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IN THE UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC, a nonprofit corporation; SHELIAH JONES, CARRIE MADDEN, and ZHANYA BONCHKOVSKAIA,

Petitioners and Plaintiffs,

-vs.-

SYLVIA BURWELL, Secretary of U.S. Department of Health and Human Services, and TOBY DOUGLAS, Director of California Department of Health and Human Services,

Respondents and Defendants.

_____/

Civil No.

PETITION FOR WRIT OF MANDAMUS AND COMPLAINT FOR INJUNCTIVE RELIEF, WITH STAY

(42 U.S.C. § 1361, RULE 65, F.R. Civ. Proc.)

TO THE ABOVE-ENTITLED HONORABLE UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA:

This verified petition for a writ of mandamus under 42 U.S.C. § 1361, and verified complaint for injunctive relief, with stay or interim relief, respectfully shows:

INTRODUCTION[1]

1. Note: All statutory references are to the Social Security Act unless otherwise specified.

2. This petition for writ of mandamus or suit for injunction, with interim relief, challenges the Coordinated Care Initiative (CCI) test project of the Medicare/Medicaid programs, which is auto-enrolling up to 456,000 persons who are covered by both Medicare and Medicaid (who are called "duals") into managed care plans in eight California counties (including Los Angeles):

- for their Medicare services, unless they opt out of the CCI for Medicare services; and,

- for their Medicaid services, whether or not they opt out for Medicare services.

3. The CCI is being conducted under a Memorandum of Understanding (MOU) between the federal Centers for Medicare and Medicaid Services (CMS) and the State of California.

4. The MOU is authorized by a § 1115A waiver by the Secretary in respect to the Medicare part of the MOU and by a § 1115 waiver by the Secretary in

[1] Captions and head notes are not allegations and need not be admitted or denied.

respect to the Medicaid part of the MOU.[2]

5. There has been no waiver, however, of § 1802(a), the Medicare freedom of choice of provider provision, because the Secretary – shockingly and erroneously -- believes that "passive enrollment" of duals, which drives the CCI test, is consistent with § 1802(a), hence need not be waived.[3]

JURISDICTION

6. The Court has jurisdiction under 28 U.S.C. §§ 1331, 1343, and 1361; under Article III, section 2, clause 1 of the U.S. Constitution; under 42 U.S.C. 1983; under 5 U.S.C. §§ 701-708; and under the Supremacy Clause. Venue lies because each of the Respondents have an office in Los Angeles County, and the actions and injuries complained of are occurring within this county.

PARTIES

7. a. The petitioner and plaintiff INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC. ("ILC") is a non-profit California corporation which was duly organized and incorporated on July 25, 1977 pursuant to the General Nonprofit Corporation Law of the State of California.

b. The ILC has its principal office and place of business in and does business in the County of Los Angeles, California.

c. The ILC is a designated center for independent living, which is a

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[2] § 1115 is codified as 42 U.S.C.§ 1315.
§ 1115A, enacted by the Affordable Care Act, is codified as 42 U.S.C. § 1315A.

[3] § 1802(a) is codified as 42 U.S.C. § 1395a(a).

community-based organization established under the California Rehabilitation Act, §§ 19800 - 19806 California Welfare and Institutions Code, (the "CRA"), to advocate and provide services to enable people with disabilities to achieve independence, including equal access to society and to all activities of society.

d. The ILC provides independent living services for over 6,000 individuals with disabilities annually, Approximately 1200 of ILC clients receive both Medicare and Medicaid services, who qualify for and are subject to the Coordinated Care Initiative. One of the ILC's statutory duties, under the CRA, is to advocate for their clients for optimum health care in order for them to be able to live independently.

8. The petitioner and plaintiff CARRIE MADDEN resides in Santa Monica, Los Angeles County, California. The petitioner and plaintiff SHELIAH JONES resides in Los Angeles, Los Angeles County, California. The petitioner and plaintiff ZHANYA BONCHKOVSKAIA resides in Santa Monica, Los Angeles County, California.

9. "Petitioner," as used herein, shall mean and refer to "petitioner and plaintiff."

10. Each of the individual petitioners is a full beneficiary of both the Medicare and the Medicaid programs. (In California, Medicaid is called "Medi-Cal"). Each has multiple disabilities or chronic conditions for which in the past, before the Coordinated Care Initiative, each received fee-for-service Medicare and Medi-Cal. Each of them, though subject to the Initiative, do not wish to be enrolled in any managed care plan, public or private, and wish to continue to have fee-for-

service Medicare and fee-for-service Medicaid.

11. Each of the Petitioners sue on their own behalf, respectively, as well as on behalf of the public of the State of California, and on behalf of all duals in the CCI test project, to procure the performance of mandatory public duty by the respondent public officers, not admitting of any exercise of discretion on their part.

12. The petitioner ILC also sues, in addition, in a prudential *jus tertii* capacity, in its capacity as an independent living center – designated and organized by law as such and with purposes and powers therefore, under and as authorized by the CRA – to assert the interests of its clients who are dually eligible for both Medicare and Medicaid services, for whom the ILC is their virtual representative, acting as such; and on behalf of all other duals who are subject to the Initiative.

13. The respondent SYLVIA BURWELL is the Secretary of the United States Department of Health and Human Services. She is sued in her official capacity only,

14. The respondent TOBY DOUGLAS (Director) is the Director of the California Department of Health Care Services (DHCS). The Director under California Welfare and Institutions Code § 14105 is the chief officer of DHCS. This respondent is sued in his official capacity only.

SUMMARY OF PETITIONERS' CLAIMS

Auto-enrolled duals are disconnected during the transition period from all medical services, which injures and threatens to injure them, in violation of (1) federal due process right not to be injured from arbitrary and capricious government action, and (2) 42 U.S.C. § 3515b.

4. The CCI project, under the terms of the MOU, systemically disconnects

and prevents duals from obtaining any health care services whatsoever during the all-important transition period, namely, from the time the dual is auto-enrolled into a Participating Plan for all Medicare and Medicaid services, to the time that the dual is able, if at all, to be seen and treated by the primary care physician (PCP) to whom the dual is assigned, *and*, obtains the medicines or treatment prescribed by the PCP.[4]

5. Many have already suffered during this transition period delay, because they were cut off from their current prescribed treatment regimes. *See*: Petitioner Sheliah Jones (she was auto-enrolled while in the hospital, so she suffered without any medicine during his recovery period from the hospital); Medina Decl. § 19 (a patient suffered a stroke because he was cut of from all medicine during a transition period); ¶ 16 (duals are shut off from all medicines); Carbonell Decl. § 4-7 (diabetic unable to obtain wound treatment); Ortega Decl. § 16 (colon cancer patient cannot obtain treatment), during the transition period.

6. And thousands more duals are similarly being daily threatened with death, injury, or suffering at the least, unless this Court acts to stop this terrible and arbitrary termination, during the transition period, of all medical care including prescriptions.

7. **NOTE:** This denial of all medicine during the transition period during the "test," shows that the CCI project is clearly an experiment with human participants which presents a danger to the physical, mental, and emotional well-

[4] Petitioners do not concede that being seen and receiving treatment from a PCP to whom the dual has been assigned is adequate care for most duals.

being of duals, in violation of the human-experiment statute, 42 U.S.C. § 3515b, and is the foreseeable inevitable result of the written terms of the MOU. Hence the entire program must be scratched, to prevent arbitrary human suffering which the human-experiment statute, and the § 1115A and § 1115 waiver statutes, and federal due process clauses were adopted to prevent. Nor have the Respondents informed duals of the danger or obtained any written, informed consent from any duals, as required by 42 U.S.C. § 3515b.

8. This also is a clear violation of Fifth and Fourteenth Amendment due process rights of duals, not to be forced into human guinea pig health care experiments by State and federal officials without written, informed consent being first obtained. This is what the Nuremberg Code and the Helsinki Declaration were all about: which were the basis for Congress enacting 42 U.S.C. § 3515b, – but has been totally ignored and violated by Respondents in this case.

"Passive enrollment" facially violates the Medicare Act

9. The Respondents also act *ultra vires,* without and in excess of jurisdiction, contrary to law, in that the so-called "passive enrollment" of duals into managed care plans for Medicare services, which is required by the MOU in question, facially violates § 1802(a), which guarantees Medicare beneficiaries freedom of choice of provider for Medicare services.[5]

[5] § 1802(a) provides:

> BASIC FREEDOM OF CHOICE.—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or persons qualified to participate under this title if such institution, agency or person who undertakes to provide him such services.

"Passively enrolling" cognitively impaired duals, and those who do not receive notices or cannot read English, into managed care for Medicare services, violates both § 1802(a) freedom of choice of Medicare provider as well as federal due process right of duals not to be deprived of this statutory § 1802(a) right without due process.

