STATE of CALIFORNIA
COMMISSION ON STATE MANDATES

May 11, 2016

Mr. Steven Presberg
Senior Personnel Analyst
City of Los Angeles
700 East Temple Street, Room 210
Los Angeles, CA 90012

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

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

Re: **Proposed Decision**
Firefighter's Cancer Presumption, 09-4081-I-01
Labor Code Section 3212.1
Statues 1982, Chapter 1568
Fiscal Year: 2003-2004
City of Los Angeles, Claimant

Dear Mr. Presberg and Ms. Kanemasu:

The proposed decision for the above-named matter is enclosed for your review.

Hearing

This matter is set for hearing on **Thursday, May 26, 2016**, at 10:00 a.m., State Capitol, Room 447, Sacramento, California. Please let us know in advance if you or a representative of your agency will testify at the hearing, and if other witnesses will appear. If you would like to request postponement of the hearing, please refer to section 1187.9(b) of the Commission's regulations.

Special Accommodations

For any special accommodations such as a sign language interpreter, an assistive listening device, materials in an alternative format, or any other accommodations, please contact the Commission Office at least five to seven *working* days prior to the meeting.

Sincerely,

Heather Halsey
Executive Director

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

ITEM 3
INCORRECT REDUCTION CLAIM
PROPOSED DECISION

Labor Code Section 3212.1

Statutes 1982, Chapter 1568

Firefighter's Cancer Presumption

Fiscal Year 2003-2004

09-4081-I-01

City of Los Angeles, Claimant

EXECUTIVE SUMMARY

Overview

This incorrect reduction claim (IRC) challenges a reduction made by the State Controller's Office (Controller) to a reimbursement claim filed by the City of Los Angeles (claimant) for fiscal year 2003-2004 under the *Firefighter's Cancer Presumption* program. Following the audit, the Controller, as a result of a mathematical error on one of the claim forms filed, deemed $516,132 "unclaimed." Due to this program's 50 percent reimbursement formula, this resulted in a reduction of the reimbursement claimed by a presumptive $258,066.

For the reasons discussed in this analysis, staff finds that the Controller's reduction is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support.

The *Firefighter's Cancer Presumption* Program

In 1982, the Legislature enacted legislation to allow firefighters, under certain circumstances, to claim workers' compensation for cancers which developed or manifested during or (for a limited period of time) after their service.[1] The act added an additional definition of "injury" to the Labor Code that "includes cancer which develops or manifests itself" during a period in which the person was an active firefighting member of a fire department or unit. Provided that the member could demonstrate that he or she was exposed to a known carcinogen while in service and provided that the carcinogen is "reasonably linked to the disabling cancer," then the member, pursuant to Labor Code section 3212.1, became entitled to a rebuttable presumption during workers' compensation proceedings that the cancer arose out of and in the course of the firefighting.

On February 23, 1984, the Board of Control, predecessor to the Commission on State Mandates (Commission), approved the *Firefighter's Cancer Presumption*, CSM-4081 test claim. On October 24, 1985, the Commission adopted parameters and guidelines for the *Firefighter's*

[1] Statutes 1982, chapter 1568, adding Labor Code section 3212.1.

Cancer Presumption program, and amended the parameters and guidelines on March 26, 1987.[2] The amended parameters and guidelines state, in relevant part, that the State of California shall reimburse 50 percent of the actual costs incurred by a local agency for workers' compensation claims that are subject to the *Firefighter's Cancer Presumption*. For a self-insured local agency, the reimbursable costs are 50 percent of "All actual costs," including administrative costs (such as staff costs and overhead costs) and benefit costs (such as "All medical expenses" and "All compensation benefits" (e.g., permanent disability benefits, life pension benefits, and death benefits)). The parties do not dispute that the provisions of the amended parameters and guidelines referring to self-insured local agencies are the provisions which apply to the City of Los Angeles and its claim.

The Controller's Audit and Reduction of Costs

The facts are not in dispute in this case. In adding together all of the costs identified on Form FCP-2.1, the claimant made an arithmetic error and obtained a bottom-line total that was $516,132 less than the actual sum of all of the Total Benefit Payments.[3] Having made an error in computing the sum of all firefighters' Total Benefit Payments on Form FCP-2.1, the claimant transferred the error to the Direct Costs schedule at the end of Form FCP-1.2[4] and to the reimbursement claim made on Form FAM-27.[5]

There is no dispute that $516,132 in disability benefit costs were identified by the claimant on its Form FCP-2.1 and that the claimant filed the Form FCP-2.1 simultaneously with its reimbursement claim on January 10, 2005, as required by the claiming instructions.[6] There is no dispute that the Controller deemed the $516,132 in disability benefit costs to be "unclaimed costs" which were not used to calculate the claimant's reimbursement.[7]

The record also indicates that the mathematical error on Form FCP-2.1 was first noticed by the Controller and summarized in its July 17, 2009 draft audit report[8] and that, on August 6, 2009, the claimant objected in writing to the Controller's decision to deem the $516,132 in disability benefit costs to be "unclaimed costs."[9] In the letter, the claimant requested that the Controller process the Form FAM-27 as if the numbers on the form had been corrected to include the $516,132 which the claimant had mistakenly omitted.[10] The Controller denied the request.

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[2] Exhibit B, Controller's Late Comments on IRC, pages 14-17.

[3] Exhibit A, IRC, pages 3, 40-43.

[4] Exhibit A, IRC, page 39.

[5] Exhibit A, IRC, page 43.

[6] Exhibit A, IRC, page 19.

[7] Exhibit A, IRC, page 19.

[8] Exhibit A, IRC, page 16, 19, 22-23.

[9] Letter from Margaret Whelan to Jim L. Spano, dated August 6, 2009. (Exhibit A, IRC, pages 22-23.)

[10] Letter from Margaret Whelan to Jim L. Spano, dated August 6, 2009. (Exhibit A, IRC, pages 22-23.)

Procedural History

The claimant signed and submitted the reimbursement claim for fiscal year 2003-2004 on January 10, 2005. The Controller commenced the audit of the reimbursement claim on June 9, 2008. The Controller provided the draft audit report to the claimant on June 17, 2009. The claimant sent a letter on August 6, 2009, objecting to the Controller's draft audit report. The Controller issued the final audit report on September 4, 2009. The claimant filed IRC 09-4081-I-01 on January 14, 2010. Commission staff deemed this IRC complete on January 26, 2010. The Controller filed late comments on the IRC on December 12, 2014. The claimant filed rebuttal comments on January 12, 2015.

Commission staff issued the Draft Proposed Decision[11] on March 18, 2016. No comments were filed on the Draft Proposed Decision.

Commission Responsibilities

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

Government Code section 17551(d) requires the Commission to hear and decide a claim that the Controller has incorrectly reduced payments to the local agency or school district. If the Commission determines that a reimbursement claim has been incorrectly reduced, section 1185.9 of the Commission's regulations requires the Commission to send the decision to the Controller and request that the costs that were incorrectly reduced be reinstated.

The Commission must review questions of law, including interpretation of parameters and guidelines, de novo, without consideration of legal conclusions made by the Controller in the context of an audit. The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.[12] The Commission must also interpret the Government Code and implementing regulations in accordance with the broader constitutional and statutory scheme. In making its decisions, the Commission must strictly construe article XIII B, section 6, and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."[13]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by courts when reviewing an alleged abuse of discretion by a state agency.[14]

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[11] Exhibit D, Draft Proposed Decision.

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

[13] *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[14] *Johnston v. Sonoma County Agricultural Preservation and Open Space District* (2002) 100 Cal.App.4th 973, 983-984; *American Bd. of Cosmetic Surgery, Inc. v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547.

The Commission must also review the Controller's audit in light of the fact that the initial burden of providing evidence for a claim of reimbursement lies with the claimant.[15] In addition, sections 1185.1(f)(3) and 1185.2(c) of the Commission's regulations require that any assertions of fact by the parties to an IRC must be supported by documentary evidence. The Commission's ultimate findings of fact must be supported by substantial evidence in the record.[16]

Claims

The following chart provides a brief summary of the claims and issues raised and staff's recommendation:

Issue	Description	Staff Recommendation
Reduction of costs due to the Controller's decision to deem $516,132 in total disability costs as "unclaimed costs." The $516,132 was listed in the line items of the claimant's Form FCP-2.1, but, due to an arithmetic error, the amount was not transferred to the claimant's Form FAM-27, and therefore did not appear on the face of the reimbursement claim.	The Controller argues that it acted within its authority because, by the time that the claimant served its protest letter dated August 6, 2009, the claimant's statutory time limit in Government Code sections 17560 and 17568 to amend a claim had expired.	*Incorrect* – The Controller's decision to deem $516,132 in disability benefit costs to be "unclaimed costs" is incorrect as a matter of law, and is arbitrary, capricious, and entirely lacking in evidentiary support. The claimant promptly requested leave to correct the arithmetic error or to conform the claim to the proof which had been attached and submitted with the reimbursement claim when it was originally filed. The Controller had no statutory or regulatory basis upon which to deny the claimant's request.

Staff Analysis

A. The Controller's decision to deem $516,132 in disability benefit costs to be "unclaimed costs" is arbitrary, capricious, or entirely lacking in evidentiary support.

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

[16] Government Code section 17559(b), which provides that a claimant or the state may commence a proceeding in accordance with the provisions of section 1094.5 of the Code of Civil Procedure to set aside a decision of the Commission on the ground that the Commission's decision is not supported by substantial evidence in the record.

The dispositive issue before the Commission is whether or not, on the facts of this record, the Controller acted within its legal authority by deeming total disability benefit costs of $516,132 identified on Form FCP-2.1 as "unclaimed costs," resulting in a reduction of costs to the claimant.

The claimant's request that the Controller process the Form FAM-27 as if the numbers on the form had been corrected to include the $516,132 which the claimant had mistakenly omitted was functionally a request to amend the Form FAM-27 to correct a mistake or to conform to the proof contained in the line items of the attached Form FCP-2.1. Government Code section 17558.5(a) refers to the fact that a reimbursement claim can be "amended," but no statute or administrative regulation delineates the Controller's authority to grant leave for a claimant to amend a claim. Lacking directly controlling legal authority to apply to this situation, the Commission should reason by analogy and apply the law which governs the Superior Court when a plaintiff requests leave to amend a complaint.

