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JUDY BOOTHBY, GITA AMINLOO, DENISE COZZA, DEBORAH HAGEY, MELISSA HALL, MAUREEN KAYE, INGRI SPARLING AND DARCI TRILL

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

JUDY BOOTHBY, GITA AMINLOO, DENISE COZZA, DEBORAH HAGEY, MELISSA HALL, MAUREEN KAYE, INGRI SPARLING AND DARCI TRILL,

Plaintiffs/Petitioners,

v.

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES; JENNIFER KENT, Director of the Department of Health Care Services, State of California,

Defendants/Respondents.

Case No: BC627948
[Assigned to the Honorable Ernest M. Hiroshige, Dept. 54]

VERIFIED SECOND AMENDED COMPLAINT FOR:

1. **WRIT OF MANDATE**
2. **DECLARATORY RELIEF;**
3. **INJUNCTIVE RELIEF**
4. **BREACH OF CONTRACT: SPECIFIC PERFORMANCE OF SETTLEMENT AGREEMENT**

THE PARTIES

1. Plaintiff/Petitioner Judy Boothby ("Boothby" or Plaintiff) is a licensed Registered Dental Hygienist in Alternative Practice (RDHAP). Boothby is RDHAP license number 1, a highly skilled and dedicated practitioner providing dental oral hygiene to seniors and the developmentally disabled since 1987 in the Greater Sacramento County Area, Sutter County, El Dorado County, and Yolo County. Boothby's patients are eligible and receive California Medi-Cal Dental benefits, through Denti-Cal. Boothby was part of the pilot program studies of dental hygiene known as the Health Manpower Pilot Projects numbers 139 and 155, which were demonstration projects pioneered by the State of California Regents to determine whether this

underserved patient population could be provided oral hygiene. By virtue of Boothby's pioneering efforts and those of other Plaintiffs herein, the State of California saved and improved the lives of countless seniors and the developmentally disabled in skilled nursing facilities and intermediate care facilities, affirming that SENIORS AND DEVELOPMENTALLY DISABLED LIVES MATTER. These were patients with cognitive and physical impairments that could not travel to a dental office; Boothby had to bring her practice to them in skilled nursing facilities and intermediate care facilities. She has over 35 facilities and over 5000 patients. She is a frequent guest lecturer for the care and treatment of the oral health care for this patient population. Boothby is a founding member of California Oral Health Coalition of the Aging & Developmentally Disabled.

2. Plaintiff/Petitioner Gita Aminloo ("Aminloo" or Plaintiff) has been a licensed RDHAP (License No. 48) since 2011; a highly skilled and dedicated practitioner, and has been providing dental oral hygiene services to seniors and the developmentally disabled, who are Denti-Cal beneficiaries, in 60 intermediate care facilities working as an RDHAP, and cares for over 400 patients in Riverside and San Bernardino Counties.

3. Plaintiff/Petitioner Denise Cozza ("Cozza" or Plaintiff) is a licensed RDHAP, (RDHAP License No. 189), a highly skilled and dedicated practitioner, and has been providing dental oral hygiene services to seniors and the developmentally disabled, who are Denti-Cal beneficiaries, in skilled nursing facilities and intermediate care facilities working as an RDHAP in Ventura, Santa Barbara, Tulare and San Luis Obispo Counties. Cozza has 200 patients and has 90 facilities.

4. Plaintiff/Petitioner Deborah Hagey ("Hagey" or Plaintiff) is a licensed RDHAP, (RDHAP License no. 68), a highly skilled and dedicated practitioner, and has been providing dental oral hygiene services to seniors and the developmentally disabled in skilled nursing facilities and intermediate care facilities working as an RDHAP for over 12 years. Hagey has 4,000 active patients of which over 900 are Denti-Cal patients. Hagey cares for this underserved patient population in Shasta County. Hagey is a founding member of California Oral Health Coalition of the Aging & Developmentally Disabled.

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5. Plaintiff/Petitioner, Melissa Hall ("Hall" or Plaintiff) is a licensed RDHAP, (RDHAP License No. 262) residing and providing dental oral services to over 500 beneficiaries of Denti-Cal, who reside in over 30 skilled nursing facilities throughout Los Angeles County. Hall is a highly qualified and dedicated RDHAP, holding the special RDHAP license specifically created by the California State Legislature in the early 1990s to treat this underserved population. Hall is a hospital trained and credentialed RDHAP with over 10 years of treating complex, compromised, and vulnerable patients, many of whom are seniors and developmentally disabled. Hall has taught periodontal instrumentation at UCLA Dental Hygiene School and has years of clinical practice in high end dental offices. Hall is President and a founding member of California Oral Health Coalition of the Aging & Developmentally Disabled.

6. Plaintiff/Petitioner Maureen Kaye ("Kaye" or Plaintiff) is a licensed RDHAP, (RDHAP License No. 171), and a highly skilled and dedicated RDHAP providing oral high services to seniors and developmentally disabled patients who are eligible and receive Denti-Cal benefits, in Ventura, Santa Barbara, Tulare and San Luis Obispo Counties since 2007.

7. Plaintiff/Petitioner Ingri Sparling ("Sparling" or Plaintiff) is a licensed RDHAP, RDHAP License No. 209, and a highly skilled and dedicated RDHAP providing dental oral hygiene services to seniors and developmentally disabled patients, who are eligible and receive Denti-Cal benefits, in Sonoma and Napa Counties since 2006. She has 10 facilities and 175 patients.

8. Plaintiff/Petitioner Darci Trill ("Trill" or Plaintiff) is a licensed RDHAP (License No. 56) and a highly skilled and dedicated RDHAP providing dental oral services to seniors and developmentally disabled patients, who are eligible and receive Denti-Cal benefits, in Alameda and Contra Costa Counties for over 12 years. She has over 25 facilities and 250 patients. Trill was in the first graduating class of the University of Pacific to obtain the RDHAP license, traveling as much as 100 miles a day to treat these "forgotten people" whose lives do matter.

9. Plaintiffs' patients are impoverished and needy seniors, developmentally disabled or catastrophically injured in skilled nursing facilities ("SNF") and/ or intermediate care facilities ("ICF"). These patients are dependent upon Denti-Cal as administrated by the California

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Department of Health Care Services ("DHCS"). Denti-Cal provides dental oral hygiene services to Plaintiffs' patients under the Medi-Cal program. The Medi-Cal program is funded by the state of California's participation in the federal Medicaid program. California's participation must be pursuant to what is known as a "State Plan." Any changes to the State Plan must be set forth in California's State Plan Amendment ("SPA") as approved by the responsible federal government department, the Department of Health & Human Services Centers for Medicare and Medicaid Services ("CMS") as set forth herein below beginning at paragraph 27: "The Denti-Cal Program."

10. DHCS has, for over 15 years, been administrating and providing dental oral health care to Plaintiff's patients, through the successful RDHAP program, which has been delivering economic, efficient, quality care, and at rates sufficient to attract the highly qualified Plaintiffs who have vast experience in treating these particular patients. Defendants have not provided a rate increase to these RDHAP providers in over a decade despite an explosion in health care costs and the cost of living. In this program, RDHAPs provide comprehensive dental oral health hygiene care in order to reduce the risk of systemic diseases such as diabetes, cardio vascular disease and bacterial pneumonia, as well as to facilitate nutrition, maintaining the patients' ability to chew, and enabling many to assist in their own care by facilitating their ability to speak so as to be understood by caregivers by preserving these patients' teeth, without which they cannot eat, chew or talk.

11. Many of Plaintiffs' patients include those in sub acute facilities who are ventilator and are tracheotomy dependent due to respiratory failure, developmental disabilities and head/brain trauma. They are unable to follow the required instructions given by providers to obtain diagnostic x-rays. They have involuntary head movements, tongue thrusting, are unable to open their mouths without a mouth prop and have constant chewing and clenching of teeth, often with very strong gag reflexes. Treating them requires unique training and abilities. For over 15 years, x-rays were not required for these very reasons so that these patients could receive their required and medically necessary dental care, lowering their risk of bacterial pneumonia, their primary health risk, due to aspiration of plaque bacteria in their mouths. Plaintiffs are informed and believe that Defendants were and are well aware of these patients' needs and inability to take

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x-rays. Requiring these patients to have x-rays denies their critically needed dental oral care. These patients can't obtain transportation to a hospital operating room, can't receive general anesthesia, which subjects these patients to an annual risk of death and compromises to their already fragile health, and can't find hospitals or dentists willing to perform these services. Plaintiffs are informed and believe that Defendants are aware of these facts as well as the fact that it is economically and practically impossible to obtain transportation for these patients or find a dentist or hospital to do such care.

12. Plaintiffs frequently have to provide patient care under challenging circumstances far removed from the pristine and comfortable clinical environments of a traditional dental office. Plaintiffs treat their patients in SNFs and ICFs often in less than ideal work environments that lack: air conditioning, readily available electric outlets, internet connectivity; and are not infrequently hot, humid, sometimes smelling of Lysol and urine, cramped quarters either bedside or if available, beauty parlors, and at times, even facility bathrooms. For every day of treatment, Defendants have imposed a day of regulatory and administrative compliance to verify eligibility, evaluate the patient's medical condition, determine whether medications need to be started or stopped, process necessary paperwork, coordinate with facility staff on scheduling, as well as to bring equipment and supplies, all at Plaintiffs' non-reimbursed expense.

13. Plaintiffs' patients who are beneficiaries of Denti-Cal are patients that have compromised oral health, such as gum disease, dry mouth, and heavily calcified teeth, appearing as either double or triple rows of teeth, which expose these patients to the risk of fracturing or sloughing off causing a choking risk, leading to possible death. This patient population is on multiple medications. They are physically and mentally unable to take care of their own oral hygiene. Plaintiffs have earned their patients' trust by their consistent quality of care over many years without which this patient population would not submit to the very care that they so desperately need.

14. Plaintiffs as licensed RDHAPs are what is known as fee for service providers and are paid at by Denti-Cal at DHCS set provider rates. Plaintiffs' well-established practices are the very definition of efficiency, economy, and quality of care. Plaintiffs are among the few and

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diminishing providers willing and available to be enlisted and accept the reimbursement rates for their services to provide dental oral health care to this underserved patient population in SNFs and ICFs. Plaintiffs are a treasure trove of information about this patient population and how to provide efficient, economic and quality care whose knowledge and expertise have been routinely ignored by Defendants.

