

Medical Exemption Requests (MERs)

Updated November 2020, Pub. #5595.01

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

Since 2011, California has been in the process of moving seniors and people with disabilities (SPDs) with Medi-Cal only and those eligible for both Medicare and Medi-Cal (dual eligible) into Medi-Cal managed care plans (Medi-Cal MCP) instead of traditional, regular, or fee-for-service Medi-Cal.ⁱ A Medical Exemption Request (MER) is a request to be exempt from mandatory enrollment in a Medi-Cal plan and instead remain in fee for service (FFS) Medi-Cal. In other words, the point of a MER is for you to maintain access to your providers who are not enrolled in a Medi-Cal MCP and to ensure your health is not put at risk during the transition to a Medi-Cal MCP.

MER are granted on a very limited basis. This publication contains information about whether you are required to enroll in a Medi-Cal MCP and what criteria must be met to qualify for a MER.

2. Who is mandatorily enrolled in a Medi-Cal managed care plan (Medi-Cal MCP)?

Most individuals who have Medi-Cal are required to enroll in a Medi-Cal MCP. You can also refer to our Medi-Cal MCP publication here: [Click here to open the Medi-Cal managed care plan publication.](#) Whether you have to enroll in a Medi-Cal MCP depends on what county you live in, whether you are an SPD or dual eligible, and what Medi-Cal programs you are enrolled in. There are *six models of managed care* in place in all California counties.ⁱⁱ You can find out what kind of model your county has on the DHCS website:

https://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf

If you know your Medi-Cal Aid Code then you can find out if you will be mandatory enrolled in a Medi-Cal MCP by looking at the DHCS website here:

<https://www.dhcs.ca.gov/services/Documents/AidCodeChartv120318.pdf>

1. County Organized Health Systems (COHS) – If you are an SPD or dual eligible in a COHS County, then you will be mandatorily enrolled into a Medi-Cal MCP. [iii](#)
2. Two-Plan – If you are an SPD or have no Share of Cost (Medi-Cal only or dual eligible) in *certain programs*[iv](#) in a Two-Plan County, then you will be mandatorily enrolled into a Medi-Cal MCP.
3. Geographic Managed Care (GMC) – If you are an SPD or have no Share of Cost (Medi-Cal only or dual eligible) in *certain programs*[v](#) and in a GMC County, then you will be mandatorily enrolled into a Medi-Cal MCP.[vi](#)
4. Regional Model (RM) – If you are an SPD in a RM County, then you will be mandatorily enrolled in a Medi-Cal MCP.
5. Imperial – If you are an SPD in Imperial County, then you will be mandatorily enrolled in a Medi-Cal MCP.
6. San Benito – If you are an SPD in San Benito County, then you will be mandatorily enrolled in a Medi-Cal MCP.

Generally, this means that you might not be mandatory enrolled in a Medi-Cal MCP if you are a dual eligible in a Regional Model County, Imperial county, or San Benito county or if you are dual eligible with a share of cost in Two-Plan Counties and Geographic Managed Care Counties.

However, if your county participates in the Coordinated Care Initiative (CCI) then you may be enrolled in a Medi-Cal MCP regardless of whether you are dual eligible or dual eligible with a share of cost. For more information on the CCI, see Section 3. Additionally, you have to enroll in Medi-Cal MCP in order to receive Community Based Adult Services (CBAS)/Adult Day Health Care regardless of what county you live in and whether you are a dual or SPD.

3. Coordinated Care Initiative (CCI)

The CCI is a program[vii](#) intended to integrate and coordinate the delivery of health benefits, including behavioral health benefits, and long-term services and supports (LTSS) for both dual eligible and SPD. In *addition* to the mandatory enrollment into a Medi-Cal MCP listed above in Section 2, all dual eligible living in one of the CCI counties will be enrolled into a Medi-Cal MCP. The *seven CCI counties are*:

1. Los Angeles – also see Two-Plan Counties in Section 2.
2. Riverside – also see Two-Plan Counties in Section 2.
3. San Bernardino – also see Two-Plan Counties in Section 2.
4. Santa Clara – also see Two-Plan Counties in Section 2.
5. Orange – also see COHS Counties in Section 2.
6. San Mateo – also see COHS Counties in Section 2.
7. San Diego – also see GMC Counties in Section 2.