"The court may, in furtherance of justice, and on any terms as may be proper, allow a party to amend any pleading or proceeding by adding or striking out the name of any party, or by correcting a mistake in the name of the party, *or a mistake in any other respect*," Code of Civil Procedure section 473(a)(1) states in relevant part. (Emphasis added.) A court may also, under appropriate circumstances, grant a motion to amend a pleading to conform to proof.[17] A court may grant a motion to amend before or during trial.[18] And, under the law, the amended claim that corrects a mistake relates back to the claim's original filing date for statute of limitations purposes.[19] Motions to amend are to be granted with great liberality; it is an abuse of discretion for a court to deny a motion for leave to amend in the absence of demonstrated prejudice to the other parties.[20]

Under the laws governing motions for leave to amend, the Controller's actions toward the claimant constituted an abuse of discretion. Nowhere in the record did the Controller identify how it or any another person would be prejudiced by allowing the claimant to amend its claim. The claimant did not engage in unwarranted delay; rather, the claimant objected to the Controller's draft audit within 20 calendar days of receipt. The claimant did not alter its theory of the case late in the proceedings; rather, the claimant's theory of reimbursement never varied. The claimant was not seeking to submit new evidence; the line items of claimant's Form FCP-2.1 contained the relevant evidence. The claimant was not adding to or increasing its claim; it was merely seeking to have the Controller treat the claim as if the information contained in Form FAM-27 had been accurately calculated. The Controller was not misled; during the course of its audit, the Controller recognized the omitted $516,132 for the arithmetic error it was. The Controller did not challenge the veracity of the line items listed on the claimant's Form FCP-2.1.

Accordingly, staff finds that the Controller's decision to deem $516,132 in disability benefit costs specifically identified on Form FCP-2.1 as "unclaimed" — when, in fact, the costs were claimed but accidentally omitted from the claim cover sheet — was arbitrary, capricious, and

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[17] Code of Civil Procedure section 469.

[18] Code of Civil Procedure section 576.

[19] *Smeltzley v. Nicholson Mfg. Co.* (1977) 18 Cal.3d 932, 934.

[20] *Atkinson v. Elk Corp.* (2003) 109 Cal.App.4th 739, 761.

entirely lacking in evidentiary support.[21] Under the law, the correction of the mistake relates back to the claim's original filing date of January 10, 2005 and is timely.

B. The Controller's position that Government Code sections 17560 and 17568 bar the claimant from correcting the claim is incorrect as a matter of law.

The Controller takes the position that Government Code sections 17560 and 17568 authorized the Controller's refusal to grant leave to the claimant to amend its reimbursement claim. "It is the city's responsibility to ensure that it files accurate mandated cost claims within the statutory time allowed. Government Code section 17568 states, 'In no case shall a reimbursement claim be paid that is submitted more than one year after the deadline specified in [Government Code] section 17560.' The city did not amend its FY 2003-04 mandated cost claim within the statutory timeframe permitted."[22]

The claimant's counter-argument reads, "The city did not need to 'amend' its claim, inasmuch as each and every dollar pertaining to it was in fact submitted in full detail. While SCO obliquely refers to 'mathematical errors on a supporting schedule' this very supporting schedule — in fact submitted and audited by them — provides all of the details of the claims."[23]

Staff finds that Government Code sections 17560 and 17568 do not support the Controller's position that the claimant no longer had the ability to correct the claim. Government Code section 17560(b) requires a claimant to "file" a claim by a certain deadline; Section 17568 authorizes the Controller to reduce (up to a specified cap) a claim which a claimant "submits" up to one year late; and Section 17568 prohibits the Controller from paying any claim which was "submitted" more than one year late.

The Controller does not dispute the fact that the claimant filed its claim on January 10, 2005, and that, at the time of the filing, the claimant's Form FCP-2.1 contained a four-page listing of all of the relevant disability benefit costs which, by this IRC, the claimant is requesting be included in the total used to calculate the claimant's reimbursement. Claimant was not and is not attempting to add new or late-filed data. Consequently, the claimant's request for reimbursement — a claim which listed the $516,132 in disability benefit costs — was timely filed under Section 17560(b).

In addition, both Government Code section 17560(b) and section 17568 are silent regarding a claimant's ability to amend a previously and timely filed claim. The Controller has not adopted regulations on point. Therefore, as explained above, the law regarding amendments of pleadings to correct a mistake or to conform to proof is applied, and, under that body of law, the Controller's actions constituted an abuse of discretion. Neither Government Code section 17560(b) nor 17568 alters that result.[24]

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[21] Since the Commission's ruling regarding the Controller's refusal to grant leave to the claimant to amend its claim disposes of this IRC, the Commission declines to address the other arguments proffered by the parties.

[22] Exhibit A, IRC, page 21. See also Exhibit B, Controller's Late Comments on IRC, pages 10, 11 [similar language].

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

[24] Alternatively, an amendment of the Form FAM-27 would relate back to the claim's original filing date for statute of limitations purposes — an outcome unaffected by Government Code

Accordingly, staff finds that Government Code sections 17560 and 17568 do not support the Controller's position that the claimant no longer had the ability to correct the claim.

C. A line of Court of Appeal decisions upholding the authority of the Medi-Cal program to refuse to allow the amendment of reimbursement claims is not applicable to this IRC.

A line of published Court of Appeal decisions held that the formerly named Department of Health Services (Department) acted within its authority in declining to allow the amendment of erroneous reimbursement claims submitted under the Medi-Cal program. However, as explained below, these cases are not applicable to this IRC.

In *Mission Community Hospital v. Kizer*, and *Kaiser Foundation Hospitals v. Belshe*, the claimants were attempting to add new and additional claims or information to their cost reports;[25] *Coastal Community Hospital v. Belshe* does not specify the nature of the claimant's error but, based on language in the opinion, the claimant was also attempting to add new and additional claims or information.[26] In contrast, the claimant in this IRC had submitted all relevant costs in its Form FCP-2.1 and was merely attempting to correct the face of its Form FAM-27; the claimant in this IRC was not attempting to add new or additional claims or information.

The Medi-Cal program does not reimburse a claimant for its actual costs. Rather, following a federal revision of the program in 1980 and 1981, a claimant is entitled to be reimbursed according to a formula "based upon the costs that would have been incurred by an efficient and economically operated facility, even if a provider's actual costs were greater."[27] While the actual costs contained in the cost reports are a factor in determining a Medi-Cal claimant's ultimate reimbursement, the cost reports are merely one part of the equation.[28] In contrast, a claimant incurring state-mandated expenses is entitled to a reimbursement of all actual costs mandated by the state, and the claimant's actual costs are the principal variable in the equation when the claimant is (like the claimant in this IRC) requesting reimbursement under an actual cost methodology.[29] While both the Medi-Cal program and the state mandate program involve claimants filing requests for reimbursement of expenses, the two programs are fundamentally

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sections 17560 and 17568. See *Smeltzley v. Nicholson Mfg. Co.* (1977) 18 Cal.3d 932, 934 ["California courts have established the rule that an amended complaint relates back to the filing of the original complaint, and thus avoids the bar of the statute of limitations, so long as recovery is sought in both pleadings on the same general set of facts."].

[25] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1685-1686; *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1556-1558.

[26] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 395 ["inaccuracies in the cost reports which resulted in a lesser reimbursement"].

[27] *Robert F. Kennedy Medical Center v. Belshe* (1996) 13 Cal.4th 748, 752.

[28] *Robert F. Kennedy Medical Center v. Belshe* (1996) 13 Cal.4th 748, 757.

[29] Government Code section 17561(a) states that "[t]he state shall reimburse each local agency and school district for *all 'costs* mandated by the state[.]'" (Emphasis added.)

different in terms of the claimant's legal entitlement and the State's use of the submitted expense data.

Furthermore, claimants seeking reimbursement under Medi-Cal operate within a web of federal and state statutes and regulations which provide the claimants with notice of myriad substantive and procedural requirements — including deadlines to amend or correct claims. The *Mission Community Hospital* and *Kaiser Foundation Hospitals* courts based their decisions in part on the fact that the claimants had been placed on notice by a state regulation that the claimants could file amended cost reports with the Department any time before the final settlement of the cost reports.[30] In a decision involving a different aspect of the Medi-Cal program, claimants were placed on notice by a statute that the Department had the ability to correct mathematical or typographical errors.[31]

In sharp contrast, the Controller has not issued regulations regarding the procedure to be followed by claimants or by the Controller when mandate reimbursement claims are audited. Unlike *Mission Community Hospital* and *Kaiser Foundation Hospitals*, the claimant was not placed on notice by the Controller of a deadline by which to amend or correct its previously submitted claim.[32] In the absence of such a regulation, the Controller cannot take advantage of the reasoning in *Mission Community Hospital* and *Kaiser Foundation Hospitals*.

Finally, the *Kaiser Foundation Hospitals* court placed weight on the fact that Medi-Cal cost reports are required by statute to be certified as true and correct by the provider's executive officer[33] and, if unaudited within three years, are deemed to be true and correct.[34] Similarly, the claim in this IRC was certified under penalty of perjury to be true and correct,[35] and the Controller has a three-year window in which to audit mandate reimbursement claims.[36] A distinguishing difference is that, while the Department in *Kaiser Foundation Hospitals* did not conduct an audit, the Controller did. The certification of the data is a moot issue in this IRC, where the presumption of accuracy created by the certification was superseded by the evidence requested and reviewed by the Controller during its year-long field audit.[37] In addition, the *Kaiser Foundation Hospitals* claimants were attempting to add information; in the instant IRC,

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[30] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1560-1561.

[31] *Santa Ana Hospital Medical Center v. Belshe* (1997) 56 Cal.App.4th 819, 824. See also Welfare and Institutions Code section 14105.98(f)(5).

[32] As discussed above, the statutory deadline for a claimant to file a claim does not constitute a limitation on a claimant's ability to seek to amend a claim.