15. Plaintiffs are informed and believe that: (1) Defendant and Respondent California Department of Health Care Services (DHCS or Defendant) is a California governmental agency responsible for the Denti-Cal program,with well appointed air conditioned comfortable offices, their decision makers in Sacramento, California who have never provided or even seen the type of care provided by Plaintiffs nor have Defendants exhibited any interest in even visiting these patients to learn first hand these patients' special needs and how the RDHAP is providing the efficient, economic quality of care necessary for their care; (2) For calendar year 2016-2017, DHCS has a $19.2 billion budget, an 8% increase over budget calendar year 2015-2016, and anticipates receiving a $750 million infusion from the federal government for oral health care; (3) The stated mission of DHCS is to be the "safety net" that ensures that California's needy and most disadvantaged, particularly its seniors and developmentally disabled, such as Plaintiffs' patients, have access to healthcare services, including dental oral care; (4) DHCS proclaims that it provides Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care; (5) DHCS is the single California State agency charged with the administration of California's Medicaid program, known as Medi-Cal and the Medi-Cal dental program, known as Denti-Cal (See, Welfare and Institution Code §14000 et seq.); (6) Since 2008, Denti-Cal providers have decreased by more than 15% while 5 million Californians have enrolled in the program; (7) On April 1, 2016, the Little Hoover Commission's report stated that a silent disease of oral health disease was ravaging Californians jeopardizing the overall health of millions. The Little Hoover Commission stated that Denti-Cal was broken and unable to deliver the kind of dental care that most Californian's enjoy due to dreadful provider reimbursements and outdated paper based administration and billing processes alienating its dental providers; (8) DHCS has been the subject of numerous prior

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lawsuits filed by providers. These lawsuits' subject matter was the efficient, economic and quality of care for disadvantaged patients and DHCS' indifference to the economic and administrative burdens imposed by DHCS on providers to continue the very care that these patients' need; and (9) DHCS was the subject of a December 2014 scathing audit lambasting DHCS' limiting access to care failures to deliver services to California's needy poor children by California's State Auditor.

16. Plaintiffs are informed and believe that (1) Defendant/Respondent Jennifer Kent (Defendant or Kent) is the most current Director of DHCS, appointed by Governor Brown on January 26, 2016, overseeing a staff of 3,700. Defendant Kent is sued solely in her official capacity. Her executive office is located in Sacramento, California at DHCS Headquarters.

17. Pursuant to *California Code of Civil Procedure Sections 1085 and 1086*, Plaintiffs, are beneficially interested parties, as Denti-Cal approved providers to critically compromised patients who are Denti-Cal beneficiaries, and have standing to compel Defendants to comply with their federally and state mandated duties. Under well established California law, a party, who may not have standing to enforce the Medicaid Act under *Section 1983 of title 42 of the United States Code*, may still be entitled to enforce that act by means of a writ of mandate under *California Code of Civil Procedure Section 1085* if they are a beneficially interested party under *California Code of Civil Procedure Section 1086*. It is well settled that a "beneficially interested party [such as Plaintiffs] is one who has some special interest to be served or some particular right to be preserved or protected over and above the interest held in common with the public at large. As Professor Davis states the rule: 'One who is in fact adversely affected by governmental action should have standing to challenge that action if it is judicially reviewable.' (Davis, 3 Administrative Law Treatise (1958) p.291), see *Mission Hospital Regional Medical Center vs. Sandra Shewry* (2008) 168 Cal. App. 4th 460, 480.

18. Plaintiffs are informed and believe that sometime in January 2016 through October 2016, Defendants have circumvented and continue to circumvent, well established federal requirements for changes to Medicaid payment rates to providers, such as Plaintiffs, as summarized in the Department of Health and Human Services' Center for Medicare & Medicaid

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Services' ("CMS") November 2, 2015 Final Rule: "Medicaid Program: Methods for Assuring Access to Covered Medicaid Services" (FR 67576) and CMS' June 24, 2016 Informational Bulletin attached hereto as Exhibit 1.

19. CMS's Exhibit 1 lays out what Defendants were required to do ***but failed to do*** before issuing and enforcing Exhibit 2 attached hereto (Denti-Cal Bulletin July 2016, Volume 32, Number 12) which slashed and eliminated provider rates for dental oral health services to Denti-Cal beneficiaries. Exhibit 2, allegedly effective July 15, 2016, wasn't published until 2:08 pm on July 18, 2016. Defendants via Exhibit 2 imposed a 68% reduction for the critical to Plaintiffs' patients treatment called perio-maintenance ($130 to $55) and wiped out all provider payments to Plaintiffs' patients for the lynch pin to perio-maintenance, a treatment called scaling and root planing ("SRPs") with a new impossible to meet x-ray requirement. Defendants illegal, non CMS approved rate reductions and elimination of vital services, gutted the proven RDHAP oral health care program that had successfully served Plaintiffs' patients and the 105,700 Denti-Cal beneficiaries in SNFs and ICFs for over a fifteen years. While Defendants' presumed target was RDHAPs such as Plaintiffs, Defendants' victims were disadvantaged Californians who are primarily Denti-Cal's impoverished seniors, developmentally disabled, and mentally or physically disabled or both and unable to live independently.

20. Defendants violated their mandatory duties as set for in Exhibit 1 to: 1.provide public notice of all proposed changes to provider payment rates or methodologies before imposing them and submitting same to CMS; 2. Provide public input process policies before reducing rates to obtain input related to access to care for CMS review and; 3. Obtain CMS approval for reducing or eliminating payment rates by submitting and getting approval for a State Plan Amendment ("SPA") to supersede and replace California's current SPA, Exhibit 3, to impose the draconian provider rates reductions in Exhibit 2. The penalty for Defendants' failure to comply with their mandatory duties are set forth in by CMS in Exhibit 1: "Failure to issue proper public notice can result in states being required to re-issue notice and a delay in the effective date of the state plan amendment (SPA implementing the proposed change. It can also result in disapproval of the SPA…Failure to conduct the public processes and analyze input from

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beneficiaries, providers and stakeholders ON THE IMPACT PAYMENT CHANGES WILL HAVE, IF ANY, ON ACCESS TO CARE CAN ALSO RESULT IN A DELAY OF THE SPA APPROVAL OR DISAPPROVAL OF THE SPA." (emphasis added).

21. Defendants' currently existing California State Plan Amendment ("SPA") 15-005), Exhibit 3, was approved by CMS on March 16, 2016 *and submitted by Defendants on April 30, 2015*. Defendants failed to follow these federally mandated requirements before implementing their Exhibit 2 draconian 68% provider rate reduction for the critically needed perio-maintenance and elimination of foundational lynch pin for perio-maintenance, the SRP benefits by imposing impossible to meet radiographic requirement for Plaintiffs' patients***. Defendants in fact not only failed to give <u>the minimum 1 day notice</u> but imposed their draconian provider rate reductions and elimination of critical benefits by impossible to meet radiographic requirements in Exhibit 2, posting same on their website on July 18, 2016 at 2:08 pm <u>effective as of July 15, 2016</u>. Defendants did so despite failing to ever advise CMS of their illegal, non approved plan and scheme to gut beneficiary benefits, slash provider payment rates and wipe out the highly successful and proven dental oral hygiene RDHAP program. So far as CMS knows providers are still receiving the provider rates CMS approved on March 16, 2016 as set forth in CMS' March 16, 2016 Notice of Approval of State Plan Material, Exhibit 3 attached hereto.***

22. The payment rates to Plaintiffs in the successful program that DHCS capriciously and arbitrarily abandoned ***effective July 15, 2016 as posted after the fact on July 18, 2016 at 2:08 pm*** provided: 1. Efficiency 2. Economy; 3. Quality of Care; and 4. Sufficiently enlisted barely enough providers so that care and services were available at least to the extent that such care and services are available to the general population in Plaintiffs' geographic areas, as well as throughout California. Plaintiffs are informed and believe that 11 of California's 58 counties have no Denti-Cal providers who will accept the dreadfully low reimbursements, and therefore, the payment rates are insufficient to meet the beneficiaries' needs.

23. Plaintiffs are informed and believe that under the guise of allegedly offering more, albeit medically unnecessary benefits as described herein below, Defendants have slashed or eliminated Plaintiffs' patients' critical Denti-Cal oral health care benefits for the very foundation

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of this highly successful RHDAP program known as periodontal maintenance by a whopping 68% and eliminated the lynch pin of periodontal maintenance per DHCS policies, scaling and root planning ("SRPs") by imposing physically impossible administrative and dangerous diagnostic burdens, the impossible to perform x-rays that has and will continue to destroy Plaintiffs' patients' ability to receive the oral health care that they desperately need and have received for over 15 years. Defendants predicate perio-maintenance treatments on having SRPs every two years. Defendants ' Exhibit 2 July 2016 Bulletin is a retro active, ex post facto, illegal and a federally impermissible draconian 68% rate reduction of critical benefits and total elimination of SRP benefits in favor of medically unnecessary benefits for Plaintiffs' patients as described herein below.

24. Without approval by CMS, Defendants capriciously and arbitrarily devised and mandated a woefully misguided and medically flawed oral health care scheme to provide Plaintiffs' patients with care they do not need given their oral health condition while taking away the very care they do need and had received for over 15 years. Plaintiffs are informed and believe that if Defendants achieved any budgetary savings, it might be on the order of $100,000, ***a statistically insignificant number in a total budget of $19.2 billion***. Any possible savings is far outweighed by the enormous administrative costs to DHCS and providers such as Plaintiffs, as well as the health care risks and elimination of needed services to Denti-Cal beneficiary patients.

VENUE AND JURISDICTION

25. The Court has jurisdiction over this action pursuant to Code of Civil Procedure §§525, 526, 1085 and Government Code §11350, and California Constitution Article VI, §10.

26. Venue is proper in this Court pursuant to Code of Civil Procedure §§395 and 401(1) because the DHCS is a state agency and the California Attorney General has an office in Los Angeles County.

THE DENTI-CAL PROGRAM

27. Medicaid is a cooperative federal-state program through which the federal government provides financial assistance to states to furnish medical care to needy individuals. *42 U.S.C. Sec. 1396, Mission Hospital Regional Medical Center v. Sherwy (2008) 168 Cal. App. 4th*

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460,469. Although state participation is voluntary, once a state chooses to participate it must prepare and submit plan for approval to the federal government describing its Medicaid program. *Mission Hospital, supra, 168 Cal. App. 4th at page 470, fn.1).* "As a participant in the federal Medicaid program, the State of California has agreed to abide by certain requirements imposed by federal law in return for federal financial assistance in furnishing medical care to the needy". *Olszewski v. Scripps Health (2003) 30 Cal. 4th 798, 804.* California's Medicaid program, Medi-Cal, is a major component of the "safety net" that ensures the State's poor have access to healthcare services. (*42 U.S.C. §§1396-1396v.*)

28. Title XIX of the Social Security Act, The Medicaid Act (*42 U.S.C. §§1396a-1396v*), 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, with the federal financial participation level currently ranging between 50 to 83 percent. To receive matching federal funding, states must agree to comply with the applicable Medicaid law.

