

Medical Exemption Requests (MERs)

January 2017, Pub. #5595.01

1. What is a Medical Exemption Request (MER)?

California is in the process of moving seniors and people with disabilities who have Medi-Cal into managed care plans instead of traditional, or fee for service, [Medi-Cal](#).ⁱ A MER is a request to stay out of a Managed Care Plan. If you want to stay out of managed care and instead receive medical services through your choice of facility or provider who takes fee-for-service (FFS) Medi-Cal, you may request a MER. You have to meet certain criteria to qualify for a MER.

2. How does the Process Work?

You and your doctor fill out a MER form and return it to the Department of Health Care Services through Health Care Options. DHCS staff then reviews your MER application and any evidence from your doctor to determine if you can be safely transitioned into a managed care health [plan](#).ⁱⁱ In general, if you are only receiving maintenance care or being seen for routine follow up care you will not be granted a MER.

3. Who is Eligible for a MER

- You have a complex medical condition (see list below in Section 7); AND
 - Your condition will worsen if you change doctors;
 - You are undergoing a course of treatment that cannot be interrupted;
- If you are an American [Indian](#)ⁱⁱⁱ

- If you have a diagnosis of HIV/AIDS
- If you are enrolled in a Medi-Cal waiver program, including an HCBS, NF/AH, IHO, or AIDS waivers, then you are automatically eligible for a MER. However, you must still complete the MER application in order to receive a MER.

4. Who Cannot Request a MER

- You live in a County Organized Health System (COHS) [County^{iv}](#)
 - You have both Medi-Cal and Medicare (“medi-medi”) and you live in a Coordinated Care Initiative County – Los Angeles, Riverside, San Bernardino, San Diego, or Santa Clara County
 - You have been enrolled in any Medi-Cal plan for more than 90 days combined.
 - Your doctor is part of a managed care plan in the county where you live.
 - Your plan of treatment is scheduled to begin AFTER your enrollment in the managed care plan. 22 C.C.R. § 53887(a)(2)(B)(1)-(3).

5. When You Should Request a MER

When you receive the notice requiring you to select a managed care plan, you have 30 days to submit a MER. 22 C.C.R. § 53882(c). If you do not request a MER within 30 days, you will automatically be enrolled in a Managed Care Plan. 22 C.C.R. § 53882(d)(1).

If you want an exemption from enrolling in managed care, you and your doctor have to fill out the MER form which is at the end of the enrollment packet. You can also call Health Care Options (HCO) at 1-800-430-4263 to get a copy of the MER form or download and print the form here: http://www.healthcareoptions.dhcs.ca.gov/HCOCSPE/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx.

It is important for your doctor to include information describing the ongoing medical supervision and/or complex medical treatment you

receive, and why this prevents you from transferring into managed care right now. You should also be sure to include an explanation as to why you cannot be safely moved into managed care at this time. This information should come from a doctor that you see frequently and who has ongoing knowledge of your condition. The best evidence for this is a supporting letter from your doctor, which you include with your MER, and any medical records that your doctor feels are necessary to support the information.

Call Health Care Options (HCO) if you have any questions. You or your doctor can also get help with your medical exemption request by calling the Medi-Cal managed care ombudsman at 1-888-452-8609, or sending an email to the following address: merhelp@dhcs.ca.gov. When you call HCO, make sure to keep notes of when you made the phone call and with whom you spoke. Maintaining notes of your conversations can help you correct mistakes.

The most common reason for a MER denial is that DHCS has determined that your condition is stable and that you can safely be moved to managed care. Your doctor will need to explain why, and provide evidence, your condition is not stable.

6. Legal Standard for Exemption from Plan Enrollment

Eligibility criteria for a medical exemption from mandatory managed care plan enrollment are found in 22 C.C.R. § 53887. An eligible beneficiary may request fee for service Medi-Cal based upon the exception for a complex medical condition requiring continuity of care for up to 12 months or longer. 22 C.C.R. §§ 53887(a), (a)(4).

The regulations state that an eligible beneficiary who is receiving fee for service Medi-Cal treatment for services for a “complex medical condition,” from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of either plan (in a Two-Plan model county) in the eligible beneficiary’s county of residence, may request a medical exemption to continue fee for service Medi-Cal for purposes of continuity of care. 22 C.C.R. § 53887(a)(2).

The regulations also state that an eligible beneficiary who is an American Indian, member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis, may request a medical exemption to continue fee for service Medi-Cal for purposes of continuity of care. 22 C.C.R. § 53887(a)(1).

Conditions for meeting the criteria for a “complex medical condition” include, among other conditions, that an individual has a complex and/or progressive disorder that requires ongoing medical supervision and/or the individual has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be disrupted. 22 C.C.R. § 53887(a)(2)(A)(7).

Other conditions meeting the criteria for “complex medical condition” include:

- An eligible beneficiary is pregnant.
- An eligible beneficiary is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.
- An eligible beneficiary is receiving chronic renal dialysis treatment.
- An eligible beneficiary has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).
- An eligible beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.
- An eligible beneficiary has been approved for a major surgical procedure by the Medi-Cal fee-for-service program and is awaiting surgery or is immediately post-operative.