You can also refer to our Coordinated Care Initiative publication here: [Click here for DRC Coordinated Care Initiative publication.](#)

4. Who Cannot Request a MER

- You receive Community Based Adult Services (CBAS)/Adult Day Health Care.
- You live in a COHS or GMC county.^{viii}
- You are a dual eligible and live in a CCI county.
- You have been enrolled in any Medi-Cal managed care plan for more than 90 days combined.
- Your doctor is part of a Medi-Cal managed care plan in the county where you live.
- Your plan of treatment is scheduled to begin AFTER your enrollment in the Medi-Cal managed care plan. 22 C.C.R. § 53887(a)(2)(B)(1)-(3), 22 CCR § 53923.5(b).

5. Who May Be Eligible For a MER?

- You have a complex medical condition (**see Section 9a – 9c**):
 - You have a complex medical condition AND
 - You are undergoing a course of treatment that cannot be interrupted AND
 - Your condition will worsen if you change doctors.
- You are an American [Indian](#)^{ix}
- You have a diagnosis of [HIV/AIDS](#)^x

- You do not live in a CCI county (**see Section 3**) *and* are enrolled in a Medi-Cal waiver program, including an HCBS, NF/AH, IHO, or AIDS waivers.

6. How Does the MER Process Work?

You and your doctor fill out a MER form ([Form HCO 7101](#)) and return it to the Department of Health Care Services (DHCS) through Health Care Options (HCO). DHCS staff then review your MER application and any evidence from your doctor to determine if you can be safely transitioned into a Medi-Cal MCP.^{xi} In general, if you are only receiving maintenance care or being seen for routine follow up care you will not be granted a MER.

7. When Can a MER Be Requested?

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 Medi-Cal MCP. 22 C.C.R. § 53882(d)(1). Note that even after you are enrolled in a Medi-Cal MCP following this 30-day window, you can still request a MER as long as you have not been in a Medi-Cal MCP for more than 90 days combined.

8. How to Request a MER?

There are two types of MERs: one for complex medical conditions; and another for American Indians who receive health services through an Indian Health Service facility. 22 C.C.R. § 53887(a)(1) – (2).

If you want an exemption from enrolling in managed care, you and your doctor have to fill out the MER form ([Form HCO 7101](#)). 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: [Click here for webpage with Instructions for Completing Request for Temporary Medical Exemption from Plan Enrollment Form.](#)

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 MMCDombudsmanOffice@dhcs.ca.gov. When you call the Office of the Ombudsman,^{xii} 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.

TIPS to complete the MER:

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 a Medi-Cal MCP. Your doctor will need to explain why, and provide evidence, your condition is not stable.

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.

9. Legal Standard for Exemption from Plan Enrollment

9a. Two-Plan County^{xiii} Exemption from Plan Enrollment Criteria

An eligible beneficiary in a Two-Plan county 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. 22 C.C.R. §§ 53887(a)(2), (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 interrupted. 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](#).^{xiv}
- 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).

TIP: Los Angeles, Riverside, San Bernardino, and Santa Clara are Two-Plan and CCI counties; therefore, if you live in one of these counties then also see Section 9c.

9b. GMC County^{xv} Exemption from Plan **Enrollment** Criteria

An eligible beneficiary living in Sacramento and San Diego Counties (the only GMC Counties in California) may request to disenroll from a Medi-Cal MCP to remain in fee-for-service Medi-Cal in very limited circumstances. This request is different than a MER and is done by contacting the county's enrollment contractor because there is no MER form in GMC counties.

The regulations state that an eligible beneficiary who is receiving fee for service Medi-Cal treatment for services for a "complex medical situation" from a physician who is participating in the Medi-Cal program but is not a contracting provider of any GMC plan in the eligible beneficiary's county of residence, may request to continue fee for service Medi-Cal. 22 CCR § 53923.5(b). This treatment must have started on or before March 31, 1995.