29. "To qualify for federal assistance, a state must submit to the secretary of the federal department of Health and Human Services (Secretary) for approval a plan for medical assistant (*42 U.S.C. Sec. 1396(a)* that contains a comprehensive written statement describing the nature and scope of the states Medicaid program. Once approved, the state plan enables the state to receive federal funding. The state must amend its state plan to reflect material changes in state policy of in the state's operation of the Medicaid program. Amendments approved by the state must also be approved by the Secretary. *Mission Hospital Regional Medical Center v. Sherwy (2008) 168 Cal. App. 4th 460,470*

30. California has elected to participate in the Medicaid program. The state program in California is called Medi-Cal and as a part, has a dental program, known as Denti-Cal. The California Medi-Cal program provides an array of medical services, treatments, and therapies and dental services to children and the elderly that are authorized based on individuals' meeting "medical necessity" criteria. *Cal.Welf. & Inst. Code §§14059, 14059.5, 14133.3; 22 California Code of Regulations ("CCR") §51303(a)).*

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31. States participating in Medicaid must designate a "single state agency" to administer or supervise the administration of the Medicaid program. (*42 U.S.C. §1396a(a)(5)*). DHCS is the single state agency so designated in California.

32. DHCS administers the state's Medicaid program, Medi-Cal. (*22 CCR §50004*) DHCS, in accordance with federal law, decides eligible beneficiary groups, types and ranges of services, payment level for services, and administrative procedures. The Medi-Cal program is charged with the responsibility of complying with the state Medicaid plan, which in turn must comply with the provisions of the applicable federal Medicaid law. (*42 U.S.C. §1396a(a)(5*); *42 CFR §§430.10, 431.10.*)

33. Each State's Medicaid plan must provide that medical assistance will be furnished with reasonable promptness to all eligible individuals. (*42 U.S.C §1396a(a)(8*).)

34. The state Medicaid plan must be submitted to the Secretary of the United States Department of Health and Human Services for approval. The state plan describes the policies and methods to be used to set payment rates for each type of service included. (*42 CFR §§430.10, 447.201(b).*)

35. California's state plan provides that the methodology for establishing payment rates is to develop an evidentiary base or rate study resulting in the determination of a proposed rate, to present the proposed rate at a public hearing to gather public input, to determine the payment rate based on both the evidentiary base and the public input, and to establish the payment rate through the adoption of regulations.

36. California must determine the payment levels for services, and make payment for services directly to the individuals or entities furnishing the services. The Medicaid Act requires California to adopt a state plan describing the policy and methods to be used to set payment rates.

37. States must establish rates through a public process that includes: (a) publication of proposed rates, the methodologies underlying the establishment of such rates, and justifications for the rates; (b) a reasonable opportunity for comment on the proposed rates, methodologies and justifications by providers, beneficiaries and their representatives, and other concerned State residents; and (c) publication of opportunity for comment on the proposed

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rates, methodologies and justifications for such final rates. *See (42 U.S.C. §1396a(a)(l3*); *42 CFR §447.205,* and Exhibit 1.) Payment rates are to be sufficient to meet the beneficiaries' needs. *Keffeler v Partnership Healthplan of California* (2014) 224 Cal.App.4th 322.

38. Pursuant to *42 USC §1396a(a)(30)(A*) (hereinafter Section 30(A)), California's state plan must, "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area … ." "Section 30(A) requires a substantive result--reimbursement rates must be consistent with efficiency, economy, and quality care, and sufficient to enlist enough providers to ensure adequate beneficiary access." *See, Keffeler v Partnership Healthplan of California* (2014) 224 Cal.App.4th 322, 336.

39. A purpose of a review of services is to ensure that the rates comply with Section 30(A), which requires payments to be: (1) consistent with efficiency, economy, and quality of care; and (2) sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

40. DHCS's payments must be sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population. (42 CFR §447.204).

41. State law reinforces DHCS's mandatory duty to comply with the State Plan pursuant to *Title 22 CCR §50004(b)(l),* which specifically requires that the Department "administer the Medi-Cal program in accordance with .. . [t]he State Plan under Title XIX of the Social Security Act." *See also, Cal.Welf. & Inst. Code §14100*. DHCS is required to administer the Medi-Cal program in accordance with: (1) the State Plan; (2) applicable California law, as specified in the Welfare and Institutions Code; (3) Medi-Cal regulations; and (4) federal Medicaid law and regulations, including *42 U.S.C. §1396a(a)(8)*'s requirement to

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provide medical and dental care with reasonable promptness.

42. The California Legislature has independently stressed that all eligible Medi-Cal beneficiaries receive necessary care and has established a system designed to ensure that health care providers will be available to render this care: "The Legislature intends that Medi-Cal recipients have reasonable access to medical care services …. In order to obtain such access, the Legislature intends that, to the extent feasible and permitted by federal law, physicians be reimbursed equally statewide for comparable services, at a rate sufficient to provide Medi-Cal recipients with such reasonable access … (*Cal.Welf. & Inst. Code §14075*).

43. Accordingly, the Legislature created a procedure to ensure that Medi-Cal beneficiaries have reasonable access to physician and dental services. (*Cal. Welf. & Inst. Code §14079*). State law requires that Medi-Cal fee for service rates be adopted pursuant to the regulatory process and requires that the Department annually review Medi-Cal rates for physician and dental services, taking into account annual Consumer Price Index cost increases, reimbursement levels under Medicare arid other third party payors, prevailing customary charges and other factors. (*Cal. Welf. & Inst. Code §14079*). Based on these reviews, the Legislature mandated that DHCS revise reimbursement rates "to physicians and dentists to ensure reasonable access of Medi-Cal beneficiaries ...." *Id.* Plaintiffs are informed and believe that Defendants failed to follow the mandates of *Cal. Welf. & Inst. Code §14079* before retroactively imposing the crippling provider rate reductions and elimination of payments entirely with impossible to meet x-ray requirements as contained in Exhibit 2. Tellingly, Defendants' Exhibit 2 concedes that Defendants' new requirement for x-rays for SRPs on Denti-Cal beneficiaries is in fact physically impossible and undesirable for Plaintiffs' patients. Defendants' Exhibit 2 references an ill defined, yet to be published "radiographic exemption". Defendants thereby imposed yet a further futile as well as costly administrative burden on Plaintiffs to substantiate the obvious – why this patient population cannot have x-rays taken and needs perio maintenance, which is per Defendants' predicated on SRPs every two years. Defendants stonewalled RDHAP attempts to obtain Defendants' so called radiographic exemption leaving Plaintiffs to guess what Defendants had in mind. The result: blanket denials of Plaintiffs' treatment authorization requests for a

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radiographic exemption by Defendants who have no guidelines on how to obtain such a radiographic exemption. Plaintiffs' experience is that Defendants' promise of a radiographic exemption is both illusory and a "fig leaf" to cover themselves in the event some legislative body ever inquired about Defendants' change in policy after 15 years of not imposing such a requirement.

44. Plaintiffs rendered dental oral care to their patients prior to Exhibit 2 being posted at 2:08 pm on July 18, 2016. Defendants thereafter summarily refused to issue payment for those services at the CMS approved provider rates. Instead, Defendants made payments at the non CMS approved rates set forth in Exhibit 2. Further, Defendants, *without notice on July 22, 2016,* after Exhibit 2 was posted on July 18, 2016 at 2:08 p.m., added new, restrictive language relating to a new treatment Defendants called "gross debridement" stating Plaintiffs wouldn't be paid for any gross debridements "within 24 months following the last Scaling and Root Planing (SRP). Although Plaintiffs relied upon Exhibit 2 as originally posted and performed gross debridements pursuant to Exhibit 2, Defendants refused to pay for same based on their newly added restrictive language on July 22, 2016.

45. DHCS capriciously and arbitrarily drafted and implemented Exhibit 2, with its July 2016 retroactive rate reduction without CMS approval; without the required review of services and rate reductions or any analysis of how Exhibit 2 would negatively impact recipients of Denti-Cal and eliminate necessary services, and limit or eliminate necessary providers of these necessary services, including though not limited to Plaintiffs. Defendants failed to adequately consider all relevant factors (or any) and cannot demonstrate a rational connection between those factors, the choice made, and the purposes of their draconian provider rate slashes and elimination of services. *California Association for Health Services at Home v. State Department of Health Care Services* (2012) 204 Cal.App.4th 676, 686.

46. According to the DHCS, there are over 100,000 impacted beneficiaries. The vast majority of the Denti-Cal beneficiaries are seniors and developmentally disabled in skilled nursing facilities and intermediate care facilities. For over 15 years, no pre-authorization or x-rays have been required to obtain scaling and root planing by RDHAPs, without which quarterly

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periodontal maintenance is not authorized under Defendants' rules. These patients cannot brush their own teeth. Often facility staff is unable, given all their other duties, to provide oral care. These patients have poor diets aggravating their oral gum disease. Bacterial plaque rapidly develops in their mouths, impacted by multiple medications which often produce "dry mouth." Defendants know that 64.5% of these patients' oral care services were performed by RDHAPs who, for over 15 years, have never been required to seek pre-authorization and submit x-rays. Plaintiffs are informed and believe that RDHAPs, whether they are independent contractors or employees of dentists, provide over 90% of the scaling and root planing.

47. Plaintiffs are informed and believe that: 1 DHCS asserts that 42.5% of pre authorizations are denied, without evaluating whether such denials are due to poor quality x-rays due to the patient's inability to take x-rays or the poor quality of the mobile x-ray equipment; 2. independent surveys of DHCS denials are substantially higher – closer to 75%; 3. DHCS promised to process authorizations in 5 days. However, authorization reviews are outsourced by Defendants and take up to 4 to 8 weeks; and 4. Long delays are the norm, resulting in a denial of care especially for patients who are discharged from the facility or transferred to another facility or to a hospital, thus violating *42 U.S.C. §1396a(a)(8)*'s reasonable promptness requirement. Plaintiffs are informed and believe that just the review of all the new x-rays required by Exhibit 2, *if those x rays could be taken*, would require over 400 a day to be reviewed and processed or one every 90 seconds. Plaintiffs are informed and believe that DHCS has not calculated the cost of reviewing these newly required x-rays, has not calculated the economic and administrative of obtaining their newly required x rays or performed a realistic cost benefit analysis.

48. Plaintiffs are informed and believe that: 1. DHCS has not performed a cost benefit analysis of the provider rate reductions and elimination of vital services; 2. DHCS has no methodology of studying the impact of same ; 3. DHCS has not done an analysis of whether portable x-ray equipment will capture the information it believes is necessary; 4. DHCS has no research on this population of patients to demonstrate this patient population can tolerate x-rays, have x-rays taken or the safety of doing so in a SNF or ICF, which are not x-ray protected environments, for either the patient or the x-ray technician, where x-rays would have to be taken

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in patient's rooms that have 2-3 other patients all of whom would be exposed to scatter radiation; 5. DHCS has no study as to the cost of the equipment and software required to comply with Exhibit 2.

49. Plaintiffs are informed and believe DHCS is imposing on the patients a standard of care that is inapposite and contra indicated for patients with obvious gum disease and their compromised oral health.

