DEPARTMENT 85 LAW AND MOTION RULINGS

Case Number: BC644539 **Hearing Date:** May 10, 2018 **Dept:** 85

Thaddeus Moncrief, et al. v. County of Los Angeles, et al., BC 644539

Tentative decision on petition for writ of mandate: granted in part

Petitioners Thaddeus Moncrief ("Moncrief"), Carol Northern ("Northern"), Hilda Rodriguez ("Rodriguez"), and St. John's Well Child and Family Center ("St. John's") seek a writ of mandate prohibiting Respondents County of Los Angeles ("County"), Los Angeles County Department of Public Social Services ("DPSS"), and Sheryl L. Spiller ("Spiller") from (1) terminating Medi-Cal eligibility for beneficiaries who timely submit redetermination information until they ensure that all submitted information is properly processed, (2) delaying the restoration of Medi-Cal eligibility for beneficiaries who submit redetermination information within the 90-day cure period, (3) refusing to accept beneficiary redetermination information via the Internet and telephone, and (4) failing to send adequate and timely notices regarding the redetermination process as required by law.

The court has read and considered the moving papers, opposition, and reply, and renders the following tentative decision.

A. <u>Statement of the Case</u>

1. <u>Petition</u>

Petitioners commenced this proceeding on December 21, 2016. The Petition and Complaint ("Petition") allege in pertinent part as follows.

Respondents have a policy and practice of unlawfully discontinuing Medi-Cal eligibility for thousands of beneficiaries due to their delay in complying with their obligation to process annual redetermination submissions. Respondents also have a policy and practice of failing to restore Medi-Cal eligibility for thousands of beneficiaries during the 90-day cure period. More than 90 days after termination, Respondents fail to restore Medi-Cal, thereby causing beneficiaries to incur additional medical expenses and suffer delays in reinstating Medi-Cal coverage for which they are eligible.

Respondents terminate Medi-Cal eligibility during annual renewals at a far higher rate than other counties in California. According to data for March through August 2016 from the California Department of Health Care Services ("DHCS"), Respondents had a much lower percentage of continued Medi-Cal eligibility through renewals compared to the other 57 counties in the state. Between January and September 2016, Respondents failed to timely scan 24,525 renewal submissions. The scanning of renewal submissions is a necessary initial step in processing. Respondents have admitted that they had a backlog of 12,700 terminated cases, as recently as October 2016 despite the beneficiaries' submission of timely renewal information.

Petitioners Moncrief, Northern, and Rodriguez timely submitted all of the information required to continue their Medi-Cal eligibility without interruption. Respondents failed to continue their Medi-Cal eligibility pending evaluation of their redetermination information. Respondents also did not permit Petitioners to submit redetermination information via the Internet and telephone as required by state law. Instead, Respondents required Petitioners to submit redetermination information via mail and in-person office visits.

With respect to Petitioners Moncrief and Northern, Respondents failed to issue timely and adequate notice of Medi-Cal eligibility terminations, contrary to state law requirements.

Respondents are violating their ministerial duties under the laws by, *inter alia*, (a) failing to timely process annual Medi-Cal redeterminations in compliance with Welfare and Institutions Code ("W&I") section 14005.37 and related regulations, (b) failing to issue adequate and timely notices of action ("NOA"), and (c) unlawfully terminating Medi-Cal eligibility for thousands of eligible County residents.

2. Course of Proceedings

On March 21, 2017, the instant case was temporarily reassigned from Department 32 to Department 85 for purposes of resolution of all writs causes of action.

On May 9, 2017, the court stayed all causes of action other than those for mandate and declaratory relief.

On July 13, 2017, the court granted Petitioners' motion to compel production of documents.

B. Standard of Review

"A writ of mandate may be issued by any court to any inferior tribunal, corporation, board, or person, to compel the performance of an act which the law specially enjoins, as a duty resulting from an office, trust, or station, or to compel the admission of a party to the use and enjoyment of a right or office to which the party is entitled, and from which the party is unlawfully precluded by such inferior tribunal, corporation, board, or person." CCP §1085(a).

A traditional writ of mandate under CCP section 1085 is the method of compelling the performance of a legal, ministerial duty. Pomona Police Officers' Assn. v. City of Pomona, (1997) 58 Cal.App.4th 578, 583-84. Generally, mandamus will lie when (1) there is no plain, speedy, and adequate alternative remedy, (2) the respondent has a duty to perform, and (3) the petitioner has a clear and beneficial right to performance. Id. at 584 (internal citations omitted). Whether a statute imposes a ministerial duty for which mandamus is available, or a mere obligation to perform a discretionary function, is a question of statutory interpretation. AIDS Healthcare Foundation v. Los Angeles County Dept. of Public Health, (2011) 197 Cal.App.4th 693, 701.

A ministerial act is one that is performed by a public officer "without regard to his or her own judgment or opinion concerning the propriety of such act." Ellena v. Department of Insurance, (2014) 230 Cal.App.4th 198, 205. It is "essentially automatic based on whether certain fixed standards and objective measures have been met." Sustainability of Parks, Recycling & Wildlife Legal Defense Fund v. County of Solano Dept. of Resource Mgmt., (2008) 167 Cal.App.4th 1350, 1359. By contrast, a discretionary act involves the exercise of judgment by a public officer. County of Los Angeles v. City of Los Angeles, (2013) 214 Cal.App.4th 643, 653-54.

No administrative record is required for traditional mandamus to compel performance of a ministerial duty or as an abuse of discretion.

C. Governing Law

Title XIX of the Social Security Act, 42 USC sections 1396 *et seq*. ("Medicaid Act"), authorizes federal financial support to states for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the states. California has elected to participate in the Medicaid program through the Medi-Cal program. W&I §§ 14000 *et seq.*; 22 CCR §§ 50000 *et seq.* DHCS is the state agency that administers Medi-Cal.

1. Eligibility Redeterminations

A county shall (1) perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months and (2) promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits. W&I §14005.37(a). Medi-Cal eligibility shall continue during the redetermination process and a beneficiary's Medi-Cal eligibility shall not be terminated until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis. W&I §14005.37(d).

a. Redetermination Not Requiring Beneficiary Response

For purposes of acquiring information necessary to conduct the eligibility redeterminations described in this section, a county shall gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. W&I §14005.37(e)(1). Sources for these efforts shall include information contained in the beneficiary's file. Id.

