that ward to a juvenile hall, camp, or ranch for 30 days or longer, to notify CWDs when a juvenile is incarcerated so that the CWD can

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<sup>4</sup> States must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." (42 CFR § 435.930(b).)

<sup>5</sup> Department of Health Care Services, "Medi-Cal Eligibility Procedures Manual." Page 6A-1.

<sup>6</sup> Welfare and Institutions Code, section 14053(b). California Code of Regulations, title 22, section 50273.

<sup>7</sup> Assembly Committee on Health, Analysis of SB 1469 (2005-2006 Reg. Sess.) amended June 15, 2006, page 4.

<sup>8</sup> *Ibid.*

determine before the ward is released from custody if the juvenile will be eligible for Medi-Cal, the Healthy Families Program or other appropriate health coverage.<sup>9</sup> The test claim statute also requires the CWD to initiate an application for Medi-Cal or Healthy Families for the juvenile with the cooperation of the juvenile's parent or guardian. Specifically, the test claim statute requires the county juvenile detention facility to:

- Provide the CWD with the ward's name, scheduled or actual release date, any known information regarding the ward's Medi-Cal status prior to disposition, and sufficient information, when available, for the CWD to begin the process of determining the ward's eligibility for benefits including, if the ward is a minor,<sup>10</sup> contact information for the ward's parent or guardian, if available.
- If the ward is a minor, before providing the information in the paragraph above to the CWD, notify the parent or guardian, in writing, of its intention to submit the information listed above to the CWD.

The CWD is required, upon receipt of the ward's information, to:

- Initiate an application and determine the individual's eligibility for benefits under the Medi-Cal program.
- If the ward is a minor, promptly contact the parent or guardian to arrange for completion of the application.
- Expedite the application of a ward who is scheduled to be released in fewer than 45 days.
- If the CWD determines that the ward is not eligible for Medi-Cal, it shall, with the consent of the parent or guardian if the ward is a minor, forward the ward's information to the appropriate entity to determine eligibility for the Healthy Families Program or other appropriate health coverage as determined by the CWD.
- If the CWD determines that the ward is eligible for Medi-Cal, it shall provide sufficient documentation to enable the ward to obtain necessary medical care upon his or her release from custody.

The test claim statute also requires the Department of Health Care Services (DHCS) to establish protocols and procedures necessary to implement section 14029.5. On January 2, 2008, the DHCS issued an all county letter describing the activities required to comply with the test claim statute.<sup>11</sup>

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<sup>9</sup> The Healthy Families Program (California's version of the federal Children's Health Insurance Program) is administered by Managed Risk Medical Insurance Board and provides low-cost, subsidized health, vision and dental insurance to uninsured children, with family incomes up to 250% of federal poverty level, who are not eligible for no-cost Medi-Cal.

<sup>10</sup> The juvenile justice system has jurisdiction over persons up to 21 years of age, or in certain instances up to 25 years of age. (Welf. & Inst. Code, § 607).

<sup>11</sup> Exhibit G.

The Senate Health Committee described the legal background of the test claim statute as follows:

Under [federal] Medicaid law, states do not receive federal matching funds for services provided to individuals in jail. However, federal law does not require states to terminate inmates' eligibility. Inmates may remain enrolled in Medicaid even though services received while in jail are not covered. Accordingly, someone who had a Medicaid card when jailed may be able to use it to obtain needed services and medication immediately after release.

Under federal rules, Medicaid eligibility should be reinstated upon release unless the person is no longer eligible. Before ending eligibility, states must determine the potential for qualifying under all the state's eligibility categories. Regrettably, this re-determination often does not occur.

Even inmates who keep their Medicaid eligibility may lose Medicaid coverage unnecessarily because of procedures in correctional facilities. Many individuals will be incarcerated for so long that they will lose their Medicaid benefits after the state's customary re-determination of eligibility is conducted (annually for California). Something as simple as the loss of a Medicaid card following arrest can make it impossible to obtain mental health services from Medicaid providers upon release. Cards are often lost because jails take possession of all personal property when booking a person. In many jurisdictions, this property is destroyed if it is not claimed within a certain time. Inmates cannot claim the property themselves and if they have no one to do it for them, their Medicaid card is destroyed.<sup>12</sup>

**C. Subsequent Amendments to Welfare and Institutions Code section 14029.5 (SB 1147, Stats. 2008, ch. 546)**

On October 16, 2007, the City and County of San Francisco and the County of Santa Clara filed a lawsuit against the state and DHCS requesting that the court end the state's policy of terminating Medi-Cal eligibility for juveniles in custody and failing to restore enrollment immediately upon release.<sup>13</sup>

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<sup>12</sup> Senate Health Committee, Analysis of SB 1469 (2005-2006 Reg. Sess.) amended March 30, 2006, page 4. Exhibit G.

<sup>13</sup> *City and County of San Francisco, et al. v. State of California, et al.*, Superior Court of the County of San Francisco, Case No. 468-241. The petitioners also requested a writ requiring the state to provide Medi-Cal coverage for inpatient psychiatric hospital services provided to juveniles under the age of 21 and in custody, consistent with federal law. On this point, petitioners recognized that federal Medicaid law contains an exclusion generally barring the availability of federal financial participation for medical services provided to inmates of a public institution (42 U.S.C. § 1396(a)(A)). But they argued that the exclusion was subject to an exception for inpatient psychiatric hospital services provided under paragraph 16 of 42 U.S.C. § 1396(a)(A). The court agreed and issued a peremptory writ of mandate against the state.

While the case was pending, the Legislature enacted Senate Bill 1147 in 2008, which ended the policy of terminating Medi-Cal eligibility for incarcerated juveniles under the age of 21, and instead required that eligibility for juveniles who are Medi-Cal beneficiaries at the time they become inmates of a public institution be suspended during incarceration. To implement the process for suspending benefits, the bill added Welfare and Institutions Code section 14011.10, which became operative on January 1, 2010, or at such time the federal government approved the state's amended plan. Section 14011.10 provides in relevant part the following:

- (a) Benefits provided under this chapter to an individual under 21 years of age who is an inmate of a public institution shall be suspended in accordance with Section 1396d(a)(28)(A) of Title 42 of the United States Code as provided in subdivision (c).
- (b) County welfare departments shall be required to notify the department [of Health Care Services] within 10 days of receiving information that an individual; under 21 years of age on Medi-Cal in the county is or will be an inmate of a public institution.
- (c) If an individual under 21 years of age is a Medi-Cal beneficiary on the date he or she becomes an inmate of a public institution, his or her benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date he or she becomes an inmate of a public institution. The suspension will end on the date he or she is no longer an inmate of a public institution or one year from the date he or she becomes an inmate of a public institution, whichever is sooner.
- (d) Nothing in this section shall create a state-funded benefit or program. Health care services under this chapter and Chapter 8 (commencing with Section 14200) shall not be available to inmates of public institutions whose Medi-Cal benefits have been suspended under this section.
- (e) This section shall be implemented only if and to the extent allowed by federal law. This section shall be implemented only to the extent that any necessary federal approval of state plan amendments or other federal approvals are obtained.
- (f) If any part of this section is in conflict with or does not comply with federal law, this entire section shall be inoperable.
- (g) This section shall be implemented on January 1, 2010, or the date when all necessary federal approvals are obtained, which is later.

In addition, Statutes 2008, chapter 546, effective January 1, 2009, limited the requirement that CWDs initiate a Medi-Cal application for all juvenile wards following receipt of the information from the county detention facility, to only those wards *not already enrolled* in the Medi-Cal program. The 2008 statute added the following underlined text to section 14029.5:

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(Order Granting in Part and Denying in Part Petitioner's Motion for Peremptory Writ, filed April 5, 2010.)

(b) (1) Upon receipt of the information described in paragraph (1) of subdivision (a), and pursuant to the protocols and procedures developed pursuant to subdivision (c) the county welfare department shall initiate an application for any ward not already enrolled in the Medi-Cal program, and determine the individual's eligibility for benefits under the Medi-Cal program. If the ward is a minor, the county welfare department shall promptly contact the parent or guardian to arrange for completion of the application. If the cooperation of the minor's parent or guardian is necessary to complete the application, but the parent or guardian fails to cooperate in completing the application, the county welfare department shall deny the application in accordance with due process requirements. The county shall expedite the application of a ward who, according to the information provided pursuant to paragraph (1) of subdivision (a), is scheduled to be released in fewer than 45 days.

