UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 05-23037-CIV-JORDAN/MCALILEY

FLORIDA PEDIATRIC SOCIETY/ THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, et al.,

Plaintiffs,

vs.

ELIZABETH DUDEK, in her official capacity as the Secretary of the Agency for Health Care Administration, et al.,

Defendants.
_____/

DEFENDANTS' REPLY TO PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO AMEND OR ALTER FINDINGS OF FACT CONTAINED IN THE COURT'S DECEMBER 30, 2014TH FINDINGS OF FACT AND CONCLUSIONS OF LAW

REPLY

Defendants, sued in their official capacities as the heads of the AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA), DEPARTMENT OF HEALTH (DOH), and DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCF), submit this reply to Plaintiffs' Opposition to Defendants' Motion to Amend or Alter Findings of Fact Contained in the Court's Findings of Fact and Conclusions of Law (Response):

Plaintiffs concede that they now lack standing to sue DCF for outreach claims at all (Count IV). D.E. 1304 p. 3-4. They also concede that L.C., K.K., and J.S. lack standing to sue DOH. *Id*. at 4-5. To remedy the fact that they now have no representative Plaintiff with standing to sue DOH under Count II, Plaintiffs erroneously argue that N.G. has proven standing to sue under Count II as well as Count I (notwithstanding the fact that the Court only found standing for N.G. to sue under Count I). *Id*. at 5-6.

Plaintiffs also concede that expert witnesses are unable to testify about the motivations or intentions of particular providers. D.E. 1304 pg. 13. With this concession and the absence of any testimony by a provider who interacted with any of the named Plaintiffs that his or her treatment decisions were motivated by inadequate reimbursement rates, it is clear that Plaintiffs have failed to prove the standing of the named Plaintiffs to sue under Count II (or under Count I to the extent that the alleged policy at issue is inadequate reimbursement rates). Nonetheless, Plaintiffs argue that it is enough if they prove systemic issues, without proving a causal link between those systemic issues and the actual harm experienced by the named Plaintiffs. *Id.* They are in error. As discussed below, it is particularly important that the named Plaintiffs prove that their specific providers (including those from whom they unsuccessfully sought treatment) were motivated by inadequate reimbursement rates where, as here, they challenge the impact that

those reimbursement rates have on the decisions by those third party providers to treat Medicaid patients.

I. None of the record evidence cited by Plaintiffs shows that DCF or AHCA is responsible for "switching" J.W. in 2005, or that DCF is responsible for "switching" K.K.

As discussed below, no record evidence proves that any "switching" harm found by the Court as to J.W. or K.K. was fairly traceable to any conduct by DCF. The same is true with respect to AHCA as to J.W. and the 2005 change in primary care providers.

A. J.W.

Plaintiffs erroneously claim that the record shows that DCF was responsible for the change in J.W.'s primary care provider in 2005, and cite to two documents: Defendants' Exhibits 178 and 169a. D.E. 1304 p. 7. The two record citations do not establish DCF's responsibility for "switching" J.W. at all, and the record evidence shows that neither AHCA nor DCF was responsible for any change in J.W.'s primary provider in the summer of 2005.

The Florida Medicaid Management Information System (FMMIS) screen shots pertaining to J.W. prove that he was assigned to Healthease of Florida, Inc., from April 1, 2005 to February 28, 2007 without any interruption. DX 5, p. 620.[1] There is no evidence that J.W. experienced any interruptions in his Medicaid eligibility during this time period.[2] In fact, reviewing together the FMMIS screenshots about plan assignments and eligibility for J.W., it is abundantly clear that there were no breaks in eligibility.