10. a. To impose a requirement – that a dual must opt out of a CCI managed care plan for Medicare services in order to continue to exercise the § 1802(a) statutory right to choose one's Medicare provider, – imposes a pre-condition which simply cannot be considered or performed by the 40% or more of duals who are mentally or cognitively impaired, and the many duals who do not actually receive any opt out notices, or who cannot read the notices because they are not in Spanish. This facially deprives them of liberty and property, (namely, the freedom and right, under § 1802(a) to select their Medicare providers) without any due process, contrary to the Fifth and Fourteenth Amendments.

b. Further, – because the *ultra vires* character of the "passive enrollment" rule of CMS affects such a broad range of duals, and because it is inherently difficult as a practical matter to administratively ascertain in the CCI test which duals are so impaired or do not receive any opt out notice, – it follows that this *ultra vires* policy must be struck down in its entirety, not, just in respect, only, to duals who are mentally impaired, do not receive the notices, or cannot understand them because of language barrier.

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The CCI "test" project is *ultra vires*, because the dangers it presents to duals have been arbitrarily and unreasonably extended far beyond the scope, in numbers of duals and area, than is needed to conduct the posited test; which violates § 1115A and § 1115; 42 U.S.C. § 3515b, and federal due process rights of duals.

11. The entire CCI test project falls because of the violations of these jurisdictional perquisites for a § 1115A and § 1115 test.

STATEMENT OF PRELIMINARY FACTS

"Duals"

12. A "dual beneficiary" or"dual" for the purposes of this lawsuit, is a person 21 years or older who is or becomes enrolled for benefits under the Medicare Act, Part A (hospital services),[6] and Part B (physician services),[7] and Part D (prescription drugs)[8] and is also eligible for medical assistance under the Medicaid Act,[9] (medical, hospital, and prescription drug benefits which are not covered by Medicare) under the Medicaid Act; and does not:

- pay a share of costs for Medi-Cal benefits,
- receive Home and Community Based services (HCBS),
- have end-state renal disease,
- reside in any Veterans' Home in California,
- receive any services through a regional center or state development center,

and has not been diagnosed as having HIV/AIDS, or have any other health coverage.

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[6] § 1811, codified as 42 U.S.C. § 1395c.

[7] §§ 1831, 1836, codified as 42 U.S.C. §§ 1395, 1395o.

8. § 1860D-1, codified as 42 U.S.C. § 1395w-101.

[9] § 1902(a)(10)(A), codified as 42 U.S.C. § 1396a(a)(10)(A).

HISTORICAL AND LEGISLATIVE BACKGROUND

FIRST

Auto-enrollment of duals into managed care, has an injurious track record.

13. In 1965 Congress enacted:

(1) the Medicare program (Social Security Act Title XVIII) to fund physician hospital, and long term care to (I) low income persons with Social Security credits who become permanently disabled (i.e., SSDI recipients), and (ii) the elderly with Social Security credits, who are 65 or older; and,

(2) the Medicaid program (Social Security Act Title XIX), by which the federal government and consenting States jointly fund health care for qualified poor.

14. Many of the qualified poor who receive Medicaid services are also eligible for Medicare, particularly, disabled SSDI recipients and those 65 or older who are poor: who are called "duals" for short.

15. Hence by definition, duals are the poorest, sickest, most frail, elderly, and disabled of all the population.

16. At least 40 percent or more of duals are mentally or cognitively impaired, to the degree that they "may not be able to navigate complicated program changes even if education and communication efforts are appropriate for an elderly population." (California Senate Rules Committee report, 2006.[10]

[10] California Senate Rules Committee Bill Analysis of SB 1233. This bill was enacted to fund prescription drugs for duals in 2006, when thousands of them were cut off their medicine regimes because computers failed to match them to any Medicare Part D plans. **RJN Ex. M**.

17. According to the Medicare Payment Advisory Commission (MedPAC) which was created by §§ 1805[11] and 1900[12] to advise Congress on beneficiary access to Medicare and Medicaid, 38 percent of all duals have mental or cognitive limitations.[13]

18. One quarter of duals reside in institutions, such as nursing homes.[14]

19. Many duals, because homeless or resident in nursing homes, never receive the notices sent out by Respondents concerning the changes in the CCI program.[15]

20. For these reasons, or albeit in any event, a key to both the Medicare and Medicaid programs is that Congress, in each program, has determined and enacted that duals, especially, shall have freedom of choice of provider.

21. Thus in the Medicare program, Congress enacted from the start that all Medicare beneficiaries have a right to freedom of choice of provider of Medicare services. *See,* § 1802(a).

22. In the Medicaid program, Congress also enacted from the start that all Medicaid beneficiaries have a right of freedom of choice of provider of Medicaid

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[11] § 1805 is codified as 42 U.S.C. § 1395b-6.

[12] § 1900 is codified as 42 U.S.C, § 1396-1.

[13] June 2004, MedPAC Report to Congress, p. 77. **RJN Ex. K.**

[14] *Id.*, p. 75.

[15] Vescovo Decl. p. 4.

services. *See,* § 1902(a)(23)(A).[16]

23. However, when managed care commenced in the '90s, duals were mandated into many state Medicaid managed care plans, through use of federal waivers which allowed it. But, Congress found after hearings in 1997 that for many duals, access to care was compromised.

24. Thus, Senator Grassley, Chairman of the Senate Special Committee on Aging, speaking for the Committee in his opening statement at a Committee hearing on People With Special Needs in June 1997, reported that:

> Each year, States have enrolled increasing numbers of Medicaid beneficiaries into mandatory managed care plans. For many of these beneficiaries, Medicaid provides services that were otherwise unavailable. Yet many beneficiaries currently enrolled in managed care have experienced serious difficulties in accessing appropriate health care services. . . . At this time there is considerable concern that most managed care plans are not yet prepared to effectively serve special needs populations."[17]

25. Accordingly, although Congress in the same 1997 session enacted new § 1932 to allow States to impose managed care upon Medicaid beneficiaries, generally, nevertheless, Congress in § 1932(a)(2)(B) took care to especially exempt and protect duals from being so mandated into managed care plans for Medicaid, by any such mere amendment of the State Medicaid Plan.[18]

26. Congress, by allowing States to impose managed care upon Medicaid beneficiaries, but reserving and prohibiting, by § 1932(a)(2)(B), duals from being

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[16] § 1902(a)(23)(A) is codified as 42 U.S.C. § 1396a(a)(23)(A).

[17] U.S. Senate Special Committee on Aging, June 14, 1997. **RJN Ex. J**.

[18] § 1932 is codified as 42 U.S.C. § 1396w-2.

mandated into managed care, implicitly found that mandating duals into managed care endangers duals.[19]

27. In 2006, when Congress enacted Medicare Part D to auto-enroll duals into Medicare Part D pharmacy plans, thousands of duals throughout the country were immediately deprived of medicines because the auto-enrollments did not match. (When the auto-enrolled duals presented their prescriptions, the Part D plans who were supposed to be their plan, signaled to the pharmacy that they had no record of the auto-assignment.)

28. It was so bad that the California legislature enacted Senate Bill 1233 to provide that the State should temporarily continue to cover medicine for duals, utilizing the established fee-for-service system of Medi-Cal to facilitate timely furnishing of medicines to duals, using State funds.[20]

SECOND

29. Despite the historic injurious track record of auto-enrolling duals into managed care plans, and despite the Congressional prohibitions against mandatory enrollment of duals into managed care plans, CMS announced in a July 8, 2011 Directors Letter to all State Medicaid Directors, that it would work with 15 or more States, under the Affordable Care Act,[21] "to combine Medicare and Medicaid authorities to test a new payment and service delivery model to reduce program

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[19] § 1932(a)(2)(B) is codified as 42 U.S.C. § 1396w-2(a)(2)(B).

[20] California Senate Floor Analysis, p. 3, of SB 1233. **RJN, Ex.** M.

[21] P. Law 111-148, enacted March 23, 2010, as revised by the Health Care and Reconciliation Act of 2010 (P. Law 111-152).

expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees in this capitated program."[22]

30. This test would be facilitated, in each State conducting such a test, by using "a **single, seamless passive enrollment process** that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from" a managed care plan for all Medicare and Medicaid services.[23] (Emphasis supplied).

31. The Secretary, by this July 8, 2011, Director's Letter, with its approved form of MOU, thereby adopted a rule and policy that a dual who is given an opportunity to affirmatively opt out of being enrolled into a Medicare managed care plan, **thereby freely elects to be enrolled into that plan if the dual fails to opt out**; such that, in such wise, the "passive enrollment" in the Medicare part of the CCI test project would not, in the Secretary's safe harbor ruling, violate the free-choice-of-provider provision of § 1802(a) of the Medicare Act or § 1902(a)(23)(A) of the Medicaid Act.

32. Following this safe-harbor ruling of the Secretary, divers laws were enacted by the California Legislature to permit the Director, on behalf of the State of

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[22] **RJN Ex. F**.

