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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

JANE H. and MARY A., Petitioners, v. JENNIFER KENT, in her capacity as Director, California Department of Health Care Services, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES. Respondents.	Case No. **PETITION FOR ADMINISTRATIVE MANDAMUS (CODE CIV. PROC. §§ 1094.5 and 1085) AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

INTRODUCTION

1. Medi-Cal beneficiaries are entitled to receive medically necessary services pursuant to state and federal law. In administering the Medi-Cal program, the Department of Health Care Services (DHCS) must follow the law and ensure due process for beneficiaries. This case concerns DHCS' adjudication of "medical exemption" requests, where beneficiaries with rare or complex conditions request to remain with their treating doctors to avoid the harm that would result from transitioning to a Medi-Cal managed care health plan. In the appeal process for medical exemption requests, DHCS and its Director, Jennifer Kent (Respondents), routinely alternate decisions by administrative law judges which have upheld beneficiaries' medical exemption requests. The alternating of these administrative decisions violate controlling law and circumvent due process.

2. Petitioner Mary A. has life-threatening scleroderma and lung disease. Her condition has no cure and is worsening. Petitioner Jane H. was struck with relapsing-remitting multiple sclerosis in 2014 and has severe depression and anxiety made worse by her diagnosis. Both petitioners are low-income and rely on Medi-Cal coverage to receive the treatment they need from doctors who specialize in treating their rare, complex medical conditions. Petitioners accordingly filed medical exemption requests to remain under the care of those doctors. Respondents denied their medical exemption requests. Petitioners appealed the denials and prevailed in their respective administrative hearings before administrative law judges. But, respondents improperly reversed or "alternated" these favorable hearing decisions.

3. Respondents' actions violate state laws and regulations governing the transfer of Medi-Cal beneficiaries with complex medical conditions into managed care plans as well as Petitioners' due process rights. By ripping petitioners away from the care of their doctors and forcing them into managed care plans, respondents place petitioners' already precarious health at serious risk, and in Mary A.'s case, at risk of death. On information and belief, respondents have a policy and practice of "alternating" favorable hearing decisions issued by administrative law judges adjudicating medical exemption requests, putting beneficiaries with severe,

complex medical conditions at risk. Petitioner Mary A. and Jane H. bring this action to end the Department's unlawful practice and policy of wrongfully depriving patients of the life-sustaining care from their regular doctors. Petitioner Jane H. also seeks to prevent respondents from forcing her to enroll by October 1, 2017, into a managed care health plan that her doctor cannot participate in.

4. Petitioner Jane H. seeks an administrative writ under Code of Civil Procedure ("C.C.P.") § 1094.5 vacating her final hearing decision and granting her a 12-month MER because DHCS abused its discretion in alternating the hearing decision.

5. Petitioners Jane H. and Mary A. also seek a writ of mandate under C.C.P. § 1085 ordering Respondents to comply with their ministerial duties to comply with state law and to provide due process in reversing or alternating medical exemption request hearing decisions favorable to Medi-Cal beneficiaries.

PARTIES

6. Petitioner Jane H. resides in Los Angeles County. She is 51 years old. Her only income is Supplemental Security Income (SSI). As an SSI recipient, she automatically receives Medi-Cal. 42 U.S.C. § 1396a(a)(10)(A)(i)(II); *see also* 22 C.C.R. §§ 50145(a), 50227(a)(2). Jane H. has relapsing-remitting multiple sclerosis (MS), depression and anxiety. She has been receiving treatment from Dr. Revere Kinkel, a neurologist since 2014. Dr. Kinkel practices at University of California, San Diego Health (UCSD), where he directs the multiple sclerosis program. Jane H. sought a medical exemption from enrollment in a Medi-Cal managed care plan in order to remain in Dr. Kinkel's care.

7. Petitioner Mary A. resides in Los Angeles County. She is 48 years old and a Medi-Cal beneficiary. She also receives SSI. Mary A. has scleroderma and interstitial lung disease. She receives treatment from Dr. Elizabeth Volkmann, a rheumatologist and scleroderma expert, at University of California, Los Angeles Medical Center (UCLA), and Dr. Paul Noble, a pulmonologist and expert in interstitial lung disease, at Cedars-Sinai Medical Center.

8. Respondent DHCS is the single state agency responsible for administering the Medi-Cal program in California and ensuring that the Medi-Cal program is operated in conformity with all state and federal laws.

9. Respondent Jennifer Kent is the current Director of DHCS and is sued in her official capacity. Director Kent is responsible for the lawful administration of the Medi-Cal program.

JURISDICTION AND VENUE

10. Venue is proper in this Court because Petitioners Jane H. and Mary A. reside in Los Angeles County, where they have been injured by DHCS' actions. C.C.P. § 393(b).

11. Petitioners have a clear, present and beneficial right to respondents' accurate review of their medical exemption requests and the lawful administration of their Medi-Cal benefits.

12. Petitioners have no plain, speedy, and adequate remedy at law.

13. Petitioners have exhausted all available administrative remedies, as alleged below, including at paragraphs 50 through 54 and 73 through 78. Under section 10962 of the Welfare and Institutions Code, Petitioner Jane H. is entitled to seek judicial review of her Medi-Cal fair hearing decision under section 1094.5 of the Code of Civil Procedure. All petitioners are entitled to seek judicial review of respondents' actions and omissions in breach of their ministerial duties, as alleged in this petition, under section 1085 of the Code of Civil Procedure.

14. Because Medi-Cal is a fundamental vested right, this Court must exercise its independent judgment on the evidence. C.C.P. § 1094.5(c).