50. DHCS has slashed the critically needed periodontal maintenance provider rate by 68% from $130 to $55 and with Exhibit 2's x-ray requirement will make it impossible to perform perio maintenance. Plaintiffs are informed and believe that no provider can or will provide treatment at that level of reimbursement whose cost exceeds the benefit paid. The result is payment rates which are insufficient to meet the beneficiaries' needs. *Keffeler v Partnership Healthplan of California* (2014) 224 Cal.App.4th 322. Defendants have mandated scaling and root planing every two years in order for Denti-Cal beneficiaries to receive the very care they need -- periodontal maintenance so as to mitigate the risks of gum disease on this population. By imposing its new impossible to meet x-ray requirement, Defendants have eliminated the critically needed perio-maintenance under the guise of utilization control for the purpose of a thinly disguised and ham handed provider rate reduction.

51. Defendants' non CMS approved Exhibit 2 bulletin wrongfully imposed prophylaxis, which Plaintiffs' patients don't need, is medically contra indicated, and falls below the standard of care for these patients. Prophylaxis is a dental cleaning for removal of supra plaque and supra coronal calculus. The real detrimental bacterium lies under the gum line and in the pockets. Defendants' July 2016 bulletin, Exhibit 2, is based a false premise that prophylaxis is medically necessary for these patients in place of a perio-maintentence. Exhibit 2 is falsely premised on the concept that by allowing prophylaxis once a quarter, Plaintiffs' Denti-Cal patients would receive the dental oral health care they needed. In fact, prophylaxis is below the standard of care for this patient population which have gum disease. Prophylaxis is utilized to treat a healthy dentition. A prophylaxis is for a healthy mouth, not a diseased mouth. This patient population needs periodontal maintenance not prophylaxis instead of perio-maintenance. Further,

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Exhibit 2's new benefit of a full mouth debridement has no proven medical benefits and is no substitute for scaling and root planing, without which every 24 months, no perio maintenance can be performed per Defendants.

52. Plaintiff Hall met with staff of Defendants in an effort to educate them as to the special needs of her patients and those similarly situated in over 1,300 SNFs and ICFs in California. Defendants' estimate these patients number 105,700. During the time Plaintiff Hall met with DHCS and its representatives, including DHCS Director Kent, they were indifferent at best and refused to look at representative photographs of the conditions of these patients.

FIRST CAUSE OF ACTION

WRIT OF MANDATE (FAILURE TO FOLLOW MEDICAID PROCEDURES FOR CHANGES TO PROVIDER RATES: NOTICE, ANALYSIS AND SUBMISSION OF NEW STATE PLAN AMENDMENT).

(AGAINST ALL DEFENDANTS)

53. Plaintiffs hereby incorporate by reference paragraphs 1 through 52, inclusive, as though fully set forth herein.

54. Having elected to participate in Medicaid and receive federal funding, Defendants have a clear, present, and ministerial duty to comply with Medicaid procedures and regulations of public notice, public process and obtaining approval of a State Plan Amendment when lowering or eliminating provider rate payments, as alleged hereinabove, which Defendants did with Exhibit 2. Defendants failed to comply with their clear, present and ministerial duties before posting and implementing retroactively Defendants July 2016 Bulletin on July 18, 2016 at 2:08 p.m. effective as of July 15, 2016, Exhibit 2 and materially changing Exhibit 2 as to gross debridement at an unknown time of July 22, 2016, without any notice to or approval by CMS.

55. Since July 18, 2016, Defendants have rigorously enforced Exhibit 2 with its draconian 68% slashing of perio-maintenance provider rates from $130 to $55 and the elimination of the perio-maintenance lynch pin of scaling and root planning (note Exhibit 2 illegally reduced provider rates for SRP treatments, assuming x-rays could somehow be taken that Defendants in their sole discretion could and routinely did determine to be unacceptable).

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56. Plaintiffs have no plan, speedy and adequate remedy in the ordinary course of the law on an act which the law specifically enjoins: Defendants must comply with federal Medicaid procedures and requirements of public notice, analysis of impact, and obtaining CMS approval ***before lowering or eliminating provider rates as set forth herein above and in Exhibit 1, which Defendants failed to do before posting and enforcing Exhibit 2.***

57. Defendants must be mandated to stay and vacate Exhibit 2, its illegal and CMS non approved July 2016 bulletins with its draconian 68% slashing of perio-maintenance provider rates from $130 to $55 and the elimination of the perio-maintenance lynch pin of scaling and root planning (note provider rates were also illegally reduced for SRP treatments).

58. Defendants must be mandated to pay Plaintiffs and all RDHAPs at the provider rates approved by CMS on March 16, 2016, Exhibit 3.

59. Defendants must be mandated to comply with federal requirements for changes to Medicaid payment rates as set for hereinabove and in Exhibit 1 should Defendants elect to implement and enforce Exhibit 2, its non CMS approved July 2016 bulletins.

60. IF not otherwise directed by this Court's issuance of the requested writ of mandate, Defendants will continue to violate their clear, present, and ministerial duty to comply with the federal Medicaid regulations as set forth herein above and in Exhibit 1. Issuance of the requested writ of mandate is therefore necessary to prevent Defendants from continuing to violate federal and California law and to ensure that Exhibit 2 is not used by Defendants to deny critically needed dental services and not to pay Plaintiffs and all other RDHAPs pursuant to California's approved SPA of March 16, 2016.

SECOND CAUSE OF ACTION

WRIT OF MANDATE (WELFARE & INSTITUTIONS CODE §14079)

(AGAINST ALL DEFENDANTS)

61. Plaintiffs hereby incorporate by reference paragraphs 1 through 60, inclusive, as though fully set forth herein.

62. Defendants have a clear, present, and ministerial duty to comply with Welfare & Institutions Code §14079 to conduct an annual review of provider services and periodically raise

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provider payment rates to ensure reasonable access of Medi-Cal beneficiaries taking into account at least the following factors: annual cost increases as reflected by the Consumer Price Index; Reimbursement rates of Medicare, Blue Shield and other third party payors; prevailing customary charges with the state and in various geographic areas; procedures reflected by the Relative Value Studies (RVS); Characteristics of the current population of Medi-Cal beneficiaries and the medical services needed.

63. Defendants' Exhibit 2 must be stayed and vacated until Defendants comply with the requirements of Welfare & Institutions Code §14079.

64. Defendants must pay Plaintiffs and all RDHAPs at the provider rates existing prior to Defendants' posting and enforcement of Exhibit 2 as of July 15, 2016.

65. There is no express statutory exemption excusing Defendants from complying with the Welfare & Institutions Code §14079 with respect Exhibit 2. A writ of mandate should be issued under Code of Civil Procedure §1085 "to compel the performance of an act which the law specifically enjoins, as a duty resulting from an office, such as compliance with *Cal. Welf. & Inst. Code §14079.*

66. If not otherwise directed by this Court's issuance of the requested writ of mandate, Defendants will continue to violate their clear, present, and ministerial duty to comply with *Cal. Welf. & Inst. Code §14079* by continuing to utilize, enforce, or attempt to enforce Exhibit 2. Issuance of the requested writ of mandate is therefore necessary to prevent Defendants from continuing to violate California law and to ensure that the Exhibit 2 is not used by Defendants to deny critically needed dental services and illegally materially change provider payment rates to Plaintiffs.

THIRD CAUSE OF ACTION

WRIT OF MANDATE (CAPRICIOUS AND ARBITRARY RULE)

(AGAINST ALL DEFENDANTS)

67. Plaintiffs hereby incorporate by reference paragraphs 1 through 66, inclusive, as though fully set forth herein.

68. DHCS has failed to comply with federal and state law requiring that its decision-

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making not be capricious and arbitrary.

69. Exhibit 2 is based on a capricious and arbitrary decision-making process, (or lack thereof) by Defendants. Defendants capriciously and arbitrarily drafted and implemented Exhibit 2 without the required review of services, rate reductions or how the Exhibit 2 would negatively impact recipients of Denti-Cal and eliminate necessary services, and limit or eliminate necessary providers of these necessary services, including though not limited to Plaintiffs. Defendants failed to adequately consider all relevant factors (or any) and cannot demonstrate a rational connection between those factors, the choice made, and the purposes of the Exhibit 2. *California Association for Health Services at Home v. State Department of Health Care Services* (2012) 204 Cal.App.4th 676, 686.

70. A writ of mandate may be issued under *California Code of Civil Procedure §1085* "to compel the performance of an act which the law specifically enjoins, as a duty resulting from an office."

71. If not otherwise directed by this Court's issuance of the requested writ of mandate, Defendants will continue to violate their clear, present, and ministerial decision-making duty under California state law in implementing its duties by continuing to utilize, enforce, or attempt to enforce Exhibit 2. Issuance of the requested writ of mandate is therefore necessary to prevent Defendants from continuing to violate California law and to ensure that Exhibit 2 is not used by Defendants to deny critically needed dental services.

FOURTH CAUSE OF ACTION

INJUNCTIVE RELIEF

(AGAINST ALL DEFENDANTS)

72. Plaintiffs hereby incorporate by reference paragraphs 1 through 56, inclusive, as though fully set forth herein.

73. Unless and until Defendants are mandated to stay Exhibit 2 and maintain provider reimbursement rates existing before the posting and enforcement of Exhibit 2 thereby preserving retain the highly successful RDHAP program which provided the oral health care this patient population received for over 15 years and implementing, Defendants' Exhibit 2 will eliminate

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critical services and slash provider rates by 68% for dental services as set forth in Exhibit 2. Plaintiffs and Plaintiffs' patients, as Denti-Cal beneficiaries, will be irreparably harmed because of the invalid and illegal reduction in rates and services in violation of state regulations and statutes, federal law and federal regulations, as follows:

a. Exhibit 2 has and will continue to result in a large number of licensed RDHAP and other providers of dental care services to either withdraw from or reduce their participation in the Medi-Cal program due to the inadequacy of the Medi-Cal rates to meet the administrative, physical and economic burden of providing services to these most compromised of patients, *not in a pristine dental office but in the field, at facilities, where providers have to bring their own equipment for* Medi-Cal beneficiaries in need of dental care services will not have access to needed service and there have and will be delays in necessary health care services or the inability of Medi-Cal beneficiaries to receive needed services at all.

b. The well established and hard won relationships, built at great personal expense by Plaintiffs between patients and providers will be permanently and irreparably disrupted, because many Medi-Cal beneficiaries will be forced to interrupt current courses of treatment with their providers, as those providers are forced to withdraw from or reduce their participation in the Medi-Cal program due to the draconian slashes in Medi-Cal rates in Exhibit 2.

c. The draconian reductions in and elimination of Medi-Cal provider rates established in Exhibit 2 which are below the levels necessary to be consistent with efficiency, economy and quality of care have and will continue to make it impossible for providers who do remain to provide services consistent with community standards of quality care since the administrative, physical and economic burdens in providing those services exceed Exhibit 2's applicable Medi-Cal payments, thus endangering the health and well-being of Medi-Cal beneficiaries and the providers. The result is payment rates which are insufficient to meet the beneficiaries' needs. *Keffeler v Partnership Healthplan of California* (2014) 224 Cal.App.4th 322.

