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Superior Court Of California,
Sacramento
07/02/2014
amacias
By ______________, Deputy
Case Number:
34-2014-80001884

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

WESTSIDE CENTER FOR INDEPENDENT LIVING, a corporation; SOUTHERN CALIFORNIA REHABILITATION SERVICES, INC., a corporation; COMMUNITIES ACTIVELY LIVING INDEPENDENT & FREE, a corporation; BLANE BECKWITH; NANCY BECKER KENNEDY; MANUEL PUIG-LLANO, M.D. and LOS ANGELES COUNTY MEDICAL ASSOCIATION, a corporation, Petitioners, vs. CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES and TOBY DOUGLAS, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, Respondents.	CASE NO. **VERIFIED PETITION FOR A WRIT OF MANDATE (CODE OF CIVIL PROCEDURE § 1085)**

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INTRODUCTION

1. By this lawsuit, Petitioners WESTSIDE CENTER FOR INDEPENDENT LIVING, SOUTHERN CALIFORNIA REHABILITATION SERVICES, INC., COMMUNITIES ACTIVELY LIVING INDEPENDENT & FREE, BLANE BECKWITH; NANCY BECKER KENNEDY; MANUEL PUIG-LLANO, M.D. and LOS ANGELES COUNTY MEDICAL ASSOCIATION sue on behalf of themselves, their clients, their members and patients, and on behalf of the public to procure performance of public duties, without which harm will befall many of California's most vulnerable residents. Respondents CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES and TOBY DOUGLAS, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES are embarking on a "[h]uge [e]xperiment. . . to [s]ave on [c]are for [its p]oorest, [s]ickest [p]atients," as described by the Kaiser Health News website in December 2012.[1] The residents in question are commonly known as "dual-eligible beneficiaries," who are enrolled in both the Medicare and Medicaid programs. Individuals become eligible for both programs by being both: (1) elderly or disabled individuals and (2) of limited financial means.

2. This controversial "experiment" is the Coordinated Care Initiative ("CCI"), whicb would force many of California's poorest and sickest patients in eight counties to receive their healthcare benefits through managed care plans. This program has caused vast confusion among these patients. At the same time, regulators have discovered that various plans approved to participate in the program have had inadequate networks, or received low quality scores or failed to meet financial solvency requirements. Yet - Respondents have insisted on implementing the CCI – even in the absence of statutory authority to do so.

3. Respondents continue to implement the CCI in a manner that violates the unambiguous commands of state statutes that create a right of dual-eligible individuals not to be

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[1] Mary Agnes Carey & Sarah Varney, Huge Experiment Aims to Save on Care for Poorest, Sickest Patients, Kaiser Health News (Dec. 5, 2012), http://www.kaiserhealthnews.org/stories/2012/december/06/medicare-medicaid-managed-care-
(footnote continued)

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involuntarily auto-enrolled into managed care plans for their Medicare benefits unless and until Respondents use notices and enrollment materials written at no more than a sixth-grade reading level that plainly state dual-eligible beneficiaries can elect to retain their traditional Medicare benefits so long as they return the notice form to indicate their choice. Instead of complying with these requirements, Respondents have adopted and implemented a *de facto* policy and practice which is without and in excess of their jurisdiction and authority and contrary to the state statutory requirements, by using materials written well above a sixth-grade reading level that deceptively require a dual-eligible beneficiary to make an election under a non-Medicare program in order to retain their traditional Medicare benefits. These actions by Respondents, without and in excess of jurisdiction, place a void precondition upon the unconditional statutory right of dual-eligible individuals to opt out of the CCI for their Medicare services.

4. Not surprisingly, an incidental effect of these failures to perform mandatory, non-discretionary duties imposed by statutes has been widespread confusion, threatening the continuity of health care for many dual-eligible beneficiaries who suddenly might find or actually do find themselves "passively" enrolled in a combined Medicare and Medicaid managed care plan, and unable to see their preferred physician or other health care provider.

5. Relief in mandamus is authorized by Code of Civil Procedure section 1085 in order to compel the performance of statutory duties, which are not discretionary in nature, such as those at issue here.

6. Petitioners each sue on their own behalf, on behalf of their clients, patients and members, and on behalf of dual-eligible beneficiaries in the eight affected counties in California and on behalf of the public to procure the performance of a public duty by Respondents.

JURISDICTION AND VENUE

7. This court has jurisdiction under California Constitution, article VI, section 10 and Code of Civil Procedure section 1085.

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8. Venue is proper in the Superior Court for the County of Sacramento. (Code Civ. Proc., § 401.)

PARTIES

9. Petitioners WESTSIDE CENTER FOR INDEPENDENT LIVING; SOUTHERN CALIFORNIA REHABILITATION SERVICES, INC.; and COMMUNITIES ACTIVELY LIVING INDEPENDENT & FREE (collectively, the "ILCs") are duly organized and existing nonprofit California corporations that were incorporated pursuant to the General Nonprofit Law of the State of California, each with its principal office and place of business in the County of Los Angeles, California. Each of the ILCs is established under the California Rehabilitation Act (Welf. & Inst. Code, § 19800 et seq.), which requires them to advocate on behalf of, and to provide services to, persons with disabilities to enable them to achieve independence, including equal access to society and all activities of society. The ILCs annually serve over 12,000 persons with disabilities in Los Angeles County, approximately one-sixth of whom are dual-eligible beneficiaries.

10. Petitioner BLANE BECKWITH is a paraplegic who is a dual-eligible beneficiary. He is a resident of the County of Alameda, California, and has within the past 12 months paid taxes to the State of California, namely, sales taxes of which the State receives a portion. He is subject to and has an interest in the CCI at issue in this case. He also has standing as a state taxpayer under Code of Civil Procedure section 526a to prevent waste of state public funds expended without and in excess of jurisdiction, contrary to the laws at issue in this case.

11. Petitioner NANCY BECKER KENNEDY is a dual-eligible beneficiary. She is a resident of the County of Los Angeles, California, and has within the past 12 months paid taxes to the State of California, namely, sales taxes of which the State receives a portion. She is subject to and has an interest in the CCI at issue in this case. She also has standing as a state taxpayer under Code of Civil Procedure section 526a to prevent waste of state public funds expended without and in excess of jurisdiction, contrary to the laws at issue in this case.

12. Petitioner MANUEL PUIG-LLANO, M.D. is a medical doctor specializing in ophthalmology. He has been licensed to practice medicine in the state of California since 1983,

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and has had his own practice for approximately twenty-five years. His office is located at 276 Church Ave, Chula Vista, CA, 91910. He serves approximately 3,000 dual-eligible beneficiaries as patients, a vast majority of whom are Spanish-speaking immigrants. His patients are subject to and have an interest in the CCI at issue in this case. As a medical doctor, he has standing to sue to raise the interests of his patients. *See Ballard v. Anderson* (1971) 4 Cal.3d 873, 877. He also has standing as a state taxpayer under Code of Civil Procedure section 526a to prevent waste of state public funds expended without and in excess of jurisdiction, contrary to the laws at issue in this case.