In the case of an annual redetermination, if the county can make a determination of continued eligibility based on this information, the county shall notify the beneficiary, *inter alia*, of the eligibility determination and the

information it is based on. W&I §14005.37(e)(2).
In the case of a redetermination due to a change in circumstances, if a county determines that the change in circumstances does not affect the beneficiary's eligibility status, the county shall not send the beneficiary a notice unless required to do so by federal law. W&I §14005.37(e)(4).

b. Redetermination Requiring Beneficiary Response

In the case of an annual redetermination, if the county is unable to determine continued eligibility based on information obtained, the beneficiary shall be so informed and provided with an annual renewal form at least 60 days prior to the beneficiary's annual redetermination date. W&I §14005.37(f)(1). The form must be prepopulated with information that the county has obtained and that identifies any additional information needed by the county to determine eligibility. Id. The form must notify the beneficiary that the beneficiary is required to provide the necessary information to the county within 60 days of the date that the form was sent to the beneficiary. W&I §14005.37(f)(1)(A).
The beneficiary may respond to the county with the needed information via the Internet, by mail, by telephone, in person, or through other commonly available electronic means if those means are available in that county. W&I §14005.37(f)(1)(B). If the beneficiary does not provide a response to the written request for information within 60 days from the date the form is sent, the county shall terminate the beneficiary's eligibility for Medi-Cal benefits. W&I §14005.37(f)(3).
In the case of a redetermination due to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, the county shall send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. W&I §14005.37(g)(1). The requested information shall only relate to the change in circumstances. Id. The beneficiary shall have 30 days from the date the form is mailed to respond. Id.

c. Post-Termination Beneficiary Response

If the beneficiary submits to the county a signed and completed form or otherwise provides the needed information within 90 days of termination of a Medi-Cal beneficiary's eligibility or a change in eligibility status, eligibility shall be redetermined by the county and, if the beneficiary is found eligible, or the beneficiary's eligibility status has not changed, whichever applies, the termination shall be rescinded as though the form were submitted in a timely manner. W&I §14005.37(i). Further, DPSS must "immediately" enter the information in LRS. Zohar Decl. Ex. 21 (Medi-Cal Eligibility Division Information Letter).

D. Statement of Facts[1]

1. Termination of Medi-Cal Benefits Despite Timely Renewal Applications

a. The Procedure

DHCS issues performance standards that govern counties' annual redeterminations of Medi-Cal cases. Flores Decl. ¶9, Ex. A; Williams Decl. ¶2. These standards provide, "Ninety percent of the annual [redeterminations] shall be completed within 60 days of the recipient's annual [redetermination] date for those [redeterminations] based on forms that are complete and have been returned to the county by the recipient in a timely manner." Flores Decl. ¶9, Ex. A, p.4; Williams Decl. ¶2.
Respondents' computer system, "LRS", is set up so that Medi-Cal renewal applications are due approximately in the middle of each month. Zohar Decl. Ex. 8, p.42; *see also* Zohar Decl. Exs. 12, p.129; 23, p.2. If they are not received by the mid-month cutoff date, the LRS system will terminate the Medi-Cal benefits and designate the case as "Inactive". Zohar Decl. Ex. 8, pp. 42, 71. LRS sends out a NOA advising the participant that his/her benefits will be terminated at the end of the month. Zohar Decl. Ex. 8, p. 72. If a renewal packet is received before the end of the month, DPSS's workers must manually rescind the termination or request verification if necessary. Zohar Decl. Ex. 8, pp. 72-73. If the worker is starting the rescission process, he or she will list the renewal as "Pending" if verification still is required or else make the case "fall off the list" because it has been fully processed for renewal. Zohar Decl. Ex. 8, p. 73.
Reports entitled "MC [Medi-Cal] Renewals Received Not Processed" ("Unprocessed Renewal Reports") promulgated by DPSS twice a week identify unprocessed renewal applications. Zohar Decl. Ex. 13. DPSS uses the Unprocessed Renewal Reports to track the status of Medi-Cal cases and to ensure their adequate processing. Flores Decl. ¶7. The data in Unprocessed Renewal Reports represent the volume of cases that have yet to be completely processed. Flores Decl. ¶7.

Once the case is processed, it "falls off" the Unprocessed Renewal Report. Zohar Decl. Ex. 15, p.64.
The Unprocessed Renewal Report specifically shows the number of discontinued and pending cases where Medi-Cal benefits have been terminated. *See, e.g.*, Zohar Decl. Exs. 30-31; *see also* Ex. 15, pp. 43-44, 69 ("AC" means "Active", meaning the beneficiary is eligible) ("PE" means "Pending"), 91 ("DS" means "Discontinued"). For each case listed, the Unprocessed Renewal Reports set forth (a) the eligibility renewal due date, (b) the date DPSS marked the renewal packet as "Received," (c) whether the beneficiary needs to submit additional information (marked as "Incomplete"), and (d) whether DPSS has reviewed the beneficiary's submission (marked as "Reviewed"). *See, e.g.*, Zohar Decl. Exs. 30-31. There are a variety of reasons why a case may be terminated. Flores Decl. ¶7. A case marked as "Inactive" does not necessarily mean the case has been terminated; cases are often manually activated in the state's eligibility system pending resolution of technical or other issues in DPSS's systems. Id.

b. The Backlog

Delays existed in the processing of Medi-Cal renewals in 2015 and 2016. Flores Decl. ¶8. These delays resulted from a unique set of circumstances — the issuance of a preliminary injunction in another lawsuit — which no longer exists. Id., Ex. B. DPSS resolved these delays in 2016. Id.
On January 13, 2017, Michelle Sepulveda, Chief of DPSS's Line of Operations Development Section, informed a colleague via email that DPSS's senior official is "not gonna like the numbers" contained in the contemporaneous MC renewal report. Zohar Decl. Ex. 12, p.104. On April 19, 2017, Benny Liang, DPSS Division Chief, informed DPSS employees that "[n]umbers are going up." Zohar Decl. Ex. 12, p.257. On November 28, 2017, Patricia Ramos, a DPSS employee, remarked "[a]ction required" with respect to the MC renewal report issued that day. Zohar Decl. Ex. 14, p.322.
The Unprocessed Renewal Report dated November 28, 2017 showed that DPSS had over 40,000 unprocessed renewal cases. Zohar Decl. Ex. 14, pp. 325-26.