74. There is no administrative or other avenue by which expedited relief from

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draconian rate reduction and elimination set forth in Exhibit 2, for the Plaintiffs or their patients who are Medi-Cal recipients, can be had. All of the said injuries are great, immediate, and irreparable, for which damages at law are inadequate, and for which Plaintiffs have no plain, adequate or speedy relief at law or otherwise.

FIFTH CAUSE OF ACTION

DECLARATORY RELIEF

(AGAINST ALL DEFENDANTS)

75. Plaintiffs hereby incorporate by reference paragraphs 1 through 56, inclusive, as though fully set forth herein.

76. An actual and justiciable controversy exists between Plaintiff and Defendants regarding the validity of Exhibit 2 posted on July 18, 2016, retroactive to July 15, 2016.

77. Plaintiffs contend that Exhibit 2 is invalid and the rate reduction is invalid and unlawful in violation of state law, the state Constitution, federal law and federal regulations, while the Defendants contend Exhibit 2 and the rate reductions are valid in all respects.

78. Accordingly, pursuant to Code of Civil Procedure §1060, Plaintiffs request this Court to declare the New Regulation and the rate reductions invalid and unlawful.

SIXTH CAUSE OF ACTION

BREACH OF CONTRACT: SPECIFIC PEFORMANCE

OF SETTLEMENT AGREEMENT

(AGAINST ALL DEFENDANTS)

79. Plaintiffs hereby incorporate by reference paragraphs 1 through 78, inclusive, as though fully set forth herein and state this cause of action against all Defendants.

80. On November 28, 2016, Defendants' authorized agent, attorney Carmen Snuggs, orally offered to settle this action (First through Fifth Causes of Action) in its entirety to Plaintiffs' attorney, Laurence C. Hall in a telephone call. Defendants' attorney stated that the DHCS had authorized her to make the settlement offer and the terms were that DHCS would rescind the July 2016 provider bulletin at issue in this matter and reprocess the affected claims that have been submitted since the bulletin's effective date, in exchange for petitioners' dismissal

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of the operative amended petition/complaint with prejudice, and that each side to bear its own attorney's fees and costs. In response, Plaintiffs' counsel orally stated that he would communicate the offer to the Plaintiffs.

81. On November 28, 2016 at 6:24 p.m., Plaintiffs' counsel received Defendants' authorized written settlement offer sent by Carmen Snuggs in her email to Plaintiffs' counsel. Defendants authorized settlement offer is quoted *verbatim* as follows, and Carmen Snugg's email is attached hereto as Exhibit 4:

> "Dear Mr. Hall:
>
> This letter serves to confirm our telephone conversation this evening. The Department of Health Care Services (DHCS) has authorized me to make the following settlement offer: DHCS will rescind the July 2016 provider bulletin at issue in this matter and reprocess the affected claims that have been submitted since the bulletin's effective date, in exchange for petitioners' dismissal of the operative amended petition/complaint with prejudice. Each side to bear its own attorney's fees and costs.
>
> Please let me know whether petitioners accept DHCS's settlement offer. If petitioners do accept, then I will draft a settlement agreement for your review and signature.
>
> As you know, a Trial Setting Conference has been scheduled for December 1, 2016. In addition, you previously gave ex parte notice for December 1, 2016, at which time petitioners would request an alternative writ and preliminary injunction. Please confirm, if petitioners' accept the Department's settlement offer in principle, that petitioners are withdrawing their ex parte application.
>
> Please respond as soon as possible given the impending December 1, 2016 hearing date.
>
> Best,
> Carmen D. Snuggs
> Deputy Attorney General"

82. On November 29, 2016, at 9:39 a.m., in writing by email, Plaintiffs accepted Defendants' offer on all terms, with a request that Defendants consider allowing the modification that Plaintiffs would file a dismissal, without prejudice, so as to avoid a potential retraxit argument and that Plaintiffs would file a Notice of Settlement with the Court.

83. On November 29, 2016, Plaintiffs and Defendants entered into an oral agreement to settle the First Amended Complaint in its entirety, (the First through Fifth Causes of Action of this Second Amended Complaint), with the material terms memorialized in writing. (Hereinafter referred to as the "settlement agreement.")

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84. On December 5, 2016, Defendants advised they would not consider a dismissal without prejudice. On December 5, 2016, at 11:03 a.m., Plaintiffs agreed to a dismissal with prejudice.

85. The settlement agreement terms were clear enough that Defendants and Plaintiffs understood what each side was required to do. The parties understood and agreed to the terms of the settlement agreement.

86. The parties agreed to give each other something of value: Defendants agreeing to rescind in full the July 2016 Bulletin and reprocess the affected claims that have been submitted since the July 2016 Bulletin's effective date and Plaintiffs agreeing to serve and file a Notice of Settlement and a dismissal of the action in addition to waiving their attorney fees and costs as well as agreeing to have Defendants take a credit for payments for services that would no longer exist with the July 2016 Bulletin rescinded.

87. On November 29, 2016, Plaintiffs served on Defendants and filed with the Court a Notice of Settlement that the entire case had been unconditionally settled and a dismissal would be filed within 45 days of the date of settlement. On November 30, 2016, Plaintiffs served on Defendants a filed endorsed copy of the Notice of Settlement filed on November 29, 2016. In response to the Notice of Settlement of the entire case, the Court set an OSC re Dismissal for February 27, 2017 in Department 54.

88. By agreeing to the terms of the settlement agreement and the filing of the Notice of Settlement with the Court on November 29, 2016, the parties agreed to be bound by the terms of the settlement agreement before a written agreement was completed and signed.

89. In reliance on the settlement agreement, Plaintiffs returned to work to treat their patients and thereafter were denied payment for services rendered as Defendants continued to enforce its July 2016 Bulletin and failed to honor the terms of the settlement agreement.

90. On January 4, 2017, Defendants breached the settlement agreement when Defendants' attorney, Supervising Deputy Attorney General Leslie Elroy advised Plaintiffs' attorney that Defendants were not fully rescinding the July 2016 bulletin at issue and would be adding a new claim into the case that Defendants were not required to comply with federal

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requirements of notice, stakeholder comments or obtain CMS approval for pre-authorization and x-rays for scaling and root planing. Defendants have refused and continue to refuse to comply with the settlement agreement.

91. Plaintiffs have performed all duties, covenants, conditions, promises and obligations required on their part to be performed under the settlement agreement, including filing and serving the Notice of Settlement with the Court, except for those excused or prevented by the acts, omissions and breaches of the settlement agreement by Defendants, including dismissing the First Amended Complaint (First through Fifth Cause of Action of the Second Amended Complaint).

92. Plaintiffs remain ready, willing and able to perform the duties, conditions and obligations, including dismissing the First Amended Complaint (First through Fifth Cause of Action of the Second Amended Complaint) once Defendants specifically perform their obligations of the material terms of the settlement agreement, and waiving their attorney fees and costs as well as agreeing to have Defendants take a credit for payments for services that would no longer exist with the July 2016 Bulletin rescinded.

93. To enforce the settlement agreement, Plaintiffs have filed this Second Amended Complaint to allege this cause of action for specific performance.

PRAYER

WHEREFORE, Plaintiffs and Petitioners pray as follows:

1. For a Writ of Mandate to stay and vacate Exhibit 2;

2. For a Writ of Mandate for Defendants to pay Plaintiffs and all RDHAPs at the provider rates approved by CMS on March 16, 2016;

3. For a Writ of Mandate to compel Defendants to comply with Exhibit 1 – all federal requirements for changes to Denti-Cal payment rates to providers.

4. For a Writ of Mandate that Defendants comply with *Cal. Welf & Inst Code §14079* before promulgating and enforcing any changes to Denti-Cal payment rates to providers;

5. For a declaration that Exhibit 2 is invalid and unenforceable as against Plaintiffs.

6. For an order requiring Defendants and Respondents to show cause, if any, why they

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should not be enjoined from implementing Exhibit 2 during the pendency of this action.

7. For an order the Exhibit 2 is null and void based on capricious and arbitrary decision-making (or any) by the Defendants and Respondents.

8. Temporary, preliminary and permanent injunctive relief.

9. Recovery of attorney's fees as allowed under California law.

10. On the Sixth Cause of Action: For a Court Order that Defendants shall comply with Defendants' duties, promises and obligations of the settlement agreement, bearing their own attorney's fee and costs, and immediately take any and all steps required to rescind in full the July 2016 Bulletin at issue, Exhibit 2 hereto; and reprocess all claims since the effective date of the subject July 2016 Bulletin at issue, Exhibit 2 hereto.

11. On all Causes of Action: Costs of suit incurred herein;

12. On all Causes of Action: For such other and further relief as the Court deems just and proper.

Dated: February 22, 2017

THE HALL LAW CORPORATION

By: _____
Laurence C. Hall
Attorneys for Plaintiffs and Petitioners

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6242 Westchester Parkway, Ste. 200
Los Angeles, CA 90045

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Fair Oaks, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: _____
JUDY BOOTHBY

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Arroyo Grande, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: S. Denise Cozza
S. DENISE COZZA

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Castro Valley, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: Darci Trill
DARCI TRILL

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Hermosa Beach, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: Melissa Hall RDHAP
MELISSA HALL

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Redding, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: _____
DEBORAH HAGEY

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Tustin, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: _____
GITA AMINLOO

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Santa Rosa, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: Ingri Sparling
INGRI SPARLING

VERIFICATION

State of California, County of Los Angeles.

I have read the foregoing document, **VERIFIED SECOND AMENDED COMPLAINT FOR: 1. WRIT OF MANDATE; 2. DECLARATORY RELIEF; 3. INJUNCTIVE RELIEF; 4. SPECIFIC PERFORMANCE OF SSETTLEMENT AGREEMENT,** and know its contents.

I am a party to this action, and I make this verification for that reason. I am informed and believe and on that ground allege that the matters stated in the foregoing document are true.

Executed on February 22, 2017, at Atascadero, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

By: _____
MAUREEN KAYE

EXHIBIT “1”

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMCS Informational Bulletin

DATE: June 24, 2016

FROM: Vikki Wachino, Director
Center for Medicaid and CHIP Services

SUBJECT: Federal public notice and public process requirements for changes to Medicaid payment rates

The purpose of this CMCS Informational Bulletin is to summarize procedures states must follow when making changes to provider payments under the Medicaid state plan and to emphasize the importance of public notice content and timing requirements. Specific to payment changes, there are three types of procedures:

- public notice policies that pertain to all proposed changes to provider payment rates or methodologies
- public input process policies, which apply when states reduce rates or restructure payments, and are designed to obtain input related access to care
- public input process policies that are specific to changes to institutional provider payment rates

Some of these requirements are longstanding; others were codified in CMS' November 2, 2015 final rule: "Medicaid Program: Methods for Assuring Access to Covered Medicaid Services" (80 FR 67576). This rule updated public notice requirements and provided guidance on public process procedures to identify and analyze access to care concerns, among other policies. The final rule established a new transparent, data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act (the Act). The final rule applies to services covered under the Medicaid state plan and paid on a fee-for-service basis. Where relevant, these new requirements are noted below.