[33] Welfare and Institutions Code section 14107.4(c).

[34] Welfare and Institutions Code section 14170(a)(1).

[35] Exhibit A, IRC, page 34.

[36] Government Code section 17558.5(a).

[37] See, e.g., *Rogers v. Interstate Transit Co.* (1931) 212 Cal. 36, 38 ["[I]t is well established in this state that a presumption in favor of a party is entirely dispelled by the testimony of the party himself or of his witnesses."]; *Coffey v. Shiomoto* (2015) 60 Cal. 4th 1198, 1210 ["[I]f evidence sufficient to negate the presumed fact is presented, the 'presumption disappears' (Citation.) and 'has no further effect' (Citation.) . . . ."].

the claimant submitted all information at the time it submitted the claim. Finally, a verified pleading may also be amended.[38]

Thus, while a line of Court of Appeal decisions upholds the authority of the Department to reject amended cost reports, the decisions are not applicable to this IRC, which should be decided on the basis that, on this record, the Controller should have granted the claimant leave to amend its Form FAM-27.

Conclusion

Staff finds that the Controller's decision to deem $516,132 in disability benefit costs as "unclaimed" is incorrect as a matter of law and is arbitrary, capricious, and entirely lacking in evidentiary support.

Staff Recommendation

Staff recommends that the Commission adopt the proposed decision approving the IRC and, pursuant to Government Code section 17551(d) and section 1185.9 of the Commission's regulations, request that the Controller reinstate the costs incorrectly reduced, and authorize staff to make any technical, non-substantive changes following the hearing.

[38] *Macomber v. State of California* (1967) 250 Cal.App.2d 391, 399.

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE INCORRECT REDUCTION CLAIM ON: Labor Code Section 3212.1 Statutes 1982, Chapter 1568 Fiscal Year 2003-2004 City of Los Angeles, Claimant	Case No.: 09-4081-I-01 *Firefighter's Cancer Presumption* DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (*Adopted May 26, 2016*)

DECISION

The Commission on State Mandates (Commission) heard and decided this incorrect reduction claim (IRC) during a regularly scheduled hearing on May 26, 2016. [Witness list will be included in the adopted decision.]

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

The Commission [adopted/modified] the proposed decision to [approve/partially approve/deny] this IRC by a vote of [vote count will be included in the adopted decision] as follows:

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

Summary of the Findings

This IRC was filed by the City of Los Angeles (claimant) in response to an audit by the State Controller's Office (Controller) of the claimant's annual reimbursement claim under the *Firefighter's Cancer Presumption* program for fiscal year 2003-2004. Following the audit, as a result of a mathematical error on one of the claim forms filed, the Controller deemed $516,132 "unclaimed." Due to this program's 50 percent reimbursement formula, this resulted in a reduction of reimbursement claimed by a presumptive $258,066.

Specifically, the claimant submitted its reimbursement claim by filing Form FAM-27, which erroneously failed to include $516,132 in costs even though that $516,132 in costs was listed on the individual line items of the claimant's attached Form FCP-2.1. While the audit report was still in draft, the Controller declined the claimant's request to treat the Form FAM-27 as if the cost and reimbursement totals conformed to the attached proof. The Controller and the claimant concur that (1) the reimbursement amount requested on the face of the claim was inaccurate and incomplete due to an arithmetic error by the claimant and (2) the claimant had submitted correct and complete documentation appended to the claim.

The Commission finds that the Controller's decision to deem $516,132 in disability benefit costs to be "unclaimed costs" is incorrect as a matter of law and is arbitrary, capricious, and entirely lacking in evidentiary support. The Controller had no statutory or regulatory basis upon which to deny the claimant's request. The Controller has not identified any cognizable prejudice which would have resulted if the Controller had treated the Form FAM-27 as if its cost and reimbursement totals had been accurately calculated. The Controller opted to disregard the evidence attached to the claim. The Commission further finds that Government Code sections 17560 and 17568 do not support the Controller's position that the claimant no longer had the ability to correct the claim, and that a line of Court of Appeal decisions upholding the authority of the Medi-Cal program to refuse to allow the amendment of reimbursement claims is not applicable to this IRC.

Accordingly, the Commission approves this IRC and requests the Controller to reinstate all costs incorrectly reduced.

I. Chronology

01/10/2005 Claimant submitted the reimbursement claim for fiscal year 2003-2004.[39]

06/09/2008 Controller commenced an audit of the reimbursement claim.[40]

07/17/2009 Controller issued the draft audit report.[41]

08/06/2009 Claimant sent a letter objecting to the Controller's draft audit report.[42]

09/04/2009 Controller issued the final audit report.[43]

01/14/2010 Claimant filed this IRC.[44]

01/26/2010 Commission staff deemed the IRC complete and issued it for review and comment.

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[39] Exhibit A, IRC, page 34.

[40] Affidavit of Jim L. Spano, dated December 12, 2014, paragraph 7. (Exhibit B, Controller's Late Comments on IRC, page 5.)

[41] Exhibit A, IRC, page 16 ["We issued a draft audit report on July 17, 2009."].

[42] Letter from Margaret Whelan to Jim L. Spano, dated August 6, 2009. (Exhibit A, IRC, pages 22-23.)

[43] Exhibit A, IRC, page 12 [cover letter], pages 11-23 [final audit report].

[44] Exhibit A, IRC, page 1.

12/12/2014 Controller filed late comments on the IRC.[45]

01/12/2015 Claimant filed rebuttal comments.[46]

03/18/2016 Commission staff issued the Draft Proposed Decision.[47]

II. Background

The *Firefighter's Cancer Presumption* Program

In 1982, the Legislature enacted legislation to allow firefighters, under certain circumstances, to claim workers' compensation for cancers which developed or manifested during or (for a limited period of time) after their service.[48] The act (which shall be referred to herein as the "Firefighter's Cancer Presumption" or the "Act"[49]) added an additional definition of "injury" to the Labor Code that "includes cancer which develops or manifests itself" during a period in which the person was an active firefighting member of a fire department or unit.[50] Provided that the member could demonstrate that he or she was exposed to a known carcinogen while in service and provided that the carcinogen is "reasonably linked to the disabling cancer," then the member, pursuant to Labor Code section 3212.1, became entitled to a rebuttable presumption during workers' compensation proceedings that the cancer arose out of and in the course of the firefighting.[51]

On February 23, 1984, the Board of Control, predecessor to the Commission, approved the *Firefighter's Cancer Presumption*, CSM-4081 test claim, finding that the statutes imposed a new program or higher level of service and increased costs mandated by the state within the meaning

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[45] Exhibit B, Controller's Late Comments on IRC. Note that pursuant to Government Code section 17553(d) "the Controller shall have no more than 90 days after the claim is delivered or mailed to file any rebuttal to an incorrect reduction claim. The failure of the Controller to file a rebuttal to an incorrect reduction claim shall not serve to delay the consideration of the claim by the Commission." In this instance, due to the backlog of IRCs, the Controller's late comments have not delayed consideration of this item and thus, have been included in the analysis and decision. (See also California Code of Regulations, title 2, section 1181.10(b)(1)(A), providing that comments received at least 15 days before a Commission meeting shall be included in the Commission's meeting binders.)

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

[47] Exhibit D, Draft Proposed Decision.

[48] Statutes 1982, chapter 1568, adding Labor Code section 3212.1.

[49] Upon its chaptering in 1982, the Act did not have a name. A 1989 amendment added peace officers to the statute's coverage and was named the "Police Officer's Cancer Protection Act." Statutes 1989, chapter 1171, section 1. A 2010 amendment doubled the maximum length of time following a firefighter's termination of service — from 60 months to 120 months — during which the evidentiary presumption continued to apply; the 2010 amendment renamed the entirety of Labor Code section 3212.1 the "William Dallas Jones Cancer Presumption Act of 2010." (Statutes 2010, chapter 672, section 1.)

[50] Statutes 1982, chapter 1568, section 1.

[51] Statutes 1982, chapter 1568, section 1.

of article XIII B, section 6 of the California Constitution. On October 24, 1985, the Commission adopted parameters and guidelines for the *Firefighter's Cancer Presumption* program, and amended the parameters and guidelines on March 26, 1987.[52] The amended parameters and guidelines state, in relevant part, that the State of California shall reimburse 50 percent of the actual costs incurred by a local agency with regard to workers' compensation claims that are subject to the *Firefighter's Cancer Presumption*.[53] For a self-insured local agency, the reimbursable costs are 50 percent of "All actual costs," including administrative costs (such as staff costs and overhead costs) and benefit costs (such as "All medical expenses" and "All compensation benefits" (e.g., permanent disability benefits, life pension benefits and death benefits)).[54] The parties do not dispute that the provisions of the amended parameters and guidelines referring to self-insured local agencies are the provisions which apply to the City of Los Angeles and its claim.

In or about September 1997,[55] the Controller issued an updated Mandated Costs Manual, which included the claiming instructions for this program which detailed the process local agencies were required to follow to apply for reimbursement of costs associated with the *Firefighter's Cancer Presumption* program.[56] In accordance with the amended parameters and guidelines, 50 percent of the costs incurred are eligible for reimbursement and, with regard to self-insured local agencies, the actual costs were a combination of the administrative costs and the benefit costs.[57]

The Controller's claiming instructions specified the four forms which a self-insured claimant was required to submit:

- Form FCP-2.2 — on which the claimant was to detail its relevant administrative costs;
- Form FCP-2.1 — on which the claimant was to list the amount of disability benefit payments actually made to or on behalf of each affected firefighter;
- Form FCP-1.2 — on which the claimant was to re-state the totals on Form FCP-2.2 and Form FCP-2.1 in order to "summarize the increased disability and administrative costs incurred as a result of the mandate." Per the claiming instructions, "Only fifty percent (50%) of the increased costs derived from this form is carried forward to form FAM-27, line (13) for the Reimbursement Claim . . . ."; and
- Form FAM-27 — Per the claiming instructions, "This form contains a certification that must be signed by an authorized representative of the local agency. All applicable

[52] Exhibit B, Controller's Late Comments on IRC, pages 14-17.

