EXHIBIT A

TITLE 22. SOCIAL SECURITY
DIVISION 3. HEALTH CARE SERVICES
SUBDIVISION 1. CALIFORNIA MEDICAL ASSISTANCE PROGRAM
CHAPTER 4.1. TWO-PLAN MODEL MANAGED CARE PROGRAM
ARTICLE 7. MARKETING, ENROLLMENT, ASSIGNMENT, AND DISENROLLMENT

22 CCR 53887 (2012)

§ 53887. Exemption from Plan Enrollment

(a) An eligible beneficiary meeting the criteria specified in section 53845(a), who satisfies the requirements in (1) 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 as specified in (b) below.

(1) An eligible beneficiary who is an American Indian as specified in section 55100(i), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) 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.

(A) For purposes of this section, 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. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.

3. An eligible beneficiary is receiving chronic renal dialysis treatment.

4. An eligible 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.

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.

9. An eligible beneficiary is participating in a pilot project organized and operated pursuant to *sections 14087.3, 14094.3, or 14490 of the Welfare and Institutions Code.*

(B) 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.

(3) 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.

(4) Any extension to the 12-month medical exemption time limit shall be requested through the Health Care Options Program no earlier than 11 months after the starting date of the exemption currently in effect. The Health Care Options Program will notify the beneficiary 45 days before the expiration of an approved medical exemption and will inform the beneficiary how to request an extension. An extension to the medical exemption shall be approved if the eligible beneficiary continues to meet the requirements of subsection (a)(2).

(b) Exemption from plan enrollment or extension of an approved exemption due to a complex medical condition, as specified in (a)(2)(A), shall be requested on the "Request for Medical Exemption from Plan Enrollment" form (HCO Form 7101, June 2000), hereby incorporated by reference, which is available from the Health Care Options Program. Exemption from plan enrollment or extension of an approved exemption due to a beneficiary's enrollment in a Medi-Cal waiver program, as specified in (a)(2)(A)8, or a beneficiary's acceptance for care at an Indian Health Service facility, as specified in (a)(1), shall be requested on the "Request for Non-Medical Exemption from Plan Enrollment" form (HCO Form 7102, October 2000), hereby incorporated by reference, which is available from the Health Care Options Program. The completed request for exemption shall be submitted to the Health Care Options Program by the Medi-Cal fee-for-service provider or the Indian Health Service facility treating the beneficiary and shall be submitted by mail or facsimile. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(c) The Health Care Options Program, as authorized by the department, shall approve each request for exemption from plan enrollment 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.

(d) Approval of requests for exemption from plan enrollment is subject to the same processing times and effective dates specified in section 53889 for the processing of enrollment and disenrollment requests.

(e) The Health Care Options Program, as authorized by the department, or the department may revoke an approved request for exemption from plan enrollment at any time if the department determines that 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 or has not been providing services to the beneficiary. The department shall provide written notice to the beneficiary that the approved request for exemption from plan enrollment has been revoked and shall advise the

beneficiary that they must enroll in a Medi-Cal plan and how that enrollment will occur, as specified in section 53882. The revocation of an approved request for exemption from plan enrollment shall not otherwise affect an eligible beneficiary's eligibility or ability to receive covered services as a plan member.

AUTHORITY:

Note: Authority cited: *Sections 10725, 14105 and 14124.5, Welfare and Institutions Code.* Reference: *Sections 14087.3 and 14087.4, Welfare and Institutions Code.*

HISTORY:

1. New section filed 7-1-96 as an emergency; operative 7-1-96. Submitted to OAL for printing only pursuant to Section 147, SB 485 (Ch. 722/92) (Register 96, No. 28).

2. Repealer of section and Note and new section and Note filed 3-4-97; operative 3-4-97. Submitted to OAL for printing only pursuant to Section 147, SB 485 (Ch. 722/92) (Register 97, No. 10).

3. Amendment of subsections (b), (b)(4) and (c) filed 10-1-97 as an emergency; operative 10-1-97. Submitted to OAL for printing only pursuant to Section 147, SB 485 (Ch. 722/92) (Register 97, No. 40).

4. Repealer and new section heading, section and Note filed 12-19-2000 as an emergency; operative 12-19-2000. Submitted to OAL for printing only pursuant to section 147, SB 485 (Ch. 722/92) (Register 2000, No. 51).

EXHIBIT B

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-8076

December 28, 2000

MMCD All-Plan Letter 00013

TO: Medi-Cal Managed Care Plans

SUBJECT: **AMENDED REGULATIONS FOR ENROLLMENT AND DISENROLLMENT FOR TWO-PLAN MODEL PLANS**

PURPOSE

The purpose of this letter is to inform Medi-Cal managed care plans that amended regulations related to enrollment in and disenrollment from two-plan model Medi-Cal managed care plans (MCPs) were filed with the Secretary of State on December 19, 2000. These amended regulations were filed under the Department's emergency rulemaking authority and so became effective immediately.

BACKGROUND

The Department is amending the following sections Title 22 of the California Code of Regulations in order to update the enrollment and disenrollment criteria for MCP members, improve the clarity of various aspects of enrollment and disenrollment process, and provide increased control over the granting of exemptions to plan enrollment:

- Section 53845 Enrollment Criteria
- Section 53881 Marketing and Member Materials
- Section 53886 Health Care Options Presentation
- Section 53887 Alternative to Plan Enrollment
- Section 53888 Enrollment/Disenrollment Form
- Section 53889 Enrollment/Disenrollment Form Processing
- Section 53891 Disenrollment of Members
- Section 53892 Problem Resolution Process for Members
- Section 53895 Information to New Members

Many of the amendments to these regulations simply update the regulations to reflect current program operation. However, an important focus of these amendments is updating and strengthening the process for granting exemptions to plan enrollment, whether for medical or non-medical reasons.

In mid-1999 the Department noted that the number of requests for medical exemptions had dramatically increased. MMCD staff became increasingly concerned about the possibility of fraud and abuse in the medical exemption request process. Subsequent investigation by the Department's Audits and Investigations Program revealed significant problems with virtually all of over 10,000 exemptions, such as no verification of the complex medical conditions in patient charts, beneficiaries not receiving care from the physicians requesting exemptions, and beneficiaries not knowing that an exemption had been submitted on their behalf. As a result of fraudulent medical exemptions, the State not only has paid more for fee-for-service claims than would have been paid if these beneficiaries had been enrolled in Medi-Cal MCPs, but also has in some cases paid for health care that was never provided.

These regulatory changes will help ensure that exemptions from enrollment in Medi-Cal MCPs will be granted only when appropriate and that dollars allocated for health care for Medi-Cal beneficiaries – whether through Medi-Cal managed care or the fee-for-service program – will be used for that purpose. The amendments also provide many critical improvements to the enrollment and disenrollment regulations, making it easier for beneficiaries, legal representatives and advocates, and healthcare providers to understand the criteria and timelines for enrollment in and disenrollment from Medi-Cal MCPs in two-plan model counties.

FURTHER DISCISSION

This section of All-Plan Letter 00013 will highlight the regulatory changes contained in each amended section of Title 22. However, plan personnel should not rely on this summary for a thorough understanding of these amended regulations, but should also review the entire regulatory proposal. The proposal contains not only the full text of the amended regulations, but also a detailed discussion of the reason for every change, both substantive and non-substantive.

Section 53845, "Enrollment Criteria"

This section has been updated to correctly list the Medi-Cal programs designated for either mandatory or voluntary enrollment of beneficiaries in those programs in Medi-Cal MCPs in two-plan model counties. This update includes the recent addition of children in the Percent of Poverty program to the mandatory enrollment category. Note that these changes have already been implemented for Medi-Cal MCPs in both two-plan model and GMC counties, so these amendments will not result in any aid code changes in plan contracts.

Section 53881, "Marketing and Member Materials".

The amendments to this section are generally technical language changes or updated cross-references. Plan contracts already specify the same requirements now reflected in this section.

Section 53886, "Health Care Options Presentation"

The amendments to this section are generally technical language changes or updated cross-references to other sections. Plan contracts already specify the same requirements now reflected in this section.

Section 53887, Exemption from Plan Enrollment

This section has been completely rewritten in order to more clearly explain all the situations that qualify a beneficiary (in a mandatory enrollment category) for exemption from enrollment in a Medi-Cal MCP. To qualify for an exemption from plan enrollment, the beneficiary must satisfy one of the following conditions:

- Be an American Indian who has been accepted to receive healthcare services from an Indian Health Service facility on a fee-for-service basis. (This is usually referred to as an "Indian Health Program exemption.")
- Be under treatment for a complex medical condition from a Medi-Cal provider who is not contracted with either Medi-Cal MCP in the beneficiary's residence county. (This is usually referred to as a "medical exemption" and is granted in order to prevent any interruption of care for a beneficiary with a complex medical condition until such time when the beneficiary has completed treatment or may safely be transitioned to a new provider.)

Section 53887 now lists the specific medical conditions that qualify a beneficiary for a medical exemption:

- Pregnancy
- Under evaluation for organ transplant or approved for and awaiting transplant.
- Receiving chronic renal dialysis treatment.
- HIV positive or diagnosed with AIDS.

- Diagnosed with cancer and currently receiving a course of accepted therapy (such as chemotherapy or radiation).
- Approved for a major surgical procedure by the Medi-Cal FFS program and awaiting surgery or immediately post-operative.
- Has another complex and/or progressive disorder not listed above, such as cardiomyopathy or amyotrophic lateral sclerosis that is already under treatment.
- Is enrolled in a Medi-Cal waiver program that allows the beneficiary to receive sub-acute, acute, intermediate or skilled nursing care at home rather than as an in-patient. (This is known as a "waiver exemption" and currently includes four Medi-Cal waiver programs – AIDS Waiver, Model Waiver, In-Home Medical Care Waiver, and Skilled Nursing Facility Waiver.)
- Is enrolled in a Medi-Cal pilot project.

This section also specifies that medical exemptions cannot be approved for a beneficiary who has:

- Been a member of either plan for more than 90 days.
- Has a current Medi-Cal provider who is contracted with either plan.
- Began treatment or was scheduled to begin treatment after the date of plan enrollment.

This amended section also specifies that medical exemptions will be granted for up to 12 months, except those granted due to pregnancy which are granted through delivery and 90 days post-partum. An extension to a 12-month medical exemption can be requested, but no earlier than 11 months after the starting date of the current exemption.

The following new exemption request forms (attached) are incorporated by reference in this amended section and are available through the Health Care Options (HCO) Program:

- "Request for Medical Exemption from Plan Enrollment" (HCO Form 7101, dated 6/2000)
- "Request for Non-Medical Exemption from Plan Enrollment" (HCO Form 7102, dated 10/2000). This form is used for Indian Health Program and Waiver Program exemptions.

This amended section also specifies that the HCO Program approves or disapproves exemption requests and that the Department may at its discretion verify the "complexity, validity, and status" of the beneficiary's medical condition and verify that the provider is not contracted with a plan. The HCO Program or the Department may revoke approved exemptions if a provider fails to cooperate with the verification of the beneficiary's medical condition or the Department determines that:

- The approval was based on false or misleading information.
- The medical condition was not complex.
- Treatment for the medical condition has been completed.
- The requesting provider has not been providing services to the beneficiary.

Section 53888

This section now specifies that Medi-Cal MCPs must make the combined enrollment/disenrollment form available through their member services departments and that the form must be mailed within three working days of the plan receiving a telephone or written request for a form. Other amendments to this section were non-substantive language changes made for clarity and consistency.

Section 53889

This section has been completely rewritten in order to more clearly explain the following:

- Manner in which enrollment and disenrollment requests are to be submitted. An eligible beneficiary shall submit an enrollment or disenrollment request on an original, signed enrollment/disenrollment form to the Health Care Options Program by mail or in person at department-approved Health Care Options Program sites. Expedited disenrollment requests may also be submitted by facsimile. An eligible beneficiary also may request expedited disenrollment over the telephone from the Health Care Options Program.

- Information that must be provided on the enrollment/disenrollment form. These include: first and last name of the beneficiary; sex; date of birth; Social Security Number; Medi-Cal number; complete mailing address; telephone number, if available; plan choice, if requesting enrollment; name and address of doctor or clinic beneficiary is choosing as primary care provider; language of the beneficiary; and the reason for disenrolling, if requesting disenrollment.

- Processing timelines for completed enrollment and disenrollment requests. Fully completed enrollment/disenrollment forms with all required supporting documentation shall be processed within two working days if the request meets

the conditions for plan disenrollment. Beneficiaries shall be notified of approval or disapproval within seven working days of receipt of the request.

- The authorized individuals who may submit enrollment and disenrollment requests on behalf of beneficiaries. These include: persons with legal authority to act on the beneficiaries behalf; Department staff responsible for the administration of the Two-Plan Model Program and Health Care Options staff; Two-Plan Model Program contractors; Case managers, physicians or medical staff in home and community-based services waiver programs; and Care coordinators at Regional Center for the Developmentally Disabled.

- Effective dates for enrollment and both regular and expedited disenrollment. Enrollment requests and non-expedited disenrollment requests will be effective either the fist day of the first month, or the first day of the second month, following the month in which the request is processed, based on whether the request was processed before or after the monthly update to MEDS. Expedited disenrollment requests shall be effective on the first day of the month in which the request is processed.

- Reasons for which expedited disenrollment may be granted. These include: the beneficiary is an American Indian, is receiving services under the Foster Care or Adoption Assistance Program, has a complex medical condition, is enrolled in a Medi-Cal waiver program, is participating in a pilot project, was incorrectly assigned to a plan, as well as a number of other reasons. Each of the reasons includes the documentation required to be submitted with the request.

- **Section 53891, "Disenrollment of Members"**

This section has been amended to update the list of reasons for which disenrollment can be requested, as follows:

- Eligibility for Medi-Cal enrollment is terminated
- Incorrectly assigned to a plan not of the beneficiary's choosing
- Plan merger or reorganization
- Change of residence to outside the plan's service area
- Any reason, made not during restricted disenrollment period
- For good cause, as defined, during restricted disenrollment period
- Meets criteria set forth in Section 53887
- Meets criteria for expedited disenrollment as set forth in Section 53889
- Obtains other health coverage, as defined

Plan contracts already specify the same disenrollment reasons that are included in this amended regulation.

Section 53892, "Problem Resolution Process for Members"

This section has been amended primarily to add further clarity to provisions related to how the HCO Program must assist beneficiaries with problems related to enrollment and disenrollment. The primary changes are as follows:

- The regulation now specifies that plan members may request assistance from the HCO Program by telephone, fax, in writing or in person.

- The regulation specifies that, when the member's problem cannot be resolve by the HCO Program, the member must be referred to not only the plan's problem resolution process and the Medi-Cal Managed Care Office of the Ombudsman, but also to the Department of Managed Health Care's Office of Patient Advocate.

Section 53895, "Information to New Members"

This section has been updated to reflect information that Medi-Cal MCPs are already required, by statute and by contract, to provide to new members. Plan new member materials that have been approved by the Department will already be in compliance with this amended regulation.

Effective Date of New Regulations and Exemption Request Forms

The regulatory proposal was filed with the Secretary of State on December 19, 2000, and became effective December 20, 2000 pursuant to the Department's emergency regulatory authority. The amended regulations were thereafter to be published in the California Notice Register on December 29, 2000.

The HCO Program will begin placing both the new Medical Exemption Form and the new Non-Medical Exemption Form in Enrollment Packets on January 1, 2001. Also, as of that date the HCO Program will have these forms available to fax or mail to providers or enrollees. It is anticipated that the HCO Program will only accept the old exemption forms until February 1, 2001.