[23] *Id.,* at page 4 of form MOU which was part of the July 8, 2011 Directors Letter packet:

> [E]nrollment into a Participating Plan may be conducted using a single, seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time.

California, to enter into the prior-mentioned MOU on March 27, 2013,[24] and to obtain, also, the § 1115 waiver dated March 19, 2014 in respect to mandatory Medicaid services, so as to implement the CCI project.[25]

33. Under the MOU, CMS and DHCS agreed to jointly organize and implement the CCI project, the manifest purpose of which is to place up to 456,000 duals – which is 56% of the 814,659 duals in all 58 counties of California who would meet the CCI project eligibility specifications, – into managed care plans for all their Medicare and Medicaid services, in the eight counties of Los Angeles, San Diego, San Bernardino, Riverside, Orange, San Mateo, Santa Clara, and Alameda, for a 32-month period ending December 31, 2016.[26]

34. In Los Angeles County alone, 200,000 of 271,072 duals residing in the county are to be auto-enrolled.[27]

35. a. The MOU, p. 11, provides that duals in the eight counties:

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[24] MOU, at **RJN Ex. A**.

[25] § 1115 waiver, at **RJN Ex. B**.

[26] MOU, at **RJN Ex. A**.

NOTE: DHCS' Medi-Cal Statistical Brief, p. 5 (**RJN Ex. P),** shows that the total CCI population in 58 counties is 814,659.

The same DHCS document, at p. 11, shows the total CCI population for the eight counties in the CCI test project, is 526,902.

The MOU, (**RJN A**), at p. 8, limits enrollment of duals in Los Angeles County to 200,000 of the 271,072 duals population which is shown at p. 11 of the Medi-Cal Statistical Brief,

This leaves 455,830 duals, – rounded off to 456,000 duals, – as the total number of duals who are included in the CCI test project in the eight test counties.

[27] MOU, p. 8. *Id.,* Medi-Cal Statistical Brief, p. 11. **RJN Ex. N**.

- shall be "passively enrolled" by the California Department of Health Care Services (DHCS) into managed care plans in the CCI project (which are called "Medi-Connect plans") which are to integrate and furnish all the dual's Medicare and Medicaid services;

- *except that* the MOU provides, p. 64, that the dual shall be notified by DHCS in writing, 60 days before the auto-enrollment into a Medi-Connect plan, that the dual may opt out of the assigned Med-Connect plan; in which case, the dual (1) continues to receive Medicare services from providers chosen by the dual, under the regular Medicare fee-for-service program, but (2) under California Welf. & Inst. Code, § 14182.17(d)(1))(H)(iii), becomes auto-enrolled into a regular Medi-Cal managed care plan for all Medicaid services (instead of receiving the Medicaid services from a Medi-Connect plan).

36. Therein, by these provisions of the MOU, executed by CMS and the State, the Secretary re-adopted and is implementing her July 8, 2011 passive enrollment policy, that a dual who is given an opportunity to affirmatively opt out of being enrolled into a Medicare managed care plan, **thereby freely elects to be enrolled into that plan if the dual fails to opt out**; and that such passive enrollment complies with the freedom-of-choice-of-provider requirement of § 1802(a).

37. Under the MOU, DHCS is currently sending, – on or about the 29th of each month, – 60-day notices and information packets which contain a choice form, to duals in four counties (Los Angeles, San Diego, Riverside, and San Bernardino) whose birth month is the third month following the 29th of the month that the notices are sent, which state in substance that:

- the dual will be auto-enrolled into a Medi-Connect plan for all

Medicare and Medicaid services in the birth month of the dual, unless the dual affirmatively opts out of the Medi-Connect plan before then for all Medicare services; and,

- that the dual may only opt out of the Medi-Connect plan for all Medicare services by selecting a Medi-Cal plan for all the dual's Medicaid services: which may only be done by (1) checking a box on the choice form to select one of the Medi-Cal plans listed on the right-hand side of the choice form, and returning the checked choice form to DHCS, or (2) by calling a telephone number listed on the 60-day notice, to select a Medi-Cal plan and, thereby, also opt out of the CCI for all Medicare services.[28]

38. By these provisions of the MOU, and by the above 60-day notice and choice form of DHCS,– which forms are pre-approved by CMS, – the Secretary and DHCS have, *ultra vires,* added *two* administrative preconditions to the exercise of the statutory right of duals, under § 1802(a), to freely choose their Medicare providers: namely.

- (1) that the dual must affirmatively act to opt out the CCI project for all Medicare services, but that (2) that the dual may only opt out for Medicare services, if the dual also selects a regular Medi-Cal plan for all Medicaid services.

THIRD

39. Note: In doing all the foregoing acts in respect to carrying out the purely federal Medicare Act, the DHCS and the Director act subject to the control of CMS, who, under the MOU, also approves the wording and form of each notice.

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[28] *See,* 60-day notice form, (**RJN Ex. C**); Choice Form, **RJN Ex. D**.

Thus at all times, DHCS and the Director are each also acting at all times as an instrumentality and agency of the United States and engaged in carrying out the federal Medicare Act, (as well as, simultaneously, acting as a State officer carrying out the laws of California).

FOURTH

History of dual auto-enrollment into managed care plans, since the Directors Letter of July 8, 2011

40. MedPAC, the commission especially created by Congress in §§ 1805 and 1900 to report to Congress on how the interaction of policies of Medicare and Medicaid affects access to services of duals, found, determined, and reported to Congress on July 11, 2012, that the Commission has identified concerns with the demonstrations being approved by CMS, and that out of desire "**to protect dual-eligible beneficiaries,**" that:

> The Commission believes the scope of the demonstrations as proposed is too broad. . . . CMS' target enrollment **represents a program change** in the delivery and financing of Medicare benefits for dual-eligible beneficiaries **rather than a demonstration designed to test new models . . .**

and that the Commission was concerned that:

> The Commission and others have documented that only a limited number of health plans have experience managing the full range of benefits in a capitated environment for these complex populations (cognitively impaired, frail, physically or developmentally disabled).
>
> Not all demonstration plans may have the capacity to serve large numbers of dial-eligible beneficiaries that will be newly enrolled into the plan en masse at the beginning of the demonstration.

(**RJN**, **Ex.** , page 3).

41. Also, Senator Jay Rockefeller. who wrote part of the Affordable Care

Act under which a CMS sub-agency was created to facilitate "integration" of Medicare and Medicaid benefits, warned the Secretary in July 2012 that mass auto-enrollment of duals into unproven managed care would undoubtedly lead to disruptions in access to care, significant confusion among seniors and their families; and that duals should not be moved out of their current fee-for-service coverage without their affirmative consent. (I.e., that they "opt in," rather than being auto-enrolled unless they succeed in "opting out.")[29]

42. Then, the so-called "test" of CCI mandatory managed care program in eight counties has already failed in three of the counties, and the largest Medi-Connect plan has been barred from receiving any auto-enrolled duals.

43. Thus:

- CMS banned the CCI program in Orange County in December 2013;[30] with CMS finding that the conduct of CalOptima "poses a serious threat to the health and safety of Medicare beneficiaries."[31]

- The Alameda County's public CCI managed care plan went bankrupt.

- Santa Clara's CCI program has "technical problems," so, cannot function.

44. Further, the history of the typical inadequacy of this CCI test has continued, in that CMS has banned passive enrollment of duals into L.A. Care, in

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[29] Senator Rockefeller letter to the Secretary, dated July 11, 2012. **RJN, Ex. H**.

[30] Cal. Senate Report, **RJN, Ex. I**., p. 1, fn. 1.

[31] *Id.,* p. 14.

Los Angeles, – the largest public managed care plan in the country, – for Medicare services, due to a low-performing icon (LPI) based on its Medicare quality scores. (California Senate Budget & Health Committees report ("Cal. Senate Report") of February 6, 2014, p. 13.)[32]

45. The Cal. Senate Report found that:

> This situation calls into question the meaningfulness of the health plan readiness review assessment . . . and whether or not these plans are qualified and ready to participate in the demonstration, particularly given the audit revealed that "CalOptima's performance issues are widespread and systematic in nature."[33]

46. In sum, the only reasonable inference from just the above facts is that the CCI test has already failed in 3/8ts of its territory, and what remains of it poses threats to the safety of the duals who are being forced into it each month.

FIRST CLAIM FOR RELIEF

Auto-enrollment of Duals Into CCI Managed Care, Without Any Medical Services During the Transition Period, Without Written, Informed Consent, Violates 42 U.S.C. § 3515b

47. Petitioners incorporate each of the allegations in the preceding Paragraphs.

48. 42 U.S.C. § 3515b prohibits any agency experiment which endangers

[32] *Id.*, p. 13.