STATUTORY AND REGULATORY FRAMEWORK

Overview of Medi-Cal Statutes and Regulations

15. Medicaid is a cooperative federal and state program designed to furnish health care to the poor. 42 U.S.C. §§ 1396 *et seq.* California's Medicaid program is known as "Medi-Cal." Welf. & Inst. §§ 14000 *et seq.* Respondent DHCS is the single state agency responsible

for ensuring Medi-Cal complies with all relevant laws and regulations. 42 U.S.C. § 1396a(a)(5); Welf. & Inst. Code § 14100.1.

16. DHCS must provide beneficiaries with medically necessary services covered by the Medi-Cal program. 42 C.F.R. § 440.230(b). All Medi-Cal beneficiaries are entitled to receive certain mandatory services, including physician services, prescription drugs, and more. 42 U.S.C. § 1396d(a); Welf. & Inst. Code §§ 14131 *et seq*.

17. The federal Medicaid statute protects a beneficiary's right to a fair hearing. 42 U.S.C. § 1396a(a)(3). In addition, state law allows a beneficiary to appeal any action relating to her receipt of public social services. Welf. & Inst. Code § 10950.

18. Medi-Cal benefits, like all public social services, must be provided promptly and humanely such that each beneficiary is able to access all of the aid to which he is entitled. Welf. & Inst. Code §§ 10000, 10500.

Enrollment in Medi-Cal Managed Care

19. The Medi-Cal program provides health care to beneficiaries either on a "fee-for-service" or a managed care basis. With fee-for-service Medi-Cal, 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. *See, e.g.*, Welf. & Inst. Code § 14016.5. With managed care Medi-Cal, DHCS contracts with health plans to provide health care to Medi-Cal beneficiaries within a managed care system. The managed care plans receive a per capita reimbursement based on the number of Medi-Cal beneficiaries enrolled in that plan. *See* Welf. & Inst. Code §§ 14087.3, 14089. That per capita rate, known as the "capitation" or "capitated rate," is part of a comprehensive risk contract that sets a pre-determined amount DHCS pays the managed care plan per person per month, regardless of the number, extent, or cost of medical services the plan actually provided to the person. 42 C.F.R. § 438.2.

20. Over time, DHCS has required mandatory enrollment in managed care plans for more and more categories of Medi-Cal beneficiaries. *See, e.g.*, Welf. & Inst. Code § 14087.3

(allowing DHCS to enter into contracts for the provision of care to Medi-Cal beneficiaries); § 14182 (requiring Seniors and Persons with Disabilities to enroll into managed care).

Medical Exemption Requests (MERs)

21. DHCS allows for exemptions from mandatory enrollment in managed care for qualifying Medi-Cal beneficiaries in most counties. *See* California Code of Regulations, tit. 22 (22 C.C.R.) §§ 53887 (managed care exemptions available within two-plan and Regional plan counties), 53923.5 (managed care exemptions available within Geographic Managed Care (GMC) counties).

22. In "Two-Plan" counties, DHCS has established contracts with two plans—a county-organized local initiative plan and a commercial health insurance plan—to provide Medi-Cal benefits to managed care enrollees in the county. *See* 22 C.C.R. § 53800(b). The two-plan counties are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare. See DHCS Medi-Cal Managed Care Fact Sheet, available at http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf (last visited August 1, 2017). Title 22 section 53887 of the California Code of Regulations governs the process for obtaining a temporary medical exemption to managed care enrollment in Two-Plan counties. *See* 22 C.C.R. § 53887.

23. In Regional Plan counties, DHCS has contracted with two commercial health insurance plans to provide Medi-Cal benefits to managed care enrollees in the county. The Regional plan counties are: Alpine, Amador, Butte, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. DHCS Medi-Cal Managed Care Fact Sheet, *supra*. Title 22 section 53887 of the California Code of Regulations also governs the process for obtaining a temporary medical exemption to managed care enrollment in Regional plan counties. *See* Dep't of Health Care Services All Plan Letter 17-007 at 2 n.1.

24. This petition and complaint focuses on the medical exemption request process

in Two-Plan and Regional Plan counties, and all other counties in which the MER process is governed by 22 C.C.R. § 53887.

MERs Under 22 C.C.R. § 53887

25. To obtain an exemption from Medi-Cal managed care, a beneficiary's treating physician must submit to DHCS a request for the beneficiary to retain fee-for-service Medi-Cal. 22 C.C.R § 53887(a).

26. A Medi-Cal beneficiary does not qualify for a MER if her treating physician contracts with any Medi-Cal managed care plan in the beneficiary's county of residence or if the beneficiary is a member of such a plan for more than 90 days. *Id.* § 53887(a)(2)(B).

27. If these disqualifying factors do not exist, DHCS must evaluate the beneficiary's medical conditions. *Id.* § 53887(a)(2). DHCS must evaluate the beneficiary for exemption from managed care enrollment if the beneficiary has a complex medical condition for which she is undergoing treatment. *See id.* § 53887. A complex medical condition includes "a complex and/or progressive disorder . . . 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." *Id.* § 53887(a)(2)(A)(7). This also includes "complex neurological disorder[s], such as multiple sclerosis." *Id.* DHCS "*shall* approve each request…that meets the requirements of [section 53887]." *Id.* § 53887(c) (emphasis added).

28. A MER is granted for up to 12 months at a time and allows a beneficiary to remain in fee-for-service Medi-Cal until her medical condition has stabilized such that she could "change physicians and begin receiving care from a plan provider without deleterious medical effects." *Id.* § 53887(a)(3). That determination of stability must be made by the beneficiary's treating physician in the Medi-Cal fee-for-service program. *Id.* DHCS defines the "risk of suffering deleterious medical effects" if care is transferred as "increasing illness, disability or pain and/or prolong necessary treatment." *See* HCO Form 7101, Instructions for Completing Box 15.