Public Comment Period

Following the publication in the Notice Register on December 29, 2000, there will be a 45-day Written Comment Period, during which the plans, or any member of the public, may comment upon the regulatory proposal. All comments, however, are required to be in writing. Any concerns or problems related to the regulatory

amendments should not be discussed with Contract Managers or other Department employees.

Relationship of New Regulations to Enrollment and Disenrollment in GMC Counties

As previously noted, most of the provisions in these amended regulations are already in effect in Two-Plan Model counties because many of the amendments reflect program changes already in place. This is also true with respect to GMC counties, and in nearly every aspect the Two-Plan Model enrollment/disenrollment regulations reflect rules which are applicable to current procedures in GMC counties. The one exception is that GMC counties are not able at this time to deny exemption requests on the basis that the member has been in the plan for over 90 days. The Department plans to amend the GMC enrollment/disenrollment regulations to mirror the Two Plan Model enrollment/disenrollment regulations during the 2001 calendar year.

If you have questions about compliance with these amended regulations, please contact your MMCD contract manager for assistance.

Roberto Martinez
Acting Chief
Medi-Cal Managed Care Division

Enclosure

State of California – Health and Human Services Agency — Department of Health Services

REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Each area of the Request For Exemption From Plan Enrollment form must be completed. If not, the medical exemption will be denied. – Please Print or Type (Ink Only)

To Be Completed and Signed By Beneficiary
Part I

1. Name: (Please Print) Last Name First Name M.I.		2. Social Security Number:
3. Date of Birth: ___/___/___ Month Day Year	4. Check One: ☐ Female ☐ Male	5. Medi-Cal ID Number:
6a. Are you a member of a health Plan? ☐ Yes (go to box 6b) ☐ No (go to box 7a)	6b. Plan Name:	6c. Plan Membership Number:
7a. Is someone other than the beneficiary completing this section? ☐ Yes (go to box 7b) ☐ No (go to box 8)	7b. If yes, please provide the following information: Print Name Relationship Phone Number	
8. I am requesting that Dr. _____ send in a request for a Medi-Cal Managed Care medical exemption for me. Name of Doctor		
9. Beneficiary's Signature: Signature of Beneficiary or Parent of Beneficiary if a minor child		10. Date Signed: ___/___/___ Month Day Year

This information is requested by the Department of Health Services, Medi-Cal Managed Care Division, under Title 22, California Code of Regulations, Sections 53887 or 53923.5, in order to comply with requirements of continuing with Fee-for-Service medical care. Completion of this form is mandatory for an exemption. Not completing this form could result in enrollment in a Managed Care health plan. For help with this form, please call Health Care Options at (800) 430-4263. This call is free.

Physician's Certification For Medical Exemption
Part II

The Beneficiary's rendering physician MUST fill out AND SIGN this section.

Approved: ☐ Date: _____

11. Date you started treating beneficiary for one of the conditions listed below in box 13: ___/___/___ Month Day Year	12. Estimated date of completion of treatment or therapy for condition requiring exemption: ___/___/___ Month Day Year

	13. Please check the following as appropriate (ICD-9-CM code must be included in column 14 at right, or the exemption will be considered incomplete and returned.)	14. ICD-9 Codes
	☐ A. Pregnant and currently under your care for the pregnancy. Due Date _____	
	☐ B. HIV+ or has been diagnosed with AIDS	1. 2.
	☐ C. Receiving chronic renal dialysis treatment under your supervision	1. 2.
	☐ D. Undergoing one of three transplant classifications (see item 13-D on page 4) Classification: _____ Medi-Cal designated transplant center: _____	1. 2.

INSTRUCTIONS FOR COMPLETING REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

PART I – To Be Completed and Signed By Beneficiary

Dear Medi-Cal Beneficiary: You and/or your family is now or may soon be required to receive your health care through a Medi-Cal Managed Care health plan. You may be seeing a doctor who is not part of a health plan. If you want to keep seeing this doctor, you may qualify for what is called a **medical exemption.** To receive a medical exemption, you must be seeing your doctor for something serious, and your doctor must NOT be a part of a health plan in the county where you live.

If you want to ask for a medical exemption, you must fill out Part I of this form. Please sign it and give it to your doctor. Your doctor will fill out and sign Part II of this form. If your request for a **medical exemption** is approved, you will NOT have to join a Medi-Cal Managed Care health plan for the time being. You can remain on regular Medi-Cal (non-managed care) and keep seeing your current doctor for up to 12 months. (In some cases, the exemption will be for fewer months. Your doctor will decide this.) If you need another medical exemption after your exemption period is over, you and your doctor must fill out and sign a new exemption form.

All information in this medical exemption form will be kept confidential. This information will only be used by the Medi-Cal program, its employees, and contractors.

If you have any questions regarding this form, please call Health Care Options at (800) 430-4263.

INSTRUCCIONES PARA COMPLETAR LA CERTIFICACION DE EXENCION DE ATENCION MEDICA DE LOS PLANES ADMINISTRADOS DE MEDI-CAL

Primera Parte - Para Ser Completado y Firmado Por el Benificiario.

Estimado Benificiario de Medi-Cal : Usted o su familia estan ahora o pueden requerirse que pronto reciban su cuidado de salud a través de un plan de Medi-Cal por Managed Care. Usted puede estar viendo a un doctor que no es parte de un plan de salud. Si usted quiere seguir viendo a este doctor, usted puede calificar para lo que se llama una exención médica. Al recievir una exención médica, usted debe estar viendo a su doctor para algo serio, y su doctor no debe de participar en uno de los planes de Managed Care en el condado donde usted vive.

Si usted quiere pedir una exención médica, usted debe completar la primera parte de esta forma. Por favor firmelo y déselo a su doctor. Su doctor completata la segunda parte de esta forma. Si su peticion para una exención médica es aprovada, usted no tendrá que afiliarse en un plan de Medi-Cal Managed Care por el momento. Usted puede permanecer en Medi-Cal regular (sin plan de salud) y seguir viendo a su actual doctor hasta por 12 meses. (En algunos casos, la exención sera por menos meses. Su doctor decidirá esto.) Si usted necesita otra exención médica después de que su pedodo de la exención haya terminado, usted y su doctor deben completar y firmar una nueva forma de exención.

Nos gustaria informarle que toda la información en esta forma de la exención médica se mantendra confidencial. Esta información sólo será usada por el programa de Medi-Cal, sus empleados, y contratistas.

Para mas informacion por favor llame a Health Care Options al (800) 430-3003 esta llamada es completamente gratis.

Part II Continued

	14. ICD-9 Codes
☐ E. Undergoing one of two cancer classifications (see item 13-E on the reverse side). Classification: _____ Type of Therapy: _____	1. 2.
☐ F. Has been approved for and is awaiting a major surgical procedure (see item 13-F on the reverse side). CPT code(s) for pending procedure(s): _____	1. 2.
☐ G. Has a complex neurological disorder, such as multiple sclerosis	1. 2.
☐ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease	1. 2.
☐ I. Has other complex and/or progressive disorder not covered above which requires ongoing medical supervision (See item 13-I on the reverse side). Describe treatment: _____	1. 2.

Please note that chronic disorders, such as asthma and diabetes, do not generally constitute grounds for approval as a medical exemption. Providers who believe that the severity of such a condition, or any other condition or combination of conditions, is/are sufficient to require a medical exemption should attach to this form additional medical documentation to establish the necessity for an exemption. Please include the Beneficiary's Medi-Cal identification number and Social Security Number on each page of medical documentation submitted.

15. Beneficiary's Social Security Number
_____-_____-_____

16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the Beneficiary's county of residence?
☐ Yes _____ Print the name of health plan
☐ No

17. Physician Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary:

18. Medi-Cal Provider:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

19. Medi-Cal Billing Information: (If different from box 18 above.)
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

20. Rendering Physician's Medical License Number:

21. If you are NOT affiliated with any Medi-Cal Managed Care health plan(s) in the Beneficiary's county of residence, you MUST complete this box. If you are affiliated with any Medi-Cal Managed Care health plan(s) in the Beneficiary's county of residence, please make sure boxes 18 and 19 are complete.
Rendering Physician's Phone number: _____ FAX: _____

22. Signature: (No Stamp) _____ (Authorized Rendering Medical Physician)

23. Date Signed: _____/_____/_____ Month Day Year

MAIL COMPLETED FORM to: Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850

or FAX this form to: (916) 364-0287

PART II – To Be Completed and Signed By Beneficiary's Rendering Physician

Dear Medi-Cal Physician: If you are currently providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual. The beneficiary must request a medical exemption, and you and the beneficiary must fill out this form, sign it, and mail or fax it (Part I and Part II) to the Health Care Options office (see mailing address and fax number at the bottom of Part II). Please refer to Title 22, California Code of Regulations, Sections 53887 or 53923.5, for additional information concerning requirements for medical exemptions.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved. An exemption can be requested for a maximum of 12 months. An extension may be requested at the end of 12 months by submitting a new exemption form.

Instructions for completing Boxes 13-D through 13-I (and 14):

Item 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD-9 code for organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption does not apply to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed.

Item 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease or who are classified as "cured" are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

Item 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, including surgery for cancer.

List both ICD-9 (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If beneficiary is immediately post-operative, estimate duration of time necessary for recovery under your supervision in box 12.

Item 13-I (and all box 14 ICD codes)

The ICD-9 code must be listed in box 14, and the treatment must be stated on the line provided.
Please check this item if beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

EXHIBIT C

State of California – Health and Human Services Agency | Department of Health Care Services

REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Each area of the Request For Exemption From Plan Enrollment form must be completed.
If not, the medical exemption will be denied – Please Print or Type (Ink Only)

To Be Completed and Signed By Beneficiary
Part I

1. Name: (Please Print) Last Name First Name M.I.		2. Benefits Identification Card Number:
3. Date of Birth: Month / Day / Year	4. Check One: ☐ Female ☐ Male	5. Medi-Cal ID Number:
6a. Are you a member of a health plan? ☐ Yes (go to box 6b) ☐ No (go to box 7a)	6b. Plan Name:	6c. Plan Membership Number:
7a. Is someone other than the beneficiary completing this section? ☐ Yes (go to box 7b) ☐ No (go to box 8)	7b. If yes, please provide the following information: Print Name / Relationship / Phone Number	
8. I am requesting that Dr. _____ (Name of Doctor) send in a request for a Medi-Cal Managed Care medical exemption for me.		
9. Beneficiary's Signature: Signature of beneficiary or Parent of beneficiary if a minor child		10. Date Signed: Month / Day / Year

This information is requested by the Department of Health Care Services, Medi-Cal Managed Care Division, under Title 22, California Code of Regulations, Sections 53887 or 53923.5, in order to comply with requirements of continuing with Fee-for-Service medical care. Completion of this form is mandatory for an exemption. Not completing this form could result in enrollment in a Managed Care health plan. For help with this form, please call Health Care Options at (800) 430-4263. This call is free.

Physician's Certification For Medical Exemption
Part II

The beneficiary's rendering physician MUST fill out AND SIGN this section.

For State Use Only: Approved: ☐ Denied: ☐ Deferred: ☐ Initials: _____ Date: _____

11. Date you started treating beneficiary for one of the conditions listed below in box 13: ____/____/____ Month Day Year	12. Estimated date of completion of treatment or therapy for condition requiring exemption: ____/____/____ Month Day Year	
For state use only:	13. Please check the following as appropriate (ICD-9-CM code must be included in column 14 at right, or the exemption will be considered incomplete and returned.)	14. ICD-9 Codes
P	☐ A. Pregnant and currently under your care for the pregnancy. Due Date _____	
F	☐ B. HIV+ or has been diagnosed with AIDS	1. 2.
D	☐ C. Receiving chronic renal dialysis treatment under your supervision	1. 2.
E	☐ D. Undergoing one of three transplant classifications (see item 13-D on page 4) Classification: _____ Medi-Cal designated transplant center: _____	1. 2.

INSTRUCTIONS FOR COMPLETING REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

PART I – To Be Completed and Signed By Beneficiary

Dear Medi-Cal Beneficiary: You and/or your family is now or may soon be required to receive your health care through a Medi-Cal Managed Care health plan. You may be seeing a doctor who is not part of a health plan. If you want to keep seeing this doctor, you may qualify for what is called a medical exemption. To receive a medical exemption, you must be seeing your doctor for something serious, and your doctor must NOT be a part of a health plan in the county where you live.

If you want to ask for a medical exemption, you must fill out Part I of this form. Please sign it and give it to your doctor. Your doctor will fill out and sign Part II of this form. If your request for a medical exemption is approved, you will NOT have to join a Medi-Cal Managed Care health plan for the time being. You can remain on regular Medi-Cal (non-managed care) and keep seeing your current doctor for up to 12 months. (In some cases, the exemption will be for fewer months. Your doctor will decide this). If you need another medical exemption after your exemption period is over, you and your doctor must fill out and sign a new exemption form.

All information in this medical exemption form will be kept confidential. This information will only be used by the Medi-Cal program, its employees, and contractors.

If you have any questions regarding this form, please call Health Care Options at (800) 430-4263.

INSTRUCCIONES PARA COMPLETAR LA CERTIFICACION DE EXENCION DE ATENCION MEDICA DE LOS PLANES ADMINISTRADOS DE MEDI-CAL

Primera Parte - Para Ser Completado y Firmado Por el Benificiario.

Estimado Benificiario de Medi-Cal : Usted o su familia estan ahora o pueden requerirse que pronto reciban su cuidado de salud a través de un plan de Medi-Cal por Managed Care. Usted puede estar viendo a un doctor que no es parte de un plan de salud. Si usted quiere seguir viendo a este doctor, usted puede calificar para lo que se llama una exención médica. Al recievir una exención médica, usted debe estar viendo a su doctor para algo serio, y su doctor no debe de participar en uno de los planes de Managed Care en el condado donde usted vive.

Si usted quiere pedir una exención médica, usted debe completar la primera parte de esta forma. Por favor firmelo y déselo a su doctor. Su doctor completara la segunda parte de esta forma. Si su peticion para una exención médica es aprovada, usted no tendrá que afiliarse en un plan de Medi-Cal Managed Care por el momento. Usted puede permanecer en Medi-Cal regular (sin plan de salud) y seguir viendo a su actual doctor hasta por 12 meses. (En algunos casos, la exención sera por menos meses. Su doctor decidirá esto.) Si usted necesita otra exención médica después de que su periodo de la exención haya terminado, usted y su doctor deben completar y firmar una nueva forma de exención.

Nos gustaria informarle que toda la información en esta forma de la exención médica se mantendra confidencial. Esta información sólo será usada por el programa de Medi-Cal, sus empleados, y contratistas.

Para mas informacion por favor llame a Health Care Options al (800) 430-3003 esta llamada es completamente gratis.

Part II Continued

For state use only		14. ICD-9 Codes
C	☐ E. Undergoing one of two cancer classifications (see item 13-E on the reverse side). Classification: _____ Type of Therapy: _____	1. 2.
G	☐ F. Has been approved for and is awaiting a major surgical procedure (see item 13-F on the reverse side). CPT code(s) for pending procedure(s): _____	1. 2.
A	☐ G. Has a complex neurological disorder, such as multiple sclerosis	1. 2.
B	☐ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease	1. 2.
M	☐ I. Has other complex and/or progressive disorder not covered above which requires ongoing medical supervision (See item 13-I on the reverse side). Describe treatment: _____	1. 2.

Please note that chronic disorders, such as asthma and diabetes, do not generally constitute grounds for approval as a medical exemption. Providers who believe that the severity of such a condition, or any other condition or combination of conditions, is/are sufficient to require a medical exemption should attach to this form additional medical documentation to establish the necessity for an exemption. Please include the beneficiary's Medi-Cal identification number and Benefits Identification Card Number on each page of medical documentation submitted.