[33] *Id.,* p. 15.

its human participants without their written, informed consent.[34]

49. However, the CCI project is an experiment which involves human beings which presents a danger to their physical, mental, or emotional well-being, without either their consent or any informed written consent: hence violates 42 U.S.C. § 3515b.

50. a. Among the many *known dangers* of the CCI project is this: that the dual is cut off from *all* health care services for a transition period, which, under any view, lasts at least from the instant the dual is auto-enrolled into a Medi-Connect for all Medicare and Medicaid services, to the time the dual is both able to be seen by the primary care physician (PCP) to which the dual is assigned, *and*, receives the services prescribed by the PCP.

b. During this transition period the total absence of any health care services manifestly endangers the physical, mental, and emotional well-being of auto-enrolled duals without their consent or any informed consent.

51. The total absence of any health care services to duals during this transition period, in this CCI experimental project, has already injured many duals and will inevitably injure more as the monthly auto-enrollments, such as monthly

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[34] 42 U.S.C. § 3515b provides in relevant part:

None of the funds appropriated by this Act or subsequent Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act shall be used to pay for any research program or project or any program, project, or course which is of experimental nature, or any other activity involving human participants, which is determined by the Secretary or a court of competent jurisdiction, to present a danger to the physical, mental, or emotional well-being of a participant or subject of such program, project, or course, without the written, informed consent of each participant or subject, or a participant's parents or legal guardian, if such participant or subject is under eighteen years of age. The Secretary shall adopt appropriate regulations respecting this section.

auto-enrollment of approximately 16,667 duals per month in Los Angeles County continues.

52. For example, Petitioner Sheliah Jones was auto-enrolled without her knowledge while in the hospital, which automatically cut her out of the regular Medi-Cal fee-for-service program. When she was discharged from the hospital she took her post-discharge prescription to a pharmacy. The pharmacist informed her they could not fill her prescription because her Medi-Cal fee-for-service ID card was denied. The pharmacy staff then informed her she had been auto-enrolled into a HealthNet managed care plan. She never received any information from Health Net about her new enrollment, or who would be her providers. Meanwhile, during this transition period following her auto-enrollment, she was forced to go without the medication and suffered great pain. (Jones Decl.)

90. Her experience is typical.

53. *See,* Declaration of Benjamin Medina, M.D.,:

- ¶19: stroke was caused to 70-year-old high-blood pressure patient because she could not get medication during transition period.

- ¶ 16-18: Dr. Medina states that his dual clients are unable to obtain prescriptions during the transition, as follows:

> 16. The circumstances in which many Duals have been enrolled creates a substantial risk of serious irreparable harm. For example, to obtain certain medications, patients must have an authorization from their primary treating physician [in a managed care plan]. Duals who have been unknowingly enrolled into Medi-Connect visit me for a routine prescription. When I write a prescription, if it needs an authorization, I am not able to obtain a prior authorization, because I am no longer their primary care physician. Further, these patients do not know why their primary care physician is . . . This causes substantial delays in a Dual's

ability to obtain essential medications

17. Delays in a Dual's ability to obtain essential medications creates a risk of serious, irreparable harm. Diabetics, for example, require regular medication to regulate their blood sugar. Without properly regulating their blood sugar, within a matter of days, patients can experience significant health problems, including altered states of consciousness, diabetic coma, and in extreme cases, death.

18. Another example is patients who utilize medication to control high blood pressure. Without such medications, within three to four days, these patients may experience an increase in their blood pressure that is even higher than before they started taking medications, due to a phenomenon known as "rebound hypertension." Rebound hypertension substantially increases the patient's risk of stroke, intra cranial bleed, and myocardial infarctions (heart attacks).

(End of Medina Decl.)

See, also:

- Carbonell Decl. ¶ 4-7: 87-year-old diabetic unable to obtain wound treatment.

- Ortega Decl. ¶ 16: this auto-enrolled colon cancer patient cannot schedule any appointment with any doctor at the Plan because he has not been told who his providers are.

54. Thousands more duals are being similarly threatened with death, injury, or suffering at the least, due to total, inexcusable disconnection and being systemically prevented, during their transition periods, from all medical care

including prescriptions.[35]

55. NOTE:

a. It is true that the MOU, (pages 94-96, at **RJN Ex. A**), does provide that duals shall be assessed by the Medi-Connect within 90 days of enrollment; and, that the plan must allow duals to "maintain their current providers and service authorizations" for 6 months (Medicare) and 12 months [Medicaid]; but, this is ***if and only if,*** the dual **requests** to use a "current provider;" and ***if and only if*** the plan, – by using its data apparatus, – identifies that the dual has seen the "requested" out-of-network provider at least twice in the past 12 months. (Page 95 of MOU, at **RJN Ex. A**).[36]

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[35] *Compare,* the § 1115 waiver of Hawaii's mandatory Medicaid managed care plan for duals, in *G. v. State of Hawaii* (D.C. Hawaii 2009) 576 F.Supp.2d 1006, 1021-22.

In Hawaii, duals may use their current Medicare providers during the period from auto-enrollment until the dual is assessed and given a treatment plan by the managed care plan. Period. Without any limiting small print conditions as in the CCI project which prevent the dual from obtaining medical treatment from their current providers during the transition period.

[36] The MOU, p. 95, provides:

H. Participating Plans must allow enrollees to maintain their current providers and service authorizations at the time of the enrollment for :

1. A period of up to 6 months for Medicare services *if all of the following criteria are met* under Welfare and Institutions Code section 14132.275(k)(2)(A):

a. *Beneficiary demonstrates* an existing relationship with the provider prior to enrollment. This will be established by the Participating Plan by identifying whether the beneficiary has seen the *requested* out-of-network provider at least twice within the previous 12 months *from the date of the request*. The link between the newly beneficiary and the out-of-network provider may be established by the Participating Plan using Medicare data provided by California or by *documentation by the provider or enrollee.*

b. However, these "small print" limitations destroy the ultra grand statement in the MOU that duals may "maintain their current providers and service authorizations" for 6 months (Medicare) and 12 months (Medicaid).[37]

56. I.e., a mere recitation of the actual mechanics of this bizarre provision in California's MOU shows at once that California's MOU shockingly ***prevents*** duals from obtaining *any needed health care services* during the transition period: hence, endangers them within the meaning of 42 U.S.C. § 3515b. Thus:

- First, the dual has to **make a request** to the plan to use a current provider

- But this cannot be done until the dual has been informed that under the MOU that the dual has this right to request to use a provider the dual was currently using; which information is not given to the dual at the time of the silent, distant, auto-enrollment by a flick of a computer key at DHCS headquarters.

- Then, the dual has to make a "request" to the plan to use a current provider. (In many cases this cannot be done because the dual is incapacitated, is in a nursing home, cannot read or write, or is cognitively unable to do this.

- Of course, the MOU fails to disclose how, or to whom, a "request" can be made to the Medi-Connect for permission to use a "current provider."

- Accordingly no "request" can be made because the MOU does not inform duals how to make any such "request."

(Emphasis supplied)

[37] MOU, pp. 95-96. **RJN Ex. A**.

- Then the plan has to have its computer staff take the time to run a computer check on the treatment history of the dual; print out the report, and deliver it back to whomever at the plan is in charge of dual requests-to-use-current-providers.

- Then the staff person has to review the printout and determine if the dual has met the administrative obstacle of having seen the "requested out-of-network provider at least twice within the previous 12 months from the date of the request."

- Then the staff person has to notify the dual that the requested provider can be used by the dual during the transition period.

However, all this takes substantial time. Meanwhile, the dual is forced to go without any medical services or medications during the transition period, (i.e., the period before the dual is first seen and treated by the staff of the Medi-Connect into which the dual has been auto-enrolled).

57. It is therefore obvious that this so-called "transition clause" of the MOU is no transition clause at all.

58. Rather, it is an obstacle course masquerading as a transition clause.

59. It does not provide for, and prevents, any health care services to duals who are auto-enrolled into Medi-Connect plans for their Medicare and Medicaid services, during the crucial transition period. It is instead a clear and inexcusable violation of 42 U.S.C. § 3515b, which prohibits any experiment, which uses federal funds, which would endanger the human beings who are participating in the experiment, – namely, auto-enrolled duals, – without their written, *informed*

consent.[38]

60. In contrast, **no other State operating one of these duals demonstration uses any such preventive conditions on the free use of the dual's current physician during the transition period.**

61. California is the *only* State preventing duals from using their pre-auto-enrollment physicians and prior service authorizations, during the transition period: which is the reason that California is the *only* State in which duals are having strokes, being denied their medicines, being unable to obtain colon cancer treatment, – and the like, – during the transition period.

- *See,* the MOU's of Illinois, (at page 15), Virginia (at page 17), and Massachusetts (at page 11), of the white paper of National Senior Citizens Law Center, at **RJN Ex. Q**.

