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SUPERIOR COURT OF CALIFORNIA

COUNTY OF LOS ANGELES, CENTRAL DISTRICT

DELLA SAAVEDRA; JUAN CAMEROS; ANITA VALADEZ; RAQUEL ALVAREZ, by her mother and guardian ad litem Raquel Martell Alvarez; by her guardian ad [redacted] and JANET FARAHMAND, Petitioner (s), vs. TOBY DOUGLAS, in his official capacity as Director, California Department of Health Care Services CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, and DOES 1-20, inclusive, Respondent(s).	Case No. BS140896 JOINT SETTLEMENT AGREEMENT; [PROPOSED] ORDER DATE OSC: July 7, 2015 TIME: 1:30 P.M. DEPT: 85 JUDGE: Honorable James C. Chalfant

[Additional Counsel]

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Petitioners and Respondents have entered into this good faith Settlement Agreement to resolve all pending and remaining claims raised in the Second Amended Petition for Writ of Mandate in the matter of *Della Saavedra et al. v. Toby Douglas and the California Department of Health Care Services* to avoid the uncertainty, time, and expense of further litigation.

DEFINITIONS

1. For purposes of this Settlement Agreement, the following definitions shall apply:

A. "Seniors and Persons with Disabilities" means those "seniors and persons with disabilities" referenced in Welfare and Institutions Code §14182(a)(1);

B. "Medi-Cal managed care plan" or "managed care health plan" has the same definition as "managed care health plan" set forth in Welfare and Institutions Code §14182(a)(2)(B);

C. "DHCS" refers to Respondent California Department of Health Care Services in the matter, *Della Saavedra et al. v. Toby Douglas and California Department of Health Care Services*, Los Angeles County Superior Court, Case No. BS140896 (the "subject action");

D. The "sixteen California counties" where Seniors and Persons with Disabilities have been subject to mandatory enrollment in Medi-Cal managed care plans, beginning June 2011, are the following: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties;

E. "Medical Exemption Requests" or "MERs" refers to requests by Seniors and Persons with Disabilities to be exempt on medical grounds from enrollment in Medi-Cal managed care plans and to remain in fee-for-service Medi-Cal as referenced in Welfare and Institutions Code §14182(b)(15) and (21);

F. "Medi-Cal waiver programs" refers collectively to the AIDS, Home and Community Based Services ("HCBS"), In Home Operations ("IHO"), Nursing Facility/Acute Hospital ("NF/AH"), and other waiver programs wherein participants in those programs were previously required to submit an HCO 7102 form to disenroll from Medi-Cal managed care and stay in their waiver programs and/or to exempt themselves from enrollment in Medi-Cal managed care plans;

G. "Respondents" refer to DHCS and DHCS's current Director who has been sued in the subject action only in his or her official capacity;

H. "Petitioners" refers to petitioners in the subject action, Della Saavedra, Juan Cameros, Raquel Alvarez, Anita Valadez, [redacted] and Janet Farahmand.

RECITALS

2. The subject action arose out of Petitioners' allegations regarding DHCS's processing of MERs that were submitted on behalf of Medi-Cal recipients who are Seniors and Persons with Disabilities and, at all times relevant to this Settlement Agreement, resided in one of the sixteen counties where enrollment in Medi-Cal managed care plans is mandatory for Seniors and Persons with Disabilities.

3. In 2010, the California Legislature authorized DHCS to require Seniors and Persons with Disabilities who do not have other health care coverage to be assigned as mandatory enrollees into new or existing managed health care plans to receive their Medi-Cal services.

4. At all times relevant herein, Seniors and Persons with Disabilities were, and still are, allowed to request, from DHCS, medical exemptions from mandatory enrollment in a managed care plan if they can demonstrate that they have a complex medical condition requiring them to continue to see their fee-for-service providers.

5. At all times relevant herein, registered nurses, who are DHCS's employees, have rendered their clinical judgment to either approve MERs for medical reasons or to recommend the denial of MERs for medical reasons; and for those MERs for which DHCS nurses have recommended a denial, licensed physicians, who are also DHCS's employees, have reviewed the nurses' recommendations to deny MERs for medical reasons and have made the final clinical decision on whether to approve or deny those MERs.

6. Beginning in June 2011, DHCS commenced the mandatory enrollment of Seniors and Persons with Disabilities into Medi-Cal managed care plans in the sixteen California counties and has continued such mandatory enrollment through the present day. At the same time, Seniors and Persons with Disabilities began to submit MERs and DHCS denied approximately 80% of those

MERS by sending certain standards notices to these Medi-Cal beneficiaries.

7. In the summer of 2012, Respondents investigated allegations by stakeholders - including Petitioners' Counsel - that some Seniors and Persons with Disabilities had received incorrect or inconsistent information from MAXIMUS, the DHCS managed care enrollment broker, regarding the MER process.

8. Responding to the assertions made by Petitioners' counsel and others, DHCS embarked on an audit of MAXIMUS and imposed a corrective action plan to prevent further problems with providing notice to Seniors and Persons with Disabilities regarding mandatory enrollment in Medi-Cal managed care.

9. On October 15, 2012, DHCS took action to protect Seniors and Persons with Disabilities who may have received inaccurate or improper notice about mandatory enrollment in Medi-Cal managed care by voluntarily implementing a process to automatically approve (for 6 months) completed MERs filed by Seniors and Persons with Disabilities to ensure that they continue to receive necessary services from their fee-for-service providers. This auto-approval process has remained in effect before and during the pendency of the subject action up until April 8, 2015.

10. On or about November 28, 2012, Respondents publically announced the actions taken to correct the problems identified by their above-mentioned investigation concerning the transition of Seniors and Persons with Disabilities. Respondents disclosed that its audit of MAXIMUS found that between March 2011 and October 2012, approximately 9,098 Seniors and Persons with Disabilities had received improper or inaccurate notice of the transition to managed care from MAXIMUS.

11. On December 21, 2012, Petitioners Della Saavedra, Juan Carneros, Raquel Alvarez, Anita Valadez, and [redacted] filed the subject action.

12. In January 2013, to remediate the above-mentioned issues involving MAXIMUS, Respondents offered all of the impacted Seniors and Persons with Disabilities the opportunity to leave managed care and return to fee-for-service Medi-Cal. Of the impacted Seniors and Persons with Disabilities, 73% chose to stay in managed care and 27% chose to return to fee-for-service.

13. On June 18, 2013, Petitioners filed a Motion for Peremptory Writ under Code of Civil Procedure section 1094; or in the Alternative Motion for Preliminary Injunction in the subject action. The Court heard the matter on August 29, 2013, and September 5, 2013. After oral argument, the Court denied Petitioners' Motion for Peremptory Writ under Code of Civil Procedure section 1094, or in the Alternative Motion for Preliminary Injunction. A true and correct copy of that court order is attached hereto, marked as Exhibit A, and incorporated herein by reference.

14. On November 4, 2013, Petitioners Della Saavedra, Juan Cameros, Raquel Alvarez, Anita Valadez, [redacted] and Janet Farahmand (collectively, "Petitioners") filed the Second Amended Petition for Writ of Mandate, which is the operative pleading in the subject action. A true copy of the Second Amended Petition for Writ of Mandate is attached hereto, marked as Exhibit B, and incorporated herein by reference.

15. On December 9, 2013, Respondents filed their Answer to the Second Amended Petition for Writ of Mandate. A true copy of Respondents' Answer to the Second Amended Petition for Writ of Mandate is attached hereto, marked as Exhibit C, and incorporated herein by reference.

16. Since April 29, 2014, the Parties have stayed discovery, during which time they have engaged in good faith settlement discussions to resolve the remaining issues in the subject action.

17. Throughout the settlement discussions with Respondents, Petitioners' counsel have participated in drafting the revisions discussed below to the HCO 7101 form, the denial notice, and the detailed medical and/or administrative reasons for denying MERs from Seniors and Persons with Disabilities.

18. Respondents DHCS and DHCS's Director have asserted and continue to assert defenses to the Second Amended Petition for Writ of Mandate in the subject action, and have expressly denied and continue to deny any wrongdoing or legal liability arising out of any of the facts or conduct alleged in the subject action.

19. The Parties desire to resolve all pending and remaining claims raised by the Second Amended Petition for Writ of Mandate to avoid the uncertainty, time, trouble and expense of further litigation, and for those reasons, have entered into this Settlement Agreement.

TERMS OF THE SETTLEMENT

20. Respondents agree that the revised HCO 7101 form, which is currently in production, will be used to process and determine MERs on behalf of Medi-Cal recipients who are Seniors and Persons with Disabilities by no later than June 1, 2015. A true and correct copy of the revised HCO 7101 form is attached hereto, marked as Exhibit D, and incorporated herein by reference. Respondents intend to use this revised HCO 7101 form with regard to MERs on behalf of all Medi-Cal recipients and not only Seniors and Persons with Disabilities. It is understood by the Parties that the scope of the subject action and this Settlement Agreement does not cover any Medi-Cal recipients beyond Seniors and Persons with Disabilities.

21. Respondents agree that the revised denial notice, when denying MERs on behalf of Seniors and Persons with Disabilities, will be used no later than June 1, 2015. A true and correct copy of the revised denial notice is attached hereto, marked as Exhibit E, and incorporated herein by reference. Respondents intend to use this revised denial notice when denying MERs on behalf of all Medi-Cal recipients and not only Seniors and Persons with Disabilities. It is understood by the Parties that the scope of the subject action and this Settlement Agreement does not cover any Medi-Cal recipients beyond Seniors and Persons with Disabilities.

22. Respondents will enumerate in the above-mentioned revised denial notice the medical and/or administrative reasons for denying MERs from Seniors and Persons with Disabilities. Whenever more than one reason (medical or administrative) could be the basis for denying a MER, Respondents will choose the more specific reason over the more general reason as the basis for the denial. The revised denial notice will be used no later than June 1, 2015. True and correct copies of the complete revised lists of these medical and/or administrative reasons (also known as denial codes) to be used in denying MERs are attached hereto, marked respectively as Exhibits F and G, and incorporated herein by reference. Respondents intend to use these denial codes when denying MERs on behalf of all Medi-Cal recipients and not only Seniors and Persons with Disabilities. It is understood by the Parties that the scope of the subject action and this Settlement Agreement does not cover any Medi-Cal recipients beyond Seniors and Persons with Disabilities.

23. It is acknowledged and agreed to by the Parties, that in the future, Respondents may make revisions to improve the documents referenced in paragraphs 20, 21, and 22, above, as well as make revisions to improve any other related documents. As such, the Parties agree that the exemplars of the revised documents referenced in paragraphs 20, 21, and 22, above, and attached hereto, will likely evolve over time as the Medi-Cal program, governing law, stakeholder input, and process improvements may warrant changes to these and related documents. Nothing in this Settlement Agreement will prevent or impede Respondents' ability to make such changes to these revised or other related documents in the future. If, in the future, Respondents make any such changes to the documents referenced in paragraphs 20, 21, and 22, above, Respondents will endeavor, whenever possible, to timely apprise Petitioners and other stakeholders of proposed substantive changes. Nothing in this Settlement Agreement will prevent Petitioners from seeking judicial relief on the grounds that future changes to the exemplar documents attached to this Settlement Agreement may violate the law.

24. By no later than June 1, 2015, when DHCS's Office of the Ombudsman receives telephone calls or emails from Seniors and Persons with Disabilities with requests for legal assistance concerning their MERs, DHCS's Office of the Ombudsman will provide contact information for the appropriate local law offices that offer free legal assistance. A true and correct listing of those local law offices is attached hereto, marked as Exhibit H and incorporated herein by reference. However, the Parties also acknowledge and agree that DHCS may revise and update this list as necessary to remain current, accurate, and relevant.

25. Although not part of the Parties' settlement negotiations or this Settlement Agreement, the Parties also acknowledge that Respondents are presently amending regulations governing the MER process and drafting new regulations governing the Non-Medical Exemption Process pursuant to California's Administrative Procedures Act (commencing with Government Code §11340). Respondents intend that these amendments to the regulations will cover Seniors and Persons with Disabilities in the Medi-Cal waiver programs. Respondents are also in the process of issuing a Provider Bulletin. The Provider Bulletin was initially posted as a Newsflash on the DHCS

website on April 10, 2015. On April 24, 2015, DHCS requested comments on the Provider Bulletin from the Medi-Cal Managed Care Advisory Group to be considered before the Provider Bulletin is posted on the DHCS Provider Bulletin website. Additionally, Respondents will notify the appropriate policy and fiscal committees of the Legislature of its intent to issue the Provider Bulletin at least 5-days in advance of its issuance. Respondents intend to issue the final Provider Bulletin no later than June 1, 2015, advising that Seniors and Persons with Disabilities who currently receive Medi-Cal waiver program services are no longer required to disenroll from a Medi-Cal Managed Care Plan to remain in a Medi-Cal waiver program. The Provider Bulletin will further advise that Seniors and Persons with Disabilities must file a request for a temporary medical exemption from enrollment in Medi-Cal managed care with the revised HCO 7101 form (Exhibit D) if they wish to continue treatment for a complex medical condition with a fee-for-service provider. In the meantime, Respondents have initiated the process of sending the standard 45-day notice to all Seniors and Persons with Disabilities whose MERs were or are automatically approved, informing them that they will have to submit a new MER on the revised HCO 7101 form if they wish to remain in fee-for-service Medi-Cal.

26. The Parties acknowledge that as of June 27, 2013, that DHCS's Office of Ombudsman has changed and ceased the following activities: (a) advocating on DHCS's behalf in disputes between Medi-Cal recipients and DHCS involving MERs; (b) preparing statements of positions on DHCS's behalf in hearings involving the denial or termination of MERs; (c) overruling decisions by administrative law judges that Medi-Cal recipients would either remain in or be returned to fee-for-service Medi-Cal until the hearing decision was issued; (d) serving as the presiding officer in deciding whether to grant or deny rehearing requests from Medi-Cal recipients after the administrative law judge has denied their MERs; and (e) denying these rehearing requests from Medi-Cal recipients without explaining the facts and law to justify the decision. Respondents shall continue to ensure that DHCS's Office of Ombudsman does not engage in any of the above-mentioned activities.

27. Petitioners are currently exempt from enrollment in Medi-Cal managed care through

June 30, 2015. Respondents agree to continue the MERs for Petitioners Della Saavedra, Juan Cameros, Raquel Alvarez, Azutui Charkhchyan, and Janet Farahmand through and including December 31, 2015, unless any of these individuals otherwise indicates that he or she no longer wants to be exempt from enrollment in Medi-Cal managed care. At the end of this additional six-month period, Ms. Saavedra, Mr. Cameros, Ms. Alvarez, Ms. [redacted] and/or Ms. Farahmand, may submit a request to extend their MERs, or initiate a new MER, pursuant to the same criteria and procedures as the MERs for other Medi-Cal recipients.

28. The Parties further agree that as part of the final settlement of this matter, Respondents will compensate Petitioners' Counsel in the amount of $475,000 as an all-inclusive sum to fully address and resolve any and all claims for attorneys' fees and costs, including expert costs, retrospectively or prospectively for the duration of court jurisdiction for this Settlement Agreement that Petitioners may contend they would be entitled to, were Petitioners to pursue a formal motion for an award of attorneys' fees and costs, including expert costs, in this matter. Respondents will make this payment to Petitioners' Counsel by October 31, 2015, in which case no interest will accrue on the attorneys' fees and costs sum; if payment is made after October 31, 2015, interest shall accrue at the rate of 7% per annum on any outstanding balance of the fees and costs due to Petitioners under this Settlement Agreement.

29. The Court will retain jurisdiction over this Settlement Agreement for eighteen (18) months after the date the Settlement Agreement is fully executed by the Parties, at which time the Court's jurisdiction will expire. The Parties agree that this expiration of court jurisdiction shall not be extended, for any reason, beyond the 18-month period following execution of the Settlement Agreement. The Parties also agree that no provision of the Settlement Agreement will be enforceable beyond the 18-month period following execution of the Settlement Agreement, and the

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Parties will not seek to enforce any provision of the Settlement Agreement beyond the 18-month period following execution of the Settlement Agreement. At the end of the 18-month period, Petitioners shall fully dismiss the subject action, with prejudice.

