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DANIEL E. LUNGREN, Attorney General
of the State of California
CHARLTON G. HOLLAND, III
Assistant Attorney General
DENNIS ECKHART, 70730
Supervising Deputy Attorney General
1515 K Street
Sacramento, California 94244-2550
Telephone: (916) 323-8987

Attorneys for Defendants

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

GEORGE HUNT, et al., Plaintiffs, v. MOLLY JOEL COYE, M.D., M.P.H., Director, State Department of Health Services, et al. Defendants.	Civ S-89-836 EJG JFM CLASS ACTION **AMENDED STIPULATION FOR ENTRY OF JUDGMENT FOR PERMANENT INJUNCTION** Fairness Hearing Date: Nov. 19, 1993 Time: 9:00 a.m. Courtroom No. 1

HISTORY OF THE CASE

1. This is a civil rights action brought under 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201 and 2202 to require defendants, the California Department of Health Services (DHS) and its director[1/] (collectively referred to as defendants), to comply with federal Medicaid law in their operation of California's medically needy Medicaid program, also known as the medically needy Medi-Cal or Medi-Cal share-of-cost program.

2. On August 25, 1989, this case was certified as a class action pursuant to Rule 23(a) and (b)(2) of the Federal

1. Dr. Coye has recently been succeeded by Ron Joseph.

Rules of Civil Procedure. The class as certified on August 25, 1989, consisted of all persons who are, were, or will be applicants for or recipients of medically needy Medi-Cal. See Order dated August 25, 1989.

3. Two preliminary injunctions have been issued by the court (see Orders dated August 25, 1989 and December 18, 1989), and defendants agreed to the entry of a third order which grants additional preliminary relief. (See Order dated September 17, 1990.) These orders and actions by the Legislature and by defendants to comply with these orders resolved the procedures for prospective relief on plaintiffs' first two causes of action as follows:

a) Welfare and Institutions Code § 14005.9 has been amended to eliminate the one-month time limit on medical expenses which may be used as income deductions in the Medi-Cal share-of-cost program;

b) Defendants revised the MC-177 Record of Health Cost reporting forms and accompanying instructions to eliminate the limitation that only medical expenses incurred in the month of eligibility (see paragraph 5h) may be used to meet the share of cost. Paragraph two of the Instructions to the Patient found on the back of the MC-177 was revised for use on January 1, 1991, to allow persons who are eligible for Medi-Cal and who have been assessed a share of cost the option of either having their provider complete the MC-177 form or submitting their bills for medical expenses to the county;

c) Defendants issued All County Welfare Directors Letters (ACL) on October 2, 1989, January 19, 1990, May 16, 1990, and August 20, 1990, to implement these orders. These All County Letters are attached as Exhibits A, B, C, and D respectively, and are incorporated as if set forth fully herein.

4. Differences in state and federal concepts and terminology have been the source of disagreements between the parties as to how federal Medicaid law governs the issues in this case. These disagreements were evident in Plaintiffs' (First) Motion for Contempt and for Additional Preliminary Relief dated November 9, 1989, the Court's Order dated December 18, 1989, defendants' appeal of that Order and voluntary dismissal of that appeal dated July 2, 1990, and defendants' separate action against the Secretary of the Department of Health and Human Services and voluntary dismissal of that action (Kizer v. Sullivan, 90-472 EJG (E.D. Ca. 1990)).

DIFFERENCES IN FEDERAL AND STATE MEDICAID TERMINOLOGY

5. The following terms are defined pursuant to either pertinent federal or state authority.

Federal Terms

a) Medically Needy Persons - Certain defined families and aged, blind and disabled persons who meet certain other Medicaid eligibility criteria but whose income exceeds a "medically needy income standard" pursuant to 42 U.S.C. § 1396a(a)(10)(C) and 42 Code of Federal Regulations, Part 435, Subpart D.

b) Medically Needy Income Standard - The medically needy income level applicable in determining the income eligibility of medically needy persons referred to in 42 U.S.C. § 1396a(a)(10)(C) and 42 Code of Federal Regulations, Part 435, Subpart I.

c) Medically Needy Income Eligibility - The determination made by deducting incurred medical expenses from countable income pursuant to 42 U.S.C. section 1396a(a)(10)(C) and 42 Code of Federal Regulations, section 435.831.

d) Spenddown Liability - The term used in section 3628 of the Health Care Financing Administration (HCFA) State Medicaid Manual to refer to the amount by which a medically needy person's countable income exceeds the medically needy income standard for the budget period.

e) Budget Period - The term used in section 3627 of the HCFA State Medicaid Manual to refer to the period in which medically needy income eligibility must be determined pursuant to 42 Code of Federal Regulations, section 435.831. Pursuant to Welfare and Institutions Code section 14005.9, California has adopted a one-month budget period.

State Terms

f) Share of Cost - The term which California uses to refer to the spenddown liability and which, pursuant to Welfare and Institutions Code section 14054, means "[t]he amount of the costs of health care which a person or family eligible under Welfare and Institutions Code sections

14005.4 or 14005.7 must incur prior to being certified by the Department as specified in Welfare and Institutions Code section 14018."

g) Certification for Medi-Cal - Pursuant to Welfare and Institutions Code section 14018, certification for Medi-Cal is defined in title 22, California Code of Regulations, section 50029 to mean "the determination by the county department that a person is eligible for Medi-Cal and has no share of cost, has met the share of cost or is in long-term care and has a share of cost which is less than the cost of long-term care at the Medi-Cal rate."

h) Month of Eligibility - Month in which a share of cost is to be met, pursuant to Welfare and Institutions Code section 14005.9, which provides that Medi-Cal share of cost shall be determined on a monthly basis.

i) Procedure Code - The term used by DHS to refer to the Physicians' Current Procedural Terminology defined in title 22, California Code of Regulations, section 51050 to mean "a coded listing and description of medical services prepared and updated annually by the American Medical Association."

6. For the purpose of ease of implementation, this Amended Stipulation and Order use state Medicaid terminology.

7. In order to resolve all three of plaintiffs' causes of action set forth in their complaint on file herein, and in final settlement of this action, the parties stipulate that the Court may enter a permanent injunction as follows:

JURISDICTION

8. Jurisdiction is conferred pursuant to 28 U.S.C. section 1331.

CLASS DEFINITION

9. The class definition for purposes of permanent injunction is amended as follows: all persons who are or were eligible for medically needy Medi-Cal in any month since July 1988 and who have or had been assessed a share of cost in any such month since July 1988, and all persons who will be eligible for medically needy Medical and who will have a share of cost assessed in the future, as they become eligible and have a share of cost assessed. A class member is any person who falls within this definition.

PROSPECTIVE RELIEF

10. Defendants shall eliminate the limitation that medical expenses incurred only in the month of eligibility may be used to meet the share of cost in the medically needy Medi-Cal program. Defendants shall allow each class member to use unpaid medical expenses incurred prior to the month of eligibility for which the class member is liable and which have not previously been used to meet or reduce the class member's share of cost, to meet or reduce (at the class member's option) the share of cost for the month of eligibility without regard to when the medical expenses were incurred except as limited in paragraphs 13, 14 and 16, below. Specifically, defendants shall take the following steps:

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a) No later than January 1, 1991, defendants shall have permanently revised the Record of Health Costs form (MC-177) to eliminate the limitation that medical expenses incurred only in the month of eligibility may be used to meet the share of cost in the medically needy Medical program; and

b) Permanently remove the edit which conflicts with the revision described in paragraph (a), from the computer program for processing the MC-177 form.