13. Petitioner LOS ANGELES COUNTY MEDICAL ASSOCIATION ("LACMA") is an organization of dedicated physicians who advocate quality healthcare for all patients and serve the professional needs of its members. The protection of these interests is germane to LACMA's purpose. LACMA is bringing this action on its own behalf and as the "representative" of its member physicians. The individual participation of LACMA's members is not required for the claims asserted or the relief requested. Since its founding in 1871, LACMA has set standards of professional excellence that, even to this day, define what it means to practice medicine in Los Angeles County. LACMA is organized as a not-for-profit organization under Section 501(c)(6) of the Internal Revenue Code. Its principal office is in the County of Los Angeles, California.

14. Respondent CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES ("DHCS") is, and at all times mentioned herein was, a California governmental agency. DHCS is the single state agency charged with administering California's Medicaid program, known as Medi-Cal. (See Welf. & Inst. Code, §§ 14000 et seq.) DHCS is located in the County of Sacramento, California.

15. Respondent TOBY DOUGLAS (the "Director") is, and at all times mentioned herein was, the Director of DHCS. The Director's office is located in the County of Sacramento, California. The Director is sued in his official capacity only.

FACTUAL AND STATUTORY BACKGROUND

DUAL-ELIGIBLE BENEFICIARIES GENERALLY

16. Dual-eligible beneficiaries represent a highly vulnerable subgroup of Medicare and

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Medicaid beneficiaries. As DHCS itself has noted, dual-eligible beneficiaries are the "most chronically ill patients within both Medicare and Medicaid, requiring a complex array of services from multiple providers." (Cal. Dept. of Health Care Services, Dual-eligible Service Integration Projects Fact Sheet (May 2010), p. 1.) The Medicare Payment Advisory Commission ("MedPAC"), wbicb is an independent congressional agency established to advise Congress on issues affecting the Medicare program, similarly reports that dual-eligible beneficiaries "are more likely to have characteristics that make them more vulnerable—such as fewer resources and poorer health—than nondual-eligibles." (Medicare Payment Advisory Com., Report to the Congress: New Approaches in Medicare (June 2004), p. 75.)

17. Furthermore, dual-eligible beneficiaries are statistically older and more often disabled, as compared to the rest of the Medicare population: "More than one-third of dual-eligibles are eligible for Medicare because they are disabled, and 14 percent are age 85 or older. In fact, dual-eligibles are three times more likely to be disabled than the nondual-eligible population." (*Ibid.*) In addition, "[d]ual eligibles are also more likely to have greater limitations in activities of daily living (ADLs)—e.g., bathing and dressing—than nondual-eligibles." (*Ibid.*) DHCS also reports that dual-eligible beneficiaries are "more likely than otber non-dual-eligible Medicare beneficiaries to reside in an institutional setting." (Cal. Dept. of Health Care Services, Medi-Cal's Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden (Nov. 2012), p. 29.)

18. Importantly, the vulnerability of dual-eligible beneficiaries impacts every step of the health care delivery process, including the enrollment process and the ability to understand and compare plan documents. In discussing the enrollment transition for dual-eligible beneficiaries in state demonstration projects, MedPAC specifically warned that it "may be difficult for some dual-eligible beneficiaries to be informed about their choices, particularly those who are cognitively impaired and may need help to understand their choices." (Medicare Payment Advisory Com., Report to the Congress: Medicare and the Health Care Delivery System (June 2012), p. 89.) DHCS has highlighted the high incidence of cognitive impairment and mental health problems among dual-eligible beneficiaries, explaining that "[o]ver 40% of the dual-eligible population

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suffers from a cognitive or mental impairment, while only 9% of the non-dual-eligible Medicare population suffers from such mental health problems." (Cal. Dept. of Health Care Services, Medi-Cal's Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden (Nov. 2012), p. 29.) Other researchers have estimated a higher incidence of cognitive impairments among dual-eligible beneficiaries. (See, e.g., Randall Brown & David R. Mann, Kaiser Fam. Foundation, Best Bets for Reducing Medicare Costs for Dual-eligible Beneficiaries: Assessing the Evidence (Oct. 2012), p. 5 [reporting that "[n]early 60 percent of all dual-eligible beneficiaries have a mental or cognitive problem"].) In light of these issues, some researchers have recommended targeted dissemination of information through multiple venues and in multiple formats to effectively communicate the full range of options to consumers and to minimize disruptions in care for this population. (See, e.g., Kathryn G. Kietzman, et al., UCLA Center for Health Policy Research Policy Note, Disconnected?: Challenges of Communicating Cal MediConnect to Low-Income Older Californians (Jan. 2014), p. 6.)

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BACKGROUND OF THE COORDINATED CARE INITIATIVE

19. Medi-Cal is the name given California's Medicaid program. Medicaid is the joint federal and state health care insurance program for the poor. The Respondents implement the Medi-Cal program with federal financial assistance from the Centers for Medicare and Medicaid Services ("CMS").

20. Medicare is the health insurance program for the aged and disabled. The federal CMS operates the Medicare program. Historically, the Respondents have had no involvement in the implementation of the Medicare program. As such, prior to the development of the CCI, the Legislature had never previously granted the Respondents any authority to implement any portion of the Medicare program on behalf of CMS.

SENATE BILL 1008

21. In 2012, the Legislature enacted Senate Bill 1008 ("SB 1008"), which empowered the State (through DHCS) to enter into a Memorandum of Understanding ("MOU") to implement the Coordinated Care Initiative ("CCI"). The legislation was passed by the Legislature and was signed into law by the Governor on June 27, 2012 (Stats. 2012, ch. 33).

22. The passage of SB 1008 granted to Respondents the authority to implement the CCI based on a proposal that the Respondents had submitted to CMS on May 31, 2012. California had sought approval for a three-year demonstration for the State of California to provide both Medicare and Medi-Cal benefits through the State's existing network of Medi-Cal health plans in eight counties. These included four counties (Los Angeles, Orange, San Diego, and San Mateo) that had already been selected under then-current legislation adopted through Senate Bill 208 (Stats. 2010, ch. 74) at Welfare & Institutions Code section 14132.275, as well as four additional counties to be determined later. In addition, the California proposal included the element that the combined Medicare and Med-Cal savings from this demonstration would be shared equally between the State and Federal Governments. (The Department of Health Care Services's Proposal to the Center for Medicare and Medicaid Innovation, Coordinated Care Initiative: State Demonstration to Integrate Care for Dual-eligible Beneficiaries (May 31, 2012), p. 33.)

23. SB 1008 authorized the implementation of CCI in the four original counties, along with the counties of Alameda, Riverside, San Bernardino, and Santa Clara. The central elements of the CCI were set forth in the following sections of the Welfare and Institutions ("W & I") Code: (1) section 14132.275, which amended the previous version contained in SB 208 and empowered DHCS to enter into an MOU with CMS for the CCI; (2) section 14182.16, which established mandatory Medi-Cal managed care for dual-eligible beneficiaries in the specified CCI counties; (3) section 14182.17, which defined the assignment process for enrollment of dual-eligible beneficiaries into a CCI managed care plan (called "Cal MediConnect Plans"), their rights associated therewith, the obligations of the State as to the enrollment process, and the CCI as a whole; and (4) sections 14186 through 14186.4, which covered the integration of LTSS under Medi-Cal.