Dated: May__, 2015

PETITIONER DELLA SAAVEDRA

Dated: May __, 2015

PETITIONER JUAN CAMEROS

Dated: May __, 2015

PETITIONER RAQUEL ALVAREZ BY HER MOTHER AND GUARDIAN AD LITEM RAQUEL MARTELL

Dated: May __, 2015

PETITIONER [redacted] BY HER GUARDIAN AD LITEM [redacted]

Dated: May 6, 2015

Janet Farahmand
PETITIONER JANET FARAHMAND

Dated: May __, 2015

SARAH CATHERINE BROOKS
CHIEF OF THE MEDI-CAL QUALITY AND MONITORING BRANCH, ON BEHALF OF RESPONDENT THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Parties will not seek to enforce any provision of the Settlement Agreement beyond the 18-month period following execution of the Settlement Agreement. At the end of the 18-month period, Petitioners shall fully dismiss the subject action, with prejudice.

Dated: May __, 2015

PETITIONER DELLA SAAVEDRA

Dated: May __, 2015

PETITIONER JUAN CAMEROS

Dated: May __, 2015

PETITIONER RAQUEL ALVAREZ BY HER MOTHER AND GUARDIAN AD LITEM RAQUEL MARTELL

Dated: May __, 2015

PETITIONER [redacted] BY HER GUARDIAN AD LITEM [redacted]

Dated: May __, 2015

PETITIONER JANET FARAHMAND

Dated: May 14, 2015

Sarah Brooks

SARAH CATHERINE BROOKS
CHIEF OF THE MEDI-CAL QUALITY AND MONITORING BRANCH, ON BEHALF OF RESPONDENT THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

APPROVED AS TO FORM:

Dated: May 26, 2015

LEGAL AID FOUNDATION OF LOS ANGELES
WESTERN CENTER ON LAW & POVERTY
NATIONAL HEALTH LAW PROGRAM

By: _____

Attorneys for Petitioners

Dated: May 14, 2015

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Deputy Attorney General
S. PAUL BRUGUERA
Deputy Attorney General

By: _____

Attorneys for Respondents

ORDER

IT IS HEREBY ORDERED that the Court will retain jurisdiction over this Settlement Agreement for eighteen (18) months after the date the Settlement Agreement is fully executed by the Parties, at which time the Court's jurisdiction will expire. The Parties agree that this expiration of court jurisdiction shall not be extended, for any reason, beyond the 18-month period following execution of the Settlement Agreement. The Parties also agree that no provision of the Settlement Agreement will be enforceable beyond the 18-month period following execution of the Settlement Agreement, and the Parties will not seek to enforce any provision of the Settlement Agreement beyond the 18-month period following execution of the Settlement Agreement. At the end of the 18-month period, Petitioners shall fully dismiss the subject action, with prejudice.

Dated: May ___, 2015

THE HONORABLE JAMES C. CHALFANT

Exhibit A

Della Saavedra, et al. v. Toby Douglas, Director of CDHS, et al.
BS 140896

Tentative decision on (1) motion for judgment: denied; (2) motion for preliminary injunction: denied

Petitioners Della Saavedra ("Saavedra"), Juan Cameros ("Cameros"), Anita Valadez ("Valadez"), Raquel Alvarez ("Alvarez"), Azatui Charkhchyan ("Charkhchyan"), and Janet Farahmand ("Farahmand") (collectively "Petitioners") move for judgment under CCP section 1094 on the first and second causes of action in the First Amended Petition ("FAP")[1] or, in the alternative, a preliminary injunction.

The court has read and considered the moving papers, opposition,[2] and reply, and renders the following tentative decision.

A. Statement of the Case

Petitioners commenced this proceeding against the Department of Health Care Services ("DHCS" or the "Department") and its Director, Toby Douglas, on December 21, 2012.

Petitioners are six Medi-Cal beneficiaries who for years have received care for their complex medical conditions from free-for-service providers. Until recently, these Medi-Cal beneficiaries were able to obtain necessary specialty care on an ongoing and coordinated manner from physicians who treated them on a fee-for-service basis. Petitioners allege that, beginning in June 2011, more than 240,000 Seniors and Persons with Disabilities ("SPDs") in Los Angeles and fifteen other California counties have no longer been allowed to receive medical care on a fee-for-service basis and instead been involuntarily enrolled in Medi-Cal managed care plans that often are ill-equipped to meet all of their complicated medical needs and unwillling to provide the specialty care and medications they need.

According to Petitioners, state law provides that Medi-Cal beneficiaries are entitled to remain in Medi-Cal on a fee-for-service basis when (1) they are receiving treatment for "complex medical conditions" from fee-for-service providers, (2) their providers do not belong to any Medi-Cal managed care plans, and (3) the beneficiaries make timely requests to be exempt from involuntary enrollment in Medi-Cal managed care. Welfare & Institutions Code ("W&I") §14182(b)(15); 22 CCR §53887. Petitioners allege that Respondent DHCS has exceeded the scope of the relevant statute and regulations by imposing additional criteria for approving Medi-Cal beneficiaries' requests to be exempt from enrollment in managed care by requiring proof that beneficiaries will also suffer "deleterious medical effects" if placed in managed care and by eliminating altogether the exemption for beneficiaries who are in nursing home care. According

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[1]At the September 5, 2013 hearing, Petitioners' counsel stated that the third cause of action, which concerns the Department's notices and refusal to permit a beneficiary to remain in fee-for-service, should not have been included in the motion.

[2]The Department applied for an order sealing its declarations. The application was not well taken as it was overbroad, and it is hereby denied. The court directed the clerk to inform the Department's counsel that it intended to deny the application for sealing, and gave counsel the option of withdrawing or unsealing the evidence. The Department chose to unseal, and the declarations have been considered.

to Petitioners, DHCS has adopted these new requirements, and others, without giving any notice to the public or holding a hearing, in violation of the Administrative Procedures Act ("APA"), Govt. Code §11340 *et seq.*

Petitioners filed the FAP on March 20, 2013, asserting causes of action for, *inter alia*, (1) violations of W&I section 14182(b)(15) and 22 CCR section 53887 with regard to applying the proper standards in deciding whether to grant MERs submitted by SPDs; and (2) violations of the APA with regard to applying and enforcing "underground regulations" concerning the "deleterious effects" standard and other requirements that have not been adopted in accordance with the APA and were not even put into writing until July 2012.

The FAP asserts five other causes of action not at issue in the instant motion, including four claims for traditional mandamus and a claim in which Petitioner Charkhchyan seeks administrative mandamus from the decision of an administrative law judge ("ALJ") denying her request for a medical exemption.

On July 8, 2013, the parties entered into a stipulation concerning the handling of confidential information. The proposed protective order was signed by the court on July 10, 2013 and filed on July 11, 2013.

B. Standard of Review

A party may seek to set aside an agency decision by petitioning for either a writ of administrative mandamus (CCP §1094.5) or of traditional mandamus. CCP §1085. A petition for traditional mandamus is appropriate in all actions "to compel the performance of an act which the law specially enjoins as a duty resulting from an office, trust, or station...." CCP §1085.

A traditional writ of mandate under CCP section 1085 is the method of compelling the performance of a legal, ministerial duty. Pomona Police Officers' Assn. v. City of Pomona, (1997) 58 Cal.App.4th 578, 583-84. Generally, mandamus will lie when (1) there is no plain, speedy, and adequate alternative remedy, (2) the respondent has a duty to perform, and (3) the petitioner has a clear and beneficial right to performance." Id. at 584 (internal citations omitted). Whether a statute imposes a ministerial duty for which mandamus is available, or a mere obligation to perform a discretionary function, is a question of statutory interpretation. AIDS Healthcare Foundation v. Los Angeles County Dept. of Public Health, (2011) 197 Cal.App.4th 693, 701.

Where a duty is not ministerial and the agency has discretion, mandamus relief is unavailable unless the petitioner can demonstrate an abuse of that discretion. Mandamus will not lie to compel the exercise of a public agency's discretion in a particular manner. American Federation of State, County and Municipal Employees v. Metropolitan Water District of Southern California, (2005) 126.Cal.App.4th 247, 261. It is available to compel an agency to exercise discretion where it has not done so (Los Angles County Employees Assn. v. County of Los Angeles, (1973) 33 Cal.App.3d 1, 8), and to correct an abuse of discretion actually exercised. Manjares v. Newton, (1966) 64 Cal.2d 365, 370-71. In making this determination, the court may not substitute its judgment for that of the agency, whose decision must be upheld if reasonable minds may disagree as to its wisdom. Id. at 371. An agency decision is an abuse of discretion only if it is "arbitrary, capricious, entirely lacking in evidentiary support, unlawful, or procedurally unfair." Kahn v. Los Angeles City Employees' Retirement System, (2010) 187

Cal.App.4th 98, 106. A writ will lie where the agency's discretion can be exercised only in one way. Hurtado v. Superior Court, (1974) 11 Cal.3d 574, 579.

No administrative record is required for traditional mandamus to compel performance of a ministerial duty or as an abuse of discretion.

C. Governing Law

1. W&I Section 14182

Medi-Cal is California's enactment of the federal program for Medicaid, a health care for the poor. *See* 42 U.S.C. §1396. The Medi-Cal program provides health care coverage to beneficiaries on either a fee-for-service or managed care basis.[3] W&I §14016.5(b).

Since 2010, and in furtherance of California's Bridge to Reform Demonstration Project,[4] the Legislature authorized DHCS to require "seniors and persons with disabilities who do not have other health care coverage to be assigned as mandatory enrollees into new or existing managed care health plans." W&I §14182(a). Where DHCS requires management care enrollment, it shall not terminate an enrollee's access to fee-for-service Medical-Cal until the enrollee has been assigned to a managed care health plan. Ibid. The purpose of managed care programs is to "reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to quality care for Medicaid recipients." Life Care Centers of America v. Cal Optima (2005) 133 Cal.App.4th 1169, 1174.

In exercising its authority to require SPDs on Medi-Cal to have managed care, DHCS is required to ensure that managed care plans provide for a continuity of care by permitting fee-for-service providers who have an ongoing relationship with a new managed care member to continue that relationship for up to 12 months if the provider will accept Medi-Cal rates and have no quality of care issues (W&I §14182(b)(13), (14)). The Department must "[e]nsure that the [MERs] criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800) or Chapter 4.5 (commencing with Section 53900) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations are applied to seniors and persons with disabilities served under this section." (W&I §14182(b)(15)).

With regard to rule-making generally, the Administrative Procedures Act ("APA") provides that "[n]o state agency shall issue, utilize, enforce, or attempt to enforce any guideline,

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[3] Under fee-for-service, the Medi-Cal beneficiary gets care from any provider(s) willing to treat the beneficiary and accept reimbursement from DHCS at a set amount for the services provided. W&I §14016.5(b)(1). With managed care, DHCS contracts with plans to provide health care to Medi-Cal beneficiaries. W&I §14204. The plans are reimbursed on a capitated basis -- a predetermined amount per person, regardless of the number of services provided to a particular person. W&I §14301(a).

[4] Section 1115 of the Social Security Act (42 U.S.C. §1315) gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. California's project is the "Bridge to Reform Demonstration." California received a Medicaid Demonstration Waiver ("Demonstration Project Waiver") for its project from the federal government.

criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in Section 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to this chapter." Govt. Code §11340.5(a).

Notwithstanding the APA's provisions, DHCS may implement, interpret, or make specific [W&I section 14182] and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. ..." W&I §14182(k)

In the event of a conflict between the Special Terms and Conditions of the Demonstration Project and any provision of this part, the Sepcial Terms and Conditions \shall control. W&I §14182(m).

2. Section 53887

As relevant to Los Angeles County, 22 CCR sections 53800 *et seq*. set forth the regulations that apply to geographical regions designated by DHCS to health care services to eligible Medi-Cal beneficiaries through no more than two prepaid health plans.

DHCS must mail an enrollment form and plan information to each eligible beneficiary, which must include instructions on how to enroll in a plan and how to request an exemption for either medical or non-medical reasons. 22 CCR §53882. After receiving this notice, beneficiaries have 30 days to either choose a managed care plan or file for a medical exemption request ("MER"). If they do neither, they are defaulted into managed care. 22 CCR §53883.

In effect since 2000, 22 CCR section 53887 ("section 53887") sets forth the criteria for a temporary MER from managed care plan enrollment: "An eligible beneficiary ... who satisfies the requirements in (1)[5] or (2) below, may request fee-for-service Medi-Cal for up to 12 months as an alternative to plan enrollment by submitting a request for exemption from plan enrollment to the Health Care Options Program ...." §53887(a).

A MER may be granted for continuity of care for a complex medical condition with a fee-for-service provider: "An eligible beneficiary who is receiving fee-for-service Medi-Cal treatment or services for a complex medical condition, from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of either plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medi-Cal for purposes of continuity of care." §53887(a)(2).

"For purposes of [section 53887], conditions meeting the criteria for a complex medical condition include, and are similar to, the following: (1) an eligible beneficiary is pregnant; (2) an eligible beneficiary is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant ...; (3) an eligible beneficiary is receiving chronic renal dialysis treatment; (4) an eligible

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[5]Requirement (1) concerns Native Americans and is not at issue.

beneficiary has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS); (5) an eligible beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy; (6) an eligible beneficiary has been approved for a major surgical procedure by the Medi-Cal fee-for-service program and is awaiting surgery or is immediately post-operative; (7) an eligible beneficiary has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in 1 through 6 above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted; and (8) an eligible beneficiary is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility." §53887(a)(2)(A).

A MER based on complex medical condition may be denied in certain circumstances where plan provider services were available: "A request for exemption from plan enrollment based on complex medical conditions shall not be approved for an eligible beneficiary who has: 1. Been a member of either plan on a combined basis for more than 90 calendar days, 2. A current Medi-Cal provider who is contracting with either plan, or 3. Begun or was scheduled to begin treatment after the date of plan enrollment." §53887(a)(2)(B).

The duration of the MER is limited: "Except for pregnancy, any eligible beneficiary granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without deleterious medical effects, as determined by a beneficiary's treating physician in the Medi-Cal fee-for-service program, up to 12 months from the date the medical exemption is first approved by the Health Care Options Program. A beneficiary granted a medical exemption due to pregnancy may remain with the fee-for -service Medi-Cal provider through delivery and the end of the month in which 90 days post-partum occurs.

A MER based on complex medical condition must be requested on the "request for Medical Exemption from Plan Enrollment" form (HCO Form 7101, June 2000) available from the Health CAre Options Program. §53887(b).

A MER based on a beneficiary's enrollment in a Medi-Cal waiver program (§53887(a)(2)(A)8) shall be requested on the "Request for Non-Medical Exemption from Plan Enrollment" form (HCO form 7102, October 2000), available from the Health Care Options Program. Ibid.

DHCS may evaluate the bona fides of a MER at any time: "The Health Care Options Program, as authorized by the department, shall approve each [MER] that meets the requirements of this section. At any time, the department may, at its discretion, verify the complexity, validity, and status of the medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a plan. The Health Care Options Program, as authorized by the department, or the department may deny a request for exemption from plan enrollment or

revoke an approved request for exemption if a provider fails to fully cooperate with this verification." §53887(c).

Approval of MERs is subject to the same processing times and effective dates as the processing of enrollment and disenrollment requests set forth in 22 CCR section 53889. §53887(d). Thus, DHCS must process MERS within two working days and notify beneficiaries in writing of approval or disapproval within seven working days. 22 CCR 53889(e), (g).

DHCS or the Health Care Options Program may revoke a MER at any time if DHCS determines taht the approval was based on false or misleading information, the medical condition was not complex, treatment has been completed, or the requesting provider is not providing services to the beneficiary. §53887(e).

D. Statement of Facts[6]

1. Exemption from Managed Care

Under federal Medicaid law, a Medi-Cal beneficiary generally has the right to choose between providers of health care, including fee-for-service and managed care. The federal government can waive that right to choose, however. It has done so for some Medi-Cal beneficiary populations, and beneficiaries in those populations are required to receive their benefits through managed care unless exempted.[7]

Section 53887, amended in 2000, is the principal DHCS regulation governing medical

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[6]The court has ruled on Petitioners' written objections, wrongly filed as "Response of Petitioners to Respondents' Objections to Petitioners' Evidence," by placing "O" for "overruled" and "S" for "sustained" next to the objection, interlineating the original evidence where an objection was sustained. All of the objections to the Declaration of Sarah Catherine Brooks was overruled because the declaration interprets the underlying records. While the records should be in evidence, they do not "speak for themselves" and require interpretation.

Petitioners ask the court to judicially notice two documents: (1) a November 2, 2010 public announcement letter from DHCS' director, and (2) the federal government's Special Terms and Conditions for the Demonstration Project Waiver. Both requests are granted. Ev. Code §452(c).

The court also has ruled on the Department's more than 240 written objections by placing "O" for "overruled" and "S" for "sustained" next to the objection. The vast majority of objections fail to quote the evidence (*see* CRC 3.1354(b)) and the court has no obligation to sift through the evidence to look for objected to material. Therefore, very few objections were sustained. The Department also purports to object to argument in Petitioners' reply brief, and this also is improper. Objections may only be made to evidence, not argument.