The regulations also state "[a]n eligible beneficiary who is an Indian, is a member of an Indian household, or has written acceptance from an Indian Health Service program facility to receive health care services through that facility, may, as an alternative to GMC plan enrollment and upon request, choose to receive health care services through an Indian Health Service program facility." 22 CCR § 53923.5(a)

In addition to having a complex medical situation, the beneficiary needs to meet one of the following, 22 C.C.R. § 53923.5(b):

- Is under the care of a specialist. This specialty is not practiced by any physician within the county's managed care plan, and the specialist accepts fee-for-service Medi-Cal and is not part of the county's managed care plan; OR
- Is in a complex, high risk medical treatment plan. The physician accepts fee-for-service Medi-Cal and is not part of the county's managed care plan. The beneficiary "[m]ay experience deleterious medical effects if that treatment were to be disrupted by leaving the care of that physician to begin receiving care from a county managed care plan; OR
- Is pregnant and under the care of a physician who accepts fee-for-service Medi-Cal and is not part of the county's managed care plan.

TIP: San Diego is a GMC and CCI county; therefore, if you live in San Diego then also see Section 9c.

9c. CCI County Exemption from Plan Enrollment Criteria

An eligible SPD living in a CCI County may request fee for service Medi-Cal based upon the exception for a complex medical condition or situation requiring continuity of care for up to 12 months under either the Two-Plan *or* GMC criteria described above. Cal. Welf. & Inst. Code § 14182.

10. If Your MER Is Granted

You may continue to see your fee-for-service Medi-Cal doctor. You will have to reapply for a MER before the date of the MER expiration. DHCS requires you to reapply in order to determine if your medical condition has stabilized. If your condition has stabilized, meaning you can be safely transferred to a managed care plan, your MER may be denied. Please be advised that MERs are granted very infrequently.

11. Appealing a MER Denial

You have 90 days from the date 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 but before you are mandatorily enrolled into a Medi-Cal MCP. 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. However, in order to continue to see your FFS Medi-Cal doctor, you must request the hearing before you are enrolled in a Medi-Cal MCP and ask for “aid paid pending.” Requesting “aid paid pending” means that you are requesting to continue in FFS Medi-Cal until the outcome of the hearing.

You can ask for a hearing and “aid paid pending” by writing using the hearing request form, which is included with the Notice of Action. You can say that you disagree with the decision, you want a fair hearing, and you are requesting aid paid pending. You can also request a hearing on-line, 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 9-17-37
Sacramento, CA 94244-2430

Phone: 1-800-743-8525 or 1-855-795-0634

TDD: 1-800-952-8349
Fax: 1-833-281-0905

On-Line: <https://acms.dss.ca.gov/acms/login.request.do>. You can also file an appeal without creating an ACMS account here: https://acms.dss.ca.gov/acms/page.request.do?page=public.intakeForm#acms_columns

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.

TIPS to prepare for your MER hearing:

Review your file from DHCS: As soon as your MER is denied, you should request your file from DHCS. Once you receive your file from DHCS, review the evidence DHCS has to deny your MER. You have the right to know who at DHCS made a decision in your case. This will be a physician contracted with DHCS to review MERs. DHCS should tell you the professional qualifications of the reviewing physician, such as their area of specialty

Review the Statement of Position: The Statement of Position must be available for you to review 2 business days before the hearing. The Statement of Position should have an explanation of why DHCS believes you can be safely transferred to managed care. It must contain an analysis of the medical records and any other supporting documents you provided with your MER.

Assemble your evidence: 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 five most recent office visits, and current medical history and physical exam results. [xvi](#)

- You can write your own Statement of Position, which can contain a response to DHCS's Statement of Position.

- You can have witnesses. You can ask your doctor to appear at the hearing to testify on your behalf. You can also request that someone from DHCS be there, including the DHCS-contracted physician who reviewed your medical records and recommended to deny your MER.

If you need more time, then ask for an extension by contacting CDSS State Hearings Division (the contact listed above) to request that your hearing be postponed. A postponement request must be made before the day that the hearing is scheduled.

You can call the Health Consumer Alliance hotline at 1-888-804-3536 for additional information on MER and MER Hearings.