24. Also contained in SB 1008 at Section 10 was the following provision in uncodified language:

> SEC. 10. (a) In the event [DHCS] has not received, by February 1, 2013, federal approval, or notification indicating pending approval, of a mutual ratesetting process, shared federal savings, and a six-month enrollment period in the demonstration project pursuant to paragraph (2) of subdivision (*l*) of Section 14132.275, effective

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March 1, 2013, Sections 14132.275, 14182.16 and 14182.17, and Article 5.7 (commencing with Section 14186) of Chapter 7 shall become inoperative. The director [of DHCS] shall execute a declaration of these facts and post it on [DHCS's] Internet Web site.

(b) For purposes of this section, "shared federal savings" means a methodology that meets the conditions of paragraphs (1) and (2) or paragraph (3).

(1) The state and CMS share in the combined savings for Medicare and Medi-Cal, as estimated in the Budget Act of 2012 for the 2012-13, 2013-14, 2014-15, and 2015-16 fiscal years.

(2) Federal approval for the provisions of paragraph (2) and (3) of subdivision (*l*) of Section 14132.275 regarding the requirement that, upon enrollment in a demonstration site, specified beneficiaries shall remained enrolled on a mandatory basis for six months from the date of initial enrollment.

(3) An alternate methodology that, in the determination of the Director of Finance, in consultation with the Director of Health Care Services, and the Joint Legislative Budget Committee, will result in the same level of ongoing savings, as estimated in the Budget Act of 2012 for the 2012-13, 2013-14, 2014-15, and 2015-16 fiscal years.

(Emphasis added.)

TRIGGERING OF SECTION 10

25. Based on the provisions of Section 10, the required federal approval or notice of pending approval of the CCI from CMS by February 1, 2013, was required to include: (1) a mutual ratesetting process for the capitation payments, (2) the State's sharing of federal savings, and (3) a six-month mandatory enrollment for dual-eligible beneficiaries that did not initially "opt out" of the Medicare portion of the CCI. Moreover, this approval or pending approval was required to be effective on March 1, 2013. If any of these conditions were not met, the referenced provisions contained in SB 1008 (i.e., W & I Code sections 14132.275, 14182.16, 14182.17, and 14186-14186.4) would "become inoperative."

26. As of February 1, 2013, CMS had not approved or provided pending approval of the CCI or any of the three conditions specified in Section 10. Instead, on that date, CMS sent a letter to DHCS stating that:

> For the previous 18 months, [CMS] and [DHCS] have worked in partnership to develop the Demonstration to Integrate Care for Dual-eligible Individuals (Demonstration) based on our shared vision of

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creating an integrated system of care that will improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and reduce costs for both the state and the federal government.

We have made significant progress and continue to work with the State toward finalizing the Memorandum of Understanding (MOU) that will outline the principles under which CMS and DHCS will implement and operate the Demonstration. The final agreement will be contingent upon resolving outstanding policy considerations, including those related to Demonstration financing, rate-setting, and additional benefits.

We appreciate that DHCS has done a significant amount of work already to ensure that all parties involved in the Demonstration, including beneficiaries, providers, and the health plans, have timely, actionable information.

Assuming the remaining policy considerations can be resolved, we look forward to finalizing the MOU in the near term and continuing to work in partnership toward a successful implementation beginning in September 2013.

(Letter from Melanie Bella, Center for Medicare & Medicaid Services, to Toby Douglas, Department of Health Care Services, dated February 1, 2013.) (Emphasis added.)

27. Though not set forth in the CMS letter, by February 1, 2013, CMS had already informed DHCS that CMS would not share federal savings with California or permit a six-month enrollment period (i.e., "stable enrollment"), both of which were required by Section 10. As a result, even before February 1, 2013, the requirements of Section 10 were already incapable of being met.

THE ILLEGAL MEMORANDUM OF UNDERSTANDING

28. Notwithstanding the inoperative nature of SB 1008, on March 27, 2013, the Director of DHCS entered into the MOU with CMS to implement the CCI. In doing so, the Director acted contrary to the specific provisions of Section 10 and acted without and in excess of jurisdiction and authority. Moreover, although executed more than 50 days after the statutory authority expired, the MOU did not include either the ability of the State to share in federal savings or contain the six-month mandatory enrollment, as specified in Section 10 of SB 1008. (Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of California Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees: California Demonstration to

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Integrate Care for Dual-eligible Beneficiaries, dated March 27, 2013.)

29. Despite executing the MOU without and in excess of jurisdiction to do so, DHCS developed legislation to repeal Section 10 of SB 1008, as well as to amend W & I Code sections 14132.275, 14182.16, 14182.17, and 14186-14186.3. Senate Bill 94 ("SB 94"), which was passed by the Legislature and signed by the Governor on June 27, 2013. (Stats. 2013, ch. 37.) The attempted repeal of Section 10 (at Section 30 of SB 94) was ineffective and has no force and effect as SB 1008 had already become inoperative under its provisions.

30. Notwithstanding the absence of authority to enter into the MOU and implement the CCI, DHCS subsequently executed three-way contracts with CMS and the participating health plans and proceeded to implement the program in the eight covered counties. Because DHCS without and in excess of its jurisdiction and authority to implement the CCI, a writ should issue to vacate its present policies and practices to implement the CCI and to refrain from implementing the CCI in whole or in any part.

THE CCI PROGRAM

31. The structure of the CCI as set forth in the MOU allowed the participating health plans to be responsible for delivering a full continuum of all current Medicare and Medi-Cal services, including medical care, behavioral health services, and long-term services and supports ("LTSS") to duals. (MOU, p. 1.) LTSS includes home- and community-based services, such as in-home supportive services, community-based health services, multipurpose senior services, and nursing facility services. (*Id.*, p. 30.) In return for these services, the plans would receive capitation payments from CMS (for Medicare) and the State (for Medi-Cal) using a ratesetting methodology based on baseline spending in both programs and anticipated savings that would result from the integration of services and improved care management. (*Id.*, pp. 43-45.)

32. The MOU also mandated that all Medi-Cal health care benefits of the dual-eligible beneficiaries be provided exclusively through participating health plans. (*See* MOU, p. 1.) However, the Legislature specifically dictated that no dual-eligible beneficiary could be forced into any Cal MediConnect Plan for their Medicare services. The Legislature required that they be given a choice. As a result, these individuals are required to be given the option to "opt out" of the

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Medicare portion of the CCI.

33. The CCI establishes "active" and involuntary auto-enrollment, referred to by Respondents as "passive" enrollment, of dual-eligible beneficiaries into Cal MediConnect Plans that would take over the administration of virtually all of their Medicare and Medi-Cal benefits. (MOU, p. 11.) "Active" enrollment would occur through dual-eligible beneficiaries voluntarily choosing to have their Medicare benefits administered along with their Medi-Cal benefits by a particular health plan. "Passive" enrollment would occur, under W & I Code section 14182.17(d)(1)(H) for any dual-eligible beneficiary who either did not return the notice of choice form (to be received by the individual at least 60 days before passive auto enrollment) or who did not affirmatively choose to have their Medicare benefits administered by a Cal MediConnect Plan. However, CMS ultimately rejected the proposal by DHCS to require any dual-eligible beneficiary who is enrolled in the CCI to stay enrolled for at least six (6) months until they can exercise their rights to "opt out" of the Medicare portion of the CCI by permitting disenrollment on a month-to-month basis. (*Ibid.*)

THE NOTICES CONTRARY TO STATE LAW

34. In addition to acting without and in excess of jurisdiction and authority to implement the CCI, various problems have arisen in the implementation of the CCI. Even if the statutes were operative and DHCS had the authority to implement the CCI, which it did not, DHCS also violated and continues to violate several key statutory provisions designed by the Legislature to protect dual-eligible beneficiaries.