29. DHCS must ensure that the medical exemption criteria set forth in § 53887 are

applied to seniors and persons with disabilities whom DHCS otherwise seeks to transfer into a managed care plan. Welf. & Inst. Code § 14182.

Notice and Hearing Requirements

30. Under the California Constitution, a "person may not be deprived of life, liberty, or property without due process of law." Cal. Const. art. I, §§ 7, 15. The federal Medicaid statute protects a beneficiary's right to a fair hearing. 42 U.S.C. § 1396a(a)(3). Medi-Cal fair hearings "must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970)." 42 C.F.R. § 431.205(d). In addition, state law allows a beneficiary to appeal any action relating to his receipt of public social services. Welf. & Inst. § 10950; 22 C.C.R. § 50951.

31. Beneficiaries are entitled to notice and a fair hearing when DHCS denies their MERs. 42 C.F.R. § 438.56(f); 22 C.C.R. § 53889(d). The notice of action to beneficiaries must state, at a minimum the action to be taken, the reasons for the action, the regulations supporting the action, and an explanation of the circumstances under which aid is continued if a hearing is requested. 42 C.F.R. § 431.210; 22 C.C.R. §§ 50179, 51014.1(c).

32. DHCS has delegated the administration of Medi-Cal fair hearings to the Department of Social Services. Welf & Inst. Code §§ 10966, 10950(f); 22 C.C.R. § 50953(c). Decisions rendered by the administrative law judges (ALJs) must "be treated, for all purposes, as the decision of the [DHCS] director." Welf & Inst. Code § 10966(b).

Evidence in the Administrative Hearing

33. When defending a MER denial, DHCS has "the burden of going forward in the hearing to support its determination" of why the MER should be denied. Department of Social Services Manual of Policies and Procedures (MPP) § 22-073.36.

34. The administrative hearing decision must be based "exclusively on the evidence and other material introduced at the hearing . . . and shall specify the reasons for the decisions and identify the supporting evidence and regulations." MPP § 22-061.5. If the evidence necessary to determine the case is not available at the hearing, the ALJ can continue the

hearing or hold the record open. *Id*. § 22-053.21. The ALJ can also reopen a closed hearing record for additional information if all parties are notified of the reason for the reopening. *Id*. § 22-059.12. ALJs must make satisfactory evidentiary findings and assess the probative value of admitted evidence. *Id.* § 22-050.3. The beneficiary's rights during the hearing include the right to conduct direct and cross-examination of parties and witnesses, examine all documents prior to and during the hearing, and rebut the evidence. *Id*. § 22-049.7.

DHCS Director Action on Administrative Hearing Decisions

35. Once the ALJ has concluded the fair hearing and issued a proposed decision, DHCS has 30 days to adopt the decision in its entirety; decide the matter himself or herself, or "alternate" the ALJ decision; or order a further hearing to be conducted by himself or herself, or another ALJ on behalf of the director. Welf. & Inst. Code § 10959. If the DHCS director decides the matter for herself on the record, the DHCS director must state the reason for her decision and specify the evidence supporting her decision. *Rogers v. Carleson*, 30 Cal. App.3d 54, 57 (1973); *see also* 42 C.F.R. § 431.244 (same requirements). The director's alternate decision must be made on the record, including the transcript, with or without taking additional evidence. Welf. & Inst. Code § 10959. The alternate decision must also include a statement of the facts, the statutes and regulations involved, and the reasoning which supports the decision. MPP § 22-062.31 The director is required to review the administrative record, including the transcript, of the hearing in alternating a hearing decision or otherwise deciding the matter herself. Welf. & Inst. Code § 10959.

36. The director may not alternate the factual findings of the hearing decision without providing the beneficiary the opportunity for a new hearing. *See Ventimiglia v. Bd. of Behavioral Science*, 168 Cal. App. 4th 296, 303-314 (2008) (appellant is entitled to opportunity to be heard when agency rendered final administrative decision based on new facts and evidence).

STATEMENT OF FACTS

Petitioner Jane H.

37. Petitioner Jane H. is a Medi-Cal beneficiary who is permanently disabled. She has rapidly progressing relapsing-remitting Multiple Sclerosis. Multiple sclerosis (MS) is a neurological condition for which there is no cure, characterized by inflammatory attack on nerve fibers and their protective layers, disrupting nervous system function. Patients with relapsing-remitting MS experience periods of stability punctuated by relapses, wherein they experience new or worse symptoms.

38. Jane H. first began experiencing symptoms of her disease in mid-February 2014. She began to experience vertigo, and lost her balance easily. She had to walk very slowly to avoid falling. At first, Jane H.'s vertigo was intermittent but it became continuous. Within one month, Jane H. began to experience pins and needles sensations in her feet, legs, hands, and ribcage. By mid-March 2014, Jane H. had recurrent low back pain.

39. Between March and June 2014, Jane H.'s health deteriorated rapidly. In early April 2014, Jane H. started falling down seemingly without cause. By June 2014, Jane H. became so weak that her mother had to buy a wheelchair for her use inside and outside the home. Jane H. could not get out of the wheelchair without assistance. She could not use a walker. She began to experience a painful tightness around her chest and ribs, making it difficult to breathe—a disease symptom known as the "MS hug." At Jane H.'s appointments to undergo MRI in early June, she was so weak she required assistance transferring from her wheelchair to the table.

40. On June 10, a neurologist with Magan Medical Clinic tentatively diagnosed Jane H. with Multiple Sclerosis. He was uncertain about the diagnosis and presented no treatment options, except to prescribe prednisone for her weakness.