The Department asks the court to judicially notice two documents: (1) the regulation package for title 22 section 53877 entitled "Two-Plan Model Enrollment/Disenrollment," and (2) excerpts from the California Bridge to Reform Demonstration, amended on various dates. The request is granted. Ev. Code §452(c).

[7]Petitioners' counsel made these representations about federal Medicaid law at the September 5 hearing.

exemptions from managed care. Pursuant to this regulation, a Medi-Cal beneficiary in a population required to enroll in managed care who had serious medical conditions could apply for a MER to avoid disruption in their medical care caused by the transfer from fee-for-service to managed care until such time as the beneficiary has completed treatment or could safely be transitioned to managed care.

In conjunction with section 53887, in 2000 DHCS introduced HCO Forms 7101 and 7102 for beneficiaries to request a medical exemption. Form 7101 contains all the necessary prompts and instructions for a beneficiary to request an exemption on the basis of a complex medical condition. Form 7102, in part, was for beneficiaries seeking a medical exemption because they are enrolled in a Medi-Cal waiver program allowing the beneficiary to receive nursing care at home rather than as an in-patient in a hospital or nursing home facility ("home waiver" or "nursing waiver"). The home waiver exemption included four Medi-Cal Waiver programs: AIDS Waiver, Model Waiver, In-Home Medical Care Waiver, and Skilled Nursing Facility Waiver.[8]

2. The Policy Choice to Include SPDs in Managed Care

In November 2010, California obtained federal approval of the Demonstration Project Waiver for the mandatory enrollment of Medi-Cal Seniors and Persons with Disabilities ("SPDs") from fee-for-service to managed care plans. In exchange, California committed to develop and implement specific standards to protect SPDs, including MERs for recipients with complex medical conditions receiving fee-for-service care, continuity of care for recipients enrolled in managed care, adequate notice of any changes, and rights to appeal.

In June 2011, DHCS began the mandatory transition of SPDs from fee-for-service Medi-Cal to managed care plans. California's decision to rely upon managed care plans to organize care for Medi-Cal's SPDs was consistent with national trends in the Medicaid program. States are increasingly requiring people with disabilities to enroll in managed care programs. By 2010, all but three states had Medicaid managed care programs, and participation in a managed care plan was mandatory for at least some Medicaid enrollees in thirty-three states.

a. The Benefits of Managed Care

The Department perceives a number of benefits in managed care for Medi-Cal SPDs, including the benefit of care coordination for the SPD population, which has complex care needs. Better coordination can yield improvement in care and outcomes.

SPDs, with their reliance upon multiple specialists to treat their varied conditions, are at particular risk of receiving duplicative, unnecessary, and sometimes dangerously contradictory care. The characteristics of the SPD population make them especially at risk for poor care. Nationally, approximately twenty percent of SPDs are eligible due to an intellectual disability and thirty-six percent have a primary diagnosis of mental illness. Unless enrollees have a family member or other advocate who can manage their care, they are subject to the potential of fragmented, unorganized care.

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[8]Form 7102 remained the same from 2000 until May 2012, when the nursing home waiver exemption was deleted. *See infra.*

Managed care requires the engagement of all of a patient's direct care providers, a care coordinator with knowledge of the patient's social context and awareness of available social supports, and the patient him or herself or the patient's personal representative. Effective care coordination requires knowledge of all existing care plans, prescribed medications, and a comprehensive medical record. In a fee-for-service environment, each health care provider generally only has access to information related to the patient's interaction with that one provider and must rely upon the patient him or herself for information on medications, treatments, or diagnostic information related to another provider. This incomplete picture of the patient's circumstances presents a barrier to care coordination.

Capitated managed care plans have the ability and strong incentive to make appropriate investments in care coordination. The primary source of financial savings from managed care is a reduction in institutional care (particularly hospital care) and reductions in prescription drug spending.

Managed care also can help develop accountability for enrollee access to care and care quality. Quality of care in fee-for-service is difficult to measure, in part because each patient encounter with the health care system is an independent episode viewed outside of the context of the patient's broader needs.

Managed care further can improve program efficiency, obtain budget predictability, and generate cost savings. When the state determines the budget for Medi-Cal in a fee-for-service payment environment, it faces uncertainty because the service utilization of the enrollee population can be estimated, but not known in advance. In a capitation payment environment, the only uncertainty is the number of enrollees, because the cost per enrollee is known in advance.

Apart from the perceived benefits, California wants to reallocate its Medi-Cal resources. The federal Demonstration Project Waiver includes a requirement of overall budget neutrality for the federal government, meaning that the federal government will not spend more to support the Medi-Cal program than it would have in the absence of the waiver. California wants to spend its Medi-Cal funds on populations other than SPDs, and savings from this population's care is an important part of the state's overall policy. If the highest need patients remain in fee-for-service Medi-Cal, the state and Medi-Cal enrollees will fail to realize the benefits that can be obtained through care coordination. For all these reasons, California decided to move SPDs into managed care.

b. The Negatives of Managed Care

Petitioners dispute the benefits of this public policy choice of moving Medi-Cal SPDs into managed care. They present evidence from Venice Family Clinic, which describes the massive, involuntary transfer of SPDs as a "travesty" and a "tragic shame" where "[a]ll too often, these frail individuals went from receiving comprehensive health care at the same facility, such as UCLA Medical Center, to receiving disjointed health care dispersed over Los Angeles County." Venice Family Clinic struggled to absorb the "deluge" of 2,400 additional patients, many of whom presented with a "much higher level of acuity" than their typical patients, and often came to the clinic with no medical records. This community clinic "did the best" it could to provide primary care to patients with such serious medical conditions as metastatic breast

cancer, kidney failure, cerebral palsy and end stage cardiomyopathy, but often experienced difficulties in securing specialty care for these patients from the managed care plans.

Petitioners present anecdotal evidence that one Petitioner, Della Saavedra, was forced into managed care and, as a result, a recommended MRI to diagnose the extent of her multiple myeloma was delayed two months. Another Medi-Cal recipient who cannot walk due to juvenile onset rheumatoid arthritis was unable to receive a scheduled surgery to enable her to transfer from bed to hair, was denied access to a specialist, and eventually was forced to the emergency room and hospitalization.

c. The Policy Choice Has Been Made

Whatever the merits of the policy transitioning SPDs to managed care, the Legislature has made that decision. The court does not set policy, and its personal view is irrelevant. To date, 504,836 SPDs have been moved from fee-for-service Medi-Cal to managed care.

3. The MER Process

The intent of a MER is to provide continuity of care with a fee-for-service provider when a beneficiary is in the midst of treatment for a complex condition. An SPD who is enrolled into a managed care plan can continue to see his or her fee-for-service doctor for up to 12 months if his or her doctor agreed to work with the plan, accept plan payments, and had no quality of care issues. *See* W&I §14182(b)(13), (14). In addition, an SPD who suffers from a complex medical condition and cannot safely change providers is permitted to file a MER, which, if granted, will permit him or her to remain with his or her fee-for-service provider until it was safe to move him or her to a managed care plan. *See* W&I §14182(b)(15). A MER is only approved until a beneficiary's medical condition has stabilized to a level that would enable them to change physicians and begin receiving care from a plan provider without deleterious medical effects, or a maximum of 12 months.

DHCS processes the MERs through its Health Care Options program ("HCO"), with the assistance of its enrollment broker, MAXIMUS, a private corporation. Once DHCS receives a completed MER, first MAXIMUS and then DHCS staff reviews and verifies the information in that MER to determine (1) if the beneficiary has a complex or high-risk medical condition, (2) that requires continuity of care, and (3) is treated by a fee-for-service Medi-Cal physician who is not contracted with any of the available Medi-Cal managed care health plans.

Maximus and DHCS staff review the MER to make sure that it is complete and that the beneficiary's physician is not affiliated with any of the managed care plans available to the beneficiary. If the MER is complete, DHCS medical personnel review the MER to determine if the beneficiary has a complex medical condition that justifies the beneficiary receiving continued care from his or her existing fee-for-service Medi-Cal physician rather than being transferred to a managed care plan. Fifteen doctors and nurses at DHCS review MERs. Any of them can grant a MER, but only a doctor can deny a MER.

3. Denials of MERs on New Grounds

Beginning in the Spring 2011, DHCS has denied MERs on the ground that beneficiaries' treating physicians have not provided documentation showing that the beneficiaries' medical

conditions are so unstable that they cannot be transferred without "deleterious effects" to managed care providers with the same specialties as the fee-for-service medical providers. The Department also has denied MERs on the ground that the beneficiary's physician has not provided notes from the last five office visits and/or the most recent history and physical and/or treatment plan.

DHCS applied the new ground not only to MERs from SPDs, but also to MERs from pregnant women. DHCS implemented the new standard without adopting any corresponding changes to section 53887, the MER eligibility regulation, and without sending notices to Medi-Cal beneficiaries or their providers advising them of the changes. The denial notices that were sent did not mention the "deleterious effects" standard, instead offering reasons such as "Your medical condition does not qualify for a medical exemption. This decision is based on information sent to us by your doctor."

In May 2012, DHCS revised Form HCO 7102 to remove the section permitting SPDs to file a MER for the home waiver exemption. The Department permitted a SPD participating in the home waiver program to request a medical MER just like any other SPD beneficiary on form HCO 7101, but under the Demonstration Project's Special Terms and Conditions the fact that the beneficiary participates in the home waiver program by itself does not exempt him or her from managed care.[9]

Since June 2011, SPDs have filed more than 27,000 MERs. DHCS has approved less than 20% of them.

Petitioners are among those whose MERs were denied despite their complex medical conditions. Petitioner Anita Valadez is diabetic, legally blind, and was diagnosed with breast cancer in January 2012. Petitioner Raquel Alvarez has a narrowing of the valve that separates the lower right chamber of her heart from the artery that supplies blood to her lungs, a genetic disorder that prevents normal development in various parts of the body, and an extremely rare condition which causes chronic inflammation of the blood vessels. Petitioner Juan Cameros suffers from chronic painful joint inflammation and a rare disease of the joints and tendon sheaths.

4. Deficiencies in the MER Process

In 2012, DHCS began receiving complaints about its handling of MERS for SPDs and later about problems with respect to the MERs process, in particular the notifications to beneficiaries. There were widespread errors by MAXIMUS in processing MERs from more than 9,000 SPDs, including failing to mail any denial notices, denying MERs as incomplete without giving beneficiaries the requisite 30 days to provide additional information, and providing incorrect MER status information to beneficiaries who contact the call center.

In the late summer, early fall of 2012, DHCS investigated allegations that beneficiaries

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[9]The Department previously amended its contracts with managed plans to delete language that in-home waiver beneficiaries be disenrolled from managed care, replacing them with language that such beneficiaries will continued to have comprehensive case management and all medically necessary covered services. The amendments were reviewed and approved by the federal government's Centers for Medicare and Medicaid Services.

were not receiving MER denial letters or received incorrect information about their MERs when they called MAXIMUS. This investigation revealed that, due to data entry problems, MAXIMUS had failed to send denial letters to some beneficiaries and had provided inaccurate information to some beneficiaries. DHCS also discovered that some MERs were not processed completely and were being denied prior to the treating physician being given a second chance to supply the information necessary to support the MER.[10]

DHCS admitted to the widespread errors, and issued new notices in January 2013. DHCS also issued a notice of deficiencies to MAXIMUS, imposed a Corrective Action Plan, and initiated an audit of the MAXIMUS MER processes. DHCS further conducted bi-weekly MER workgroups with stakeholders to receive their input and suggestions on drafts of revised communications, launched a MER email inbox to receive communications specifically related to MERs, and has been working with MAXIMUS to improve the accurate and timely processing of MERs.

Because of confusion regarding the MERs process, DHCS drafted a July 2012 Provider Bulletin (the "Bulletin") that explained the bases for a MER and the procedures to be used in submitting a MER. The Bulletin provided, *inter alia*, that the MER must include documentation of the beneficiary's medical condition and evidence that it is unstable and that the beneficiary's treatment cannot safely be transferred to a managed care plan physician(s) of the same specialty. Tatar Decl., Ex. V. A beneficiary granted a medical exemption from managed care enrollment shall remain with the fee-for-service provider "only until the medical condition has stabilized to a level that would enable the individual to change to an in-network physician of the same specialty without deleterious medical effects." Ibid. A MER for pregnancy will be reviewed to determine if the beneficiary is eligible for exemption and "unable to safely change providers." Ibid. "An uncomplicated pregnancy is not considered a condition that requires a beneficiary to stay with the current physician for mother and infant safety." Ibid.

DHCS concluded that it would be disruptive — the opposite of continuity of care — to move all SPDs back into regular Medi-Cal or to attempt to "redo" the transition of SPDs into managed care. This decision was supported by language in section 53887 which precludes beneficiaries who have been receiving managed care for a significant amount of time from being moved back to fee-for-service.

DHCS chose to offer those SPDs impacted by the erroneous MER process the opportunity to leave their managed care plans and return to fee-for-service Medi-Cal. The Department mailed letters to 9,098 impacted SPDs. Only 2,453 (27%) of those beneficiaries chose to return to fee-for-service. By almost a three to one margin, those SPDs who had filed MERs chose to remain in managed care.

Since October 15, 2012, DHCS has routinely approved for six months a completed MER from a SPD rather than issuing a denial in order to allow time for DHCS, MAXIMUS, and the beneficiary to resolve the issues. DHCS also is doing the following: (1) allowing beneficiaries to return to fee-for-service Medi-Cal pending a hearing on their denied MER; (2)

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[10]DHCS has admittedly "denied some MERs from Seniors and Persons with Disabilities who meet at least one of the complex medical condition categories set forth in 22 CCR section 53887(a)(2) and on HCO 7101 and 7102 forms. ..."

allowing beneficiaries to return to fee-for-service Medi-Cal and file a new MER; and (3) allowing beneficiaries to remain in fee-for-service Medi-Cal until the final resolution of their MER.

5. The MERS Process Does Not Concern Problems With Managed Care Services

Medi-Cal managed care plans are legally and contractually responsible for providing covered services, as defined in the plan's contract with DHCS, to Medi-Cal beneficiaries enrolled in such plans. Managed care plans are required to establish provider networks through which they deliver those covered services and coordinate member care.

If a SPD does not believe he or she is receiving appropriate care from his or her managed care plan, there are established procedures in place for the beneficiary to raise those concerns by filing a grievance with the plan and/or with the Department of Managed Health Care ("DMHC"). The MER process is not intended to address issues regarding the availability or quality of care received by a beneficiary from a managed care health plan, issues which are properly addressed by filing a grievance with the plan or with DMHC.

E. Analysis

This case concerns DHCS's mandatory transition of SPDs to managed care. Petitioners seek judgment on their first and second causes of action for traditional mandamus. The first cause of action seeks mandamus to prevent DHCS from using the deleterious medical effects standard to deny MERs, requiring progress notices from the last five visits and a history and physical and treatment plan,[11] and eliminating the nursing home waiver by ceasing to provide a form for that exemption. The second cause of action seeks mandamus to set aside the Department's deleterious effects standard and as an underground regulation violating the APA.

Petitioners note that Medi-Cal beneficiaries are entitled to remain in Medi-Cal on a fee-for-service basis under W&I section 14182(b)(15) and section 53887 when (1) receiving treatment for complex medical conditions from fee-for-service providers, (2) their providers do not belong to any Medi-Cal managed care plans, and the (3) beneficiaries make timely requests to be exempt from involuntary enrollment in Medi-Cal managed care. Mot. at 1. They contend that Respondent DHCS has been exceeding the scope of these provisions by imposing additional criteria for approving Medi-Cal beneficiaries' requests for exemption from enrollment in managed care. Ibid.

1 Mootness

The Department argues that the court lacks jurisdiction to address Petitioners' claims which are moot. A court may only determine "a genuine and existing controversy, calling for present adjudication as involving present rights." Housing Group v. United National Insurance Co. (2001) 90 Cal.App.4th 1106, 1111. Courts will not render opinions on moot questions or abstract propositions, or declare principles of law that cannot affect the matter at issue. Giles v. Horn (2002) 100 Cal.App.4th 206, 227. DHCS presents evidence that Petitioners have been returned to fee-for-service Medi-Cal, and contend that their claims are moot.

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[11]Petitioners present no evidence or argument on this issue.

Petitioners argue that even if their personal claims are mooted by the Department's interim remedy, they bring the first three mandamus causes of action as representatives of other SPD beneficiaries, citing Mission Hospital Regional Medical Center v. Shewry, ("Mission Hospital") (2008) 168 Cal.App.4th 460, 477-81. Reply at 2.