35. The Legislature enacted and DHCS commenced the implementation of the CCI with full knowledge of the fragility of the dual-eligible population that both increased the importance of ensuring that these beneficiaries were fully informed of the impending transition, while complicating how to ensure that these beneficiaries fully understood the changes the CCI posed to their healthcare delivery. For example, nearly half of this population suffers from a cognitive or mental impairment, which makes achieving comprehension not only more difficult, but prevents such duals, with mental and cognitive impairment, from being able to competently choose to opt out, or not opt out, of the CCI program for their Medicare services. Moreover,

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because of the complicated health status and institutionalized status of many of these beneficiaries, any lapse in care for these beneficiaries is more likely to lead to health problems than with other populations.

36. Accordingly, the Legislature enacted several important statutory rights for dual-eligible beneficiaries in enacting SB 1008 and SB 94, which include very specific requirements for notices to the dual-eligible beneficiaries impacted by this experiment, and how they may opt out of the CCI program for their Medicare services.

37. For example, W & I Code section 14182.17, subdivision (d)(1)(A) requires that before contracting with managed care health plans, DHCS must "[a]t least 90 days prior to enrollment, inform dual-eligible beneficiaries through a notice written at not more than a sixth-grade reading level that includes, at a minimum": (1) "how the Medi-Cal system of care will change," (2) "when the changes will occur," and (3) "who they can contact for assistance with choosing a managed care health plan or with problems they encounter."

38. DHCS violated at least two nondiscretionary duties imposed by section 14182.17, subdivision (d)(1)(A), if it is operative. First, the 90-Day Notice prepared by DHCS is written above a sixth-grade reading level. Second, the 90-Day Notice prepared by DHCS does not advise dual-eligible beneficiaries "when the changes will occur" to the Medi-Cal system. Instead, the 90-Day Notice merely advises dual-eligible beneficiaries that they will receive additional information "soon." (A true and correct copy of the 90-Day Notice is attached as Exhibit 1 hereto.)

39. Moreover, W & I Code section 14182.17, subdivision (d)(1)(H)(ii) requires that before contracting with managed care health plans and before implementing enrollment of dual-eligible beneficiaries, DHCS must ensure that its enrollment materials are "in a not more than sixth grade reading level . . . ." DHCS violated this nondiscretionary duty because the enrollment materials prepared by DHCS are written above a sixth-grade reading level.

40. W & I Code section 14182.17, subdivision (d)(1)(H)(iii) requires that before contracting with managed care health plans and before implementing enrollment of dual-eligible beneficiaries, DHCS must ensure that its enrollment materials "plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate

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this choice, and that if the beneficiary does not return the form, the state shall assign the beneficiary to a plan and all Medicare and Medi-Cal benefits shall only be available through that plan."

41. Assuming the operative nature of the statute, Respondents violated this nondiscretionary duty because the enrollment materials prepared by Respondents do not state, either plainly, in suhstance, or at all that the dual-eligible beneficiary may choose fee-for-service Medicare or Medicare Advantage but must return a form to do so. Instead, the enrollment materials prepared by Respondents violate this unconditional statutory right of dual-eligible individuals under W &I Code section 14182.17(d)(1)(H)(iii) by placing a restriction or pre-condition upon the exercise of that right by stating that in order to remain in fee-for-service Medicare or Medicare Advantage, the dual-eligible beneficiary must select a Medi-Cal health plan.

42. In other words, there is no clear and plain mechanism by which a dual-eligible heneficiary can communicate directly his or her decision to remain in fee-for-service Medicare or Medicare Advantage. Instead, a dual-eligible beneficiary must make a selection completely unrelated to Medicare in order to be deemed to have chosen to remain in fee-for-service Medicare or Medicare Advantage. If a dual-eligible beneficiary fails to do so, he or she will automatically be enrolled in a so-called "Cal MediConnect plan" administering both Medicare and Medi-Cal henefits. This violates the "plain statement" requirement of W & I Code section 14182.17.

43. For example, the Cal MediConnect Plan Choice Book prepared by DHCS advises dual-eligible beneficiaries that they have three choices listed in bold type. (Cal MediConnect Plan Choice Book, p. 5.) Under the heading of the first choice named "**Cal MediConnect Plans,**" the document contains a lengthy paragraph describing the supposed benefits of joining a Cal MediConnect plan. (*Ibid.*) The document then states: "You can choose to stay in regular Medicare. If you choose to stay in regular Medicare, you will still need to choose a Medi-Cal plan." (*Ibid.*) In other words, ratber than listing "Stay in Medicare" as its own option as required by W & I Code section 14182.17, subdivision (d)(1)(H)(iii), if operative, the document deceptively places this important warning under an unrelated heading after unrelated text, and then

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requires beneficiaries to make a non-Medicare selection in order to retain their existing Medicare coverage.

44. Furthermore, the Health Plan Choice Form, which is contained within the Cal MediConnect Plan Choice Book, is also confusing, in violation of the plain statement requirement of W & I Code section 14182.17, because it provides no check box by which a dual-eligible beneficiary can clearly communicate his or her decision to remain in fee-for-service Medicare or Medicare Advantage. These processes are in violation of the requirement of W & I Code section 14182.17(d)(1)(H)(iii). Instead, the Health Plan Choice Form lists certain Medi-Cal plans without advising the beneficiary that one of these Medi-Cal boxes must be checked in order for the beneficiary to remain in fee-for-service Medicare or Medicare Advantage. Only if one reads the Health Plan Choice Form Instructions does one see, under the bold heading "**Pick a Medi-Cal plan for your Medi-Cal Services,**" the important proviso: "To pick a Medi-Cal plan and keep your Medicare, fill in the circle (O) to the left of the Medi-Cal plan you want." (Cal MediConnect Plan Choice Book, p. 7 [emphasis added].)

45. The 60-Day Notice prepared by DHCS also suffers from a similar defect of violating the substantive requirements of W & I Code section 14182.17 that the materials must plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage and that they must return the form to indicate their choice. It advises dual-eligible beneficiaries that they have three choices in bold type: (1) "**Enrolling in a Cal MediConnect plan,**" (2) "**Enrolling in the Program of All-inclusive Care for the Elderly (PACE),**" and (3) "**Enrolling in a Medi-Cal health plan.**" (60-Day Notice, p. 2.) Deceptively placed within the third option is the following statement: "If you choose to stay with regular Medicare, you will not be reassigned to a Cal MediConnect Plan, but you must still choose a health plan in order to receive Medi-Cal." (*Ibid.*) (A true and correct copy of the 60-Day Notice is attached as Exhibit 2 hereto.)