41. Jane H. was approved for Medi-Cal in June 2014. At that time, the Magan Medical Center neurologist informed Jane H. that he does not accept Medi-Cal and could no longer see her.

42. Jane H. eventually found Dr. Kinkel at UCSD, a recognized specialist in MS treatment who accepts fee-for-service Medi-Cal. Dr. Kinkel has actively treated Jane H.'s MS since June 30, 2014.

43 Dr. Kinkel accepts San Diego County Medi-Cal managed care plans, but not Los Angeles County plans. Dr. Kinkel can only see Jane H. if she has fee-for-service Medi-Cal. He cannot enter a continuity of care arrangement with a Los Angeles County Medi-Cal health plan.

44. In addition to relapsing-remitting MS, Jane H. has depression and anxiety. Jane H. became more depressed and anxious as her health deteriorated in early 2014. She was quite distressed by her decline in function, cried often, and had difficulty getting out of bed. She lost motivation and interest in her usual activities, often remaining in bed all day. Jane H. thought about suicide.

45. Dr. Kinkel has had Jane H. on a transfusion treatment regimen of rituximab (commercially known as Rituxan) since November 2014 after she failed on a more conventional MS treatment, copaxone injections.

46. Dr. Kinkel prescribes rituximab, a cancer treatment drug, as an off-label use for his patients with relapsing-remitting MS. Community-based neurologists, including those who are members of Medi-Cal managed care plans, typically refer their complex MS cases to him for administration and management of rituximab.

47. Jane H.'s depression and anxiety have persisted with little improvement over the past three years. Dr. Kinkel must balance Jane H.'s psychiatric medications with her MS treatments.

48. Dr. Kinkel submitted a MER on behalf of Petitioner Jane H. on November 10, 2016, in which he stated based on his knowledge and treatment of Jane H.'s condition that her medical condition was too unstable for her to transfer into a managed care plan without severe negative health consequences.

49. DHCS denied petitioner's MER in a notice dated November 28, 2016. The notice stated that medical forms from Jane H.'s doctor were reviewed, and her neurological disorder appeared medically stable. The notice stated that Jane H. could get follow-up care from a doctor who works with the Medi-Cal managed care plan. The notice did not contain the notes of the DHCS medical reviewers explaining the basis for denial.

50. Jane H. appealed the DHCS denial and had a telephonic hearing on January 25, 2017 in Case Number 20163520124. Jane H. was represented by an attorney who submitted a statement of position on her behalf.

51. At her hearing, Jane H. submitted medical records that she has relapsing-remitting MS. The medical records reflect that her MS progressed rapidly and caused significant disability before she began rituximab, and that she has persistent depression and anxiety.

52. Jane H. also submitted into the hearing record four letters from Dr. Kinkel about the complexity of Jane H.'s medical condition and why it was necessary for her to remain in his care. According to Dr. Kinkel, Jane H.'s mental health comorbidities make her case particularly complex. Aggressive surveillance and treatment is necessary to maintain her level of functioning and quality of life. Dr. Kinkel wrote that if Jane H.'s treatment is disrupted, her condition has a high probability of full, unmanageable relapse. Dr. Kinkel stated that Jane H. has numerous poor risk factors including age of onset, large disease burden as measured by brain lesions, early onset of brain atrophy, and significant physical and cognitive impairment following recovery from her first attack.

53. DHCS only presented a position statement at the hearing. No representative of DHCS appeared in person or telephonically. In its position statement, DHCS claimed that Jane H.'s provider failed to document high risk or complex medical condition that has not been stabilized and therefore, there would be no deleterious health effects to her if she were to begin receiving care from a plan provider. DHCS's position statement contained no facts to support these assertions. DHCS did not attach to its position statement the notes of its medical

reviewers concerning their recommendation to deny Jane H.'s MER. It did not disclose the names and credentials of its medical reviewers. DHCS did not inform Jane H. about how to obtain the medical reviewers' notes recommending denial of her MER.

54. On February 5, 2017, Administrative Law Judge Betty Buccat reversed DHCS's denial and granted Jane H. a 12-month medical exemption. Judge Buccat concluded that the preponderance of the evidence established that Jane H.'s neurological disorder requires that she remain in Dr. Kinkel's care because her condition is unstable, and placing her with a managed care plan provider would result in deleterious effects to her health and safety. Judge Buccat supported her conclusion with findings that Dr. Kinkel identified numerous risk factors including large disease burden as measured by brain lesions, early onset of brain atrophy and significant physical and cognitive impairment which occurred following her first MS attack.

55. Despite the ALJ's thorough fact finding and conclusion, and without providing a basis for reversing, DHCS alternated the ALJ's proposed decision and issued the Director's Alternate Decision denying Jane H.'s MER on March 8, 2017. The Alternate Decision added one paragraph to the Facts section of the Proposed Decision finding that Jane H. is clinically stable—without citation to any evidence in the administrative record. The Alternate Decision repeated the conclusory paragraph in the Conclusion. In all other respects, the Alternate Decision is identical to the proposed decision.

56. Petitioners allege on information and belief that the Alternate Decision is based on evidence outside of the record that respondents never provided to Jane H.

57. DHCS failed to include in its statement of position or Alternate Decision any analysis of the evidence proffered by Jane H. and relied on by Judge Buccat, such as her psychiatric conditions. DHCS did not address Dr. Kinkel's concerns about the risks of deleterious health effects to Jane H. if her care is disrupted.

58. Petitioners allege, on information and belief, that respondents did not review the transcript of her hearing prior to alternating the hearing decision in her case.

59. On June 9, 2017, petitioner Jane H., through her counsel Neighborhood Legal Services of Los Angeles County, sent DHCS a letter requesting, among other things, reversal of the Director's Alternate Decision and grant of a 12-month MER until June 30, 2018.