11. Current Medical Bills - Defendants shall permanently eliminate the requirement that the sworn signature of the provider is the sole means for verifying that medical expenses have been incurred in the month of eligibility. For medical expenses incurred in the month of eligibility (whether paid or unpaid) by class members who are eligible and who have been assessed a share of cost, such class members may, in accordance with paragraph 2 of the Instructions to the Patient found on the back of the MC-177 which was revised for use on January 1, 1991, either have their provider complete the MC-177 form or submit medical bills for these expenses to the county. If class members submit such bills, then the provisions set forth in paragraphs 13, 14, 19, 21, 22, and 24, below, are applicable.

12. Old Medical Bills - To establish current liability for unpaid medical expenses incurred in any month(s) before the month of eligibility, which expenses may be used to meet or

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reduce (at the class member's option)[1/] the share of cost of class members who are eligible for Medi-Cal and who have been assessed a share of cost, defendants may instruct counties to require that such class members provide the county with provider invoices, provider billing statements or other satisfactory evidence as provided for in ACLs 90-11, 90-45 and 90-80. Exhibits B, C, and D, respectively. If class members use such provider invoices, provider billing statements or other satisfactory evidence, then the provisions set forth in paragraphs 13 through 20 and paragraphs 22 through 24 are applicable.

13. The Department may instruct the counties that bills for medical expenses must contain the following information:

a) Provider name and address;

b) Medi-Cal provider identification number, taxpayer identification number or provider license number;

c) for medical expenses incurred prior to the month of eligibility, a billing date within the last 90 days;

d) the name of the person receiving the service;

e) the type of service;

f) the date of service;

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1. As used in this Amended Stipulation for Entry of Judgment for Permanent Injunction, the phrase "reduce (at the class member's option)" means that medical expenses incurred prior to the month of eligibility may be used in combination with medical expenses incurred during the month of eligibility in order to meet the share of cost of class members who are eligible for Medi-Cal and who have been assessed a share of cost.

g) for medical expenses incurred prior to the month of eligibility, the amount still owed to the provider; and

h) for medical expenses incurred in the month of eligibility, the amount billed to the beneficiary.

(See Exhibit D, ACL 90-80, Answer 1.)

14. The Department may instruct the counties that bills for medical expenses incurred in the month of eligibility and for all medical expenses incurred after January 1, 1992, should contain a Procedure Code indicating type of service rendered or item supplied to the patient. Additionally, the Department may instruct the counties that in the event the bills specified in this paragraph do not contain a Procedure Code, the class member must provide evidence of making a good faith effort to obtain the Procedure Code. Evidence of making a good faith effort may consist of a sworn statement, as specified in the answer to question five in ACL 90-80, that the class member contacted the provider and was unable to obtain the Procedure Code from the provider for the specified services.

15. Defendants may impose a four-year limit on the age of any bill for medical expenses consistent with statute of limitations set forth in California Code of Civil Procedure section 337. Class members shall be allowed to provide evidence that they remain liable for any medical expense older than four years to the extent consistent with the laws of the State of California, by showing that:

a) the medical expense is less than four years old;

b) the medical expense has been reduced to a judgment;

c) there is a contract extending the statute of limitations for the expense;

d) any payment has been made on the expense within the last four years;

e) there is an agreement to pay on the expense; or

f) there is other reasonable verification showing the person is still responsible for the expense.

(ACL 90-11, Exhibit B.)

16. The Department shall instruct counties to accept bills for medical expenses which have been referred to collection agencies as mandated and set forth in answer four of ACL 90-80. (Exhibit D.)

17. Defendants may instruct counties to require that the billing date for medical expenses be within the last 90 days; however, if defendants do so, defendants shall instruct counties to provide for exceptions to this 90-day requirement if the class member can otherwise verify that the bill is unpaid, as set forth in answer two of ACL 90-80. (Exhibit D.)

18. In the event that a class member is unable to produce a bill that contains the required documentation as specified in paragraphs 13 and 14 above, the class member shall be permitted to make a sworn statement as specified in the answer to question five in ACL 90-80. (Exhibit D.)

19. Defendants shall instruct counties to assist class members who are unable to produce a bill that contains the required documentation as specified in paragraphs 13 and 14 above, in obtaining the missing information. (See ACL 90-80, Exhibit D.)

20. Defendants shall instruct the counties to permit class members to use credit card statements as evidence of having incurred medical expenses if:

a) There are no other charges on the credit card and the class member can show that the charge for medical expenses has not been paid. In order to show that these charges remain unpaid, the class member must provide all charge account statements received since the date of the charge for the medical expense; or

b) The class member can show that the charge for medical expenses and all of the charges made to the credit card since the date of the charge for medical expenses are unpaid. In order to show that these charges remain unpaid, the class member must provide all charge account statements received since the date of the charge for medical expenses.

c) The credit card statement contains all of the required documentation as specified in paragraphs 13 and 14 above, or if a combination of the credit card statement(s) and other original billing statements provide the missing information, a sworn statement may be used within the guidelines of ACL 90-80. (See Exhibit D.)

21. As set forth in ACL 90-80 (Exhibit D), defendants shall instruct the counties to permit class members to use credit card statements as evidence of having incurred medical expenses if the medical expenses charged to the credit card are used to reduce the share of cost for the month in which the medical expenses were incurred.

22. Defendants shall instruct counties to issue Notices of Action (NOA) when the use of medical expenses to meet or reduce the share of cost is approved. The NOA shall indicate, based upon current information available regarding the class members' income, the period of time for which the expenses may be used to meet the share of cost.

23. In accordance with ACL 90-80 (Exhibit D), defendants shall instruct counties to issue a NOA whenever the eligibility worker determines that medical bills reflecting amounts incurred for medical expenses cannot be used to meet or reduce the share of cost. If further documentation is required in order to meet the verification requirements set forth in paragraph 13, defendants shall instruct the counties:

a) To issue a written letter that specifies that the class member is allowed at least 10 days within which to provide the required documentation;

b) To issue the NOA no later than 30 days following the tenth day in the period referred to in paragraph 23(a), denying the use of such expenses if the necessary

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documentation is not received in accordance with paragraph 23(a), and

c) To advise the class member that, following the 10-day period in (a) or after the NOA is issued as set forth in (b), if the class member obtains the documentation required for the medical expense, the expense may be resubmitted to meet or reduce (at the class member's option) the share of cost.

24. Defendants may instruct counties to require that the bill for medical expenses be an "original." If defendants so instruct the counties, then they shall also instruct them that a photocopy of a bill is acceptable if it has an original stamp, an original initial or original signature of the provider on it, or if other original supporting documentation confirms that the bill is an accurate statement of the outstanding balance. (ACL 90-80, Answer one.)

25. Defendants shall issue a comprehensive ACL informing the county welfare departments of all the changes in the medically needy Medi-Cal program resulting from this lawsuit and directing them to comply with the terms of this Amended Stipulation for Entry of Judgment for Permanent Injunction, a copy of which shall be sent to them.

26. Defendants shall, as determined by DHS to be necessary, take corrective actions, prepare training materials and train county welfare departments on the operation

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of the medically needy Medi-Cal program consistent with this order.

27. Defendants shall draft and file with the Office of Administrative Law regulations in accordance with the procedures set forth in California Govt. Code § 11346.1 as necessary to implement the changes specified in paragraphs 10 through 24, above.