c. The Problem

On November 29, 2016, Marina Cooper, a DPSS Administrative Services Manager, noted in an email to numerous DPSS employees that "[r]enewals not updated as 'Received' before cut-off will result in: [e]rroneous terminations…." Zohar Decl. Ex. 28, p.2. If a renewal packet is submitted before the end of the month, the eligibility worker must work to rescind the case and request verification if needed in order to revert the case back to "Active" status. Zohar Decl. Exs. 8, pp. 72-73; Ex. 25, p.96. As of February 12, 2018, this automatic termination issue has ostensibly not been resolved. Zohar Decl. Ex. 17, p.34.
The Unprocessed Renewal Reports dated January 2, 2018 reflect a sub-category of cases whose renewal applications were submitted by their respective due dates but which were nevertheless terminated at the end of the month. Zohar Decl. ¶¶ 31-32, Exs. 30-31. In some of these cases, DPSS received the renewal information but had not reviewed it (marked as "Received"). In other cases, DPSS received the information, reviewed it, and concluded that all required information was present (marked as "Reviewed-Ready"). Zohar Decl. Exs. 30-31; *see also* Ex. 15, pp. 60-61 ("Received" means DHSS received packet, it either was manually or automatically scanned and marked, and the renewal processing is not yet complete); 63 ("Reviewed-Ready" means eligibility worker has reviewed information in the packet and that case is ready for annual redetermination).
Petitioners' counsel compiled a table of the cases in the Unprocessed Renewal Reports between December 2016 and December 2017 in which DPSS terminated Medi-Cal eligibility even though DPSS had marked the renewal application as "Received" prior to the due date and had not designated the case as "Incomplete". Ozurovich Decl. ¶16; Exs. 30-31, 43-58. The table reflects 11,879 terminated cases in this timeframe. Id. For the month of December 2017, with a report date of January 2, 2018, the number of terminated cases peaked at over 2,000 cases. Id.
Petitioners' counsel also computed the average number of persons per eligibility case by using individual figures from the preceding six-month period (August 2016 to January 2017). Ozurovich Decl. ¶4. Applying this number, Petitioners' counsel extrapolates that the termination of these 11,879 cases resulted in 22,391 persons losing Medi-Cal benefits. Ozurovich Decl. ¶17. For December 2017, this means that over 3,800 Medi-Cal beneficiaries lost health care coverage even though DPSS had received the beneficiary's renewal paperwork. *See* Ozurovich Decl. ¶¶ 16-17. Even as of January 31, 2018, some evidence suggests that

Respondents were still terminating Medi-Cal eligibility for beneficiaries who submitted renewal information on time. *See* Wei Decl. ¶¶ 5, 9.
There were a total of 1,513,416 renewals for the period from December 2016 through November 2017. Flores Decl. ¶11. The cases that Petitioner deem unlawfully terminated account for 0.933% of the total renewals for the corresponding period, excluding December 2017, and 1.128% of the total renewals, including December 2017. Id. DPSS processed approximately 98-99% of the renewals within the performance standard of a 60-day window. Id. With the exception of May 2017, DPSS's processing of Medi-Cal annual redeterminations for this timeframe meet or exceed the timeliness requirements reflected in W&I section 14154(d)(3)(B). Williams Decl. ¶4.

d. Impacts from Lost Medi-Cal despite Timely Submissions
Moncrief
Moncrief has been paraplegic since 1989 when he suffered a spinal injury. Zohar Decl. Ex. 22: Moncrief Decl. ¶3. He uses a wheelchair to get around. Id. He does not work due to his long-term disabilities. Moncrief Decl. ¶4. He has been on Medi-Cal since 1989. Id.
In April 2016, Moncrief received a renewal packet from the County. Moncrief Decl. ¶6. Because he had been on Medi-Cal for several years, he was familiar with the annual renewal process. Id. He filled out the packet and sent it back in May 2016, the month that it was due. Id.
In late June or early July 2016, Moncrief received a letter from his health plan provider that he was no longer eligible to receive care because he had been dropped from Medi-Cal. Moncrief Decl. ¶7. This letter informed Moncrief for the first time that he had lost his Medi-Cal coverage as of June 1, 2016. Id.
Moncrief called Medi-Cal repeatedly over a two to three week period but kept getting the runaround. Moncrief Decl. ¶8. Eventually, an eligibility worker called him back. Id. The worker sent Moncrief a new renewal packet. Id. Moncrief filled it out and mailed it back promptly. Id. He did not hear back. Id.
By late July 2016, Moncrief ran out of his hypertension medicine, catheters, and colostomy pouches. Moncrief Decl. ¶9. His wheelchair also required repair. Id. Without this repair, his wheelchair presented dangers. Id.
On September 19, 2016, Moncrief called legal aid for help. Moncrief Decl. ¶11. Neighborhood Legal Services got involved, and a week later, Moncrief was informed that his Medi-Cal benefits would be reinstated. Id. However, due to further administrative complications, Moncrief was not able to see his normal primary care physician, and, in the interim, ran out of medically-necessary colostomy pouches and catheters that prevented him from leaving the house because he feared that he might suffer an accident in public. Moncrief Decl. ¶¶ 12-13.

Avak Kizirian
Avak Kizirian ("Kizirian") is 92 years old. Kizirian Decl. ¶1. Kizirian is unable to hear without a hearing aid and has difficulty seeing. Id. Kizirian has had Medi-Cal for at least 13 years. Kizirian Decl. ¶3. He depends on Medi-Cal to cover his Medicare premiums, deductibles, and coinsurance. Id.
In June 2016, Kizirian received a request for annual eligibility redetermination information from DPSS. Kizirian Decl. ¶4. The renewal forms stated that the forms were due by mid-August 2016. Id. Kizirian filled out the forms and his son mailed them around the mid-August 2016. Kizirian Decl. ¶5.
In January 2017, Kizirian learned that his Medi-Cal had been terminated because the County failed to process his renewal on time. Kizirian Decl. ¶6. Kizirian's son called DPSS and was told to resend a copy of the renewal forms. Kizirian Decl. ¶7. Kizirian did not hear back from DPSS. Kizirian Decl. ¶8. Kizirian's son called DPSS again and learned that too much time had transpired since Kizirian's eligibility termination and that he would have to reapply. Id.
Kizirian faced several problems due to these complications. Kizirian Decl. ¶11. First, in February 2017, Kizirian's hearing aid broke and needed to be replaced. Id. Because Medi-Cal covers his hearing aid and he did not have hearing aid, it was not replaced until January 2018 following his Medi-Cal reinstatement on August 31, 2017. Id. Second, Medi-Cal covered 20 percent of the bills for Kizirian's doctor visits. Id. Because it was terminated, Kizirian started to receive stacks of medical bills. Id. Third, Medi-Cal's termination resulted in financial difficulties paying for rent and groceries. Id. Kizirian's son lost $12,000 annual income as Kizirian's IHSS worker since his eligibility for IHSS terminated when his Medi-Cal eligibility terminated. Kizirian Decl. ¶12. Fourth, Kizirian suffered a great amount of stress and anxiety

because of the financial straits that he placed his son in as a result of his Medi-Cal termination. Kizirian Decl. ¶14.