[53] Amended parameters and guidelines, section VII [claiming formula]. (Exhibit B, Controller's Late Comments on IRC, page 15.)

[54] Amended parameters and guidelines, section VIII(B) [reimbursable costs]. (Exhibit B, Controller's Late Comments on IRC, pages 15-17.)

[55] See Exhibit A, IRC, pages 5-10.

[56] Exhibit A, IRC, pages 5-10.

[57] Exhibit A, IRC, pages 6-7.

information from . . . FCP-1.2 must be brought forward to this form in order for the State Controller's Office to process the claim for payment."[58]

Data is entered and compiled on Form FCP-2.1 and Form FCP-2.2, and the totals of that data are transferred to Form FCP-1.2 (the claim summary) and Form FAM-27 (the claim itself).[59]

The Reimbursement Claim

On January 10, 2005, the claimant timely submitted to the Controller a reimbursement claim for fiscal year 2003-2004 costs.

On its Form FAM-27 (the claim form itself), the claimant entered the amount of money that it was claiming. With regard to the reimbursement for fiscal year 2003-2004, the claimant filled the following boxes with the following totals:

FCP-1.2, (4)(1)(d):	$985,118.76	[disability benefit costs]
FCP-1.2, (04)(2)(d):	$ 18,683.11	[administrative costs]
Total Claimed Amount:	$501,913.45	
Net Claimed Amount:	$501,913.45	
Due From State:	$501,913.45[60]	

The Form FAM-27 submitted by the claimant was certified under the authority and signature of General Manager Margaret M. Whelan. Ms. Whelan's signature appears directly underneath Form FAM-27's Certification of Claim, which reads in relevant part, "The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements."[61]

The Form FCP-1.2 submitted by the claimant contains the service information of 110 firefighters, followed by a one-page schedule titled Direct Costs.[62] The schedule contains, among other things, the following line items:

(04) Reimbursable Components

Disability Benefit Costs:	$985,118.76
Administrative Costs:	$18,683.11

(05) TOTAL DIRECT COSTS: $1,003,826.90

…

(08) TOTAL DIRECT AND INDIRECT COSTS, SELF INSURED METHOD: $1,003,826.90

[58] Exhibit A, IRC, page 9.

[59] Exhibit A, IRC, page 8.

[60] Exhibit A, IRC, page 34.

[61] Exhibit A, IRC, page 34.

[62] Exhibit A, IRC, pages 35-38.

…

(11) TOTAL CLAIMED AMOUNT

(50% of (08) Total Direct and Indirect Costs): $501,913.45[63]

The Form FCP-2.1 submitted by the claimant details the disability benefit costs for 111 firefighters.[64] For each firefighter, the claimant detailed the costs incurred with regard to that person in ten separate cost categories.[65] Then, in the right-most column of the spreadsheet, the claimant added together the ten categories to yield each firefighter's "Total Benefit Payments."[66]

At the bottom of Form FCP-2.1, the claimant added together the Total Benefit Payments of the 111 firefighters, yielding $985,118.76.[67]

The claimant erred. The sum of the 111 firefighters' Total Benefits Payments was not $985,118.76. The correct sum of the 111 firefighters' Total Benefit Payments was $1,501,250.76. In adding together all of the costs on Form FCP-2.1, the claimant made an arithmetic error and obtained a bottom-line total that was $516,132 less than the actual sum of all of the Total Benefit Payments.[68]

Having made an error in computing the sum of all firefighters' Total Benefit Payments on Form FCP-2.1, the claimant transferred the error to the Direct Costs schedule at the end of Form FCP-1.2 and to the reimbursement claim made on Form FAM-27. If the Total Benefit Payments on Form FCP-2.1 had been calculated correctly, the claimant argues, it would have certified total costs of $1,519,933.87 and would have requested a 50 percent reimbursement totaling $759,966.94.[69]

The claimant's exact arithmetic error is not obvious from the face of the record. The claimant has attached as Exhibit 1 to its IRC a spreadsheet which purports to identify the arithmetic error by shading the spreadsheet cells which it failed to include in the computation of Total Benefit Payments.[70] It is difficult to ascertain from the paper and electronic copies of the record precisely which spreadsheet cells are shaded; moreover, the claimant appears to have shaded

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[63] Exhibit A, IRC, page 39.

[64] Exhibit A, IRC, pages 40-43. While the claimant listed 110 firefighters on its Form FCP-1.2, the claimant listed 111 firefighters on its Form FCP-2.1.

[65] The ten categories are: Medical Expense, Temporary Disability Payment, Permanent Disability Payment, Award, IOD Benefits, Death Benefits, Legal Expense, Travel Expense, Photocopying Expense and Rehabilitation Expense. Accord, Labor Code section 3212.1(c) ("The compensation that is awarded for cancer shall include full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by this division.").

[66] Exhibit A, IRC, pages 40-43.

[67] Exhibit A, IRC, page 43.

[68] Exhibit A, IRC, page 43.

[69] Exhibit A, IRC, page 3.

[70] Exhibit C, Claimant's Rebuttal Comments, pages 7-9.

cells which are located at such disparate but non-random locations within the spreadsheet that it is difficult for the Commission to reconstruct how such an arithmetic error could have occurred.

However, for purposes of deciding the claimant's IRC, the exact provenance of the arithmetic error need not be determined. Throughout the record, both the claimant and the Controller repeatedly state or imply that:

(1) the individual line items of the claimant's Form FCP-2.1, if added together accurately, would have read $1,501,250.76;[71]

(2) the bottom line total appearing on the claimant's Form FCP-2.1 read $985,118.76;[72]

(3) the claimant's bottom-line total of $985,118.76 was inaccurate and was the result of an arithmetic error by the claimant;[73]

(4) the claimant transferred the inaccurate total of $985,118.76 to the Direct Costs schedule of Form FCP-1.2 and to the claiming portion of Form FAM-27;[74] and

(5) the claimant requested, via the Direct Costs schedule of Form FCP-1.2 and the claiming portions of Form FAM-27, a reimbursement of $501,913.45 based on an inaccurate cost total of $1,003,826.90 when the claimant could have, if its arithmetic had been accurate, requested a reimbursement of $759,966.94 based on an accurate cost total of $1,519,933.87.[75]

The Commission utilizes these numbers in this Decision based upon the Commission's independent review of the record and because both the claimant and the Controller used and do not dispute these numbers.[76]

The Controller's Audit and Reduction of Costs

The Controller conducted a field audit of the City of Los Angeles' claim; the field audit commenced on June 9, 2008, and ended on June 19, 2009.[77]

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[71] Exhibit A, IRC, pages 19 [Controller admission], 40-43 [claimant admission].

[72] Exhibit A, IRC, page 43.

[73] Exhibit A, IRC, pages 19 [Controller admission], 22 [claimant admission].

[74] Exhibit A, IRC, pages 34, 39.

[75] Exhibit A, IRC, pages 19 [Controller admission], 40-43 [claimant admission].

[76] The bulk of the arithmetic error appears to be attributable to the claimant's omission of costs incurred in relation to a single firefighter. One particular firefighter referred to in the record incurred medical expenses and total benefit payments which were the highest, by a significant margin, of any firefighter in the claim. In Exhibit A to its Rebuttal Comments, the claimant conceded that it failed to include this firefighter's medical expenses ($391,697.20) and death benefit ($7,500) in the total at the bottom of Form FCP-2.1. (Exhibit C, Claimant's Rebuttal Comments, page 9.)

[77] Affidavit of Jim L. Spano, dated December 12, 2014, paragraph 7. (Exhibit B, Controller's Late Comments on IRC, page 5.)

On July 17, 2009, the Controller provided the claimant with a draft of the audit report.[78] In the draft, the Controller identified the $516,132 which the claimant had listed on the line items of its Form FCP-2.1, but which, due to an arithmetic error, the claimant had failed to include when calculating its requested reimbursement amount.[79] The Controller deemed the $516,132 to be "unclaimed costs," and the Controller excluded the $516,132 from the total used to calculate the claimant's reimbursement.[80]

On August 6, 2009, the claimant served a letter upon the Controller taking exception to the draft audit report and requesting that the $516,132 in disability costs be added back into the total used to calculate the claimant's reimbursement.[81]

On September 4, 2009, the Controller issued a final audit report and served a copy upon the claimant.[82] The draft audit report is not in the record; all references are to the final audit report dated September 4, 2009.[83]

Over the claimant's written objections, the Controller decided in its final audit report to exclude the $516,132 in disability costs from the total used to calculate the claimant's reimbursement.

"The city made mathematical errors on the claim form FCP-2.1, for its 2003-04 and FY 2004-05 claims. The mathematical errors resulted in unclaimed costs totaling $516,132 for FY 2003-04, and $5,440 for FY 2004-05," the final audit report stated.[84] The claimant's incorrect reduction claim is limited to fiscal year 2003-2004.[85]

"The city submitted mandated claim forms FAM-27 (claim for payment), FCP-1.2 (claim summary), and FCP-2.1 (component/activity cost detail). On all these claim forms, the city identified disability benefits costs totaling $985,119. On forms FAM-27 and FCP-1.2, the city identified administrative costs totaling $18,683, actual mandate-related direct costs totaling $1,003,827, and reimbursable costs totaling $501,913 (the mandated program reimburses 50% of total mandate-related costs)," the Controller stated.[86] The administrative costs of $18,683 are not a part of the claimant's IRC.

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[78] Exhibit A, IRC, page 16 ["We issued a draft audit report on July 17, 2009."].

[79] Exhibit A, IRC, page 19.

[80] Exhibit A, IRC, page 19.

[81] Letter from Margaret Whelan to Jim L. Spano, dated August 6, 2009. (Exhibit A, IRC, pages 22-23.)

[82] Exhibit A, IRC, page 12 [letter], pages 11-23 [final audit report].

[83] Exhibit A, IRC, pages 11-23 [final audit report].

[84] Exhibit A, IRC, page 19.

[85] Exhibit A, IRC, page 1.

[86] Exhibit A, IRC, page 21.