Public Notice for All Proposed Changes to Payment Rates or Methodologies

Longstanding federal regulations at 42 CFR 447.205 require states to issue public notice of proposed changes in statewide methods and standards for setting Medicaid payment rates. Public notice is necessary to inform providers and other stakeholders of any changes states intend to make to their Medicaid payment methodologies, so that providers and others do not rely on prior payment methodologies. The notice must be issued at least one day prior to the effective date of the state's proposed change. CMS' November 2015 final rule modified these requirements slightly to authorize states to issue public notice on state websites or, as was previously allowable, in newspapers and state registers.

Importantly, the final rule issued in November 2015 did not modify the requirements regarding the content states must include in the public notice, which have been in place for many years. Failure to issue proper public notice can result in states being required to re-issue notice and a delay in the effective date of the state plan amendment (SPA) implementing the proposed change. It can also result in disapproval of the SPA.

Public Input Processes Related to Access to Care

The final rule also described new requirements for provider and public input processes to inform determinations about access to care when states propose to reduce rates or restructure Medicaid payments. These new requirements, effective January 4, 2016, were established in the November 2015 final rule and are described in regulations at 42 CFR 447.204. Prior to submitting SPAs to CMS, states are required to make information available so that beneficiaries, providers and other stakeholders may provide input on beneficiary access to the affected services and the impact that the proposed payment change will have, if any, on continued service access. States are expected to obtain input from beneficiaries, providers and other stakeholders, and analyze the input to identify and address access to care concerns. States must obtain this information prior to submitting a SPA to CMS and maintain a record of the public input and how the agency responded to the input. When a state submits the SPA to CMS, the regulation requires the state to also submit a specific analysis of the information and concerns expressed in input from affected stakeholders. CMS will rely on this and other documentation submitted by the state to inform our SPA approval decisions. Failure to conduct the public processes and analyze input from beneficiaries, providers and stakeholders on the impact payment changes will have, if any, on access to care can also result in a delay of the SPA approval or disapproval of the SPA.

Public Input Processes Specific to Changes to Institutional Provider Rates

Specific public input processes pertain when states propose to change institutional provider payment methodologies. These are described in statute at section 1903(a)(13)(A) of the Act and predate the November 2015 rulemaking.[1] These public input processes are designed to give providers and other affected stakeholders an opportunity to review and comment on changes to institutional provider payment rates.

The attachment to this informational bulletin, Summary of Public Notice and Public Process Requirements, provides a summary of the three above requirements.

Public Notice Content Requirements:

To meet CMS public notice requirements, states must include all of the information required by 42 CFR 447.205 in their public notice of rate changes. The public notice must identify the

[1] Section 1902(a)(13)(A) of the Act requires a public process for institutional payment rate or methodology changes. For more information see State Medicaid Director's letter dated 12/10/97: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD121097.pdf .

specific services and/or benefits that are affected by changes in state plan methods and standards for setting payment rates. In addition, states should not rely on information referenced external to the public notice, such as state legislative websites or provider bulletins, to meet the content requirements in the regulation. The actual published notice must include all of the required content.

The public notice content requirements are described in Federal regulations:

42 CFR 447.205(c) Content of notice. The notice must –

(1) Describe the proposed change in methods and standards;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; and

(6) If there are public hearing, give the location, date and time for hearing or tell how this information may be obtained.

With respect to the above regulations, CMS expects states will issue public notices that:

1) Explicitly identify the Medicaid service(s) being affected by the proposed payment change.
2) Identify the dollar amount of any rate change(s) or the percent increase or decrease in the rate(s).
3) Explain the expected increase or decrease in annual aggregate expenditures by the benefit category or service being affected.
4) In instances where the changes in methods and standards are applied across benefit categories, such as across the board percentage rate increases or decreases, provide a comprehensive list of the services that will be affected by the change.
5) Provide all relevant information required by the regulation within the text of the public notice without reliance on websites or documents external to the public notice.

<u>Efficiencies for Operationalizing Notices and Processes</u>:

States may find it efficient to coordinate the implementation of these public notice and public input process requirements. States may use a single mechanism to meet all three requirements as long as:

- all of the statutory and regulatory requirements for each process are met;

- the public is notified of changes in state plan methods and standards for setting payment rates prior to the effective date of the change;
- parties interested in institutional rates have a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications; and
- beneficiaries, providers and stakeholders are able to provide input to the Medicaid agency on the impact payment changes will have on access to care before the state submits the SPA to CMS for review. These processes could include input received through: face-to-face meetings, written letters, emails, online forms, or other effective mechanisms a state uses to solicit public input.

For example, a state proposing to decrease inpatient hospital payment rates could use the state Medicaid agency's website as the source of public notice and the processes for institutional rate-setting and informing access to care. Prior to submitting the SPA to CMS, the state could issue a public notice that includes all of the information required for the notice, the proposed inpatient hospital rates, methodologies and justifications, and a state agency email box address available for stakeholders to submit comments and concerns about the rates or the effects the changes may have on beneficiary access to care. The state would need to analyze and consider the public input and republish the rates once they are finalized. The state would also need to submit its analysis of the public comments on access to care to CMS with the SPA submission. Such a process would fulfill the three requirements for notice and public process.

If states have further questions, they may contact their CMS Regional Office.

Requirement	Authority	Timing	Purpose
Public Process for Determining Institutional Rates	1903(a)(13)(A)	The state agency must allow time to publish the proposed rates, allow for review and comments, and publish the final rates.	Gives interested parties a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications. In the case of hospitals, such rates must take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs. States must publish proposed and final rates, the methodologies underlying the rates, and justifications for the rates.
Public Process to Inform Access to Care	1902(a)(30)(A) 42 CFR 447.204	Before the state submits the SPA to CMS for consideration.	Ensures beneficiaries, providers and other affected stakeholders an opportunity to provide input on the impact that proposed payment changes will have, if any, on continued service access. The state should maintain a record of the public input and how it responded to such input. States must also conduct a specific analysis of the information and concerns expressed in input from affected stakeholders.
Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates	1902(a)(4) 1902(a)(30) 42 CFR 447.205	At least one day before the effective date of the methodology change. Prior to CMS SPA approval.	Ensures providers are aware of changes in payment methods and standards and are not relying on prior payment methodologies. See informational bulletin for content of notice requirements.

Attachment: Summary of Public Notice and Public Process Requirements

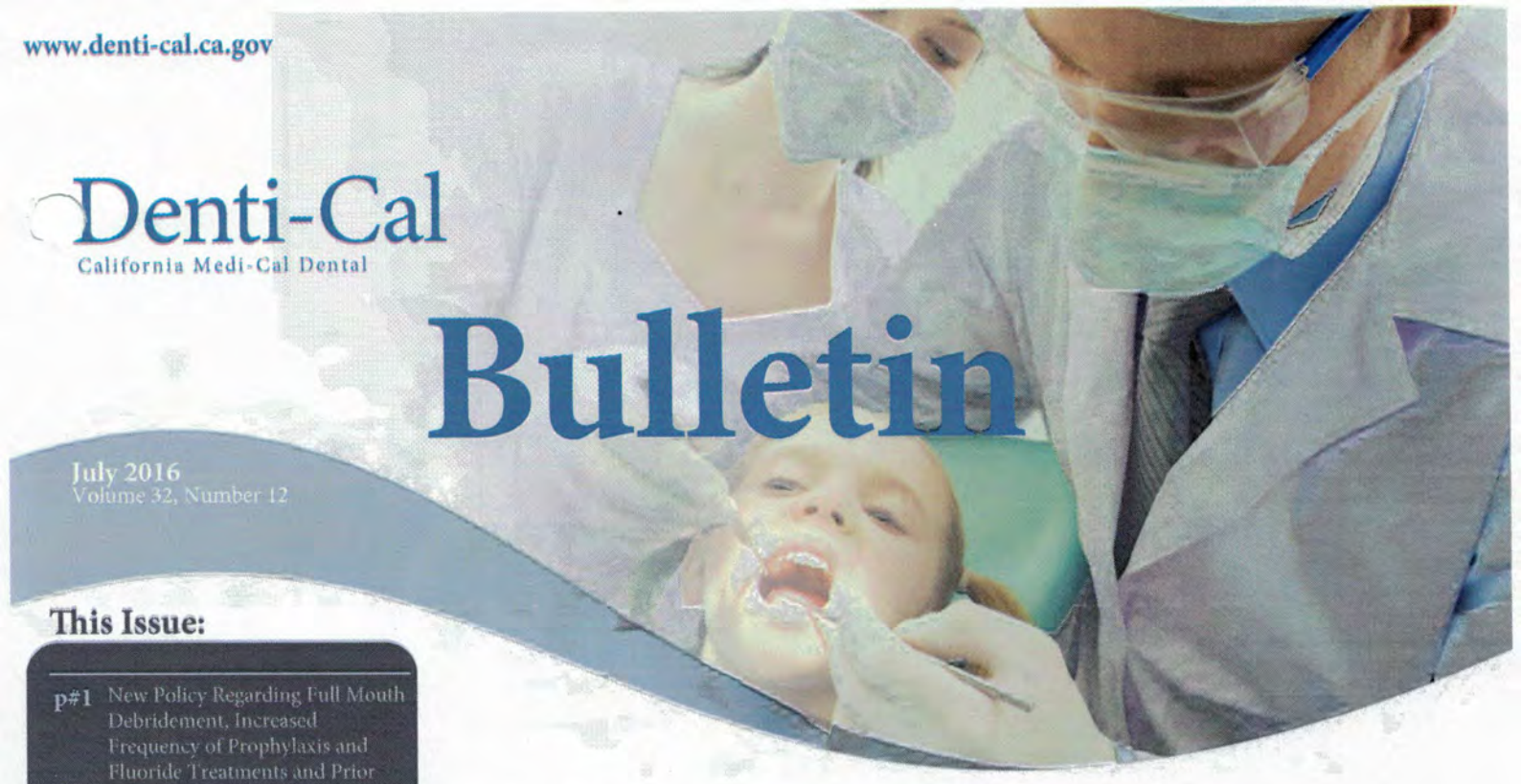
EXHIBIT “2”

www.denti-cal.ca.gov

Denti-Cal
California Medi-Cal Dental

Bulletin

July 2016
Volume 32, Number 12



This Issue:

Training Seminars

erve an available spot for one of open training seminars.

Webinar
Basic & EDI/D619 - July 20, 2016

Provider Enrollment Assistance Line

Speak with an Enrollment Specialist. Go here for more information!

Wednesday, July 20, 8 am - 4 pm.