Frances Jordan

Frances Jordan ("Jordan") is 85 years old. Fisher Decl. ¶1. She has suffered several strokes and, as a result, possesses very limited mobility. Id. She also suffers from diabetes, kidney failure, and high cholesterol. Id. Jordan has had Medi-Cal for approximately ten years. Fisher Decl. ¶3.

Around the end of July 2017, Jordan received a request for information for her annual eligibility redetermination. Fisher Decl. ¶5. The renewal forms were due in mid-August 2017. Id. Jordan mailed them to DPSS near the beginning of August. Fisher Decl. ¶6. About a month later, Jordan was informed that her Medi-Cal had been terminated. Fisher Decl. ¶7. As a result of this termination, Jordan's monthly caretaker could no longer care for her. Id.

In mid-September, Jordan received a letter from DPSS informing her that her Medi-Cal was terminated on September 1, 2017. Fisher Decl. ¶9. Jordan's daughter called DPSS customer service and eventually learned that DPSS received Jordan's paperwork late and that it would take time to process. Fisher Decl. ¶10. The DPSS agent would not give Jordan's daughter an estimate of how long processing would take. Id.

St. John's

St. John's is a network of thirteen licensed health clinics which provide free and low-cost medical, dental, and mental health services. Zohar Decl. Ex. 42: Mangia Decl. ¶1. St. John's had over 330,000 patient visits in 2017. Id. Over 57,000 of its patients are enrolled in Medi-Cal. Id. In 2016, thousands of its patients had their Medi-Cal benefits terminated due to the County's processing delays. Id. St. John's ability to serve its patients' health needs has been dramatically hampered by the County's delays. Id.

Since January 2016, St. John's has seen over 5,000 patients whose Medi-Cal has been cut off and not reinstated even though they submitted their renewal information on time. Mangia Decl. ¶2. St. John's has also seen over 6,000 additional patients who were terminated and then reinstated, but in the interim experienced significant delay. Id.

St. John's benefits counselors must spend significant time resolving renewal processing delays. Mangia Decl. ¶4. In January 2018, St. John's received a list of 1,709 patients who are no longer assigned to St. John's by their health plans because the County terminated their Medi-Cal. Id. St. John's estimates that over 300 of the 1,709 patients were disenrolled from their health plans and Medi-Cal because of the county's renewal processing issues. Id.

Nearly 100 Medi-Cal patients served by St. John's each week have had their Medi-Cal benefits terminated because of the County's flawed processing. Mangia Decl. ¶5. St. John's absorbs the high cost of primary care for these patients until their benefits are reinstated. Id. When St. John's is finally reimbursed, St. John's loses out on 50 to 75 percent of its normal reimbursement rate. Id.

The County's Medi-Cal renewal processing has affected St. John's and its patients in three profound ways. Mangia Decl. ¶13. First, providing care to Medi-Cal enrollees after the County terminates their eligibility even though they timely submitted their renewals poses a major financial strain for St. John's and the medical system as a whole. Mangia Decl. ¶13. Since January 2016, St. John's has provided 11,508 uncompensated visits to patients, most of whom were patients who are Medi-Cal eligible and were awaiting delayed Medi-Cal renewal. Id. Second, the renewal backlog harms St. John's patients' short- and long-term health. Mangia Decl. ¶13. Some patients need specialty care referrals that St. John's cannot timely obtain through the County health system alternative without Medi-Cal. Mangia Decl. ¶13. Third, St. John's day-to-day operations are severely taxed by the flawed processing of Medi-Cal annual renewals and the resulting eligibility terminations. Mangia Decl. ¶13. St. John's enrollment staff spends exorbitant amounts of time attempting to resolve renewal backlog cases with a non-responsive bureaucratic county system. Id.

Steven P. Wallace

Dr. Steven P. Wallace ("Wallace") is a professor of public health at the University of California – Los Angeles' Fielding School of Public Health. Zohar Decl. Ex. 32: Wallace Decl. ¶1. Wallace opines that "losing Medicaid coverage, even temporarily, reduces ambulatory care use, increases emergency department use, and leads to worse health." Wallace Decl. ¶6. When beneficiaries lose Medicaid coverage, they often experience a delay in finding a medical provider to treat their conditions at an affordable price, assuming that

they can find such a provider at all. Id. High need groups, such as the elderly and disabled, often prioritize keeping established sources of care above added benefits and services that they would receive if they shifted providers under the new system. Wallace Decl. ¶7.

According to Wallace, research shows that terminating Medicaid has the greatest impact on those with on-going health conditions such as the disabled, older adults who commonly have multiple chronic conditions that require constant monitoring, and younger adults/children with ambulatory sensitive conditions such as asthma and diabetes. Wallace Decl. ¶8.

2. Processing of Renewal Applications Received within 90-Day Cure Period

a. The Problem

The Unprocessed Renewal Reports each month show hundreds of renewal applications received during the 90-day cure period, which Respondents marked as "Received" or "Reviewed-Ready." Zohar Decl. Exs. 30-31, 43-58; Ozurovich Decl. ¶¶ 22-23. The 2017 Unprocessed Renewal Reports show over 4,700 renewal submissions received during the 90-day cure period that remained unprocessed. Ozurovich Decl. ¶23. This failure to promptly re-determine eligibility affected over 8,000 Medi-Cal beneficiaries. Ozurovich Decl. ¶24.

The Unprocessed Renewal Reports also show that 718 terminated beneficiaries timely submitted their information during the 90-day cure period and yet their submissions had been pending for more than a month. Ozurovich Decl. ¶25, 28.

DPSS promptly processes renewals received within the 90-day cure period in an overwhelming majority of cases. Flores Decl. ¶12. The alleged unprocessed renewals account for 0.379% of the total renewals for the corresponding period, excluding December 2017, and 0.453% of the total renewals, including December 2017. Id.

Since the Unprocessed Renewals Reports capture fluid data at a moment in time, they do not show how long the case has been pending. Flores Decl. ¶13. Thus, the Reports fail to show whether a case was received immediately before the Report date or whether it was processed immediately thereafter. Id.

b. Impacts

Maria Salas

Maria Salas ("Salas") is 60 years old. Zohar Decl. Ex. 33: Salas Decl. ¶1. She has diabetes and has been on Medi-Cal for four years. Salas Decl. ¶2. Salas needs Medi-Cal in order to receive medical services to control her diabetes, as it helps provide medications, test strips, and doctors' appointments. Salas Decl. ¶3.