28. In order to resolve plaintiffs' third claim for relief concerning the delay between class members' submission of medical expenses for share-of-cost determinations and the issuance of Medi-Cal cards, defendants shall, over the course of eighteen months from December 1, 1990, conduct a comprehensive study of any delays which may exist in the issuance of Medi-Cal cards in the medically needy Medi-Cal program. This study shall examine the cause(s) of any delays discovered. This study shall direct corrective actions as the Department determines necessary. The study shall also examine the effectiveness of any corrective actions implemented. The study shall be statewide. Defendants shall report results of the study to plaintiffs' counsel in bimonthly status reports pursuant to paragraph

29. Defendants shall include the nature and results of any corrective actions in the bimonthly status reports. If any party believes it necessary to conduct a meeting regarding the progress of the above-referenced eighteen-month study and the need for and/or the nature of any corrective actions, such a meeting shall be scheduled

within 20 days after written notice to counsel has been given by either party. The party or parties shall include in the notice of demand for such a meeting a detailed agenda of the issues to be discussed at the meeting. All such meetings shall be held at a time and place agreed upon by the parties. Defendants shall make reasonable efforts to ensure that DHS personnel responsible for the delay study and corrective actions shall be available for these meetings. In the event the parties are unable to agree on the need for and/or nature of corrective actions, plaintiffs may move for additional relief on this claim.

29. Defendants shall, by the 15th of every other month beginning with October 15, 1990, and ending with a final report to be completed by October 15, 1992, provide status reports to plaintiffs. These reports shall summarize the results of the study referred to in paragraph 28 and shall provide plaintiffs with detailed reports on defendants' activities related to implementation of this order. These status reports shall cite each action taken by defendants and the date each is implemented, except that as to delay study provisions the status report requirements are modified as set forth in paragraph 28 above. In addition, these status reports shall also include the nature of inquiries from the counties regarding this lawsuit and of defendants' responses; the numbers, locations and agendas for any training(s) held regarding share-of-cost issues, along with copies of any training material(s) or handouts,

if used; and county statistics, as provided by reporting counties, showing separately the numbers of NOAs issued by the counties both approving and denying the use of medical expenses to meet or reduce a class member's share of cost. The Department shall instruct the counties that the statistics reported should identify the number of times each reason code has been the basis for issuing a denial NOA. Defendants shall also provide plaintiffs with two additional status reports covering the six-month period following defendants' mailing of the comprehensive class notice, described in paragraph 35, below, to the class. These reports shall describe the nature of inquiries received from the counties regarding this lawsuit, the comprehensive ACL referred to in paragraph 25, above, and the comprehensive class notice, and the nature of defendants' responses to those inquiries. The first of these additional status reports will be due on or before January 5, 1994, and will cover the period through December 5, 1993. The second report shall be due on or before June 5, 1994, and cover the period from December 5, 1993, through April 5, 1994.

30. Defendants shall, no later than October 1, 1991, publish in English, and no later than November 1, 1991, publish in Spanish, a new pamphlet explaining in detail and in simple and understandable terms how the medically needy Medi-Cal program operates consistent with the provisions of this order. A draft shall be submitted to plaintiffs' counsel in sufficient time for plaintiffs'

comments and revisions to be considered for incorporation into the pamphlet. Defendants shall subject the pamphlet to a readability review. Defendants shall distribute this pamphlet so that it is available to any interested individual. Defendants shall direct each county to provide a copy of the pamphlet to persons receiving the Medi-Cal Statement of Facts pursuant to title 22, California Code of Regulations §§ 50159 and 50161 no later than the date such form is provided to such persons. Defendants shall also direct each county to provide a copy of the pamphlet to individuals whose eligibility for the medically needy Medi-Cal program is being redetermined as a result of being discontinued from a cash grant program. Defendants shall include a sentence in the ACL referred to in paragraph 25 of this Amended Stipulation for Entry of Judgment for Permanent Injunction, which encourages the county to provide a copy of the pamphlet to class members who are subject to an annual redetermination within the twelve months following issuance of the pamphlet.

RETROACTIVE RELIEF

31. For class members who are eligible for Medi-Cal with a share of cost assessed as of the date the notice referred to in paragraph 35 is issued by DHS, defendants shall treat as unpaid, for the purpose of prospective Medi-Cal share-of-cost determinations for future months' Medi-Cal cards, all medical expenses, whether currently paid or not, which were unpaid at any time during any of the

months in the period July 1988 through May 1990. If, at the end of six months from the date the notice referred to in paragraph 35 is issued by DHS, the class member is ineligible for Medi-cal or is eligible without a share of cost assessed, the medical bills referred to in this paragraph may no longer be used to meet or reduce any share of cost assessed in following months unless they are unpaid. If, at the end of this six-month period, the class member is and remains eligible for Medi-Cal with a share of cost assessed, the class member shall be allowed to continue to use any previously unused medical bills, or portions of such bills, referred to in this paragraph to meet or reduce (at the class member's option) a share of cost.

32. Each class member who is not eligible for Medi-Cal or who is determined eligible for Medi-Cal without a share of cost assessed as of the date the notice referred to in paragraph 35 is issued by DHS, and who was determined eligible for Medi-Cal with a share of cost assessed for any of the months from July 1988 through May 1990 shall be given the option of either a or b set forth below:

a) Using bills for medical expenses, whether paid or unpaid, to meet his or her share of cost for any month from July 1988 through May 1990 in which he or she can show that the bill for such expenses was unpaid at any time in any such month and his/her share of cost would have been met by these medical expenses. Defendants shall issue a Medi-Cal card to the class member for

any month in which the criteria for meeting the share of cost specified in this option have been met.

b) Using bills for medical expenses referred to in paragraph 32(a) to meet or reduce (at the class member's option) his or her share of cost in any future months in which the class member is determined eligible for Medi-Cal with a share of cost assessed. If class members exercise this option, they must be determined eligible with a share of cost assessed within six months from the date the notice referred to in paragraph 35 is issued by DHS in order to submit the bills to meet or reduce their share of cost. If, at the end of six months from the date the notice referred to in paragraph 35 is issued by DHS, the class member is ineligible for Medical or is eligible without a share of cost assessed, the medical bills referred to in this paragraph may no longer be used to meet or reduce any share of cost assessed in following months unless they are unpaid. If, at the end of this six-month period, the class member is and remains eligible for Medi-Cal with a share of cost assessed, the class member shall be allowed to use any previously unused medical bills, and portions of such bills, referred to in this paragraph to meet or reduce a share of cost.

33. If, pursuant to paragraphs 31 or 32, a class member submits a medical bill to the county, paragraphs 16, 18, 19, 20, 22, 23, and 24, above, shall be applicable, and

DHS may require that the bill contain the following information:

a) Provider name and address;

b) Medi-Cal provider identification number, taxpayer identification number or provider license number;

c) the name of the person receiving the service;

d) the type of service;

e) the date of service; and

f) the amount charged for the medical service.

In addition, such bills must demonstrate that the medical expenses were unpaid at some time during any of the months in the period July 1988 through May 1990.

34. Class members referred to in paragraphs 31 and 32 must submit their medical bills for the medical expenses referred to in paragraphs 31 and 32, not later than six months from the date the notice referred to in paragraph 35 is sent to class members by defendants.

CLASS NOTICE

35. By October 5, 1993, defendants shall send a comprehensive notice to all class members ("comprehensive class notice") informing them of their rights pursuant to this order and advising them of the changes to the share-of-cost program resulting from this lawsuit including the procedures for use of medical expenses to meet or reduce (at the class member's option) a share of cost. Until this comprehensive class notice is issued, defendants shall pro-

vide to each class member who is eligible for medically needy Medi-Cal and who has been assessed a share of cost, the MC-177 HK notice distributed in accordance with ACL No. 90-75. The defendants shall instruct counties to distribute the comprehensive class notice to each applicant and reapplicant for medically needy Medi-Cal. Such distribution shall continue for a period of six months from October 5, 1993.