60. On June 20, 2017. DHCS denied Jane H.'s request to reverse the Director's Alternate Decision and grant Jane H.'s MER. DHCS stated that Jane H. is scheduled to be enrolled into a health plan on October 1, 2017.

61. Petitioner files this writ to challenge Respondents' final decision in her case, and its unlawful practice of improperly reversing MER state fair hearing decisions favorable to claimants.

Petitioner Mary A.

62. Petitioner Mary A. has an autoimmune disease called systemic progressive scleroderma. She also has interstitial lung disease secondary to systemic scleroderma.

63. Systemic scleroderma is an extremely rare autoimmune condition for which there is no cure. It has an annual incidence of just 20 cases per one million adults. Systemic scleroderma affects multiple body systems causing problems of the skin, heart, lungs, blood vessels, brain, and gastrointestinal, musculoskeletal and endocrine systems. The most common fatal complications are progressive pulmonary fibrosis, pulmonary hypertension, severe gastrointestinal involvement, and heart disease.

64. Mary A., once an athlete and avid hiker, first experienced symptoms of her conditions in late 2013 when she had shortness of breath while training for a hiking trip.

65. Needing to support herself financially and for health insurance coverage, Mary A. continued to work as much as she was able for the next two years as her health deteriorated. Her insurance at that time came with a $6,000 annual deductible that she could not afford and as a result, Mary A. could not afford to seek care from July through November 2015. During that time, Mary A.'s circulation in her hands became very poor, her skin became very sensitive to contact, her shortness of breath grew worse, she developed a persistent dry cough, she had gastrointestinal reflux and discomfort, and she developed aches and pains throughout her body.

66. By January 2016, Mary A. realized that she was too sick to continue working. Mary A. lost her job-based health insurance. She applied for Medi-Cal in January 2016 and she was approved shortly thereafter.

67. Meanwhile, in November 2015, Mary A. sought care from Dr. Elizabeth Volkmann, rheumatologist and scleroderma expert at UCLA, and Dr. Paul Noble, pulmonologist and expert in pulmonary fibrosis at Cedars-Sinai. Drs. Volkmann and Noble have been treating Mary A.'s sclerosis and lung fibrosis since that time. They only accept fee-for-service Medi-Cal. Drs. Volkmann and Noble do not contract with either of the two Medi-Cal managed care plans in Los Angeles County.

68. Drs. Volkmann and Noble agreed in November 2015 that Mary A.'s disease progression warranted treatment with immunosuppressive agent mycophenolate, commercially known as CellCept.

69. Mary A. started on mycophenolate in November 2015 at 1000 milligrams (mg) per day. While monitoring Mary A.'s response, Dr. Volkmann gradually doubled her mycophenolate dose by September 2016.

70. Mary A. relies on Dr. Volkmann's expertise to balance the benefits of mycophenolate with the health risks that treatment poses. Potential complications of mycophenolate include kidney failure, increased susceptibility to cancer and leukemia, and suppressed immune response. Because individuals taking mycophenolate are at a much greater risk of infection, Mary A. must take a prophylactic dose of Bactrim in order to prevent lung infections.

71. Dr. Noble must also manage the precarious interaction between the scleroderma and her other symptoms. Mary A. experiences joint and muscle pain on a daily basis—a symptom of scleroderma related to poor circulation throughout the body. Because mycophenolate does not improve these painful sclerosis symptoms for Mary A., Dr. Noble prescribed Mary A. prednisone in November 2015. Prednisone reduces the inflammation and pain, but also carries a risk of kidney failure. As a result of taking prednisone Mary A. has

early onset osteoporosis, *i.e.*, osteopenia. Drs. Volkmann and Noble gradually tapered Mary A.'s prednisone dose from 10 mg daily in November 2015 to 6 mg daily in September 2016. Unfortunately, as Mary A.'s dose is tapered, the aches and pains returns.

72. On July 20, 2016, Dr. Volkmann requested a MER for Mary A. DHCS denied the MER on July 27, 2016.

73. Mary A. appealed the denial and had a hearing on November 9, 2016 in Case Number 20162310409. Mary A. represented herself.

74. At her hearing, Mary A. submitted medical records showing that she has the complex diagnoses of systemic scleroderma and idiopathic lung disease, that her lungs' ability to transfer oxygen to the blood stream, called "DLCO score," has continually decreased since May 2014, and that she was being treated with mycophenolate. The records showed that Mary A.'s mycophenolate dose had been gradually increased to 2000 mg daily, and that her prednisone dose had been gradually decreased. Mary A.'s medical records reflected that Dr. Volkmann tests Mary A.'s medication-related toxicity at each visit.

75. Mary A. submitted a letter from Dr. Volkmann at the hearing. Dr. Volkmann wrote that:

(a) Systemic sclerosis is a progressive, debilitating condition, for which there is no known cure.

(b) Mary A.'s condition is complicated by her interstitial lung disease, which has progressed in severity despite treatment with immunosuppressive therapy.

(c) Mary A.'s condition is not stable and her symptoms include difficulty breathing, digestive issues, and muscle and joint pain.

(d) Mary A. cannot switch to another provider because if her condition is not treated aggressively and closely monitored by known experts in systemic sclerosis, she is likely to develop irreversible parenchymal lung damage leading to respiratory failure and death.

76. DHCS only presented a position statement at the hearing. No representative from DHCS appeared in person or telephonically. DHCS claimed that Mary A.'s provider failed to document any high risk or complex medical condition that has not been stabilized and therefore, there would be no deleterious health effects to her if she were to begin receiving care from a plan provider. The DHCS position statement contained no facts to support these assertions. DHCS did not attach to its position statement the notes of its medical reviewers concerning their recommendation to deny Mary A.'s MER. It did not disclose the names and credentials of its medical reviewers.