"Our audit report shows that we allowed the reimbursable costs that the city claimed. . . . It is the city's responsibility to ensure that it files accurate mandated cost claims within the statutory time allowed," the final audit report stated.[87]

Consequently, the Controller excluded the $516,132 in disability costs, used the claimant's mathematically incorrect disability cost total of $985,118.76 which appeared on the Form FAM-27 and, adding in administrative costs and applying the program's 50 percent reimbursement formula, approved a reimbursement of $501,913.[88]

The claimant's argument in this IRC is that the Controller should have included the $516,132 in disability costs and used the mathematically correct disability cost total of $1,501,250.76 regardless of what amount appeared on the Form FAM-27 and, adding in administrative costs and applying the program's 50 percent reimbursement formula, should have approved a reimbursement of $759,966.94.[89]

The difference between the reimbursement amount which the Controller approved $501,913.45 and the reimbursement amount which the claimant argues the Controller should have approved $759,966.94 is $258,053.49 — the amount of reimbursement in controversy in this IRC.

III. Positions of the Parties

A. City of Los Angeles

The claimant objects to the Controller deeming $516,132 in disability costs to be "unclaimed costs."[90] When the claimant was adding up the total of disability costs listed on Form FCP-2.1, the claimant mistakenly failed to add in $516,132 in disability costs which were listed on the form; this error propagated through the claim, resulting in the claimant requesting a reimbursement (at 50 percent of actual costs) of $501,913.45 based on an inaccurate disability cost total of $985,118.76 when, in fact, the claimant had submitted documentation supporting a reimbursement of $759,966.94 based on $1,501,250.76 in disability costs.[91]

The claimant takes the following positions:

1. The IRC should be granted because the Controller filed its rebuttal more than four years late.[92]

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[87] Exhibit A, IRC, page 21.

[88] "For the fiscal year (FY) 2003-2004 claim, the State made no payment to the city. Our audit disclosed that $501,913 is allowable. The State will pay that amount, contingent upon available appropriations." Exhibit A, IRC, page 16.

[89] Exhibit A, IRC, page 3.

[90] Exhibit A, IRC, page 3.

[91] Exhibit A, IRC, page 3; Exhibit C, Claimant's Rebuttal Comments, pages 2-3. The claim also included an additional $18,683.11 in administrative costs, which are not disputed.

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

2. The Controller lacks the authority to deem costs "unclaimed," because Government Code section 17561(d) limits the Controller's authority to reducing only claims that are "excessive" or "unreasonable."[93]

3. The Controller, aware that the claimant made an arithmetic error, should have based its reimbursement on a disability cost total of $1,501,250.76 — the amount substantiated on the four pages of Form FCP-2.1.[94]

4. The Controller may exercise its authority under Government Code section 17561(d)(2)(C) — which grants the Controller the power to adjust for underpayments or overpayments in prior fiscal years — to pay the claimant the reimbursement it requests in this IRC.

The claimant did not file comments on the Draft Proposed Decision.

B. State Controller's Office

The Controller contends that it acted within its authority when it held the claimant to its $516,132 arithmetic error and deemed that amount to be "unclaimed costs" which would not be used to calculate the claimant's reimbursement.[95]

The Controller takes the following positions:

1. The claimant bears the burden of filing mathematically accurate claims.[96]

2. The claimant failed to timely amend its claim, and the Controller was prohibited by the time bar of Government Code section 17568 from allowing the claimant to revise its claim.[97]

3. The claimant cites Government Code section 17561(d)(2)(C) out of context. In any event, while the Controller has the statutory authority to adjust claims for overpayments or underpayments made in prior fiscal years, the authority is irrelevant to this IRC. The Controller's adjustments are based on the claims submitted, and, for FY 2003-2004, the claimant requested a reimbursement of $501,913.[98]

The Controller did not file comments on the Draft Proposed Decision.

IV. Discussion

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

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[93] Exhibit A, IRC, page 3; Exhibit C, Claimant's Rebuttal Comments, pages 3-4.

[94] Exhibit A, IRC, page 3; Exhibit C, Claimant's Rebuttal Comments, pages 2-3.

[95] Exhibit B, Controller's Late Comments on IRC, pages 10-12.

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

[97] Exhibit B, Controller's Late Comments on IRC, page 10.

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

Government Code section 17551(d) requires the Commission to hear and decide a claim that the Controller has incorrectly reduced payments to the local agency or school district. If the Commission determines that a reimbursement claim has been incorrectly reduced, section 1185.9 of the Commission's regulations requires the Commission to send the decision to the Controller and request that the costs that were incorrectly reduced be reinstated.

The Commission must review questions of law, including interpretation of the parameters and guidelines, de novo, without consideration of legal conclusions made by the Controller in the context of an audit. The Commission is vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6.[99] The Commission must also interpret the Government Code and implementing regulations in accordance with the broader constitutional and statutory scheme. In making its decisions, the Commission must strictly construe article XIII B, section 6, and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."[100]

With regard to the Controller's audit decisions, the Commission must determine whether they were arbitrary, capricious, or entirely lacking in evidentiary support. This standard is similar to the standard used by the courts when reviewing an alleged abuse of discretion by a state agency.[101] Under this standard, the courts have found that:

> When reviewing the exercise of discretion, the scope of review is limited, out of deference to the agency's authority and presumed expertise: 'The court may not reweigh the evidence or substitute its judgment for that of the agency. [Citation.]'"… "In general, …the inquiry is limited to whether the decision was arbitrary, capricious, or entirely lacking in evidentiary support…." [Citations.] When making that inquiry, the " ' "court must ensure that an agency has adequately considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." [Citation.]' "[102]

The Commission must also review the Controller's audit in light of the fact that the initial burden of providing evidence for a claim of reimbursement lies with the claimant.[103] In addition, sections 1185.1(f)(3) and 1185.2(c) of the Commission's regulations require that any assertions

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

[100] *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[101] *Johnston v. Sonoma County Agricultural Preservation and Open Space District* (2002) 100 Cal.App.4th 973, 983-984; *American Bd. of Cosmetic Surgery, Inc. v. Medical Bd. of California* (2008) 162 Cal.App.4th 534, 547.

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

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

of fact by the parties to an IRC must be supported by documentary evidence. The Commission's ultimate findings of fact must be supported by substantial evidence in the record.[104]

A. The Controller's decision to deem $516,132 in disability benefit costs to be "unclaimed costs" is incorrect as a matter of law and is arbitrary, capricious, and entirely lacking in evidentiary support.

The facts are not in dispute in this case. In adding together all of the costs identified on Form FCP-2.1, the claimant made an arithmetic error and obtained a bottom-line total that was $516,132 less than the actual sum of all of the Total Benefit Payments. Having made an error in computing the sum of all firefighters' Total Benefit Payments on Form FCP-2.1, the claimant transferred the error to the Direct Costs schedule at the end of Form FCP-1.2 and to the reimbursement claim made on Form FAM-27.[105]

There is no dispute that these $516,132 in disability benefit costs were identified by the claimant on its Form FCP-2.1 and that the claimant filed the Form FCP-2.1 simultaneously with its reimbursement claim on January 10, 2005, as required by the claiming instructions.[106] There is no dispute that the Controller deemed the $516,132 in disability benefit costs to be "unclaimed costs" which were not used to calculate the claimant's reimbursement.[107]

The record also indicates that the mathematical error on Form FCP-2.1 was first noticed by the Controller and summarized in its July 17, 2009 draft audit report[108] and that, on August 6, 2009, the claimant objected in writing to the Controller's decision to deem the $516,132 in disability benefit costs to be "unclaimed costs."[109] In the letter, the claimant requested that the Controller process the Form FAM-27 as if the numbers on the form had been corrected to include the $516,132 which the claimant had mistakenly omitted.[110] The Controller denied the request.

Although the claimant's letter of August 6, 2009, objecting to the draft audit report did not use the word "amend" nor explicitly request leave to file amended paperwork, the claimant's letter was functionally a request to amend its claim to conform to proof. Specifically, the claimant was requesting that, for purposes of its reimbursement under the *Firefighter's Cancer Presumption* program, the totals on the claimant's Form FAM-27 be amended or corrected to match the data

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[104] Government Code section 17559(b), which provides that a claimant or the state may commence a proceeding in accordance with the provisions of section 1094.5 of the Code of Civil Procedure to set aside a decision of the Commission on the ground that the Commission's decision is not supported by substantial evidence in the record.

[105] Exhibit A, IRC, page 43.

[106] Exhibit A, IRC, page 19.

[107] Exhibit A, IRC, page 19.

[108] Exhibit A, IRC, page 16, 19, 22-23.

[109] Letter from Margaret Whelan to Jim L. Spano, dated August 6, 2009. (Exhibit A, IRC, pages 22-23.)

[110] Letter from Margaret Whelan to Jim L. Spano, dated August 6, 2009. (Exhibit A, IRC, pages 22-23.)

listed on the line items of its Form FCP-2.1 which was submitted with the original reimbursement claim.

The Commission must therefore decide whether the Controller's denial of claimant's request for leave to amend its claim was correct as a matter of law and not arbitrary, capricious or entirely lacking in evidentiary support.

Government Code section 17558.5(a) expressly refers to a claimant's ability to "amend" a claim; in fact, Section 17558.5(a)'s reference to the time when a claim is "last amended" implies that the Legislature intended for a claimant to have, at least under some circumstances, multiple opportunities to amend.[111]

However, the Government Code provisions regarding the Controller's authority to audit mandate reimbursement claims do not address the specific question of when the Controller may lawfully deny leave to amend. Nor has the Controller promulgated regulations on the topic.

Lacking directly controlling legal authority to apply to this situation, and recognizing that the Commission has no authority to rule in equity,[112] the Commission must reason by analogy and decide this IRC by identifying and applying the law which governs the situation most similar to a request by a claimant to amend a mandate reimbursement claim.[113]

The claimant's request to correct the mathematical error in the reimbursement claim is the functional equivalent of a party to a civil action requesting leave to amend a pleading. Under the law, a party to a civil lawsuit may seek permission from the court to amend a pleading to correct a mistake. "The court may, in furtherance of justice, and on any terms as may be proper, allow a party to amend any pleading or proceeding by adding or striking out the name of any party, or by correcting a mistake in the name of the party, *or a mistake in any other respect*," Code of Civil Procedure section 473(a)(1) states in relevant part. (Emphasis added.) A court may also, under

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[111] "A reimbursement claim for actual costs filed by a local agency or school district pursuant to this chapter 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." Government Code section 17558.5(a).