At your hearing, you will be able to present evidence that your condition is not stable enough to transfer to a managed care plan. 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 care from your current physician, and (3) that transferring to a doctor in a managed care plan would cause deleterious medical effects. Note, if you live in San Diego or Sacramento Counties, your care needs to have started on or before March 31, 1995. 22 CCR § 53923.5(b)(1)-(3).

If you receive an unfavorable decision,^{xvii} 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). Whether or not you decide to appeal the unfavorable hearing decision, you are still entitled to continuity of care, and should ask for that from the Medi-Cal MCP you choose to enroll in (**See Section 12**).

12. If your MER Is Denied and You Do Not appeal, Then You Can Request Continuity of Care or a 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 Medi-Cal managed care plan (Medi-Cal MCP). You can request to continue seeing your FFS Medi-Cal providers that are not part of the Medi-Cal MCP's network by requesting what is called continuity of [care](#).^{xviii} Health care providers that are not part of the Medi-Cal MCP's network are called out of network providers. Out of network providers may include the fee for service providers that you received care from prior to Medi-Cal MCP enrollment.

Request for Continuity of Care

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); and
- Your provider is willing to accept the higher of managed care plan's contract rates or Medi-Cal fee for service 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](#)).^{xix}

Managed care plans must consider an exemption from plan enrollment from beneficiaries who request continuity of care. Health and Safety Code § 1373.96. For more information on continuity of care: [Click to open DRC Continuity of Care publication](#). You may call your Medi-Cal MCP to request more information and help with obtaining continuity of care.

Single Case Agreement

Another option is to get out-of-network care using a single-case [agreement](#).^{xx} Beneficiaries who are already in a Medi-Cal MCP 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. This is an agreement between the managed care plan and the out-of-network provider to authorize: (1) payment at a specified rate (2) for identified services (3) during a specific time frame for your care.

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 Medi-Cal MCP immediately about MCP grievance or appeals [options](#).^{xxi}

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

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 Medi-Cal managed care plan (Medi-Cal MCP). You can request to continue seeing your FFS Medi-Cal providers that are not part of the Medi-Cal MCP's network by requesting what is called continuity of [care](#).^{xxii} Health care providers that are not part of the Medi-Cal MCP's network are called out of network providers. Out of network providers may include the fee for service providers that you received care from prior to Medi-Cal MCP enrollment.

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If your request to see an out-of-network provider is denied, you should contact your Medi-Cal MCP immediately about MCP grievance or appeals [options](#).^{xxv}

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. ([Return to main document](#))

ⁱⁱIn November 2010, the Centers for Medicare and Medicaid Services (CMS) approved California's Section 1115 Bridge to Reform Waiver (1115 Waiver) that expanded mandatory managed care to Seniors and People with Disabilities (SPDs) who were covered by Medi-Cal. This 1115 Waiver was reauthorized in 2015, and is now called the Medi-Cal 2020 Waiver. ⁱⁱ As a result of these waivers, the Department of Health Care Services (DHCS) created six models of Medi-Cal managed care in California. ([Return to main document](#))

ⁱⁱⁱ In COHS counties, all individuals receiving Medi-Cal have always been mandatorily enrolled in Medi-Cal managed care, including duals, share of cost, and nursing facility residents. ([Return to main document](#))

^{iv} 22 CCR § 53840, Mandatory enrollment for full-scope, zero share of cost Medi-Cal beneficiaries in Two-Plan counties apply to all of the following:

1. 109% FPL Modified Adjusted Gross Income (MAGI) Medi-Cal for Parents and Caretakers;
2. Medi-Cal eligible due to prior receipt of cash assistance for foster care;
3. Medi-Cal eligible due to prior receipt of Supplemental Security Income (SSI) or Pickle;
4. 185% to 200% FPL MAGI Medi-Cal for pregnancy and infants under 1 years old
5. 133% FPL MAGI Medi-Cal for children from 1 year to 6 years old
6. 100% FPL MAGI Medi-Cal for children 6 years old to 19 years old
7. Transitional Medi-Cal Program