On July 19, 2016, Salas received a letter from the County informing her that her Medi-Cal was scheduled to terminate at the end of the month. Salas Decl. ¶4. The letter explained that her benefits were terminated because she did not complete the redetermination process. Id. This surprised her because she did not receive a request for annual eligibility redetermination information. Id.

Because she felt ill, she did not go to a DPSS office right away. Salas Decl. ¶5. In the first week of August, Salas called DPSS' customer service line. Salas Decl. ¶7. Once that failed, she went to a DPSS office and met with her case worker on September 21, 2016. The case worker informed her that her packet was complete and that DPSS would let her know if they needed further information. Salas Decl. ¶8. Salas returned to DPSS when she did not hear back by the second week of October 2016. Salas Decl. ¶9. A DPSS clerk told Salas that she just needed to wait for her packet to be processed. Id. Salas eventually sought help from Neighborhood Legal Services of Los Angeles County in February 2017. Salas Decl. ¶12. Ten days later, an advocate for Neighborhood Legal Services got her Medi-Cal reinstated. Id.

While waiting for her packet to be processed, Salas' family paid for her medications, test strips, and a doctor's appointment. Salas Decl. ¶11. Because of financial constraints, Salas missed three doctor's appointments, and her blood sugar levels spiked. Id.

E. Analysis

Petitioners seek a writ of mandate prohibiting Respondents from (1) terminating Medi-Cal eligibility for beneficiaries who timely submit renewal packets until they ensure that all submitted information is properly processed; (2) delaying the restoration of Medi-Cal eligibility for beneficiaries who submit redetermination information within the 90-day cure period; (3) refusing to accept beneficiary redetermination information via the Internet and telephone; and (4) failing to send adequate and timely notices regarding the redetermination process as required by law.

1. Tables 1 and 2

Preliminarily, Respondents suggest that Petitioners' Tables 1 and 2 showing that 11,879 cases were unlawfully automatically terminated and that there were 4,765 unprocessed 90-day cure period renewals are suspect. Respondents argue that Petitioners' conclusion that the Table 1 cases were unlawfully terminated is "baseless and unfounded" and the Table 2 listed reports are merely a snapshot of fluid data. Opp. at 9.

Respondents do not explain in detail their concern about Tables 1 and 2. There is some evidence that a case marked as "Inactive" on an Unprocessed Renewal Report does not necessarily mean the case has been terminated; there may be a pending technical or other issue in DPSS's system that would cause Inactive status. Id. Flores Decl. ¶7. This evidence is insufficient to overcome a conclusion that the vast majority of the 11,879 cases cited in Table 1 were automatically terminated by LRS at the end of a month despite the fact that the renewal submission had been received.

The court agrees, however, that Table 2 shows only a snapshot of unprocessed 90-day cure period renewals. *See* Pet. Op. Br. at 8. The Unprocessed Renewal Reports referred to in Table 2 do not show the exact date the renewal submission was received (only the "Month Received") or when it was finally acted upon. They show only that the listed submissions were made within the 90-day cure period and had not been acted upon as of the Report date.

2. Termination of Medi-Cal Despite Timely Renewal Submissions

"Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section and a beneficiary's Medi-Cal eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis and due process rights guaranteed under this division have been met." W&I §14005.37(d) (emphasis added). This provision means that "[a]ll established Medi-Cal beneficiaries…are entitled to continue their benefits until they are found to be ineligible by a redetermination of eligibility by the county." Armando D. v. Shewry, (2004) 124 Cal.App.4th 13, 17.

Petitioners contend that Respondents are unlawfully terminating the Medi-Cal benefits of beneficiaries who have timely submitted renewal packet and are waiting for Respondents' specific determination of their eligibility. Respondents did not timely process approximately 11,000 cases between December 2016 and December 2017, resulting in thousands of automatic and unlawful terminations. The system remains unchanged as of February 12, 2018. Ex. 17, p. 34. Pet. Op. Br. at 9.

Despite their concern about the evidence, Respondents implicitly concede that a number of beneficiaries who made timely renewal submissions were erroneously terminated. *See* Opp. at 8. Respondents contend that Petitioners fail to consider the volume of renewal applications DPSS receives. Id. DPSS processes on average over 120,000 redeterminations a month and approximately 98 to 99% are handled properly. Flores Decl. ¶11. Respondents argue that any resulting errors are acceptable because 100% accuracy cannot be expected from a large institution operating on DPSS's scale. Opp. at 8, 10.

Respondents note that DPSS's timely processing of 98-99% of renewal cases significantly exceeds DHCS's performance standards. Opp. at 9; Flores Decl. Ex. A. DHCS guidelines set forth performance standards for state cost control purposes. *See* W&I §14154. The guidelines state, "Ninety percent of the annual [redeterminations] shall be completed within 60 days of the recipient's annual [redetermination] date for those [redeterminations] based on forms that are complete and have been returned to the county by the recipient in a timely manner." Flores Decl. Ex. A, p.4. With the exception of May 2017, DPSS's processing of Medi-Cal annual redeterminations for the pertinent timeframe met or exceeded the timeliness requirements reflected in W&I section 14154(d)(3)(B). Williams Decl. ¶4. Respondents conclude that there is no systemic problem that requires the court to issue a writ. Opp. at 10.

The problem with Respondents' argument is that W&I section 14005.37(d) imposes a ministerial duty for Respondents to continue Medi-Cal eligibility during the redetermination process until DPSS makes a specific determination of non-eligibility. The LRS computer system of automatic termination if a renewal packet is not received by mid-month of the month it is due, and then manual reinstatement if the renewal packet is received sometime during the balance of the that month, puts the cart before the horse and results in numerous unlawful terminations when the manual reinstatement does not occur due to backlog or clerical error. Table 1 shows that this unlawful termination occurred for 11,879 cases during an almost one year period in 2017. Pet.

Op. Br. at 4. This procedure is non-compliant with DPSS's ministerial duty to continue Medi-Cal eligibility until there is a determination of non-eligibility.