CMS'S KEY FINDINGS REPORT

46. On or about June 11, 2014, CMS issued a document entitled "Key Findings from California Duals Demonstration Testing" (the "Key Findings Report"). The Key Findings Report described the results of a study performed by CMS in May 2014, in and around Los Angeles

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County. (Key Findings Report, p. 1.) CMS's study sought to test the "comprehensibility and usability of [DHCS] materials for dual-eligible beneficiaries who will be passively enrolled into Cal MediConnect Plans . . ." as part of the CCI. (*Ibid.*) Participants in the study were dual-eligible beneficiaries currently enrolled in traditional Medicare. (*Ibid.*)

47. The Key Findings Report corroborates many of the violations of W & I Code section 14182.17(d)(1)(H) described above with respect to the 90-Day Notice, 30-Day Notice, and Choice Book. For example, the report found that "[a]fter reviewing the notice letters, many [dual-eligible beneficiaries] did not understand that they would be automatically enrolled in the pre-selected Cal MediConnect plan if they do not take any action, believing that inaction would result in continuing to receive benefits as they currently receive them. Without a clear call to action, beneficiaries may overlook the notices entirely." (Key Findings Report, p. 1.) Furthermore, "few participants were aware of or looked at the instructions for completing the [Choice] Form." (*Id.*, p. 2.)

VIOLATION OF DUE PROCESS UNDER THE CALIFORNIA CONSTITUTION

48. W & I Code section 14182.17(d)(1)(H)(iii) violates the California Due Process rights (California Constitution, article 1, section 7) of the 40-50% of duals eligible beneficiaries who have mental or cognitive impairment.

49. These highly compromised and vulnerable individuals manifestly do not have the mental or cognitive ability to understand and make an intelligent, fully free choice to opt out of, or, choose a Cal MediConnect Plan to control their Medicare services (if they did understand their choices) nor the mental or cognitive ability by which to comprehend the 90-day, 60-day and 30-day notices or the Choice Book or Choice Forms.

50. It is in violation of state Due Process guaranteed by the California Constitution to auto-enroll (1) mentally or cognitively impaired individuals (who comprise up to or more than 50% of the dual-eligible population) and (2) homeless or other duals whose notices are returned undelivered, into Cal MediConnect Health Plans for their Medicare services. Respondents are auto-enrolling these compromised individuals on the false fiction that they received the notices and choice forms, understood them and exercised free choice not to opt out of the CCI for

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Medicare services. For those that did not even receive the notices or choice forms, they could not have been informed of their rights and were deprived of their state statutory right of free choice to opt out of the CCI for Medicare services, which was granted to them by W & Code section 14182.17(d)(1)(H).

51. The Legislature recognized and determined the significant impairment of this population. In 2006, the Senate Floor Analysis found and determined, in a report to all state Senators concerning an upcoming vote concerning dual-eligible individuals, that dual-eligible individuals:

> . . . have higher rates of Alzheimer's disease . . . than other Medicare beneficiaries. Nearly four in ten [40 percent] have a mental or cognitive impairment, meaning that 400,000 California dual-eligibles may not be able to navigate complicated program changes even if education and communication efforts are appropriate for an elderly population.[2]

52. Because SB 94 lacks a severability clause, the judgment which voids auto-enrolment of thousands of dual-eligible individuals with mental or cognitive impairment or those that are homeless whose notices are returned undelivered for violation of state Due Process, voids the entire statute and the CCI program.

FIRST CAUSE OF ACTION

PETITION FOR WRIT OF MANDATE

(Writ of Mandate Against Respondents)

(Violation of SB 1008, Section 10)

53. The allegations set forth in paragraphs 1 through 52 *supra*, are incorporated herein by reference.

54. Notwithstanding the absence of authority to enter into the MOU and implement the

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[2] Senate Floor Analysis, February 6, 2006, of Senate Bill 1233.

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CCI, DHCS subsequently executed a three-way contracts with CMS and the participating health plans and proceeded to implement the program in the eight covered counties. Because Respondents are without and in excess of their jurisdiction and authority to implement the CCI, a writ should issue to vacate their present policies and practices to implement the CCI and to refrain from implementing the CCI in whole or in any part; with interim relief pending the final determination of this proceeding.

55. Petitioners have no administrative relief and no plaint, adequate, or speedy relief other than a writ of mandamus.

56. No other adequate remedies exist under statute, regulation, or other provision of law.

57. WHEREFORE, Petitioners pray for judgment and orders as shall be hereinafter specified.

SECOND CAUSE OF ACTION

(Writ of Mandate Against Respondents)

(Violations of Welfare & Institutions Code section 14182.17(d)(1))

58. The allegations set forth in paragraphs 1 through 52, *supra*, are incorporated herein by reference.

59. By the facts prior alleged, the Respondents are engaging in *ultra vires* policy and practice, without and in excess of jurisdiction, contrary to W & I Code section 14182.17, subdivisions (d)(1)(A) and (d)(1)(H)(i)-(iv), by contracting with health plans to provide Medicare and Medicaid services, and by auto-enrolling dual-eligible beneficiaries into CCI plans, without first publicly posting or delivering to dual-eligible beneficiaries enrollment or notice forms at least 60 days before auto-enrollment commences, which plainly state, in nor more than a sixth grade reading level, that that beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate this choice; and also without furnishing other notices to dual-eligible beneficiaries; all contrary to W & I Code section 14182.17(d)(1)(H)(i)-(iv).

60. By such facts, Petitioners are entitled to a writ of mandate, with interim relief

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pending final determination of this proceeding, which commands Respondents to vacate and cease the foregoing *ultra vires* policies, practices and actions identified in this Second Cause of Action; and instead, by appropriate provisions, commands the Respondents to comply with the foregoing provisions of W & I Code section 14182.17(d)(1)(H)(i)-(iv).

61. Petitioners have no administrative relief and no plain, adequate or speedy relief other than a writ of mandamus.

62. WHEREFORE, Petitioners pray for judgment and orders as shall be hereinafter specified.

THIRD CAUSE OF ACTION

(Writ of Mandate Against Respondents)

(Violation of W & I Code, section 14182.17, subdivision (d)(1)(H)(iii).)

63. The allegations set forth in paragraphs 1 through 55 supra, are incorporated herein by reference.

64. By the facts prior alleged, W & I Code section 14182.17, subdivision (d)(1)(H)(iii), enacts and creates both (1) a state statutory right in dual-eligible beneficiaries to opt out of the CCI program for all Medicare services, and (2) a state statutory right to indicate, exercise, and effectuate such opt out right, namely, by simply returning a form -- which the statute requires Respondents to furnish, -- to DHCS, without more, (herein, collectively, the "opt out right").

65. However, notwithstanding that the opt out right is unconditional in character, the Respondents are nevertheless engaging in an *ultra vires* policy and practice, without and in excess of jurisdiction, contrary to W & I Code section 14182.17, subdivision (d)(1)(H)(iii), to violate and disregard the unconditional opt out right, by not furnishing any form for dual-eligible beneficiaries to simply return, without more, to indicate, exercise, and effectuate this opt out right.