And there is no evidence that J.W.'s eligibility was ever terminated during his continuous eligibility period. Due to his age in 2005, J.W. was entitled to 6 months of continuous eligibility. *See* § 409.904(6), Fla. Stat. He was initially determined eligible effective February 1, 2005, and

[1] / Exhibit page number references are to the BATES page number.
[2] / This contrasts with the record evidence for S.M. While FMMIS screen shots relating to S.M.'s eligibility information did not show any gaps, those same screen shots did show gaps in S.M.'s assignment to his preferred MediPass Provider (Tallahassee Pediatric Foundation). *Compare* DX 73 p. 10897 *with* p. 10901.

his continuous eligibility period would have run on July 31, 2005. His Medicaid eligibility was not terminated then or prior to December 7, 2007, and his grandmother, E.W., never testified to the contrary (and neither did anyone else). Depo. of E.W. *See, e.g.*, DX 5 pp. 597 & 620.

Likewise, there is no record evidence that J.W. experienced any changes in Medicaid coverage categories. *See* DX 5 p. 597. The Court found that changes in coverage categories cause a child to "sometimes" lose eligibility in Florida's FMMIS system. D.E. 1294 p. 70. However, J.W. remained in the "MM C" category from February 1, 2005 through the date "screen shots" were printed in the FMMIS system (December 7, 2007). DX 5 p. 597. The information from the BEST system (used to keep track of communications about Medicaid managed care plan changes) also does not show any breaks in eligibility. DX 7. Rather, AHCA is statutorily required to have an annual open enrollment period for individuals enrolled in managed care. § 409.9122(2)(j), Fla. Stat. If a recipient, given the opportunity to select another plan during open enrollment did not do so, the recipient would be assigned to a plan through an auto-assignment process. § 409.9122(2)(k), Fla. Stat.

J.W.'s Open Enrollment Period began in December each year and lasted for 60 days (or through January). *See, e.g.*, DX 7 pp. 813, 816, & 818; § 409.9122(2)(k), Fla. Stat. On March 19, 2007, after the end of the Open Enrollment Period (and after auto-assignment would have occurred), E.W. did call about J.W.'s Medicaid open enrollment, but she was not listed as J.W.'s legal contact and so could not make a decision as to J.W.'s enrollment. (At that time, J.W.'s father was still alive). On March 20, 2007, J.W.'s father called and notified AHCA that E.W. had his authorization to make changes for J.W. On that date, E.W. requested that J.W. be enrolled in Healthease and that Dr. Patrick Murray continue as J.W.'s primary care provider. DX 7 pp. 813-815. There is no record of any other communication regarding that Open Enrollment

period before March 2007. DX 7. Hence, AHCA simply cannot be held liable for J.W.'s enrollment changes in 2005. In the absence of evidence that AHCA caused the 2005 change in primary care providers for J.W., the Court must find that J.W. lacks standing to sue AHCA under Count I.

Turning to DCF, while Plaintiffs may wish to confuse and mislead the Court regarding the evidence at trial, there simply is no evidence that DCF had any responsibility for any change in J.W.'s primary care provider in the summer of 2005, or any responsibility for "switching" in 2007. Defendants' exhibit 178, referenced by Plaintiffs at page 7 of their Response, is a memorandum sent by Nathan Lewis to various DCF staff. It provides guidance on how to reduce the number of Medicaid errors. However, nothing in this memorandum applied to J.W. Specifically, there is no evidence that J.W. was missing his social security number, had a change in assistance groups (referenced at page 2), or was a presumptively eligible newborn. This document provides no proof of why J.W. experienced a change in primary care providers in the Summer of 2005 (or a change in managed care plans in 2007).

Defendants' exhibit 169a likewise contains no evidence that would aid the Court in determining why J.W. experienced a change in primary care providers in 2005 (or a change in managed care plans in 2007). Plaintiffs reference page 2, which deals with Medicaid for newborns closed in error (not applicable here), errors in ex parte reviews (also not proven to be at issue here, as there was no evidence that J.W.'s eligibility was ever terminated), and missing social security numbers (also not at issue here). Without any record support, Plaintiffs state that "the record shows that every time a child was switched, the switch was caused either by the child's termination of eligibility by DCF or a change in the child's eligibility category in DCF's computer, which was erroneously interpreted by AHCA's computer as a termination of

eligibility." D.E. 1304 p. 7. The only citations for this broad statement are to Defendants exhibits 169a and 178, neither of which supports the premise that "the record shows that every time a child was switched, the switch was caused by . . ."