77. On November 29, 2016, twenty days after the hearing, DHCS submitted an Addendum to the administrative law judge recommending upholding the MER denial in response to the evidence Mary A. submitted at her hearing. DHCS did not give Mary A. notice or a copy of the Addendum. Therefore, Mary A. was unable to respond to the DHCS Addendum in any way.

78. After considering the evidence, Administrative Law Judge Lee Ormasa granted Mary A.'s claim for a 12-month MER, on January 25, 2017. Judge Ormasa found that Mary A.'s condition is not stable and is progressing as evidenced by her declining DLCO score despite immunosuppression therapy that had been gradually increased in 2016. Judge Ormasa found that Mary A. had developed an increased dry cough. Judge Ormasa concluded that the preponderance of the medical evidence established that: Mary A. has a qualifying complex medical condition that is not stable; she requires frequent and close medical supervision; her condition is worsening, progressive and without a known cure; and Mary A. is at serious risk of deadly harm to her health if required to treat with a managed care physician. Accordingly, Judge Ormasa determined that Mary A. qualifies for an exemption from mandatory enrollment in a Medi-Cal managed care health plan.

79. On March 2, 2017, DHCS alternated the proposed decision and issued the Director's Alternate Decision. DHCS acknowledged that Mary A. has a complex condition covered by § 53887(a)(2)(A), her condition will continue to worsen over time, and she will

need continued specialist care for the rest of her life. Yet DHCS found that Mary A.'s health was not "precipitously worse as compared with her most recent prior visits," and found that her conditions are stable. DHCS did not dispute or disprove Dr. Volkmann's statements about the risks of deleterious health effects to Mary A. if her care is disrupted. Without citation to any evidence in the hearing record, DHCS concluded that Mary A. does not qualify for a MER because (1) Medi-Cal managed care plans are contractually obligated to provide all medically necessary care, including complex specialty care, by way of out-of-network authorizations if necessary; and (2) Mary A. can make a continuity of care request with the health plan to extend her care with her current fee-for-service provider.

80. Petitioners allege, on information and belief, that respondents did not review the transcript of Mary A.'s hearing prior to alternating the hearing decision in her case.

81. Mary A. requested rehearing within 30 days of the decision. DHCS denied Mary A.'s request for rehearing on April 19, 2017.

82. In early 2017 Mary A.'s scleroderma symptoms worsened dramatically. In January 2017, Mary A. began to experience extreme shortness of breath. Drs. Volkmann and Noble became concerned that Mary A. was suffering from a lung infection, or that her lung disease has progressed to pulmonary hypertension. On February or March 2017, they increased her dose of prednisone to 20 mg daily. On April 28, Drs. Volkmann and Noble took Mary A. off of mycophenolate in order to assess for lung infection. By June 2017, Mary A.'s DLCO score had dropped to 46 percent down from 57 percent in November 2016. Mary A. fortunately began to recover pulmonary function in July 2017. However pulmonary hypertension has not been ruled out as a possible explanation for her recent rapid decline. Mary A.'s specialists are trying to determine whether to put her back on mycophenolate, or escalate her treatment to a new therapy.

83. On May 11, 2017, Mary A. through her counsel, Neighborhood Legal Services of Los Angeles County, sent DHCS a demand letter requesting that DHCS grant her medical exemption request through May 31, 2018. Counsel for Mary A. further demanded, among other

things, that DHCS articulate a written policy in collaboration with stakeholders on how to review and weigh medical evidence submitted for the evaluation of MERs.

84. On May 18, 2017, DHCS agreed to grant Mary A. a 12-month MER. DHCS did not respond to Mary A.'s other demands in her letter of May 11, 2017.

Other Medi-Cal beneficiaries' Alternated MER Hearing Decisions

85. Respondents alternated well over one hundred decisions between March 1, 2015 and the present concerning MERs, which represent an estimated 40 to 50 percent of proposed decisions granting MERs to appellants. Respondents disregard the evidentiary record and conclude, in summary fashion, that the beneficiary's condition is stable and that the beneficiary will not be harmed by a forced transition to managed care. Respondents' alternated decisions typically ignore all evidence and opinions of the beneficiary's treating physician, in many cases multiple treating physicians, and all of the legal and factual findings of the ALJ. As with the alternated decisions regarding petitioners, many of the alternated decisions denying MERs are based on standards other than those in the governing regulations, 22 C.C.R. § 53887.

86. Petitioners allege on information and belief that respondents do not review the hearing transcript prior to alternating MER hearing decisions.

CAUSES OF ACTION

First Cause of Action

Writ of Mandate Code Civil Proc. § 1094.5

Petitioner Jane H. Against All Respondents

(Abuse of Discretion—Findings Not Supported by the Evidence,

Decision Not Supported by the Findings, Error of Law)

87. Petitioner Jane H. realleges and incorporates by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

88. Petitioner submitted sufficient medical evidence such that an ALJ made a factual finding that Jane H.'s condition was unstable and as a result she was exempt from enrollment in a Medi-Cal managed care plan.

89. Respondents prejudicially abused their discretion in the findings made and evidence used in the final decision. C.C.P. § 1094.5(b). Respondents made findings in the final decision without reviewing the complete evidence in the record. Respondents also made findings in the final decision that lack support in the evidence.

90. Respondents did not review the hearing transcript. DHCS ignored the medical evidence in the record submitted by Jane H.'s doctor.