- *See* also, the § 1115 waiver for Hawaii's mandatory managed care plan for duals, in *G. v. State of Hawaii* (D.C. Hawaii 2009) 576 F.Supp.2d 1006, 1021-22.

62. I.e., in Hawaii, duals may use their current Medicare providers during the period from auto-enrollment until the dual is assessed and given and commences a treatment plan by the managed care plan. Period. Without any limiting small print conditions as in the CCI project which prevent the dual from obtaining medical

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[38] Indeed, by these provisions of the MOU which prevent any medical treatment to auto-enrolled duals during the transition period, the CCI project is no better ethically and morally, and is in the same category as the Tuskegee Experiment, which "tested" to see what would happen if no medical treatment was given to a group of poor black share-croppers with syphilis.

treatment from their current providers during the transition period.

63. No administrative relief is available, and Petitioners have no plain, adequate or speedy relief except by this petition for writ of mandamus or in the alternative, – if and only if mandamus relief is not available, – injunctive relief, which is requested in the event that mandamus relief is not available.

WHEREFORE, Petitioners pray for judgment as shall hereinbelow be specified:

SECOND CLAIM FOR RELIEF

Violation of § 1802(a)
Medicare Freedom of Choice of Provider

64. Petitioners incorporate each of the allegations in the preceding Paragraphs.

65. As prior alleged, the MOU of March 23, 2013, provided for managed care plans, called "Medi-Connect plans," to provide all Medicare and Medicaid services in the eight counties prior mentioned, to such duals who may enroll or be enrolled in each plan, for a 32 month period April 2014 through December 2016.[39]

66. The MOU, page 11, also provided that duals would be given written notice 60 or more days before the effective date of their mandatory enrollment into a Medi-Connect, (herein, "auto-enrollment"), and that duals will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment; and that if and when no active choice has been made by the dual, the dual shall be auto-enrolled into a Medi-Connect for all Medicare and Medicaid

[39] **RJN Ex. A**.

services.

67. This process is referred to in the MOU as "passive enrollment," and, shall be so referred to in this Petition.[40]

68. Petitioners allege, without limitation thereby, that the passive enrollment provisions of the MOU, – as well as the passive enrollment policy of the Secretary adopted in and by the Directors Letter of March 23, 2011, under which the Secretary acted in approving the passive enrollment provision of the MOU, – are each *ultra vires,* without and in excess of jurisdiction, contrary to law.

69. This is because passive enrollment of duals into managed care plans for Medicare services blatantly and deliberately violates § 1802(a), which guarantees Medicare beneficiaries freedom of choice of provider for Medicare services by providing:

> (a) BASIC FREEDOM OF CHOICE,–Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

70. I.e, such policy and construction of § 1802(a) by the Secretary is clearly erroneous, such that the Respondents, in auto-enrolling duals into Medi-

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[40] The MOU, page 64. describes "passive enrollment" as the process of providing notice to duals 60 or more days prior to auto-enrollment, that:

> . . . identifies the Medi-Conncect in which the dual would be enrolled unless he/she selects . . . **the option to opt out** of the Demonstration;

and, of providing a further 30-day notice to "remind beneficiaries **of their options**;" that they will be assigned to a Medi-Conncect if they "do not opt out;" and that the State will "proceed with passive enrollment . . . for beneficiaries who do not . . . opt out."

Conncects for their Medicare services, in the CCI, unless the dual opts out before auto-enrollment into a Medi-Conncect, are each acting without and in excess of jurisdiction, in violation of the absolute § 1802(a) guarantee that Medicare beneficiaries may obtain their Medicare services form any provider willing to furnish such services.

71. Further, the right of freedom of choice of Medicare provider is, by the *Gonzaga/Blessing* tests, clearly a right which is enforceable as a private right of action by every Medicare beneficiary, including the petitioners Carrie Madden, Sheliah Jones, Zhanya Bonchkovskaia; as well as the duals who are the clients of the petitioner ILC, who is their virtual representative in this proceeding; and all other duals.

72. a. Also, such policy and interpretation by the Secretary of freedom of choice of provider of § 1802(a), and the provisions of the MOU, and Respondents' implementation of this policy of the Secretary, was clearly arbitrary and capricious from the start.

b. I.e., the Respondents' claim essentially is that the Executive can violate any Congressional statute by simply pre-announcing it is going to violate the Congressionally-created statutory right unless the citizen, – within a time specified by the Executive law-breaker, – states an objection or, as here, states that the citizen opts

out.[41]

b. Also, by the same premises as above, (1) the action of the Secretary in the Directors Letter of July 8, 2011 and (2) the actions of the Secretary and of the Director in the MOU to adopt and implement the *ultra vires* passive enrollment policy contrary to § 1802(a), and (ii) the actions of the Director to carry out this *ultra vires* passive enrollment policy in the CCI project, – all, contrary to the freedom of choice of provider provision of § 1802(a), -- directly deprives duals of their liberty and property guaranteed by § 1802(a), contrary to Fifth and Fourteenth Amendment due process.

The § 1115A waiver of § 1851(a) is irrelevant

73. Further, the fact that the Secretary, under § 1115A, waived § 1851(a), which provides that a Medicare beneficiary may elect to receive either Medicare fee-for-services or Medicare managed care services, is irrelevant.[42]

a. First, the specified subject of § 1851(a) is *not* freedom of a

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[41] Respondent's theory of passive enrollment makes as much sense, and is as un-American as the Sheriff notifying X on Monday that the Sheriff is going to jail X on Saturday unless, on or before Wednesday, X tells the Sheriff that he opts out of jail..

Then, when X does not respond, the Sheriff jails X on Saturday, stating that because X did not respond when he was informed he could opt out of going to jail, that hence X "freely chose" to go to jail.

The false theorem of Respondents here is based, essentially, on the misconception that if X has an unconditional statutory right, that a government agency can, by imposing, *ultra vires,* an administrative *condition* upon the exercise of the unconditional statutory right, terminate the citizen's statutory right when the citizen is unable to or fails to satisfy the *ultra vires* pre-condition unlawfully imposed by the agency, upon the unconditional statutory right.

[42] § 1851(a) is codified as 42 U.S.C. § 1395w-21(a).

Medicare beneficiary to choose any willing provider, but, guarantees only a selection between Medicare fee-for-services (which may or may not be on a managed care basis), and managed care services.

b. Second, if *arguendo* § 1851(a) incorporates into itself the same meaning as § 1802(a), – (which is not the case), – nevertheless, § 1851(a) in no way *repealed* § 1802(a).

Thus, if Congress had repealed § 1851(a), this would not have operated to repeal § 1802(a).

It follows therefore that if Congress could not repeal § 1802(a) by repealing § 1851(a), it follows that the Secretary, by *de facto* repealing § 1851(a) by *waiving* § 1851(a) under § 1115A, could not possibly, and did not, repeal or affect § 1802(a), either *de jure* or *de facto*.

Further, under *expressio unius est exclusio alterius,* it follows that the Secretary, by limiting her waiver in the MOU to § 1851(a), solely, thereby intended *not* to waive § 1802(a) or any part of § 1802(a).

Need for writ to avoid losing jurisdiction, with certain stay provisions

74. Further, under the MOU, the Director is enrolling duals into CCI managed care plans on a rolling monthly basis, according to the birth month of beneficiaries.[43]

[43] MOU, pp 65-66. **RJN Ex. A**.

75. Hence because there are 200,000 beneficiaries allowed by the MOU to be enrolled in Los Angeles County in the CCI test project, in the first year of this test project, it follows that for each of the next ten months, that approximately 16,667 duals will be auto-enrolled into the CCI each month in Los Angeles County (less those who succeed in somehow opting out).[44]

76. Thus the Court, *each month, is losing jurisdiction – i.e., actual power to act, – to command* the Respondents to refrain from auto-enrolling those particular 16,667 duals into CCI managed care plans, who are being auto-enrolled that month, unless the Court issues an appropriate writ, or a stay, *before they are auto-enrolled*, to prevent them from being auto-enrolled.

77. Hence, writ of mandamus is the appropriate remedy which, with an appropriate stay, is the appropriate relief provided for this situation by 28 U.S.C. § 1361, in order to preserve the status quo, i.e., preserve the jurisdiction of the Court to issue effective preventive relief.

78. Similarly, in the other four counties in which the CCI project commenced in April and May 2014, the Court, each month, is also losing jurisdiction, monthly, to command the Respondents to cease implementing the auto-enrollment of the duals *in those counties* into CCI plans for their Medicare services.

79. No administrative relief is available, and Petitioners have no plain, adequate or speedy relief except by this petition for writ of mandamus or in the

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[44] MOU, p. 8. **RJN Ex. A**.

alternative, – if and only if mandamus relief is not available, – injunctive relief, which is requested in the event that mandamus relief is not available.