66. Instead, without and in excess of jurisdiction, contrary to subdivision (d)(1)(H)(iii), the respondents are unlawfully imposing an additional act and condition upon the exercise of the opt out right, by requiring dual-eligible beneficiaries to check a box on a form to pick a Medi-Cal plan for their Medi-Cal services, and return the form, as the sole means, in the enrollment materials, by which to indicate and exercise the opt out right; -- which imposition of such non-

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1 statutory condition upon the unconditional statutory opt out right, is a continuing ultra vires
2 violation of the unconditional opt out right, created by the Legislature, in favor of dual-eligible
3 beneficiaries.

4 67. Therein the petitioners are entitled to a writ of mandate, with interim relief pending
5 final determination of this proceeding, which commands Respondents to vacate and cease
6 imposing this ultra vires pre-condition upon the unconditional statutory right of dual-eligible
7 beneficiaries to opt out of the CCI for their Medicare services.

8 68. Petitioners have no administrative relief and no plain, adequate, or speedy relief
9 other than a writ of mandamus.

10 69. WHEREFORE, the petitioner pray for judgment and orders as shall be hereinafter
11 specified.

12 **FOURTH CAUSE OF ACTION**

13 (Writ of Mandate Against Respondents)

14 (Violation of Due Process under the California Constitution)

15 70. The allegations set forth in paragraphs 1 through 52 *supra*, are incorporated herein
16 by reference.

17 71. W & I Code section 14182.17(d)(1)(H)(iii) violates the California Due Process
18 rights (California Constitution, article 1, section 7) of the 40-50% of dual-eligible beneficiaries
19 who have mental or cognitive impairment.

20 72. It therefore shocks the conscience, and is contrary to the concept of ordered liberty,
21 in violation of state Due Process guaranteed by the California Constitution to auto-enroll (1)
22 mentally or cognitively impaired individuals (who comprise up to or more than 50% of the dual-
23 eligible population) and (2) homeless or other duals whose notices are returned undelivered, into
24 Cal MediConnect Health Plans for their Medicare services. Respondents are auto-enrolling these
25 compromised individuals on the false fiction that they received the notices and choice forms,
26 understood them and exercised free choice not to opt out of the CCI for Medicare services. For
27 those that did not even receive the notices or choice forms, they could not have been informed of
28 their rights and were deprived of their state statutory right of free choice to opt out of the CCI for

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Medicare services, which was granted to them by W & Code section 14182.17(d)(1)(H).

73. Moreover, these beneficiaries are required to select a Medi-Cal plan in order to indicate their choice to avoid auto-enrollment for *Medicare*.

74. Because SB 94 lacks a severability clause, the judgment which voids auto-enrolment of thousands of dual-eligible individuals with mental or cognitive impairment or those that are homeless and the notices are returned undelivered for violation of state Due Process, voids the entire statute and the CCI program.

75. Petitioners have no administrative relief and no plain, adequate, or speedy relief other than a writ of mandamus.

PRAYER

WHEREFORE, Petitioners pray for judgment in their favor and against Respondents:

1. FIRST, that an alternative writ of mandamus, under Code of Civil Procedure section 1085, issue which commands Respondents, and their agents, servants, and employees, as follows:

a. Refrain from implementing the CCI (Senate Bill 1008, enacted on June 27, 2012 as Cal. Statutes 2012, chapter 33, as amended by Senate Bill 94, enacted on June 27, 2013 as Cal. Statutes 2013, chapter 37) in whole or in any part;

b. Refrain from auto-enrollment of dual-eligible beneficiaries into Cal MediConnect Health Plans for Medicare services in the counties of Los Angeles, San Diego, Riverside, San Bernardino, Alameda, Santa Clara, Orange and San Mateo.

c. Disenroll all dual-eligible beneficiaries from Cal MediConnect Health Plans for Medicare that have been enrolled since the commencement of the CCI in the counties of Los Angeles, San Diego, Riverside, San Bernardino, Alameda, Santa Clara, Orange and San Mateo.

d. Cease all passive enrollment of dual-eligible beneficiaries in the eight CCI counties into managed care plans.

all followed by a peremptory writ of mandamus so providing as above, after the return hearing.

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2. SECOND, that an alternative writ of mandamus, under Code of Civil Procedure section 1085, issue which commands that Respondents refrain from further implementing the CCI unless and until Respondents demonstrate, to this Court's satisfaction, compliance with all requirements imposed by the California Constitution, state law, including but not limited to the requirements imposed by W & I Code section 14182.17, subdivision (d)(1); followed by peremptory writ of mandamus after the return hearing.

3. THIRD, for a preliminary injunction issued against Respondents enjoining them from implementing of the CCI and all enrollment pending final determination of the mandate proceedings;

4. For attorneys' fees under Code of Civil Procedure section 1021.5 and costs of suit; and

5. For such other and further relief as the Court may deem just and proper.

DATED: July 2, 2014

HOOPER, LUNDY & BOOKMAN, P.C.

By: ______________________
MARK A. JOHNSON
Attorneys for Petitioners MANUEL PUIG-LLANO, M.D.

DATED: July 2, 2014

MEDICAID DEFENSE FUND

By: ______________________
LYNN S. CARMAN
Attorneys for Petitioners WESTSIDE CENTER FOR INDEPENDENT LIVING, a corporation; SOUTHERN CALIFORNIA REHABILITATION SERVICES, INC., a corporation; COMMUNITIES ACTIVELY LIVING INDEPENDENT & FREE, a corporation; NANCY BECKER KENNEDY and BLANE BECKWITH

DATED: July 2, 2014

LINER LLP

By: ______________________
ROCKARD J. DELGADILLO
Attorneys for Petitioners LOS ANGELES COUNTY MEDICAL ASSOCIATION

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EXHIBIT 1

Cal MediConnect
Your choice for complete care

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information

You are getting this letter because you have **BOTH** Medicare and Medi-Cal. The way you get your health care is changing. You will now have more choices to meet your health care needs.

What is a Cal MediConnect plan?

A Cal MediConnect plan is a Medicare/Medi-Cal plan that will manage your Medicare and Medi-Cal benefits. Enrolling in a Cal MediConnect plan means that you keep your Medicare and Medi-Cal benefits with no extra cost but you must use your Cal MediConnect providers. You can also get additional transportation and vision benefits.

What are my plan choices?

You will get more information about your health plan choices soon. You may choose a Cal MediConnect plan, or choose to stay with regular Medicare. If you choose to stay with regular Medicare, you must choose a Medi-Cal health plan for your Medi-Cal benefits. If you do not make a choice, we will choose one of the Cal MediConnect plans for you. You keep the benefits and services you have now, and the Cal MediConnect plan will work with your doctors and providers.

This is the first letter telling you about your new choices. You will get a second letter with more information about your choices soon. You may choose a Cal MediConnect plan in your county, or choose to stay with regular Medicare.

Your choices are:

1. **Enroll in a Cal MediConnect plan.** These health plans cover both Medicare and Medi-Cal services. If you join a Cal MediConnect plan you will receive In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care through the

Cal MediConnect plan. They also cover vision care and transportation. The Cal MediConnect plan will work with you, your doctors and providers to ensure you get the care you need.