There is a difference between the capacity to bring suit (standing) and whether there a genuine controversy remains (mootness). If Petitioners' individual claims are moot, but they have standing to bring representative claims on behalf of other SPD beneficiaries, the first and second causes of action are not moot.

Mission Hospital does not aid Petitioners. It is a standing case that does not authorize representative mandamus. Mission Hospital merely held that 100 hospitals had standing to allege that the Department violated federal and state law by freezing Medicaid reimbursement rates. Id. at 477. The court noted that a party has traditional mandamus standing if he is a beneficially interested party – meaning one who is in fact adversely affected by governmental action. Id. at 479. The beneficial interest standard is broad, and hospitals interested in being compensated for medical services under the Medicaid program had standing to challenge the freeze. Id. at 480.

At the September 5 hearing the court invited the parties to file one-page supplemental briefs on representative standing in mandamus. Petitioners took advantage of this offer, and cite a number of cases. The court need only refer to two: Green v. Obledo, ("Green") (1981) 29 Cal.3d 126, and Brown v. Crandall, ("Brown") (2011) 198 Cal.App.4th 1.

In Green, the California Supreme Court acknowledged the general rule that a petitioner must have a beneficial interest in order to have mandamus standing. 29 Cal.3d at 126. But it reaffirmed an exception to this general rule where a question of public right and public duty is involved. In such a case, the petitioner need not show that he has any legal or special interest in the result; his interest as a citizen in enforcing the laws is sufficient. Id. at 144-45. The court held that the proper calculation of welfare benefits (AFDC) is a matter of public right, and as citizens seeking to procure the enforcement of a public duty, the plaintiffs had standing to seek mandamus commanding the agency from enforcing a regulation. Id. at 145.

In Brown, the petitioner had a beneficial interest in a writing directing the county to implement its standards for indigent health coverage and reevaulate her own claim. 198 Cal.App.4th at 13. She did not have such an interest in requiring the county to supplement its residual indigent health coverage standards to provide a process for identifying and notifying potential applicants and removing a time limit for the application. Ibid. Nonetheless, the "public right/public duty" exception to the beneficial interest (standing) requirement reaffirmed in Green applied to her case. Brown was a citizen seeking to enforce a public duty to provide "safety net health care to indigents," and the county had a duty to provide medical care to all indigent residents that a private citizen could enforce. Id. at 14. While the policy underlying the public right/public duty exception can be outweighed by competing considerations in a proper case, the public interest in the provision of health care to indigents is "weighty." Ibid.

Collectively, Green and Brown demonstrate that a petitioner who has standing to present his or her own indigent health coverage claim also has standing to present the claims of others. Even a mere citizen seeking to enforce a public duty may have standing. Consequently, Petitioners have standing to present the claims of other SPDs in the Department's application of

the deleterious medical effects standard to deny MERs, and eliminating the home waiver. While Petitioners own claims on these issues arguably are moot,[12] their claims with respect to other SPDs are not.

The first and second causes of action are not moot.

2. Adequate Remedy at Law

The Department argues that Petitioners have adequate remedies at law concerning their allegations of availability and quality of their managed care. Opp. at 5-6. The MER process is not intended to address issues regarding the availability or quality of care received by a beneficiary from a managed care health plan, issues which are properly addressed by filing a grievance with the plan or with DMHC, and seek a fair hearing and judicial review for that grievance. Ibid.

This is a red herring. It is true that Petitioners present detailed evidence on the delays, cancellations, and denial of prescription and other services which they have undergone while in managed care. It is also true that this evidence is relevant only to the public policy issue of whether SPDs should be subject to mandatory managed care, an issue which the Legislature has decided and over which the court has no control. Nonetheless, the mandamus claims concern Petitioners' eligibility for approval of a MER, not the quality of care received in managed care. There is no administrative process for the Department's failure to follow the law in its MER process.

3. The Deleterious Medical Effects Standard

Petitioners challenge DHCS's application of section 53887 in deciding MERs based on the requirement for verification that beneficiaries' medical conditions are so unstable that they will suffer "deleterious medical effects" if placed in managed care.

a. Petitioners' Position

Petitioners argue that SPD eligibility for a medical exemption from managed care is contained in section 53887(a)(2). The plain language of section 53887(c) requires DHCS to approve a MER that meets the section's requirements. A beneficiary is eligible for a temporary continuity of care exemption if he or she files a MER and has a complex medical condition and receives treatment or services from a Medi-Cal physician who is not a managed care provider in

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[12]Petitioner's individual claims arguably are not moot. "Claims are not moot where (1) a matter is of general public interest and is likely to recur in the future or (2) a case presents questions that are capable of repetition, yet evade review." Californians for Alternatives to Toxics v. Dept. of Pesticide Regulation, (2006) 136 Cal.App.4th 1049, 1069. Although the Department has agreed to keep Petitioners on fee-for-service through the pendency of this case, their claims are a matter of general public interest and are likely to occur in the future if the 12-month period has not expired and they apply for another MER. While DHCS argues that any future claims will be subject to administrative review (Opp. at 4-5), the Department cites no evidence or law permitting Petitioners to challenge the Department's failure to comply with its own statutory and regulatory obligations in a MER appeal hearing.

his/her county. §53887(a)(2). There are nine conditions meeting the criteria for complex medical condition, and Petitioners correctly note that subsection (a)(2) does not impose any requirement for proof of "deleterious medical effects." Mot. at 7.

Petitioners argue that deleterious medical effects also are not listed as a ground for denial of a MER. Rather, a MER based on a complex medical condition shall not be approved for an eligible beneficiary only where the beneficiary has been in managed care more than 90 days, the beneficiary began treatment after the day of enrollment in managed care, or the beneficiary's current Medi-Cal doctor contracts with a managed care plan. §53887(a)(2)(B). Petitioners conclude that since neither the eligibility nor the denial provisions in section 53887 discuss deleterious medical effects, it is not a ground for denial. Mot. at 8.

Petitioners acknowledge that deleterious effects appears in section 53887(a)(3)'s statement that an eligible beneficiary granted a MER shall remain in fee-for-service only until the medical condition has stabilized, permitting a change to managed care without deleterious medical effects, as determined by the beneficiary's fee-for-service physician. They contend that this provision concerns the *duration* of a MER, not the eligibility for continuity of care and *granting* of a MER. They contend that the Department has wrongly conflates the two, and point out that section 53887(a)(3) begins with an express exception for "pregnancy" from the deleterious medical effects requirement. Petitioners argue that DHCS has routinely denied MERs from pregnant women on the ground they have not proven that their transfer would have deleterious medical effects. Mot. at 8-9.[13]

Petitioners argue that the use of both past and present tense in section 53887(a)(3) – a beneficiary "granted" a MER "shall remain"[14] until stabilized -- is significant for purposes of interpretation, and the regulation cannot be clearer that the fee-for-service doctor decides whether the stabilization has occurred. Mot. at 9. Moreover, section 83887(b) requires a beneficiary to request a MER on Form 7101, which concerns principally the nature of the complex medical condition and contains no questions about the medical consequences of transfer to managed care and no reference to "deleterious medical effects." Mot. at 9-11.

Thus, according to Petitioners, DHCS has implemented and has been enforcing an informal policy requiring proof of deleterious medical effects to approve MERs. The MER

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[13]Petitioners clarified at the September 5 hearing that this case concerns only SPDs, not pregnant women, and their argument concerning the denial of pregnancy MERs is made in support of their statutory interpretation. Petitioners' supplemental brief shows that a pregnant woman is presumptively eligible for Medi-Cal on a fee-for-service basis while full Medi-Cal eligibility is being determined. W&I §14148.7. This lasts until the third trimester, when the woman is moved into another program applicable to parents and children (the unborn child is considered a dependent). Women in the third trimester are automatically enrolled in managed care. Petitioners have presented evidence that this move to managed care in the last trimester can be disruptive in the woman's care. Women in the third trimester are eligible for a medical exemption under section 53887.

[14]The court is no grammarian, but believes that "shall remain" is a future perfect, not present, tense.

process is supposed to happen quickly. DHCS must accept and process a MER within two working days and notify a beneficiary within seven working days. As a practical matter, DHCS should accept the treating physician's determination of the complex medical condition and how long he or she should be exempt from managed care. The Department's new policy requiring proof of no deleterious medical effects is an additional eligibility requirement not authorized by statute or regulation. Mot. at 11.

b. DHCS Is Entitled to Test the Validity of a MER at Any Time

Petitioners acknowledge, but do not really address (Mot. at 10), the fact that the express language of section 83887(c) permits DHCS to verify the validity of the complex medical condition supporting a MER "at any time" (emphasis added). They suggest that the first sentence of section 83887(c) requires the HCO program to approve the MER if it meets the section 83887 requirements, and the Department is permitted to verify the statements later on. Ibid.[15]

Petitioners' approach -- approval of a MER based on a treating physician's Form 7101 certification and a subsequent verification of the medical condition -- is certainly permissible under section 83887. But that does not mean that the Department's practice of verifying that the medical condition has not stabilized such that the SPD can be moved to managed care without deleterious medical effects is not.

Section 83887(c)'s language permits the Department to test the validity of a MER at any time. This means it has the discretion to perform the verification that the SPD cannot be moved to managed care at the very outset of the approval process. The Department correctly argues: "There is no language in section 53887 that states, or implies, a beneficiary is entitled to automatic approval of a MER if a form is submitted by the treating physician." Opp. at 6.

Indeed, section 53887(c) merely requires approval of a MER that "meets the requirements of this section." The entirety of section 83887 includes not just subdivision(a)(2)'s eligibility requirements but also subdivision (a)(3)'s duration requirement that the beneficiary remain with the fee-for-service provider only until his/her condition has stabilized so that he/she can be transferred to managed care without deleterious medical effects. The Department has the discretion to consider this duration issue at the very outset of the temporary continuity of care exemption. Simply put, "at any time" means at any time.

The plain language of section 83877(c) supports the Department's interpretation that it may verify that the beneficiary's medical condition has not yet stabilized to a level that would enable him or her to change physicians and begin treating with a managed care provider without deleterious effects before granting a MER. The Department's interpretation of its own regulation is entitled to considerable deference, and must be upheld unless unauthorized or clearly

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[15]At the September 5 hearing, Petitioners counsel clarified their position that there is a three step process. First, the state obtains the involuntary enrollment of a Medi-Cal population through federal waiver. Second, the affected beneficiary applies for and obtains a medical exemption through a MER. Third, the Department ends the exemption because his/her condition has stabilized so that he/she can be transferred to managed care without deleterious medical effects

erroneous. *See* Communities for a Better Environment v. State Water Resources Control Board, (2003) 109 Cal.App.4th 1089, 1107.

Petitioners' interpretation of section 83877 as requiring the Department to engage in a two-step process of exception from managed care enrollment and subsequent termination of such enrollment would permit doctors to control the transition of their patients to managed care. Yet, managed care for SPDs is mandatory under the federal Demonstration Project Waiver unless the beneficiary is exempt. The Department presents evidence that section 58377(c)'s purpose was to protect the Department against fraud by a small number of unscrupulous Medi-Cal doctors. Opp. at 8-9. Petitioners' position would prevent the Department from moving SPDs to managed care even where it is determined that the beneficiary never should have received a medical exemption.

Petitioners incorrectly rely on section 53887(a)(2)(B), which merely provides that a MER for an eligible beneficiary (that is, one with a qualifying complex medical condition) still may be denied under certain circumstances. The issue in this case is whether an otherwise eligible SPD should be moved to managed care anyway because their medical condition has stabilized. Section 53887(c) is a different limitation on the exemption from managed care than section 53887(a)(2)(B).

Petitioners rely on W&I section 14182(b)(15), which provides that DHCS shall "[e]nsure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800) ... of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations... are applied to seniors and persons with disabilities." They argue that this provision codified the existing regulations for processing MERs set forth in 22 CCR section 53800 *et seq*. Petitioners rely on a principle of law that where a statute adopts a regulation by specific reference, the regulation is incorporated "in the form in which they exist at the time of the reference and not as subsequently modified," citing to Palermo v. Stockton Theatres, ("Palermo") (1948) 32 Cal.2d 53, 58-59; *accord*, In re Jovan B. (1993) 6 Cal.4th 801, 816: Mot. at 6; Reply at 6-7.

In essence, Petitioners argue that section 53887 is frozen, both in language and interpretation, by W&I section 14182(b)(15)'s reference to medical exemption criteria applied to SPDs in Title 22 CCR.

In Palermo, the California Supreme Court addressed a lease of commercial property to Japanese nationals who by definition were aliens not eligible for citizenship in the United States. Id. at 55. A California statute granted the right of aliens to lease real property in California to the extent permitted by "any treaty now existing between the United States and Japan." Ibid. (second quotation omitted). In addition to the principle that a statute adopting a regulation by specific reference incorporates the reference in the form that existed at the time of adoption, the Palermo court also stated: "It also [] [must] be noted that there is a cognate rule, recognized as applicable to many cases, to the effect that where the reference is general instead of specific, such as a reference to a system or body of laws or to the general law relating to the subject in hand, the referring statute takes the law or laws referred to not only in their contemporary form, but also as they may be changed from time to time..." 32 Cal.2d at 59. The Palermo court ultimately decided that the reference to the treaty with Japan was specific and not general in order to avoid the constitutional issues that would be created to the treaty-making authority of the federal

government by delegating California's power to control future acts. Id. at 60. Thus, the California statute incorporated the then-existing provisions of the treaty and retained them even after the treaty was abrogated. Ibid.

Unlike Palermo, the interpretation of W&I section 14182(b)(15) bears no constitutional restraints. That provision does not incorporate by reference, expressly or implicitly, section 53887 itself. Instead, it refers to the medical exemption criteria which happened to be contained in section 53887, and directs that they be applied to SPDs. W&I section 14182(b)(15) only requires that the medical exemption criteria used by certain counties (those operating under a particular chapter of Title 22) be applied to SPDs. Medical exemption criteria can change. Nothing in W&I section 14182(b)(15) suggests that these criteria must be immutable. The reference to section 53887 in W&I section 14182(b)(15) is a general reference, not specific, and section 53887 is not frozen by the statute.

Again unlike Palermo, in which the statute referred to another jurisdiction's law (the treaty), section 53887 was promulgated pursuant to the very statutory scheme that permits the Department to require Medi-Cal populations to enroll in managed care. It would be strange indeed if the Legislature authorized DHCS in W&I section 14182(a) to require SPDs to be assigned as mandatory enrollees into managed care plans, but froze the criteria used by the Department to evaluate their medical conditions to determine if their MER is actually valid.

Finally, as DHCS argues (Opp. at 8-9), neither the language of section 53887 nor its interpretation has changed. In 2000, the Department amended section 53887 in part to address a problem of unscrupulous fee-for-service providers. The Department has always interpreted section 53887 to permit it to verify a medical exemption at any time. It is only the practice that has changed. The Department performs that verification for SPDs at the outset of the MER process.

Nor does section 53887(a)(3)'s reference to an express exception for "pregnancy" benefit Petitioners' argument. That exception is not from the deleterious medical effects requirement, but from the 12-month time limit imposed on any other medical exemption. Section 53887(a)(3) states that a beneficiary granted a medical exemption due to pregnancy may remain with the fee-for-service provider through delivery and the end of the month that is 90 days after delivery. But DHCS may deny a MER from a pregnant woman on the ground she has not proven that her transfer would have deleterious medical effects.[16]

In sum, section 83887(c)'s language permitting the Department to test the validity of a MER at any time provides it discretion to perform that test at the very outset of the approval process.

4. Form 7101 Must Be Amended

Although the Department has discretion under section 53887 to verify that the

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[16]As the Department argues (Opp. at 12), any lack of clarity was remedied by the Bulletin, which provides that exemption requests for pregnancy are reviewed under the criteria (including deleterious medical effects), an uncomplicated pregnancy is not considered a condition that requires a beneficiary to stay with a fee-for-service provider, but special consideration will be given to women in their third trimester.

beneficiary's medical condition has not yet stabilized to a level that would enable him or her to change physicians and begin treating with a managed care provider without deleterious effects, it seems clear that the Department is violating its own regulation in one respect.

Section 53887(b) stipulates that Form 7101 shall be used by a beneficiary to request "[e]xemption from plan enrollment or extension of an approved exemption due to a complex medical condition." Yet, nothing in Form 7101 mentions the requirement that the beneficiary show that he or she cannot transition to managed care without deleterious medical effects.