91. Respondents failed to produce or cite to any evidence to support its finding that Jane H.'s health is stable. Respondents did not disclose the identities and credentials of those who reviewed Jane H.'s MER. Respondents' final hearing decision improperly relied on DHCS' conclusory and unsubstantiated statements about petitioner Jane H.'s medical conditions and the availability of continued treatment in a plan.

92. Respondents further abused their discretion in petitioner Jane H.'s case because the final decision is not supported by the findings. Respondents merely repeated—nearly verbatim—in the Conclusion of the Final Decision the same conclusory statements it added to the fact section. In violation of Jane H.'s due process rights, DHCS made findings based on a selective review of the evidence in the record, failed to produce evidence for Jane H. to challenge, and concluded its MER denial was proper in cursory fashion. The final decision rests on unlawful findings.

93. Respondents applied a secret standard to deny Jane H.'s medical exemption in its final decision. Under the regulations, a beneficiary's treating physician determines whether the beneficiary's "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" *see* 22 C.C.R. § 53887(a)(3), meaning, according to DHCS's own instructions, increased illness, disability, pain and/or prolonged treatment. In Jane H.'s case, respondents instead applied a different standard—that there would be no interruption in Jane H.'s rituximab treatment regimen because the managed care plan is obligated to provide Jane H. with what is medically necessary.

94. Petitioner Jane H. has no plain, speedy, and adequate remedy to obtain DHCS' compliance with the law other than relief sought by this Petition. Under Code of Civil Procedure section 1094.5, Jane H. is entitled to a writ of administrative mandamus reversing the final hearing decision and granting her a 12-month medical exemption request.

Second Cause of Action

Writ of Mandate. Code Civil Proc. § 1085

Petitioners Jane H. and Mary A. Against All Respondents

(Violation of Welf. & Inst. Code § 10959)

95. Petitioners reallege and incorporate by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

96. Respondents alternated the medical exemption request hearing decisions of Petitioners and other Medi-Cal beneficiaries without reviewing the transcript, stating the reason for alternating the proposed decisions, or providing the evidence supporting the alternated decisions.

97. Respondents' actions and omissions violated Welfare & Institutions Code Sec. 10959.

98. Petitioners are beneficially interested in respondents' faithful execution of its duty to comply with Welfare & Institutions Code Sec. 10959. They have no plain, speedy, and adequate remedy to obtain respondents' compliance with the law other than the relief sought by this Petition. Unless and until enjoined by this court, respondents' unlawful conduct will cause great and irreparable injury.

Third Cause of Action

Writ of Mandate Code Civil Proc. § 1085

Petitioners Jane H. and Mary A. Against All Respondents

(Violation of Due Process, Cal. Const. art. I, §§ 7, 15)

99. Petitioners reallege and incorporate by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

100. Respondents alternated the medical exemption request hearing decisions of petitioners and other Medi-Cal beneficiaries without reviewing the transcript, stating the reason for or providing the evidence supporting the alternated decisions.

101. Respondents alternated the factual findings of the administrative law judges in alternating the medical exemption request hearing decisions of petitioners and other Medi-Cal beneficiaries.

102. Respondents' actions and omissions in alternating MER hearing decisions favorable to petitioners and other Medi-Cal beneficiaries violated due process.

103. Petitioners are beneficially interested in respondents' faithful execution of its duty to provide due process. They have no plain, speedy, and adequate remedy to obtain Respondents' compliance with the law other than the relief sought by this Petition. Unless and until enjoined by this court, respondents' unlawful conduct will cause great and irreparable injury.

Fourth Cause of Action

Writ of Mandate Cal. Code Civil Proc. § 1085

Petitioners Jane H. and Mary A. Against All Respondents

(Violation of Welf & Inst. Code § 14182 and 22 C.C.R. § 53887)

104. Petitioners reallege and incorporate by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

105. Welf. & Inst. Code § 14182 and 22 C.C.R**. §** 53887 govern medical exemption request determinations.

106. In alternating the MER hearing decisions favorable to petitioners and other Medi-Cal beneficiaries, respondents did not follow the standards codified in Welf. & Inst. Code § 14182 and 22 C.C.R**. §** 53887, including the standard that requires allowing the beneficiary to remain with the fee-for-service provider for up to 12 months, "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."

107. Petitioners are beneficially interested in respondents' faithful execution of its duty to apply the proper criteria set forth in 22 C.C.R. **§** 53887 in reviewing and making decisions regarding MER hearing decisions. They have no plain, speedy, and adequate remedy to obtain respondents' compliance with the law other than the relief sought by this Petition. Unless and until enjoined by this court, respondents' unlawful conduct will cause great and irreparable injury.

Fifth Cause of Action

Writ of Mandate Cal. Code Civil Proc. § 1085

Petitioners Jane H. and Mary A. Against All Respondents

(Violation of Administrative Procedure Act, Gov't Code § 11340.5)

108. Petitioners reallege and incorporate by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

109. The Administrative Procedures Act provides that a state agency shall not "issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule. . .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't. Code § 11340.5.

110. Respondents have drafted amendments to and represented that they intend to amend 22 C.C.R. § 53887. The proposed amendments include *inter alia* changes to how complex medical conditions are defined, and elimination of the role a beneficiary's treating physician in determining whether a beneficiary's transfer to a managed care plan from fee-for-service Medi-Cal would have a deleterious medical effect.

111. Respondents have never amended 22 C.C.R. § 53887, nor issued any letters, bulletins or instructions regarding the draft amendments to § 53887. Yet, they have alternated

the MER hearing decisions of petitioners and others in accordance with the draft amended regulation. Respondents' actions violate the Administrative Procedure Act.