WHEREFORE, Petitioners pay for judgment as shall be hereinbelow specified:

THIRD CLAIM FOR RELIEF

Violation of 5th and 14th Amendment Due Process Rights of Cognitively Impaired and Those Who Do Not Receive or Are Unable to Read Opt Out Notices

80. Petitioners incorporate each of the allegations in the preceding Paragraphs as if fully set forth herein.

40% or more of duals are mentally or cognitively impaired

81. It is a fact that the California Legislature has determined the significant impairment of the duals population. In 2006, the Senate Floor Analysis of a pending bill concerning duals, found, determined, and reported to Senators 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.[45]

82. MedPAC, the special commission enacted by §§ 1805 and 1900 to advise Congress concerning Medicare and Medicaid, reported in its June 2010

[45] Senate Floor Analysis, February 6, 2006, of Cal. Senate Bill 1233. **RJN Ex. I**.

report to Congress, at page 133, that 44 percent of those who are duals on account of disability, (which is one-third of all duals), are mentally ill. Of duals who are over 65, – which comprise two-thirds of all duals, – 16 percent have dementia.[46]

83. Norma Vescovo, executive director of petitioner ILC, an independent living center, which assists over 1200 disabled duals and an equal number of elderly duals, over 65, annually in northern Los Angeles County, reports that 20-30 percent of their duals clients have mental health problems which renders it impossible for them to comprehend notices from DHCS, and prevents them from making a free or mentally competent choice to opt out, or not opt out, of auto-enrollment into managed care.[47]

84. Executive Director Vescovo states that it is impossible for duals who have mental health problems to comprehend from the State's notices how to, and what to do, to execute and deliver an opt out notice or other choice to Medi-Cal;[48] or to competently self-select any Medi-Connect plan or to execute or mail the documents to enroll or disenroll from any given health plan. or even understand they have a right to enroll or disenroll into or from any given health plan, or to opt out of CCI managed care.[49]

Homeless, non-English-reading duals, and others are denied freedom of

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[46] MedPAC report to Congress, June 2010, page 133. **RJN Ex. L**.

[47] Vescovo Decl., ¶ 7.A (page 2).

[48] *Id.*, ¶ 7.A (pages 2-3).

[49] *Id.*, ¶ 7.A.iv (page 4).

choice

85. Vescovo also reported that 40 to 50 percent of the ILCSoCal duals clients are homeless, and do not receive opt out notices at all, so that they are precluded from any ability to opt our from CCI managed care.[50]

86. Benjamin Medina, M.D., of National City, in San Diego County, who specializes in internal medicine and geriatrics, has 400 active patients, 80% of whom are duals, of which approximately 70% speak Spanish only, with most having a low level of education and some are entirely illiterate.[51]

87. His duals patients have been coming to him and his staff for assistance with the CCI notices and forms by which to opt out for Medicare services.[52] However, not a single one understood the information on the forms, or how to fill out or process the opt out form, or knew they had a right to remain in standard fee-for-service Medicare.[53] Therefore they are being auto-enrolled into Medi-Connect plans in the CCI because they are unable to read or fill our or return the opt out forms they received, because of the language barrier.[54] Of these, 20% claim they never received any notices or opt out forms.[55]

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[50] *Id.*, ¶ 7.B (page 4).

[51] Medina Decl., ¶¶ 2-4.

[52] *Id.*, ¶ 6.

[53] *Id.*, ¶ 6.

[54] *Id.*, ¶¶ 8, 15.

[55] *Id.*, ¶ 10.

88. Despite these well known indisputable facts, – that 38 to 40% or more of duals are mentally or cognitively impaired; many cannot read English; and many are homeless or for other reasons never receive any CCI opt out notices, – DHCS is nevertheless, under the MOU, – as the agent of the Secretary and as instrumentality of the United States, – auto-enrolling these compromised cognitively impaired individuals, the Spanish-and-other-language populations who cannot read opt out notices, and the many who do not receive any forms in the first place; all, on the false pretense and fiction that they *did* receive the notices and opt out forms, *did* understood them and exercised free choice not to opt out of the CCI for Medicare services.

89. This patently violates the freedom of choice of provider provision of § 1802(a).

90. This also shocks the conscience, and is contrary to all concepts of ordered liberty, and arbitrarily and capriciously deprives these many cognitively impaired duals, many duals who never receive any notices, and many non-English reading duals, – who easily comprise *half or more* of the entire duals population, – of their liberty and property right under § 1802(a) to choose their own Medicare doctors, hospital, and prescription services; all, contrary to the Fifth and Fourteenth Amendments.

91. Further, – because this *ultra vires* federal due process violation affects such a broad range of duals, and because it is inherently difficult as a practical matter to administratively ascertain in the CCI project *which* duals are so impaired, or are unable to read the forms because of language barriers, or are homeless, or for

other reasons do not receive any opt out notices, – it follows that this *ultra vires* policy requiring duals to opt out in order to retain their statutory § 1802(a) right to select their own Medicare providers, must be struck down in its entirety, not, just in respect only to duals who are mentally impaired or otherwise unable to exercise any choice in the matter in any form.

92. No administrative relief is available, and Petitioners have no plain, adequate or speedy relief except by this petition for writ of mandamus or in the alternative, – if and only if mandamus relief is not available, – injunctive relief, which is requested in the event that mandamus relief is not available.

WHEREFORE, Petitioners pray for judgment as shall be hereinbelow specified:

FOURTH CLAIM FOR RELIEF

Violation of §1802(a) by Imposing Condition That Dual Must Select a Medi-Cal Plan for Medicaid Services, in Order to Opt Out of CCI for Medicare Services

93. Petitioners incorporate each of the allegations in the preceding Paragraphs.

94. By the 60-day notice, instructions, and choice form which are prior mentioned in this Petition, the only way a dual can opt out of the Medi-Connect plan to which the dual is to be auto-enrolled into, *before* the auto-enrollment occurs, is for the dual to check a box on the choice form to select one of the Medi-

Cal plans listed on the right-hand side of the choice form, and return it to DHCS.[56]

95. By such provisions of the MOU, 60-day notice, and forms of DHCS, – which forms are pre-approved by CMS, – the Secretary and DHCS have, *ultra vires,* added an administrative precondition to the free exercise of the § 1802(a) right of duals to freely choose their Medicare providers: namely, that the dual may only exercise the precious § 1802(a) right, if and only if the dual also selects a regular Med-Cal plan for all the dual's Medicaid services.

96. Hence imposing this extra pre-condition upon the unconditional statutory right in § 1802(a) to freely choose one's Medicare providers, facially violates the absolute freedom guaranteed by §1802(a), to freely choose which provider or providers to use for one's Medicare services.

97. No administrative relief is available, and Petitioners have no plain, adequate or speedy relief except by this petition for writ of mandamus or in the alternative, – if and only if mandamus relief is not available, – injunctive relief, which is requested in the event that mandamus relief is not available.

WHEREFORE, Petitioners pray as shall be specified hereinbelow:

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[56] *See,* 60-day notice form, (**RJN Ex, C**), and the choice form, (**RJN Ex. E**), which make this option explicit. I.e., the *only way Respondents allow a dual to opt out to keep their chosen Medicare doctor, hospital, and prescription drugs,* is for the dual to check a box on the choice form to "select" a Medi-Cal managed care plan, and return it.

FIFTH CLAIM FOR RELIEF

The MOU and the § 1115A (Medicare) and § 1115 (Medicaid) waivers violated each of these waiver statutes; 42 U.S.C. § 3135b; federal due process rights of duals; and the APA.

98. Petitioners incorporate each of the allegations in the preceding Paragraphs.

99. The Secretary acted arbitrarily and capriciously, and contrary to the provisions of these waiver statutes, and in abuse of discretion, to issue these waivers, because the unprecedented huge number of 456,000 duals participants, in eight counties, is (1) clearly far, far greater in extent than required to test the adequacy of managed care services for duals, (in violation of §§1115A and 1115); and (2) arbitrarily extended the risks of dangers to an unnecessarily large population of duals, (a violation §§ 1115A and 1115, as well as 28 U.S.C. § 3515b, and 48 Fed. Register, pp. 9266-67, and 9269 (1983)).

100. Hence both 28 U.S.C. § 1361 writ relief, and APA injunctive relief should be granted, first, to command the Secretary to vacate and set aside each of the MOU, the § 1115A (Medicare) waiver in the MOU, and the § 1115 waiver (Medicaid) issued in respect to the CCI on March 23, 2014; and to command each of the Respondents to refrain from implementing any part of the MOU, § 1115A waiver, § 1115 waiver, or the CCI project; *except* as may be provided in the requested judgment and orders.

FACTORS

101. *Beno v. Shalala* (9th Cir. 1994) 30 F.3d 1057, 1071, held that under a

statute which permits a test, that its extent may be no more than is necessary, and indicated that the test must be scrutinized for danger to the beneficiaries who are the participants or subjects of the test. (*Id.,* 1070-71), citing 48 Fed. Reg. at 9266-67 and 9269 (1983).[57] It follows that where there is danger to the population involved, as in the case at bar, its scope should not extend the danger to an unreasonably large population.