2. **Enroll in the Program of All-Inclusive Care for the Elderly (PACE).** If you are 55 or older and need a higher level of care in order to live at home, you may be able to join PACE. PACE provides all Medicare and Medi-Cal benefits plus some extra services to help seniors who have chronic conditions live at home.
3. **Enroll in a Medi-Cal health plan only. Your Medicare will stay the way it is now.** If you join a Medi-Cal health plan you keep your Medicare doctors and hospitals, and you will receive your Medi-Cal benefits like In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care through the Medi-Cal health plan.

How does a Cal MediConnect plan help me?

A Cal MediConnect plan helps you because your Medicare and Medi-Cal benefits work together and work better for you.

Your doctors, pharmacists, IHSS, CBAS, MSSP, and other providers work together to care for you and coordinates who assists you in getting the care and services that you need. This is called "care coordination."

What should I do now?

- Talk about your choices with someone who knows about your health care needs, like your family, your doctors, or your local senior center and/or Independent Living Center.
- Watch your mail for a packet from Health Care Options in about one month.
- If you want to talk to a health insurance counselor about your choices, call the **California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222.**
- If you need this letter in another language or alternate format, like large print, audio, or Braille; or if you need help understanding this letter, please call:

Health Care Options
1-844-580-7272 • TTY: 1-800-430-7077
Monday - Friday, 8 am - 5 pm
www.HealthCareOptions.dhcs.ca.gov

EXHIBIT 2

CalMediConnect
Your choice for complete care

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information

You are getting this letter because you have BOTH Medicare and Medi-Cal. The way you get your health care is changing. You will now have more choices to meet your health care needs.

This is the second letter telling you about your new options. You may choose a Cal MediConnect plan, or choose to stay with regular Medicare. If you choose to stay with regular Medicare, you must choose a Medi-Cal health plan for your Medi-Cal benefits. If you do not make a choice, we will choose one of the Cal MediConnect plans for you.

Based upon your past services and health care needs, you have been assigned to the Cal MediConnect plan named below. Unless you choose to stay with regular Medicare, you do not need to do anything and your coverage in this plan will become effective on MM/DD/YYYY: [Health Plan Name]

How will this change affect me?

Enrolling in a Cal MediConnect plan will:

- Keep your Medicare or Medi-Cal benefits without any extra costs.
- Keep all of the services or benefits you receive now.
- Ensure that all of your doctors, specialists, and other providers will work together to get you the care you need.
- Give additional transportation and vision benefits.

How does a Cal MediConnect plan help me?

The change is happening so your Medicare and Medi-Cal benefits work better together and work better for you.

Your choices include:

1. **Enrolling in a Cal MediConnect plan.** Cal MediConnect plans cover both Medicare and Medi-Cal services. If you join a Cal MediConnect plan, you will receive In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care through the Cal MediConnect plan. They also cover vision care and transportation. The Cal MediConnect plan will work with your doctors and providers to ensure you get the care you need.

2. **Enrolling in the Program of All-inclusive Care for the Elderly (PACE).** If you are 55 or older and need a higher level of care in order to live at home, you may be able to join PACE. PACE provides all Medicare and Medi-Cal benefits plus some extra services to help seniors who have chronic conditions live at home.

3. **Enrolling in a Medi-Cal health plan.** If you choose to stay with regular Medicare, you will not be assigned to a Cal MediConnect plan, but you must still choose a health plan in order to receive Medi-Cal. Joining a Medi-Cal plan will allow you to keep your Medicare doctors and hospitals and you will not lose any services. You will receive In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing facility care through the plan.

What should I do now?

Review the three choices above and decide which is best for you. Use the Health Plan Guidebook and Choice Book that will come in the mail from Health Care Options to help you. Ask your doctors and other health care providers to see which plans they work with.

You do not need to do anything to join the Cal MediConnect plan below.

If you do not want to enroll in [Health Plan Name,]
you can contact Health Care Options to select a different Cal MediConnect plan or to stay in regular Medicare. Contact Health Care Options by

MM/DD/YYYY.

Call Health Care Options at the number below OR by filling out and mailing back the Choice Form with the enclosed envelope. This form is in your Choice Book that will come in the mail from Health Care Options.

For help or more information

If you want to talk to a health insurance counselor about these changes and your choices, call the **California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222.**

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

If you want to select a different Cal MediConnect plan, stay in regular Medicare, or get this letter in another language or alternate format – like large print, audio, or Braille, please call Health Care Options Monday-Friday 8am-5pm at 1-844-580-7272 or TTY: 1-800-430-7077.

If you need further help, call the **Cal MediConnect Ombudsman** at 1-855-501-3077. This number will be operational starting 4/1/2014.

Frequently Asked Questions and Answers

1. What is the difference between Medicare and Medi-Cal?

Medicare and Medi-Cal are two separate programs that cover different services for eligible Individuals. By joining a Cal MediConnect plan, your Medicare and Medi-Cal benefits work better together and work better for you.

- **Medicare** covers medical services like doctors, specialists, hospitals, and prescription drugs. Medicare also covers some medical equipment and home health.
- **Medi-Cal** covers any costs that Medicare doesn't pay for, including:
  a. Deductibles,
  b. IHSS, CBAS, MSSP, and nursing home care,
  c. Transportation to medical appointments,
  d. Medical equipment and supplies, like bandages or diapers.

2. What are the benefits of enrolling in a Cal MediConnect plan?

- You will get all of your Medicare and Medi-Cal benefits in one health plan, including doctors, hospitals, and prescription drugs.
- You will get one membership card and one phone number to call when you need help.
- You will get vision care and transportation to medical appointments.
- You can call a 24-hour nurse advice line for help.
- You can get a care coordinator. This person will answer your questions, help you find community services, assist you in making your medical appointments, and help you talk with your doctors.
- Your Cal MediConnect plan will ask you about your health care needs and work with you to create a personal care plan based on your goals.

3. How can I be sure my care continues after I join a Cal MediConnect plan?

Your new Cal MediConnect plan is required to ensure that you receive the quality care that you need. Your Cal MediConnect plan will contact you after you enroll to learn about your health care needs. They will work with you to make sure you get all the care you need.

If you have a scheduled treatment and are changing health plans, call your new Cal MediConnect plan right away. Tell the health plan about your upcoming treatment so they can work with you.

- **If you see a doctor who is not a part of the health plan's network,** you can keep seeing this doctor for up to six months if the doctor agrees to your new health plan's, rates, and has no quality issues.
- **If you are in a Medi-Cal nursing home,** the Cal MediConnect plan will work with you and your care team so you get the care you need. You can stay in your nursing home.

4. What can I do if I join a Cal MediConnect or PACE plan and don't like it?

In any month, you can dis-enroll from Cal MediConnect or PACE and go back to the regular Medicare or a Medicare Advantage plan. To do this, call Health Care Options at 1-844-580-7272 (TTY: 1-800-430-7077), or tell your health plan that you want to leave the plan. The health plan can help you make this choice.

- Remember that you will still be enrolled in the health plan for your Medi-Cal benefits. Your dis-enrollment only affects how you get your Medicare benefits.

5. What are Long Term Services and Supports? How will they work in a health plan?

Long Term Services and Supports (LTSS) are Medi-Cal benefits that help you with on-going personal care needs. In a health plan, these services and supports will work like they do today.