15. Beneficiary's Benefits Identification Card Number
_____

16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence?
☐ Yes _____ Print the name of health plan
☐ No

17. Physician National Provider Identication Number used to bill the Medi-Cal Program for this beneficiary:
_____

18. Medi-Cal Provider:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

19. Medi-Cal Billing Information: (If different from box 18 above.)
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Care Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

20. Rendering Physician's Medical License Number:

21. If you are NOT affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence, you MUST complete this box. If you are affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence, please make sure boxes 18 and 19 are complete.
Rendering Physician's Phone number: _____ FAX: _____

22. Signature: (No Stamp) _____ (Authorized Rendering Medical Physician)

23. Date Signed: ____/____/____ Month Day Year

MAIL COMPLETED FORM to: Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850

or FAX this form to: (916) 364-0287

PART II – To Be Completed and Signed By Beneficiary's Rendering Physician

Dear Medi-Cal Physician: If you are currently providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual. The beneficiary must request a medical exemption, and you and the beneficiary must fill out this form, sign it, and mail or fax it (Part I and Part II) to the Health Care Options office (see mailing address and fax number at the bottom of Part II). Please refer to Title 22, California Code of Regulations, Sections 53887 or 53923.5, for additional information concerning requirements for medical exemptions.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved. An exemption can be requested for a maximum of 12 months. An extension may be requested at the end of 12 months by submitting a new exemption form.

Instructions for completing Boxes 13-D through 13-I (and 14):

Item 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD-9 code for organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption does not apply to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed.

Item 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease or who are classified as "cured" are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

Item 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, including surgery for cancer.

List both ICD-9 (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If beneficiary is immediately post-operative, estimate duration of time necessary for recovery under your supervision in box 12.

Item 13-I (and all box 14 ICD codes)

The ICD-9 code must be listed in box 14, and the treatment must be stated on the line provided.
Please check this item if beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

EXHIBIT D

State of California – Health and Human Services Agency | Department of Health Services

[redacted]

Dear Indian Health Service Facility: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The Indian Health Exemption is valid until the individual chooses to enroll in a Medi-Cal managed Care health plan.

1. Beneficiary Name Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC)
3. Name of Indian Health Facility	
I certify that the information I have provided on this form is correct. I understand that the Department of Health Services may audit this form to determine if the information provided is accurate.	
4a. Authorized Signature of IHS Provider	4b. Date Signed Month Day Year
4c. Printed Name of IHS Provider Last Name First Name M.I.	4d. Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary.
5. Telephone Number of IHS Provider (_____)_____-_____	6. Fax Number of IHS Provider (_____)_____-_____

[redacted]

Dear Medi-Cal Physician: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal Waiver Program benefits, please complete this portion of the form.

1. Beneficiary Name Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC)
3. Medi-Cal Provider Number	4. Medi-Cal Waiver Program: u. ☐ AIDS Waiver Program v. ☐ Model Waiver Program w. ☐ In-Home Medical Care (IHMC) Waiver Program y. ☐ Skilled Nursing Facility (SNF) Waiver Program
I certify that the information I have provided on this form is correct. I understand that the Department of Health Services may audit this form to determine if the information provided is accurate.	
5. Authorized Signature of Medi-Cal Physician	6. Date Signed Month Day Year
7. Printed Name of Medi-Cal Physician Last Name First Name M.I.	8. Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary.
9. Telephone Number of Medi-Cal Physician (_____)_____-_____	10. Fax Number of Medi-Cal Physician (_____)_____-_____

MAIL COMPLETED FORM to: Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or FAX this form to:
(916) 364-0287

If you have questions regarding this form, please call HCO at 1-800-430-4263

State of California – Health and Human Services Agency | Department of Health Services

MEDI-CAL MANAGED CARE NON-MEDICAL EXEMPTION

• See other side for the Non-Medical Exemption Form •

Indian Health Program Exemption:

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you or a family member is a Native American, Alaskan Native or qualified non-Indian and you want to receive medical services through an Indian Health Service (IHS) facility, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through an Indian Health Service facility.

To be excused from plan enrollment you must have an Indian Health Services facility representative complete this form, certifying that you are or will be receiving services from an Indian Health Service facility. The facility representative must submit this completed form to the HCO program.

Medi-Cal Waiver Program Exemption:

Dear Medi-Cal Beneficiary: If you are enrolled in a Medi-Cal waiver program which allows you to receive skilled nursing services at home or are enrolled in any of the waiver programs listed below, you may NOT have to join a plan.

If you are enrolled in a Medi-Cal waiver program and wish to continue receiving medical services from your doctor, clinic or other primary care provider, you must have your doctor complete this form. If approved, you will NOT have to join a Medi-Cal Managed Care health plan for up to 12 months. At the end of 12 months, if an extension is required, your doctor must submit a new form. Your approval for medical exemption will allow you to continue to receive medical services through fee-for-service Medi-Cal by using your white Medi-Cal card.

Medi-Cal Waiver Programs:

- AIDS Waiver Program
- Model Waiver Program
- In-Home Medical Care (IHMC) Waiver Program
- Skilled Nursing Facility (SNF) Waiver Program

EXCEPCIÓN POR RAZONES NO MÉDICAS PARA ATENCIÓN MÉDICA ADMINISTRADA DE MEDI-CAL

• Vea el reverso de este formulario para información sobre la Excepción por Razones Médicas •

Excepción para el Programa Indian Health Program:

Estimado beneficiario de Medi-Cal: Si usted o un miembro de su familia está recibiendo beneficios de Medi-Cal, es posible que deba inscribirse en un Plan de Salud Administrado de Medi-Cal. Sin embargo, si usted o un miembro de su familia es de origen Indígena Americano, Nativo de Alaska o reúne los requisitos para personas de origen no indígena y desea recibir servicios médicos a través de un centro de Indian Health Service (IHS), puede solicitar que esté excluido de inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal para recibir los servicios a través del centro de Indian Health Service.

Para que esté excluido de inscribirse en el plan, debe solicitarle a un representante del centro de Indian Health Services que llene este formulario, en el que certifica que usted recibe o recibirá servicios a través de un centro de Indian Health Service. El representante del centro debe enviar este formulario completo al programa HCO.

Excepción para los programas de renuncia a Medi-Cal:

Estimado beneficiario de Medi-Cal: Si está inscrito en un programa de renuncia a Medi-Cal que le permite recibir servicios de atención médica especializada en el hogar o en cualquiera de los programas de renuncia que figuran a continuación, tal vez NO tenga que inscribirse en un plan.

Si está inscrito en un programa de renuncia a Medi-Cal y desea continuar recibiendo servicios médicos a través de su médico, clínica, u otro proveedor de atención médica primaria, debe solicitarle a su médico que llene este formulario. Si se aprueba su solicitud, NO tendrá que inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal durante un período de hasta 12 meses. Al cumplirse los 12 meses, si se requiere una extensión, su médico deberá presentar un nuevo formulario. Su aprobación para una excepción por razones médicas le permitirá continuar recibiendo servicios médicos mediante el sistema de pago por servicio de Medi-Cal (fee-for-service), utilizando su tarjeta blanca de Medi-Cal.

Programas de renuncia a Medi-Cal:

- Programa de renuncia para SIDA (AIDS Waiver Program)
- Programa de renuncia modelo (Model Waiver Program)
- Programa de renuncia para atención médica en el hogar (In-Home Medical Care (IHMC) Waiver Program)
- Programa de renuncia para atención médica especializada (Skilled Nursing Facility (SNF) Waiver Program)

EXHIBIT E

Medi-Cal Managed Care
Non-Medical Exemption

Excepción Por Razones No Médicas
Para Atención Médica Administrada de Medi-Cal

Request for Non-Medical Exemption from Plan Enrollment
Indian Health Program Exemption

Each area of the Indian Health Program Exemption form must be completed or the form will be returned unprocessed.

Please Print or Type (Ink Only)

Dear Indian Health Service Facility: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The Indian Health Exemption is valid until the individual chooses to enroll in a Medi-Cal Managed Care health plan.

1. Beneficiary Name Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC)
3. Name of Indian Health Facility	
I certify that the information I have provided on this form is correct. I understand that the Department of Health Care Services may audit this form to determine if the information provided is accurate.	
4a. Authorized signature of Medi-Cal Provider	4b. Date signed Month Day Year
4c. Printed name of Medi-Cal Provider Last Name First Name M.I.	4d. Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary.
5. Telephone number of Medical Provider ( ) -	6. Fax number of Medical Provider ( ) -
9. Telephone number of Medical Physician ( ) -	10. Fax number of Medical Physician ( ) -

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you or a family member is a Native American, Alaskan Native or qualified non-Indian and you want to receive medical services through an Indian Health Service (IHS) facility, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through an Indian Health Service facility.

To be excused from plan enrollment you must have an Indian Health Service facility representative complete this form, certifying that you are or will be receiving services from an Indian Health Service facility. The facility representative must submit this completed form to the HCO program.

Mail completed form to:
Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or Fax this form to: (916) 364-0287
If you have any questions regarding this form, please call HCO at 1-800-430-4263; TDD/TTY users, call 1-800-430-7077

Estimado beneficiario de Medi-Cal: Si usted o un miembro de su familia está recibiendo beneficios de Medi-Cal, es posible que deba inscribirse en un Plan de Salud Administrado de Medi-Cal. Sin embargo, si usted o un miembro de su familia es de origen Indígena Americano, Nativo de Alaska o reúne los requisitos para personas de origen no indígena y desea recibir servicios médicos a través de un centro de Indian Health Service (IHS), puede solicitar que esté excluido de inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal para recibir los servicios a través del centro de Indian Health Service.

Para que esté excluido de inscribirse en el plan, debe solicitarle a un representante del centro de Indian Health Services que llene este formulario, en el que certifica que usted recibe o recibirá servicios a través de un centro de Indian Health Service. El representante del centro debe enviar este formulario completo al programa HCO.

EXHIBIT F

Date: July 18, 2012

To: All Medi-Cal Providers

Subject: **Provider Bulletin: Introduction and Supplemental Instructions for Form HCO 7101, Request for Medical Exemption from Plan Enrollment**

The provider bulletin that accompanies this letter details the policy of the Department of Health Care Services (DHCS) regarding Medical Exemption Requests (MERs).

A MER is a request for temporary exemption from enrollment into a Medi-Cal managed care plan only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer, without deleterious medical effects, from a physician in Fee-for-Service (FFS) Medi-Cal to a physician of the same specialty in a managed care plan.

To initiate the MER process, the treating physician must fill out form HCO 7101, Request for Medical Exemption from Plan Enrollment. The DHCS clinical staff then reviews and verifies the information in each MER form. For DHCS to complete its review and avoid a delay in processing, DHCS requests the healthcare providers of Medi-Cal beneficiaries to consider the following five points:

1. Only one MER form should be submitted for a beneficiary unless a previous MER was denied and the beneficiary's medical condition has since changed. Submitting multiple MERs for one beneficiary slows down the review and verification process.

2. The MER form should be filled out in its entirety and may be considered incomplete if necessary fields are left blank or responses are not legible. Examples of commonly missed fields include:

   - Beneficiary's Medi-Cal Client Identification Number (CIN).
   - ICD-9 Code(s).
   - Description of treatment plan that cannot be interrupted.
   - Estimated date of completion of treatment.
   - Requesting and rendering provider are not the same.
   - Rendering provider's NPI and Medical License Number.
   - Telephone number of the rendering provider's office.
   - Original signature of beneficiary or authorized representative.
   - Original signature of rendering physician (no stamp or staff signature allowed).

3. 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 or specialties. Supporting documents may include, but are not limited to legible copies of:

   - Notes from five most recent MD office visits.
   - Current medical history and physical exam results.
   - Treatment plan.

4. A MER will be returned as incomplete if it fails to meet the standards listed above. To be reconsidered, the missing information or completed form must be provided within 30 days of DHCS's request to the submitting provider for additional information. Any MER incomplete for over 30 days will be denied.

   While the MER is in an incomplete status for 30 days, the beneficiary will remain in FFS Medi-Cal, if not already enrolled in a managed care plan.

5. If a beneficiary has a provider affiliated with a managed care plan in the beneficiary's county of residence, the MER will be denied because the beneficiary can continue to receive services from his or her current provider as a member of the managed care plan with which the provider is currently affiliated.

Please read the accompanying provider bulletin for the detailed policy statement related to MERs. If you have questions regarding this provider bulletin, please contact Health Care Options at 800-430-4263.

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Provider Bulletin

Medical Exemption from Plan Enrollment Request Process

The purpose of this bulletin is to reaffirm the Medical Exemption Request (MER) process that exempts Medi-Cal beneficiaries from enrollment into managed care and ensure that providers are reminded that Seniors and Persons with Disabilities (SPDs) have the opportunity to request continued access to an out-of-network provider for up to 12 months after they have been enrolled in a managed care health plan. This bulletin also serves as notification that the MER form is in the process of being revised to better reflect the requirements for a MER to be processed.

Reminder: SPD Extended Continuity of Care

The recent implementation of mandatory enrollment of SPDs into managed care has generated a significant increase in requests for MERs. The Department of Health Care Services (DHCS) wants to remind providers that a MER might not be necessary for an SPD to continue to see their existing out-of-network provider, even if the SPD is enrolled in a managed care health plan. SPD beneficiaries have the opportunity to request continued access to see an out-of-network provider for up to 12 months after enrollment in a managed care health plan to assure continuity of care. Although certain requirements must be fulfilled, it is not necessary for the provider to contract with the managed care health plan to continue treating the beneficiary. Additional information is provided in the links below.

- Provider Bulletin: http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ProviderBulletinSept2011.pdf
- SPD Extended Continuity of Care Frequently Asked Questions: http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDHCPFAQ.aspx

MER Background

Per Title 22 of the California Code of Regulations, Section 53887, an eligible beneficiary in a Two Plan county, who is receiving fee-for-service (FFS) Medi-Cal treatment or services for a complex medical condition from a physician, certified nurse midwife, or licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of the managed care health plans available in the eligible beneficiary's county of residence may request a medical exemption to temporarily continue treatment under FFS Medi-Cal to support the beneficiary's continuity of care. A beneficiary who has been granted a medical exemption from health plan enrollment shall remain with the

FFS 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.

MER Overview and General Considerations

The DHCS clinical staff reviews each MER to determine if the beneficiary can be safely transitioned into a managed care health plan where they will continue to receive all medically necessary covered services. A MER is not reviewed to determine if medical services should be provided or to determine if such services are medically necessary: **this is not a Treatment Authorization Request.**

In general, a beneficiary receiving maintenance care or being seen for routine follow-up of their complex medical condition(s) will not be granted an exemption from health plan enrollment. Additionally, per Title 22, a request for exemption shall not be granted for a beneficiary who has been a member of a health plan for more than 90 days; has a current provider who is contracting with a managed care health plan operating in the beneficiary's county of residence, including subcontracting plans, clinics, and/or Independent Physician Associations; or has begun or was scheduled to begin treatment after the date of health plan enrollment.

As beneficiaries with more complex medical conditions are being moved into managed care, DHCS has found that additional information is required for clinical staff to verify the complexity, validity, and status of the medical condition and treatment plan that necessitates the exemption. To expedite the review process, providers must supply this documentation to help verify that the beneficiary is unable to safely transfer to a health plan provider of the same specialty. The type of information that DHCS needs may include, but is not limited to, approved FFS TARs, progress notes, information from the last history and physical exam, a treatment plan, and any additional information that demonstrates that the beneficiary cannot safely transfer to a new provider. To help avoid delays in these important requests, DHCS asks that providers include the information described above as documentation in the initial MER request.