The Department relies on the Bulletin, which explained that (1) a beneficiary will be granted a medical exemption "only until the medical condition has stabilized to a level that would enable the individual to change to an in-network physician of the same specialty without deleterious medical effects," and (2) the MER must include documentation of the beneficiary's medical condition and evidence that it is unstable and that the beneficiary's treatment cannot safely be transferred to a managed care plan physician(s) of the same specialty. Opp. at 10.

This Bulletin may constitute adequate constructive notice to providers, but it does not appear to be actual notice.[17] Nor is it actual notice to the SPD beneficiary. Section 53887(b) expresely requires the beneficiary to apply for a MER on Form 7101, and it requires the treating physician to certify the Form and submit it by mail or facsimile. How can a physician present the proper information if he does not actually know that a complex medical condition is insufficient, and that he or she must also provide proof of the condition's instability such that the beneficiary cannot be transitioned without deleterious medical effects? It is one thing to grant the MER and subsequently evaluate the status of the medical condition without including this information in the Form or its instructions. It is quite another for the Department to include the deleterious medical effects requirement as a ground for denying a MER at the outset without instructing providers what is necessary.

Section 53887(b) requires that the SPD's MER be evaluated based on Form 7101 and its attachments. Therefore, the Department must list all information necessary for the evaluation on the form or in its instructions. A Bulletin is insufficient. The Form, and its instructions, must be amended to clearly provide the information concerning deleterious medical condition and the need for documentation of its instability discussed in the Bulletin. Without that information, the Department has violated section 53887(b).

At the September 5 hearing, Petitioners counsel confirmed that the content of Form 7101 is not at issue in the first or second causes of action. Therefore, this failure is irrelevant to the outcome of this motion.

5. <u>The Department's Removal of the Home Waiver Programs from MER Eligibility</u>

Petitioners challenge DHCS's decision no longer to accept MERs in the home waiver program. Petitioners note that section 53887(a)(2)(A)(8) provides that a MER should be granted for a Medi-Cal beneficiary who "is enrolled in Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in

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[17]The Department's counsel could not say at the September 5 hearing whether actual notice was provided because she did not know the manner in which the Bulletin was given to Medi-Cal providers, and whether every fee-for-service provider would have received it.

a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility." Prior to 2012, Medi-Cal beneficiaries submitted the original Form 7102 to request a medical exemption based on their enrollment in one of these four nursing home waiver programs. In May 2012, DHCS removed the nursing home waiver from the Form so that there is no nursing care home waiver exemption.

Thus, according to Petitioners, DHCS has effectively eliminated an entire category of MER eligibility, violating both section 53887(a)(2)(A)(8) and W&I section 14182(b)(15). Petitioners request that the court prohibit DHCS from using the new Form 7102 and, more importantly, from denying MERs from beneficiaries who qualify under the home waiver exemption.

DHCS has complied with federal and state law governing the SPD transition in deciding MERs filed by SPDs who were enrolled in waiver programs. By definition, home waiver program enrollees receive benefits from Medi-Cal which enable them to live at home or in the community rather than an institutional setting. The Terms and Conditions of the Demonstration Project, which control (*see* W&I §14182(m)), authorize the inclusion of SPDs as a population required to enroll in managed care. The Terms and Conditions do not identify home waiver program enrollees as an exempt population. *See* Portela Decl., Ex.B, p.161. Nor does W&I section 14182 purport to exempt home waiver enrollees from mandatory enrollment in managed care. Thus, they are like any other SPD population.

In essence, the Demonstration Project Waiver and W&I section 14182(a) authorize the Department to require that SPDs be included in managed care. The Department has included all SPDs in managed care unless a medical exemption applies. Section 53887(a)(2) provides for a medical exemption for continuity of care for certain complex medical conditions. Participation in a home waiver program is a complex medical condition under Section 53887(a)(2)(A)8. Although participation in a home waiver program is a qualifying medical condition, the deleterious medical effects standard in section 53887(a)(3) still applies. An SPD with a complex medical condition due to participation in a home waiver program must show that his or her condition has not stabilized such that he/she can be moved to managed care without deleterious effects.

Petitioners argue that the fact that the Terms and Conditions and W&I section 14182 do not expressly exempt home waiver program enrollees from managed care is not controlling. They do not expressly exempt SPDs with other complex medical conditions either. Reply at 7-8. There is no reason to treat waiver program beneficiaries differently. Ibid.

The Department does not treat waiver program beneficiaries differently. Beneficiaries who participate in a home waiver program are not categorically exempt from managed care. That is, they do not simply have to show that they are in a home waiver program and become eligible for a medical exemption. This is no different than a pregnant woman, a beneficiary receiving chronic renal disease dialysis treatment, an HIV or AIDs patient, or any of the other categories in section 53887(a)(2)(A). Each must show their complex medical condition and that the condition has not stabilized to a level that would enable him or her to change to managed care

without deleterious medical effects.[18]

DHCS continues to accept MERs from SPDs enrolled in the home waiver program on the regular Form 7101, and processes them just like other MERs according to the criteria of the regulation. "In May 2012, as part of the implementation of the...Demonstration Project, the Department revised form HCO 7102 to remove the section of that form permitting non-medical MERs to be filed by SPDs participating in a 1915(c) [HCBS] waiver. SPDs who are participating in such a waiver program may request a medical MER just like any other SPD beneficiary – on form HCO 7101, but under the demonstration's terms they were no longer entitled to a non-medical exemption from plan enrollment simply because they were receiving HCBS waiver services." Portela Decl., ¶4.

Petitioners complain that the revised Form 7102 no longer includes language advising of the home waiver exemption. Mot. at 11. However, this is appropriate, since there is no right to a *per se* exemption based on the existence of a home waiver. Petitioners' objection to the revision of Form 7102 is not well taken.

But again there is a problem with the Department's lack of instructions to beneficiaries and their fee-for-service providers, and in this instance, also of notice. At the September 5 hearing, the Department's counsel conceded that the Bulletin does not address the revision of Form 7102, the availability of an exemption for SPDs with a home waiver as their complex medical condition, or that they should apply on Form 7101. The Department should have notified Medi-Cal providers of this change. It is insufficient to simply accept MERs from SPDs enrolled in a home waiver program on Form 7101. *See* Opp. at 12. Moreover, the same defect in Form 7101 discussed *post* concerning the deleterious medical effects standard applies.

As this motion does not concern either the issue of notice for the change in forms, or the adequacy of Form 7101, the Department's failure is irrelevant to the outcome.

6. Underground Regulation

Petitioners argue that the deleterious medical effects standard and elimination of the home waiver is an underground regulation that violates the APA's mandate that "[n]o state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in Section 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State ..." Govt. Code §11340.5(a). The APA was designed in part to prevent the use of underground regulations by agencies. California Advocates for Nursing Home Reform v. Bonta, (2003) 106 Cal.App.4th 498, 506. DHCS has implemented an informal, general regulation of denying a MER where the beneficiary does not have proof that they would suffer deleterious medical effects from transition to manage care and by eliminating the home waiver as a MER eligibility category by ceasing to use Form 7102. Mot. at 13.

While the Department's policy concerning deleterious medical effects could be considered an informal, general regulation, the Department was expressly authorized to

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[18]At the September 5 hearing, the Department's counsel acknowledged that the Bulletin does not address this issue. This would seem to be a deficiency.

implement it. W&I section 14182(k) provides that, notwithstanding the APA's requirements, the Department may "implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action."

At the September 5 hearing, the Department's counsel clarified its position that, in issuing the Bulletin, it was "implementing" W&I section 14182, and "implementing and interpreting" section 53887.

Clearly, the Bulletin is a provider bulletin. The Bulletin also explains the bases for a MER and the procedures to be used in submitting a MER. The Bulletin provides, *inter alia*, that the MER must include documentation of the beneficiary's medical condition and evidence that it is unstable and that the beneficiary's treatment cannot safely be transferred to a managed care plan physician(s) of the same specialty. It further explains that a beneficiary granted a medical exemption from managed care enrollment shall remain with the fee-for-service provider "only until the medical condition has stabilized to a level that would enable the individual to change to an in-network physician of the same specialty without deleterious medical effects."

By discussing a new practice with respect to the timing of medical exemption verification, the Bulletin is at least implementing W&I section 14182 and 53887. As such, it is exempt from the APA.

Although the Bulletin discusses the deleterious medical effects standard, the Department's counsel conceded at the September 5 hearing that the Bulletin does not cover its elimination of the home waiver program from automatic medical exemption by deleting Form 7102. Thus, there is nothing to support DHCS's change in policy/practice on the home waiver. Notably, the Bulletin does discuss the fact that an uncomplicated pregnancy is not considered a condition that requires a beneficiary to remain with fee-for-service. It should have discussed the home waiver as well.

Given that there is no provider bulletin or other informal document supporting the Department's change in policy with respect to SPDs who are home waiver enrollees, Petitioners would seemingly be entitled to judgment that the change constitutes an "underground regulation." However, Petitioners incorrectly argue that this issue is part of the FAP's second cause of action. That claim alleges only that the deleterious medical effects standard is an underground regulation. *See* FAP, ¶65.[19] The home waiver is not within the scope of the second cause of action.

The motion for judgment is denied in its entirety.

4. The Motion for a Preliminary Injunction

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[19]Paragraph 65 does refer to "other requirements" but the FAP does not provide any information suggesting that these other requirements include a change in policy for home waivers. The paragraphs incorporated by reference in the second cause of action merely state that DHCS removed the home waiver from Form 7102 and has not sent information to enrollees on how to apply for it (¶42), and that the "standards and practices" used in the MER determination process include the effective elimination of the home waiver by ceasing to use a form (¶60).

In the alternative, Petitioners seek a preliminary injunction prohibiting DHCS from (1) denying MERs from Petitioners and other Medi-Cal beneficiaries on the grounds that the beneficiary has not proved that their transfer to Medi-Cal managed care will have deleterious medical effects, (2) denying MERs from Petitioners and other Medi-Cal beneficiaries who qualify under the nursing home exemption, and (3) using the new HCO Form 7102 and ceasing to provide Petitioners and other Medi-Cal beneficiaries with old HCO Form 7102, or some other form which includes the nursing home waiver.

CCP section 526 provides for issuance of a preliminary injunction where moving party can establish a reasonable likelihood of success on the merits and threat of irreparable harm. A ruling on a motion for preliminary injunction involves determination of contested fact issues relating to the merits. The judge actually weighs evidence and resolves conflicts. Kohn v. Superior Court (1966) 239 Cal.App.2d 428, 430; Pacific & Southwest Annual Conf. of United Methodist Church v. Superior Court (1978) 82 Cal.App.3d 72, 80.

For the reasons set forth *ante*, Petitioners have failed to establish that the Department's denial of MERs which do not show that transfer to managed care would have deleterious medical effects, and the Department's decision to require home waiver program enrollees to seek a medical exemption just like any other SPD were an abuse of discretion. Petitioners have therefore failed to establish a reasonable likelihood of prevailing on the merits of the first and second causes of action.

Nor have Petitioners demonstrated irreparable harm. There is no harm *pendent lite* for Petitioners individually, and there has not been a showing of irreparable harm to other SPD beneficiaries. Margaret Tatar, Chief of the Medi-Cal Managed Care Division, declares that DHCS is drafting an All Plan Letter to provide additional direction to managed care plans on continuity of care requests by SPDs. Tatar Decl., ¶13. While the court believes additional actions should occur as outlined above, these actions are not within the scope of Petitioners's claims. Therefore, Petitioners have failed to establish an immediate threat of irreparable harm.

The court must consider the public interest in deciding whether to enjoin a state agency in the performance of its duties. O'Connell v. Superior Court, (2006) 141 Cal.App.4th 1452, 1464. Petitioners have not shown a probability of success or an immediate threat of irreparable harm. The motion for a preliminary injunction is denied.

F. Conclusion

Petitioners' motion for peremptory writ of mandate on their first two causes of action, and the alternative motion for preliminary injunction, are denied.

DECLARATION OF SERVICE BY U.S. MAIL

Case Name: **Saavedra, Della, et. al vs. Douglas, Toby; DHCS**
Case No.: **BS140896**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service with postage thereon fully prepaid that same day in the ordinary course of business.

On September 16, 2013, I served the attached **NOTICE OF RULING ON PETITIONERS' MOTION FOR PEREMPTORY WRIT OF MANDATE UNDER CODE OF CIVIL PROCEDURE SECTION 1094, AND FOR PRELIMINARY INJUNCTION** by placing a true copy thereof enclosed in a sealed envelope in the internal mail collection system at the Office of the Attorney General at 300 South Spring Street, Suite 1702, Los Angeles, CA 90013, addressed as follows:

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I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on September 16, 2013, at Los Angeles, California.

Yesenia Caro
Declarant

Signature

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51366914.doc

Exhibit B

CONFIRMING COPY

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No filing fee is required per Welf. & Inst. Code §10962

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SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

DELLA SAAVEDRA; JUAN CAMEROS ANITA VALADEZ; RAQUEL ALVAREZ, by her mother and guardian Martell Alvarez; [redacted] by her guardian ad JANET FARAHMAND,	) CASE NO: BS140896)) Unlimited Civil Case) SECOND) AMENDED PETITION FOR) WRIT OF MANDATE) [Code of Civ. Proc. §§1085 and) 1094.5; Welf. & Inst. Code § 10962];
Petitioners,	)
v.	)
TOBY DOUGLAS, in his official capacity as Director, California Department of Health Care Services CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, and DOES 1-20, inclusive,	)
Respondents.	)

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INTRODUCTION

1. At stake in this lawsuit is the health of Petitioners and thousands of other low income California residents who are Seniors and Persons with Disabilities, who suffer from complex, often life threatening, medical conditions, and who should be exempt from enrollment in Medi-Cal managed care plans. These individuals are some of the State's most fragile citizens as they live with such severe, long lasting diseases as cancer and AIDS. Petitioner Della Saavedra, for example, suffers from Multiple Myeloma, hypertension and diabetes. Until recently, these Medi-Cal beneficiaries were able to obtain necessary specialty care on an ongoing and coordinated manner from physicians who treated them on a fee-for-service basis.

2. Beginning in June 2011, more than 240,000 Seniors and Persons with Disabilities in Los Angeles and fifteen other California counties have no longer been allowed to receive medical care on a fee-for-service basis. They have instead been involuntarily enrolled in Medi-Cal managed care plans that often are ill equipped to meet all of their complicated medical needs and unwilling to provide the specialty care and medications they need. Respondent Department of Health Care Services ("Department" or "DHCS") has effectuated this massive transfer of these often frail individuals into managed care without regard to the adverse impact on their ability to receive necessary medical services and in violation of these individuals' rights under the law.

3. Continuing the course of treatment, without interruptions, is critical for Seniors and Persons with Disabilities who have complicated health care needs. Thus, under state law and regulations, these Medi-Cal beneficiaries are entitled to remain with their fee-for-service providers if they are currently receiving "treatment or services for a complex medical condition." *See* Welfare and Institutions Code ("W&IC") §14182(b)(15); 22 California Code of Regulations ("CCR") §53887. "[C]onditions meeting the criteria for a complex medical condition, include, and are similar to" nine specified conditions, such as receiving chronic renal dialysis treatment or chemotherapy, radiation therapy or other course of accepted therapy for cancer. *Id.*

4. For beneficiaries to be exempt from enrollment in managed care, their current treating physicians must submit a Medical Exemption Request ("MER") on their behalf on the prescribed HCO 7101 or 7102 forms. Apart from the information requested on these standard

forms, state law does not require Medi-Cal beneficiaries to provide any additional documentation to remain in fee-for-service (also known as regular) Medi-Cal for up to twelve months and further exemptions can be allowed thereafter. Moreover, decisions on MERs are required to be made within two days of receipt.

5. DHCS has, however, routinely denied MERs from elderly and disabled beneficiaries with complex medical conditions by applying additional, secret and more stringent criteria to grant their exemption requests. Under one of these unwritten standards, Medi-Cal beneficiaries are now required to present evidence that their conditions are so unstable that they cannot be safely transferred to a physician with the same specialty in the managed care plan without suffering deleterious effects.

6. DHCS is unlawfully enlarging the scope of W&IC §14182(b)(15) and 22 CCR §53887 by imposing extra eligibility conditions for Seniors and Persons with Disabilities to remain in regular Medi-Cal. The Department is also violating Government Code §11340.5 by enforcing what are in effect underground regulations concerning MERs from these Medi-Cal beneficiaries that have not been adopted in conformity with the California Administrative Procedures Act.

7. DHCS is further violating the rights of Seniors and Persons with Disabilities under a host of other state laws. Recently enacted W&IC §14182(b)(21) in particular mandates that "[a] beneficiary who has not been enrolled in a plan shall remain in fee-for-service Medi-Cal if a request for exemption from plan enrollment or appeal is submitted, until the final resolution."