In the absence of any record evidence to show that DCF caused the change in primary care providers for J.W. (or the change in managed care plans in 2007), or that any harm to J.W. was fairly traceable to DCF, this Court must find that J.W. lacks standing to sue DCF for Count I.

B. K.K.

There also is no proof that DCF caused K.K. to be switched from MediPass. The testimony of A.D. did not prove that "switching" was fairly traceable to any act or omission by DCF. A.D. provided Plaintiffs' only evidence on this issue. Therefore, Plaintiffs have failed to prove K.K.'s standing to sue DCF.

In their response, Plaintiffs argue that the Court found an additional incident of switching which provides the basis for K.K.'s standing to sue DCF, citing to a footnote in the Court's Findings of Fact and Conclusions of Law. D.E. 1304 p. 6-7. The Court stated "K.K. was also switched on another occasion to a Medicaid HMO that K.K.'s pediatrician's office did not accept A.D. on 1/25/2012 Rough Tr. at 73." D.E. 1294 p. 46 n. 14. It is not clear that the incident referenced by the Court is indeed an additional incident of switching. A.D. testified as follows:

> Q. You previously testified that you always received regular care from LMH pediatrics in your testimony last time you were here in August, 2010, correct?
>
> A. I want to say no, sir.
>
> Q. He had not always received care from LMH pediatrics?
>
> A. No, sir.

> Q. Since 2008, has he always received regular care from LMH pediatrics?
>
> A. I'm not exactly sure of the dates but associates pediatrics have always been his pediatrician. ***Due to a switching situation one time being switched, the insurance, when I had picked a plan for MediPass, he was switched to another plan that associates and pediatrics did not accept it***.

Testimony of A.D., 1/25/2012 Rough Trial Trans. pp. 73 (emphasis supplied). A.D. testified that K.K. was switched one time, when she had picked a plan for MediPass. *Id.* Rather than this being an additional event of switching, it appears that, during the single event where A.D. testified that she selected MediPass in 2011, K.K. was not only unable to obtain Vyvance, but was also unable to see his primary care provider. These weren't separate events of switching, and the record does not support a contrary conclusion. However, even if there was record evidence to support a finding that this was a separate instance of "switching," there is no record evidence that DCF was in any way responsible for it.

There is no record evidence that any of the activities of DCF that the Court found caused switching *sometimes* actually did occur with K.K., either in 2011 or at any other time. There is no evidence about any change in coverage categories associated with any event of switching for K.K. There also is no evidence that K.K.'s Medicaid was terminated (other than the appropriate termination when he was no longer eligible because of his mother's job). *Record.*

K.K. was 8 years of age when the parties submitted their proposed findings of fact and conclusions of law in early 2012. D.E. 692 p. 14 ¶65. He was well over the age of 5 in 2011 when the single switching event about which his mother provided detail occurred. Therefore, he was entitled to 6 months of continuous eligibility for Medicaid. § 409.904(6), Fla. Stat. There is no evidence that, after he turned 5 years of age, his Medicaid was terminated within any 6 month period of continuous eligibility, or in any way inappropriately terminated. *Record.*

The evidence shows that K.K. was enrolled in Medicaid in the "medically needy" category for a period of time, because of his mother's income. When she lost her job, he was placed back on "straight Medicaid." 1/25/2012 Testimony of A.D., rough transcript, p. 69-70. Both of these would be entirely appropriate changes in coverage categories, and there is no evidence to the contrary.