102. However, 465,000 duals in eight counties is an unreasonably large population and scope for testing managed care for duals, given the historical and known risks of danger that managed care poses to duals. Hence:

- the Secretary acted arbitrarily, capriciously, and contrary to § 1115A (Medicare) and § 1115 (Medicaid), as well as contrary to 28 U.S.C. § 3515b and Fed. Register 9266-67 and 9269 (1983), as well as in gross abuse of discretion, to approve the MOU and the § 1115A and § 1115 waivers, for a project whose

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[57] 48 Fed. Register pp. 9266-67 provides:

(T)he Department has an obligation, pursuant to the condition imposed upon its appropriations [by 42 U.S.C. § 3515b] to ensure that research activity not present a danger to the physical, mental, or emotional well-being of participants. . . . the Department will include in its review of proposed research activity consideration of the effects on participants. *To the extent that the proposed activity is determined to pose a danger* to the participants, informed consent in writing will be required.

48 Fed. Register p. 9269 provides:

(T)here will be a well-defined responsibility of federal program officials to take into consideration potential risks to the health and safety of participants in research activity before making a decision whether or not to approve particular projects.

(Emphasis supplied).

geographic size of eight counties, and 465,000 number of duals to be tested, is far beyond anything that is reasonably needed to enable testing of the managed care form of furnishing Medicare and Medicaid services to duals.

103. The Secretary and the Director are hence each acting *ultra vires,* to implement the CCI test by auto-enrolling duals into Medi-Connect plans for Medicare and Medicaid services, and into Medi-Cal managed care plans for Medicaid services, in the eight counties, for testing; so that a writ of mandamus under 28 U.S.C. 1361, or an injunction under Rule 65 of F.R.C.P. as well as under 5 U.S.C. §§ 702 - 704 of the Administrative Procedure Act (APA) should be issued forthwith, with interim relief.

Evidence of the danger

104. As prior mentioned, duals were mandated into Medicaid managed care plans in the 1990s by waivers issued by the Secretary. But after nearly a decade of *that* experiment, the Chairman of the U.S. Senate Special Committee on Aging, speaking for the Committee in June, 1997, reported that many duals "have experienced serious difficulties in accessing appropriate health care services. . . . At this time there is considerable concern that most managed care plans are not yet prepared to effectively serve special needs populations."[58]

105. Then in 1997, Congress enacted subd. (a)(2)(B) of § 1932,to *exclude* duals from the blanket permission otherwise granted to States by § 1932(a) to use managed care in the Medicaid program.

106. Congress thereby implicitly found and concluded that managed care is

[58] U.S. Senate Special Committee on Aging, June 14,1997. **RJN Ex. I**.

dangerous for duals in the Medicaid program.

107. Then, – when in 2011 the Secretary commenced the approval process for large managed care programs for Medicare and Medicaid programs in a number of states, including the proposed CCI project, – MedPAC (which was created by Congress to advise Congress on access to Medicare and Medicaid services)[59] – found and objected, in a July 11, 2012 letter to the Acting Administrator of CMS,[60] that:

> - The scope of the demonstrations as projected *is too broad*.
>
> - Only a limited number of health plans have experience handling the full range of benefits in a capitate environment for these complex populations (cognitively impaired, frail, physically or developmentally disabled).
>
> - Not all demonstration plans may have the capacity to serve large numbers of dual-eligible beneficiaries that will be newly enrolled.
>
> - The large scope could complicate winding down or terminating the demonstration if, for example, they are shown to reduce quality of care. If the demonstrations . . .enroll . . . *most* dual-eligible beneficiaries in a state, it may be difficult to transition beneficiaries out of the demonstration plans and back into FFS or other Medicare plans. . . . In addition, it may be difficult for large numbers of beneficiaries to re-establish their provider networks in Medicare FFS if the demonstrations are ended . . .
>
> - Finally, moving large numbers of beneficiaries into a new program creates a significant challenge if the states are to fully monitor the program given the states' already limited resources.
>
> - MedPAC believes that it is in the best interest of beneficiaries to test the demonstration models *on a smaller scale* within any given state.
>
> (**RJN Ex. G**, p. 3).

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[59] § 1805 (Medicare); § 1900 (Medicaid).

[60] **RJN Ex. G**.

108. Then, on July 10, 2012, Senator Jay Rockefeller, – who wrote the section of the ACA which enacted the Federal Coordinated Health Care Office to better enable state and federal officials to coordinate the Medicare and Medicaid Acts, – objected in a letter to the Secretary to the arbitrary excessively large scope of the demonstrations, and on the basis also that, among other things, managed care historically has injured duals by reducing access to health care.[61]

109. Specifically, Senator Rockefeller found that the demonstrations were of excessive scope, on page 4 of his July 10, 2012 objections to the Secretary:

> I am . . . troubled by state proposals to enroll large majorities of the dually eligible population or subpopulations into statewide managed care demonstrations *before they have been evaluated and proven effective* in improving quality of care. Approval of these state proposals at their current size and scope *prior to a thorough evaluation would more closely resemble a waiver than it would a demonstration,* circumventing the ACA's requirement [i.e., § 1115A), that the Secretary expand the duration and scope of demonstrations under the Innovation Center authority [under § 1115A] *only if she first finds that such an expansion* would reduce spending without reducing quality of care, or would improve quality of care without reducing spending, *and* if the chief actuary of CMS certifies this expansion would not increase spending.
>
> <u>Infringements on Beneficiary Rights and Protection</u>
>
> * *Passively enrolling dual eligibles into unproven managed care plans.* Freedom of choice is a hallmark of the Medicare and Medicaid programs, het under the demonstration as currently designed, Medicare beneficiaries who happen to be poor or disabled would be held to a different standard than other Medicare beneficiaries. (Emphasis in the text).

Senator Rockefeller also found on pages 4-5 that passive enrollment endangered

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[61] **RJN Ex. H**, p. .

duals and that the managed care model of health care delivery was not new or innovative but instead historically is known to pose risks of danger to the dual population, as follows:

> *Passive enrollment would undoubtedly lead to disruptions in access to care,* significant confusion among seniors and their families . . . Beneficiaries should not be moved out of their current coverage without their affirmative consent. (Emphasis added).

and:

> Benefit and service reductions
>
> *Relying on models of care that do not work for this population, leading to reduced access.* Medicaid managed care is a model that has not been shown to work for even small numbers of dual eligibles because of the varying range and intensity of services required to meet their special health care needs. . . . MedPAC has pointed out that many of health plans participating in the demonstration have little experience caring for this population or delivering the full range of services proposed – a concern that is exacerbated if dual eligibles are involuntarily assigned to a plan. Congress charged . . . the Centers for Medicare and Medicaid Innovation, with testing new and innovative models of care coordination, not with recycling old ideas already proven to be ineffective for this population and ***risking the health of millions by forcing them to comply***. (Boldface italics supplied).[62]

94. Then the California Legislative Analyst, who is charged by California law to advise the California Legislature, issued a thorough and extensive analysis of the 2012-13 California Budget proposals for the CCI project, and concluded, again and again that the project risked the health and safety of the duals who are subject to it.

95. *See,* complete copy of this extensive risk analysis by the Legislative Analyst, at **RJN Ex. P.**

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[62] *Id.,* p. 5.

96. Thus it is clear from:

- the history of managed care, summarized by the Senate Special Committee on Aging chairperson, (Senator Grassley);

- the fact that Congress inferentially concluded in 1997 that managed care is a threat to adequacy of services for duals in the Medicaid program;

- the thousands of computer glitzes when the Part D prescription drug program was rolled out in early 2006, which prevented thousands of duals from obtaining medicines;

- the fact that MedPAC has found, and objected to the Secretary, that the too-large scope of these demonstrations threatens access of duals to Medicare and Medicaid services;

- the fact that Senator Rockefeller, an expert on the subject, found and concluded, and informed the Secretary, that these demonstrations which auto-enroll duals into these demonstrations, are dangerous,

- the fact that the California Legislative Analyst has found and advised the California Legislature that the CCI managed care test poses known risks of danger to the health and safety of duals, unless the risks are successfully dealt with in the course of carrying out the test,

that at the very minimum, that the *scope* of the CCI test of 456,000 participants in eight counties approved by the Respondents, under any view which is not unreasonable, (a) far exceeded the minimum or reasonable geographic and population size for conducting a valid and useful test; and that (b) in view of the known dangers, that the ethics of conducting such human tests on poor populations dictated and required a much smaller scope endangering far, far fewer than the super-huge number – greater than the entire population of some states, – 456,000 poor individuals who have selected by Respondents for this dangerous human experiment.