The legislative history of the 2008 bill recognized the pending lawsuit filed by the City and County of San Francisco, and further recognized that the federal Center for Medicare and Medicaid Services encouraged states to suspend, rather than terminate, Medicaid benefits while a person is incarcerated as part of a federal effort to reduce homelessness.<sup>14</sup>

On March 23, 2010, DHCS issued an all-county letter (Letter No. 10-06) informing counties of the implementation requirements of SB 1147. As summarized in the letter, the 2006 and 2008 statutes impose two processes: one for those wards who are Medi-Cal beneficiaries at the time they become inmates and whose benefits are suspended during incarceration; and one for those wards who are not enrolled in the Medi-Cal program at the time of incarceration, requiring the CWD to determine eligibility when warranted and to start the application process for Medi-Cal or other health program.<sup>15</sup> A test claim has not been filed on SB 1147 and, thus, no analysis or findings are provided in this statement of decision on the requirements for suspending Medi-Cal benefits for juvenile wards pursuant to Welfare and Institutions Code section 14011.10, or on the new language in section 14029.5(b)(1) requiring the CWD to deny the application for Medi-Cal benefits in accordance with due process requirements when the parent or guardian fails to cooperate with the county to complete the application for benefits. However, SB 1147 does limit the duties of the CWD that were imposed by the test claim statute to initiate an application for Medi-Cal benefits and, thus, SB 1147 will be analyzed for that purpose below.

On April 15, 2010, the Superior Court in the City and County of San Francisco case denied the challenge by local government regarding the termination of Medi-Cal benefits on the ground that the issue was moot with the passage of SB 1147.

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<sup>14</sup> Senate Rules Committee, Office of Senate Floor Analyses, Analysis of SB 1147 (2007-2008 Reg. Sess.) as amended August 8, 2008. Exhibit G.

<sup>15</sup> Exhibit G.



### III. Positions of the Parties

#### A. Claimant's Position

The claimant alleges that the test claim statute imposes a reimbursable state-mandated program under article XIII B, section 6 and Government Code section 17514 for counties. The test claim is supported by declarations from the County of Alameda, which estimates \$14,948.41 in annual costs to implement the mandate.<sup>16</sup> A separate declaration submitted with the test claim estimates a minimum of 30 minutes of a probation officer's time and 30 minutes of clerical time per juvenile to carry out the probation department's duties under the test claim statute.<sup>17</sup>

#### B. State Agency Positions

Department of Health Care Services: DHCS argues that the test claim statute does not impose a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution and recommends that the Commission deny the test claim for the following reasons:

- The test claim statute's costs are incidental to a federal mandate. Federal regulations require agencies to have procedures to ensure that recipients make timely and accurate reports of any change in circumstances (such as incarceration) that may affect a recipients' eligibility for benefits. Because the test claim statute requirement does not exceed federal law, the test claim is not reimbursable.
- Under existing laws, counties are already required to assist all applicants and beneficiaries and provide care for all juvenile detainees. Specifically, CWDs have an obligation to conduct eligibility screenings of all applicants and perform re-determinations of individuals whenever there is a change of circumstances or at least every 12 months.
- The test claim statute does not shift the financial responsibility of carrying out governmental functions to local agencies. The statute merely clarifies that the eligibility determination or re-determination can commence when the county probation department learns of the juvenile's disposition and notifies the CWD.

DHCS also argues that the statute does not result in costs mandated by the state for the following reasons:

- County stakeholders supported the test claim legislation and, thus, Government Code section 17556(a) applies to bar reimbursement.
- The alleged costs of the county probation department are not "costs" for the purposes of article XIII B, section 6 because CWDs are already reimbursed for the eligibility determinations and any cost attributed to the test claim statute is a facet of its case management duties.

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<sup>16</sup> Declaration of Patricia Fair, Deputy Chief Probation Officer for Juvenile Facilities, County of Alameda, test claim, page 1.

<sup>17</sup> Declaration of Allan P. Burdick, Maximus, page 1.

- Welfare and Institutions Code section 14011.10 (Stats. 2008, ch. 546) results in lower county costs to re-determine Medi-Cal eligibility because re-determination would be less work intensive when eligibility is suspended. The resulting offsetting savings means there are no costs mandated by the state in accordance with Government Code section 17556(e).
- Any de minimis costs of forwarding printouts of juvenile information to CWDs are made up for by offsetting savings, such as no longer having responsibility for the health of the juvenile 60-90 days after release. Under prior law, the juvenile could be deemed eligible 45-90 days after release and Medi-Cal would cover that period retroactively. After the test claim statute, the CWD would not have to expend work hours managing the transition or directing the health care of the juvenile, since Medi-Cal would be immediately online. Also saved would be any incurred costs during the 45-90 day period provided by non-Medi-Cal providers. And there would be savings from lower recidivism because the juvenile inmate would receive mental health and drug and alcohol treatment upon release.

In its August 2013 comments on the draft staff analysis, DHCS disagrees with the finding to partially approve the test claim, restating its position that no additional costs would be incurred by county probation departments because counties are already being reimbursed for their services incidental to juvenile incarceration. According to DHCS, a partial finding of a reimbursable mandate would result in duplicative reimbursement to counties. DHCS states the following:

As DHCS as previously noted, counties are already being reimbursed for their intake, investigation, and other services incidental to juvenile incarceration. Counties are responsible for the case management of juveniles who have been incarcerated in the juvenile justice system. (See Welf. & Inst. Code, §§ 650 et seq., 850 et seq., and 207.1, subd. (e)(1).)

The draft analysis does acknowledge that determining eligibility for benefits under the Medi-Cal program is not a new activity for the County. This, together with the fact that counties are already reimbursed and responsible for services incidental to juvenile incarceration, means that even a partial finding of a reimbursable mandate would result in duplicative reimbursement to counties.

Department of Finance: Finance believes that partial approval of the test claim may be appropriate for the sole requirement on county detention facilities to provide specified information to the CWD, if additional costs have been incurred. Finance states that counties are fully reimbursed through state and federal funding for all costs of Medi-Cal eligibility determinations.

In its September 2013 comments on the draft staff analysis, Finance reiterates the position that approving the part of the test claim relating to juvenile detention facility administration costs may be appropriate. Finance also states that it does not have documentation to show whether the test claim activities performed by CWDs are already funded through federal Medicaid or state Medi-Cal, or through county tax proceeds, and in this regard, Finance states the following:

Finance has requested that the DHCS take a closer look toward the activities claimed by Alameda County's welfare department which may result in the claiming providing additional documentation to support its claim that the costs in question have been, in fact, borne by the county's general tax fund. It is our intent to request that staff of the DHCS be present at the December 6, 2013, Commission hearing to provide a more detailed discussion of the costs and funding of county welfare departments activities under Medi-Cal.

#### **IV. Discussion**

Article XIII B, section 6 of the California Constitution provides in relevant part the following:

Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the state shall provide a subvention of funds to reimburse such local government for the costs of such programs or increased level of service.

The purpose of article XIII B, section 6 is to "preclude the state from shifting financial responsibility for carrying out governmental functions to local agencies, which are 'ill equipped' to assume increased financial responsibilities because of the taxing and spending limitations that articles XIII A and XIII B impose."<sup>18</sup> Thus, the subvention requirement of section 6 is "directed to state-mandated increases in the services provided by [local government] ..."<sup>19</sup>

Reimbursement under article XIII B, section 6 is required when the following elements are met:

1. A state statute or executive order requires or "mandates" local agencies or school districts to perform an activity.<sup>20</sup>
2. The mandated activity either:
  - a. Carries out the governmental function of providing a service to the public; or
  - b. Imposes unique requirements on local agencies or school districts and does not apply generally to all residents and entities in the state.<sup>21</sup>
3. The mandated activity is new when compared with the legal requirements in effect immediately before the enactment of the test claim statute or executive order and it increases the level of service provided to the public.<sup>22</sup>

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<sup>18</sup> *County of San Diego v. State of California* (1997)15 Cal.4th 68, 81.

<sup>19</sup> *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56.

<sup>20</sup> *San Diego Unified School Dist. v. Commission on State Mandates (San Diego Unified School Dist.)* (2004) 33 Cal.4th 859, 874.

<sup>21</sup> *San Diego Unified School Dist., supra*, 33 Cal.4th at pgs. 874-875 (reaffirming the test set out in *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56.

<sup>22</sup> *San Diego Unified School Dist., supra*, 33 Cal.4th 859, 874-875, 878; *Lucia Mar Unified School Dist. v. Honig*, (1988) 44 Cal.3d 830, 835.