Further, while K.K. was in the Medicaid medically needy program, he would have been excluded from and not eligible for enrollment in a managed care plan, including MediPass. § 409.9122(2)(a), Fla. Stat.[3] This was because it was necessary for his medical expenses to exceed a certain threshold before he would be eligible for any Medicaid services. It was only after K.K. was enrolled in "straight Medicaid" that he would have been required to choose a managed care plan. § 409.9122(2)(a), Fla. Stat. Given the absence of any record evidence to support a finding that DCF caused harm to A.D., the Court must find that A.D. lacks standing to sue DCF.

II. By finding that Plaintiffs demonstrated standing to sue under Count II without any evidence showing that Plaintiffs' injuries were "fairly traceable" to an act or omission of AHCA, the Court committed manifest error.[4]

Plaintiffs acknowledge that it is their burden to prove that their injury is "fairly traceable to the challenged actions of the defendant." D.E. 1304 p. 10. However, Plaintiffs erroneously contend that the evidence presented was adequate to establish causation. *Id.* at 10-11. Plaintiffs failed to offer any evidence that provider reimbursement rates actually caused, directly or indirectly, any specific provider to either not treat a named Plaintiff or to delay treatment. Therefore, they have failed to prove a crucial element of standing as discussed below.

As noted by the Supreme Court in *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992), if plaintiff is the object of a governmental action, there ordinarily is little question about

[3] / Coverage in the "medically needy" category is described in section 409.904(2), Fla. Stat.
[4] / This same argument would apply to all claims predicated on inadequate reimbursement rates, including the claims that N.G. brings against DOH under Count II.

whether action or inaction causes injury. However, when a plaintiff's injury arises from the government's allegedly unlawful regulation of someone else (or as the case here, establishment of reimbursement rates for third party providers), much more is needed to establish causation and redressibility. *Id.* at 562. In those circumstances, it is the plaintiff's burden to prove "that the choices of those third party providers have been or will be made in such a manner as to prove causation and permit redressibility." *Id*.

While Plaintiffs are not required to prove causation beyond a reasonable doubt or by clear and convincing evidence to establish standing, and a showing that a plaintiff's injury is indirectly caused by a defendant's actions satisfies the fairly traceable requirement, *Resnick v. AvMed, Inc.*, 693 F.3d 1317 (11th Cir. 2012), there was no evidence adduced at trial that inadequate reimbursement rates directly or indirectly motivated the decision of any of the providers with whom the named Plaintiffs interacted.

The Court has acknowledged that, although reimbursement rates are "by far the most important factor," providers may be influenced by other factors in their decision to participate in Medicaid. D.E. 1294 p. 153. That being the case it was incumbent on Plaintiffs to prove that the "most important factor" was the factor which actually influenced Plaintiffs' providers in how they acted. No such proof was offered and it is mere speculation to tie a general dissatisfaction with rates to a specific injury to a named Plaintiff. Further, in the absence of proof that low reimbursement rates caused the injury to the named Plaintiffs, they have failed to prove that increased reimbursement rates will redress their injuries, another requirement of standing. *Lujan v. Defenders of Wildlife*, 504 U.S. at 561.

While Plaintiffs claim that other cases were tried successfully with the same type of evidence, those cases do not support their argument that they are not required to prove causation

here. *Equal Access for El Paso v. Hawkins*, 509 F.3d 697 (5th Cir. 2007), was an appeal of an order granting in part and denying in part a motion to dismiss. It did not and could not address the issue present in this case - how causation is proven at trial for representative plaintiffs who claim that they have been injured (in whatever manner) as a result of inadequate reimbursement rates. *Clayworth v. Bonta*, 295 F. Supp. 2d 110 (E.D. Cal. 2003), *reversed*, 140 Fed. Appx. 677 (9th Cir. 2005), and *Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) v. Fogarty*, 366 F. Supp. 3d 1050 (N.D. Okla. 2005), *reversed* 472 F.3d 1208 (10th Cir. 2007), were both reversed on appeal in their entirety (based on intervening decisions that the statutes on which Plaintiffs relied did not create enforceable rights or a right to actual provision of medical assistance). None of the cases cited by Plaintiffs, including *Memisovski ex rel. Memisovski v. Maram*, 2004 WL 1878332 (N.D. Ill. 2004), reflect any discussion of the issue whether standing as to the named Plaintiffs may be proven by reference to systemic testimony in the absence of any testimony of motivation by the Plaintiffs' actual providers or would-be providers.