[112] In making its decisions, the Commission must strictly construe section 6 of article XIII B of the California Constitution and not apply section 6 as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities." *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[113] See, e.g., *Stockton Theatres, Inc. v. Palermo* (1961) 55 Cal.2d 439, 442 ["There is no controlling authority to which we have been referred, or found, that deals with this particular subject. But the law applicable to the effect of reversals or modifications on interest on judgments generally would seem, by analogy, to be applicable."]; *Fitzpatrick v. Sonoma County* (1929) 97 Cal.App. 588, 596 ["Our attention has not been called to any case directly in point involving a municipal corporation when joined with individual defendants. We are therefore constrained to reason by analogy."]. See also Weinreb, Legal Reason: The Use of Analogy In Legal Argument (2005) page vii [noting "the indubitable fact that the use of analogy is at the very center of legal reasoning, so much so that it is regarded as an identifying characteristic not only of legal reasoning itself but also of legal education."].

appropriate circumstances, grant a motion to amend a pleading to conform to proof.[114] A court may grant a motion to amend before or during trial.[115] And, under the law, the amended claim that corrects a mistake relates back to the claim's original filing date for statute of limitations purposes.[116]

Motions to amend are to be granted with great liberality; it is an abuse of discretion for a court to deny a motion for leave to amend in the absence of demonstrated prejudice to the other parties. "Although courts are bound to apply a policy of great liberality in permitting amendments to the complaint at any stage of the proceedings, up to and including trial, this policy should be applied only where no prejudice is shown to the adverse party. . . . . It is an abuse of discretion to deny leave to amend where the opposing party was not misled or prejudiced by the amendment."[117]

In deciding whether to grant or deny a motion to amend, a trial court may review the relevant facts and circumstances to determine whether the other parties will be prejudiced by the amendment. "Although failure to permit such amendment where justice requires it is an abuse of discretion (Citations.), the objectionable subject matter of the amendment, the conduct of the moving party, or the belated presentation of the amendment are appropriate matters for the reviewing court to consider in evaluating the trial court's exercise of discretion."[118] "The law is also clear that even if a good amendment is proposed in proper form, unwarranted delay in presenting it may — of itself — be a valid reason for denial. The cases indicate that the denial may rest upon the element of lack of diligence in offering the amendment after knowledge of the facts, or the effect of the delay on the adverse party."[119]

The Controller's refusal to consider the evidence included in the original claim filing was incorrect as a matter of law and arbitrary and capricious and entirely lacking in evidentiary support. Nowhere in the record did the Controller identify how it or any another person would be prejudiced by allowing the claimant to amend its claim. The claimant did not engage in unwarranted delay; rather, the claimant objected to the Controller's draft audit within 20 calendar

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[114] "No variance between the allegation in a pleading and the proof is to be deemed material, unless it has actually misled the adverse party to his prejudice in maintaining his action or defense upon the merits. Whenever it appears that a party has been so misled, the Court may order the pleading to be amended, upon such terms as may be just." Code of Civil Procedure section 469.

[115] "Any judge, at any time before or after commencement of trial, in the furtherance of justice, and upon such terms as may be proper, may allow the amendment of any pleading or pretrial conference order." Code of Civil Procedure section 576.

[116] *Smeltzley v. Nicholson Mfg. Co.* (1977) 18 Cal.3d 932, 934 ["California courts have established the rule that an amended complaint relates back to the filing of the original complaint, and thus avoids the bar of the statute of limitations, so long as recovery is sought in both pleadings on the same general set of facts."].

[117] *Atkinson v. Elk Corp.* (2003) 109 Cal.App.4th 739, 761 [citations and internal punctuation omitted].

[118] *Roemer v. Retail Credit Co.* (1975) 44 Cal.App.3d 926, 939.

[119] *Roemer v. Retail Credit Co.* (1975) 44 Cal.App.3d 926, 939-940.

days of receipt. The claimant did not alter its theory of the case late in the proceedings; rather, the claimant's theory of reimbursement never varied. The claimant was not seeking to submit new evidence; the line items of claimant's Form FCP-2.1 contained the relevant evidence. The claimant was not adding to or increasing its claim; it was merely seeking to have the Controller treat the claim as if the information contained in Form FAM-27 had been accurately calculated. The Controller was not mislead; during the course of its audit, the Controller recognized the omitted $516,132 for the arithmetic error it was. The Controller did not challenge the veracity of the line items listed on the claimant's Form FCP-2.1. The Controller has not explained in the record how correcting an audit report which was still in draft form would have resulted in a prejudice, nor has the Controller explained in the record how the Controller or any third party is prejudiced by reimbursing the claimant for costs which, it is undisputed, the claimant actually incurred and which the law requires be reimbursed.

The record reveals at best one potential prejudice to an amended claim: the State of California may be required to reimburse the claimant an additional $258,053.49 (50 percent of the omitted disability benefit costs). But such a payment is not an example of a prejudice sufficient to deny leave to amend; the payment would, if all other aspects of the claimant's paperwork are in order, be a legal duty. Throughout the constitutional and statutory scheme related to mandates, the duty to reimburse is worded in affirmative and mandatory language. Section 6 of article XIII B of the California Constitution provides that, once the existence of a mandate has been established, "the State *shall* provide a subvention of funds to reimburse that local government . . . ." Government Code section 17561(a) states that "[t]he state *shall* reimburse each local agency and school district for *all* 'costs mandated by the state[.]'" (Emphases added.) Government Code section 17561(d) states that the "[t]he Controller *shall* pay any eligible claim pursuant to this section by October 15 or 60 days after the date the appropriation for the claim is effective, whichever is later." With regard to both initial reimbursement claims and claims made in subsequent fiscal years, "[t]he Controller *shall* pay these claims" from the funds appropriated therefor.[120] The State cannot be prejudiced by the requirement that it follow its own laws.

With regard to the question of whether the Controller's action is supported by evidence in the record, the answer is no. All of the evidence contained within the line items of the claimant's Form FCP-2.1 supports the claimant's position that it incurred $516,132 in total disability costs which the Controller excluded when calculating the claimant's reimbursement. No evidence in the record supports the Controller's conclusion that $516,132 in disability benefit costs was "unclaimed" or that the claimant was not entitled to a reimbursement which was calculated including the $516,132 in disability benefit costs.

Based on this record, the Commission finds that claimant did in fact claim the $516,132 in disability benefit costs and that the Controller has not shown that any prejudice would result by allowing the claimant to correct the mathematical error on its Form FCP-2.1.

Accordingly, the Controller's decision to deem $516,132 in disability benefit costs specifically identified on Form FCP-2.1 as "unclaimed" — when, in fact, the costs were claimed but accidentally omitted from the claim cover sheet — was arbitrary, capricious, and entirely lacking

[120] Government Code section 17561(d)(1)(C)(2). (Emphases added.)

in evidentiary support.[121] Under the law, the correction of the mistake relates back to the claim's original filing date of January 10, 2005 and is timely.[122]

B. The Controller's position that Government Code sections 17560 and 17568 bar claimant from correcting its claim is incorrect as a matter of law.

The Controller argues that by the time that the claimant served its protest letter dated August 6, 2009, the claimant's statutory time limit to amend a claim had expired.[123]

At the time that the claimant submitted its claim to the Controller in January 2005, Government Code section 17560(b) read:

> A local agency or school district may, by January 15 following the fiscal year in which costs are incurred, file an annual reimbursement claim that details the costs actually incurred for that fiscal year.[124]

At the time that the Controller received the objection letter from the claimant and issued the final audit report (the year 2009), the above-quoted portion of Government Code section 17560 read the same, except that "January 15" had been amended to read "February 15" and that the entire provision, previously designated subdivision (b), had been re-designated subdivision (a).[125]

At the time that the claimant submitted its claim to the Controller in 2005, Government Code section 17568 read in relevant part:

> If a local agency or school district submits an otherwise valid reimbursement claim to the Controller after the deadline specified in Section 17560, the Controller shall reduce the reimbursement claim in an amount equal to 10 percent of the amount which would have been allowed had the reimbursement claim been timely filed, provided that the amount of this reduction shall not exceed one thousand dollars ($1,000). In no case shall a reimbursement claim be paid which is submitted more than one year after the deadline specified in Section 17560.[126]

In 2009, when the Controller received the objection letter from the claimant and issued the final audit report, the above-quoted portions of Government Code section 17568 read the same, except

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[121] Since the Commission's ruling regarding the Controller's refusal to grant leave to the claimant to amend its claim disposes of this IRC, the Commission declines to address the other arguments proffered by the parties.

[122] *Smeltzley v. Nicholson Mfg. Co.* (1977) 18 Cal.3d 932, 934.

[123] Exhibit A, IRC, page 21; Exhibit B, Controller's Late Comments on IRC, pages 8, 10, 11.

[124] Statutes 1998, chapter 681, section 4. This version of Government Code section 17560 was in effect from September 22, 1998, to August 24, 2007.

[125] Statutes of 2007, chapter 179, section 15 [in effect from August 24, 2007, to February 16, 2008]; Statutes of 2008, 3rd Extraordinary Session, chapter 6, section 3 [in effect from February 16, 2008, to the present].

[126] Statutes 1989, chapter 589, section 2, emphasis added. This version of Government Code section 17568 was in effect from January 1, 1990, to August 24, 2007.

that the amount of $1,000 had been raised to $10,000[127] and that the two occurrences of the word "which" had been changed to "that."[128]

Government Code sections 17560 and 17568 as amended by Statutes 1989, chapter 589 which are quoted above and which were in effect when the claimant submitted its reimbursement claim in January 2005 therefore apply to this Decision.