97. I.e., 456,000 duals are manifestly not required, in eight counties, to

enable the Respondents to adequately test whether this "innovative payment and service delivery model" (sic) of CCI managed care does or may, in fact, "reduce program expenditures . . . while preserving or enhancing the quality of care furnished" to duals, as permitted by § 1115A for Medicare services, and (by similar extension) by § 1115 for Medicaid services.

98. Indeed, the setup in each of the eight counties is the same (except where it has already failed in Orange County, Alameda County, and in L.A. Care's plan).

99. Hence a test in one county of the order of, – for example, San Diego County with typically only 50,952 duals, – would **clearly have sufficed for the proposed test**, *if this was to be truly a test.* Hence the Respondents have clearly needlessly endangered the health, safety, and lives of the other approximately **400,000 duals in the other seven counties,** by needlessly including them in this purported "test model."

100. Also, testing of dual populations in excess of 50,000 in any given county was clearly not required in order to obtain sufficient dual participants to make it economically worthwhile for a private managed care entity to participate in that "small"of a managed care market.

101. Nor was testing of dual populations in excess of 50,000 in any given county necessary in order to obtain data from a sufficiently large data base of dual patients, for CMS and DHCS' test purposes.

102. The foregoing conclusions are compelled because, in every case of a geographical county area in this CCI test with a duals population of 34,000 to

51,000, one or more private managed care plans **agreed to participate**, – indicating that a *larger* test with *more participants being tested* was not and is not (1) deemed necessary for the managed care entity to make a reasonable profit, *and* (2) the data to be obtainable from use of a duals population in the particular county of "only" 34,000 to 50,000 dual population **was deemed sufficient** by Respondents to produce the requisite information by which to evaluate the CCI test in that county. (See, DHCS' own Medi-Cal Statistical Brief, page 11, showing the duals population available for the CCI test to be, invariably 50,000 or less in 7 of the counties in which tests were to be conducted:

	CCI Population
Alameda	31,076
Los Angeles	271,072***
Orange	57,060
Riverside	34,477
San Bernardino	36,368
San Diego	50,952
San Mateo	10,652
Santa Clara	35,245

*** L.A. County is limited to only 200,000 duals in the CCI test.

103. It follow therefore that "testing" in no more than one or two counties of population of 35,000 to 50,000 was needed for true test purposes, at most; and, that the granting of the § 1115A and § 1115 waivers, and executing the MOU, to **needlessly impose** this risky managed health care *test* on the remainder 400,000-

plus population of the poorest, in six or seven counties in which **no need to test anybody was shown or claimed,** egregiously and shockingly violated the limits for permissible waivers, laid down by *Beno*, by 42 U.S.C. § 3515b, by the Fed. Register standards, and by ethical considerations which must guide government officials today.

104. Hence the only conclusion that can be derived from these facts is that the granting of the § 1115A waiver (Medicare), the § 1115 waiver (Medicaid), and the approval and implementation of the MOU, by the Secretary; the action of the Director to execute the MOU; and the actions of each of the Respondents to implement the MOU and the § 1115A waiver and the § 1115 waiver in respect to the MOU, were and are manifestly arbitrary, capricious, and contrary to law, in violation of §§1115A and 1115; and (2) arbitrarily extended the risks of dangers to an unnecessarily large population of duals, – which is also a violation §§ 1115A and 1115; of 28 U.S.C. § 3515b, and 48 Fed. Register, pp. 9266-67, and 9269 (1983); of the APA, 5 U.S.C. §§ 701- 708; and of the federal due process rights of duals including the individual petitioners and the dual clients of the petitioner ILC.

105. No administrative relief is available, and Petitioners have no plain, adequate or speedy relief except by this petition for writ of mandamus or in the alternative, – if and only if mandamus relief is not available, – injunctive relief, which is requested in the event that mandamus relief is not available..

WHEREFORE, Petitioners pray for judgment and orders as follows:

1. That judgment be entered for Petitioners and that Respondents take nothing.

2. That pursuant to 28 U.S.C. § 1361 that an alternative writ of mandamus, and then a peremptory writ of mandamus, (after hearing on the return of the alternative writ), be granted, – **OR IN THE ALTERNATIVE**, that a preliminary injunction and then a permanent injunction be granted, under Rule 65, F.R.C.P which commands and orders the Respondents, and each of them, and all those working in concert with them, as follows:

A. **IN RESPECT TO THE FIRST, SECOND, THIRD, FOURTH AND FIFTH CLAIMS FOR RELIEF:**

That the respondents Secretary and Director each, respectively, forthwith, without delay:

First, vacate and set aside, and refrain from implementing in the future, namely, from and after the date of the order, judgment, or writ, each of:

- the *ultra vires* and void policy which the Secretary adopted in the July 8, 2011 Directors Letter, in violation of Social Security Act §§ 1802(a) and 1902(a)(23)(A), namely, that persons who are Medicare or Medicaid beneficiaries, or those who are beneficiaries of both Medicare and Medicaid, may be passively enrolled into managed care plans for their Medicare services or Medicaid services or both, as the case may be (hereinafter, "the passive enrollment policy"),

and,

- the *ultra vires* and void policy, in violation of §§ 1802(a) and 1902(a)(23)(A), namely, that persons who are Medicare or Medicaid beneficiaries, or those who are beneficiaries of both Medicare and

Medicaid, may be passively enrolled into managed care plans for their Medicare services or Medicaid services or both, as the case may be, which policy is set forth in the Memorandum of Understanding (MOU) dated March 27, 2013 at page 11.

Second, vacate and set aside, and refrain from implementing in the future, namely, from and after the date of the order, judgment, or writ, each of:

- the Memorandum of Understanding (MOU) executed on March 27, 2013;

- the § 1115A waiver mentioned in Appendix 4 of the MOU;

- the § 1115 waiver dated March 19, 2014,

in whole and in every part.

Third, permanently refrain from enrolling, auto-enrolling, or accepting any enrollment of any duals, – (who meet the qualifications – as listed in the MOU, – to be a dual eligible to participate in the managed care program known as the Coordinated Care Initiative (CCI)) -- into the CCI, into any Cal Medi-Connect managed care plan, into any managed care plan in the California federal/state funded Medicaid program known as Medi-Cal, or into any managed care plan or entity; at least, without first applying to this Court in this case, to obtain a change in the Court's order and judgment in this case, based on proof by a preponderance that conditions that pertained at the time of the order or judgment, have substantially changed so as to now comply with law.

Fourth, in respect to all duals who are already enrolled or passively enrolled into any Medi-Connect plan in the CCI project, that the Respondents and each of them take all speedy steps forthwith to notify each of them (1) in writing at least

once a month for six consecutive months, (2) by a display notice published at least once in the front section of the newspaper with the largest circulation in each county of the CCI, and (3) by informing all such enrolled or auto-enrolled duals, and their representatives or next friends who happen to have telephone conversations with staff of the Respondents or communicators hired and paid by either Respondent, that enrolled or auto-enrolled duals may simply return the notice or a notice form to the address shown on the notice or form: – upon which event the dual will be sent back, without delay, Medi-Cal and Medicare fee-for-service ID cards, which fee-for-service ID cards, among other things, shall be immediately effective to be able to obtain all services for the dual by the Medicare or Med-Cal fee-for-service programs which are covered by Medicare and/or Medicaid, as the case may be.

B. That in respect to the respondent Director, that the Court finds that the Director has acted at all times in both his several capacities:

– on the one hand, as an instrumentality and agent of the United States in carrying out both the federal Medicare Act and the federal Medicaid Act, all however as authorized by State law, (namely, California Senate Bill 94 and amendments thereto); as well, simultaneously,

- -on the other hand, as a State officer, carrying out duties imposed upon him by State law;

but which foregoing actions were all done color of both state and federal law, simultaneously, but were *ultra vires* in conflict with federal law, and did injure and continuously threatened to injure persons (as specified or mentioned in this order);

so that under 42 U.S.C. §1988 that the Petitioners and their counsel are entitled to reasonable attorneys' fees herein;

C. That Petitioners have their costs of suit and such other and further relief as may be just and proper.

August 29, 2014

Respectfully submitted,

/s. Lynn S, Carman
Attorneys for Petitioners and Plaintiffs

V E R I F I C A T I O N

I declare and state as follows:

I am one of the attorneys for the Petitioners and Plaintiffs (herein"Petitioners") in the within proceeding and action.

I make this Verification for the several reasons each of the Petitioners is absent from the County of Marin where I have my office, and for the reason that the facts are within my knowledge, and for the reason that I know the facts, particularly the facts that comprise the grounds for relief in this case, better than the Petitioners.

The facts alleged in the within Petition for Writ of Mandamus and Complaint for Injunctive Relief, With Stay, are true of my own knowledge, except as to the matters that are therein stated on information or belief, and as to those matters 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 on August 29, 2014 in San Rafael, California.

/s/ Lynn S. Carman
Lynn S. Carman