Regarding Plaintiffs' claim, D.E. 1304 p. 12, that the Court did make factual findings that establish causation for the named Plaintiffs, they again miss the point. While the Court found that L.C.'s therapist would not provide the therapy because she did not accept Medicaid, there is no record evidence as to <u>why</u> that therapist did not accept Medicaid. *Record.* Regarding K.K., the only provider testimony about K.K. came from John Donaldson, M.D., via deposition, and Dr. Donaldson never testified that he was in any way motivated by reimbursement rates in his treatment decisions (including the delay of hours in the appointment time) for K.K. *See* deposition designations for J. D. Donaldson.[5] Regarding N.G., there was no testimony that Dr.

[5] /When asked if Medicaid covered his costs, Dr. Donaldson said: "Am I complaining? Only from the point of view that it requires a practice such as mine to exist on huge volumes." Donaldson designation, pg. 49:4-8. He testified about firing HMOs because "they do not maintain the necessary quality of care." *Id.* at 64-67. He testified to a

Alperstein's decision regarding the scheduling of N.G.'s visit had anything to do with reimbursement rates. Plaintiffs presented no testimony from Dr. Alperstein at all. *Record*. J.S. presented no testimony from any of the orthopedists her mother contacted that they would not accept Medicaid because of low reimbursement rates. Neither did J.S. present testimony that any provider delayed in treating her due to low reimbursement rates. *Record*. Plaintiffs presented no evidence from any neuropsychologist, including the one who saw N.V. in November of 2011, that they delayed in seeing N.V. because of low reimbursement rates. *Record*. To the extent that the Court found that the cause of any injuries to these named Plaintiffs was inadequate reimbursement rates, it did so in the absence of evidence from any of Plaintiffs' providers on this issue.

Finally, Plaintiffs appear to agree that to establish the motivations and intentions of particular actors, expert witnesses would not be appropriate. D.E. 1304 p. 13. That being the case, it makes no sense that they would argue that they are not required to produce evidence of the motivations or intentions of the named Plaintiffs' provider witnesses. While expert testimony may be relied upon to show causation on a system wide basis, it is not adequate to establish motivation for the named Plaintiffs' providers, as Plaintiffs concede.

CONCLUSION

For the foregoing reasons, Defendants' Motion to Amend or Alter Findings of Fact should be granted and the Findings of Fact and Conclusions of Law should be amended accordingly.

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variety of issues he has with HMOs, but none of them were reimbursement rates. *See* Donaldson deposition designations. In fact, he testified that if a child were on Medicaid MediPass, he would see them. *Id.* at 80.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been served by Notice of Electronic Filing on Stuart H. Singer, Esq., Carl E. Goldfarb, Esq., Damien J. Marshall, Esq., and Sashi Bach Boruchow, Esq., Boies, Schiller & Flexner LLP, 401 East Las Olas Blvd., Suite 1200, Fort Lauderdale, FL 33301, and Robert D.W. Landon, III, Esquire, Kenny Nachwalter, P.A., 201 South Biscayne Boulevard, 1100 Miami Center, Miami, Florida 33131-4327; and by United States Mail on Benjamin D. Geffin, Esq., Public Interest Law Center of Philadelphia, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103; and Louis W. Bullock, Esq., Bullock, Bullock, & Blakemore, 110 W. 7th Street, Tulsa, Oklahoma 74112, on February 23, 2015.

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