OTHER PROVISIONS

36. Plaintiffs' counsel shall have the opportunity to review and comment on all notices or written information to either class members, county welfare departments, or providers, as required by the above items, and on the wording of emergency regulations drafted by the defendants pursuant to paragraph 27 prior to submission to the Office of Administrative Law. In order to ensure that defendants are able to comply with the time requirements set forth in this order, defendants will specify with each document submitted to plaintiffs' counsel for review, a reasonable time by which comments must be returned to defendants. In the event comments are not received by the defendants within the time period specified, defendants shall be entitled to assume that no comments are forthcoming and may proceed as necessary to achieve compliance with this order. In the event that plaintiffs' counsel objects to the language of the comprehensive ACL or the comprehensive class notice, referred to in paragraphs 25 and 35 respectively, the parties

shall attempt to resolve their disagreement and meet and confer as necessary. If the parties are unable to resolve their disagreement, and plaintiffs contend that as a result of the objectionable language defendants have violated or failed to implement this Amended Stipulation for Entry of Judgment for Permanent Injunction, plaintiffs may seek relief from the court upon five days' notice to defendants. In that event defendants shall not distribute the comprehensive ACL or comprehensive class notice pending judicial review. If plaintiffs petition the court for relief, the timeframes anticipated by this Amended Stipulation for Entry of Judgment for Permanent Injunction shall be suspended until such times as are set by agreement of the parties or by order of the court. Upon plaintiffs' receipt of the final status report referred to in paragraph 29, defendants' obligation to afford plaintiffs' counsel an opportunity to review and comment on documents as provided for in this paragraph shall cease.

37. For a period of one year following the entry of the court order approving this Amended Stipulation, in the event that plaintiffs' counsel objects to defendants' proposed implementation of any portion of this Amended Stipulation and Order or in the event that defendants fail to perform any portion of this Amended Stipulation and Order, or in the event that unforeseen problems regarding implementation of a portion or portions of this Amended Stipulation and Order arise, the parties shall attempt to

resolve their disagreement and shall meet and confer as necessary. If they are unable to resolve their disagreement, plaintiffs or defendants may seek relief from the court upon five days notice to opposing counsel.

38. Defendants shall make all good faith efforts to see that the terms of this Amended Stipulation and Order are fully implemented. Defendants, as the single state agency for Medicaid pursuant to 42 C.F.R. § 431.10(e)(3), shall make every reasonable effort to ensure that the counties follow defendants' instructions for implementation of this Amended Stipulation and Order and that the counties do not substitute their judgment with respect to application of the provisions of this order.

39. This Amended Stipulation for Entry of Judgment for Permanent Injunction shall be binding upon the Director of DHS, his agents, employees, and successors in interest.

40. It is understood between the parties that there remain disagreements between them as to the following items, and that this injunction therefore shall not bar further legal or administrative actions, independent of this action, as to the following items:

a) whether interest or finance charges which accumulate on incurred medical expenses can be used as medical expenses for share-of-cost purposes;

b) how to treat medical expenses paid through loans, or charged to credit cards when other items have

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also been charged and when the situations referred to in paragraphs 20 and 21 do not exist;

c) how to treat third-party payor situations, i.e., when the Medi-Cal beneficiary has private insurance with deductibles and partial coverage; and

d) whether long-term care patients are included in this class.

41. Defendants shall not take any appeal from the order entered upon this Amended Stipulation for Entry of Judgment for Permanent Injunction.

42. In the event that defendants attempt to bring a separate action against any federal official or agency related to any issue raised by this action, defendants shall provide a copy of the complaint to plaintiffs' counsel at the time of its service on any defendant, and shall not oppose any intervention in that action by any plaintiff or class member herein.

43. The parties declare, represent, acknowledge, and agree that no promise, inducement or agreement not herein expressed has been made to plaintiffs or defendants and that this Amended Stipulation for Entry of Judgment for Permanent Injunction contains the entire agreement between the parties.

44. The parties agree that this Amended Stipulation is the product of mutual negotiations and is deemed to have been drafted by both plaintiffs and defendants.

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45. This Amended Stipulation for Entry of Judgment for Permanent Injunction has been drafted pursuant to current federal and state law. In the event that a change occurs in either federal or state law, it is agreed that DHS shall implement mandatory changes, and may implement optional changes, in federal law and in state law insofar as it is consistent with federal law. However, during the period of time that the court retains jurisdiction, DHS shall provide plaintiffs' counsel with written notice prior to implementing mandatory changes which affect this Amended Stipulation and in the event an optional change in state or federal law occurs which impacts this Amended Stipulation, DHS shall meet and confer with plaintiffs' counsel to attempt to resolve by further stipulation any modification of this Amended Stipulation prior to implementing any changes which affect it. For an additional period of 30 months, DHS will provide plaintiffs' counsel with written notice prior to implementing mandatory or optional changes in state or federal law that impact this Amended Stipulation.

46. The Court shall retain jurisdiction for a period of thirty months from the date of entry of this Order to enforce or amend any provision of this order and, if necessary, to modify or clarify any of its provisions upon noticed motion by counsel for any party. This clause does not prohibit any party, after the thirty-month period, from instituting enforcement procedures for violations of the permanent injunction as otherwise provided by law.

COSTS AND ATTORNEYS' FEES

47. Plaintiffs are prevailing parties in this lawsuit for purposes of attorneys' fees under 42 U.S.C. section 1988. Notwithstanding Local Rules 292 and 293, plaintiffs may move for an award of reasonable attorneys fees and for costs no later than 180 days after the date of entry of this order. Plaintiffs' counsel shall, within three months of entry of this order, submit to defendants compilations documenting their hours for an award of reasonable attorneys fees. The parties shall make a good faith effort to resolve and settle the question of payment of reasonable attorneys' fees and costs prior to submitting the issue to the Court for adjudication.

48. In consideration of this agreement, and in order to avoid duplication of litigation, defendants hereby waive any defense which they may have under the Eleventh Amendment to the United States Constitution insofar as is necessary to enable the Court to award retroactive benefits to the class members pursuant to this Amended Stipulation for Entry of Judgment for Permanent Injunction.

49. The parties acknowledge that they must seek court approval for this Stipulation pursuant to Fed. R. Civ. P. 23. In the event that obtaining court approval for entry of the judgment pursuant to this Amended Stipulation for Entry of Judgment for Permanent Injunction renders compliance with the timeframes anticipated herein impossible, the

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timeframes may be suspended until such times as are set by agreement of the parties or by further order of the court.

The parties agree and stipulate to the foregoing.

Dated: Nov. 4, 1993

LEGAL SERVICES OF NORTHERN CALIFORNIA
WESTERN CENTER ON LAW AND POVERTY
NATIONAL HEALTH LAW PROGRAM

Eugenie Denise Mitchell

EUGENIE DENISE MITCHELL
Attorney at Law

Attorneys for Plaintiffs

DANIEL E. LUNGREN, Attorney General
of the State of California
CHARLTON G. HOLLAND, III
Assistant Attorney General

Dennis Eckhart

DENNIS ECKHART, Supervising Deputy
Attorney General

Attorneys for Defendants

DEPARTMENT OF HEALTH SERVICES

By: Jose Fernandez

JOSE FERNANDEZ, Deputy Director,
Medical Care Services

ORDER

The Court finds that:

1) the terms of this Amended Stipulation are fair to the members of the class;

2) the class has been adequately represented in the negotiations which resulted in this Stipulation;

3) class notice has been adequately provided for; and

4) this is an action seeking solely injunctive and declaratory relief.