4. The mandated activity results in the local agency or school district incurring increased costs. Increased costs, however, are not reimbursable if an exception identified in Government Code section 17556 applies to the activity.<sup>23</sup>

The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.<sup>24</sup> The determination of whether a statute or executive order imposes a reimbursable state-mandated program is a question of law.<sup>25</sup> In making its decisions, the Commission must strictly construe article XIII B, section 6, and not apply it as an “equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities.”<sup>26</sup>

**A. The Test Claim Statute Imposes a State-Mandated New Program or Higher Level of Service on Counties.**

1. The Test Claim Statute Requires Counties to Perform New Activities.

The plain language of Welfare and Institutions Code section 14029.5, as added by the 2006 test claim statute, requires county detention facilities to perform the following activities beginning January 1, 2008:

1. Subject to the provisions in 2. below, immediately following the issuance of an order of the juvenile court committing the ward to a juvenile hall, camp, or ranch for 30 days or longer, provide the appropriate CWD with the following information: the ward’s name, scheduled or actual release date, any known information regarding the ward’s Medi-Cal status prior to disposition, and sufficient information when available for the CWD to begin the process of determining the ward’s eligibility for the Medi-Cal program, including available contact information for the ward’s parent or guardian if the ward is a minor.
2. If the ward is a minor and before providing information to the CWD, notify the parent or guardian in writing of the intention to submit the information to the CWD. The parent or guardian shall be given a reasonable time to opt out of the Medi-Cal eligibility determination. If the parent or guardian opts out of the Medi-Cal eligibility determination, the county detention facility shall not provide information to the CWD.

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<sup>23</sup> *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1265, 1284; Government Code sections 17514 and 17556.

<sup>24</sup> *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 331-334; Government Code sections 17551 and 17552.

<sup>25</sup> *County of San Diego, supra*, 15 Cal.4th 68, 109.

<sup>26</sup> *County of Sonoma, supra*, 84 Cal.App.4th 1265, 1280, citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

The CWD is then required to perform the following activities:

1. Upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by DHCS, initiate an application *and determine the eligibility for benefits* under the Medi-Cal program.

From January 1, 2008, until December 31, 2008, the CWD is required to perform these activities following the receipt of information from the county detention facility for all juvenile wards.

Beginning January 1, 2009, the CWD is required to initiate an application and determine eligibility for benefits under the Medi-Cal program only for wards not already enrolled in the Medi-Cal program.<sup>27</sup>

2. If the ward is a minor, promptly contact the parent or guardian to arrange for completion of the application. Applications shall be expedited for those wards scheduled to be released in fewer than 45 days.
3. If the ward does not meet the eligibility requirements for the Medi-Cal program, forward the ward's information to the appropriate entity to determine eligibility for the Healthy Families Program, or other appropriate health coverage program, with the consent of the ward's parents or guardian if the ward is a minor.
4. If the ward meets eligibility requirements for the Medi-Cal program, provide sufficient documentation to enable the ward to obtain necessary medical care upon release from custody.

The italicized activity required by section 14029.5 for CWDs to “determine the individual’s eligibility for benefits under the Medi-Cal program” is not new. Under prior law, CWDs were already required to perform annual eligibility determinations whenever the county received information about changes in a beneficiary’s circumstances that could affect eligibility for the Medi-Cal program, or at least every 12 months.<sup>28</sup> Since incarceration is a circumstance that changes a beneficiary’s Medi-Cal eligibility, prior law required CWDs to re-determine eligibility (from eligible to ineligible) for incarcerated Medi-Cal recipients, and then another determination of eligibility was required once the ward filed a new application following release from custody. Thus, this activity is not new.

All other required activities, however, are newly required of counties. CWDs were not required under preexisting law to initiate a Medi-Cal application, contact a minor’s parent or guardian for completion of the Medi-Cal application, or forward a ward’s information to the appropriate entity to determine eligibility for the Healthy Families Program or other appropriate health coverage program if not eligible for Medi-Cal.

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<sup>27</sup> Welfare and Institutions Code section 14029.5 as amended by Statutes 2008, chapter 546 (SB 1147).

<sup>28</sup> Welfare and Institutions Code sections 14012 and 14005.37. California Code of Regulations, title 22, section 50189.

Providing documentation to enable the ward to obtain medical care is also new. Under existing law, when a person applies for Medi-Cal and is certified as eligible by the CWD, the state issues a Medi-Cal card based on documentation submitted to DHCS by the CWD.<sup>29</sup> CWDs issue “current or past month” (temporary) Medi-Cal cards to certain categories of individuals, such as those who have a need for medical services prior to the normal anticipated receipt of a state-issued Medi-Cal card<sup>30</sup> or those eligible for Supplemental Security Income or State Supplementary Payments.<sup>31</sup> CWDs may issue Medi-Cal cards to others, such as those who do not have a share of cost, or are not enrolled in a comprehensive prepaid health plan for the month for which a card is requested, or did not receive a Medi-Cal card.<sup>32</sup> However, preexisting law did not require the CWD to provide sufficient documentation to enable wards to obtain necessary medical care upon release from custody, so this is a new and additional requirement. According to a DHCS memo, the requirement to provide sufficient documentation means that the county is required to “issue an immediate need paper Medi-Cal card for the juvenile as soon as eligibility is established.”<sup>33</sup>

2. The New Requirements Imposed by the Test Claim Statute are Mandated by the State and not by Federal Law.

DHCS argues that the requirements imposed by the test claim statute are incidental to a federal mandate and, thus, are not considered state-mandated activities. DHCS states:

The requirements of this [test claim] statute come within the federal requirement to re-determine eligibility whenever there is a change in circumstances. Federal law requires states to re-determine eligibility every 12 months or whenever the agency is informed of a change in circumstances. This duty is concomitant to the eligibility determinations that are already delegated to the CWD.

DHCS quotes the federal Medicaid eligibility re-determination regulation (with underlined emphasis) as follows:

- (a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, however –  
[¶] . . . [¶]

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<sup>29</sup> Welfare and Institutions Code section 14017.8. California Code of Regulations, title 22, section 50741; California Code of Regulations, title 22, section 50742.

<sup>30</sup> California Code of Regulations, title 22, section 50658(d).

<sup>31</sup> California Code of Regulations, title 22, section 50743(a).

<sup>32</sup> California Code of Regulations, title 22, section 50743(b).

<sup>33</sup> DHCS memo to County Welfare Directors “Medi-Cal Pre-Release Application Process for Wards in County Juvenile Facilities Re: Senate Bill (SB) 1469, Chapter 657, Statutes of 2006, Welfare and Institutions (W&I) Code section 14029.5” January 2, 2008, page 2.

- (b) Procedures for reporting changes. The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.
- (c) CWD or local agency action on information about changes.
  - (1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.
  - (2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.<sup>34</sup>

DHCS argues that this federal requirement defeats the claim for reimbursement because of the holding in *San Diego Unified School District v. Commission on State Mandates*, which states: “for purposes of ruling upon a request for reimbursement, challenged state rules or procedures that are intended to implement an applicable federal law-- and whose costs are, in context, de minimis—should be treated as part and parcel of the underlying federal mandate.”<sup>35</sup>

The Commission finds, however, that even though the state's Medi-Cal program implements a federal program, the activities required by Welfare and Institutions Code section 14029.5 are mandated by the state and not by federal law.

Article XIII B, section 6 requires reimbursement only for state mandated costs. “When the federal government imposes costs on local agencies those costs are not mandated by the state and thus would not require a state subvention. Instead, such costs are exempt from local agencies' taxing and spending limitations” under article XIII B.<sup>36</sup>

In this case, the federal Medicaid program was passed under Congress' spending powers and provides financial assistance to states participating in the program to furnish health care to low-income persons based on a cost sharing formula with the states. In order to receive federal funding, states that participate in the program are required to comply with certain requirements, including those identified above by DHCS to re-determine eligibility when a recipient's circumstances change. As determined by the courts, a federal program in which the state participates is not a federal mandate on the state unless the program leaves the state with no discretion as to alternatives and no true choice but to participate.<sup>37</sup> In the case of the Medicaid

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<sup>34</sup> 42 CFR section 435.916.

<sup>35</sup> *San Diego Unified School District, supra*, 33 Cal.4<sup>th</sup> 859, 889.

<sup>36</sup> *Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4<sup>th</sup> 1564, 1593, citing *City of Sacramento v. State of California* (1990) 50 Cal.3d 51, 76; see also, *San Diego Unified School District, supra*, 33 Cal.4<sup>th</sup> 859, 880; Government Code sections 17513, 17556(c).

<sup>37</sup> *City of Sacramento, supra*, 50 Cal.3d 51, 76; *Hayes, supra*, 11 Cal.App.4<sup>th</sup> 1564, 1581.

program, the U.S. Supreme Court has recently suggested that the states' participation in that federal program is not truly voluntary.<sup>38</sup>

Even if Medicaid were determined to be a federal mandate on the states, the mandates analysis does not end there. The key question then turns on how the costs of complying with the new requirements in Welfare and Institutions Code section 14029.5 came to be imposed on the counties. "If the state freely chose to impose those costs upon the local agency as a means of implementing a federal program then the costs are the result of a reimbursable state mandate regardless whether the costs were imposed upon the state by the federal government."<sup>39</sup> In this case, the state freely chose to impose the costs of terminating Medi-Cal benefits of incarcerated juveniles and establishing a process to determine eligibility before the juvenile was released.