112. Petitioners are beneficially interested in respondents' faithful execution of its duty to comply with the Administrative Procedure Act in reviewing and making decisions regarding MER hearing decisions. Petitioners have no plain, speedy, and adequate remedy to obtain respondents' compliance with the law other than the relief sought by this Petition. Unless and until enjoined by this court, respondents' unlawful conduct will cause great and irreparable injury.

Sixth Cause of Action

Writ of Mandate Code Civil Proc. § 1085

Petitioners Jane H. and Mary A. Against All Respondents

(Failure to Humanely Administer Benefits to Which Applicants Are Entitled – Welf. & Inst. Code §§ 10000, 10500)

113. Petitioners reallege and incorporate by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

114. In alternating the MER hearing decisions of petitioners and other Medi-Cal beneficiaries, respondents have failed to administer the Medi-Cal program promptly and humanely in a way that complies with the law. Welf. & Inst. Code § 10000. DHCS' administration of the Medi-Cal program has deprived petitioners "the amount of aid to which [they are] entitled . . . . " *Id.* § 10500.

115. Petitioners are beneficially interested in respondents' faithful execution of its duty to administer the Medi-Cal program promptly and humanely. They have no plain, speedy, and adequate remedy to obtain respondents' compliance with the law other than the relief sought by this Petition. Unless and until enjoined by this court, respondents' unlawful conduct will cause great and irreparable injury.

Seventh Cause of Action

Petitioners Jane H.and Mary A. against all Respondents

Relief from Illegal Expenditure of Public Funds

(Violation of C.C.P. § 526(a))

116. Petitioners reallege and incorporate by reference each and every allegation contained in the above paragraphs as though fully set forth herein.

117. Respondents have expended public funds in the promulgation and implementation of the unlawful policies and practice alleged in this petition and complaint.

118. Petitioners have paid a tax within and to the State of California within one year before commencement of this action.

119. Unless and until enjoined by this court, respondents' unlawful conduct will cause great and irreparable injury to petitioners in that respondents will continue to make illegal expenditures.

REQUEST FOR RELIEF

WHEREFORE, petitioners request the following relief:

1. A stay under C.C.P. § 1094.5(g) for petitioner Jane H. to maintain her existing eligibility for Medi-Cal fee-for-service during the pendency of her appeal of the final hearing decision.

2. An administrative writ vacating the Director's Final Decision in petitioner Jane H.'s case and an order compelling DHCS and DHCS' current director, Jennifer Kent, to grant Jane H. a twelve-month exemption from managed care enrollment, or in the alternative, an order remanding Jane H.'s case for a new hearing conducted in accordance with applicable law and due process rights.

3. A peremptory writ of mandate prohibiting respondents from:

(a) Alternating medical exemption request hearing decisions without presenting evidence to support the alternated decision, reviewing the transcript of the hearing, stating the reason(s) for alternating the decision;

and;

(b) Alternating medical exemption request hearing decisions based on facts not in the record.

(c) Alternating medical exemption request hearing decisions based on criteria other than those set forth in 22 C.C.R. § 53887; and

(d) Alternating medical exemption request hearing decisions based on proposed, but not adopted, amendments to 22 C.C.R. § 53887.

4. Issue a temporary restraining order and preliminary and permanent injunction prohibiting respondents from:

(a) Alternating medical exemption request hearing decisions without presenting evidence to support the alternated decision, reviewing the transcript of the hearing, stating the reason(s) for alternating the decision;

(b) Alternating medical exemption request hearing decisions based on criteria other than that set forth in 22 C.C.R. § 53887;

(c) Alternating medical exemption request hearing decisions based on facts not in the record; and

(d) Alternating medical exemption request hearing decisions based on proposed, but not adopted, amendments to 22 C.C.R. § 53887.

5. Declare that the following actions by respondents violate state law and regulation:

(a) Alternating medical exemption request hearing decisions without presenting evidence to support the alternated decision, reviewing the transcript of the hearing, stating the reason(s) for alternating the decision;

(b) Alternating medical exemption request hearing decisions based on criteria other than that set forth in 22 C.C.R. § 53887;

(c) Alternating medical exemption request hearing decisions based on facts not in the record; and

(d) Alternating medical exemption request hearing decisions based on

proposed, but not adopted, amendments to 22 C.C.R. § 53887.

6. Reasonable costs of suit.

7. An award of attorneys' fees payable to petitioners' counsel.

8. Such other relief as this Court may deem just and proper.

Dated: August 7, 2017

Respectfully submitted,

By: ELLA HUSHAGEN for
NEIGHBORHOOD LEGAL SERVICES
OF LOS ANGELES COUNTY
WESTERN CENTER ON LAW &
POVERTY
Attorneys for Petitioners

VERIFICATION

I, Jane H, declare:

I am a petitioner in this action. I have read the foregoing Petition for Writ of Mandate and know the contents to be true, except as to those matters that are alleged on information and belief, and as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the State of California that the same is true of my knowledge.

Executed at San Dimas, California this 27th day of July, 2017.

Jane H

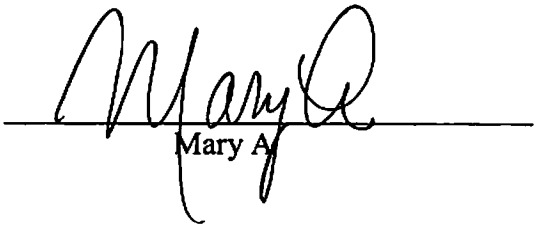
VERIFICATION

I, Mary A, declare:

I am a petitioner in this action. I have read the foregoing Petition for Writ of Mandate and know the contents to be true, except as to those matters that are alleged on information and belief, and as to those matters, I believe them to be true.

I declare under penalty of perjury under the laws of the State of California that the same is true of my knowledge.

Executed at Los Angeles, California this 27th day of July, 2017.



Mary A