The foregoing appearing satisfactory to the Court and pursuant to Rule 23(e) of the Federal Rules of Civil Procedure, the same is approved and SO ORDERED this 19th day of Nov, 1993.

UNITED STATES DISTRICT JUDGE

DECLARATION OF SERVICE BY MAIL

Case Name: HUNT v. COYE

Court No.: U.S.D.C. No. S-89-836 EJG JFM

I declare:

I am employed in the County of Sacramento, California. I am 18 years of age or older and not a party to the within entitled cause; my business address is 1515 K Street, P. O. Box 944255, Sacramento, California 94244-2550.

On November 8, 1993, I served the attached

AMENDED STIPULATION FOR ENTRY OF JUDGMENT FOR PERMANENT INJUNCTION

in said cause, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Sacramento, California, addressed as follows:

Eugenie Denise Mitchell
Managing Attorney
LEGAL SERVICES OF
NORTHERN CALIFORNIA
1370 West Street
Redding CA 96001

Melinda R. Bird
Western Center on Law
and Poverty
3535 W Sixth Street
Los Angeles CA 90020

William H. Whitaker
Northern California Legal
Services
190 Reamer Street
Auburn CA 95603

Michael C. Parks
Michele Melden
National Health Law Program
2639 S La Cienaga Blvd.
Los Angeles CA 90034

I declare under penalty of perjury the foregoing is true and correct, and that this declaration was executed at Sacramento, California on November 8, 1993.

D. CRISWELL

EXHIBIT A

STATE OF CALIFORNIA—HEALTH AND WELF. EALTY
DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
GEORGE DEUKMEJIAN, Gover

TO: All County Welfare Directors
All County Administrative Officers

October 2, 1989
Letter No.: 89-87

SUBJECT: HUNT vs KIZER IMPLEMENTATION

BACKGROUND:

As a result of a recent Preliminary Injunction issued by the U. S. District Court in the case of Hunt vs. Kizer, any Medi-Cal applicant or beneficiary (including those in long term care) having old medical expenses incurred and unpaid prior to the date he/she became eligible for Medi-Cal must be allowed to use these medical expenses to reduce his/her share-of-cost. This decision applies to any person determined eligible for Medi-Cal with a share-of-cost, except those Medi-Cal applicants and beneficiaries being aided under state only programs (Aid codes 53 and 81).

The Preliminary Injunction issued by the U.S. District Court requires the Department of Health Services (DHS) to "eliminate the month-of-application time limit on medical expenses incurred that may be used as income deductions in the medically needy Medi-Cal share-of-cost program." Medical expenses incurred has been interpreted by the U. S. Department of Health and Human Services to mean "only those unpaid medical expenses for which the applicant is still liable, incurred at anytime prior to the date of application for Medi-Cal." As part of the injunction, DHS was required to notify share-of-cost recipients of this change. Attachment 1 is the recipient notice that was sent on October 1, 1989 to all Medi-Cal beneficiaries who were eligible with a share-of-cost on September 1, 1989.

COUNTY PROCEDURES

To comply with this court order, which became effective September 1, 1989 counties must use old unpaid medical expenses to reduce the current or the future month(s) share-of-cost. This means that anyone having unpaid medical expenses for which they are still legally liable, with dates of service prior to his/her effective date of eligibility for Medi-Cal must have these bills used toward reducing the share-of-cost in current and if necessary future month(s). A person is considered to be legally liable for the debt if the debt is less than four years old, there is a judgment, or a contract extending the statute of limitations or other reasonable verification showing the person is still responsible for the debt.

EXHIBIT A

Intake:
At intake the applicant must be informed of his/her right to use old medical expenses incurred prior to the date of eligibility. These expenses will be used to reduce the current and, if necessary, future month(s) share-of-cost. A copy of "Important Notice - Hunt v Kizer Lawsuit" is included as Attachment 2. This notice must be provided to all persons who have applied for Medi-Cal and been approved since September 1, 1989 and to all future applicants.

Continuing:
Persons currently on Medi-Cal with a share-of-cost may request consideration of their old medical expenses that were unpaid, prior to the date of eligibility. These expenses will be used to reduce the current and, if necessary, future month(s) share-of-cost.

Required Documentation:
Medi-Cal eligibility workers must review the billing statements for old medical expenses from the medical providers to ensure that the required information is provided. If any of the items listed below are missing, the Medi-Cal applicant must contact the provider to obtain the information. Bills with any of the required items missing are not acceptable.

Bills being used to reduce an applicant's or beneficiary's share-of-cost must have:

1. a current billing date;
2. the provider's name and address;
3. the name of the person receiving the service;
4. the type of service;
5. date of service;
6. the amount owed in the month for which eligibility is established;
7. the provider federal tax identification number or provider license number or Medi-Cal provider identification number.

Adjusting the Share-of-Cost:
When all of the necessary information is provided, the county workers shall complete an MC176 M noting in the Underpayment Adjustment Box (Column III, line 15) "OME" (Old Medical Expenses) and the amount of the adjustment. Make a copy of the bill for the applicant and retain the original in the case file. Original bills are not to be returned to the applicant.

Cases must be flagged (either manually or on MEDS [REDETERM-MONTH]) so the counties will be alerted when it is necessary to readjust the reduced share-of-cost. The share-of-cost must be recomputed prior to the 20th of the last month in which the old medical expenses have been used to reduce the share-of-cost. A ten day Notice of Action advising the beneficiary of the return to his/her previous share-of-cost must be sent in the month prior to the change.

If original bills with dates of service prior to the first month of Medi-Cal eligibility are presented at any time, counties must adjust the beneficiary's current and, if necessary, future month(s) share-of-cost.

Medical expenses may be used for anyone who would have been a member of the MFBU on the date the medical expenses were incurred.

Denied Medical Bills:
When reviewing the medical bills to determine if the required information is included, note on each original bill either "accepted - Hunt vs. Kizer" or "Denied - reason code (numbers 1-8) Hunt vs. Kizer."

Denial Codes:

1. Billing date not current.
2. Provider's name or address missing or illegible.
3. Name of the person receiving the service is missing or illegible.
4. Type of service not provided.
5. Date of service not provided.
6. Amount owed not provided.
7. Missing or illegible provider's federal tax ID #, license # or Medi-Cal ID #. (only one needed)
8. Failure to provide original bill.

If the original bill appears to have been altered, the applicant must obtain from the provider an unaltered bill. An original bill means one prepared by the provider of services.

Tracking
Counties must maintain a record of the number of new beneficiaries after using old medical expenses to reduce their share-of-cost; the number of continuing beneficiaries who have reduced a future month(s) share-of-cost using old medical expenses; the total amount of the old medical expenses being used; and the amount the share of cost is reduced. Counties may develop their own method of keeping this information. A "Monthly Reporting Form" will be developed to forward your monthly statistics to the DHS, Medi-Cal Eligibility Branch. This form will be provided and shipped to you in

EXAMPLES

Example 1 - Share-of-cost Applicant with Old Medical Expenses
Mr. A applies on September 5, 1989, and is determined eligible with a $300 share-of-cost. He has $1500 in unpaid medical expenses with dates of service between June 1987 and August 31, 1989. These unpaid bills are to be divided and used to meet his share-of-cost for September, October, November, December 1989, and January 1990. Also in January, the county must complete a new MC176 M adjusting his share-of-cost to $300 effective February 1990.