As DHCS points out, federal law requires states to have procedures to determine or re-determine Medicaid eligibility for applicants and recipients, but California already had these procedures in place before the test claim statute was enacted. Preexisting law required counties to conduct eligibility screening of Medi-Cal applicants and perform re-determinations whenever there is a change of circumstances or at least every 12 months.<sup>40</sup> The test claim statute was not necessary for California to comply with federal law. In addition, the federal government encouraged states to suspend benefits upon incarceration instead of terminate them. Thus, the federal Medicaid program did not force the state to enact Welfare and Institutions Code section 14029.5.

Moreover, DHCS's reliance on the *San Diego Unified School District* case is misplaced. The court did find, as asserted by DHCS, that "for purposes of ruling upon a request for reimbursement, challenged state rules or procedures that are intended to implement an applicable federal law-- and whose costs are, in context, de minimis—should be treated as part and parcel of the underlying federal mandate."<sup>41</sup> However, that finding was made in a factual context that does not apply here. The *San Diego Unified* case addressed the costs associated with due process hearings triggered by discretionary student expulsion recommendations. The discretionary expulsion recommendation then triggered federal due process requirements. The court found that the state's hearing procedures required by the test claim statute were adopted to implement federal due process requirements, and that even in the absence of the test claim statute, school districts would still be required to comply with federal law. Even though the state

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<sup>38</sup> See, *National Federation of Independent Business v. Sebelius* (2012) 132 S.Ct. 2566, where the court determined the constitutionality of the Patient Protection and Affordable Care Act of 2010, including the provisions governing the Medicaid expansion, which gives funds to the States on the condition that they provide specified health care to all citizens whose income falls below a certain threshold. In that case, the court recognized that Medicaid has long been the largest federal program of grants to the States; and noted the consequences of nonparticipation. (*Id.* at pp. 2604-2605.)

<sup>39</sup> *Hayes, supra*, 11 Cal.App.4th 1564, 1592-1593.

<sup>40</sup> Welfare and Institutions Code section 14012, California Code of Regulations, title 22, section 50189.

<sup>41</sup> *San Diego Unified School District, supra*, 33 Cal.4<sup>th</sup> 859, 889.



adopted some additional notice and recording requirements that were not expressly articulated in federal due process law, those excess requirements were intended to implement the federal mandate and did not significantly increase the cost of compliance with the federal law. Thus, the excess requirements in that case were viewed as part and parcel of the federal mandate.<sup>42</sup>

Here, on the other hand, there is no federal mandate to establish a process to determine eligibility before a juvenile is released from incarceration. Thus, in the absence of the test claim statute, counties would *not* be required by federal law to comply with the process outlined in Welfare and Institutions Code section 14029.5.

Moreover, the intent of section 14029.5 was not to implement a federal requirement. The intent of the statute was to carry out the state's policy of addressing the huge rates of recidivism among the juvenile population, which was thought to be at least partially caused by the termination of benefits upon incarceration and the lack of benefits immediately upon release for the care of mental health and substance abuse issues. The central purpose article XIII B, section 6 is to prevent the state from shifting to local government the fiscal responsibility for providing services which the state believed should be extended to the public.<sup>43</sup> Here it is state law, not federal law that requires counties to incur the costs of complying with section 14029.5.

Accordingly, the Commission finds that the new requirements imposed by Welfare and Institutions Code section 14029.5 are mandated by the state.

3. The New Mandated Activities Impose a New Program or Higher Level of Service on Counties.

DHCS argues that the test claim statute does not shift the financial responsibility of carrying out governmental functions from the state to local agencies and, thus, does not mandate a new program or higher level of service. The Commission disagrees.

In order for the newly-mandated activities to impose a new program or higher level of service, the activities must be new, as determined above, and either carry out the governmental function of providing a service to the public, or impose unique requirements on local government to carry out the state's policy, which do not apply generally to all residents and entities in the state.<sup>44</sup> Both factors are present here. The activities mandated by the test claim statute are uniquely required of counties and implement the state's policy with respect to ensuring medical coverage through Medi-Cal, the Healthy Families program, or other health care program for incarcerated juveniles immediately upon release. As indicated in the legislative history of the test claim statute, the purpose of the bill was to reduce recidivism, which in theory reduces the rate of crime. Thus, the activities provide a service to the public.

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<sup>42</sup> *Id.* at pp. 888-890.

<sup>43</sup> *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56.

<sup>44</sup> *San Diego Unified School Dist., supra*, 33 Cal.4th 859, 874-875, 878; *Lucia Mar Unified School Dist. v. Honig, supra*, 44 Cal.3d 830, 835; *Carmel Valley Fire Protection Dist. v. State of California* (1987) 190 Cal.App.3d 521, 537.

DHCS further argues that the test claim statute is similar to the one at issue in *County of Los Angeles*,<sup>45</sup> where reimbursement was denied. There, the test claim statute required local law enforcement officers to participate in two hours of domestic violence training every two years. There was a preexisting requirement for officers to spend 24 hours in continuing education training every two years, of which the two hours of domestic violence training could be part. The court found that the statute did not mandate a higher level of service because the training requirement remained at 24 hours before and after enactment of the test claim statute, so there were no increased training hours and costs associated with the domestic violence training course. As the court said, “the state is requiring certain courses to be placed within an already existing framework of training. This loss of ‘flexibility’ does not, in and of itself, require the county to expend funds that previously had been expended on the POST program by the State.”<sup>46</sup>

Unlike the statute in the *County of Los Angeles* case, the test claim statute in this case imposes a new process on counties that does not fit within an existing framework of minimum program requirements. Accordingly, the Commission finds that the test claim statute mandates a new program or higher level of service on counties.

#### **B. The Test Claim Statute Imposes Costs Mandated by The State Within the Meaning of Government Code Section 17514.**

In order for the activities required by the test claim statute to be reimbursable under article XIII B, section 6 of the California Constitution, they must impose “costs mandated by the state,” defined as any increased cost that a local agency or school district incurs as a result of any statute or executive order that mandates a new program or higher level of service.<sup>47</sup>

The claimant contends that all activities required by the test claim statute result in increased costs mandated by the state within the meaning of Government Code section 17514. The test claim is supported by declarations from the County of Alameda, which estimates \$14,948.41 in annual costs to implement the test claim statute.<sup>48</sup>

Government Code section 17556 prohibits the Commission from finding costs mandated by the state if, after a hearing, the Commission makes certain specified findings. DHCS argues that the test claim statute does not impose costs mandated by the state for the reasons stated in Government Code section 17556(a) and (e). The Commission finds that Government Code section 17556(a) and (e) do not apply to deny this claim.

##### 1. Government Code Section 17556(a) Does Not Apply to this Test Claim.

DHS argues that local agencies requested legislative authority to implement the program specified in Welfare and Institutions Code section 14029.5 and, thus, reimbursement is not required pursuant to Government Code section 17556(a).

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<sup>45</sup> *County of Los Angeles v. Commission on State Mandates* (2003) 110 Cal.App.4th 1176.

<sup>46</sup> *Id.* at 1194.

<sup>47</sup> Government code section 17514.

<sup>48</sup> Declaration of Patricia Fair, Deputy Chief Probation Officer for Juvenile Facilities, County of Alameda, test claim page 1.

Government Code section 17556(a) prohibits the Commission from finding that the test claim statute imposes costs mandated by the state if the Commission finds that:

The claim is submitted by a local agency or school district that requests or previously requested legislative authority for that local agency or school district to implement the program specified in the statute, and that statute imposes costs upon that local agency or school district requesting the legislative authority. A resolution from the governing body or a letter from a delegated representative of the governing body of a local agency or school district that requests authorization for that local agency or school district to implement a given program shall constitute a request within the meaning of this subdivision.

DHCS points out that the bill that enacted the test claim statute (SB 1469) was supported by the following organizations and local agencies: County Alcohol and Drug Program Administrators Association of California, California Mental Health Directors Association, Chief Probation Officers of California, City of Los Angeles, City of Santa Monica, Urban Counties Caucus, and the National Association of Social Workers. DHCS argues that this support constitutes a request for legislative authority to implement the program specified in Welfare and Institutions Code section 14029.5 pursuant to Government Code section 17556(a).

The Commission finds that Government Code section 17556(a) does not apply to the test claim.

Government Code section 17556(a) requires “a resolution from the governing body or a letter from a delegated representative of the governing body of a local agency or school district that requests authorization for that local agency or school district to implement a given program.” The legislative history of the bill indicates that it was *supported* by associations representing local agencies. But there is no resolution in the record from a governing body of a county, or any evidence that a county delegated a representative to draft a letter requesting authorization to implement the test claim statute.