Additionally, DHCS cannot review incomplete MER forms. An incomplete MER will be sent back to the provider, which will delay the processing of the exemption request. The request review will be delayed if:

- All fields in the MER form are not complete when submitted.
- Necessary documentation is not provided with the initial submission of the MER that allows clinical staff to make a determination.

- The provider submitting the MER is not the same as the non-contracted provider actually providing the services that the MER is being requested for, such as specialty treatment centers or hospitals.

If the MER is returned as incomplete and additional information requested by DHCS is not received within 30 days of the date on the request for additional information, the MER will be administratively denied by DHCS.

Pregnancy Requests

Exemption requests for pregnancy will be reviewed as described above to determine if the beneficiary is eligible for an exemption and unable to safely change providers. Providers must supply the appropriate ICD-9 codes and any additional information to assist in the review of the request. An uncomplicated pregnancy is not considered a condition that requires a beneficiary to stay with the current physician for mother and infant safety. However, special consideration is given to women in their 3rd trimester who have an established relationship with a provider during their 1st and 2nd trimesters to ensure continuity of care for the delivery. Exemptions will not be granted for members assigned to a health plan clinic who request to receive services from a non-contracted provider affiliated with the clinic. The beneficiary's primary provider is considered the clinic.

Transplant Requests

Kidney and corneal transplants are the only transplants covered by managed care health plans in most counties. All other transplants are provided on a FFS basis, regardless of managed care enrollment. However, exemption requests for beneficiaries experiencing specific transplant situations will be reviewed and evaluated with the same criteria previously described.

General Guidelines

Exemption from plan enrollment or extension of an approved exemption due to a complex medical condition must be requested on the "Request for Medical Exemption from Plan Enrollment" form, which can be accessed by calling 1-800-430-4263 or online at:

http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx

Questions regarding these documents may be directed to Health Care Options at: 1-800-430-4263 or TDD/TTY 1-800-430-7077, or www.healthcareoptions.dhcs.ca.gov.

EXHIBIT G1

CONFIDENTIAL

State of California-Health and Human Services Agency

Department of Health Care Services

P.O. Box 989009

West Sacramento, CA 95798-9850

*** IMPORTANT INFORMATION ABOUT YOUR MEDI-CAL ENROLLMENT***

March 19, 2012

079L1111D-000087-19-7

L - L-120790GF7-03/19/12

RE: I 120790GF7/402643

Dear

Your request for an exemption from enrollment in a Medi-Cal managed care health plan has been denied. The reason for this denial is listed below (Reference: California Code of Regulations, Title 22, Section 53887 or 53923.5)

- Your medical condition does not qualify for a medical exemption. This decision is based on the information sent to us by your doctor.
- Your health plan may allow you to continue seeing your current doctor for up to 12 months from your enrollment in managed care. Please contact your health plan for more information.

Note: This denial does not change your Medi-Cal eligibility. You can still get all Medi-Cal services that are medically needed.

You must enroll in a Medi-Cal managed care health plan because you do not qualify for an exemption. If you are already in a Medi-Cal managed care health plan, you do not need to do anything. If you are not in a Medi-Cal managed care plan, in about 30 days you will receive information telling you how to enroll. The packet will have the information you need to choose a Medi-Cal managed care health plan.

FOR HELP ENROLLING IN A MEDI-CAL PLAN: Call Health Care Options at 1-800-430-4263 from 8:00 AM to 5:00 PM Monday through Friday if you need help enrolling in a Medi-Cal managed care health plan.

SEE YOUR DOCTOR ABOUT YOUR MEDICAL CONDITION: Once you are in a Medi-Cal managed care health plan, please see your plan doctor about your medical condition. If you are already in a Medi-Cal managed care health plan, be sure your doctor knows about your medical condition.

FOR HELP WITH YOUR MEDI-CAL PLAN: If you need help getting care from your Medi-Cal managed care health plan, call the plan's member services department. You can also call the Office of the Ombudsman at 1-888-452-8609 from 8:00 AM to 5:00 PM Monday through Friday.

YOUR RIGHT TO A STATE HEARING: You have the right to ask for a State Hearing about this denial. (Welfare and Institutions Code Section 10950 and California Code of Regulations, Title 22, Section 50951).

626301897J/39739

You must ask for a State Hearing within 90 days from the date of this notice. You can ask for a State Hearing even if you have filed a grievance with your health plan.

To ask for a State Hearing, write:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You also can ask for a State Hearing by calling 1-800-952-5253 from 8:00 AM to 5:00 PM Monday through Friday. This number can be very busy. You may get a message asking you to call back later. (If you have trouble hearing or speaking, call TDD 1-800-952-8349). This call is free.

If you ask for a State Hearing in writing, please include:

- Your name
- Person asking for a State Hearing
- Your Medi-Cal Benefits Identification Number
- Your address
- Your telephone number
- Reason you are asking for a State Hearing
- Language or dialect (in case you need an interpreter)
- Name, address, and telephone number of your authorized representative

If you ask for a State Hearing, the State Hearing Office will set up a file. You and/or your authorized representative have the right to see this file.

You can represent yourself at the State Hearing or have someone else represent you. For information about how to get free legal help, call the California Department of Social Services at 1-800-952-5253 from 8:00 AM to 5:00 PM Monday through Friday. You can also call your local County Bar Association for a list of organizations that give free legal help.

Sincerely,

California Health Care Options
1-800-430-4263

CONFIDENTIAL

Verification

I, Azatui Charkhchyan, am a petitioner in the above-entitled action. I declare under penalty of perjury that the facts alleged in the foregoing document that relate to me are true and correct to the best of my information and belief.

Executed in Los Angeles, California this 18th day in October, 2013.

Roland Manukian
For Azatui Charkhchyan

Verification

I, Juan Cameros, am a petitioner in the above-entitled action. I declare under penalty of perjury that the facts alleged in the foregoing document that relate to me are true and correct to the best of my information and belief.

Executed in Los Angeles, California this 15 day in October, 2013.

Juan Cameros

Verification

I, Raquel Alvarez, am a petitioner in the above-entitled action. I declare under penalty of perjury that the facts alleged in the foregoing document that relate to me are true and correct to the best of my information and belief.

Executed in Los Angeles, California this 21 day in October, 2013.

Raquel Alvarez Martell
For Raquel Alvarez

Verification

I, Della Saavedra, am a petitioner in the above-entitled action. I declare under penalty of perjury that the facts alleged in the foregoing document that relate to me are true and correct to the best of my information and belief.

Executed in Los Angeles, California this 21 day in October, 2013.

Della Saavedra

Della Saavedra

PROOF OF SERVICE

STATE OF CALIFORNIA)
)
COUNTY OF LOS ANGELES)

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 1550 W. 8th St., Los Angeles, CA 90017

On November 4, 2013. I served the following documents (s) described as: **Second Amended Petition for Writ of Mandate** on the interested party (ies) in this action by handing true copies thereof in sealed envelopes and/ or packages as follow:

Parties served:

Janet E. Burns, Esq.
S. Paul Bruguera, Esq.
Deputy Attorney General
300 South Spring Str., Ste. 1702
Los Angeles, CA 90013
Attorneys for Respondents

☐ By Email: Personally transmitting the document(s) via electronic service to the e-mail addresses set forth below on this date.

☒ (By U.S. Mail) As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. *[C.C.P. §§ 1012 and 1013(a)]*

☐ (By Personal Service) I personally handed such envelope or package to the party or person authorized to receive service for the party.

☒ (STATE) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on November 4, 2013 at Los Angeles, California.

Karen Ruiz

LEGAL AID FOUNDATION OF LOS ANGELES
1550 W. 8th Street
Los Angeles, CA 90017

Exhibit C

KAMALA D. HARRIS
Attorney General of California
LESLIE P. MCELROY
Supervising Deputy Attorney General
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Attorneys for Respondents Toby Douglas, Director, and the Department of Health Care Services

SUPERIOR COURT OF THE STATE 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; and AZATUI [redacted], BY HER GUARDIAN AD LITEM [redacted]; AND [redacted] FARAHMAND, 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.	Case No. BS140896 **ANSWER TO SECOND AMENDED PETITION FOR WRIT OF MANDATE**

Respondents Toby Douglas, in his official capacity as Director of the California Department of Health Care Services and the California Department of Health Care Services (Respondents) hereby answer the Second Amended Petition for Writ of Mandate (Second Amended Petition) as follows:

1. Answering paragraph 1 of the Second Amended Petition, Respondents admit that Petitioner Della Saavedra asserts that she suffers from Multiple Myeloma, hypertension and diabetes. Respondents allege that pursuant to a waiver granted by the Centers for Medicare and Medicaid Services (CMS), the California Department of Health Care Services (DHCS) began in June 2011, requiring certain Seniors and Persons with Disabilities to receive their Medi-Cal services through managed care health plans rather than fee-for-service health care providers. Respondents deny the remaining allegations in this paragraph.

2. Answering paragraph 2 of the Second Amended Petition, Respondents admit that 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 paid for by Medi-Cal, and have been mandatorily enrolled in Medi-Cal managed care plans. Respondents deny the remaining allegations in this paragraph.

3. Answering paragraph 3 of the Second Amended Petition, the allegations purport to paraphrase and quote from Welfare and Institutions Code section 14182(b)(15) and Title 22, California Code of Regulations, section 53887, subdivision (a)(2)(A). That regulation and statute speak for themselves and no answer is required to those allegations of this paragraph. To the extent a response may be required to the remaining allegations, Respondents deny the remaining allegations in this paragraph.

4. Answering paragraph 4 of the Second Amended Petition, Respondents admit that "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." Respondents deny the remaining allegations.

5. Answering paragraph 5 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

6. Answering paragraph 6 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

7. Answering paragraph 7 of the Second Amended Petition, Respondents admit that petitioners have accurately quoted a sentence in Welfare and Institutions Code section

14182(b)(21). However, the statute speaks for itself and no answer is required to those allegations of this paragraph. To the extent a response may be required to the remaining allegations, Respondents deny the remaining allegations in this paragraph.

8. Answering paragraph 8 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

9. Answering paragraph 9 of the Second Amended Petition, Respondents admit that the Medi-Cal Managed Care Office of the Ombudsman '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'". . Respondents deny the remaining allegations contained in this paragraph.

10. Answering paragraph 10 of the Second Amended Petition, Respondents admit that: (1) in November 2012, DHCS publicly acknowledged that processing errors had occurred in connection with thousands of MERs filed by Seniors and Persons with Disabilities; (2) in January 2013, DHCS sent a notice, known as Letter X, to thousands of these Medi-Cal beneficiaries, who were Seniors and Persons with Disabilities, informing them that their MERs had been denied without the beneficiary being sent any notice of that denial; and (3) Letter X did not state the reasons for the denial of their MERs, but did state that the beneficiaries had 45 days to appeal the denial of their MERs. Respondents deny the remaining allegations of this paragraph.

11. Answering paragraph 11 of the Second Amended Petition, Respondents admit that: (1) in January 2013, DHCS also sent a notice, known as Letter B, to thousands of additional Medi-Cal beneficiaries who were Seniors and Persons with Disabilities, informing them that their MERs had been denied before their treating physicians had the opportunity to present further documentation to support their MERs; (2) Letter B did not inform the beneficiaries of what further documentation had not been presented by their providers; and (3) Letter B stated that the beneficiaries had 30 days to make a telephonic request for reinstatement to fee-for-service pending a decision on the new MER, and had 45 days to file a new MER for beneficiaries who remain in the managed care plan. Respondents deny the remaining allegations in this paragraph.

12. Answering paragraph 12 of the Second Amended Petition, Respondents admit that in January 2013, DHCS sent the X letter to some people who should have received the B letter. Respondents deny the remaining allegations of paragraph 12.

13. Answering paragraph 13 of the Petition, Respondents admit that Petitioners Della Saavedra, Juan Cameros, Anita Valadez, Raquel Alvarez, Azatui Charkhchyan, and Janet Farahmand are Medi-Cal beneficiaries who have received treatment for their medical conditions from Medi-Cal providers on a fee-for-service basis, and that DHCS reinstated Petitioners Saavedra, Cameros, Valadez, and Alvarez to fee-for-service in October 2012 and granted their respective MERs effective from November 1, 2012, to October 31, 2013. DHCS granted an additional extension allowing all Petitioners to stay in fee-for-service through June 30, 2014. DHCS granted petitioner Charkhchyan a temporary exemption, and returned petitioner Farahmand to fee-for-service pending resolution of her MER. Respondents deny every remaining allegation contained in this paragraph.

14. Answering paragraph 14 of the Second Amended Petition, Respondents deny every allegation contained in the paragraph.

15. Answering paragraph 15 of the Second Amended Petition, Respondents admit that Petitioners have provided information indicating the following: (1) Petitioner Della Saavedra (Saavedra) is a Medi-Cal recipient with disabilities and 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, and insulin-dependent diabetes; (2) beginning in 1990, Saavedra was treated at City of Hope by Dr. Anthony Stein, Dr. Wei Feng and other physicians on a fee-for-service basis; (3) in November 2011, Saavedra's physicians filed a timely MER on her behalf; (4) on March 19, 2012, DHCS denied the MER and enrolled her in a managed care plan; (5) Saavedra filed a timely appeal of the denial of her MER; (6) on July 17, 2012 the administrative law judge (ALJ) granted Saavedra a temporary exemption from enrollment in managed care pending a hearing decision; (7) the Department overturned the decision of the ALJ granting the temporary exemption because the beneficiary was already enrolled in the managed care plan for an extended period of time and

there would be no disruption of continuity of care; (8) the Department submitted a position statement stating that Saavedra had failed to document "any high risk or complex medical condition that has not been stabilized and requires continuity of care from a Fee-for-Service provider. Therefore there is no deleterious medical effects to the beneficiary if she began receiving care from a plan provider;" (9) Saavedra received an unfavorable hearing decision denying her medical exemption; (10) on October 22, 2012, Respondents granted Saavedra's MER for a twelve-month period. DHCS granted an additional extension allowing all Petitioners to stay in fee-for-service through June 30, 2014. Respondents lack sufficient information or belief to admit or deny the remaining allegations and on that basis deny them.

16. Answering paragraph 16 of the Petition, Respondents admit that Petitioners have provided information indicating the following: (1) Petitioner Juan Cameros is a Medi-Cal recipient, and a Person with Disabilities with complex medical conditions, including Ankylosing Spondylitis (chronic painful inflammation of joints, including his hips, knees and eyes); (2) Cameros is 35 years old, and both of his hips have been replaced; (3) 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; (4) Cameros submitted a MER; (5) DHCS sent a notice of the denial of the MER on February 27, 2012; (6) on March 1, 2012, the Department enrolled Cameros into managed care; (7) on June 25, 2012, an administrative law judge (ALJ) granted his request to be temporarily returned to fee-for-service Medi-Cal while his MER appeal was pending; (8) on July 3, 2012, the Office of the Ombudsman reversed that order; (9) the ombudsman submitted a position statement stating that Cameros had failed to document "any high risk or complex medical condition that has not been stabilized and requires continuity of care from a Fee-For-Service provider. Therefore there is no deleterious medical effects to the beneficiary if he began receiving care from a plan provider"; (10) Cameros was returned to fee-for-service at the end of July 2012; and (11) on October 22, 2012, Respondents granted Cameros' MER for a twelve-month period of time. DHCS granted an additional extension allowing all Petitioners to stay in

fee-for-service through June 30, 2014. Respondents lack sufficient information or belief to admit or deny the remaining allegations of paragraph 16, and on that basis deny them.

17. Answering paragraph 17 of the Petition, Respondents admit that Petitioners have provided information indicating the following: (1) Petitioner Raquel Alvarez is a Medi-Cal recipient, and 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); (2) Alvarez is age 24, and is developmentally delayed; (3) Alvarez's mother, Raquel Martell Alvarez, is her guardian ad litem; (4) for much of her life, 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; (5) Alvarez was enrolled into managed care on May 1, 2012; (6) Alvarez filed a MER, appealed the denials of her MER, and sought to disenroll from the managed care plan; (7) DHCS returned Alvarez to fee-for-service on October 1, 2012, pending the administrative hearing on her MER denial; and (8) on October 22, 2012, Respondents granted Alvarez's MER for a twelve-month period. Respondents lack sufficient information or belief to admit or deny the remaining allegations of paragraph 17, and on that basis deny them.

18. Answering paragraph 18 of the Petition, Respondents admit the following allegations of paragraph 18: (1) Petitioner Anita Valadez was a Medi-Cal recipient; (2) on or about April 10, 2012, Dr. Haowei Zhang, who was then providing chemotherapy to Ms. Valadez, submitted a MER on her behalf; (3) on July 1, 2012, DHCS transitioned Valadez into a Medi-Cal managed care plan; (4) on July 9, 2012, DHCS sent Valadez a written notice of the denial of her MER; (5) Valadez sent in an appeal the following day; (6) on July 10, 2012, Valadez requested a hearing, and was thereafter temporarily returned to fee-for-service Medi-Cal pending a hearing decision on the appeal of the denial of her MER; (7) on August 24, 2012, the Department submitted a position statement advocating a denial of the appeal on the grounds that Valadez failed to

document "any high risk or complex medical condition that has not been stabilized and requires continuity of care from a fee-for-service provider. Therefore there is no deleterious medical effects to the beneficiary if she began receiving care from a plan provider;" (8) on October 22, 2012, prior to any hearing, Respondents granted Valadez's MER for a twelve-month period of time. Respondents lack sufficient information or belief to admit or deny the remaining allegations of paragraph 18, and on that basis deny them.

19. Answering paragraph 19 of the Petition, Respondents admit the Petitioners have provided information alleging the following: (1) Petitioner Azatui Charkhchyan is a Medi-Cal recipient 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; (2) in July 2011, Charkhchyan was enrolled in a Nursing Facility Sub-Acute Hospital (NF/AH) waiver program; (3) presently, she is in a vegetative state and receives around-the-clock nursing care in her home; (4) on May 30, 2012, Dr. Robert N. Titcher completed an HCO 7101 form stating that Charkhchyan suffered from anoxic brain injury, seizure disorder, chronic vegetative state, severe anemia requiring transfusions and gastrointestinal tube feeding; (5) DHCS denied her MER; (6) Petitioner's son filed a timely appeal from the denial of her MER; (7) DHCS filed a position statement, dated July 26, 2012, stating that the provider failed to document "any high risk or complex medical condition;" (8) on September 6, 2012, the administrative law judge denied the MER; (9) a rehearing request was timely filed asserting the nursing home waiver exemption under 22 California Code of Regulations § 53887 (2)(a)(8)(A); (10) on October 26, 2012, DHCS denied the rehearing request; (11) Respondents have returned Charkhchyan to fee-for-service Medi-Cal. Respondents lack sufficient information or belief to admit or deny the remaining allegations contained in paragraph 19, and on that basis deny them.

20. Answering paragraph 20 of the Second Amended Petition, Respondents admit that Petitioners have provided information alleging the following: (1) petitioner Janet Farahmand is a Medi-Cal recipient, is 61 years old, and a Person with Disabilities, with complex medical conditions, including diabetes, a kidney transplant and open heart surgery; (2) Farahmand was transferred to LA CARE on or about November 2011; (3) Farahmand and her doctor filed a MER

on February 12, 2012, which was denied on April 14, 2012; (4) the notice of denial was written in English; (5) a hearing was requested, and a telephonic hearing took place in the summer of 2012; (6) 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 medical effects that would result from enrollment in managed care;" (7) in January 2013, Farahmand received Letter X in Farsi, and requested reinstatement to fee-for-service pending a hearing; and (8) Farahmand is now in fee-for-service and awaiting hearing on the MER denial. Respondents lack sufficient information or belief to admit or deny the remaining allegations contained in paragraph 20, and on that basis deny them.

21. Answering paragraph 21 of the Petition, Respondents allege that the allegations contained in this paragraph are legal arguments, which do not require an admission or denial. On this basis, and to the extent that the allegations contained in this paragraph are factual statements that require a response, Respondents deny every allegation contained in the paragraph.

22. Answering paragraph 22 of the Petition, Respondents admit the allegations in this paragraph.

23. Answering paragraph 23 of the Petition, Respondents admit every allegation in this paragraph.

24. Answering paragraph 24 of the Petition, Respondents lack sufficient information and belief to admit or deny the allegations in paragraph 24, and on that basis deny every allegation contained in this paragraph.

25. Answering paragraph 25 of the Second Amended Petition, to the extent Petitioners purport to paraphrase and quote 42 United States Code § 1396, Respondents admit the allegations in this paragraph.

26. Answering paragraph 26 of the Petition, Respondents allege that some of the federal Medicaid requirements can be waived. Respondents admit the remaining allegations in this paragraph.

27. Answering paragraph 27 of the Petition, Respondents admit the allegations in this paragraph.

28. Answering paragraph 28 of the Second Amended Petition, Respondents admit that 42 United States Code § 1396a (a)(5) states that the State plan for medical assistance must provide for either the establishment or designation of a single State agency to administer or to supervise the administration of the plan. Respondents deny the remaining allegations in this paragraph.

29. Answering paragraph 29 of the Second Amended Petition, to the extent that Petitioners purport to paraphrase and quote from 42 U.S.C. § 1396a(a)(8), (10), and (17), and 42 C.F.R. § 4325.930, the statute and regulation speak for themselves and no answer is required to those allegations of this paragraph.

30. Answering paragraph 30 of the Second Amended Petition, the allegations purport to paraphrase and quote from Welfare and Institutions Code section 14000. That statute speaks for itself and no answer is required to those allegations of this paragraph.

31. Answering paragraph 31 of the Second Amended Petition, the allegations purport to paraphrase and quote from Welfare and Institutions Code sections 14100.1 and 14154(d). These statutes speaks for themselves and no answer is required to those allegations of this paragraph.

32. Answering paragraph 32 of the Second Amended Petition, the allegations purport to paraphrase and quote from Welfare and Institutions Code sections 10500 and 10000. Those statutes speak for themselves and no answer is required to those allegations of this paragraph.

33. Answering paragraph 33 of the Second Amended Petition, Respondents admit the allegations in this paragraph.

34. Answering paragraph 34 of the Second Amended Petition, Respondents deny that the Medi-Cal program provides health care to beneficiaries. Respondents allege that the Medi-Cal program reimburses for health care services provided to beneficiaries. Respondents admit the

remaining allegations in this paragraph.

35. Answering paragraph 35 of the Second Amended Petition, Respondents admit that 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. Respondents deny each and every remaining allegation in this paragraph.

36. Answering paragraph 36 of the Second Amended Petition, Respondents admit the allegations in this paragraph.

37. Answering paragraph 37 of the Second Amended Petition, Respondents admit the allegations in this paragraph.

38. Answering paragraph 38 of the Second Amended Petition, Respondents deny that: (1) the HCO Form 7101 and its instructions have remained the same up until the present day; and (2) the HCO Form 7102 and its instructions have remained the same up until February 2012. Respondents admit the remaining allegations in this paragraph.

39. Answering paragraph 39 of the Second Amended Petition, the allegations purport to paraphrase and quote 22 California Code of Regulations section 53882. That regulation speaks for itself and no answer is required to those allegations of this paragraph. Respondents deny each and every remaining allegation in this paragraph.

40. Answering paragraph 40 of the Second Amended Petition, the allegations purport to paraphrase and quote from Assembly Bill No. 208 and Welfare and Institutions Code section 14182(b)(15). That Assembly Bill and statute speak for themselves, and no answer is required to those allegations of this paragraph.

41. Answering paragraph 41 of the Second Amended Petition, the allegations purport to paraphrase and quote from Senate Bill No. 1008 and Welfare and Institutions Code section 14182(b)(21). That Senate Bill and statute speak for themselves, and no answer is required to

those allegations of this paragraph.

42. Answering paragraph 42 of the Second Amended Petition, Respondents admit that in November of 2010, California obtained federal approval for a Social Security Act, section 1115(b) (42 U.S.C. § 1315) Medicaid Demonstration Waiver (Waiver) from the Centers for Medicare and Medicaid Services (CMS). Among the provisions of this Waiver is the mandatory enrollment of Seniors and Persons with Disabilities in managed care. The remaining allegations of paragraph 42 purport to paraphrase and quote from the Waiver. That Waiver speaks for itself, and no answer is required to those allegations of this paragraph. On that basis, Respondents deny the remaining allegations of this paragraph.

43. Answering paragraph 43 of the Second Amended Petition, Respondents admit that "Beginning in June 2011, more than 240,000 Seniors and Persons with Disabilities in California counties (Alameda, Contra Costa, Fresno, Kern, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare and Kings County) were required to join a managed care plan by the month of their birthday unless they met the medical exemption criteria" or were exempt for some other reason, and that thirteen of these counties have two managed care plans. Respondents deny the remaining allegations of this paragraph.

44. Answering paragraph 44 of the Second Amended Petition, Respondents admit that since June 2011, more than 27,000 MERs have been filed by Seniors and Persons with Disabilities. Respondents deny the remaining allegations of this paragraph.

45. Answering paragraph 45 of the Second Amended Petition, Respondents admit that since June 2011, DHCS has denied some MERs from Seniors and Persons with Disabilities who meet at least one of the complex medical condition categories set forth in 22 C.C.R. section 53887(a)(2), and on HCO 7101 and 7102 forms, on the 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. Respondents deny each and every remaining allegation contained in this paragraph.

46. Answering paragraph 46 of the Second Amended Petition, Respondents deny that DHCS removed the nursing home waiver from the HCO Form 7102 in February 2012. Respondents allege that DHCS revised the HCO Form 7102 in May 2012, and that a true copy of the form is attached to the Second Amended Petition as Exhibit E. Respondents further allege that there never was a "separate form with which to apply for a nursing home waiver exemption" ." Respondents deny the remaining allegations in this paragraph.

47. Answering paragraph 47 of the Second Amended Petition, Respondents deny every allegation contained in this paragraph.

48. Answering paragraph 48 of the Second Amended Petition, Respondents admit that DHCS has not amended the HCO Form 7101 and its instructions. Respondents deny the remaining allegations in this paragraph.

49. Answering paragraph 49 of the Second Amended Petition, Respondents admit that a copy of a notice is attached to the Second Amended Petition as Exhibit G. Respondents deny each and every remaining allegation contained in this paragraph.

50. Answering paragraph 50 of the Second Amended Petition, Respondents admit the allegations in this paragraph.

51. Answering paragraph 51 of the Second Amended Petition, Respondents admit the allegations contained in this paragraph.

52. Answering paragraph 52 of the Second Amended Petition, Respondents deny the allegations contained in this paragraph.

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53. Answering paragraph 53 of the Second Amended Petition, Respondents deny the allegations contained in this paragraph.

54. Answering paragraph 54 of the Second Amended Petition, Respondents admit that Letter X instructs beneficiaries that they have 45 days from the date of the letter's mailing to request a state hearing. Respondents deny all remaining allegations in this paragraph.

55. Answering paragraph 55 of the Second Amended Petition, Respondents deny the allegations contained in this paragraph.

56. Answering paragraph 56 of the Second Amended Petition, Respondents admit that Letter B does not inform beneficiaries of what additional information their fee-for-service providers were supposed to provide in support of their MERS. Respondents further admit that Letter B gives beneficiaries six months to file a new MER. Respondents deny the remaining allegations in this paragraph.

57. Answering paragraph 57 of the Second Amended Petition, Respondents admit that certain beneficiaries who received the X Letter should have received the B letter, and that DHCS then sent a letter to those beneficiaries forwarding the correct notice and asking them to disregard the letter they originally received. Respondents deny the remaining allegations in this paragraph.

58. Answering paragraph 58 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

59. Answering paragraph 59 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in paragraphs 1 through 58 of this Answer to the Second Amended Petition.

60. Answering paragraph 60 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

61. Answering paragraph 61 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

62. Answering paragraph 62 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in all paragraphs of the Answer to the Second Amended Petition.

63. Answering paragraph 63 of the Second Amended Petition, the allegations purport to paraphrase and quote from a statute. That statute speaks for itself and no answer is required to those allegations in this paragraph.

64. Answering paragraph 64 of the Second Amended Petition, the allegations purport to paraphrase and quote from a statute. That statute speaks for itself and no answer is required to those allegations in this paragraph.

65. Answering paragraph 65 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

66. Answering paragraph 66 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

67. Answering paragraph 67 of the Second Amended Petition, Respondents deny each and every allegation contained in this paragraph.

68. Answering paragraph 68 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in all paragraphs of this Answer to the Second Amended Petition.

69. Answering paragraph 69 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

70. Answering paragraph 70 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

71. Answering paragraph 71 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

72. Answering paragraph 72 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in all paragraphs of the Answer to the Second Amended Petition.

73. Answering paragraph 73 of the Second Amended Petition, the allegations purport to paraphrase and quote from the California Constitution. That Constitution speaks for itself and no answer is required to those allegations of this paragraph. Respondents deny the remaining allegations in this paragraph.

74. Answering paragraph 74 of the Second Amended Petition, the allegations purport to paraphrase and quote from regulations and statutes, and the Manual of Policies and Procedures. The regulations, statutes, and Manual speak for themselves and no answer is required to those allegations of this paragraph. Respondents deny the remaining allegations in this paragraph.

75. Answering paragraph 75 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

76. Answering paragraph 76 of the Second Amended Petition, the allegations purport to paraphrase and quote from regulations. The regulations speak for themselves and no answer is required to those allegations of this paragraph. Respondents deny the remaining allegations in this paragraph.

77. Answering paragraph 77 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

78. Answering paragraph 78 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

79. Answering paragraph 79 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in all paragraphs of the Answer to the Second Amended Petition.

80. Answering paragraph 80 of the Second Amended Petition, the allegations purport to paraphrase and quote from a regulation. The regulation speaks for itself and no answer is required to those allegations of this paragraph. Respondents admit that DHCS has designated a Medi-Cal Managed Care Office of the Ombudsman. Respondents deny the remaining allegations in this paragraph.

81. Answering paragraph 81 of the Second Amended Petition, the allegations purport to paraphrase and quote from a statute. The statute speaks for itself and no answer is required to those allegations of this paragraph.

82. Answering paragraph 82 of the Second Amended Petition, the allegations purport to paraphrase and quote from a statute. The statute speaks for itself and no answer is required to those allegations of this paragraph.

83. Answering paragraph 83 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

84. Answering paragraph 84 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

85. Answering paragraph 85 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in all paragraphs of the Answer to the Second Amended Petition.

86. Answering paragraph 86 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

87. Answering paragraph 87 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

88. Answering paragraph 88 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

89. Answering paragraph 89 of the Second Amended Petition, Respondents reallege and incorporate by reference each and every answer contained in all paragraphs of the Answer to the Second Amended Petition.

90. Answering paragraph 90 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

91. Answering paragraph 91 of the Second Amended Petition, Respondents deny the allegations in this paragraph.

AFFIRMATIVE DEFENSES

FIRST AFFIRMATIVE DEFENSE

The petition for traditional mandamus fails to state a claim upon which relief can be granted based on Code of Civil Procedure section 1085.

SECOND AFFIRMATIVE DEFENSE

The petition for writ of mandate is moot because Petitioners have been returned to fee-for-service Medi-Cal, affording them the relief they seek in this proceeding.

///

THIRD AFFIRMATIVE DEFENSE

The petition for writ of mandate fails to state a claim upon which relief can be granted because Petitioners and other Medi-Cal beneficiaries, who are seniors and persons with disabilities, were transferred from fee-for-service Medi-Cal to Medi-Cal managed care plans pursuant to a federal waiver known as the California Bridge to Reform, 1-W-00193/9, issued under Social Security Act section 1115 (42 U.S.C. § 1315).

FOURTH AFFIRMATIVE DEFENSE

The First and Second Causes of Action fail to state claims upon which relief can be granted because Welfare and Institutions Code section 14182, subdivision (k), provides that the Department may implement or make specific changes to any applicable federal waiver and state plan amendment by means of all-county letters, plan letters, or provider bulletins without taking regulatory action.

FIFTH AFFIRMATIVE DEFENSE

The petition for writ of mandate is barred by the statute of limitations.

SIXTH AFFIRMATIVE DEFENSE

Petitioners have failed to exhaust their administrative remedies.

SEVENTH AFFIRMATIVE DEFENSE

At all times relevant hereto, Respondents acted within the scope of their jurisdiction and discretion, with due care, in good faith fulfillment of their responsibility pursuant to applicable statutes, rules, regulations, and practices, within the bounds of reason under all the circumstances known to them, and with the good faith belief that their actions comported with all applicable laws.

///

///

EIGHTH AFFIRMATIVE DEFENSE

The relief Petitioners seek is barred because their remedy was to file a grievance against their Medi-Cal managed care plan.

Dated: December 9, 2013

Respectfully Submitted,

KAMALA D. HARRIS
Attorney General of California
LESLIE P. MCELROY
Supervising Deputy Attorney General
S. PAUL BRUGUERA
Deputy Attorney General

JANET E. BURNS
Deputy Attorney General
Attorneys for Respondents

LA2013508479
51417249.doc

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 December 9, 2013, I served the attached **ANSWER TO SECOND AMENDED PETITION FOR WRIT OF MANDATE** 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:

Robert D. Newman, Esq.
Western Center on Law & Poverty
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010

Kimberly Lewis, Esq.
National Health Law Program
3701 Wilshire Boulevard, Suite 750
Los Angeles, CA 90010

Barbara Schultz, Esq.
Legal Aid Foundation of Los Angeles
1550 W. 8th Street
Los Angeles, CA 90017

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 December 9, 2013, at Los Angeles, California.

Yesenia Caro
Declarant

Signature

LA2013508479
51417472.doc

Exhibit D

Instructions For Completing Request for Medical Exemption from Plan Enrollment Form

Who Should Fill Out This Form?

You need to enroll in a Medi-Cal Managed Care Plan (i.e. Plan) now.

You should fill out this form if:

- You need to continue the medical care you get from your Regular Medi-Cal (Fee-for-Service) doctor (doctors, nurse practitioners and midwives can complete Part II of this form);
- Your doctor is not part of a Plan in the county where you live; AND
- Your only health insurance is Medi-Cal.

You should fill out this form even if you are enrolled in a Medi-Cal waiver program. These waiver programs are AIDS, Home and Community Based Services (HCBS), In Home Operations (IHO), and Nursing Facility/Acute Hospital (NF/AH) or other waiver programs.

You May Qualify for A Medical Exemption If:

- You have a complex medical condition; AND
- The care you get from your Regular Medi-Cal doctor for the complex medical condition cannot be interrupted because your condition could worsen; AND
- **Your Regular Medi-Cal doctor is NOT part of a plan in your county. You may see more than one Regular Medi-Cal doctor. If you do, have the form filled out by the doctor who sees you most often. Ask your Regular Medi-Cal doctor if he or she is part of a Plan in your county. This should be done before you submit this form.**

If the Medical Exemption is Approved:

You can see your Regular Medi-Cal doctor until your complex medical condition is not a problem anymore as determined by the Department of Health Care Services. This can continue up to 12 months (or 90 days postpartum). You will need another medical exemption after the first one ends. The department will mail a new exemption form to you and your Regular Medi-Cal doctor to complete when it is time to apply for a new exemption.

If the Medical Exemption is Denied:

You and your doctor will get a copy of the denial letter. You may appeal the denial. Information on how to appeal will be in the denial letter. Your new Medi-Cal plan will know about the denial and will try to arrange for you to see your Regular Medi-Cal doctor.

(over)

Instructions Continued:

Part I — To Be Filled Out and Signed By the Medi-Cal Member.

Please answer questions 1-10, then sign and date the form. After completing Part I give the form to your Regular Medi-Cal doctor. Your doctor will fill in Part II.

Part II — To Be Filled Out and Signed by Your Regular Medi-Cal Doctor.

If the form is not complete, it will be sent back to your Regular Medi-Cal doctor to finish filling it out. Your Regular Medi-Cal doctor may be asked to send in more information to explain why you cannot be moved to a Medi-Cal Managed Care Plan right now. If your Regular Medi-Cal doctor does not send in all of the information, your exemption request will be denied.

All information in this medical exemption form is private. This information will be used by the Medi-Cal program, its employees, and contractors only.

- If you have any questions about the following form, please call the Medi-Cal Managed Care Ombudsman at (888) 452-8609.

State of California - Health and Human Services Agency | Department of Health Care Services

REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Submit this request if your condition could get worse if you enroll in a Medi-Cal Managed Care Plan.

Each area of the Request for Exemption from Plan Enrollment form must be filled out. If not all filled out the medical exemption will be denied. - Please Print or Type (Ink Only)

Part I – To Be Completed and Signed by the Medi-Cal Member

SEPARATOR

For help with this form please call: Health Care Options at 1-800-430-4263. This call is free.

1. Name: (Please Print)

Last Name First Name M.I.

2. Benefits Identification Card (BIC) Number

3. Date of Birth: ____/____/____ (Month / Day / Year) 4. Check One: ☐ Female ☐ Male

5. Social Security Number

6. Are you a member of a Medi-Cal Plan? ☐ Yes ☐ No

7. Is someone other than the beneficiary completing this section? ☐ Yes ☐ No

If yes, please provide the following information:

Print Name

Relationship Phone Number

8. I am requesting that my doctor send in a request for a Medi-Cal Managed Care medical exemption for me.

Doctor's Name (Please Print):

9. Beneficiary's Signature:

Signature of Beneficiary or Parent of Beneficiary if a minor child

10. Date Signed: ____/____/____ (Month / Day / Year)

This information is requested by the Department of Health Care Services, under Title 22, California Code of Regulations, Sections 53887 or 53923.5, in order to comply with requirements of continuing with Fee-for-Service (FFS) medical care. Completion of this form is mandatory to request a medical exemption from enrollment in managed care. Incomplete forms will be returned and could result in enrollment in a Managed Care health plan.

Your Doctor MUST fill out AND SIGN this section.

Part II – Doctor's Certification for Medical Exemption

11. Date you started treating beneficiary for this condition: ____/____/____ (Month / Day / Year)

12. Estimated date of completion of treatment or therapy for condition requiring exemption: ____/____/____ (Month / Day / Year)

	13. Please check the following as appropriate (ICD-9 code must be included in column 14 to the right, or the exemption will be considered incomplete and returned and could result in enrollment in a Managed Care Health Plan.) See included instructions for further detail.	14. ICD-9 Codes
OR	☐ A. Pregnant and currently under your care for the pregnancy. Due Date ____/____/____ (Month / Day / Year)	1. 2.
OR	☐ B. HIV+ or has been diagnosed with AIDS	1. 2.
OR	☐ C. Receiving chronic renal dialysis treatment under your supervision	1. 2.
OR	☐ D. Undergoing one of three transplant classifications (see included instructions for further details). Classification: Medi-Cal designated transplant center:	1. 2.

PART II — To Be Filled Out and Signed By the Member's Regular Medi-Cal Doctor (Doctors, Nurse Practitioners and Midwives fill out Part II)

ATTENTION: You should not complete this form if you are a doctor contracted with any Medi-Cal Managed Care health plan in the county where the beneficiary lives because the medical exemption request will be denied.

Dear Regular Medi-Cal (Fee-for-Service) Doctor: If the beneficiary requests a medical exemption, you and the beneficiary must fill out this form, sign it, attach required documentation, and mail or fax it (Part I and Part II) to the Health Care Options office:

MAIL COMPLETED FORM to:	Health Care Options P.O. Box 989009	or FAX this form to: (916) 364-0287
Questions? Call (800) 430-4263	West Sacramento, CA 95798-9850	

Both you and the beneficiary should retain a copy of the completed form.

The doctor and the beneficiary will receive a written decision from Health Care Options.

The medical exemption is granted only until the beneficiary's medical condition has stabilized and the beneficiary is able to receive care from a Medi-Cal Managed Care plan doctor. An exemption can be requested for a maximum of 12 months, at which time a renewal may be requested. The renewal form will be sent directly to the beneficiary.

Conditions meeting the criteria for a complex medical exemption may include, but are not limited to:

- Conditions requiring temporary continuation of treatment with the current Fee-for-Service doctor, such as high risk or advanced pregnancy;
- Under active evaluation for or awaiting organ transplant;
- New diagnosis and treatment for cancer or other complex and/or progressive disorder that cannot be interrupted;
- Awaiting an approved surgical procedure (approved TAR) or immediately post-operative.

Routine ongoing treatment of chronic disorders does NOT constitute grounds for approval of a medical exemption.

A request for exemption from plan enrollment shall be denied if:

1. The beneficiary has been a Medi-Cal managed care beneficiary on a combined basis for more than 90 consecutive calendar days prior to the submission of the medical exemption request,
2. The submitted form was completed by a current Medi-Cal doctor who is contracting with a Medi-Cal managed care plan in the county where the beneficiary lives,
3. The beneficiary began or was scheduled to begin treatment after the date of plan enrollment.
4. The beneficiary does not meet eligibility requirements as set forth in Title 22, California Code of Regulations, Sections 53887, and/or
5. The doctor submitting the exemption request did not provide adequate documentation, as described in regulation or other Department issued guidance, for the Department to evaluate the exemption request.

INSTRUCTIONS FOR COMPLETING BOXES 13-D THROUGH 13-I:

ITEM 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD code for the organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption will not be granted to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant by a fee-for-service doctor
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed

ITEM 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

		14. ICD-9 Codes
E	☐ E. Undergoing one of two cancer classifications (see included instructions for further details). Classification: _____ Type of therapy: _____	1. _____ 2. _____
F	☐ F. Has been approved for and is awaiting a major surgical procedure (see instructions for details). CPT code(s) for pending procedure(s): _____	1. _____ 2. _____
G	☐ G. Has a complex neurological disorder, such as multiple sclerosis	1. _____ 2. _____
H	☐ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease	1. _____ 2. _____
I	☐ I. Has other complex and/or progressive disorder not covered above which requires on-going medical supervision (see included instructions for further details). Describe treatment: _____	1. _____ 2. _____

15. Doctors who assess that the severity of a condition(s) preventing a beneficiary from receiving treatment from an in-network provider of the same specialty without deleterious medical effects should explain the deleterious medical effects that could occur and provide the basis for their assessment. See included instructions for further details. Doctors **MUST** provide at the least one of the following items:

Check each box to confirm you have submitted the required documentation. See included instructions for further details.

- ☐ **Notes from up to the five most recent MD office visits (if not available, please provide detailed information stating why you believe the medical exemption is necessary.)**
- ☐ **Current medical history and physical**
- ☐ **Treatment Plan**
- ☐ **Justification of medical exemption request.** You should explain both why the beneficiary's condition is complex and how much the beneficiary's medical condition could worsen if he or she is transferred into a Medi-Cal Managed Care plan, and include any examples. If available, provide information about complex medical conditions being treated by other Fee-for-Service doctors to the extent you have that information.

You should also submit any additional documentation that you believe is necessary to show that the beneficiary could suffer deleterious medical effects due to enrollment in a Medi-Cal Managed Care plan. Deleterious medical effects mean the severity of the beneficiary's medical condition could worsen in terms of increasing illness, disability, or pain and/or prolong necessary treatment, if the beneficiary is requested to change doctors due to enrollment in a Medi-Cal Managed Care plan.

16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence?

☐ Yes _____ ☐ No

Print the name of health plan

17. Rendering Provider's National Provider Identification (NPI) number: _____

18. Rendering Medi-Cal Provider:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

FAX: _____

19. Medi-Cal Billing Information: (If different from box 18)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

FAX: _____

State Use Only

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Care Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

22. Signature (No Stamp):

_____

(Authorized Rendering Provider)

23. Date Signed:

_____/_____/_____

Month Day Year

MAIL COMPLETED FORM to: Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850

Or FAX this form to: (916) 364-0287

ITEM 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, **including surgery for cancer.**
List both ICD code (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If the beneficiary is immediately post-operative, estimate the duration of time necessary for recovery under your supervision in box 13.

ITEM 13-I

The ICD code must be listed in box 14, and the treatment must be stated on the line provided.

Please check this item if the beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

INSTRUCTIONS FOR COMPLETING BOX 14:

Box 14 should contain the applicable ICD Code(s) for each medical condition in items 13-A-I that form the basis for the request for a medical exemption from mandatory enrollment in a Medi-Cal Managed Care Plan.

INSTRUCTIONS FOR COMPLETING BOX 15:

Doctors who believe that the complexity of a condition(s) prevents a beneficiary from transitioning into a Medi-Cal managed care plan without possible deleterious medical effects or consequences must complete this box, provide the requested documentation, and include an explanation as to why the medical exemption is justified. Deleterious medical effects means the complexity of the beneficiary's medical condition could worsen in terms of increasing illness, disability or pain and/or prolong necessary treatment, if the beneficiary is required to change doctors due to enrollment in a Medi-Cal Managed Care plan. The documentation submitted in this section should demonstrate that the beneficiary's medical condition is not sufficiently stable so that she or he could safely transfer to a doctor in a Medi-Cal Managed Care plan without risk of suffering deleterious medical effects. Information provided should be in accordance with any guidance issued by the Department about exemption requests. You should specify if the beneficiary has a relatively rare medical condition. You may also provide information about complex medical conditions being treated by other fee-for-service doctors to the extent you have that information.

It is important that you specify the probable consequences if the patient is required to change doctors due to enrollment in a Medi-Cal Managed Care plan or if there is an interruption in care. Include the basis for your conclusions about why you believe the beneficiary could have deleterious medical effects as a result of such a change in care. In most cases, it will not be sufficient to only provide the medical records, unless those records clearly indicate that the beneficiary's condition is unstable. You need to indicate the possible consequences that could occur from the transfer of the patient to a Managed Care health plan.

Check the box next to each field to confirm that the documentation is attached to the exemption. *(Please note, a medical exemption request may be returned or denied if it lacks the required documentation and additional information is not provided).*

- **Notes from the five most recent MD office visits.** These notes should support your justification for the medical exemption request. If the beneficiary has not seen you for five visits, you should submit your notes for as many office visits as he or she has attended. **Illegible notes will not be accepted and may cause the medical exemption request to be denied.**
- **Current medical history and physical.** To qualify for a medical exemption request, you must explain how the beneficiary's health is likely to worsen if he or she is transferred to a managed care health plan.
- **Treatment Plan.** The medical exemption request will be denied if the beneficiary is not receiving treatment or monitoring for his or her complex medical condition.
- **Justification of medical exemption request.** You should explain both why the beneficiary's condition is complex and how the beneficiary's medical condition could worsen if he or she is transferred into a Medi-Cal Managed Care plan, and include any examples.

If the medical exemption request is denied, you can continue to see the beneficiary for up to 12 months, as determined by the Plan, as long as you are willing to agree to the Medi-Cal Managed Care plan's Continuity of Care policies. The beneficiary's Medi-Cal Managed Care plan will contact you to determine whether you will agree to continue to treat the beneficiary under its Continuity of Care policies. You may continue to see the beneficiary after the Continuity of Care period ends if you enter into an agreement with the Medi-Cal Managed Care plan that the beneficiary is assigned to.

DECLARATION OF SERVICE BY E-MAIL and 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 April 14, 2015, I served the attached **DECLARATION OF SARAH CATHERINE BROOKS IN SUPPORT OF RESPONDENTS' OPPOSITION TO SECOND AMENDED PETITION FOR WRIT OF MANDATE** by transmitting a true copy via electronic mail. In addition, I placed a true copy thereof enclosed in a sealed envelope, in the internal mail system of the Office of the Attorney General, addressed as follows:

Robert D. Newman, Esq.
Sue L. Himmelrich, Esq.
Western Center on Law & Poverty
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010
Email: rnewman@wclp.org
shimmelrich@wclp.org

Barbara Schultz, Esq.
Elena Ackel, Esq.
Legal Aid Foundation of Los Angeles
1550 W. 8th Street
Los Angeles, CA 90017
Email: bschultz@lafla.org
eackel@lafla.org

Kimberly Lewis, Esq.
National Health Law Program
3701 Wilshire Boulevard, Suite 750
Los Angeles, CA 90010
Email: lewis@healthlaw.org

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 April 14, 2015, at Los Angeles, California.

Yesenia Caro
Declarant

Signature

LA2013508479
51749454.doc

Exhibit E

State of California-Health and Human Services Agency
Department of Health Care Services
P.O. Box 989009, West Sacramento, CA 95798-9850

JOHN SAMPLE
1234 SAMPLE STREET
ANYTOWN CA 90000.

04/13/2015

Important Information About Your Medi-Cal Enrollment

Your request for a Medical Exemption was denied. The Department of Health Care Services (DHCS) reviewed all the medical information that was sent from your Medi-Cal doctor (doctor, nurse practitioner, or midwife). The information did not show that your condition could get worse if you are seen by a doctor in a Medi-Cal Managed Care Plan. You will get your care from the same type of doctor. The reasons for your denial are on the reverse page.

If you do not agree with this result, you may appeal it. **PLEASE READ** the rest of this letter. It will give you information about your right to appeal, and it will tell you how to file an appeal.

This letter does NOT change your Medi-Cal eligibility. You will still get the same services.

Our records show the following information and status for you:

Date MER Received:	03/31/2015
Provider NPI Number:	1234567890
Requesting Entity's Name:	Johnathan Sample
Requesting Entity's Registered Service Address: (May not be the actual address where the member receives services.)	1234 Street Way, Suite 100, City, State 12345
Requesting Entity's Service Phone:	(555) 555-1234
Reason for Exemption Request:	(I.e. Cancer Therapy/Kidney Disease)
Diagnosis Codes	
202.80	LYMPHOMA OT UNSPEC
V42.0	KIDNEY TRANSPLANT STATUS

The reason(s) why your exemption was denied is below.

Decision	Reason(s).
Denial	The Medical Exemption Request submitted by your provider has been denied. Your medical condition/s would not cause harmful medical effects by changing to a health plan provider or specialist.
Denial	When you filed your exemption you had been enrolled in a Medi-Cal Managed Care Health Plan for more than 90 days.
Denial	You are enrolled in a Medi-Cal Managed Care Plan (Plan). You were in the Plan when you started treatment for your medical condition.
Denial	You are enrolled in a Medi-Cal Managed Care Plan (Plan). Your doctor works with the same Plan. You can still go to your doctor. You do not need a medical exemption to see your doctor. If you have any questions, please call your Plan's member services department.

PLEASE READ the rest of this letter. The letter has information about your right to appeal, and tells you how to appeal.

What do I do now?

1. **IF YOU WANT TO APPEAL:** You can appeal the denial. You must appeal within 90 days from the date of this letter. To find out how to ask for a hearing for your appeal, see *Your State Hearing Rights* enclosed with this letter.

   If you are not in a plan, you will stay in Regular Medi-Cal until your appeal is heard. You will continue to get your medical care through Regular Medi-Cal.

   If you are already in a health plan, you will stay in the plan until your appeal is heard, and you will continue to get your medical care from your plan.

2. **IF YOU DO NOT WANT TO APPEAL:** If you do not appeal, you will be enrolled in a Medi-Cal Managed Care Plan. If you are in a Medi-Cal Managed Care Plan, you will continue to get your medical care from your plan.

   - **If you are not in a Medi-Cal Managed Care Plan, you will need to choose one. A Choice Form is enclosed, it will give you information about the plans you can choose to enroll in and tell you how long you have to choose your plan. If you do not choose a plan, one will be chosen for you.** If you have questions, call Health Care Options (HCO) at 1-800-430-4263 for help.
   - If you are in a Medi-Cal Managed Care Plan you like, you can stay in your plan. You do not have to do anything. You will get your medical care through your plan.
   - If you want to still see your Regular Medi-Cal doctors, you may get Continuity of Care from your plan. This means that you may still be able to see your Regular Medi-Cal doctor for up to 12 months. Continuity of Care is a way for you to see your doctor who does not work with a Plan, however, you must have visited your doctor within the last year. Your Plan will reach out to your doctor, but your doctor must agree to work with your Plan for you to get Continuity of Care. You do not have to do anything, your Plan will reach out to your doctor.
   - **If you have an appointment with your doctor, call your health plan provider.** Tell them your doctor is not in their network, and you do not want to miss your next appointment. Also tell them you need "Continuity of Care" right away. If you have any problems, call the Ombudsman's Office at 1-888-452-8609.
   - **You can change your Medi-Cal Managed Care Plan.** You can ask to change to another plan in your county at any time.

What if I do not agree with this denial?

YOUR STATE HEARING RIGHTS: You can appeal the decision and ask for a State Hearing. The two forms enclosed with this letter can help you.

1. **"Your State Hearing Rights"** form tells you about your State Hearing rights.
2. **"State Hearing Request"** form tells you how to ask for a State Hearing.

Your State Hearing Rights

What Are the Time Limits to Ask for a State Hearing?

- You only have 90 days to ask for a hearing.
- The 90 days start the day after this notice was mailed.
- You may still ask for a hearing after 90 days if:
  - You have a good reason why you did not ask for one on time.
  - This notice did not tell you why your request was denied.
  - The notice was not in the language you told DHCS that you wanted to receive information in.

Can I Still See My Regular Medi-Cal Doctors While I Wait for My Hearing?

Yes, if you appeal within 90 days and are not in a plan. You will continue to see your Regular Medi-Cal doctor until a hearing decision is made.

Can I Ask for a Quick Hearing to Go Back to Regular Medi-Cal?

Yes. It is called an "expedited" hearing. If you have any urgent health care issues, you can ask for this while you wait for your hearing, and the outcome of your hearing. You need to write "expedited" on the hearing request. You can also call the Ombudsman's office to ask to move back to Regular Medi-Cal while you wait. The toll free number is 1-888-452-8609.

To Get Help:

You do not have to attend the hearing alone. You may bring someone with you. You can bring a friend, a relative, a lawyer, or anyone you choose. You may get free legal help at your local legal aid office.

You can get more information about your hearing rights or how to get free legal aid by calling the State numbers below:

Department of Health Care Services Office of the Ombudsman:
Call toll free: 1-888-452-8609

How to Ask for a State Hearing
Fill out the State Hearing Request and send to:

California Department of Social Services
State Hearings Division
Call toll free: 1-800-743-8525
If you are deaf and use TDD/TTY call: 1-800-952-8349

P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430
Fax: 1-916-651-5210 or 1-916-651-2789
(Attention: State Hearing Support)

You may also call the number below to ask for a hearing. They can tell you where you can get legal help near you.

Phone: 1-800-743-8525
TDD/TTY: 1-800-952-8349
Note: You cannot send an e-mail to ask for a hearing.

Other Information

Hearing File: If you ask for a hearing, the State Hearing Office will start a file. You have the right to see this file.

For Help or More Information

If you need this letter in another language or alternate format, such as large print, audio, or Braille; or if you need help with this letter, please call:

Health Care Options
Phone: 1-800-430-4263
TTY: 1-800-430-7077
Monday - Friday, 8 am - 5 pm

State Hearing Request

I am requesting a State Hearing because of an action taken by the Department of Health Care Services

Name: _____

Address: _____ Zip code: _____

Phone: _____

Social Security Number or Medi-Cal ID number: _____
(Your hearing may be delayed if this number is not provided)

I do not agree with:

☒. Determination of Ineligibility for Medical Exemption Request (MER)

Here is why

Note: If possible, attach a copy of the Notice of Action letter to this form. If you need to provide more information, please use the space below:

_____

_____

_____

_____

(If you need more space, please use another piece of paper. Make a copy for your records)

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

Check any box(es) that apply to you:

☐ I want the person named below to represent me. He/She can view my medical records related to this hearing, come to the hearing, and speak for me.

Name: _____ Phone: _____

Address: _____

☐ I need a free interpreter (a relative or friend cannot interpret for you at a hearing).

My language or dialect is: _____

☐ I would like a telephone hearing.

☐ I want to attend the hearing and I need the following ADA accommodations (e.g., wheelchair accessible, large print).

☐ Urgent. I need a quick decision and cannot wait 90 days. Please explain below:

_____

_____

_____

My Signature _____ Date: _____

After you complete this form, make a copy for your records.

Exhibit F

Tracking Code	Denial Reason
D	You are enrolled in a Medi-Cal Managed Care Plan (Plan). You were in the Plan when you started treatment for your medical condition.
E	Your treating doctor works with a Medi-Cal Managed Care Plan (Plan). If you still want to go to your doctor, you need to change Plans. You will need to dis-enroll from the Plan you are in now, and enroll into your doctor's Plan. Fill out the Choice Form that came with this letter. Send it to Health Care Options (HCO) in the enclosed postage-paid envelope. Make sure you enroll in the same Plan your doctor works with. If you are not sure, call your doctor's office and ask what Plan you should enroll in.
F	You have an open case with California Children's Services (CCS). They will give you the care you need for your CCS medical condition. You will get all your other health care from Medi-Cal. You need to be a member of a Medi-Cal Managed Care Plan (Plan) to get these services, unless one of your treating doctors does not work with either Plan. If your doctor does not work with a Plan, you can ask for a Medical Exemption. Your doctor must fill out the Form and send it to us. The Form must be sent in before you have been in a Plan for 90 days.
I	Your doctor sent in a second Exemption Form. We could not use the forms. The forms are either not all filled out, or the writing is too hard to read. We will need more information to review your request for an exemption. You can re-submit your request. Call your doctor's office. Ask them to send in new forms that are all filled out and can be read.
J	At this time, your treating doctor is not approved to provide Medi-Cal services.
L	You are enrolled in a Medi-Cal Managed Care Plan (Plan). Your doctor works with the same Plan. You can still go to your doctor. You do not need a medical exemption to see your doctor. If you have any questions, please call your Plan's member services department.
M	Your health plan may allow you to continue seeing your current doctor for up to 12 months from your enrollment in managed care. Please contact your health plan for more information.

X	You are enrolled in a Medi-Cal Managed Care Plan (Plan). And you have been in the Plan for more than 90 days. You cannot file for a medical exemption after you have been in a Plan for more than 90 days.
6	You have an open California Children's Services (CCS) case. This means CCS will give you the treatment you need for your medical condition. You are enrolled in a Medi-Cal Managed Care Plan (Plan). Your treating doctor works for a different Plan. You need to be in the same Plan as your doctor. You will need to dis-enroll from the Plan you are in now. And then you need to enroll into your doctor's Plan. Fill out the Choice Form that came with this letter. Send it to Health Care Options (HCO) in the enclosed postage-paid envelope. Make sure you enroll in the same Plan your doctor works with. If you are not sure, call your doctor's office and ask what Plan you should enroll in.
A1	You are being evaluated for a kidney transplant. You are enrolled in a Medi-Cal Managed Care Plan (Plan). And you have been in the Plan for more than 90 days. So your Plan must send you to an approved transplant center. Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.
A2	Your medical forms have been reviewed. You have not been seen by an approved transplant center. You must go to a transplant center that works with your Medi-Cal Managed Care Plan (Plan). Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.
A3	Your medical forms have been reviewed. You sent in a Treatment Authorization Request (TAR) for an evaluation for a kidney transplant. But your TAR was not approved before you enrolled in your Medi-Cal Managed Care Plan (Plan). You must go to a transplant center that works with your Plan. Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.

A4	Your medical exemption request for a kidney transplant has been denied. You have not been evaluated for a kidney transplant. You must go to a transplant center that works with your Medi-Cal Managed Care Plan (Plan). Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.
A5	Medical forms from your doctor have been reviewed. You had your kidney transplant. Your care after surgery is now done. And you do not have any current problems. You are now medically stable. You can now get follow-up care from doctors who work with your Medi-Cal Managed Care Plan. Follow-up care is care your transplant center says you should get. This includes office visits, lab tests, imaging, medicine refills, and other services.
A6	Medical forms from your doctor have been reviewed. You asked for an exemption for treatment for your cancer. You are now done with your cancer treatment. And you do not have any current problems. You can now get follow-up care from doctors who work with your Medi-Cal Managed Care Plan. Follow-up care is the care the doctor who treated your cancer says you should get. This includes office visits, lab tests, imaging, medicine refills, and other services.
A7	Medical forms from your doctor have been reviewed. Your neurological disorder is stable. And it is likely to stay that way. You can get your follow-up care from a doctor who works with the Medi-Cal Managed Care Plan. Follow-up care is the care the doctor who treated you says you should get. This includes office visits, lab tests, imaging, medicine refills, and other services.
A8	Medical forms from your doctor have been reviewed. Your renal disease is chronic. But your condition is stable. You now need routine dialysis. You can get routine dialysis from the Medi-Cal Managed Care Plan (Plan). The Plan should help make sure there is no break in your dialysis. Call your primary care doctor in your Plan. Ask your doctor to schedule your dialysis. You will go to a dialysis center that works with your Plan.

A9	Medical forms from your doctor have been reviewed. Your pregnancy is stable. You will need normal pre-natal care. You can get this care in a Medi-Cal Managed Care Plan (Plan). Under state law, you can still see your current doctor if your doctor agrees to work with your Plan. You can also get this care from the same type of doctor who is in the Plan's network.
B1	The form from your doctor has been reviewed. It does not have a diagnosis code. So you can get your pre-natal care in a Medi-Cal Managed Care Plan (Plan). Under state law, you can still see your current doctor if your doctor agrees to work with your Plan. You can also get this care from the same type of doctor who is in the Plan's network.
B2	The form from your doctor has been reviewed. Your pregnancy may have a problem or be high risk. But you do not have any current medical instability. This means you can get your pre-natal care in a Medi-Cal Managed Care Plan (Plan). Under state law, you can still see your doctor if your doctor agrees to work with your Plan. You can also get this care from the same type of doctor who is in the Plan's network.
B3	You are enrolled in a Medi-Cal Managed Care Plan (Plan). You started your pre-natal care with a doctor who works with your Plan. You can still get care from a doctor who works with your Plan.
B4	Your medical exemption is denied. The same doctor sent in this request before. It was also denied. You are enrolled in a Medi-Cal Managed Care Plan (Plan). You can get your pre-natal care from the same type of doctor who is in the Plan's network. If you started your pre-natal care before you enrolled in a Plan, you can still see your current doctor if your doctor agrees to work with the Plan.

B5	The medical forms from your doctor have been reviewed. Your condition is stable. It should stay that way with the drugs you are now taking. You can get your follow-up care from a doctor who works with your Medi-Cal Managed Care Plan (Plan). Follow-up care includes office visits, lab tests, imaging, medicine refills, and other services. Your Plan doctor should tell you what follow-up care you need. Your Plan doctor will also refer you to the type of specialist you may need. You have the right to receive the same care and treatment that you were getting before you were enrolled in the Plan.
B6	Your medical exemption request for surgery has been denied. You sent in a Treatment Authorization Request (TAR) for you to have surgery. But the TAR was also denied. Call your primary care doctor in your Medi-Cal Managed Care Plan (Plan). Ask your Plan doctor for an evaluation to see if you need the surgery.
B7	Medical forms from your doctor have been reviewed. Your surgery is complete. Your care after surgery is now done. And you do not have any current problems. You are now medically stable. You can get follow-up care from a doctor who works with your Medi-Cal Managed Care Plan. Follow-up care is the care your surgeon says you should get. This includes office visits, lab tests, imaging, medicine refills, and other services.
B8	Medical forms from your doctor have been reviewed. You do not have a complex or chronic medical condition. You only go to the doctor for normal wellness care. Wellness care includes yearly check-ups and screenings. You can get your wellness care from a doctor who works with the Medi-Cal Managed Care Plan (Plan). Your Plan doctor should tell you what follow-up care you need. Your Plan doctor will also refer you to a specialist if you need one.
B9	Medical forms from your doctor have been reviewed. Your complex or chronic medical condition(s) are now stable. You can now enroll in a Medi-Cal Managed Care Plan (Plan). You can get follow-up care from a doctor who works with your Plan. Follow-up care is care the doctor who treated you says you should get. This includes office visits, lab tests, imaging, medicine refills, and other services. [This code will only be used with the non-enumerated complex conditions]

C1	Your medical exemption request has been denied. The same doctor sent in one or more of these requests for the same diagnosis. They were also denied. There has been no major change in your health status since the last denial(s).
C2	Medical forms sent in by your doctor are more than (six) 6 months old. We asked your doctor for more recent information. Your doctor has failed to give us more recent forms. The medical forms we have do not show that you are medically unstable. This means you can get your care in a Medi-Cal Managed Care Plan. [This code must be coupled with another denial code.]
C3	Your doctor sent in medical forms for an exemption request. The diagnosis code on the forms did not relate to the reason on the request. But we still reviewed all the forms. Your condition is now medically stable. This means you can get your care in a Medi-Cal Managed Care Plan. [This code must be coupled with another denial code.]
C4	Your started your prenatal care with a doctor who works with a Medi-Cal Managed Care Plan (Plan). If you still want to go to your doctor, you need to change Plans. You will need to dis-enroll from the Plan you are in now, and enroll into your doctor's Plan. Fill out the Choice Form that came with this letter. Send it to Health Care Options (HCO) in the enclosed postage-paid envelope. Make sure you enroll in the same Plan your doctor works with. If you are not sure, call your doctor's office and ask what Plan you should enroll in.

County	Legal Services Information
Statewide Advocacy	Disability Rights California Telephone: (800)776-5746 TTY (800)719-5798
Alameda	Bay Area Legal: Telephone (510) 663-4744 • Address: 1735 Telegraph Ave, Oakland, CA 94612 Health Consumer Center: Alameda 1-855-693-7285, Bay Area Legal Aid
Contra Costa	Bay Area Legal Aid (BALA) Telephone: (510) 233-9954 • Address:1025 McDonald Avenue, Richmond, CA 94801 Health Consumer Center: Contra Costa 1-855-693-7285, Bay Area Legal Aid
Fresno	Central California Legal Services (CCLS) Telephone: (559) 570-1200 •Address: 2115 Kern Street, Suite 1, Fresno, CA 93721
Kern	Greater Bakersfield Legal Assistance (GBLA) Telephone: (661) 325-5943 •Address: 615 California Avenue, Bakersfield, CA 93304 Health Consumer Alliance: Kern 661-321-3982 Greater Bakersfield Legal Aid
Kings	Central California Legal Services (CCLS) Telephone: (559) 733-8770 • Address: 208 West Main Street, Suite U-1, Visalia, CA 93291 Health Consumer Alliance: Kings 1-800-675-8001 Central California Legal Services
Los Angeles	Legal Aid Foundation of Los Angeles (LAFLA) Telephone: (213) 640-3883 or (800) 399-4529 • Address: 5228 Whittier Blvd, Los Angeles, CA 90022
Los Angeles	Legal Aid Society Orange County Community Legal Services – Compton Office Telephone 310-638-5524 • Address: 725 W. Rosecrans Avenue, Compton, CA 90222
Los Angeles	Neighborhood Legal Services of Los Angeles County Telephone: (818) 485-0913 • Address: 13327 Van Nuys Blvd, Pacoima, CA 91331 Health Consumer Center: Los Angeles 1-800-896-3202 NLSLAC
Madera	California Rural Legal Assistance (CRLA) Telephone: (559) 674-5671 • Address: 126 North B. Street, Madera, CA 93638 Health Consumer Alliance: Madera 1-800-675-8001 Central California Legal Services
Riverside	Inland Counties Legal Services (ICLS) Telephone: (951) 368-2555 • Address: 1040 Iowa Ave., Suite 109, Riverside, CA 92507 Health Consumer Alliance: Riverside 1-877-734-3258 Legal Aid Society of San Diego
Sacramento	Legal Services for Northern California (LSNC) Telephone: (916) 551-2150 • Address: 512 12th street, Sacramento, CA 95814 Health Consumer Alliance: Sacramento 1-888-354-4474 LSNC

San Bernardino	Inland Counties Legal Services (ICLS) Telephone: (909) 884-8615• Address: 715 N. Arrowhead Avenue, Suite 113, San Bernardino, CA 92401 Health Consumer Alliance: San Bernardino 1-877-734-3258 Legal Aid Society of San Diego
San Diego	Legal Aid Society (LAS) Telephone: (877) 534-2524 •Address: 110 South Euclid Avenue, San Diego, CA 92114 Health Consumer Alliance: San Diego 1-877-734-3258 Legal Aid Society of San Diego
San Francisco	Bay Area Legal Aid (BALA) Telephone: (415) 982-1300 •Address: 50 Fell Street, San Francisco, CA 94102 Health Consumer Center: San Francisco 1-855-693-7285 BALA
San Joaquin	California Rural Legal Assistance (CRLA) Telephone: (209) 946-0605 • Address: 242 N. Sutter, Stockton, CA 95202 Health Consumer Alliance: San Joaquin 1-888-354-4474 Legal Services of Northern California
Santa Clara	Community Legal Services INC (CLS) Telephone: (408) 283-3700 •Address: P.O. Box 1840, San Jose, CA 95109-1840 Health Consumer Center: Santa Clara 1-855-693-7285, Bay Area Legal Aid
Stanislaus	California Rural Legal Assistance (CRLA) Telephone: (209) 577-3811 • Address: 1020 15th Street, Suite 11, Modesto, CA 95354 Health Consumer Center: Stanislaus 1-800-675-8001 Central California Legal Services
Tulare	Central California Legal Services, Inc. (CCLS) Telephone: (559) 733-8770 (800) 350-3654 • Address: 208 W. Main Street, Suite U-1, Visalia, CA 93291 Health Consumer Alliance: Tulare 1-800-675-8001 Central California Legal Services

Exhibit G

Tracking Code	Denial Reason
D	You are enrolled in a Medi-Cal Managed Care Plan (Plan). You were in the Plan when you started treatment for your medical condition.
E	Your treating doctor works with a Medi-Cal Managed Care Plan (Plan). If you still want to go to your doctor, you need to change Plans. You will need to dis-enroll from the Plan you are in now, and enroll into your doctor's Plan. Fill out the Choice Form that came with this letter. Send it to Health Care Options (HCO) in the enclosed postage-paid envelope. Make sure you enroll in the same Plan your doctor works with. If you are not sure, call your doctor's office and ask what Plan you should enroll in.
F	You have an open case with California Children's Services (CCS). They will give you the care you need for your CCS medical condition. You will get all your other health care from Medi-Cal. You need to be a member of a Medi-Cal Managed Care Plan (Plan) to get these services, unless one of your treating doctors does not work with either Plan. If your doctor does not work with a Plan, you can ask for a Medical Exemption. Your doctor must fill out the Form and send it to us. The Form must be sent in before you have been in a Plan for 90 days.
I	Your doctor sent in a second Exemption Form. We could not use the forms. The forms are either not all filled out, or the writing is too hard to read. We will need more information to review your request for an exemption. You can re-submit your request. Call your doctor's office. Ask them to send in new forms that are all filled out and can be read.
J	At this time, your treating doctor is not approved to provide Medi-Cal services.
L	You are enrolled in a Medi-Cal Managed Care Plan (Plan). Your doctor works with the same Plan. You can still go to your doctor. You do not need a medical exemption to see your doctor. If you have any questions, please call your Plan's member services department.
M	Your health plan may allow you to continue seeing your current doctor for up to 12 months from your enrollment in managed care. Please contact your health plan for more information.

X	You are enrolled in a Medi-Cal Managed Care Plan (Plan). And you have been in the Plan for more than 90 days. You cannot file for a medical exemption after you have been in a Plan for more than 90 days.
6	You have an open California Children's Services (CCS) case. This means CCS will give you the treatment you need for your medical condition. You are enrolled in a Medi-Cal Managed Care Plan (Plan). Your treating doctor works for a different Plan. You need to be in the same Plan as your doctor. You will need to dis-enroll from the Plan you are in now. And then you need to enroll into your doctor's Plan. Fill out the Choice Form that came with this letter. Send it to Health Care Options (HCO) in the enclosed postage-paid envelope. Make sure you enroll in the same Plan your doctor works with. If you are not sure, call your doctor's office and ask what Plan you should enroll in.
A1	You are being evaluated for a kidney transplant. You are enrolled in a Medi-Cal Managed Care Plan (Plan). And you have been in the Plan for more than 90 days. So your Plan must send you to an approved transplant center. Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.
A2	Your medical forms have been reviewed. You have not been seen by an approved transplant center. You must go to a transplant center that works with your Medi-Cal Managed Care Plan (Plan). Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.
A3	Your medical forms have been reviewed. You sent in a Treatment Authorization Request (TAR) for an evaluation for a kidney transplant. But your TAR was not approved before you enrolled in your Medi-Cal Managed Care Plan (Plan). You must go to a transplant center that works with your Plan. Call your primary care doctor in your Plan. Ask your doctor for a referral to a transplant center that works with your Plan. Then you can be evaluated for a kidney transplant.

Exhibit H

County	Legal Services Information
Statewide Advocacy	Disability Rights California Telephone: (800)776-5746 TTY (800)719-5798
Alameda	Bay Area Legal: Telephone (510) 663-4744 • Address: 1735 Telegraph Ave, Oakland, CA 94612 Health Consumer Center: Alameda 1-855-693-7285, Bay Area Legal Aid
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Fresno	Central California Legal Services (CCLS) Telephone: (559) 570-1200 •Address: 2115 Kern Street, Suite 1, Fresno, CA 93721
Kern	Greater Bakersfield Legal Assistance (GBLA) Telephone: (661) 325-5943 •Address: 615 California Avenue, Bakersfield, CA 93304 Health Consumer Alliance: Kern 661-321-3982 Greater Bakersfield Legal Aid
Kings	Central California Legal Services (CCLS) Telephone: (559) 733-8770 • Address: 208 West Main Street, Suite U-1, Visalia, CA 93291 Health Consumer Alliance: Kings 1-800-675-8001 Central California Legal Services
Los Angeles	Legal Aid Foundation of Los Angeles (LAFLA) Telephone: (213) 640-3883 or (800) 399-4529 • Address: 5228 Whittier Blvd, Los Angeles, CA 90022
Los Angeles	Legal Aid Society Orange County Community Legal Services – Compton Office Telephone 310-638-5524 • Address: 725 W. Rosecrans Avenue, Compton, CA 90222
Los Angeles	Neighborhood Legal Services of Los Angeles County Telephone: (818) 485-0913 • Address: 13327 Van Nuys Blvd, Pacoima, CA 91331 Health Consumer Center: Los Angeles 1-800-896-3202 NLSLAC
Madera	California Rural Legal Assistance (CRLA) Telephone: (559) 674-5671 • Address: 126 North B. Street, Madera, CA 93638 Health Consumer Alliance: Madera 1-800-675-8001 Central California Legal Services
Riverside	Inland Counties Legal Services (ICLS) Telephone: (951) 368-2555 • Address: 1040 Iowa Ave., Suite 109, Riverside, CA 92507 Health Consumer Alliance: Riverside 1-877-734-3258 Legal Aid Society of San Diego
Sacramento	Legal Services for Northern California (LSNC) Telephone: (916) 551-2150 • Address: 512 12th street, Sacramento, CA 95814 Health Consumer Alliance: Sacramento 1-888-354-4474 LSNC

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Santa Clara	Community Legal Services INC (CLS) Telephone: (408) 283-3700 •Address: P.O. Box 1840, San Jose, CA 95109-1840 Health Consumer Center: Santa Clara 1-855-693-7285, Bay Area Legal Aid
Stanislaus	California Rural Legal Assistance (CRLA) Telephone: (209) 577-3811 • Address: 1020 15th Street, Suite 11, Modesto, CA 95354 Health Consumer Center: Stanislaus 1-800-675-8001 Central California Legal Services
Tulare	Central California Legal Services, Inc. (CCLS) Telephone: (559) 733-8770 (800) 350-3654 • Address: 208 W. Main Street, Suite U-1, Visalia, CA 93291 Health Consumer Alliance: Tulare 1-800-675-8001 Central California Legal Services

PROOF OF SERVICE

STATE OF CALIFORNIA)
COUNTY OF LOS ANGELES)

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 5228 Whittier Boulevard, Los Angeles, California 90022.

On May 26, 2015 served the foregoing document:

JOINT SETTLEMENT AGREEMENT; [PROPOSED] ORDER

on all the interested parties in this action, by placing a true copy thereof, enclosed in a sealed envelope and mailing same at Los Angeles, California, addressed as follows:

Kamala D. Harris, Attorney General of California
Leslie P. McElroy, Supervising Deputy Attorney General
Janet E. Burns and S. Paul Bruguera
Deputy Attorneys General
300 South Spring Street, Suite 1702
Los Angeles, California 90013

(X) **BY MAIL**: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the U.S. postal service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business.

( ) **BY PERSONAL SERVICE:** I caused such envelope(s) to be delivered by hand by Law In Motion to the office(s) of the addressee(s) marked with a ***. (Said Proof of Service by Hand Delivery to be filed with the court.)

( ) **BY E-MAIL OR FACSIMILE:** I caused a copy of said document(s) to be transmitted by E-mail or Facsimile to the person listed on the Service List and that upon successful transmission I received conformation of said transmission. Absent a Service List, I emailed said document(s) to E-Mail/FAX address/number: _____.

Executed on May 26, 2015 at Los Angeles, California.

/X/ STATE I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

/__/ FEDERAL I declare under penalty of perjury that the foregoing is true and correct, and that I am employed in the office of a member of the Bar of this Court at whose direction the service was made.

By: Oralia Felix-Gualito