8. Contrary to W&IC §14182(b)(21) and other laws, the Department has ended fee-for-service Medi-Cal for elderly and disabled beneficiaries who have timely filed MERs prior to a final determination of their exemption requests. When DHCS has made decisions to deny MERs, it has also issued to these beneficiaries inadequate, conclusory notices of action which contain no explanation of the specific factual and legal reasons for these denials. These notices also fail to advise beneficiaries of the procedures whereby they could continue to receive fee-for-service Med-Cal from the time they appeal the denial of their MER until a hearing officer decides their administrative appeal.

9. Within DHCS the Medi-Cal Managed Care Office of the Ombudsman reportedly "helps solve problems from a neutral standpoint to ensure" that Medi-Cal beneficiaries "receive all medically necessary covered services for which [managed care] plans are responsible."[1] Although the Ombusdmen are supposed to be "objective" and "impartial," they represent DHCS and oppose Seniors and Persons with Disabilities in administrative hearings concerning DHCS' denials of MERs from these beneficiaries. Having sided with the Department, the Ombudsmen nonetheless make the subsequent decision whether to grant or deny rehearing requests from Medi-Cal beneficiaries as to administrative decisions affirming the denials of their MERs. The Ombudsmen often deny these rehearing requests without supplying the requisite factual or legal reasoning. In authorizing the Ombusdmen to act as advocate, judge, and jury in the same administrative proceeding, the Department is violating Government Code §11425.30(a)(1), WIC §10960(a) and (c), 22 CCR §53893, and the Due Process Clause of the California Constitution.

10. In November 2012, DHCS publicly acknowledged that thousands of Seniors and Persons with Disabilities had been defaulted into managed care even though they had timely filed MERs. In January 2013, DHCS sent a notice, known as Letter X, to thousands of these Medi-Cal beneficiaries informing them that their MERs had been denied without any notice. Letter X did not, however, supply the affected beneficiaries with any reasons for the denial of their MERs. Letter X also shortened the time that these beneficiaries could appeal the denial of their MERs from 90 days to 45 days.

11. In January 2013, DHCS also sent a notice, known as Letter B, to thousands of additional Seniors and Persons with Disabilities informing them that their MERs had been denied before their then treating physicians had the opportunity to present further documentation to support their MERs. Letter B did not, however, inform the affected beneficiaries of what further documentation had not been presented by their providers. Letter B gave beneficiaries six months to file a new MER. However, recipients had only 30 days to make a telephonic request for reinstatement to fee for service pending decision on the new MER. For beneficiaries who remain in

[1] http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx

the managed plan, Letter B requires them to file new MERs within 45 days, when they are permitted 90 days by statute.

12. In January 2013, on information and belief, DHCS further complicated matters by sending the B and X letters to the wrong people, sending no letters to some Seniors and Persons with Disabilities who should have received these letters, and in some instances sending both letters to certain beneficiaries. For Seniors and Persons with Disabilities who received the B and X letters, DHCS will continue to move forward based on inadequate notice and process and to apply improper standards in adjudicating their exemption requests, including use of the deleterious standard.

13. Petitioners Della Saavedra, Juan Cameros, Anita Valadez, Raquel Alvarez, [redacted] and Janet Farahmand are disabled Medi-Cal beneficiaries who for years have received treatment for their complex medical conditions from providers on a fee-for-service basis. Respondents wrongfully denied the MERs for these Petitioners in part due to unlawful application of the deleterious effects standard. Respondents also defaulted these Petitioners into managed care before or immediately after receiving a denial of their MERs and sent them conflicting, erroneous and/or misleading notices about their enrollment status. It was only after the intervention of undersigned counsel that DHCS ultimately reinstated all the Petitioners but Ms. [redacted] and Ms. Farahmand to regular Medi-Cal in October 2012 and granted their respective MERs effective from November 1, 2012, to October 31, 2013. It was only through the intervention of undersigned counsel that DHCS granted Ms. [redacted] a temporary exemption. Ms. Farahmand was returned to fee-for-service pending resolution of her MER.

14. Petitioners seek a writ of mandate under Code of Civil Procedure §1085 compelling Respondents DHCS and DHCS' current Director, Toby Douglas, to comply with their legal duties under state law and regulations governing the processing and disposition of MERs from Seniors and Persons with Disabilities. Petitioners also seek injunctive and declaratory relief for those Seniors and Persons with Disabilities whose due process rights are currently being violated and/or who are currently deprived or will be deprived of the necessary medical treatment they are entitled to receive as a result of the wrongful denials of their MERs. Without continued care from their fee-

for-service providers for their complex medical conditions, these desperately ill and fragile individuals are at imminent risk of irreparable harm to their health and safety.

PARTIES

A. Petitioners

15. Petitioner Della Saavedra is a Medi-Cal recipient. She is a Person with Disabilities with complex medical conditions, including Multiple Myeloma (cancer of the plasma cells), Idiopathic Thrombocytopenia (abnormally low platelet count, now in remission), iron deficiency anemia (also in remission), hypertension (high blood pressure), and insulin-dependent diabetes. Beginning in 1990, Ms. Saavedra has been treated at City of Hope by Dr. Anthony Stein, Dr. Wei Feng and other physicians on a fee-for-service basis. In November 2011 Ms. Saavedra's physician(s) filed a timely MER on her behalf, but on March 19, 2012 Respondents unlawfully denied the MER for this cancer patient and involuntarily defaulted her into a managed care plan even though she had filed a timely appeal of the denial of her MER. In a letter dated July 17, 2012 the administrative law judge granted Ms. Saavedra a temporary exemption from enrollment in managed care. However, the chief ombudsman for DHCS overturned this decision and also submitted a position statement that this Petitioner had failed to document "any high risk or complex medical conditions" and therefore she would suffer no deleterious medical effects from the transfer to managed care. She received an unfavorable hearing decision denying her medical exemption. Meanwhile, Respondents allowed Ms. Saavedra to resume treatment with Dr. Stein and Feng in July 2012, but the managed care plan would not allow her to receive her blood tests, magnetic resonance imagings ("MRIs"), or other diagnostic tests at City of Hope. This Petitioner also did not receive these tests from the managed care plan contractors in a timely manner. In early September 2012, Ms. Saavedra's adult children found her in a diabetic coma at her home and she was transported to the emergency room for treatment. On October 22, 2012, and only after Petitioners' counsel had threatened legal action, Respondents granted Ms. Saavedra's MER for a twelve-month period of time.

16. Petitioner Juan Cameros is a Medi-Cal recipient. He is a Person with Disabilities with complex medical conditions, including Ankylosing Spondylitis (chronic painful inflammation

of joints, including his hips, knees and eyes) and Pigmented Villonodular Synovitis, (an extremely rare disease which involves a lesion of the synovial membrane of the joints and tendon sheaths) which causes extreme knee pain and swelling. Although Mr. Cameros is 35-years old, both of his hips have already been replaced. Mr. Cameros was previously receiving care on a fee-for-service basis from Dr. C. Thomas Vangsness, an orthopedic surgeon and a Professor of Orthopedic Surgery in the Keck School of Medicine at the University of Southern California. One of Dr. Vangsness' specialties is treating knees in relatively young patients so as to avoid or delay knee replacements. In June 2011, Dr. Vangsness performed an arthroscopy (a minimally invasive surgical procedure) on Mr. Cameros' left knee to remove the affected joint lining. In September 2012, Mr. Cameros submitted a MER based on his complex medical condition. On February 16, 2012, Dr. Vangsness recommended that this Petitioner have arthroscopic surgery on his right knee as soon as possible. On March 1, 2012, however, the Department defaulted Mr. Cameros into managed care. (Although DHCS purportedly sent a notice of the denial of the MER on February 27, 2012, Mr. Cameros did not receive the notice). Since March 2012, Mr. Cameros has not been given permission by the managed care plan to continue receiving care from Dr. Vangsness on either a one-time or on-going basis. On June 25, 2012, an administrative law judge granted this Petitioner's request to be temporarily returned to fee-for-service Medi-Cal while his MER appeal was pending. However, on July 3, 2012, the Office of the Ombudsman reversed that order. The ombudsman also submitted a position statement asserting that Mr. Cameros had failed to document "any high risk or complex medical condition" and therefore would suffer no deleterious medical effects from enrollment in managed care. Through intervention of counsel, Mr. Cameros was returned to fee-for-service at the end of July but he was still unable to schedule needed surgery or obtain the correct dosage of Enbrel because of a series of bureaucratic snafus. While he was on managed care he was unable to obtain appropriate specialty care for his knees from the managed care plan or referral providers. One orthopedic surgeon to whom he was referred by the managed care plan only performs back surgery. Another physician to whom Mr. Cameros was referred by the managed care plan recommended that Mr. Cameros seek treatment from a large hospital medical center where there would be an appropriate specialist for his complex condition. Beginning in March 2012, the Medi-Cal managed

care plan reduced the weekly dosage of Enbrel for the treatment of his Ankylosing Spondylitis without giving appropriate written notice or advising him of his right to appeal the reduction in dosage. From March through September of 2012, Mr. Cameros has suffered extreme pain in both knees, so much pain that he sought emergency care three times and had his knees drained multiple times. He also has suffered increased pain in his joints and in his eyes. On October 22, 2012, and only after Petitioners' counsel had threatened legal action, Respondents granted Mr. Cameros' MER for a twelve-month period of time.

17. Petitioner Raquel Alvarez is a Medi-Cal recipient. She is a Person with Disabilities with complex medical conditions, including Pulmonary Valve Stenosis (a narrowing of the heart valve that separates the lower right chamber of her heart from the artery that supplies blood to her lungs), Noonan's syndrome (a genetic disorder that prevents normal development in various parts of the body), and Behcet's syndrome (an extremely rare condition which causes chronic inflammation of the blood vessels). Aged 24, Ms. Alvarez also is developmentally delayed. Her mother, Raquel Martell Alvarez, is her guardian ad litem. For much of her life, Ms. Alvarez has received care on a fee-for-service basis from a cardiologist, rheumatologist, and other specialists who have prescribed several medications to address her complex medical conditions. Ms. Alvarez was defaulted into managed care on May 1, 2012 even though she never received the enrollment form and information from DHCS explaining how she needed to either choose a managed care plan or file for a MER. She subsequently filed a MER after learning that her fee for service doctor had neglected to file the form on her behalf. Since May 2012, Ms. Alvarez has been unable to see her cardiologist and other treating physicians of many years who are familiar with her unique and complex conditions. Without any advance written notice, the managed care plan also declined to renew Ms. Alvarez's prescription for the drug Humira needed to treat her Behcets syndrome. Unable to pay approximately $1,000 per month for Humira, Ms. Alvarez's mother has been forced to obtain samples of the drug from her daughter's former doctors. Ms. Alvarez appealed the denials of her MER and the prescription of Humira and sought to disenroll from the managed care plan. She was returned to regular Medi-Cal on October 1, 20121 pending the administrative hearing on

her MER denial. On October 22, 2012, and only after Petitioners' counsel had threatened legal action, Respondents granted Ms. Alvarez's MER for a twelve-month period.

18. Petitioner Anita Valadez is a Medi-Cal recipient. She is a Person with Disabilities with complex medical conditions, including advanced breast cancer that has spread to her lymph nodes and her other breast, type one-insulin dependent diabetes, arthritis, total blindness in her left eye and, legal blindness in her right eye. For years Ms. Valadez, who also is wheelchair dependent, has received her medical care on a fee-for-service basis. Her primary care physician, Dr. Gabriela Ramirez Diaz, is intimately familiar with her medical history and has provided care that has stabilized Ms. Valadez's diabetes particularly in connection with managing her insulin levels while she has been in treatment for breast cancer. On or about April 10, 2012, Dr. Haowei Zhang, who was then providing chemotherapy to Ms. Valadez, submitted a MER on her behalf. Ms. Valadez was scheduled for surgery to remove her tumor on July 11, 2012. On July 1, 2012, DHCS defaulted her into a Medi-Cal managed care plan but did not send her a written notice of the denial of her MER until July 9, 2012. Ms. Valadez sent in an appeal the following day. Meanwhile, Ms. Valadez received oral notice that her two fee-for-service physicians had been approved to treat her through her managed care plan and these two physicians were subsequently willing to go forward on July 11 with the surgery based solely on this oral notice. However, the managed care plan refused to allow Ms. Valadez to continue to see her primary care physician, Dr. Diaz, despite the fact that this Petitioner had immediately appealed the denial of her MER even before receiving written notice. Since July of 2012, the primary care doctor available through the managed care plan has reduced the number of blood test strips to test Ms. Valadez's insulin levels even though her chemotherapy regimen necessitates that she conduct frequent blood tests. On July 10, 2012, this Petitioner requested a hearing. She was thereafter returned temporarily to fee-for-service Medi-Cal pending a hearing decision on the appeal of the denial of her MER. On August 24, 2012, the ombudsman submitted a position statement advocating a denial of the appeal on the grounds that Ms. Valadez failed to document "any high risk or complex medical conditions" or any deleterious medical effects. On October 22, 2012, prior to any hearing, and only after Petitioners' counsel had

threatened legal action, Respondents granted Ms. Valadez's MER for a twelve-month period of time.

19. Petitioner Azatui Charkhchyan is a Medi-Cal recipient. She is a Person with Disabilities with complex medical conditions, having suffered cardiac arrest in February 2011 that deprived her brain of oxygen and resulted in serious brain injury. In July 2011 Ms. Charkhchyan was enrolled in a Nursing Facility Sub-Acute Hospital (NF/AH) waiver program. At present, she is in vegetative state, is unlikely to recover and receives around-the-clock nursing care in her home. When Ms. [redacted] son, [redacted] who is her guardian ad litem, received a letter stating that this Petitioner would have to transition into managed care, he facilitated the submission of a HCO 7101 form completed by Dr. Robert N. Titcher on May 30, 2012. The HCO 7101 form stated that Ms. Charkhchyan suffered from anoxic brain injury, seizure disorder, chronic vegetative state, severe anemia requiring transfusions and gastrointestinal tube feeding. Respondents denied her MER and Petitioner's son filed a timely appeal from the denial of her MER. Prior to the administrative hearing, [redacted] sent a letter to the administrative law judge indicating that his mother was also entitled to a medical exemption because she had a complex neurological disorder that requires ongoing supervision and because she was enrolled in a Medi-Cal Nursing Home Waiver program for sub-acute level nursing care at home. The ombudsman's position statement, dated July 26, 2012, states that the provider failed to document "any high risk or complex medical conditions" or any deleterious medical effects that would result from a transfer to managed care. This statement failed to address her request for a nursing home waiver exemption. On September 6, 2012, the administrative law judge denied the MER. A rehearing request was timely filed asserting the nursing home waiver exemption under 22 CCR § 53887 (2)(a)(8)(A). On October 26, 2012, the ombudsman, denied the rehearing request, offering no reasons for the summary denial. Subsequently, and only after the intervention of Ms. Charkhchyan's attorneys, Respondents granted Ms. [redacted] a temporary extension in fee-for-service Medi-Cal through December 31, 2012. . Ms. [redacted] has subsequently remained in fee-for-service Medi-Cal while she has pursued the review of her MER pursuant to a "B" notice she received in January 2013.