Your health plan will work with your doctors and LTSS providers. If you do not get these services now, your health plan can help you get them in the future if they are medically needed.

- **In-Home Supportive Services (IHSS):** Personal care services for people who need help to live safely in their homes.
  - ▶ If you get IHSS, your services will not change. You can keep your IHSS providers and you can still hire, fire, and manage your providers. The county IHSS social worker will still assess your needs and approve your IHSS hours. Your rights to appeal will stay the same. If you want, your health plan can work with you and your IHSS providers to make sure you get the care you need.
- **Community-Based Adult Services (CBAS):** These are daytime health care services at centers that provide nursing, therapy, activities, and meals for people with certain chronic health conditions.
  - ▶ Where available, your health plan will work with you and your doctor if you need this service. If you get CBAS today, your services will not change.

- **Multipurpose Senior Services Program (MSSP):** These are social and health care coordination services for people age 65 and older.
    - If you get MSSP services, you will still receive it through your current MSSP providers. Your health plan will work with them to better coordinate your care.
- **Nursing home care:** Your health plan will work with your doctor and nursing home to give you the same services that you get now and to better coordinate your care.

6. I don't use any Medi-Cal Long Term Services and Supports benefits. Why must I join a health plan?

The reason for this choice is to better coordinate your Medi-Cal services. If you need Long Term Services and Supports, the health plan will help you. Also, in a health plan, you can get transportation to medical appointments and call a 24-hour nurse advice line for help. Medi-Cal health plans will pay any extra Medicare costs that the State pays today, like your deductibles.

VERIFICATION

NANCY BAKER KENNEDY deposes and says:

I am a Petitioner in, and have read, the within Verified Petition for Writ of Mandamus, and the same is true of my own knowledge, except as to the matters which are therein stated on information or belief, and that as to those matters that I believe it to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed in Los Angeles, California, on June 26, 2014.

NANCY BAKER KENNEDY

VERIFICATION

I have read the foregoing VERIFIED PETITION FOR WRIT OF MANDATE and know its contents.

I am a party to this action, and am authorized to make this verification for and on its behalf, and I make this verification for that reason.

The matters stated in the foregoing document are true of my own knowledge except as to those matters which are stated on information and belief, and as to those matters I believe them to be true.

Executed on July 1, 2014, at Berkeley, California.

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

BLANE BECKWITH
Print Name of Signator

Blane H. Beckwith
Signature

575 MARKET STREET, SUITE 2300
SAN FRANCISCO, CALIFORNIA 94105
TEL: (415) 875-8500 • FAX: (415) 875-8519

VERIFICATION

STATE OF CALIFORNIA, COUNTY OF SACRAMENTO

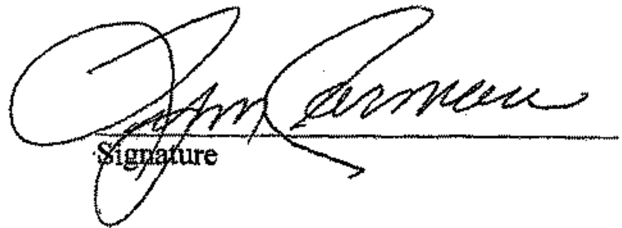
I have read the foregoing Verified Petition for a Writ of Mandate (Code of Civil Procedure § 1085) and know its contents.

I am one of the attorneys for Petitioners WESTSIDE CENTER FOR INDEPENDENT LIVING, SOUTHERN CALIFORNIA REHABILITATION SERVICES, INC., COMMUNITIES ACTIVELY LIVING INDEPENDENT & FREE, and BLANE BECKWITH. For the reasons that such Petitioners are absent from the County of Marin, where I have my office, for the reason that the facts are within my knowledge and for the reason that I know the facts, especially the facts that comprise the grounds for relief in this case for the foregoing Petitioners, better than the foregoing Petitioners, I make this verification for and on behalf of these Petitioners.

The facts alleged in the Verified Petition for a Writ of Mandate (Code of Civil Procedure § 1085) are true of my own knowledge, except as to the matters which are therein stated on information or belief, and that as to those matters that I believe it to be true.

Executed on June 30, 2014, at San Rafael, California.

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



Lynn Carman
Print Name of Signatory

Signature

DRAFT

HOOPER, LUNDY & BOOKMAN, P.C.
575 MARKET STREET, SUITE 2300
SAN FRANCISCO, CALIFORNIA 94105
TEL: (415) 875-8500 • FAX: (415) 875-8519

1 **VERIFICATION**

2 I have read the foregoing VERIFIED PETITION FOR WRIT OF MANDATE and know
3 its contents.

4 I am MANUEL PUIG-LLANO, M.D., a party to this action.

5 The matters stated in the foregoing document are true of my own knowledge except as to
6 those matters which are stated on information and belief, and as to those matters I believe them to
7 be true.

8 Executed on June 17, 2014, at SAN DIEGO, California.

9 I declare under penalty of perjury under the laws of the State of California that the
10 foregoing is true and correct.

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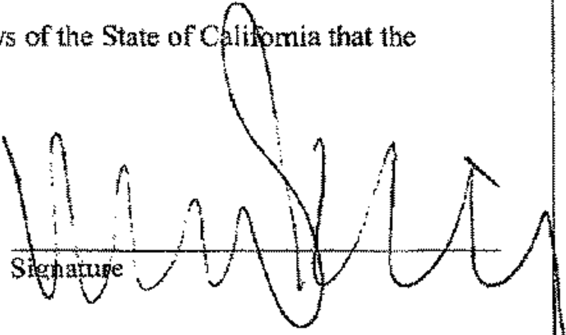
12 MANUEL PUIG-LLANO
13 Print Name of Signator



Signature

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Jun 30 14 11:30a Manuel Puig M.D. 6195859603 p.2

1 **VERIFICATION**

2 I have read the foregoing VERIFIED PETITION FOR WRIT OF MANDATE and know
3 its contents.

4 I am the Chief Executive Officer of the Los Angeles County Medical Association, a party
5 to this action, and am authorized to make this verification for and on its behalf, and I make this
6 verification for that reason.

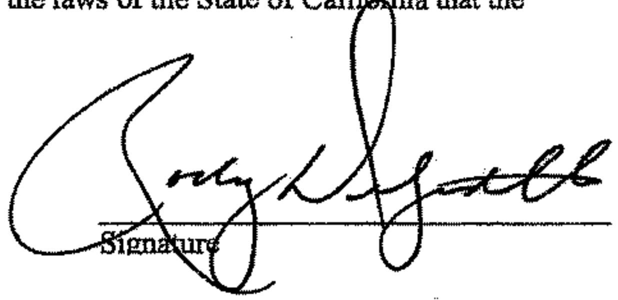
7 The matters stated in the foregoing document are true of my own knowledge except as to
8 those matters which are stated on information and belief, and as to those matters I believe them to
9 be true.

10 Executed on June 30, 2014, at Los Angeles, California.

11 I declare under penalty of perjury under the laws of the State of California that the
12 foregoing is true and correct.

13

14 Rockard J. Delgadillo



15 Print Name of Signator | Signature

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HOOPER, LUNDY & BOOKMAN, P.C.
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