Moreover, the Legislature, when enacting the exception in Government Code section 17556(a), did not intend that support for a bill would be enough to constitute a request for the legislation by a local agency. Section 17556 is derived from Statutes 1977, chapter 1135, also known as SB 90, in former Revenue and Taxation Code section 2253.2.<sup>49</sup> The original statute precluded reimbursement for a “chaptered bill ... requested by or on behalf of the local agency ... which desired legislative authority to implement the program specified in the bill.” The following year, section 2253.2 was amended by Statutes 1978, chapter 794 (SB 1490). The May 8, 1978 version of SB 1490 added the definition of request to include “expresses a desire for and support of legislation” as follows:

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<sup>49</sup> The provisions of SB 90, Statutes 1977, chapter 1135, governed the mandates process for the Board of Control, the Commission on State Mandate’s predecessor, and were repealed by Statutes 1988, chapter 160. Government Code section 17556 was added by Statutes 1984, chapter 1459 to govern the mandates process and replace the former Revenue and Taxation Codes.

For purposes of this paragraph, a resolution from the governing body or a letter from a member or delegated representative of the governing body of a local agency ...*which expresses a desire for and support of legislation to authorize that local agency ... to implement a given program shall constitute a “request”...* [Underline added.]

However, the June 21, 1978 amendments to SB 1490 deleted the “support” language and amended the section to be nearly identical to its current form in the Government Code, as follows:

For purposes of this paragraph, a resolution from the governing body or a letter from a ~~member or~~ delegated representative of the governing body of a local agency ...~~which expresses a desire for and support of legislation to authorize requests legislative authorization for~~ that local agency ...to implement a given program shall constitute a “request”...” [Italicized text in original.]<sup>50</sup>

Rejection of a specific provision contained in an act as originally introduced is most persuasive that the act should not be interpreted to include what was left out.<sup>51</sup> Here, deleting the phrase “expresses a desire for and support of legislation,” means that a “request of legislative authorization” should not be interpreted to include an expression of “desire for and support of legislation” because this phrase was left out of the final bill. In other words, the Legislature did not intend to preclude reimbursement for counties or other local entities that support legislation.

Therefore, the Commission finds that Government Code section 17556(a) does not preclude a finding that Welfare and Institutions Code section 14029.5 (Stats. 2006, ch. 657) imposes costs mandated by the state.

2. Government Code Section 17556(e) Does Not Apply to Deny the Test Claim.

DHCS and Finance also suggest that Government Code section 17556(e) applies to deny this claim. Government Code section 17556(e) precludes a finding of costs mandated by the state if the Commission finds:

The statute, executive order, or an appropriation in a Budget Act or other bill provides for offsetting savings to local agencies or school districts that result in no net costs to the local agencies or school districts, or includes additional revenue that was specifically intended to fund the costs of the state mandate in an amount sufficient to fund the cost of the state mandate.

The Commission finds that section 17556(e) does not apply to deny this claim.

***a) There is no evidence of additional revenue appropriated by the Legislature that is specifically intended to fund the costs of the mandated activities.***

DHCS asserts that counties receive sufficient funding from the state and the federal government to conduct eligibility re-determinations for Medi-Cal, and that funding is available for the

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<sup>50</sup> The word “legislative” was later amended out of the provision.

<sup>51</sup> *Bollinger v. San Diego Civil Service Comm.* (1999) 71 Cal. App. 4th 568, 575.

necessary administrative costs incurred in determining and re-determining Medi-Cal eligibility.<sup>52</sup> As discussed above, however, eligibility determinations or re-determinations are not new and do not constitute a state-mandated new program or higher level of service. Thus, the funding for determining eligibility is not relevant to the mandated activities in this case.

DHCS also argues that counties are already being reimbursed for intake, investigation, and other services incidental to juvenile incarceration and, thus, the activities mandated of county detention facilities do not result in increased costs mandated by the state.

In order for Government Code section 17556(e) to apply, evidence is required to show that “additional revenue that was *specifically intended to fund the costs of the state mandate* in an amount sufficient to fund the cost of the state mandate” has been appropriated. Although counties may receive funding to generally perform services incidental to juvenile incarceration, the activities mandated by the test claim statute are new. There is no evidence the Legislature appropriated revenue in a Budget Act or other bill “specifically intended” to fund the cost of the new activities mandated by section 14029.5. In comments filed on the test claim, DHCS acknowledged that no appropriation has been identified and no funds have been appropriated for the new activities mandated by the state.<sup>53</sup> Moreover, the County of Alameda has filed a declaration signed under penalty of perjury that it has incurred increased costs mandated by the state and estimates annual costs in the amount of \$14,948.41 to implement the test claim statute.

Accordingly, the Commission finds that the exception provided in Government Code section 17556(e) for offsetting revenue sufficient to fund the cost of the mandate does not apply to the test claim.

***b) There is no evidence of offsetting cost savings resulting from the test claim statute.***

DHCS also argues that the test claim statute results in potential offsetting savings because counties are no longer required to direct the health care needs of the juvenile for the time period following release and the subsequent approval and determination of Medi-Cal eligibility, as follows:

Specifically, the county failed to factor in potential savings that could offset the work hours as a result of Medi-Cal starting coverage immediately upon release of the juvenile. Under the old rules (before the effective date of Welf. & Inst. Code §14029.5), the county was responsible for the health care of the juvenile 60-90 days from release from incarceration. During the 45-90 day period, the juvenile was still not covered by Medi-Cal, hence, the county would expend work hours to determine and direct the health care needs of the juvenile. Once approved under Medi-Cal, Medi-Cal would retroactively cover the 45-90 day period. Under Welfare and Institutions Code section 14029.5, Medi-Cal would be on-line immediately and the county would not have to expend work hours managing the

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<sup>52</sup> 42 CFR 435.1001 states: “(a) FFP [federal financial participation] is available in the necessary administrative costs the State incurs in— (1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; . . .”

<sup>53</sup> DHCS comments filed June 22, 2009, page 13.

transition, directing the health care of the juvenile. Consequently, the counties will realize a savings from Welfare and Institutions Code section 14029.5 since they will not expend any work hours directing the juvenile's health care needs during those 60-90 days since Medi-Cal would be immediately online.

Furthermore, any services provided by non-Medi-Cal providers during the 45-90 day period would not be reimbursed to the county even after Medi-Cal eligibility is established. The process under Welfare and Institutions Code section 14029.5 will cancel out the 45-90 day period, and hence would not subject the county to potential services that are not reimbursable thereby resulting in savings to the county.

Lastly, the county failed to take into consideration any potential savings mentioned in SB 1469's analysis regarding lower costs to counties because lower recidivism will lower rates of incarceration since the juvenile inmates will receive mental health and alcohol and drug treatment upon release.<sup>54</sup>

Counties are required to provide indigent medical care under Welfare and Institutions Code sections 17000 et seq. for those not eligible for Medi-Cal or other insurance programs. Counties receive realignment money to perform these services.<sup>55</sup> And once Medi-Cal is approved, the benefits retroactively cover and fund the health services of the juvenile.<sup>56</sup> Although counties no longer have to direct the health care needs of the juvenile for the 45 to 90 days following release from incarceration pending Medi-Cal eligibility with the enactment of the test claim statute, and juvenile recidivism might decrease, county detention facilities and CWDs are now required to perform new activities mandated by the state that, as determined above, increase the level of service provided to the public without any additional revenue appropriated to the county. DHCS has filed no evidence to support the argument that counties will realize decreased costs as a result of the test claim statute. "Cost savings authorized by the state" is defined, in part, to mean "any decreased costs that a local agency or school district realizes as a result of any statute enacted or executive order adopted that permits or requires the discontinuance of or a reduction in the level of service."<sup>57</sup>

Accordingly, the Commission finds that the offsetting savings exception in Government Code section 17556(e) does not apply to this test claim.

## **V. Conclusion**

The Commission finds that Welfare and Institutions Code section 14029.5 (Stats. 2006, ch. 657) imposes a reimbursable state-mandated program within the meaning of article XIII B, section 6

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<sup>54</sup> DHCS provides a declaration from John Zapata, a Unit Chief in DHCS, Medi-Cal eligibility division, regarding these same potential offsetting costs. Exhibit B.

<sup>55</sup> Welfare and Institutions Code sections 17600, *et seq.* as amended in 1991.

<sup>56</sup> Welfare and Institutions Code section 14019; California Code of Regulations, title 22, section 50197.