If retroactive Medi-Cal is requested on the MC210, the old medical expenses must have been incurred more than 90 days prior to the date of application.

Example 2 - Utilizing Old Medical Expenses
Mrs. B applies for Medi-Cal on September 23, 1989 and is determined eligible with a $70 SOC. She asks for retroactive coverage for June, July, and August 1989. She has unpaid medical bills in the amount of $35 for services provided in April 1989, one for $18 in May 1989 and a $350 bill for June 1989.

The bills for April and May total $53 thus reducing the June share-of-cost to $17. For June 1989 Mrs. B must list the $350 on an MC177 to show her obligation for $17, which meets her June share-of-cost. The Medi-Cal card will be issued following the usual procedure for June, and the provider can then bill Medi-Cal for the unpaid portion of Mrs. B's June bill.

Example 3 - Applicant Fails to Provide Timely Required Documentation
Mr. C applies for Medi-Cal on October 1, 1989, he informs the eligibility worker that he has unpaid medical expenses for June and July 1989 but does not obtain a medical bill containing all of the necessary information. He is approved for Medi-Cal with a $100 share-of-cost. In December 1989, he brings in the required documentation. His share-of-cost is reduced beginning January 1990 until all of his unpaid medical expenses are used.

Example 4 - Old Medical Expenses for Persons No Longer in the MFBU
Mrs. D is applying for Medi-Cal today. She has unpaid bills for her husband who died in May 1989. Her husband would have been a member of the MFBU had they applied prior to Mr. D's death. Since medical expenses may be used for anyone who would have been a member of the MFBU on the date the medical expenses were incurred, Mr. D's unpaid bills may be used to reduce Mrs. D's future month(s) share-of-cost.

Example 5 - Continuing Medi-Cal Eligible with Old Medical Expenses
Ms. E has been on Medi-Cal with a share of cost since July 1988. In March 1988 she incurred $1200 in medical expenses which were unpaid on the date she became eligible for Medi-Cal. Ms. E has since been paying on these bills and she currently owes $500. On October 3, 1989 she provides documentation of these bills and the amount stilled owed on the date she became eligible. The full $1200 in expenses can be used to reduce her share of cost beginning with her November 1989 month of eligibility.

Questions concerning all aspects of this lawsuit should be directed to Kristi Allen at (916) 445-6855 (policy questions) or Frances Schurer at (916) 322-3463 (MEDS questions). Thank you for your continued cooperation.

Sincerely,

Frank S. Martucci

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Attachements

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: OCTOBER 2, 1990

ATTACHMENT 2

IMPORTANT NOTICE - HUNT V KIZER LAWSUIT

As a result of the recent U.S. District Court decision in the case of Hunt v Kizer, you may now be able to use your old medical bills to meet your current share-of-cost for Medi-Cal. An old medical bill is defined as:

1. A bill for services received less than four years before the date that you applied for Medi-Cal.

2. A bill that you are still legally responsible to pay; and

3. The bill was unpaid at the time you applied for Medi-Cal; and

4. The bill has never been used to meet your share-of-cost.

In order to have your old medical bills considered the bill must meet the following requirements:

1. The bill must be current.

2. The bill must show the amount owed in the month for which Medi-Cal eligibility is established.

3. The bill must show who provided the service and one of the following:
   a. Provider Medi-Cal identification number or
   b. Provider license number or
   c. Provider federal tax identification number.

4. The bill must show the type of service received.

5. The bill must show who received the services.

If you have medical bills that meet these requirements and you receive Medi-Cal with a share-of-cost, please notify your county worker immediately.

EXHIBIT B

STATE OF CALIFORNIA—HEALTH AND E NCY
DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
O. BOX 942732
CRAMENTO, CA 94234-7320
GEORGE DEUKMEJIAN

TO: All County Welfare Directors
All County Administrative Officers

January 19, 1990
Letter No: 90-11

Subject: Hunt vs. Kizer Preliminary Injunction

Reference: All County Welfare Directors Letter No. 89-87, 89-111

Background:

On December 15, 1989, the U. S. District Court issued a revised Preliminary Injunction in the case of Hunt vs. Kizer requiring that the Department of Health Services (DHS) no longer impose any time limitations on medical expenses which Medi-Cal applicants or beneficiaries may use to meet their share of cost (SOC). As a result, we are rescinding all notices and instructions (All County Welfare Directors Letters 89-87) that have been issued to counties and to Medi-Cal beneficiaries since August 28, 1989, on this subject.

On January 16, 1990, the enclosed notice (Enclosure 1) was sent to approximately 154,000 persons who were eligible as of January 1990 to receive Medi-Cal with a SOC. This notice advises people that their Medi-Cal SOC will be adjusted to reflect the cost of any unpaid medical bills for which they are still legally responsible. County eligibility workers will be responsible to assist Medi-Cal applicants and beneficiaries with the use of their old medical expenses to meet their SOC.

County Procedures:

To comply with this revised court order, any Medi-Cal applicant or beneficiary coming into the county welfare department (CWD) must have any unpaid medical expenses evaluated for use in reducing a current, or future, month's SOC. This means applicants for, or recipients of, Medi-Cal having unpaid medical expenses for which they are still legally liable, regardless of when they were incurred, must be allowed to use these bills toward reducing their SOC in current and, if necessary, future months. A person is considered to be legally liable for the debt if:

1. the debt is less than four years old; or
2. there is a judgment; or
3. there is a contract extending the statute of limitations; or
4. any payment has been made on the debt within the last four years; or
5. there is an agreement to pay on the debt; or
6. there is other reasonable verification showing the person is still responsible for the debt.

Until final regulations are promulgated, eligibility workers should question bills older than four years and allow beneficiaries the opportunity to show that they are still liable for these bills.

Intake:

At intake the applicant must be informed of his/her right to use any old unpaid medical expenses to reduce his/her current and, if necessary, future months(s) SOC, regardless of when they were incurred. A copy of "Important Notice Hunt vs. Kizer Lawsuit" is included as Enclosure 2. This notice must be provided by the county welfare director to all persons who have applied for Medi-Cal and been approved since September 1, 1989, and to all future applicants.

Continuing:

Persons currently on Medi-Cal with a SOC may use their old unpaid medical expenses to meet a current or future months SOC so long as the entire bill has not previously been used to meet a SOC.

Required Documentation:

Medi-Cal eligibility workers must review the billing statements for old medical expenses from the medical providers to ensure that the required information is provided. If any of the items listed below are missing, the Medi-Cal applicant must contact the provider to obtain the information. The eligibility worker must explain what items are necessary in order to allow the bill to be used. Bills with any of the required items missing are not acceptable.

Bills being used to reduce an applicant's or beneficiary's SOC must have:

1. a current billing date (billing statement dated within 60 days of the date it is presented to the eligibility worker);
2. the provider's name and address;
3. the name of the person receiving the service;
4. the type of service;
5. the date of service;
6. the amount owed in the month for which it is being used to meet the SOC;
7. the provider federal tax identification number or provider license number or Medi-Cal provider identification number.

Adjusting the SOC:

When all of the necessary information is provided, the county workers shall complete an MC 176 M noting in the Underpayment Adjustment Box (Column III, Line 15) "OME" (Old Medical Expenses) and the amount of the adjustment. Make a copy of the bill for the applicant and retain the original in the case file. Original bills are not to be returned to the applicant.

Cases that will have a SOC changed for more than the current month must be flagged (either manually or on MEDS [REDETERM-MONTH]) so the counties will be alerted when it is necessary to readjust the reduced SOC. The share of cost must be recomputed prior to the 20th day of the last month in which the old medical expenses have been used to reduce the SOC. A ten day Notice of Action advising the beneficiary of the return to his/her previous SOC must be sent in the month prior to the change.