Consequently, in order for the claimant to timely request reimbursement of actual expenses incurred in fiscal year 2003-2004 pursuant to Government Code sections 17560 and 17568, the claimant was required to file a reimbursement claim on or before January 15, 2005 which claimant did[129]. If the claimant had filed the claim between January 16, 2005, and January 15, 2006, the Controller would have been required to reduce the claim by 10 percent up to a maximum reduction of $1,000. If the claimant had filed the claim on or after January 16, 2006, the Controller would have been required to deny the claim in its entirety.

The Controller takes the position that Government Code sections 17560 and 17568 prohibited claimant from amending its reimbursement claim after the draft audit report was issued. "It is the city's responsibility to ensure that it files accurate mandated cost claims within the statutory time allowed. Government Code section 17568 states, 'In no case shall a reimbursement claim be paid that is submitted more than one year after the deadline specified in [Government Code] section 17560.' The city did not amend its FY 2003-04 mandated cost claim within the statutory timeframe permitted."[130]

The claimant's counter-argument reads, "The city did not need to 'amend' its claim, inasmuch as each and every dollar pertaining to it was in fact submitted in full detail. While SCO obliquely refers to 'mathematical errors on a supporting schedule' this very supporting schedule — in fact submitted and audited by them — provides all of the details of the claims."[131]

The claimant continues, "SCO's reference to the filing deadline having expired for FY 2003-04 is, as already noted, erroneous. Government Code Section 17561, subsection (d)(2)(C) states: [¶] 'The Controller shall adjust the payment to correct for any underpayments or overpayments that occurred in previous fiscal years.' [¶] There is in fact no time limit attached to this provision. Any overpayment, including those owing to an error of arithmetic, would presumably be the subject of a subsequent offset or recovery by the Controller's Office. Hence, under the terms of the statute, the amount 'disallowed' should have been recalculated and deemed included in the amount claimed."[132]

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[127] Statutes 2007, chapter 179, section 20. This version of Government Code section 17568 was in effect from August 24, 2007, to February 16, 2008.

[128] The current version of Government Code section 17568 came into effect on February 16, 2008. (Statutes 3rd Extraordinary Session 2008, chapter 6, section 4.)

[129] Exhibit A, IRC, page 34.

[130] Exhibit A, IRC, page 21. See also Exhibit B, Controller's Late Comments on IRC, pages 10, 11 [similar language].

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

[132] Exhibit C, Claimant's Rebuttal Comments, page 4.

The Commission is not persuaded by either party's argument.

Government Code sections 17560 and 17568 do not support the Controller's position that the claimant no longer had the ability to correct the claim. Government Code section 17560(b) requires a claimant to "file" a claim by a certain deadline; Section 17568 authorizes the Controller to reduce (up to a specified cap) a claim which a claimant "submits" up to one year late; Section 17568 prohibits the Controller from paying any claim which was "submitted" more than one year late.

Putting aside the question of whether there is a difference between a claim being "filed" as opposed to "submitted," the Controller does not dispute the fact that the claimant filed its claim on January 10, 2005, and that, at the time of the filing, the claimant's Form FCP-2.1 contained a four-page listing of all of the relevant disability benefit costs which, by this IRC, the claimant is requesting be included in the total used to calculate the claimant's reimbursement. Claimant was not and is not attempting to add new or late-filed data. Consequently, the claimant's request for reimbursement — a claim which listed the disputed $516,132 in disability benefit costs — was timely filed under Section 17560(b).

Both Government Code section 17560(b) and section 17568 are silent regarding a claimant's ability to amend a previously and timely filed claim. The Controller has not adopted regulations on point. Therefore, as explained above, the Commission applies the law regarding amendments of pleadings to correct a mistake or to conform to proof, and, under that body of law, the Controller's actions constituted an abuse of discretion and are incorrect as a matter of law. Neither Government Code section 17560(b) nor 17568 alters that result.

Meanwhile, Government Code section 17561(d)(2)(C) — 'The Controller shall adjust the payment to correct for any underpayments or overpayments that occurred in previous fiscal years.' — does not have the effect that claimant urges. Section 17561(d)(2)(C) "pertains to the Controller's audit function, allowing the Controller to correct inaccurate fund disbursements after auditing the local entity's supporting records."[133] There is no evidence in the record that the Legislature intended the provision to affect the limitations period for filing or submitting claims. The provision certainly does not authorize the Controller to overpay a claimant because the Controller also has authority to make a later downward adjustment, as the claimant seems to argue.[134] In any event, the provision is irrelevant to this IRC, which is about the Controller's authority to refuse to allow the amendment of the claimant's Form FAM-27 rather than being about the Controller's authority to make upward and downward adjustments in later fiscal years.

Accordingly, the Commission finds that Controller's position that the claimant no longer had the ability to correct the claim based on Government Code sections 17560 and 17568 is incorrect as a matter of law.

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[133] *California School Boards Ass'n v. State of California* (2011) 192 Cal.App.2d 770, 789.

[134] "Any overpayment, including those owing to an error of arithmetic, would presumably be the subject of a subsequent offset or recovery by the Controller's office. Hence, under the terms of the statute, the amount 'disallowed' should have been recalculated and deemed included in the amount claimed." Exhibit C, Claimant's Rebuttal Comments, page 4.

C. A line of Court of Appeal decisions upholding the authority of the Medi-Cal program to refuse to allow the amendment of reimbursement claims is not applicable to this IRC.

A line of published Court of Appeal decisions held that the formerly named Department of Health Services (Department) acted within its authority in declining to allow the amendment of erroneous reimbursement claims submitted under the Medi-Cal program. However, as explained below, these cases are not applicable to this IRC.

In *Mission Community Hospital v. Kizer* (*Mission Community Hospital*), a hospital which had entered into a settlement agreement with the Department for the hospital's 1983-1984 fiscal year submitted a Medi-Cal cost report for the following fiscal year. According to the hospital, however, it erroneously failed to carry forward financial terms from the settlement agreement, and the Department refused to allow the hospital to amend its cost report.[135]

A unanimous panel of the Second District Court of Appeal affirmed the Department's decision. The Court found that the Department had promulgated a regulation which specified the time period during which cost reports could be amended; since the hospital attempted to amend its cost report after the specified time period, the Department acted within its discretion in refusing to grant leave to amend.[136]

Specifically, the court held, the Department had promulgated Section 51019 of title 22 of the California Code of Regulations, which "provided that amended cost reports may be submitted only during the period before the cost report determination becomes final."[137] The Court held that the regulation was entitled to judicial deference.[138] Since the hospital had attempted to amend its cost report six months after the Department accepted the cost report as final, the court ruled that Section 51019 authorized the Department to reject the attempted amendment.[139]

In *Coastal Community Hospital v. Belshe* (*Coastal Community Hospital*), two hospitals submitted cost reports to the Department and requested reimbursement for expenses incurred under the Medi-Cal program. The cost reports contained errors, although the exact nature of the errors was not described in the appellate opinion. Because of the errors, the two hospitals requested reimbursements which were lower than what the hospitals were arguably due.[140]

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[135] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1686-1687.

[136] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1690-1691.

[137] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1691. See also Cal. Code Regs., title 22, section 51019(a) ["An amended cost report may be submitted by a provider and accepted by the Department for the fiscal period or periods for which proceedings are pending under this article."].

[138] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1691 ["section 51019 is entitled to our deference"].

[139] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1691-1692.

[140] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 393-394.

Without conducting an audit, the Department approved the cost reports "as filed," meaning that the Department agreed to reimburse the hospitals for the amounts requested on the face of the cost reports.[141]

After the Department's approval of the cost reports, the hospitals learned of their errors and requested an administrative appeal within the Department in order to obtain a larger reimbursement.[142] An administrative law judge denied the hospitals' request.

The unanimous panel of the Second District Court of Appeal affirmed, holding that the hospitals had no right to an administrative appeal. "[P]etitioners logically cannot be aggrieved by the Department's decision to accept as true petitioners' representations regarding the amount of reimbursement due them," the court held.[143] "Indeed," the court continued later in the opinion, "it would be more accurate to say that petitioners were aggrieved by their own failure to amend their cost reports in a timely manner so that, when the Department accepted the reports as filed, petitioners would be entitled to a larger reimbursement."[144]

In *Kaiser Foundation Hospitals v. Belshe* (*Kaiser Foundation Hospitals*), nine hospitals owned or affiliated with Kaiser Foundation Hospitals (Kaiser) filed inaccurate cost reports seeking Medi-Cal reimbursements. The Department served letters upon each of the nine hospitals indicating that, in accordance with Medi-Cal's multi-part process for calculating reimbursement amounts, the Department had arrived at a "tentative cost settlement" for each hospital. None of the hospitals responded to the letters which provided notice of the tentative cost settlements; the Department then accepted the cost reports "as filed" and authorized payment in the amount that each hospital had requested on the face of its claim.[145]

The hospitals objected to the final settlements and requested leave to file amended cost reports to "reflect claims not included at time of filing."[146] During the ensuing litigation, the hospitals stated that their initial cost reports were erroneous because the cost reports contained an incorrect number of Medi-Cal patient days, a statistic which was used in establishing reimbursement rates.[147]

A unanimous panel of the Third District Court of Appeal ruled in favor of the Department on three intertwined grounds.[148]

The Court of Appeal cited *Coastal Community Hospital* for the proposition that, "[i]f the reimbursement amount matches that claimed by the provider, the provider is not aggrieved and is

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[141] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 393-394.

[142] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 393-394.

[143] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 395.

[144] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 395.

[145] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1552-1556.

[146] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1556.

[147] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1556-1558.