DCSS's compliance with the performance standards in DHCS's guidelines merely shows that DCSS complies with processing deadlines for renewal submissions in 98-99% of cases. 14005.37(a). This compliance with processing standards is not germane to whether Respondents failed to perform their ministerial duty to maintain the eligibility of Medi-Cal participants until they specifically have been found to be ineligible. Respondents simply do not comply with section 14005.37(d)'s ministerial duty when LRS terminates first and then DPSS workers process timely received submissions sometime afterwards. *See* Reply at 2-3.

Respondents argue that Medi-Cal beneficiaries are entitled to an administrative hearing if they disagree with the termination of their benefits and that will retain their benefits if they exercise this right. Opp. at 12. Respondents note that the individual Petitioners already regained their Medi-Cal benefits. Id.

Petitioners characterize Respondents' argument as raising an issue of standing. Reply at 9-10. This is incorrect. Respondents are merely arguing that there is no systemic problem in the County's Medi-Cal renewal process and, to the extent that a participant is wrongly terminated or not timely renewed, he or she has an administrative remedy. Respondents are arguing a failure of proof, not standing. Respondents implicitly argue that they are substantially performing, not failing to perform, their ministerial duty.

It is true that Medi-Cal participants such as the individual Petitioners have an administrative hearing remedy when their benefits are wrongly terminated. That remedy suffices where there are mistakes made by DPSS. The LRS termination system is more than a mistake; it is an institutional failure. The refusal or neglect to perform an act which is enjoined by the law as a present duty serves as the foundation for traditional mandamus. Morris v. Harper, (2001) 94 Cal.App.4th 52, 60. The LRS computer system of terminating Medi-Cal beneficiaries mid-month before their submissions actually are untimely, and then failing in numerous cases to rescind the termination, is a neglect to perform a ministerial duty.[2]

3. Restoration of Medi-Cal Eligibility during Cure Period

If the beneficiary submits a signed and completed form or otherwise provides the needed information within 90 days of termination, "eligibility shall be redetermined by the county and, if the beneficiary is found eligible, or the beneficiary's eligibility status has not changed, whichever applies, the termination shall be rescinded as though the form were submitted in a timely manner." W&I §14005.37(i).

In a Medi-Cal Eligibility Division letter, DHCS added a "promptness" requirement to this redetermination, stating that the county "shall treat [a completed application within the cure period] as if it is received timely and immediately enter the information … for a redetermination." Zohar Decl. Ex. 21, p.2 (emphasis added). DHCS indicated that immediacy is required under the "promptness" requirement of W&I §14005.37(a). Id.

Petitioners contend that Respondents breached a ministerial duty by failing to promptly restore medical eligibility to beneficiaries who submit renewal applications during the 90-day cure period. Pet. Op. Br. at 10.

Respondents again present a volume and performance-based defense. Opp. at 10. Respondents show that unprocessed renewals within a 90-day cure period only accounts for 0.379% of the total renewals for the relevant timeframe of most of 2017. Flores Decl. ¶12. Respondents contend that this figure shows that there is no disproportionate or inadequate discrepancy in processing. DPSS promptly processes renewal submissions received within the 90-day cure period in the overwhelming majority of cases. Opp. at 10.

Petitioners' Table 2 fails to show a breach of ministerial duty. Petitioners are correct that DHCS interprets sections 14005.37(i) and (a) to impose a ministerial duty upon DPSS to promptly redetermine renewals submitted during the 90-day cure period. But Table 2 presents only a snapshot of renewal submissions received during the 90-day cure period. Petitioners' Table 2 shows only that the renewal submissions were timely received the month before the Report date. Based on this limited information, they could have been received anywhere between the first of the month and the day before the Report date. Hence, the fact that Table 2 shows that beneficiaries submitted 4,700 renewal submissions during their 90-day cure period and that these submissions remained unresolved on the Unprocessed Renewal Report date does not necessarily demonstrate lack of promptness. To show a breach of this ministerial duty, Petitioners need to show the length of time between receipt of the renewal submission and Respondents' redetermination on the renewals (or lack thereof).

Petitioners fill this missing gap with evidence that the January 2, 2018 Unprocessed Renewal Report shows that 1360 annual renewal submissions had been timely made during the 90-day cure period prior to December 2017 and still were awaiting processing, some since January 2016. Ozurovich Decl. ¶¶ 29, 34. Petitioners

also present anecdotal evidence from individual Petitioners that their timely submissions during the cure period were not immediately resolved. *See, e.g.,* Salas Decl.[3]
Respondents argue that DPSS promptly processes renewal submissions that are received within the 90-day cure period in an overwhelming majority of cases (Flores Decl. ¶12) and Petitioners' Table 2 unprocessed renewals submitted during the cure period account for only 0.379% of the total 1,052,922 renewal submissions for the pertinent timeframe in 2017. Id.
This is true, and it is also true that the 1360 timely and unprocessed 90-day cure period submissions older than one month are only .129% of the 1,052,922 renewal submissions processed by DPSS. Nonetheless, the evidence shows DPSS's violation of the immediacy requirement imposed by DHCS and W&I sections 14005.37(i) and (a). Whatever the term "immediacy" means, it surely does not permit DPSS to wait more than a month to rescind a termination and evaluate the beneficiary's submission. Yet, that is what DPSS did in 1360 cases during the pertinent 2017 period. Some of these timely cure period submissions awaited multiple months for the statutorily required rescission of termination and redetermination of annual renewal. Coupled with Petitioners' anecdotal evidence, the evidence shows that DPSS has neglected its duty to "immediately" rescind eligibility termination and evaluate 90-day cure period submissions. This is a breach of the ministerial duty in W&I sections 14005.37(i) and (a). *See* Morris v. Harper, *supra*, 94 Cal.App.4th at 60.[4]
In sum, although DPSS may promptly process renewal submissions received during the 90-day cure period in the overwhelming majority of cases, it has neglected or refused to comply with its ministerial duty in W&I sections 14004.37(i) and (a) to immediately rescind terminations and evaluate the timely submissions.