<sup>57</sup> Government Code section 17517.5.

of the California Constitution and requires county detention facilities to perform the following mandated activities beginning January 1, 2008:

1. Subject to the provisions in 2. below, immediately following the issuance of an order of the juvenile court committing the ward to a juvenile hall, camp, or ranch for 30 days or longer, provide the appropriate CWD with the following information: the ward's name, scheduled or actual release date, any known information regarding the ward's Medi-Cal status prior to disposition, and sufficient information when available for the CWD to begin the process of determining the ward's eligibility for the Medi-Cal program, including available contact information for the ward's parent or guardian if the ward is a minor.
2. If the ward is a minor and before providing information to the CWD, notify the parent or guardian in writing of the intention to submit the information to the CWD. The parent or guardian shall be given a reasonable time to opt out of the Medi-Cal eligibility determination. If the parent or guardian opts out of the Medi-Cal eligibility determination, the county detention facility shall not provide information to the CWD.

The CWD is then required to perform the following mandated activities:

1. From January 1, 2008, until December 31, 2008, upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by DHCS, initiate an application for benefits under the Medi-Cal program for all juvenile wards.
2. Beginning January 1, 2009, upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by DHCS, initiate an application for benefits under the Medi-Cal program only for wards not already enrolled in the Medi-Cal program. If the ward is a minor, promptly contact the parent or guardian to arrange for completion of the application. Applications shall be expedited for those wards scheduled to be released in fewer than 45 days.
3. If the ward does not meet the eligibility requirements for the Medi-Cal program, forward the ward's information to the appropriate entity to determine eligibility for the Healthy Families Program, or other appropriate health coverage program, with the consent of the ward's parents or guardian if the ward is a minor.
4. If the ward meets eligibility requirements for the Medi-Cal program, provide sufficient documentation to enable the ward to obtain necessary medical care upon release from custody.<sup>58</sup>

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<sup>58</sup> According to a DHCS memo, this means that the "county must issue an immediate need paper Medi-Cal card for the juvenile as soon as eligibility is established." DHCS memo to County Welfare Directors "Medi-Cal Pre-Release Application Process for Wards in County Juvenile Facilities Re: Senate Bill (SB) 1469, Chapter 657, Statutes of 2006, Welfare and Institutions (W&I) Code section 14029.5" January 2, 2008, page 2. Exhibit G.

*The activity to “determine the individual’s eligibility for benefits under the Medi-Cal program” is not reimbursable since it is not new.*

All other activities alleged by the claimant to require reimbursement do not mandate a new program or higher level of service and are, therefore, denied.



**COMMISSION ON STATE MANDATES**

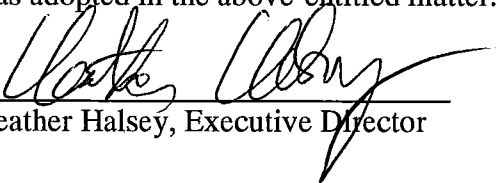
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**RE: Adopted Statement of Decision**

*Medi-Cal Eligibility of Juvenile Offenders, 08-TC-04*  
Welfare and Institutions Code section 14029.5  
Statutes 2006, Chapter 657 (SB 1469)  
County of Alameda, Claimant

On December 6, 2013, the foregoing statement of decision of the Commission on State Mandates was adopted in the above-entitled matter.

  
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Heather Halsey, Executive Director

Dated: December 16, 2013

BEFORE THE  
COMMISSION ON STATE MANDATES  
STATE OF CALIFORNIA

IN RE PARAMETERS AND GUIDELINES  
FOR:

Welfare and Institutions Code Section 14029.5  
as added by Statutes 2006, Chapter 657

Period of reimbursement begins January 1, 2008.

Case No.: 08-TC-04

*Medi-Cal Eligibility of Juvenile Offenders*

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

*(Adopted March 28, 2014)*

*(Served April 4, 2014)*

**STATEMENT OF DECISION**

The Commission on State Mandates (Commission) adopted this statement of decision and parameters and guidelines on consent during a regularly scheduled hearing on March 28, 2014.

The law applicable to the Commission’s determination of a reimbursable state-mandated program is article XIII B, section 6 of the California Constitution, Government Code section 17500 et seq., and related case law.

**I. SUMMARY OF THE MANDATE**

These parameters and guidelines address activities of county juvenile detention facilities and county welfare departments (CWDs) to assist juveniles whose Medi-Cal coverage is terminated as a result of incarceration in a juvenile detention facility for 30 days or more to obtain Medi-Cal or other health coverage immediately upon release from custody. The activities require, beginning January 1, 2008, county juvenile detention facilities to provide specified information regarding Medi-Cal eligibility to CWDs and, if the ward is a minor, provide notice to the ward’s parent or guardian. The CWD is then required to perform specified mandated activities related to initiating an application for Medi-Cal benefits for the ward. *The CWD is also required to determine the ward’s Medi-Cal eligibility; however, this requirement is not reimbursable because it is not new.*

On December 6, 2013, the Commission adopted a statement of decision on the test claim finding that Welfare and Institutions Code section 14029.5, as amended by test claim statute, imposes a partially reimbursable state-mandated program on local agencies within the meaning of article XIII B, section 6 of the California Constitution, and Government Code section 17514. The Commission approved the test claim for the reimbursable activities found under Section IV. Reimbursable Activities.

## II. PROCEDURAL HISTORY

The test claim statement of decision was adopted on December 6, 2013.<sup>1</sup> Commission staff issued draft expedited parameters and guidelines for comment on December 16, 2013.<sup>2</sup> On December 30, 2013, the State Controller's Office (Controller) filed comments requesting minor changes for clarity and consistency.<sup>3</sup> No other comments were received.

## III. COMMISSION FINDINGS

The Controller recommended changes to the parameters and guidelines for clarity and consistency, all of which were inserted into the parameters and guidelines. Other changes were made to conform the boilerplate language to recently adopted parameters and guidelines.

### Reimbursable Activities

The statement of decision included the following reimbursable activity for CWDs: "If the ward meets eligibility requirements for the Medi-Cal program, provide sufficient documentation to enable the ward to obtain necessary medical care upon release from custody." This is the wording of the test claim statute.

As noted in the statement of decision for the test claim,<sup>4</sup> a Department of Health Care Services (DHCS) memo that implemented the test claim statute requires that, for counties to provide "sufficient documentation," they must "issue an immediate need paper Medi-Cal card for the juvenile as soon as eligibility is established."<sup>5</sup>

The DHCS memo is the statutory interpretation of the state agency with expertise of this program, and its interpretation is therefore subject to deference by the Commission.<sup>6</sup> Moreover, because the DHCS memo is a directive already issued to CWDs, the parameters and guidelines should conform to the existing practices for documentation. For these reasons, the Commission has included the following underlined sentence into the parameters and guidelines under Section IV. Reimbursable Activities:

If the ward meets eligibility requirements for the Medi-Cal program, provide sufficient documentation to enable the ward to obtain necessary medical care upon release from custody. The documentation consists of issuing an immediate need paper Medi-Cal card for the juvenile as soon as eligibility is established.

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<sup>1</sup> Exhibit A.

<sup>2</sup> Exhibit B.

<sup>3</sup> Exhibit C.

<sup>4</sup> Exhibit A, page 13.

<sup>5</sup> DHCS memo to County Welfare Directors "Medi-Cal Pre-Release Application Process for Wards in County Juvenile Facilities Re: Senate Bill (SB) 1469, Chapter 657, Statutes of 2006, Welfare and Institutions (W&I) Code section 14029.5" January 2, 2008, page 2.

<sup>6</sup> *Communities for a Better Environment v. State Water Resources Control Board* (2003) 109 Cal.App.4th 1089, 1104. The agency interpretation is entitled to great weight unless unauthorized or clearly erroneous. *Id.* at 1107.

#### **IV. CONCLUSION**

Based on the foregoing analysis, the Commission hereby adopts the proposed statement of decision and attached proposed amendments to the parameters and guidelines.

BEFORE THE  
COMMISSION ON STATE MANDATES  
STATE OF CALIFORNIA

**IN RE PARAMETERS AND GUIDELINES:**

Welfare and Institutions Code Section 14029.5  
as added by Statutes 2006, Chapter 657

Period of reimbursement begins January 1, 2008.

Case No.: 08-TC-04

*Medi-Cal Eligibility of Juvenile Offenders*

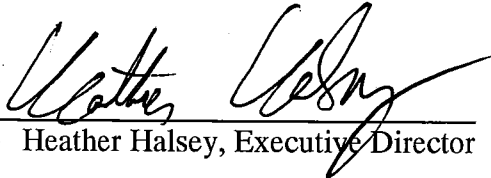
STATEMENT OF DECISION PURSUANT  
TO GOVERNMENT CODE SECTION 17500  
ET SEQ.; CALIFORNIA CODE OF  
REGULATIONS, TITLE 2, DIVISION 2,  
CHAPTER 2.5, ARTICLE 7

*(Adopted March 28, 2014)*

*(Served April 4, 2014)*

**PARAMETERS AND GUIDELINES**

The Commission on State Mandates adopted the attached parameters and guidelines on  
March 28, 2014.