20. Petitioner Janet Farahmand is a Medi-Cal recipient. She is 61-years-old and a Person with Disabilities with complex medical conditions, including diabetes, high blood pressure, a kidney transplant and open heart surgery. Ms. Farahmand speaks limited English (she speaks Farsi), and relies on her daughter to serve as her interpreter. Ms. Farahmand previously received treatment for her conditions from Harbor UCLA Medical Center on a fee-for-service basis. Ms. Farahmand also required blood tests every three months so that her nephrologist could adjust her anti-rejection medication. She was transferred to LA CARE on or about November 2011; she does not recall receiving any notice in advance about her enrollment in a managed plan. It was not until later that Ms. Farahmand's fee-for-service nephrologist, who was following her post-kidney transplant, told her daughter that she was in a managed plan. Upon learning she was in managed care, Ms. Farahmand (with the help of her daughter and her fee-for-service doctor) filed a MER on February 12, 2012. The MER was denied on April 14, 2012. The notice of denial was written in English. Ms. Farahmand's daughter timely requested a hearing, and Ms. Farahmand received a telephonic hearing in the summer of 2012 although she did not understand at the time that the phone call was a hearing. The ALJ found that, "While claimant's kidney transplant and heart problems may represent a complex medical condition, the medical evidence provided does not demonstrate any deleterious medial effects that would result from enrollment in a managed care plan." While in managed care Ms. Farahmand was informed that the wait for a kidney specialist would be two months despite her need for a refill of anti-rejection medication related to her previous kidney transplant. Ms. Farahmand also sought referral to a cardiologist, but was again told that the wait for a referral was two months. In September 2012, Ms. Farahmand started to experience diarrhea, vomiting and stomach pain. She presented herself to the managed care clinic but was not diagnosed with any ailments. It was not until several months later, in December 2012, when Ms. Farahmand was hospitalized at Cedars-Sinai Medical Center ("Cedars") twice through the emergency room that she was diagnosed with a virus of the gastrointestinal tract. After the second hospitalization, she was put on intravenous medication for 30 days on an outpatient basis. But shortly after treatment, her symptoms returned and her condition rapidly deteriorated. She has since been hospitalized at Cedars again for the same condition in February 2013, and had suffered

for weeks from shortness of breath, difficulty walking, severe diarrhea and dehydration. She lost about 40 pounds within three weeks. Her daughter believed her to be near-death. On January 14, 2013, Ms. Farahmand received Letter X in Farsi. With the help of her daughter, she requested reinstatement to fee-for-service pending hearing. Ms. Farahmand is now in fee-for-service and is seeing a nephrologist, an infectious disease doctor, and a doctor at Cedars' kidney transplant unit. She also has another physician, her former nephrologist, who is conducting regular blood tests on her. In the meantime, Ms. Farahmand is awaiting hearing on the MER denial.

21. Each of the Petitioners has a beneficial interest in Respondents' performance of their legal duties, as described herein. Each of the Petitioners also brings this action as a representative of the public interest under Code of Civil Procedure §1085 as the questions raised by the lawsuit are ones of public right and the object of this writ of mandamus is to procure the enforcement of public duties.

B. Respondents

22. Respondent DHCS is the single state agency charged with supervising the administration of the Medi-Cal program and ensuring that the Medi-Cal program is operated in conformity with all state and federal laws.

23. Respondent Toby Douglas is the current director of DHCS and, in that capacity, is responsible for ensuring the lawful administration of the Medi-Cal program. Respondent Douglas is sued in his official capacity as the Department's director.

24. The true names and capacities, whether individual, corporate, associate, or otherwise, of DOES 1 through 20 are unknown to Petitioners, who therefore sue these Respondents by such fictitious names. Petitioners are informed and believe, and based upon such information and belief, allege that at all times material herein each of the Doe Respondents was an agent or employee of one or more of the named Respondents, and was acting within the course and scope of said agency or employment. Petitioners are further informed and believe, and based thereon allege, that each of the Doe Respondents is legally responsible in some manner for the occurrences herein alleged. All allegations in this Petition which refer to the named Respondents refer in like manner to those Respondents identified as Respondents DOES 1 through 20, inclusive. Petitioners will

amend this Petition to allege the true names and capacities of the Doe Respondents when the same have been ascertained.

STATUTORY FRAMEWORK FOR MEDI-CAL PROGRAM

A. Overview of Federal Medicaid Statutes and Regulations

25. The Medicaid program was established by Congress in 1965 at Title XIX of the Social Security Act. The purpose of the Medicaid program is to enable states "as far as practicable under the conditions [of each] state, to furnish...(1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services. . . ." 42 U.S.C. §1396.

26. Medicaid is a cooperative federal-state program. Participation by states in this program is voluntary; however, once a state elects to participate, it must comply with all requirements of the federal Medicaid Act and its implementing federal regulations.

27. California has elected to participate in the federal Medicaid program. Its Medicaid program, known as "Medi-Cal," is codified at W&IC §14000 *et seq.*

28. Each state's Medicaid program "must" be administered by a single state agency which is responsible for ensuring that the program complies with all relevant laws and regulations. 42 U.S.C. §1396a (a)(5); 42 C.F.R. §430.10.

29. Each state's Medicaid program "must": make medical assistance available to all eligible recipients [42 U.S.C. §1396a(a)(10)(A)]; furnish such assistance "with reasonable promptness to all eligible individuals" [42 U.S.C. §1396a(a)(8)]; and "tak[e] into account only such income and resources as are available" to Medi-Cal recipients [42 U.S.C. §1396a(a)(17)]. *See also* 42 C.F.R. §435.930 (requiring that states which participate in the Medicaid program ensure that all covered health care services are furnished with reasonable promptness to all eligible recipients).

B. Overview of State Medi-Cal Statutes and Regulations

30. In establishing the Medi-Cal program, the California Legislature declared its "intent . . . to provide, to the extent practicable, . . . for the health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would

jeopardize the person or family's future minimum self-maintenance and security." W&IC § 14000. The fundamental purpose of the program is "to afford qualifying individuals health care and related remedial or preventative services, including related social services which are necessary for those receiving health care under this program." *Id.*

31. Respondent Department "shall be the single state agency for purposes of Title XIX of the federal Social Security Act" and the Department's Director "shall have those powers and duties necessary to conform to requirements for securing approval of a state [Medicaid] plan under the provisions of the applicable federal law." W&IC §14100.1; *see also* W&IC §14154(d) (the "department is responsible for the Medi-Cal program in accordance with state and federal law.").

32. The Legislature has generally mandated that public assistance programs, including the Medi-Cal program, "shall" be administered in such a manner "so as to secure for every person the amount of aid to which he is entitled" [W&IC §10500] and that "aid shall be administered and services provided promptly and humanely" [W&IC §10000].

33. The Medi-Cal program provides coverage for a variety of health care services, including physician, hospital, dental, prescription medication, mental health services, and durable medical equipment.

HISTORY OF MER REGULATIONS AND LEGISLATION

34. The Medi-Cal program provides health care to beneficiaries either on a fee-for-service or managed care basis. With fee-for-service, the beneficiary seeks care from any provider who is participating in the Medi-Cal program, willing to treat the particular beneficiary and willing to accept reimbursement at a set amount from DHCS for the medical services provided to the beneficiary. With managed care, DHCS contracts with managed care plans to provide health care coverage to Medi-Cal beneficiaries where the managed care plans receive reimbursement on a capitated basis, namely, a pre-determined amount per person per month, regardless of the number of services provided to a person. The Medi-Cal beneficiaries then obtain services from those providers who accept payments from the managed care plan.

35. In 2000, the then Department of Health Services (predecessor to DHCS) amended its regulations regarding disenrollment and exemptions to enrollment in Medi-Cal managed care plans.

The December 2000 amendments to 22 CCR § 53887 eliminated the "deleterious medical effects" (DME) standard. Even prior to the new regulations' effective date, the DME standard was only applied in cases wherein the beneficiary was seeking an exemption under the catch-all complex medical condition category or the subcategory for pregnancy. The DME standard was never applied in exemption cases involving the complex medical condition sub-category of HIV/AIDS or to the four additional complex medical conditions subcategories, such as cancer, which were added in the 2000 regulations.

36. At all times material herein since 2000, these regulations have remained unchanged. 22 CCR §53887 was and is the principal regulation governing MERs for Medi-Cal recipients. A true copy of this statute is attached hereto, marked as Exhibit A and incorporated herein by reference.

37. In 2000, DHCS issued MMCD All-Plan Letter 00013 which discussed the new regulations relating to the managed care medical exemptions. A true copy of MMCD All-Plan Letter 00013 is attached hereto, marked as Exhibit B and incorporated herein by reference.

38. In conjunction with the new regulation and the above-mentioned All-Plan Letter, DHCS also introduced HCO Forms 7101 and 7102, dated 6/2000, for use in applying for medical exemptions. True copies of the original HCO Forms 7101 and 7102 are attached hereto and marked respectively as Exhibits C and D. The HCO Form 7101 and its instructions have remained the same up until the present day. The form contains all the necessary prompts and instruction for completing it. The original HCO Form 7102 must be completed if beneficiaries are seeking a non-medical exemption because they are American Indians or are enrolled in a Medi-Cal nursing home waiver program that allows the beneficiary to receive sub-acute, acute, intermediate or skilled nursing care at home rather than as an in-patient in a hospital or nursing home. This exemption included four types of Medi-Cal Waiver programs: AIDS Waiver, Model Waiver, In-Home Medical Care Waiver and Skilled Nursing Facility Waiver. *See* MMCD All-Plan Letter 00013. The HCO Form 7102 and its instructions remained the same up until February 2012 as set forth below.

39. At all times material herein, 22 CCR §53882 has provided that DHCS must mail an enrollment form and plan information to each eligible beneficiary, and the mailing must include

instructions on how to enroll in a plan and how to request an exemption for either medical or non-medical reasons. After receiving this notice, beneficiaries have thirty days to either chose a managed care plan or file for a MER. Only if they do not do either of these can they be defaulted into a managed care plan, pursuant to 22 CCR §53883.

40. In 2010 the California legislature enacted Assembly Bill No. 208 allowing the mandatory enrollment in managed care of Medi-Cal recipients who are Seniors and Persons with Disabilities. One specific protection inserted in WIC §14182(b)(15) requires the Department to "[e]nsure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with § 53800). . . are applied to senior and persons with disabilities."

41. In 2012 the California legislature enacted Senate Bill No. 1008, effective June 27, 2012. The specificity of the notice that is required in MERs denial notices is now codified in W&IC §14182(b)(21), which provides:

> "The notice shall set out with specificity the reasons for the denial or failure to unconditionally approve the request for exemption from plan enrollment. The notice shall inform the beneficiary and the provider of the right to appeal the decision, how to appeal the decision, and if the decision is not appealed, that the beneficiary shall enroll in a Medi-Cal plan and how that enrollment shall occur. The notice shall also include information of the possibility of continued access to an out-of-network provider pursuant to paragraph (13). A beneficiary who has not been enrolled in a plan shall remain in fee-for-service Medi-Cal if a request for an exemption from plan enrollment or appeal is submitted, until the final resolution. The department shall also require the plans to ensure that these beneficiaries receive continuity of care.

MANDATORY ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES IN MANAGED CARE

42. At all times material herein prior to June 2011, Seniors and Persons with Disabilities had the choice between receiving medical coverage from the Medi-Cal program either on a fee-for-service or managed care basis. In November of 2010, California obtained federal approval for a §1115(b) Medicaid Demonstration Waiver ("Waiver") from the Center for Medicare and Medicaid

Services ("CMS") whereby California will receive an additional $15 billion in federal funding over a five-year period. Among the provisions of this Waiver is the mandatory enrollment of Seniors and Persons with Disabilities in managed care. The State has in return committed to develop and implement specific standards to protect these elderly and disabled recipients, including exemptions from managed care for recipients with complex medical conditions receiving fee-for service care, continuity of care or "seamless care" for recipients enrolled in managed care, and adequate notice of any changes, together with clearly delineated rights to exemptions and appeals.

43. Beginning in June 2011, more than 240,000 Seniors and Persons with Disabilities in 16 California counties (Alameda, Contra Costa, Fresno, Kern, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare) have been required to join a managed care plan by the month of their birthday unless they met the medical exemption criteria. Fourteen of these counties only have two managed care plans, and two counties have only one plan.

44. Since June 2011, more than 27,000 MERs have been filed by Seniors and Persons with Disabilities. DHCS has approved less than 20% of these MERs.

45. Since at least June 2011, DHCS has regularly denied MERs from Seniors and Persons with Disabilities who meet at least one of the complex medical condition categories set forth in 22 CCR §53887(a)(2) and the HCO Forms 7101 and 7102. DHCS has denied these MERs on the additional new grounds that the beneficiary's treating physician has not provided documentation indicating that the beneficiary's medical condition is so unstable that he/she cannot be transferred without deleterious effects to a managed care provider with the same medical specialty or specialties as the treating fee-for-service Medi-Cal physician(s). The Department has also denied MERs on the additional new grounds that the beneficiary's condition is not high risk and/or the beneficiary's physician has not provided notes from the last five office visits and/or the most recent history and physical and/or treatment plan.

46. In February, 2012, DHCS removed, among other things, the nursing home waiver from the HCO Form 7102. A true copy of the new HCO Form 7102 is attached hereto and marked as Exhibit E. There no longer is a separate form with which to apply for a nursing home waiver

exemption. Yet, up until the present day, the Department has never adopted a regulation or otherwise issued an all-county letter, plan letter, plan or provider bulletin or similar instructions concerning the elimination of the automatic nursing home waiver exemption. In addition, new enrollees have not been sent information about the nursing home waiver exemption or how they can still apply for it. The Department has never adopted a regulation setting forth the deleterious effect standard or any of the other above-mentioned additional eligibility standards for initial submission of MERs.[2] The Department also did not have an official written policy implementing the deleterious effects standard in granting MERs until July 18, 2012, when it issued an All Provider Bulletin and notice to Medi-Cal providers. A true copy of this Provider Bulletin and notice to Medi-Cal providers are attached hereto, marked collectively as Exhibit F and incorporated herein by reference. This Provider Bulletin has not been sent to all providers who treat elderly and disabled Medi-Cal beneficiaries on a fee-for-service basis. There are no instructions in the Provider Bulletin or in the notice about what information must be provided to satisfy the deleterious medical effects standard.

47. Petitioners are informed and believe and, based upon such information and belief, allege that DHCS employees have been arbitrarily denying MERs on additional grounds that are not set forth in 22 CCR §53887 and the July 18, 2012 Provider Bulletin and that have not been disclosed to beneficiaries, providers and the general public and that the denial of these MERs results in medically necessary health care services not being provided promptly and humanely to certain Seniors and Persons with Disabilities.

48. Up until the present day, DHCS has not amended the HCO 7101 form and its accompanying instructions to specify all the information that beneficiaries and their providers are

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[2] 22 CCR §53893(a)(3) addresses beneficiaries whose MERs have already been granted. The regulation provides, in pertinent part, that "[e]xcept for pregnancy, any beneficiary granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and being receiving care from a plan provider with the same specialty without deleterious medical effects, as determined by a beneficiary's treating physician in the Medi-Cal fee-for-service program, up to 12 months from the date the medical exemption is first approved. . . ."

required to submit for the review and approval of their MERs, including the new eligibility standards for MERs contained in the July 18, 2012 Provider Bulletin.

49. At all times material herein, the standard notices sent to Seniors and Persons with Disabilities denying their MERs are inadequate. The notices make no mention of the deleterious effects standard. These notices instead offer several stock reasons for denial of the MERs, such as: "Your medical condition does not qualify for a medical exemption. This decision is based on the information sent to us by your doctor." This conclusory language in the notices provides no specifics about the factual bases for denying the MER so that Seniors and Persons with Disabilities can make informed decisions on whether to appeal the denial of the MERs or the likelihood of success of such appeals. In addition, these notices do not advise Seniors and Persons with Disabilities of the procedures whereby they could continue to receive fee-for-service Med-Cal from the time they appeal the denial of their MER until a hearing officer decides their administrative appeal. A true copy of one of these standard notices is attached hereto, marked as Exhibit G and incorporated herein by reference.

DHCS ADMINISTRATIVE ERRORS LEAD TO FAILURES TO PROVIDE NOTICES TO THOUSANDS OF BENEFICIARIES

50. At all times material herein, DHCS has contracted with MAXIMUS, a for-profit publicly traded company with corporate headquarters in Reston, Virginia, to serve as the enrollment broker for Seniors and Persons and Disabilities. On November 28, 2012, DHCS announced that from March 2011 through October 2012 MAXIMUS had committed widespread errors in processing MERs from Seniors and Persons with Disabilities, including defaulting them into managed care without sending them any notices of the denials of their MERs and /or denying their MERs as incomplete without giving these beneficiaries' providers 30 days to provide additional information. Petitioners are informed and believe and, based upon such information and belief, allege that these errors by MAXIMUS affected MERs from more than 9,000 Seniors and Persons with Disabilities.

51. In January 2013, on information and belief, DHCS sent two letters, Letters X and B, to all Seniors and Persons with Disabilities whose MERS had been improperly processed by

MAXIMUS. True copies of Letters X and B are attached hereto and marked respectively as Exhibit H and I.

52. Contrary to the requirements of W&IC §14182(b)(21), Letter X did not set out with specificity the reasons for the denial of the MERs, nor did it inform the beneficiaries and their providers of the right to appeal the decision, how to appeal the decision, and if the decision is not appealed, that the beneficiary shall enroll in a Medi-Cal plan and how that enrollment shall occur. Letter X also did not inform the affected Seniors and Persons with Disabilities that those beneficiaries who have not been enrolled in a [managed] plan shall remain in fee-for-service Medi-Cal while the MER or appeal is submitted, until final resolution. . .