Additionally, ACWDL 11-24 states mandatory enrollment for additional groups of SPDs in Two-Plan counties. ACWDL 11-24 supersedes 22 CCR § 53840 therefore the ACWDL is controlling if inconsistencies exist between the CCR and the ACWDL. ACWDL 11-24 is available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c11-24.pdf>. ([Return to main document](#))

v 22 CCR § 53906. Mandatory enrollment for full-scope, zero share of cost Medi-Cal beneficiaries in GMC counties apply to all of the following: Aid to Families with Dependent Children (AFDC) program; Under 21 years of age in the Medically Indigent Program; Foster Children program. Additionally, ACWDL 11-24 states mandatory enrollment for additional groups of SPDs in GMC counties. ACWDL 11-24 supersedes 22 CCR § 53840 therefore the ACWDL is controlling if inconsistencies exist between the CCR and the ACWDL. ACWDL 11-24 is available at <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c11-24.pdf>.
(Return to main document)

vi In in GMC counties, SPD and duals must enroll in Medi-Cal managed care plans pursuant to Welf. & Inst.Code § 14182 and the Special Terms and Conditions (STC) of the Medi-Cal 2020 Waiver available at <https://www.dhcs.ca.gov/provgovpart/Documents/CA-Medi-Cal-2020-STCs-CMS-TC-11-19-19-NoExpWaiver.pdf> PDF p. 37
(Return to main document)

vii In March 2014, the Coordinated Care Initiative (CCI) was added to the Bridge to Reform (now Medi-Cal 2020) Waiver. (Return to main document)

viii Welf. & Inst.Code § 14182 and the Special Terms and Conditions (STC) of our Medi-Cal 2020 Waiver available at <https://www.dhcs.ca.gov/provgovpart/Documents/CA-Medi-Cal-2020-STCs-CMS-TC-11-19-19-NoExpWaiver.pdf> PDF p. 37 (Return to main document)

ix [Click to open Medi-Cal Managed Care Non-Medical Exemption - Request for Non-Medical Exemption from Plan Enrollment - American Indians or Beneficiaries with HIV/AIDS in Coordinated Care Initiative Counties.](#) (Return to main document)

x [Click to open Medi-Cal Managed Care Non-Medical Exemption - Request for Non-Medical Exemption from Plan Enrollment - American Indians or Beneficiaries with HIV/AIDS in Coordinated Care Initiative Counties.](#) (Return to main document)

xi [Click to open Provider Bulletin: Introduction and Supplemental Instructions for Form HCO 7101, Request for Medical Exemption from Plan Enrollment.](#) (Return to main document)

xii For more information about the Office of the Ombudsman, [Click to be directed to the DHCS Office of the Ombudsman website](#) (Return to main document)

xiii You can find out what kind of model your county has on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf (Return to main document)

xiv 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)

xv You can find out what kind of model your county has on the DHCS website:
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xvi For more information, [Click to open Provider Bulletin: Introduction and Supplemental Instructions for Form HCO 7101, Request for Medical Exemption from Plan Enrollment.](#) (Return to main document)

xvii Please be advised that in the event that you may receive a favorable hearing decision from the Administrative Law Judge, who grants your request for a MER; however, DHCS has legal authority to

reverse (“alternate”) the Judge’s decision and still deny your MER. If this results, then you have received an unfavorable hearing decision because your MER has been denied. ([Return to main document](#))

^{xviii} See, as outlined in All Plan Letter 17-007, p. 2 (May 11, 2017) (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.”). [Click to open All Plan Letter.](#)

“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 Letters. 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) 16-002 on continuity of care, APL 15-019 on continuity of care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care APLs and DPLs.” (All Plan Letter 17-007, May 11, 2017.)

Available at: [Click here for the All Plan Letter 17-007, May 11, 2017 PDF.](#) ([Return to main document](#))

^{xix} You can find the letter here: [Click here for the All Plan Letter 13-023, Dec. 24, 2013 PDF.](#) ([Return to main document](#))

^{xx} 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](#))

^{xxi} As of July 1, 2017, the rules for filing a grievance or appeal changed. For more information on Medi-Cal Managed Care Appeals and Grievances, [Click to open DRC Grievance or Appeal publication.](#) ([Return to main document](#))

^{xxii} See, as outlined in All Plan Letter 17-007, p. 2 (May 11, 2017) (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.”). [Click to open All Plan Letter.](#)

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^{xxiv} 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). [\(Return to main document\)](#)

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