New Policy Regarding Full Mouth Debridement, Increased Frequency of Prophylaxis and Fluoride Treatments and Prior Authorization Requirements for Scaling and Root Planing for Medi-Cal Beneficiaries residing in a Skilled Nursing Facility or Intermediate Care Facility

Effective July 15, 2016, full mouth debridement (D4355) is added as a covered benefit, once in a 12 month period without prior authorization, for eligible Medi-Cal beneficiaries who reside in Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF), including Medi-Cal eligible Department of Developmental Services (DDS) beneficiaries residing in a SNF or ICF. Full mouth debridement is considered a full mouth treatment and intended for beneficiaries with excessive plaque or calculus that inhibits the dental provider's ability to perform a comprehensive evaluation and diagnosis and to develop a treatment plan. Full Mouth Debridement is not a benefit when rendered the same date of service as Scaling and Root Planing (SRP), prophylaxis or periodontal maintenance.

Also effective July 15, 2016, the frequency of prophylaxis and fluoride treatments are increased to once every four months for Medi-Cal beneficiaries who reside in a SNF or ICF. The increased frequencies of these procedures do not eliminate the need for additional medically necessary procedures or treatments.

Providers are required to abide by the updated requirements outlined in this bulletin. However, submission and criteria requirements outlined in the Manual of Criteria (MOC) will not be updated with the above changes until the implementation of CDT 16 occurs.

Continued on pg 2.

Prior authorization is required for Scaling and Root Planing (SRP). Radiographs to demonstrate medical necessity for the service are required when submitting a Treatment Authorization Request (TAR) for SRP. Denti-Cal may consider radiograph exemption process with these prior authorization requirements when deemed medically appropriate based on a patient's medical condition, physical ability, or cognitive functioning. Providers may submit a TAR with documentation along with necessary photographs substantiating why radiographs of the patient are not possible; however, TARs submitted without radiographs are subject to additional review. However, per Denti-Cal Bulletin November 2014 Volume 30 Number 17, prior authorization will continue to be waived for scaling and root planing procedures rendered to pregnant/postpartum beneficiaries regardless of age, aid code and/or scope of benefits when "PREGNANT" or "POSTPARTUM" is documented.

Please see below for the Schedule of Maximum Allowances pertaining to this policy effective July 15, 2016.

New/Modified Procedures for SNF/ICF Residents		
CDT Code	**Procedure**	**Rate***
D1110	Prophylaxis – adult	$40.00
D1120	Prophylaxis – child	$30.00
D1206	Topical application of fluoride varnish - adult 21 and over	$6.00
D1208	Topical application of fluoride - adult	$6.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant (for beneficiaries in a SNF or ICF)	$70.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant (for beneficiaries in a SNF or ICF)	$50.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$75.00
D4910	Periodontal maintenance	$55.00

*Rates effective as of July 15, 2016.

For more information, please contact the Denti-Cal Provider Customer Service line at (800) 423-0507.

NEED MORE INFORMATION?

Provider Enrollment Workshops

Are you a dental provider who is interested in joining the Denti-Cal program but don't know where to start? Do you have questions about the Denti-Cal enrollment process? Then please drop-in anytime during the hours scheduled below to attend one of our enrollment workshops! Registration is preferred, but not required.

Date/Time:	Location:	County:
Friday, July 20, 2016 8:00 AM - 4:00 PM Register Now!	Double Tree 2800 Via Cabrillo Marina San Pedro, CA 90731	Los Angeles County

EXHIBIT “3”

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 16, 2016

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 15-005. This SPA was submitted to my office on April 30, 2015. This SPA allows registered dental hygienists (RDHs), registered dental hygienists in extended functions (RDHEFs), and registered dental hygienists in alternative practice (RDHAPs) to enroll as Medi-Cal dental program billing providers.

The effective date of this SPA is September 1, 2015. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Limitations to Attachment 3.1-A, pages 12a.1-12a.6
- Limitations to Attachment 3.1-B, pages 12.a.1-12.a.6
- Attachment 4.19-B, page 20b
- Supplement 6 to Attachment 4.19-B, page 2

If you have any questions, please contact Cheryl Young by phone at (415) 744-3598 or by email at Cheryl.Young@cms.hhs.gov.

Sincerely,

/s/

Kristin Dillon
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Alani Jackson, California Department of Health Care Services
Nik Ratcliff, California Department of Health Care Services
Nathaniel Emery, California Department of Health Care Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 15-005	2. STATE: CALIFORNIA
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE September 1, 2015	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR section 440.60. 42 USC section 1396d (a)(6).	a. FFY 2015 $104,705 b. FFY 2016 $1,985,351
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Limitations to ^ATTACHMENT 3.1-A; PAGE 12a.1, 12a.2, 12a.3, 12a.4, 12a.5, 12a.6 ^ATTACHMENT 3.1-B; PAGE 12a.1, 12a.2, 12a.3, 12a.4, 12a.5, 12a.6 SUPPLEMENT 6 ATTACHMENT 4.19B; PAGE 2 ATTACHMENT 4.19-B, PAGE 20b	Limitations to ^ATTACHMENT 3.1-A; PAGE 12a ^ATTACHMENT 3.1-B; PAGE 12a SUPPLEMENT 6 ATTACHMENT 4.19B; PAGE 2 ~~ATTACHMENT 4.19-B, PAGE 20b~~

10. SUBJECT OF AMENDMENT: To allow Registered Dental Hygienists (RDHs) and Registered Dental Hygienists in Extended Functions (RHDEFs) to enroll as Medi-Cal Dental Services Program billing providers, if employed in a public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity, and to allow RDHs and RDHEFs to enroll as rendering providers, if employed in a public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity, which is enrolled as a billing provider in the Medi-Cal Dental Services Program. To allow Registered Dental Hygienists in Alternative Practice (RDHAPs) to enroll as billing and or rendering providers in the Medi-Cal Dental Services Program. To allow RDHs, RDHEFs, and RDHAPs to bill for services as permitted by California state statutes and regulations.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: Mari Cantwell	Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, MS 4505 P.O. Box 997417 Sacramento, CA 95899-7417
14. TITLE: Chief Deputy Director Health Care Programs State Medicaid Director	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 30, 2015	18. DATE APPROVED: 3/16/16
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2015	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Dillon	22. TITLE: Acting Division of Medicaid & Children's Health Operations

Boxes 8 & 9: CMS added "Limitations to" and "^" (insert arrow) to Attachment 3.1-A/3.1-B to clarify that the limitation pages to these attachments are being amended by this SPA.

Box 9: Deleted "Att. 4.19-B, page 20b" since this is a new page, not a superseded page, per CA email dated 1/20/16.

Table of Contents

State/Territory Name: California

State Plan Amendment (SPA) #: 15-005

This file contains the following documents in the order listed:

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-A

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d6	Licensed Registered Dental Hygienists' services	All services permitted under scope of practice of a licensed Registered Dental Hygienists (RDH) as medically necessary, subject to limitations. All licensed RDHs meet Federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6). "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.	Any procedure performed or service provided by a licensed RDH that does not specifically require direct supervision shall require general supervision so long as the procedure or service does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death. See Program Coverage for supervision definitions for licensed RDHs. A licensed RDH may provide, without supervision, educational services, oral health training programs, and oral health screenings. A licensed RDH is authorized to provide and bill for treatment performed in the following settings and under the following conditions: • In a public health program, created by federal, state, or local law; or • In a public health program, administered by a federal, state, county, or local governmental entity; and, • The licensed RDH shall also be employed by said program and must provide documentation from the public health program attesting to the licensed RDH's employment upon program enrollment.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

(This chart is an overview only)

Limitations on Attachment 3.1-A

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d6	Licensed Registered Dental Hygienists' services (continued)		All licensed RDHs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. All licensed RDHs shall provide documentation of an existing relationship with at least one program enrolled dentist for referral, consultation, and emergency services upon program enrollment. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDH that are a benefit of the Medi-Cal Dental program and are permitted by the state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). On behalf of the state, the Dental contractor(s) shall approve and provide payment for covered dental services performed by an enrolled dental provider. In general, the Medi-Cal Dental Manual of Criteria identifies which services require prior authorization requirements for the above-mentioned services also apply to EPSDT-eligible and other beneficiaries.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d7	Licensed Registered Dental Hygienists in Extended Functions' services	All services permitted under scope of practice for a Licensed Registered Dental Hygienists in Extended Functions (RDHEFs) as medically necessary, subject to limitations. All RDHEFs meet federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6). "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.	Any procedure performed or service provided by a licensed RDHEF that does not specifically require direct supervision shall require general supervision so long as the procedure or service does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death. See Program Coverage for supervision definitions for license RDHEFs. A licensed RDHEF may provide, without supervision, educational services, oral health training programs, and oral health screenings. A licensed RDHEF is authorized to provide and bill for treatment performed in the following settings and under the following conditions: • In a public health program, created by federal, state, or local law; or • In a public health program, administered by a federal, state, county, or local governmental entity; and • The licensed RDHEF shall also be employed by said program and must provide documentation from the public health program attesting to the licensed RDHEF's employment upon program enrollment.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d7	Licensed Registered Dental Hygienists in Extended Functions' services (continued)		All licensed RDHEFs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. All licensed RDHEFs shall provide documentation of an existing relationship with at least one program enrolled dentist for referral, consultation, and emergency services upon program enrollment. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDHEF that are a benefit of the Medi-Cal Dental program and are permitted by state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). On behalf of the state, the Dental contractor(s) approves and provides payment for covered dental services performed by an enrolled dental provider. In general, the Medi-Cal Dental Manual of Criteria identifies which services require prior authorization. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d8	Licensed Registered Dental Hygienists in Alternative Practice's services	All services permitted under scope of practice for a licensed Registered Dental Hygienists in Alternative Practice (RDHAPs) as medically necessary, subject to limitations. All RDHAPs meet federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6). "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.	Any procedure performed or service provided by a licensed RDHAP that does not specifically require direct supervision shall require direct supervision shall require general supervision so long as the procedure or service does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death. See Program Coverage for supervision definitions for licensed RDHAPs. A licensed RDHAP may provide, without supervision, educational services, oral health training programs, and oral health screenings and shall be permitted to bill for said services. A licensed RDHAP may provide Scaling and Root Planing services under the general supervision of a licensed dentist, but shall be permitted to bill for said services, pursuant to state law. All licensed RDHAPs are authorized to provide and bill for treatment performed in the following settings: residences of the homebound, schools, residential facilities and other. All licensed RDHAPs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. All RDHAPs shall provide

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

(This chart is an overview only)

Limitations on Attachment 3.1-A

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d8	Licensed Registered Dental Hygienists in Alternative Practice's services (continued)		documentation of an existing relationship with at least one program enrolled dentist for referral, consultation, and emergency services upon enrollment. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDHAP that are a benefit of the Medi-Cal Dental program and are permitted by the state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). On behalf of the state, the Dental contractor(s) approves and provides payment for covered dental services performed by an enrolled dental provider. In general, prior authorization is required for Scaling and Root Planing. Also, the Medi-Cal Dental Manual of Criteria identifies any other Medi-Cal Dental program covered services that require prior authorization. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-B