[148] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1558-1561.

precluded from filing an appeal."[149] Furthermore, the relevant Medi-Cal regulation limits an appeal to a situation in which a requested reimbursement amount was adjusted — but no adjustment occurred if the claim was approved as filed.[150]

The Court of Appeal noted that, since a hospital's executive officer was required to certify a claim, the amount of reimbursement requested and the underlying data are deemed to be true and correct if the Department declines to audit or review the claim.[151] "The requirement that a provider file a true and correct cost report is therefore of great importance: a provider who files an incomplete or inaccurate report runs the risk of losing reimbursement to which it is entitled," the Court of Appeal explained.[152]

The Court of Appeal noted that the nine Kaiser hospitals failed to timely amend their cost reports.[153] Department regulations provided the hospitals with the ability to amend their cost reports at any time before final settlement of the cost reports — but the nine hospitals waited until two weeks after receiving most of the final settlement letters to request amendment.[154]

The Court of Appeal explained,

> In short, a provider is statutorily required to submit true and correct cost reports to the Department. ([Welfare and Institutions Code] § 14107.4, subd. (c).) In order to ensure that this requirement is met, a provider also has the obligation to provide

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[149] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1560. See also *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1561 ["Kaiser was reimbursed for precisely the amount it had claimed as due. Under these circumstances, Kaiser has no complaint."].

[150] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1560 ["As title 22, section 51017 of the California Code of Regulations provides, an appeal can be taken only from an adjustment to a reimbursement claim. A claim that is accepted as filed is not adjusted, and therefore no appeal will lie."].

[151] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1559-1560. See also Welfare and Institutions Code section 14170(a)(1), which currently reads in relevant part, "Cost reports and other data submitted by providers to a state agency for the purpose of determining reasonable costs for services or establishing rates of payment shall be considered true and correct unless audited or reviewed by the department within 18 months after July 1, 1969, the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Moreover the cost reports and other data for cost reporting periods beginning on January 1, 1972, and thereafter shall be considered true and correct unless audited or reviewed within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later."

[152] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1560.

[153] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1560-1561.

[154] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1556, 1560-1561. See also Cal. Code Regs., title 22, section 51019(a), which currently reads, "An amended cost report may be submitted by a provider and accepted by the Department for the fiscal period or periods for which proceedings are pending under this article."

> amended cost reports in a timely fashion if the initial reports are incorrect. To hold otherwise would permit providers to file incomplete and/or erroneous cost reports and rely on the Department to correct these errors and provide the proper amount of reimbursement, a result at odds with the clear intent of section 14107.4, subdivision (c). Kaiser had more than one year in which to file amended cost reports to include any additional reimbursable costs. It did not do so. Any fault lies with the provider, not the Department.[155]

The decisions in *Mission Community Hospital*, *Coastal Community Hospital* and *Kaiser Foundation Hospitals* are meaningfully distinguishable from the situation presented in the instant IRC.

In *Mission Community Hospital* and *Kaiser Foundation Hospitals*, the claimants were attempting to add new and additional claims or information to their cost reports;[156] *Coastal Community Hospital* does not specify the nature of the claimant's error but, based on language in the opinion, the claimant was also attempting to add new and additional claims or information.[157] In contrast, the claimant in this IRC had submitted all relevant costs in its Form FCP-2.1 and was merely attempting to correct the face of its Form FAM-27; the claimant in this IRC was not attempting to add new or additional claims or information.

The Medi-Cal program does not reimburse a claimant for its actual costs. Rather, following a federal revision of the program in 1980 and 1981, a claimant is entitled to be reimbursed according to a formula "based upon the costs that would have been incurred by an efficient and economically operated facility, even if a provider's actual costs were greater."[158] While the actual costs contained in the cost reports are a factor in determining a Medi-Cal claimant's ultimate reimbursement, the cost reports are merely one part of the equation.[159] In contrast, a claimant incurring state-mandated expenses is entitled to a reimbursement of all actual costs mandated by the state, and the claimant's actual costs are the principal variable in the equation when the claimant is (like the claimant in this IRC) requesting reimbursement under an actual cost methodology.[160] While both the Medi-Cal program and the state mandate program involve claimants filing requests for reimbursement of expenses, the two programs are fundamentally

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[155] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1561.

[156] *Mission Community Hospital v. Kizer* (1993) 13 Cal.App.4th 1683, 1685-1686; *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1556-1558.

[157] *Coastal Community Hospital v. Belshe* (1996) 45 Cal.App.4th 391, 395 ["inaccuracies in the cost reports which resulted in a lesser reimbursement"].

[158] *Robert F. Kennedy Medical Center v. Belshe* (1996) 13 Cal.4th 748, 752.

[159] "[T]he audited cost report data . . . became only one factor in the final determination of reimbursement liability. . . . . The final determination of the amount of reimbursement due a provider, therefore, requires calculations beyond the mere auditing of the hospital's cost report data." *Robert F. Kennedy Medical Center v. Belshe* (1996) 13 Cal.4th 748, 757.

[160] Government Code section 17561(a) states that "[t]he state shall reimburse each local agency and school district for *all 'costs* mandated by the state[.]'" (Emphasis added.)

different in terms of the claimant's legal entitlement and the State's use of the submitted expense data.

Furthermore, claimants seeking reimbursement under Medi-Cal operate within a web of federal and state statutes and regulations which provide the claimants with notice of myriad substantive and procedural requirements — including deadlines to amend or correct claims. The *Mission Community Hospital* and *Kaiser Foundation Hospitals* courts based their decisions in part on the fact that the claimants had been placed on notice by a state regulation that the claimants could file amended cost reports with the Department any time before the final settlement of the cost reports.[161] In a decision involving a different aspect of the Medi-Cal program, claimants were placed on notice by a statute that the Department had the ability to correct mathematical or typographical errors.[162]

In sharp contrast, the Controller has not issued regulations regarding the procedure to be followed by claimants or by the Controller when mandate reimbursement claims are audited. Unlike *Mission Community Hospital* and *Kaiser Foundation Hospitals*, the claimant was not placed on notice by the Controller of a deadline by which to amend or correct its previously submitted claim.[163] In the absence of such a regulation, the Controller cannot take advantage of the reasoning in *Mission Community Hospital* and *Kaiser Foundation Hospitals*.

Finally, the *Kaiser Foundation Hospitals* court placed weight on the fact that Medi-Cal cost reports are required by statute to be certified as true and correct by the provider's executive officer[164] and, if unaudited within three years, are deemed to be true and correct.[165] Similarly,

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[161] *Kaiser Foundation Hospitals v. Belshe* (1997) 54 Cal.App.4th 1547, 1560-1561. See also Cal. Code Regs., title 22, section 51019(a) ["An amended cost report may be submitted by a provider and accepted by the Department for the fiscal period or periods for which proceedings are pending under this article."].

[162] *Santa Ana Hospital Medical Center v. Belshe* (1997) 56 Cal.App.4th 819, 824. See also Welfare and Institutions Code section 14105.98(f)(5) ("For purposes of payment adjustment amounts under this section, each disproportionate share list shall be considered complete when issued by the department pursuant to paragraph (1). Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason, other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.").

[163] As discussed above, the statutory deadline for a claimant to file a claim does not constitute a limitation on a claimant's ability to seek to amend a claim.

[164] "The provider's chief executive officer shall certify that any cost report submitted by a hospital to a state agency for reimbursement pursuant to Section 14170 shall be true and correct. In the case of a hospital which is operated as a unit of a coordinated group of health facilities and under common management, either the hospital's chief executive officer or administrator, or the chief financial officer of the operating region of which the hospital is a part, shall certify to the accuracy of the report." Welfare and Institutions Code section 14107.4(c).

[165] "Cost reports and other data submitted by providers to a state agency for the purpose of determining reasonable costs for services or establishing rates of payment shall be considered true and correct unless audited or reviewed by the department within 18 months after

the claim in this IRC was certified under penalty of perjury to be true and correct,[166] and the Controller has a three-year window in which to audit mandate reimbursement claims.[167]

A distinguishing difference is that, while the Department in *Kaiser Foundation Hospitals* did not conduct an audit, the Controller did. The certification of the data is a moot issue in this IRC, where the presumption of accuracy created by the certification was superseded by the evidence requested and reviewed by the Controller during its year-long field audit.[168] In addition, the *Kaiser Foundation Hospitals* claimants were attempting to add information; in the instant IRC, the claimant submitted all information at the time it submitted the claim. Finally, a verified pleading may be amended provided that the different sets of allegations are not so contradictory as to carry with them "the onus of untruthfulness"[169]; in the instant IRC, there is no actual contradiction, merely an arithmetic error.

Thus, while a line of Court of Appeal decisions upholds the authority of the Department to reject amended cost reports, the decisions are not applicable to this IRC, which is being decided on the basis that, on this record, the Controller should have granted the claimant leave to amend its Form FAM-27.

V. Conclusion

The Commission finds that the Controller's decision to deem $516,132 in disability benefit costs as "unclaimed" is incorrect as a matter of law and is arbitrary, capricious, and entirely lacking in evidentiary support.

The Commission approves this IRC and, pursuant to Government Code section 17551(d) and section 1185.9 of the Commission's regulations, requests that the Controller reinstate the costs incorrectly reduced.

July 1, 1969, the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Moreover the cost reports and other data for cost reporting periods beginning on January 1, 1972, and thereafter shall be considered true and correct unless audited or reviewed within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later." Welfare and Institutions Code section 14170(a)(1).

[166] Exhibit A, IRC, page 34.

[167] Government Code section 17558.5(a).

[168] See, e.g., *Rogers v. Interstate Transit Co.* (1931) 212 Cal. 36, 38 ["[I]t is well established in this state that a presumption in favor of a party is entirely dispelled by the testimony of the party himself or of his witnesses."]; *Coffey v. Shiomoto* (2015) 60 Cal. 4th 1198, 1210 ["[I]f evidence sufficient to negate the presumed fact is presented, the 'presumption disappears' (Citation.) and 'has no further effect' (Citation.) . . . ."].

[169] *Macomber v. State of California* (1967) 250 Cal.App.2d 391, 399.

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

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

On May 11, 2016, I served the:

Proposed Decision
Firefighter's Cancer Presumption, 09-4081-I-01
Labor Code Section 3212.1
Statues 1982, Chapter 1568
Fiscal Year: 2003-2004
City of Los Angeles, Claimant

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

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on May 11, 2016 at Sacramento, California.

Jill L. Magee
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 3/24/16

Claim Number: 09-4081-I-01

Matter: Firefighter's Cancer Presumption

Claimant: City of Los Angeles

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

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