  
Heather Halsey, Executive Director

Adopted: March 28, 2014

## **PARAMETERS AND GUIDELINES**

Welfare and Institutions Code Section 14029.5

Statutes 2006, Chapter 657

*Medi-Cal Eligibility of Juvenile Offenders*

08-TC-04

County of Alameda, Claimant

Period of reimbursement begins January 1, 2008

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### **I. SUMMARY OF THE MANDATE**

These parameters and guidelines address activities of county juvenile detention facilities and county welfare departments (CWDs) to assist juveniles whose Medi-Cal coverage is terminated as a result of incarceration in a juvenile detention facility for 30 days or more to obtain Medi-Cal or other health coverage immediately upon release from custody. Beginning January 1, 2008, county juvenile detention facilities are required to provide specified information regarding Medi-Cal eligibility to CWDs and, if the ward is a minor, provide notice to the ward's parent or guardian. The CWD is then required to perform specified mandated activities to initiate an application for Medi-Cal benefits for the ward. *The CWD is also required to determine the ward's Medi-Cal eligibility; however, this requirement does not impose a reimbursable state-mandated program because it is not new.*

On December 6, 2013, the Commission on State Mandates (Commission) adopted a statement of decision on the test claim finding that Welfare and Institutions Code section 14029.5, as amended by test claim statute, imposes a partially reimbursable state-mandated program on local agencies within the meaning of article XIII B, section 6 of the California Constitution, and Government Code section 17514. The Commission approved the test claim for the reimbursable activities found under Section IV. Reimbursable Activities.

### **II. ELIGIBLE CLAIMANTS**

Any county and city and county that incurs increased costs as a result of this mandate is eligible to claim reimbursement.

### **III. PERIOD OF REIMBURSEMENT**

Government Code section 17557(e) states that a test claim shall be submitted on or before June 30 following a given fiscal year to establish eligibility for that fiscal year. The County of Alameda filed the test claim on January 29, 2009, establishing eligibility for reimbursement for the 2007-2008 fiscal year. However, the effective date of the reimbursable state-mandated activities begins January 1, 2008, the effective date of the test claim statute. As a result, any costs incurred for the activities in these parameters and guidelines are reimbursable on or after January 1, 2008.

Reimbursement for state-mandated costs may be claimed as follows:

1. Actual costs for one fiscal year shall be included in each claim.
2. Pursuant to Government Code section 17561(d)(1)(A), all claims for reimbursement of initial fiscal year costs shall be submitted to the State Controller (Controller) within 120 days of the issuance date for the claiming instructions.
3. Pursuant to Government Code section 17560(a), a local agency may, by February 15 following the fiscal year in which costs were incurred, file an annual reimbursement claim that details the costs actually incurred for that fiscal year.
4. If revised claiming instructions are issued by the Controller pursuant to Government Code section 17558(c), between November 15 and February 15, a local agency filing an annual reimbursement claim shall have 120 days following the issuance date of the revised claiming instructions to file a claim. (Gov. Code, § 17560(b).)
5. If the total costs for a given fiscal year do not exceed \$1,000, no reimbursement shall be allowed except as otherwise allowed by Government Code section 17564(a).
6. There shall be no reimbursement for any period in which the Legislature has suspended the operation of a mandate pursuant to state law.

#### **IV. REIMBURSABLE ACTIVITIES**

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

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

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

The claimant is only allowed to claim and be reimbursed for increased costs for reimbursable activities identified below. Increased cost is limited to the cost of an activity that the claimant is required to incur as a result of the mandate.

For each eligible claimant that incurs increased costs, the following activities are reimbursable:

For County Juvenile Detention Facilities:

1. Subject to the provisions in Activity 2 below, immediately following the issuance of an order of the juvenile court committing the ward to a juvenile hall, camp, or ranch for 30 days or longer, provide the appropriate CWD with the following information: (a) the

ward's name, (b) scheduled or actual release date, (c) any known information regarding the ward's Medi-Cal status prior to disposition, and (d) sufficient information when available for the CWD to begin the process of determining the ward's eligibility for the Medi-Cal program, including available contact information for the ward's parent or guardian if the ward is a minor.

2. If the ward is a minor and before providing information to the CWD, notify the parent or guardian in writing of the intention to submit the information to the CWD. The parent or guardian shall be given a reasonable time to opt out of the Medi-Cal eligibility determination. If the parent or guardian opts out of the Medi-Cal eligibility determination, the county detention facility shall not provide information to the CWD.

For County Welfare Departments:

1. From January 1, 2008, until December 31, 2008, upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by the Department of Health Services (DHCS), initiate an application for benefits under the Medi-Cal program for all juvenile wards.
2. Beginning January 1, 2009, upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by DHCS, initiate an application for benefits under the Medi-Cal program only for wards not already enrolled in the Medi-Cal program. If the ward is a minor, promptly contact the parent or guardian to arrange for completion of the application. Applications shall be expedited for those wards scheduled to be released in fewer than 45 days.
3. If the ward does not meet the eligibility requirements for the Medi-Cal program, forward the ward's information to the appropriate entity to determine eligibility for the Healthy Families Program, or other appropriate health coverage program, with the consent of the ward's parents or guardian if the ward is a minor.
4. If the ward meets eligibility requirements for the Medi-Cal program, provide sufficient documentation to enable the ward to obtain necessary medical care upon release from custody. The documentation consists of issuing an immediate need paper Medi-Cal card for the juvenile as soon as eligibility is established.

*The activity to "determine the individual's eligibility for benefits under the Medi-Cal program" is not reimbursable because it is not new.*

## **V. CLAIM PREPARATION AND SUBMISSION**

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

### **A. Direct Cost Reporting**

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



### 1. Salaries and Benefits

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

### 2. Materials and Supplies

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

### 3. Contracted Services

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

### 4. Fixed Assets

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

### 5. Travel

Report the name of the employee traveling for the purpose of the reimbursable activities. Include the date of travel, destination, the specific reimbursable activity requiring travel, and related travel expenses reimbursed to the employee in compliance with the rules of the local jurisdiction. Report employee travel time according to the rules of cost element A.1., Salaries and Benefits, for each applicable reimbursable activity.

## B. Indirect Cost Rates

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

Compensation for indirect costs is eligible for reimbursement utilizing the procedure provided in 2 Code of Federal Regulations (CFR) part 225 (Office of Management and Budget (OMB) Circular A-87). Claimants have the option of using 10 percent of direct labor, excluding fringe

benefits, or preparing an Indirect Cost Rate Proposal (ICRP) if the indirect cost rate claimed exceeds 10 percent.

If the claimant chooses to prepare an ICRP, both the direct costs (as defined and described in 2 CFR part 225, appendices A and B (OMB Circular A-87 attachments A & B) and the indirect costs shall exclude capital expenditures and unallowable costs (as defined and described in 2 CFR part 225, appendices A and B (OMB Circular A-87 attachments A & B). However, unallowable costs must be included in the direct costs if they represent activities to which indirect costs are properly allocable.

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

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

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

## **VI. RECORD RETENTION**

Pursuant to Government Code section 17558.5(a), a reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter<sup>1</sup> is subject to the initiation of an audit by the Controller no later than three years after the date that the actual reimbursement claim is filed or last amended, whichever is later. However, if no funds are appropriated or no payment is made to a claimant for the program for the fiscal year for which the claim is filed, the time for the Controller to initiate an audit shall commence to run from the date of initial payment of the claim. In any case, an audit shall be completed not later than two years after the date that the audit is commenced. All documents used to support the reimbursable activities, as described in Section IV., must be retained during the period subject to audit. If an audit has been initiated by the Controller during the period subject to audit, the retention period is extended until the ultimate resolution of any audit findings.

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<sup>1</sup> This refers to title 2, division 4, part 7, chapter 4 of the Government Code.

## **VII. OFFSETTING REVENUES AND REIMBURSEMENTS**

Any offsetting revenue the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate from any source, including but not limited to, service fees collected, federal funds, and other state funds, shall be identified and deducted from this claim.

## **VIII. STATE CONTROLLER'S CLAIMING INSTRUCTIONS**

Pursuant to Government Code section 17558(b), the Controller shall issue claiming instructions for each mandate that requires state reimbursement not later than 90 days after receiving the adopted parameters and guidelines from the Commission, to assist local agencies and school districts in claiming costs to be reimbursed. The claiming instructions shall be derived from these parameters and guidelines and the statements of decisions on the test claim and parameters and guidelines adopted by the Commission.

Pursuant to Government Code section 17561(d)(1), issuance of the claiming instructions shall constitute a notice of the right of the local agencies and school districts to file reimbursement claims, based upon parameters and guidelines adopted by the Commission.