53. As Letter X supplied no information about the reason for the denial of the MER, beneficiaries cannot make an informed decision about whether to file an appeal and request a state fair hearing. Even if a beneficiary requests a hearing, her ability to prepare her case is adversely affected because she has no information whatsoever regarding the basis for DHCS' denial.

54. Letter X instructs beneficiaries that they have forty-five (45) days from the date of the letter's mailing to request a state hearing even though W&IC §10951 provides that beneficiaries have ninety (90) days to request a state hearing.

55. Letter X is also deficient in that it requires beneficiaries who seek an appeal, to make an affirmative request to be returned to fee-for-service Medi-Cal pending the appeal. Beneficiaries are informed that the affirmative request must be made within thirty (30) days.

56. Letter B does not inform beneficiaries of what additional information their fee-for-providers were supposed to provide in support of their MERS. Letter B gives beneficiaries six months to file a new MER. However, recipients have only 30 days to make a telephonic request for reinstatement to fee for service pending decision on the new MER. For beneficiaries who remain in the managed plan, Letter B requires them to file new MERs within 45 days, when they are permitted 90 days by statute.

57. DHCS further complicated matters by sending notices to the wrong people, including erroneously sending Letter X to approximately 3,000 people who should have only received Letter B, sending no letters to some people who should have received these letters, and in

some instances sending people both letters. This has only caused further confusion, and created further obstacles for beneficiaries trying to receive the care to which they are entitled.

58. As a result of Respondents' above-mentioned actions, thousands of Seniors and Persons with Disabilities have already experienced or have been threatened or will be threatened with the catastrophic break in the health care treatment administered by dedicated professionals for years. Absent injunctive relief, Petitioners and many other vulnerable individuals who are also entitled to be exempt from mandatory enrollment in managed care have suffered and will continue to suffer irreparable harm, including even the possible loss of life, as they have been and denied and will be denied the necessary care for such complex medical conditions as cancer, HIV and kidney failure.

Demand has been made upon Respondents to perform their duties in accord with the requirements of law. Respondents have failed and refused to perform those duties as required by the law, despite having the ability to carry out those duties.

CAUSES OF ACTION

FIRST CAUSE OF ACTION

(All Petitioners for Violations of W&I C §14182(b)(15) and 22 CCR § 53887)

59. Petitioners reallege and incorporate by reference each and every allegation contained in the Petition.

60. Respondents have failed and continue to fail to apply only the standards set forth in W&IC §14182(b)(15) and 22 CCR § 53887(a)(2) (including the original HCO 7101and 7102 forms) in deciding whether to grant MERs submitted by Seniors and Persons with Disabilities. Respondents are applying additional standards inconsistent with and not found in the governing statute and regulations. These unlawful standards and practices used in the MER determination process include, but are not limited to:

a. Imposing new and more stringent requirements including the deleterious effects standard with respect to grants MERs;

b. Requiring proof from beneficiaries' fee-for-service treating physicians that transfer into managed care would have deleterious medical effects upon the beneficiaries;

c. Requiring that the treating physicians also submit the progress notices from the last five visits and sometimes a history and physical and/or treatment plan and denying the MERs when that additional information has not been provided; and

d. Effectively eliminating the nursing home waiver by ceasing to provide a form to apply for the exemption.

61. Petitioners lack a plain, speedy and adequate remedy at law except by way of peremptory writ of mandate pursuant to Code of Civil Procedure §1085.

SECOND CAUSE OF ACTION

(All Petitioners for Violations of California Administrative Procedures Act And WIC § 14182(k)

62. Petitioners reallege and incorporate by reference each and every allegation contained in the Petition.

63. The Administrative Procedure Act ("APA") provides, in pertinent part, that "[n]o state agency shall issue, utilize, enforce, or attempt to enforce *any* guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in Section 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State. . . ." Gov. Code §11340.5(a)(italics added).

64. "Regulation" is broadly defined as "every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure. . . ." Gov. Code §11342.600.

65. In reviewing and/or denying MERs submitted by Seniors and Persons with Disabilities, Respondents are unlawfully applying and enforcing underground regulations

concerning the "deleterious effects" standard and other requirements that have not been adopted in accordance with the APA and that were not even put in writing until July 2012.

66. In eliminating the automatic exemption for the home waiver program without either amending 22 CCR § 53887 or issuing an all-county letter, plan letter, plan or provider bulletin or similar instructions, Respondents are violating the APA and W&IC § 14182(k).

67. Petitioners lack a plain, speedy and adequate remedy at law except by way of peremptory writ of mandate pursuant to Code of Civil Procedure §1085.

THIRD CAUSE OF ACTION

(All Petitioners for Violations of W&I C §14182(b)(21))

68. Petitioners reallege and incorporate by reference each and every allegation contained in the Petition.

69. Contrary to WIC §11482(b)(21), Respondents have issued notices of action and continue to issue notices of action to Seniors and Persons with Disabilities that do not set out with specificity the reasons for denial or failure to approve their MERs.

70. In further violation of WIC §11482(b)(21), Respondents have refused to allow Seniors and Persons with Disabilities to remain in fee-for-service Medi-Cal when MERs have been submitted or appeals from denials of the MERs have been submitted and prior to the final resolution of those MERs. Respondents have also granted temporary exemptions for a few months without adequate notice to beneficiaries regarding the status of their MERs.

71. Petitioners lack a plain, speedy and adequate remedy at law except by way of peremptory writ of mandate pursuant to Code of Civil Procedure §1085.

FOURTH CAUSE OF ACTION

(All Petitioners for Violations of 22 CCR §§50179, 51014.1(c), 51014.2(a)&(b), 53882, 53883, and Cal. Const, Art. I, §7)

72. Petitioners reallege and incorporate herein by reference each and every allegation contained in the Petition.

73. Under state law, a "person may not be deprived of life, liberty, or property without due process of law." Cal. Const. Art. I, §7. Medi-Cal recipients have a property interest in the lawful provision of Medi-Cal benefits.

74. Medi-Cal recipients must be notified in writing by means of a notice of action of any action being taken by Respondents or their agents that would adversely affect their Medi-Cal eligibility or scope of benefits. This notice must include the nature of the action, the reason for the action, the right to a state hearing if dissatisfied with the action, and the circumstances under which benefits will continue if a hearing is requested. 22 CCR §§50179; 51014.1(c); *see also* Manual of Policies and Procedures §22-001(a)(1), which requires the notice to contain the circumstances under which aid will be continued if a hearing is requested. (The state further explains the requirements of due process in All Counties Information Notice I-151-82, which clarifies that filling in form notices does not assure that a notice is adequate and that a "Notice of Action is intended to be a personal communication to the recipient, addressing the recipient's own unique situation and circumstance.") Any recipient of public social services – including Medi-Cal benefits – who is dissatisfied with any action relating to his/her receipt of benefits has the right to seek review of the action through a state administrative hearing. W&IC §10950. The hearing must be held within 30 days of a request; be conducted by a state administrative law judge ("ALJ"); and allow the recipient the opportunity to present testimony and evidence on her/his behalf and question opposing witnesses. W&IC §§10952, 10953, 10955. The ALJ shall issue a written hearing decision, explaining the basis for the decision. W&IC §10958; 22 CCR §§50951- 50953.

75. In violation of the above-mentioned provisions of law, Respondents have issued and continue to issue notices of action to Seniors and Persons with Disabilities that do not set forth the specific reasons for denial of their MERs or the circumstances under which they could continue to remain in regular Medi-Cal if they request an administrative hearing as to the denial of their MERs.

76. Under 22 CCR §53882, DHCS must mail an enrollment form and plan information to each eligible beneficiary, and the mailing must include instructions on how to enroll in a plan and how to request an exemption for either medical or non-medical reasons. After receiving this notice,

beneficiaries have thirty days to either chose a managed care plan or file for a MER. Only if they do not do either of these can they be defaulted into a managed care plan, pursuant to 22 CCR §53883.

77. In violation of the above-mentioned provisions of law, Respondents have failed to send the necessary enrollment form, plan information, and instructions, and have defaulted Petitioners and other Seniors and Persons with Disabilities into managed care plans unlawfully.

78. Petitioners lack a plain, speedy and adequate remedy at law except by way of peremptory writ of mandate pursuant to Code of Civil Procedure §1085.

FIFTH CAUSE OF ACTION

(All Petitioners for Violations of 22 CCR §53893(a), Government Code §11425.30(a)(1), W&IC §10960(a) and (c), and Cal. Const, Art. I, §7)

79. Petitioners reallege and incorporate herein by reference each and every allegation contained in the Petition.

80. In accordance with 22 CCR §53893(a), DHCS has designated a Medi-Cal Managed Care Office of the Ombudsman. This very regulation, however, mandates that the "Ombudsman *shall* provide Medi-Cal beneficiaries access to a service which investigates and resolves complaints about managed care plans by, or on behalf, of Medi-Cal beneficiaries." *Id.* (italics added).

81. Government Code §11425.30(a)(1) provides, in pertinent part, that a "person may not serve as presiding officer in an adjudicative proceeding" if that "person has served as investigator, prosecutor, or advocate in the proceeding or its preadjudicative stage."

82. W&IC §10960(a) provides, in pertinent part, that the "director shall grant or deny" a rehearing request after the administrative law judge has issued the proposed decision. W&IC §10960(c) in turn provides that the "notice granting or denying the rehearing request shall explain the reasons and the legal basis for granting or denying the request for rehearing."

83. In violation of 22 CCR §53893(a), Government Code §11425.30(a)(1), W&IC §10960(a), and the Due Process Clause of the California Constitution, Respondents have authorized and continue to authorize the Medi-Cal Managed Care Office of the Ombusdman : (a) to oppose Medi-Cal beneficiaries on their complaints relating to managed care plans; and (b) to advocate on DHCS' behalf in an administrative proceeding relating to the denial of MER from a Senior and/or

Person with Disabilities and to later serve as the presiding officer who makes the decision on whether to grant or deny the rehearing requests from this beneficiary after the administrative law judge has denied the MER. In violation of W&IC §10960(c), Respondents also have authorized and continue to authorize the Ombudsmen to deny rehearing request without giving the requisite explanation of the facts and the law to justify the decision.

84. Petitioners lack a plain, speedy and adequate remedy at law except by way of peremptory writ of mandate pursuant to Code of Civil Procedure §1085.

SIXTH CAUSE OF ACTION

(All Petitioners for Violations of W&I §10951, W&I §14182(b)(21), 22 CCR §53887 and Cal. Const, Art. I, §7)

85. Petitioners reallege and incorporate by reference each and every allegation contained in this Petition.

86. Respondents' Letter X violates the law in three respects. First, the letter purports to communicate a denial of a Medical Exemption Request. The "denial" fails to set out with specificity the reasons for the denial or failure to unconditionally approve the request for exemption from plan enrollment. Second, Letter X cuts in half the time to request an appeal for a State Fair Hearing. Third, Letter X requires beneficiaries who seek an appeal, to make an affirmative request to be returned to fee-for-service Medi-Cal pending the appeal, and to do so within thirty (30) days. By placing the burden on the beneficiary to request to remain in (or return to) fee-for-service, DHCS is in direct violation of law, which mandates that the beneficiary remain in fee-for-service Medi-Cal "until final resolution" of the MER appeal.

87. Respondents' Letter B violates the law by requiring certain beneficiaries who remain in the managed plan to file new MERs within 45 days, when they are permitted 90 days by statute. Letter B also does not inform beneficiaries of what additional information their fee-for-providers were supposed to provide in support of their MERS. Finally, the 30-day deadline to request a return to regular Medi-cal has no basis in the law.

88. Petitioner lacks a plain, speedy and adequate remedy at law except by way of writ of mandate pursuant to Code of Civil Procedure §1085.

SEVENTH CAUSE OF ACTION

(All Petitioners for Violations of W&IC §§ 10000 and 14182(b)(21), 22 CCR §§ 53882 and 53887, and Cal. Const. Art. 1, §7)

89. Petitioners reallege and incorporate by reference each and every allegation contained in this Petition.

90. In violation of W&IC §§ 10000 and 14182(b)(21), 22 CCR §§ 53882 and 53887 and Cal. Const. Art. 1, §7, Respondents: have not made the necessary amendments to HCO Form 7101 and its accompanying instructions to provide beneficiaries and providers with notice of all the information that is required for the review and approval of MERs; are arbitrarily denying MERs from Seniors and Persons with Disabilities on additional grounds that are not set forth in 22 CCR §53887 and the July 18, 2012 Provider Bulletin and that have not been otherwise disclosed to beneficiaries, providers and the general public; and are imposing standards for granting MERs that result in inhumane delays in the provision of medically necessary health care services to certain Seniors and Persons with Disabilities.

91. Petitioners lack a plain, speedy and adequate remedy at law except by way of peremptory writ of mandamus pursuant to Code of Civil Procedure § 1085.

PRAYER

Wherefore, Petitioners pray that this Court grant the following relief against Respondents:

1. Issue a Peremptory Writ of Mandate pursuant to Code of Civil Procedure §1085 ordering Respondents to:

A. Cease enforcement of the deleterious effects standard or any other standard or requirements not set forth in 22 CCR §53887(a)(2) and W&IC §14182(b)(15) with regard to the decision on whether to grant or deny MERs;

B. Cease sending inadequate, conclusory notices of action for the denials of MERs that do not comply with W&IC §14182(b)(21), 22 CCR §§50179, 51014.1(c) and 51014.2(a)&(b), and the Due Process Clause of the California Constitution by not containing an explanation of the specific factual and legal reasons for the denials of the MERs and that also fail to advise beneficiaries of the procedures whereby they could continue to receive, or be returned to,

fee-for-service Med-Cal from the time they appeal the denial of their MER until a hearing officer decides their administrative appeal;

C. Cease failing to send enrollment forms and information as required under 22 CCR §53882, and automatically defaulting beneficiaries into managed care plans in violation of 22 CCR §53993;

D. Cease failing to provide a form with which beneficiaries requiring a nursing home waiver can apply for an exemption;

E. Cease committing violations of 22 CCR §53893(a), Government Code §11425.30(a) (1), W&IC §10960(a) and (c), and the Due Process Clause of the California Constitution by authorizing the Ombudsman to oppose MERs from beneficiaries, and to decide whether to grant or deny rehearing requests after the administrative law judge has denied their MERs and by issuing denials of these rehearing requests that do not explain the facts and law to justify such decisions; and

F. Cease starting the time in which a petitioner has to act under either Letter X or Letter B, until DHCS re-sends Letter X and Letter B to the appropriate beneficiaries.

G. Cease enforcing a 45-day time limit in which to appeal a MER denial in place of the 90 day time period to request a hearing.

H. Restore all beneficiaries who received Letter X or Letter B to fee for service Medi-Cal until a final determination on their MERs, using the correct standard, unless the beneficiary elects to stay in the managed care plan;

I. Restore all beneficiaries who received denial notices in June 2011 or thereafter, who wish to be so reinstated, to fee for service Medi-Cal until a final determination on their MERs, using the correct standard, unless the beneficiary elects to stay in the managed care plan;

J. Amend HCO Form 7101 and its accompanying instructions to set forth all the information necessary for evaluation and approval of MERs, including the information concerning the deleterious medical condition and the need for documentation of its instability

discussed in the Provider Bulletin and information enabling nursing home waiver beneficiaries to apply for a MER using Form 7101;

K. Provide notice to all beneficiaries whose MERs were denied from June 2011 until the present of all the information and documents required by Respondents for the review and approval of MERs and that these beneficiaries may re-file their MERs in conformance with the new instructions and requirements on the amended HCO Form 7101;

L. Provide notice to all beneficiaries who previously received a mandatory exemption from managed care based on the nursing home waiver by filing HCO Form 7102 of any and all changes in the nursing home waiver exemption process and that they may re-file their MERs in conformance with the new instructions and requirements on the amended HCO Form 7101;

M. Issue a provider and any other necessary bulletins informing beneficiaries and providers of the changes in the exemption process for nursing home waivers;

2. Issue a temporary restraining order, preliminary injunction and/or permanent injunction prohibiting Responding from committing any of the violations set forth in 1 above with regard to the MERs from Petitioners and all other beneficiaries like them;

3. Enter an order for Respondents to pay for costs for this lawsuit;

4. Enter an order for Respondents to pay for attorney's fees as allowed by law; and

5. Grant such other and further relief that the Court deems just and necessary.

Date: November 4, 2013

Respectfully submitted,
LEGAL AID FOUNDATION OF LOS ANGELES

BY: _____
PAUL J. ESTUAR
Attorneys for Petitioners

Date: November 4, 2013

Respectfully submitted,
WESTERN CENTER ON LAW & POVERTY

BY: _____ /s/ Robert Newman
ROBERT NEWMAN
Attorneys for Petitioners