- An eligible beneficiary has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in 1. through 6. above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be [interrupted.](#)^v
- An eligible beneficiary is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility.
- An eligible beneficiary is participating in a pilot project organized and operated pursuant to sections 14087.3, 14094.3, or 14490 of the Welfare and Institutions Code. 22 C.C.R. § 53887 (a)(2)(A)(1)-(9).

7. If Your MER Is Granted

You may continue to see your regular Medi-Cal doctor, but you will have to reapply for a MER every 12 months. DHCS will want you to reapply in order to determine if the severity of your medical condition has changed. If your condition stabilizes, your MER may be denied. Please be advised that MERs are granted very infrequently.

8. If Your MER is Denied and You Choose to Appeal

If your MER is denied, then you have 90 days to appeal and you cannot be placed into a managed care plan during that time. As soon as your MER is denied, you should request your file from DHCS.

Once you have requested your file, then you may file for the appeal. Instructions for filing an appeal are below.

9. Appealing a MER Denial

You have 90 days from the date of the mailing of the denial letter to appeal. One strategy you might consider is waiting to file the MER

towards the end of the 90- day period to extend the time you are able to continue to see your doctor. When you do request the hearing, you must ask for “aid paid pending” which means that you will continue in FFS Medi-Cal until the outcome of the hearing.

You can ask for a hearing by writing on the hearing request form, which is included with the Notice of Action, that you disagree with the decision and you want a fair hearing. You can also request a hearing by phone, or by faxing or mailing a letter or the form to the address below:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
1-800-952-5253 (Voice)
1-800-952-8349 (TDD)
(916) 229-4110 (fax)

The hearing must be set within 30 days of the request and written notice of the time and place of the hearing must be sent at least 10 days before the hearing date. Cal. Welf. & Inst. Code § 10952.

At your hearing, you will be able to present evidence that your condition is not stable enough to transfer to a managed care plan. The best way to do this is to get a letter from your doctor stating that you will suffer deleterious medical effects if you are forced to see a different doctor. Your doctor will want to provide evidence that your condition is unstable and that you cannot safely be transferred to a managed care plan physician. Supporting documents may include a treatment plan, notes from 5 most recent office visits, and current medical history and physical exam [results](#).^{vi}

You will want to argue that you are eligible for an exemption based on the fact that (1) you have a complex medical condition (2) that requires ongoing medical supervision, and (3) that you have been receiving complex medical treatment, the administration of which cannot be disrupted, as set forth in 22 C.C.R. § 53887(a)(2)(A)(7). The other thing to consider is that in our experience, you are more likely be successful if the doctor who completes the MER sees you frequently. A MER is likely to be denied if the doctor only sees a patient every six months.

Please be advised that in the event that you win your hearing and the Administrative Law Judge grants your request for a MER, DHCS has legal authority to reverse (“alternate”) that decision and still deny your MER. At that point, you can file for a rehearing (you have 30 days from the date you receive the decision). You can also file a writ in superior court. You have a year from the date of the decision to do that. If you are successful in an appeal, and the Director of DHCS alternates your decision, you are still entitled to continuity of care, and should ask for that from the managed care plan you choose to enroll in. See Section 11 below.

10. If Your MER Is Denied and You Do Not Appeal –Continuity of Care and Single Case Agreement

This section applies if your MER is denied and you decide not to appeal. If you are not granted a medical exemption request for your complex medical condition and you do not appeal, then you will have to join a managed care plan. You can request to continue seeing your health care providers that are not part of the managed care plan’s network by requesting what is called continuity of care.^{vii}

Managed care plans must allow you to continue seeing your out of network providers when:

- The managed care plan is able to determine that you have an ongoing relationship with the provider (you have seen the doctor at least once within the last 12 months);
- Your provider is willing to accept the higher of managed care plan’s contract rates or Medi-Cal FFS rates; and
- The provider meets the managed care plan’s applicable professional standards and has no disqualifying quality-of-care issues. All Plan Letter 13-023 p. 1 (Dec. 24, 2013).^{viii}

Another option is to get out-of-network care using a single-case agreement.^{ix} This is an agreement with an out-of-network provider to authorize payment at a specified rate for identified services during a specific time frame for the care of a single managed care enrollee.

Beneficiaries who are already in a Medi-Cal Managed Care Plan but who require specific medical care from a single out-of-network provider can request a single-case agreement. A single-case agreement allows a beneficiary to remain in their managed care plan while also seeing an out-of-network provider.

To request a single-case agreement, you contact your managed care plan directly and request authorization to see an out-of-network provider. To get this authorization, you will need to show that you require care that is not available from any providers in the managed care plan's network, or that you are eligible to receive continuity of care from a provider who does not contract with your managed care plan. It is helpful for your doctor to include information describing the ongoing medical supervision and/or complex medical treatment you receive, and why this requires treatment from an out-of-network provider.