4. Notice Prior to Medi-Cal Eligibility Termination

If the county is unable to determine continued eligibility for an annual eligibility redetermination based on existing information, the beneficiary shall be so informed and provided with an annual renewal form, at least 60 days prior to the beneficiary's annual redetermination date. W&I §14005.37(f)(1). If the beneficiary fails to respond, the county must provide timely notice of termination in a NOA. W&I §14005.37(f)(3); 22 CCR §50179(a). The county must send the NOA at least ten days before the date of action. 42 CFR 431.211. The NOA must include, *inter alia*, "[t]he reason an action is being taken and the law or regulation that requires the action, if the action is a denial, discontinuance, or increase in share of cost." 22 CCR §50179(c)(3). The NOA must also include a "statement, when appropriate, regarding the information or action necessary to reestablish eligibility or determine a correct share of cost." 22 CCR §50179(c)(7).
Petitioners contend that Respondents violated and continue to violate their duty to send timely and accurate NOAs to beneficiaries prior to termination of their Medi-Cal eligibility. Pet. Op. Br. at 11. Petitioners assert two breaches of ministerial duty: (1) to provide beneficiaries with a renewal packet at least 60 days prior to the annual redetermination date and (2) to provide a NOA ten days before terminating Medi-Cal benefits. Reply at 8.

a. Renewal Packets

Petitioners contend that Respondents fails to timely mail renewal packets to Medi-Cal beneficiaries. Pet. Op. Br. at 11. Petitioners rely on an email sent on May 19, 2016 by Marina Cooper ("Cooper"), a DPSS Administrative Services Manager. Zohar Decl. Ex. 27. In the email, Cooper notes that from January to June 2016 DPSS missed the timely mailing of 133,163 Medi-Cal renewal packets. Id. Cooper refers to these missed mailings as resulting from "an exception during the e-hit/validation process." Id.
Petitioners also rely individual beneficiary declarations. In mid-February 2017, Sakari Pendleton ("Pendleton") called DPSS when he learned that he lost his Medi-Cal and his daughter no longer received benefits. Zohar Decl. Ex. 24: Pendleton Decl. ¶¶ 1,5. Pendleton learned that DPSS had sent his Medi-Cal annual renewal packet to the wrong address. Id. By the time that Pendleton received the packet, it was a month past due. Pendleton Decl. ¶6. Jana Jordan Fisher's mother received her renewal packet around the end of July 2017 and the forms stated that it was due to be submitted by mid-August 2017, a span of time less than 60 days. *See* Fisher Decl. ¶5.
Respondents rely on the Flores, a DPSS administrator, who asserts that when a technical issue prevents LRS from sending renewal packets, DPSS will initiate a separate batch mailing, usually within a week, to send those packets. Flores Decl. ¶6. DPSS is unaware of systemic issues affecting statistically significant portions of its renewal process. *See* id.

Petitioners fail to evidence DPSS's present evidence of a systemic breach or a negligent or refusal to perform a ministerial duty. Cooper's two-year old email indicates a one-time failure to perform the ministerial duty, states that the violation occurred due to an "exception," and indicates that workload is anticipated to increase to address the anticipated receipt of the additional packets. The Flores declaration supports a conclusion that any failure to timely deliver renewal packets is not a ministerial breach for which a writ is warranted.

b. <u>NOAs</u>

Petitioners contend that Respondents fail to send timely and accurate NOAs to Medi-Cal beneficiaries terminating their benefits. Petitioners contend that DPSS's computer system sometimes fail to send out NOAs and automatically terminated the Medi-Cal beneficiary anyway at the end of each month. Pet. Op. Br. at 12. The deposition transcripts cited by Petitioners do not substantiate this assertion. Rather, as Petitioners acknowledge, the deposition transcripts reflect that LRS is coded to automatically notify beneficiaries ten days before their scheduled Medi-Cal termination. Zohar Ex. 17, p.53; Ex. 25, p.90. They also show that LRS will send out a ten-day notice if a renewal packet is received before the end of the month and a worker does not process it. Ex. 8, p. 72-73; Ex. 7 p. 118-119. This is not a failure to timely send NOAs, but rather a claim that the termination of Medi-Cal benefits for beneficiaries who have timely submitted renewal packets is unlawful. This issue was addressed *ante.*

Petitioners also rely on five declarations in which beneficiaries report that they were terminated without receiving notice. *See, e.g.*, Moncrief Decl. ¶¶ 9, 15. These declarations show non-receipt of NOAs, but do not show that DPSS failed to send them. *See* 42 CFR 431.211. There can be many reasons why a beneficiary does not receive a notice actually sent to him or her. Even if the declarations do evidence isolated breaches of DPSS' ministerial duty to provide a NOA ten days before termination, they do not show a negligent breach of ministerial duty. The failure may well be accidental. As the Flores declaration shows, DPSS is unaware of any systemic issues regarding NOAs affecting the renewals it processes. Flores Decl. ¶6.

Petitioners contend that NOAs are inaccurate because LRS sometimes sends a NOA despite the fact that DPSS received a timely renewal packet that has not yet been manually processed. Zohar Decl. Exs. 10, p.47; 23. Petitioners rely on four declarations in which beneficiaries state that they received a NOA despite having timely submitted their renewal packets. *See, e.g.*, Zohar Decl. Ex. 26: Rodriguez Decl. ¶¶ 9-11. Again, this is not an issue of inaccurate NOAs, but rather an issue of unlawfully terminating Medi-Cal benefits of beneficiaries who have timely submitted renewal packets addressed *ante*.

5. <u>Manner of Submission</u>

The renewal form sent to a beneficiary for annual eligibility redetermination must inform the beneficiary that he or she may respond to the county "via the Internet, by mail, by telephone, in person, or through other commonly available electronic means <u>if those means are available in that county</u>." W&I §14005.37(f)(1)(B) (emphasis added).

A DHCS All-County letter dated September 19, 2014 states that W&I section 14005.37(f) allows a beneficiary to respond "by phone, e-mail, the web, in person, or though other commonly available electronic means <u>if available in the county</u>." Zohar Decl. Ex. 3, p.4 (emphasis added).

Petitioners contend that Respondents presently violate a ministerial duty set forth by W&I sections 14005.37(f)(1)(B), (g)(1), and (q) to accept renewal packets via telephone and the internet. Petitioners present evidence that Respondents do not receive redetermination information by phone or by internet other than email. Zohar Decl. Ex. 1, p.95. Pet. Op. Br. at 13.

Respondents note that W&I sections 14005.37(g)(1) and (q) concern redeterminations based on changed circumstances, and that W&I section 14005.37(f)(1)(B) is the pertinent provision for annual eligibility redetermination submissions. Opp. at 13. Respondents contend that they are not obliged to provide beneficiaries with abilities to respond via telephone or internet because subdivision (f)(1)(B) only requires modes of submission that are available in the County. Opp. at 13.