Denied Medical Bills:

When reviewing the medical bills to determine if the required information is included, note on each original bill either "Accepted - Hunt vs. Kizer" or "Denied - denial code (numbers 1-9, Hunt vs. Kizer."

Denial Codes:

1. Billing date not current or illegible.
2. Provider's name or address missing or illegible.
3. Name of the person receiving the service is missing or illegible.
4. Type of service not provided or illegible.
5. Date of service not provided or illegible.
6. Amount owed not provided or illegible.
7. Missing or illegible provider's federal tax ID #, license # or Medi-Cal ID #. (only one needed)
8. Failure to provide original bill.
9. Medical expenses were previously used to meet a SOC.

If the original bill appears to have been altered, the applicant must obtain from the provider an unaltered bill. An original bill means one prepared by the provider of services. If a bill is denied the original should be returned to the applicant or beneficiary.

Examples:

Example 1:

Ms. Adams has a SOC of $100 each month. Currently, she must pay or obligate to pay this much each month toward your medical care before she receives a Medi-Cal card. Every month she pays approximately $20 for prescriptions that are not paid for by Medi-Cal. Since this amount is less than her SOC ($100), she was never able to meet her SOC which means she never actually received a Medi-Cal card. Now, as long as she still owes the bills after five months ($20 a month for prescriptions times 5 months = $100 SOC) she can submit all of the $20 bills to meet her SOC for one month and receive a Medi-Cal card.

Example 2:

Mrs. Brown and her children have had a SOC of $300 every month for the last two years. Her husband, Mr. Brown lives with her but he is not eligible for Medi-Cal. He has a $3,000 hospital bill from three years ago which Mr. and Mrs. Brown still owe but which is not covered by insurance or any medical program. Now, Mrs. Brown and the children may use his bill to meet their SOC for 10 months ($3,000 divided by $300 a month = 10 months).

Example 3:

Mr. Clark has had a monthly SOC of $120 for many years. For the past couple of years, he has been seeing a specialist doctor every month who charges him $60 a visit because the doctor does not accept Medi-Cal. Mr. Clark still owes the doctor for two months of these $60 bills. Now, he may meet his SOC by using two of these old doctor bills (2 times $60 = $120 SOC), no matter when they were incurred.

Questions concerning all aspects of this lawsuit should be directed to Kristi Allen at (916) 445-6855 (policy questions) or Frances Schurer at (916) 322-3463 (MEDS questions). Thank you for your continued cooperation.

Sincerely,

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: January 9, 1991

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
MEDICAL ASSISTANCE

PAGE:

NOTICE TO HUNT VS. KIZER BENEFICIARIES- January 16, 1989

As a result of a recent U.S. District Court decision in the case of Hunt v. Kizer you may now use your old unpaid medical bills, no matter when they were incurred, t meet your current and future months share of cost (SOC) for Medi-Cal.

You may have received a notice about this case earlier, but the recent court decisio has changed the instructions. The earlier notice said that to meet your SOC, yo could only use medical bills incurred before you applied for Medi-Cal. Now you ca use bills incurred anytime, as long as you still owe them.

The new court decision in Hunt v. Kizer allows you to accumulate your unpaid medica bills from any prior month until you have enough to meet your SOC. To meet it, yo can only use old bills for which you are still responsible. Then you can choose whic month you want to meet your SOC and get a Medi-Cal card in. Here are some examples:

You have a SOC of $100 each month. Currently you must pay or obligate yourself to pay this much each month for your medical care before you receive you Medi-Cal card. Every month you pay approximately $20 for prescriptions that ar not paid for by Medi-Cal. Since this amount is less that your SOC ($100), yo were never able to meet your share of cost which meant you never actuall received a Medi-Cal card. Now, so long as you still owe the bills after fiv months ($20 a month for prescriptions times 5 months = $100 share of cost) yo can submit all of the $20 bills to meet your SOC for one month and receive Medi-Cal card.

You and your children have had a SOC of $300 every month for the last five years Your husband lives with you but he is ineligible for Medi-Cal. He has a $3,00 hospital bill from last year which you and he still owe but which is not covere by insurance or any medical program. Now, you may use his bill to meet your SO for 10 months ($3,000 divided by $300 a month SOC = 10 months).

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
MEDICAL ASSISTANCE

PAGE:

You have had a monthly share of cost of $120 for many years. For the past coup of years, you have been seeing a specialist doctor every month who charges y $60 a visit because he does not accept Medi-Cal. You still owe the doctor f many months of these $60 bills. Now, you may meet your SOC in any particul month by using two of these old doctor bills (2 times $60 = $120 SOC), no matt when they were incurred.

If you have old medical bills which you still owe, you should take them in to yo eligibility worker. Even if you have old medical bills which you were not allowed use before to meet your SOC, you should take them in and ask your eligibility work for help. Each bill must provide the following information:

- The current amount due.
- The name of the person who received the service, including any person for who medical bills you are legally responsible.
- The name and address of the person (doctor, hospital, therapist, pharmac etc.) who provided the service.
- The type of service and the date of service..
- One of the following:
  - Provider Medi-Cal identification number.
  - Provider license number.
  - Federal tax identification number.

If you do not have all of this information, you should contact your eligibility work for help. If you earlier submitted old unpaid bills but were told that you could n use them because they were incurred after you applied for Medi-Cal, you should ta them back to your eligibility worker.

ALL PRIOR NOTICES ABOUT HUNT VS. KIZER ISSUED SINCE AUGUST 29, 1989, ARE HERE RESCINDED.

Enclosure 2

IMPORTANT NOTICE - HUNT VS. KIZER LAWSUIT

As a result of the recent U. S. District Court decision in the case of Hunt vs. Kizer, you may now be able to use your old medical bills to meet your current or future share of cost (SOC) for Medi-Cal. You may only use:

1. A bill that you are still legally responsible to pay; and
2. A bill which has not been used in its entirety to meet a previous SOC; and
3. A bill for which:
   a. you received services less than four years before the month in which you are trying to use it to meet your SOC; or
   b. you have judgment against you; or
   c. you have entered into a contract extending its statute of limitations; or
   d. you have made any payment on the debt within the last four years; or
   e. you have agreed to pay on the debt; or
   f. you have other reasonable verification showing you are still responsible for it.

In order to have your old medical bills considered the bill must meet the following requirements:

1. The bill must be current. (Billing date less than 60 days before the time you present it to your eligibility worker.)
2. The bill must show who provided the service, the provider's address and one of the following:
   a. Provider Medi-Cal identification number; or
   b. Provider license number; or
   c. Provider federal tax identification number.
3. The bill must show the type of service received.
4. The bill must show who received the services.

If you have an unpaid medical bill but some of this required information is missing from the bill, you may also submit an earlier bill for the same charge which provides the missing information.

If you have medical bills which you think may meet these requirements and you receive Medi-Cal with a SOC, please notify your county worker immediately for help.

EXHIBIT C

STATE OF CALIFORNIA—HEALTH AND WELFARE
DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
GEORGE DEUKMEJIAN, Governor

TO: All County Welfare Directors
All County Administrative Officers

May 16, 1990
Letter No: 90-45

SUBJECT: HUNT V. KIZER

In the course of implementing the U. S. District Court Order in the case of Hunt v. Kizer several questions have arisen. The purpose of this letter is to provide answers and clarification on these issues.

Question 1:

What is an original bill?