## **IX. REMEDIES BEFORE THE COMMISSION**

Upon request of a local agency or school district, the Commission shall review the claiming instructions issued by the Controller or any other authorized state agency for reimbursement of mandated costs pursuant to Government Code section 17571. If the Commission determines that the claiming instructions do not conform to the parameters and guidelines, the Commission shall direct the Controller to modify the claiming instructions and the Controller shall modify the claiming instructions to conform to the parameters and guidelines as directed by the Commission.

In addition, requests may be made to amend parameters and guidelines pursuant to Government Code section 17557(d), and California Code of Regulations, title 2, section 1183.2.

## **X. LEGAL AND FACTUAL BASIS FOR THE PARAMETERS AND GUIDELINES**

The statements of decision adopted for the test claim and parameters and guidelines are legally binding on all parties and provide the legal and factual basis for the parameters and guidelines. The support for the legal and factual findings is found in the administrative record. The administrative record is on file with the Commission.

Item \_\_\_

**DRAFT PROPOSED STATEWIDE COST ESTIMATE**  
**\$27,469**

**(Approximate Prospective Cost of \$5,428 Annually)**

Welfare and Institutions Code Section 14029.5

Statutes 2006, Chapter 657

*Medi-Cal Eligibility of Juvenile Offenders*

08-TC-04

**STAFF ANALYSIS**

**Background and Summary of the Mandate**

This program addresses activities of county juvenile detention facilities and county welfare departments (CWDs) to assist juveniles whose Medi-Cal coverage is terminated as a result of incarceration in a juvenile detention facility for 30 days or more to obtain Medi-Cal or other health coverage immediately upon release from custody.

On December 6, 2013, the Commission on State Mandates (Commission) adopted a statement of decision<sup>1</sup> finding that Welfare and Institutions Code section 14029.5, as amended by test claim statute, imposes a partially reimbursable state-mandated program on local agencies within the meaning of article XIII B, section 6 of the California Constitution, and Government Code section 17514.

Parameters and guidelines<sup>2</sup> were adopted on March 28, 2014 approving the reimbursable activities described below under the *Reimbursable Activities* section.

Eligible claimants were required to file initial reimbursement claims, for costs incurred for the period January 1, 2008 through June 30, 2008 and fiscal years 2008-2009 through 2012-2013, with the State Controller’s Office (SCO) by October 31, 2014. Late initial reimbursement claims may be filed until October 31, 2015.

Eligible Claimants and Period of Reimbursement

Any county and city and county that incurs increased costs as a result of this mandate is eligible to claim reimbursement.

Government Code section 17557(e) states that a test claim shall be submitted on or before June 30 following a given fiscal year to establish eligibility for that fiscal year. County of Alameda filed the test claim on January 29, 2009, establishing eligibility for reimbursement for the 2007-2008 fiscal year. However, the effective date of the reimbursable state-mandated activities begins

<sup>1</sup> Exhibit A. Test Claim Statement of Decision.

<sup>2</sup> Exhibit B. Parameters and Guidelines.

January 1, 2008, the effective date of the test claim statute. As a result, any costs incurred for the activities in these parameters and guidelines are reimbursable on or after January 1, 2008.

### **Reimbursable Activities**

The parameters and guidelines authorize reimbursement of each eligible claimant for the following activities:

For County Juvenile Detention Facilities:

1. Subject to the provisions in Activity 2 below, immediately following the issuance of an order of the juvenile court committing the ward to a juvenile hall, camp, or ranch for 30 days or longer, provide the appropriate CWD with the following information: (a) the ward's name, (b) scheduled or actual release date, (c) any known information regarding the ward's Medi-Cal status prior to disposition, and (d) sufficient information when available for the CWD to begin the process of determining the ward's eligibility for the Medi-Cal program, including available contact information for the ward's parent or guardian if the ward is a minor.
2. If the ward is a minor and before providing information to the CWD, notify the parent or guardian in writing of the intention to submit the information to the CWD. The parent or guardian shall be given a reasonable time to opt out of the Medi-Cal eligibility determination. If the parent or guardian opts out of the Medi-Cal eligibility determination, the county detention facility shall not provide information to the CWD.

For County Welfare Departments:

1. From January 1, 2008, until December 31, 2008, upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by the Department of Health Services (DHCS), initiate an application for benefits under the Medi-Cal program for all juvenile wards.
2. Beginning January 1, 2009, upon receipt of the information from the county detention facility, and pursuant to the protocols and procedures developed by DHCS, initiate an application for benefits under the Medi-Cal program only for wards not already enrolled in the Medi-Cal program. If the ward is a minor, promptly contact the parent or guardian to arrange for completion of the application. Applications shall be expedited for those wards scheduled to be released in fewer than 45 days.
3. If the ward does not meet the eligibility requirements for the Medi-Cal program, forward the ward's information to the appropriate entity to determine eligibility for the Healthy Families Program, or other appropriate health coverage program, with the consent of the ward's parents or guardian if the ward is a minor.
4. If the ward meets eligibility requirements for the Medi-Cal program, provide sufficient documentation to enable the ward to obtain necessary medical care upon release from custody. The documentation consists of issuing an immediate need paper Medi-Cal card for the juvenile as soon as eligibility is established.

*The activity to "determine the individual's eligibility for benefits under the Medi-Cal program" is not reimbursable because it is not new.*

## Offsetting Revenues and Reimbursements

The parameters and guidelines<sup>3</sup> provide:

Any offsets the claimant experiences in the same program as a result of the same statutes or executive orders found to contain the mandate shall be deducted from the costs claimed. In addition, reimbursement for this mandate from any source, including but not limited to, service fees collected, federal funds, and other state funds, shall be identified and deducted from this claim.

To the extent that the claimant has used fees or any funds provided by the state or federal government, as opposed to proceeds of local taxes, to pay for the cost of the program, those costs are not reimbursable.

## Statewide Cost Estimate

### Assumptions

Staff reviewed the reimbursement claims data submitted by the three counties that submitted initial claims, which was compiled by the SCO.<sup>4</sup> The data showed that three counties filed initial claims for fiscal years 2009-2010 through 2012-2013, two counties filed initial claims for fiscal year 2008-2009 and only one county filed an initial claim for fiscal year 2007-2008 for a total of \$27,469. Based on this data, staff made the following assumptions and used the following methodology to develop a statewide cost estimate for this program.

- *The actual amount claimed for reimbursement may increase and exceed the statewide cost estimate.*

There are currently 58 counties and 482 cities in California. Of those combined, only three counties filed initial reimbursement claims totaling \$27,469. If other eligible claimants file late or amended initial claims, the amount of reimbursement claims may exceed the statewide cost estimate. Late initial reimbursement claims for this program for the period January 1, 2008 through June 30, 2008 and fiscal years 2008-2009 through 2012-2013 may be filed until October 31, 2015. There also may be several reasons that non-claiming counties did not file reimbursement claims, including but not limited to, (1) they did not incur more than \$1,000 in increased costs for this program and (2) they did not have supporting documentation to file a reimbursement claim.

- *The annual costs of the program may vary depending on the number of Medi-Cal-eligible wards.*

The reimbursable activities of this program are based on caseload rather than a fixed cycle. The number of Medi-Cal-eligible wards at a county juvenile detention facility will directly correlate to the volume of activities such as information dissemination to the county welfare department, notice to the ward's parent or guardian, and initiation of application for Medi-Cal benefits.

- *The total amount of reimbursement for this program may be lower than the statewide cost estimate because the SCO may reduce any reimbursement claim for this program.*

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<sup>3</sup> Exhibit B. Parameters and Guidelines.

<sup>4</sup> Claims data reported as of November 18, 2014.

The SCO may conduct audits and reduce any claims it deems to be excessive or unreasonable.

Methodology

January 1, 2008 through June 30, 2008 and fiscal years 2008-2009 through 2012-2013.

The statewide cost estimate for the period January 1, 2008 through June 30, 2008 and fiscal years 2008-2009 through 2012-2013 was developed by totaling the 15 reimbursement claims filed with the SCO for this period totaling \$27,469. Staff finds that the average for the most recent three-year period is likely indicative of potential future costs. For that three-year period, costs averaged \$5,428 annually

Following is a breakdown of estimated total costs per fiscal year:

<b>Fiscal Year</b>	<b>Number of Claims Filed with SCO</b>	<b>Estimated Cost</b>
2007-2008	1	\$2,155
2008-2009	2	\$3,758
2009-2010	3	\$5,273
2010-2011	3	\$6,160
2011-2012	3	\$5,519
2012-2013	3	\$4,604
<b>TOTAL</b>	<b>15</b>	<b>\$27,469</b>

**Staff Recommendation**

Staff recommends the Commission adopt the proposed statewide cost estimate of **\$27,469 (Approximate Prospective Cost of \$5,428 Annually)** for costs incurred in complying with the *Medi-Cal Eligibility of Juvenile Offenders* program.