This is an issue of statutory interpretation. In construing a legislative enactment, a court must ascertain the intent of the legislative body which enacted it so as to effectuate the purpose of the law. <u>Brown v. Kelly Broadcasting Co.</u>, (1989) 48 Cal.3d 711, 724; <u>Orange County Employees Assn. v. County of Orange</u>, (1991) 234 Cal.App.3d 833, 841. The court first looks to the language of the statute, attempting to give effect to the usual, ordinary import of the language and seeking to avoid making any language mere surplusage. <u>Brown v. Kelly Broadcasting Co.</u>, (1989) 48 Cal 3d 711, 724. Significance, if possible, is attributed to every word,

phrase, sentence and part of an act in pursuance of the legislative purpose. Orange County Employees Assn. v. County of Orange, (1991) 234 Cal.App.3d 833, 841. The various parts of a statute must be harmonized by considering each particular clause or section in the context of the statutory framework as a whole. Lungren v. Deukmejian, (1988) 45 Cal.3d 727, 735.

Applying these rules of construction, Respondents misread the plain meaning of W&I section (f)(1)(B). The statute allows beneficiaries to respond via any of the means expressly listed: internet, mail, telephone, or in person. It does not allow the County to limit beneficiaries' means of responding to whatever is "available." The availability clause in W&I section (f)(1)(B) – "other commonly available electronic means if those means are available in that county" – does not limit these expressly permitted manners of submitting renewal packets. Every county is required to accept annual eligibility renewal information by internet, mail, telephone, and in person. It then may or may not allow other electronic means of responding (email or texting) if available.

Respondents state that DPSS accepts beneficiary information telephonically and only refuses to do so where verification, documents, or signatures are required. Opp. at 14; Flores Decl. ¶17. Respondents cite to a DHCS All-County letter to substantiate this practice:

> "If the [redetermination form's] information is provided over the phone and paper verifications are required, the beneficiary must provide a copy of the necessary paper verifications in order for the verification requirement to be met. The beneficiary may return the MC 216 by mail or in person. The form must be signed by the beneficiary or their authorized representative for it to be considered complete." Zohar Decl. Ex. 18, p.5.

Petitioners point out that W&I section 14005.37(r) requires DPSS to accept "telephonic signatures." Reply at 8. Neither the statute nor Petitioners explain what a "telephonic signature" is. W&I section 14005.37(r) also requires acceptance of electronic signatures and handwritten signatures transmitted by electronic transmission. A telephonic signature (as opposed to an electronic signature) may mean a faxed document. If so, there is no evidence that Respondents are not in compliance with W&I section (f)(1)(B)'s requirement for allowing beneficiaries to respond by telephone through faxing a verification.

As for internet submissions, Respondents contend that they are in the midst of completing internet functionality for the Medi-Cal renewal process. Opp. at 14. Presently, all beneficiaries can upload renewal documents through DPSS's portal, Your Benefits Now ("YBN"). Flores Decl. ¶14. DPSS has a four phase plan to expand YBN capabilities for beneficiaries, including viewing and updating forms online. Flores Decl. ¶15. Two phases of the plan are complete. Phase III expands the internet capability to all pertinent languages of beneficiaries and Phase IV will provide internet capability for the remaining Medi-Cal renewal packets by July 2018. Flores Decl. ¶16. The timing of Phase IV remains to be determined. Flores Decl. ¶16. Respondents contend that it is not necessary for the court to order the County to do anything in this regard. Opp. at 15.

Respondents have a ministerial duty to provide an internet mode of submission for beneficiaries' information for annual renewal. They have agreed to do so and are in the process of complying. There is no need to issue mandamus where an agency has agreed to perform its ministerial duty. A writ of mandate does not lie "when the respondent shows a willingness to perform the act without coercion, or where, in the opinion of the court, its issuance is unnecessary -- where it appears that the petitioner will obtain the relief sought without the writ and the public interest would be injuriously affected if a writ should issue." Hutchison v. Reclamation Dist. No. 1619, (1927) 81 Cal.App. 427, 432-33.[5]

F. Conclusion

The Petition for writ of mandate is granted in part. Respondents violated a ministerial duty imposed by W&I section 14005.37(d) by unlawfully terminating Medi-Cal benefits for beneficiaries who timely submitted annual renewal information and were waiting for Respondents' specific determination of their eligibility. DPSS also neglected to comply with its ministerial duty under W&I section 14004.37(i) and (a) to immediately rescind terminations and evaluate renewal information submitted during the 90-day cure period. In all other respects, the Petition is denied. A writ shall issue directing Respondents to modify their practices

in both areas accordingly. In deciding how to comply, Respondents have discretion to decide what practice must be adopted to comply with this decision.

Petitioners' counsel is ordered to prepare a proposed writ and judgment, serve them on Respondents' counsel for approval as to form, wait ten days after service for any objections, meet and confer if there are objections, and then submit the proposed judgment along with a declaration stating the existence/non-existence of any unresolved objections. An OSC re: judgment is set for June 21, 2018 at 9:30 a.m.

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[1] The court has ruled on Respondents' evidentiary objections and interlineated the original evidence where an objection was sustained. The Statement of Facts does not include all of Petitioners' declarations from Medi-Cal recipients.

[2] Respondents also contend that there was a backlog of unprocessed cases in 2015 and 2016 that was resolved in 2016. Opp. at 11. This argument is untenable. Petitioners rely on a data sample drawn from 2017, not 2015 and 2016, to substantiate the breach of this ministerial duty.

[3] Petitioners fail to show what "promptly" or "immediately" means under W&I sections 14005.37(i) and (a). Does it mean the same day of receipt or can a number of days pass before DPSS acts and still meet the requirement of immediacy? The court does agree, however, that the passage of more than a month before addressing the issue is not immediate action.

[4] The right of a terminated Medi-Cal participant to an administrative hearing is no substitute for DPSS's compliance with its ministerial duty. The beneficiaries in the 1360 terminated cases, and the individual Petitioners such as Salas and Kizirian, had the right to a fair hearing to complain about the termination. Instead of doing so, they elected to timely submit their packet during the cure period instead. They had this right, and the right to expect DPSS to immediately rescind their Medi-Cal termination.

[5] Petitioners also contend that Respondents' failure to accept renewal information via telephone and the internet violates Government Code section 11135(a)'s prohibition against denying access to state programs based on mental or physical disability. Petitioners contend that failure to accept an electronic mode of submission can pose a hardship to the disabled who might have difficulty mailing the papers or filing them in person. Pet. Op. Br. at 14.

Disabled Medi-Cal beneficiaries may be inconvenienced by the currently available modes of submission. If DPSS offered an internet mode of submission, those persons would not need to leave their home to mail their packets or appear in person. The present annual redetermination system may unlawfully discriminate against disabled Medi-Cal beneficiaries in this respect. But mandamus need not issue where DPSS is willing to, and in the process of, complying.