Answer 1:

An original bill is one that is prepared by the provider of medical services. It may not be a photocopy of a bill sent by the provider. An original bill does not have to be the first bill for a service. It may be any subsequent bill or bills so long as it contains the required information and is not a photocopy.

Question 2:

What type of secondary evidence is acceptable if the bill lacks the required information necessary for it to be used to reduce a share of cost (SOC)?

Answer 2:

Any supplemental bill or statement from the health care provider or the representative of the health care provider (i.e., an attorney or collection agency) that supplies the necessary information may be used. A sworn statement from the beneficiary is acceptable so long as the the person can knowledgeably attest to the accuracy of the required information. Example: A beneficiary has adequate knowledge to provide a sworn statement as to date of service, name of the person who received the service, the provider's name and address: he/she does not have sufficient knowledge to swear to the provider's identification number, the RVS code, the type of service or the amount for which he/she is still legally liable.

Question 3:

Must the county welfare office provide the beneficiary with a Notice of Action (NOA) for each bill that is not acceptable to offset a SOC?

Answer 3:

A NOA is not necessary initially unless the bill is totally denied for any reason. In the case of bills that are not totally denied, counties must provide beneficiaries with a written explanation of why the bill is unacceptable (i.e., lacking provider's identification number, not original bill, unable to identify who received the service), and what would be necessary to make the bill acceptable (i.e., obtain provider's identification number, submit original bill, provide sworn statement attesting to who received the service). In the eventuality that the bill cannot be used, a NOA is required.

Question 4:

Is an IHSS SOC an acceptable medical expense to be used to offset a Medi-Cal SOC?

Answer 4:

No. An IHSS SOC is not considered to be a medical expense. Only medical expenses may be used to meet a Medi-Cal SOC.

Question 5:

Example:

A beneficiary who is eligible with a $750 Medi-Cal SOC has a $1,400 unpaid medical bill. In December 1988, the Medi-Cal beneficiary agreed to pay the provider $750 and, as a result, used this amount to meet his December 1988 SOC. Nothing has been actually paid on the outstanding balance of $1,400. Can the entire amount of $1,400 be used again to meet a SOC?

Answer 5:

No. Only the amount that was not used to meet a previous month's SOC may be applied under the Hunt v. Kizer provisions. In this example, the unused amount is $650.

Question 6:

Providers charge interest on accounts that are not paid in full on a monthly basis. Can this interest be used to offset a SOC?

Answer 6:

No. Only medical expenses can be used to meet a SOC.

As we continue to implement the Hunt v. Kizer Preliminary Injunction questions will continue to arise and the Department of Health Services will be providing additional question and answer letters.

If you have questions concerning this letter or the Hunt v. Kizer lawsuit, please call Kristi Allen at (916) 445-6855.

Sincerely,

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: May 31, 1991

EXHIBIT D

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
GEORGE DEUKMEJIAN, Governor

To: All County Welfare Directors
All County Administrative Officers

August 20, 1990
Letter No.: 90-80

SUBJECT: HUNT VS KIZER QUESTIONS AND ANSWERS

REFERENCE: 89-87, 89-111, 90-11, 90-75

This letter is intended to explain the latest developments and to clarify the requirements for implementing the court orders issued in the Hunt vs. Kizer lawsuit. This letter contains a compilation of some of the most frequently asked county questions.

Question 1:

What does the term "original bill," mean as used in All County Welfare Directors Letter 89-87?

Answer 1:

An original bill is one that is not, in its entirety, a photocopy. A photocopy of a bill is acceptable so long as it has an original stamp, the initial or signature of the provider on it or if other original supporting documentation confirms that the bill is an accurate statement of the outstanding balance. The bottom-line is that there must be some objective evidence which shows that the bill remains unpaid and has not been tampered with.

An original bill can be supplemented with original documentation that provides all of the necessary items:

1. Provider name and address.

2. Medi-Cal provider identification number, taxpayer identification number, or provider license number.

3. A billing date within the last 90 days.

   NOTE: This is a change from the previous policy of 60 days.

4. The name of the person receiving the service.

5. The type of service.

6. The date of service.

7. The amount still owed to the provider.

A sworn statement may be used within the guidelines of Answer 5.

Question 2:

Are there any exceptions to the "billing/statement date within 60 days" rule?

Answer 2:

The billing or statement date must be within the last 90 days of the time that the bill is presented to the county worker. This is a change from the previously stated policy of 60 days. If the bill is not dated within the last 90 days, it may still be used if it meets the requirements set forth in Answer 1.

Question 3:

Under what circumstances must counties accept medical expenses that have been charged to credit cards?

Answer 3:

There are three situations where credit card charges for medical expenses can be used:

1. If there are no other charges on the credit card and the beneficiary can show that the charge for medical expenses has not been paid. In order to show that the charge has not been paid, the beneficiary must provide all charge account statements received since the date of the charge.

2. If the beneficiary can show that the charge for medical expenses and all of the charges made to the credit card since the date of the charge for medical expenses are unpaid.

In order to show that these charges remain unpaid, the beneficiary must provide all charge account statements received since the date of the charge for medical expenses.

3. If the medical expenses charged to the credit card are used to reduce the SOC for the month in which the medical expenses were incurred.

Please note that the finance charges which the beneficiary may incur as a result of using a charge card to pay for his/her medical expenses may not be used to reduce the SOC.

Question 4:

Can medical expenses that have been turned over to a collection agency be used to meet a SOC?

Answer 4:

Yes, if the original collection agency bill contains all of the required documentation or if a combination of the collection agency bill(s) and other original billing statements supply the missing information. A sworn statement may be used within the guidelines of Answer 5.

Question 5:

Are there any alternatives if the beneficiary is unable to obtain the required documentation?

A beneficiary should be permitted to make a sworn statement attesting to the following:

1. Provider name and address.
2. Provider identification number (if, for instance, the beneficiary has telephoned the provider to get it).
3. The name of the person receiving the service.
4. The type of service (if the RVS or Procedure Code is known).
5. The date of service.

If the beneficiary is unable to obtain missing information, the eligibility worker should assist him or her in obtaining the information. Many otherwise missing items may be obtained by a telephone call to the provider.

Question 6:

When must county welfare departments (CWDs) issue a Notice of Action (NOA) to share of cost (SOC) beneficiaries using old medical expenses (Hunt vs. Kizer)?

Answer 6:

A NOA must be issued whenever the eligibility worker determines that amounts incurred for medical expenses cannot be used to reduce the SOC. If further documentation or information is required in order to allow use of the expenses, the beneficiary must provide it within 10 days of the date requested. If the information/documentation is not received within 10 days, CWDs must issue a NOA which states that the expenses cannot be used to reduce the SOC. At this time Department of Health Services is in the process of developing NOA language for these denials. Until that time, the authority for the denial is Hunt vs. Kizer and the MC 239 must state the specific reason(s) for denial, by denial code as defined in All County Welfare Letter 89-87.

Statistical Reports:

CWDs are also reminded that the monthly statistical reports must now be sent by the 20th of each month to Kristi McCall - Department of Health Services, 714 P Street, Room 1392, Sacramento, CA 94234-7320.

We are in the process of developing a permanent form for Hunt vs. Kizer statistical reporting. The form will ask that you provide the number of persons applying to use old medical expenses to reduce their SOC, the number approved for use and the number denied and the number of persons requesting a state hearing based upon a denial of old medical expenses.

As further developments in the case occur, we will keep you informed as quickly as possible. Questions concerning Hunt vs. Kizer should be directed to Kristi McCall at (916) 445-6855.

Thank you for your continued assistance.

Sincerely,

Frank S. Martucci

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants.