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

BS140896

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

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INTRODUCTION

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

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

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

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

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

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

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

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

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

Further, DHCS has been prematurely defaulting beneficiaries into managed care plan even though they had timely filed a MER.

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

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

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

11. Petitioners seek a writ of mandate under Code of Civil Procedure §1085 compelling Respondents DHCS and DHCS' current Director, Toby Douglas, to comply with their legal duties under state law and regulations governing the processing and disposition of MERs from Seniors and Persons with Disabilities. Petitioners also seek injunctive and declaratory relief for those Seniors and Persons with Disabilities who are currently deprived or will be deprived of the necessary medical treatment they are entitled to receive as a result of the wrongful denials of their MERs. Without continued care from their fee-for-service providers for their complex medical conditions, these desperately ill and fragile individuals are at imminent risk of irreparable harm to their health and safety. Finally, Petitioner Azuti [redacted] seeks a writ of mandate under Code of Civil Procedure §1094.5 setting aside the administrative decision which upheld the denial of her MER.

PARTIES

A. Petitioners

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

magnetic resonance imagings ("MRIs"), or other diagnostic tests at City of Hope. This Petitioner also did not receive these tests from the managed care plan contractors in a timely manner. In early September 2012, Ms. Saavedra's adult children found her in a diabetic coma at her home and she was transported to the emergency room for treatment. On October 22, 2012, and only after Petitioners' counsel had threatened legal action, Respondents granted Ms. Saavedra's MER for a twelve-month period of time.

13. Petitioner Juan Cameros is a Medi-Cal recipient. He is a Person with Disabilities with complex medical conditions, including Ankylosing Spondylitis (chronic painful inflammation of joints, including his hips, knees and eyes) and Pigmented Villonodular Synovitis, (an extremely rare disease which involves a lesion of the synovial membrane of the joints and tendon sheaths) which causes extreme knee pain and swelling. Although Mr. Cameros is 35-years old, both of his hips have already been replaced. Mr. Cameros was previously receiving care on a fee-for-service basis from Dr. C. Thomas Vangsness, an orthopedic surgeon and a Professor of Orthopedic Surgery in the Keck School of Medicine at the University of Southern California. One of Dr. Vangsness' specialties is treating knees in relatively young patients so as to avoid or delay knee replacements. In June 2011, Dr. Vangsness performed an arthroscopy (a minimally invasive surgical procedure) on Mr. Cameros' left knee to remove the affected joint lining. In September 2012, Mr. Cameros submitted a MER based on his complex medical condition. On February 16, 2012, Dr. Vangsness recommended that this Petitioner have arthroscopic surgery on his right knee as soon as possible. On March 1, 2012, however, the Department defaulted Mr. Cameros into managed care. (Although DHCS purportedly sent a notice of the denial of the MER on February 27, 2012, Mr. Cameros did not receive the notice). Since March 2012, Mr. Cameros has not been given permission by the managed care plan to continue receiving care from Dr. Vangsness on either a one-time or on-going basis. On June 25, 2012, an administrative law judge granted this Petitioner's request to be temporarily returned to fee-for-service Medi-Cal while his MER appeal was pending. However, on July 3, 2012, the Office of the Ombudsman reversed that order. The ombudsman also submitted a position statement asserting that Mr. Cameros had failed to document "any high risk or complex medical condition" and therefore would suffer no deleterious medical effects from enrollment in

managed care. Through intervention of counsel, Mr. Cameros was returned to fee-for-service at the end of July but he was still unable to schedule needed surgery or obtain the correct dosage of Enbrel because of a series of bureaucratic snafus. While he was on managed care he was unable to obtain appropriate specialty care for his knees from the managed care plan or referral providers. One orthopedic surgeon to whom he was referred by the managed care plan only performs back surgery. Another physician to whom Mr. Cameros was referred by the managed care plan recommended that Mr. Cameros seek treatment from a large hospital medical center where there would be an appropriate specialist for his complex condition. Beginning in March 2012, the Medi-Cal managed care plan reduced the weekly dosage of Enbrel for the treatment of his Ankylosing Spondylitis without giving appropriate written notice or advising him of his right to appeal the reduction in dosage. From March through September of 2012, Mr. Cameros has suffered extreme pain in both knees, so much pain that he sought emergency care three times and had his knees drained multiple times. He also has suffered increased pain in his joints and in his eyes. On October 22, 2012, and only after Petitioners' counsel had threatened legal action, Respondents granted Mr. Cameros' MER for a twelve-month period of time.

14. Petitioner Raquel Alvarez is a Medi-Cal recipient. She is a Person with Disabilities with complex medical conditions, including Pulmonary Valve Stenosis (a narrowing of the heart valve that separates the lower right chamber of her heart from the artery that supplies blood to her lungs), Noonan's syndrome (a genetic disorder that prevents normal development in various parts of the body), and Behcet's syndrome (an extremely rare condition which causes chronic inflammation of the blood vessels). Aged 24, Ms. Alvarez also is developmentally delayed. Her mother, Raquel Martell Alvarez, is her guardian ad litem. For much of her life, Ms. Alvarez has received care on a fee-for-service basis from a cardiologist, rheumatologist, and other specialists who have prescribed several medications to address her complex medical conditions. Ms. Alvarez was defaulted into managed care on May 1, 2012 even though she never received the enrollment form and information from DHCS explaining how she needed to either choose a managed care plan or file for a MER.. She subsequently filed a MER after learning that her fee for service doctor had neglected to file the form on her behalf. Since May 2012, Ms. Alvarez has been unable to see her

cardiologist and other treating physicians of many years who are familiar with her unique and complex conditions. Without any advance written notice, the managed care plan also declined to renew Ms. Alvarez's prescription for the drug Humira needed to treat her Behcets syndrome. Unable to pay approximately $1,000 per month for Humira, Ms. Alvarez's mother has been forced to obtain samples of the drug from her daughter's former doctors. Ms. Alvarez appealed the denials of her MER and the prescription of Humira and sought to disenroll from the managed care plan. She was returned to regular Medi-Ca on October 1, 20121 pending the administrative hearing on her MER denial. On October 22, 2012, and only after Petitioners' counsel had threatened legal action, Respondents granted Ms. Alvarez's MER for a twelve-month period..

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

regimen necessitates that she conduct frequent blood tests. On July 10, 2012, this Petitioner requested a hearing. She was thereafter returned temporarily to fee-for-service Medi-Cal pending a hearing decision on the appeal of the denial of her MER. On August 24, 2012, the ombudsman submitted a position statement advocating a denial of the appeal on the grounds that Ms. Valadez failed to document "any high risk or complex medical conditions" or any deleterious medical effects. On October 22, 2012, prior to any hearing, and only after Petitioners' counsel had threatened legal action, Respondents granted Ms. Valadez's MER for a twelve-month period of time.

16. Petitioner [redacted] is a Medi-Cal recipient. She is a Person with Disabilities with complex medical conditions, having suffered cardiac arrest in February 2011 that deprived her brain of oxygen and resulted in serious brain injury. In July 2011 Ms. [redacted] was enrolled in a Nursing Facility Sub-Acute Hospital (NF/AH) waiver program. At present, she is in vegetative state, is unlikely to recover and receives around-the-clock nursing care in her home. When Ms. [redacted] son, [redacted] who is her guardian ad litem, received a letter stating that this Petitioner would have to transition into managed care, he facilitated the submission of a HCO 7101 form completed by Dr. Robert N. Titcher on May 30, 2012. The HCO 7101 form stated that Ms. [redacted] suffered from anoxic brain injury, seizure disorder, chronic vegetative state, severe anemia requiring transfusions and gastrointestinal tube feeding. Respondents denied her MER and Petitioner's son filed a timely appeal from the denial of her MER. Prior to the administrative hearing, Mr. [redacted] sent a letter to the administrative law judge indicating that his mother was also entitled to a medical exemption because she had a complex neurological disorder that requires ongoing supervision and because she was enrolled in a Medi-Cal Nursing Home Waiver program for sub-acute level nursing care at home. The ombudsman's position statement, dated July 26, 2012, states that the provider failed to document "any high risk or complex medical conditions" or any deleterious medical effects that would result from a transfer to managed care. This statement failed to address her request for a nursing home waiver exemption. On September 6, 2012, the administrative law judge denied the MER. A rehearing request was timely filed asserting the nursing home waiver exemption under 22 CCR § 53887 (2)(a)(8)(A). On

October 26, 2012, the ombudsman, denied the rehearing request, offering no reasons for the summary denial. Subsequently, and only after the intervention of Ms. [redacted] attorneys, Respondents have granted Ms. [redacted] a temporary extension in fee-for-service Medi-Cal through December 31, 2012. Petitioners' counsel are currently seeking an additional extension through March 31, 2012.

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

B. Respondents

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

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

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

STATUTORY FRAMEWORK FOR MEDI-CAL PROGRAM

A. Overview of Federal Medicaid Statutes and Regulations

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

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

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

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

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

B. Overview of State Medi-Cal Statutes and Regulations

26. In establishing the Medi-Cal program, the California Legislature declared its "intent . . . to provide, to the extent practicable, . . . for the health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family's future minimum self-maintenance and security." W&IC § 14000. The fundamental purpose of the program is "to afford qualifying individuals health care and related

remedial or preventative services, including related social services which are necessary for those receiving health care under this program." *Id.*

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

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

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

HISTORY OF MER REGULATIONS AND LEGISLATION

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

31. 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. As part of the 2000 amendments, the regulations were changed so as to eliminate "high risk" as an alternate basis for granting a MER. The 2000 amendments also eliminated the requirement that the

Medi-Cal beneficiary must show that moving into managed care would cause deleterious medical effects. At all times material herein since 2000, these regulations have remained unchanged. 22 CCR §53887 was and is the principal regulation governing MERs for Medi-Cal recipients. A true copy of this statute is attached hereto, marked as Exhibit A and incorporated herein by reference.

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

33. In conjunction with the new regulation and the above-mentioned All-Plan Letter, DHCS also introduced HCO Forms 7101 and 7102, dated 6/2000, for use in applying for medical exemptions. The HCO 7101 form and its instructions have remained the same up until the present day. The form contains all the necessary prompts and instruction for completing it. A true copy of HCO Form 7101 is attached hereto, marked Exhibit C. Form HCO 7102, introduced in 2000, must be completed if beneficiaries are seeking a non- medical exemption because they are American Indians or are enrolled in a Medi-Cal nursing home waiver program that allows the beneficiary to receive sub-acute, acute, intermediate or skilled nursing care at home rather than as an in-patient in a hospital or nursing home. This exemption included four types of Medi-Cal Waiver programs: AIDS Waiver, Model Waiver, In-Home Medical Care Waiver and Skilled Nursing Facility Waiver. *See* MMCD All-Plan Letter 00013. In February, 2012, the nursing home waiver (among others) was removed from the HCO 7102 form. There is no separate form with which to apply for a nursing home waiver exemption. New enrollees have not been sent information about this exemption or how they can apply for it. True copies of the original and new HCO Forms 7102 are attached hereto, marked respectively as Exhibits D and E, and incorporated herein by reference[2].

34. At all times material herein, 22 CCR §53882 has provided that DHCS must mail an enrollment form and plan information to each eligible beneficiary, and the mailing must include instructions on how to enroll in a plan and how to request an exemption for either medical or non-

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[2] See Ex. D, page 2 for Waiver programs. See Ex. E for new non-medical exemption form found on website, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CDgQFjAA&url=http%3A%2F%2Fwww.healthcareoptions.dhcs.ca.gov%2FHCOCSP%2FEnrollment%2Fcontent%2Fen%2Fforms%2FMU_0003382.pdf&ei=fpTUUKiUN6mU2QXTvoGYBA&usg=AFQjCNEpIEWAUSqJpKf3r2OtU-BbqMkC7g&bvm=bv.1355534169,d.b2I

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

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

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

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

MANDATORY ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES IN MANAGED CARE

37. At all times material herein prior to June 2011, Seniors and Persons with Disabilities had the choice between receiving medical coverage from the Medi-Cal program either on a fee-for-service or managed care basis. In November of 2010, California obtained federal approval for a §1115(b) Medicaid Demonstration Waiver ("Waiver") from the Center for Medicare and Medicaid Services ("CMS") whereby California will receive an additional $15 billion in federal funding over

a five-year period. Among the provisions of this Waiver is the mandatory enrollment of Seniors and Persons with Disabilities in managed care. The State has in return committed to develop and implement specific standards to protect these elderly and disabled recipients, including exemptions from managed care for recipients with complex medical conditions receiving fee-for service care, continuity of care or "seamless care" for recipients enrolled in managed care, and adequate notice of any changes, together with clearly delineated rights to exemptions and appeals.

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

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

40. DHCS has contracted with MAXIMUS, a for-profit publicly traded company with corporate headquarters in Reston, Virginia, to serve as the enrollment broker for Seniors and Persons and Disabilities. From June 2011 through October 2012, MAXIMUS committed widespread errors in processing MER requests from a significant number of Seniors and Persons with Disabilities, including (a) not mailing to them notices of the denials of their MERs, (b) denying their MERs as incomplete without giving these beneficiaries 30 days to provide additional information, and (c) providing incorrect information regarding the status of their MERs when these beneficiaries contacted the call center. On November 28, 2012, DHCS announced that MAXIMUS had committed the above-mentioned errors and that, as a result, DHCS intended to permit approximately 20,000 Seniors and Persons with Disabilities, who had filed MERS during the above-mentioned period to submit new MERs and any beneficiary filing a new MER will then be eligible to be returned to fee-for-service Medi-Cal pending final determination. As of this date, DHCS has not mailed the notices to these Seniors and Persons with Disabilities.

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

42. The Department has never adopted a regulation setting forth the deleterious effect standard or any of the other above-mentioned additional eligibility standards for initial submission of MERs.[3] The Department also did not have an official written policy implementing the deleterious effects standard in granting MERs until July 18, 2012, when it issued an All Provider Bulletin and notice to Medi-Cal providers. A true copy of this Provider Bulletin and notice to Medi-Cal providers are attached hereto, marked collectively as Exhibit F and incorporated herein by reference.

43. At all times material herein, the standard notices sent to Seniors and Persons with Disabilities denying their MERs are inadequate. The notices make no mention of the deleterious effects standard. These notices instead offer several stock reasons for denial of the MERs, such as: "Your medical condition does not qualify for a medical exemption. This decision is based on the information sent to us by your doctor." This conclusory language in the notices provides no specifics about the factual bases for denying the MER so that Seniors and Persons with Disabilities

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[3] 22 CCR §53893(a)(3) addresses beneficiaries whose MERs have already been granted. The regulation provides, in pertinent part, that "[e]xcept for pregnancy, any beneficiary granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and being receiving care from a plan provider with the same speciality 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. . . ."

can make informed decisions on whether to appeal the denial of the MERs or the likelihood of success of such appeals. In addition, these notices do not advise Seniors and Persons with Disabiltiies of the procedures whereby they could continue to receive fee-for-service Med-Cal from the time they appeal the denial of their MER until a hearing officer decides their administrative appeal. A true copy of one of these standard notices is attached hereto, marked as Exhibit G and incorporated herein by reference.

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

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

CAUSES OF ACTION

FIRST CAUSE OF ACTION

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

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

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

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

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

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

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

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

SECOND CAUSE OF ACTION

(All Petitioners for Violations of California Administrative Procedures Act)

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

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

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

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

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

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

THIRD CAUSE OF ACTION

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

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

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

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

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

FOURTH CAUSE OF ACTION

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

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

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

60. Medi-Cal recipients must be notified in writing by means of a notice of action of any action being taken by Respondents or their agents that would adversely affect their Medi-Cal

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

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

62. Under 22 CCR §53882, DHCS must mail an enrollment form and plan information to each eligible beneficiary, and the mailing must include instructions on how to enroll in a plan and how to request an exemption for either medical or non-medical reasons. After receiving this notice, beneficiaries have thirty days to either chose a managed care plan or file for a MER. Only if they do not do either of these can they be defaulted into a managed care plan, pursuant to 22 CCR §53883.

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

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

FIFTH CAUSE OF ACTION

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

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

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

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

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

69. In violation of 22 CCR §53893(a), Government Code §11425.30(a)(1), W&IC §10960(a), and the Due Process Clause of the California Constitution, Respondents have authorized and continue to authorize the Medi-Cal Managed Care Office of the Ombusdman : (a) to oppose Medi-Cal beneficiaries on their complaints relating to managed care plans; and (b) to advocate on DHCS' behalf in an administrative proceeding relating to the denial of MER from a Senior and/or Person with Disabilities and to later serve as the presiding officer who makes the decision on whether to grant or deny the rehearing requests from this beneficiary after the administrative law judge has denied the MER. In violation of W&IC §10960(c), Respondents also have authorized and continue to authorize the Ombudsmen to deny rehearing request without giving the requisite explanation of the facts and the law to justify the decision.

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

SIXTH CAUSE OF ACTION

(Petitioner [redacted] for Writ of Mandate under Code of Civil Procedure §1094.5)

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

72. Respondents have failed to proceed in a manner proscribed by law and the findings are not supported by the evidence in that:

a. the administrative law judge denied petitioner a medical exemption even though she had a nursing home waiver which entitled her to an exemption from managed care; 22 CCR § 53887 (2)(A)(8);

b. the request for rehearing was denied even though she was entitled to an exemption because she had a nursing home waiver; 22 CCR § 53887 (2)(A)(8);

c. the medical exemption denial notice does not set out with specificity the reasons for the denial. W&IC 14182(b)(21); and

d. the form rehearing denial notice does not "explain the reasons and legal basis" for denying a rehearing request. W&IC 10960(c).

73. Petitioner obtained a temporary stay from the ombudsman allowing petitioner to remain in fee-for-service until December 31, 2012. Petitioner will be seeking an alternate writ of mandate or a temporary stay or temporary or preliminary injunctive relief to maintain the status quo and allow the petitioner to remain in fee for service Medi-Cal until there is a final decision regarding the CCP 1094.5 writ of mandate.

74. Petitioner lacks a plain, speedy and adequate remedy at law except by way of writ of mandate pursuant to Code of Civil Procedure §1094.5

PRAYER

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

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

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

B. Cease sending inadequate, conclusory notices of action for the denials of MERs that do not comply with W&IC §14182(b)(21), 22 CCR §§50179 51014.1(c) and 51014.2(a)&(b), and the Due Process Clause of the California Constitution by not containing an explanation of the specific factual and legal reasons for the denials of the MERs and that also fail to advise beneficiaries of the procedures whereby they could continue to receive, or be returned to, fee-for-service Med-Cal from the time they appeal the denial of their MER until a hearing officer decides their administrative appeal;

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

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

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

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

2. Issue a Writ of Mandate pursuant to Code of Civil Procedure §1094.5 overturning the hearing decision and requiring that Respondents grant Petitioner [redacted] a permanent medical exemption based on her nursing home waiver.

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

4. Issue with respect to Petitioner [redacted] only, pursuant to Code of Civil Procedure §1094.5, a stay of enforcement of Respondents' decision to deny her MER, and/or alternate writ of mandate; peremptory writ and/or other appropriate injunctive relief compelling Respondents to reverse their decision to deny a medical exemption based on the nursing home waiver.

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

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

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

Date: December 21, 2012

Respectfully submitted,
LEGAL AID FOUNDATION OF LOS ANGELES

BY: _____
BARBARA SCHULTZ
Attomeys for Petitioners

Date: December 21, 2012

Respectfully submitted,
WESTERN CENTER ON LAW & POVERTY

BY: _____
ROBERT NEWMAN
Attorneys for Petitioners

EXHIBIT A

* This document is current through Register 2012, No. 47, November 23, 2012 *

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. _____ (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 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: ☐ Initials: _____
Denied: ☐ Date: _____
Deferred: ☐

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	☐ A. Pregnant and currently under your care for the pregnancy. Due Date _____	
B	☐ 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 recivan 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

		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 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. _____ 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 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: ☐ Initials: _____ Deferred: ☐ 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 recivan 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 doumentation submitted.

15. Beneficiary's Benefits Identification CardNumber

_____

16. Are you affiliated with any Medi-CalManaged 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

REQUEST FOR MEDICAL EXEMPTION FROM MEDI-CAL ENROLLMENT

For use with the Indian Health and Medi-Cal Waiver Programs

A. 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	2. Beneficiary Medi-Cal I.D. Number (BIC)
Last Name First Name M.I.	
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 (___) ___-____

B. MEDI-CAL WAIVER PROGRAM EXEMPTION

Each area of the Medi-Cal Waiver Programs exemption form must be completed or the form will be returned unprocessed.

(Please Print or Type Ink Only)

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	2. Beneficiary Medi-Cal I.D. Number (BIC)
Last Name First Name M.I.	
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

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			2. Beneficiary Medi-Cal I.D. Number (BIC)
Last Name	First Name	M.I.	
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 du su familia es de origen Indígena Americano, Nativo de Alaska o reúne los requisitos para personas de origen no indígena y desea recibir servicios medicos 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 G

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).

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,

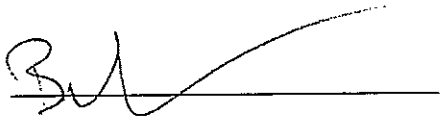
California Health Care Options
1-800-430-4263

CONFIDENTIAL

Verification

I, Barbara J. Schultz, am one of the attorneys for petitioners in the above-entitled action. I declare under penalty of perjury that the facts alleged in the foregoing document that have not otherwise been verified by petitioners are true and correct to the best of my information and belief.

Executed in Los Angeles, California this 21st day in December, 2012.

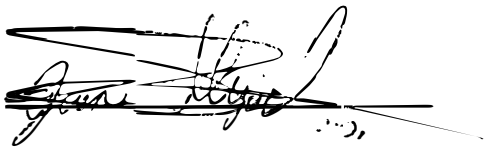


Barbara J. Schultz

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 19th day in December, 2012.



Juan Cameros

Verification

I, Anita Valadez, 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 19th day in December, 2012.

Anita Valadez

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 19th day in December, 2012.

Raquel Alvarez Daughter
Raquel Alvarez Mother

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 19th day in December, 2012.

Della Saavedra.

Della Saavedra

Verification

I, [redacted] 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 19th day in December, 2012.

[redacted]

For [redacted]