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d6	Licensed Registered Dental Hygienists' services	All services permitted under scope of practice of a licensed Registered Dental Hygienists (RDH) as medically necessary, subject to limitations. All licensed RDHs meet Federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6). "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.	Any procedure performed or service provided by a licensed RDH that does not specifically require direct supervision shall require general supervision so long as the procedure or service does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death. See Program Coverage for supervision definitions for licensed RDHs. A licensed RDH may provide, without supervision, educational services, oral health training programs, and oral health screenings. A licensed RDH is authorized to provide and bill for treatment performed in the following settings and under the following conditions: • In a public health program, created by federal, state, or local law; or • In a public health program, administered by a federal, state, county, or local governmental entity; and, • The licensed RDH shall also be employed by said program and must provide documentation from the public health program attesting to the licensed RDH's employment upon program enrollment.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

(This chart is an overview only)

Limitations on Attachment 3.1-B

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d6	Licensed Registered Dental Hygienists' services (continued)		All licensed RDHs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. All licensed RDHs shall provide documentation of an existing relationship with at least one program enrolled dentist for referral, consultation, and emergency services upon program enrollment. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDH that are a benefit of the Medi-Cal Dental program and are permitted by the state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). On behalf of the state, the Dental contractor(s) shall approve and provide payment for covered dental services performed by an enrolled dental provider. In general, the Medi-Cal Dental Manual of Criteria identifies which services require prior authorization requirements for the above-mentioned services also apply to EPSDT-eligible and other beneficiaries.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d7	Licensed Registered Dental Hygienists in Extended Functions' services	All services permitted under scope of practice for a Licensed Registered Dental Hygienists in Extended Functions (RDHEFs) as medically necessary, subject to limitations. All RDHEFs meet federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6). "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.	Any procedure performed or service provided by a licensed RDHEF that does not specifically require direct supervision shall require general supervision so long as the procedure or service does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death. See Program Coverage for supervision definitions for license RDHEFs. A licensed RDHEF may provide, without supervision, educational services, oral health training programs, and oral health screenings. A licensed RDHEF is authorized to provide and bill for treatment performed in the following settings and under the following conditions: • In a public health program, created by federal, state, or local law; or • In a public health program, administered by a federal, state, county, or local governmental entity; and • The licensed RDHEF shall also be employed by said program and must provide documentation from the public health program attesting to the licensed RDHEF's employment upon program enrollment.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d7	Licensed Registered Dental Hygienists in Extended Functions' services (continued)		All licensed RDHEFs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. All licensed RDHEFs shall provide documentation of an existing relationship with at least one program enrolled dentist for referral, consultation, and emergency services upon program enrollment. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDHEF that are a benefit of the Medi-Cal Dental program and are permitted by state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). On behalf of the state, the Dental contractor(s) approves and provides payment for covered dental services performed by an enrolled dental provider. In general, the Medi-Cal Dental Manual of Criteria identifies which services require prior authorization. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

(This chart is an overview only)
*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d8	Licensed Registered Dental Hygienists in Alternative Practice's services	All services permitted under scope of practice for a licensed Registered Dental Hygienists in Alternative Practice (RDHAPs) as medically necessary, subject to limitations. All RDHAPs meet federal provider qualifications as set forth in 42 CFR Part 440.60 and 42 USC 1396d (a)(6). "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.	Any procedure performed or service provided by a licensed RDHAP that does not specifically require direct supervision shall require direct supervision shall require general supervision so long as the procedure or service does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death. See Program Coverage for supervision definitions for licensed RDHAPs. A licensed RDHAP may provide, without supervision, educational services, oral health training programs, and oral health screenings and shall be permitted to bill for said services. A licensed RDHAP may provide Scaling and Root Planing services under the general supervision of a licensed dentist, but shall be permitted to bill for said services, pursuant to state law. All licensed RDHAPs are authorized to provide and bill for treatment performed in the following settings: residences of the homebound, schools, residential facilities and other. All licensed RDHAPs shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. All RDHAPs shall provide

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	TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d8	Licensed Registered Dental Hygienists in Alternative Practice's services (continued)		documentation of an existing relationship with at least one program enrolled dentist for referral, consultation, and emergency services upon enrollment. Limited to services provided under scope of practice and to the extent permitted by applicable statutes and regulations. Services provided by a licensed RDHAP that are a benefit of the Medi-Cal Dental program and are permitted by the state statutes and regulations are covered. Dental services are administered through an agreement with the Medi-Cal Dental program or its contractor(s). On behalf of the state, the Dental contractor(s) approves and provides payment for covered dental services performed by an enrolled dental provider. In general, prior authorization is required for Scaling and Root Planing. Also, the Medi-Cal Dental Manual of Criteria identifies any other Medi-Cal Dental program covered services that require prior authorization. Prior authorization requirements are the same for EPSDT-eligible and other beneficiaries.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Payment for Dental Services

The State developed fee schedule rates are the same for both public and private providers of dental services. The rates for dental services are published under Section 5, Manual Criteria and Schedule of Maximum Allowances, of the Medi-Cal Dental Program Provider Handbook. The agency's fee schedule rates were last updated on June 1, 2014, and are effective for services on or after that date. All rates are posted on the Denti-Cal website at: http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf#page=165

Denti-Cal

California Medi-Cal Dental Program

October 2016

Dear Denti-Cal Provider:

Enclosed is the most recent update of the Medi-Cal Dental Program Provider Handbook (Handbook). The pages reflect changes made to the Denti-Cal program during the month of October 2016. These changes are indicated with a vertical line next to the text.

The following list indicates the pages that have been updated for the Fourth quarter Handbook release. Previously released bulletins can be found on the "Denti-Cal Provider Bulletins" page of the Denti-Cal Web site: http://www.denti-cal.ca.gov/

Remove These Pages	Insert These Pages
Letter to Doctor	
Entire Section	Entire Section
How To Use This Handbook	
Entire Section	Entire Section
Section 2 - Program Overview	
Pages 2-35 and 2-36	Pages 2-35 and 2-36
Section 12 - Denti-Cal Bulletin Index	
Entire Section	Entire Section

Thank you for your continual support of the Medi-Cal Dental Program. If you have any questions, please call (800) 423-0507.

Sincerely,

DENTI-CAL

CALIFORNIA MEDI-CAL DENTAL PROGRAM

CDT Codes	Procedure Code Description	Maximum $$ Allowance
D4245	Apically positioned flap	Not A Benefit
D4249	Clinical crown lengthening – hard tissue	Global
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350.00
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant	$245.00
D4263	Bone replacement graft – first site in quadrant	Not A Benefit
D4264	Bone replacement graft – each additional site in quadrant	Not A Benefit
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Global
D4266	Guided tissue regeneration – resorbable barrier, per site	Not A Benefit
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	Not A Benefit
D4268	Surgical revision procedure, per tooth	Not A Benefit
D4270	Pedicle soft tissue graft procedure	Not A Benefit
D4273	Subepithelial connective tissue graft procedures, per tooth	Not A Benefit
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not A Benefit
D4275	Soft tissue allograft	Not A Benefit
D4276	Combined connective tissue and double pedicle graft, per tooth	Not A Benefit
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	Not A Benefit
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	Not A Benefit
D4320	Provisional splinting – intracoronal	Not A Benefit
D4321	Provisional splinting – extracoronal	Not A Benefit
D4341	Periodontal scaling and root planing – four or more teeth per quadrant (for beneficiaries in a SNF or ICF)	$70.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant (for beneficiaries in a SNF or ICF)	$50.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$30.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Global
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Global
D4910	Periodontal maintenance	$130.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$45.00
D4999	Unspecified periodontal procedure, by report	By Report

EXHIBIT “4”

To: Larry Hall
Subject: RE: Boothby v. DHCS -- DHCS Offers to Rescind July 2016 Bulletin Reprocess Claims -- WE NEED TO IMMEDIATELY ACCEPT

From: Carmen Snuggs <Carmen.Snuggs@doj.ca.gov>
Date: Monday, November 28, 2016 at 6:24 PM
To: Larry Hall <larry@larryhalllaw.com>
Subject: Boothby v. DHCS

Privileged and Confidential, Settlement Negotiations Only

Dear Mr. Hall:

This letter serves to confirm our telephone conversation this evening. The Department of Health Care Services (DHCS) has authorized me to make the following settlement offer: DHCS will rescind the July 2016 provider bulletin at issue in this matter and reprocess the affected claims that have been submitted since the bulletin's effective date, in exchange for petitioners' dismissal of the operative amended petition/complaint with prejudice. Each side to bear its own attorney's fees and costs.

Please let me know whether petitioners accept DHCS's settlement offer. If petitioners do accept, then I will draft a settlement agreement for your review and signature.

As you know, a Trial Setting Conference has been scheduled for December 1, 2016. In addition, you previously gave ex parte notice for December 1, 2016, at which time petitioners would request an alternative writ and preliminary injunction. Please confirm, if petitioners' accept the Department's settlement offer in principle, that petitioners are withdrawing their ex parte application.

Please respond as soon as possible given the impending December 1, 2016 hearing date.

Best,

Carmen D. Snuggs
Deputy Attorney General
Department of Justice
Office of the Attorney General
300 S. Spring Street, Suite 1702
Los Angeles, CA 90013-1230
(213) 897-2450 (Telephone)
(213) 897-2805 (Facsimile)
Carmen.Snuggs@doj.ca.gov

Carmen

prohibited and may violate applicable laws including the Electronic Communications Privacy Act. If you are not the intended recipient, please contact the sender and destroy all copies of the communication.

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF RIVERSIDE

I am employed in the County of Riverside, California. I am over the age of eighteen years and not a party to the within cause; my business address is 31078 Waterton Court, Murrieta, CA 92563.

On March 30, 2017, I served the within following documents: **VERIFIED SECOND AMENDED COMPLAINT FOR: WRIT OF MANDATE; DECLARATORY RELIEF; INJUNCTIVE RELIEF, BREACH OF CONTRACT: SPECIFIC PERFORMANCE OF SETTLEMENT AGREEMENT** on the interested parties in said cause, by the placing true copies thereof enclosed in sealed envelopes addressed as follows:

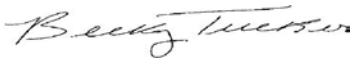
Tara L. Newman
Deputy Attorney General
Office of the Attorney General
300 S. Spring Street, Suite 1702
Los Angeles, CA 90013-1230
(213) 897-2450 (Telephone)
(213) 897-2805 (Facsimile)
Email: Tara.Newman@doj.ca.gov
Attorneys for Defendant, Department of Health Care Services, Jennifer Kent

XXX (By Email) I caused the above-referenced document to be emailed to the addressee above as per the parties Stipulated Agreement for E-Mail Service.

__ **(First Class Mail**) I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Murrieta, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing in affidavit.

___ **(By Facsimile)** The above-described document(s) were sent by facsimile transmission to the facsimile number(s) of the law offices) stated below. The transmission was reported as complete and without error.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on March 30, 2017, at Murrieta, California.



Becky Tucker