If your request to see an out-of-network provider is denied, you should contact your plan immediately about grievance or appeals [options](#).^x

11. What If I Have Medicare and Medi-Cal (dual-eligible)?

If you have Medicare in addition to Medi-Cal benefits, you may continue to see your existing Medicare doctors even if you voluntarily join a Medi-Cal plan or you have mandatorily enroll in a Medi-Cal [plan](#).^{xi} You cannot request a MER to stay out of the Medi-Cal managed care plan if you have both Medicare and Medi-Cal.

If you decide to join a Cal MediConnect plan or other type of Medicare plan, you will have to see Medicare providers that are contracted with your Medicare or Cal MediConnect plan. You can find more information on Cal MediConnect here: www.calduals.org. If you want help on deciding whether you should join a Cal MediConnect plan or other Medicare plan, contact your HICAP for free counseling at 1-800-434-0222

You can also refer to our Coordinated Care Initiative publication here: <http://www.disabilityrightsca.org/pubs/553501.pdf>.

[We want to hear from you! Please complete the following survey about our publications and let us know how we are doing!](https://docs.google.com/forms/d/1d6ezTI2M5UMAWU66exLbc1SQ9wDPzvtuS3AGR4-cgwE/viewform?c=0&w=1)

<https://docs.google.com/forms/d/1d6ezTI2M5UMAWU66exLbc1SQ9wDPzvtuS3AGR4-cgwE/viewform?c=0&w=1>

For legal assistance call 800-776-5746 or complete a [request for assistance form](#). For all other purposes call 916-504-5800 (Northern CA); 213-213-8000 (Southern CA).

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to <http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html>.

ⁱ Managed care plans are groups of doctors, hospitals, clinics etc. (known as the “network”) who work together to take care of their members' health care needs. Once enrolled in a managed care plan, the member has to see providers that are in the network. Members choose a primary care physician (PCP) who they must go to first. The PCP can treat or refer members to a specialist within the network and sometimes outside of the network. *For more information on managed care plans, see DRC Publication: Medi-Cal Managed Care Health Plans: What are they? What do I need to know about them? (January 2014, Pub #5495.01), <http://www.disabilityrightsca.org/pubs/549501.pdf>. [“Return to Main Document”](#)*

ⁱⁱhttp://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/Provider_Bull_etin_July2012.pdf [“Return to Main Document”](#)

ⁱⁱⁱhttp://www.healthcareoptions.dhcs.ca.gov/hcocsp/enrollment/content/en/forms/MU_0003382.pdf?v=0815 [“Return to Main Document”](#)

^{iv} There are 22 COHS counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo [“Return to Main Document”](#)

^v You must be able to provide evidence as to the reasons your current care cannot be interrupted. You should discuss the reasons with your doctor

and have them record them in a supporting letter which you will include with your MER application. Refer to Section 6, above, for more information. ["Return to Main Document"](#)

^{vi} *For more information, see*

http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/Provider_Bulletin_July2012.pdf ["Return to Main Document"](#)

^{vii} See, as outlined in All Plan Letter 15-001, p. 2 (Jan. 14, 2015) (managed care plans “must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services.” You can find the letter here:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-001.pdf>. *For more information on continuity of care, see* <http://www.disabilityrightsca.org/pubs/554501.pdf>.

Managed care plans must consider an exemption from plan enrollment from beneficiaries who request continuity of care. Health and Safety Code § 1373.96.

“Managed Care Plans are required to consider a request for exemption from Managed Care Plan enrollment that is denied as a request to complete a course of treatment with an existing fee for service or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the Managed Care Plan’s contract with Department of Health Care Services and any other Department of Health Care Services continuity of care All Plan Letter. Managed Care Plans must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services to the extent authorized by law. The beneficiary’s existing provider is identified by the National Provider Identifier on the Medical Exemption Request. Managed Care Plans must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under All Plan Letter 11-019, Duals Plan Letter (DPL) 14-004 on continuity of care, All Plan Letter 14-021 on continuity of care for Medi-Cal beneficiaries who

transition into managed care, and other continuity of care All Plan Letters and DPLs. (All Plan Letter 15-001, January 14, 2015)”

Available at: <http://www.dss.cahwnet.gov/shd/res/htm/ParaRegs-Medi-Cal-Managed-Care-Two-Plan.htm> ["Return to Main Document"](#)

viii You can find the letter here:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicy Letters/APL2013/APL13-023.pdf> ["Return to Main Document"](#)

ix 42 C.F.R. § 438.206(b)(4), Medi-Cal Boilerplate Contracts at Ex. A, Att. 9.

Non-COHS plans: Health & Safety (H&S) Code Section (§) 1373.96; 28 CCR § 1300.67.2.2(c)(7)(B). ["Return to Main Document"](#)

* As of July 1, 2017 the deadline to file a grievance will change. After July 1, 2017 you have 60 days to file a grievance with your plan. ["Return to Main Document"](#)

xi If you have Medicare, you have to join a Medi-Cal plan if you live in one of the Coordinated Care Initiative Counties (Los Angeles, Riverside, San Bernardino, San Diego, or Santa Clara counties). You also will have to join a Medi-Cal plan if you want to receive Community Based Adult Services (CBAS) benefits. ["Return to Main Document"](#)