UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 05-23037-CIV-JORDAN/O'SULLIVAN

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' OFFER OF PROOF

Defendants, the official capacity agency heads of the AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA), the DEPARTMENT OF CHILDREN AND FAMILIES (DCF), and the DEPARTMENT OF HEALTH (DOH), pursuant to the Court's Order Following Status Conference, D.E. 1311, submit the following Offer of Proof. Defendants have separately filed a Notice of Filing Declarations in Support of this Offer of Proof.

INTRODUCTION

Due to no fault of Defendants, the factual record on which the Court's Amended Findings of Fact and Conclusions of Law, issued on April 1, 2014 (D.E. 1315), were predicated was grossly stale.[1] The evidentiary record in this case closed on February 3, 2012, more than three

[1] / The Findings of Fact and Conclusions of Law issued on December 31, 2015, D.E. 1294, were also predicated on a stale record.

years ago; however, most fact discovery closed in 2008, more than six (6) years ago. In the intervening period, the Florida Medicaid program has gone through **numerous fundamental changes** such that the Court has issued an order requiring that Plaintiffs present an offer of proof by which they are tasked with meeting "their burden to prove that there remains an ongoing controversy such that declaratory and injunctive relief, if warranted, may issue." D.E. 1311. In turn, Defendants were authorized to provide their additional evidence that there is no ongoing controversy (although Defendants dispute Plaintiffs' claim that they ever presented the kind of scientific proof needed to show systemic issues with the Florida Medicaid Program).

Rather than demonstrate the existence of an ongoing violation of federal law, Plaintiffs have submitted a very meager number of declarations from providers. It does not appear that any effort was made to conduct a scientific or random sample of providers. Given both concerns about how these providers were selected to provide comments and the very small number of comments furnished, the declarations cannot be relied upon to provide reliable evidentiary proof of ongoing or system-wide issues that require this Court to proceed with either declaratory or injunctive relief in this case. It is extremely doubtful that Plaintiffs' selection process for affiants meets any credible standards of scientific study. Rather, Plaintiffs appear to have invited providers only to report their problems or issues. It is little wonder that Plaintiffs were able to obtain a small non-random sample of providers (from a pool of thousands) willing to express dissatisfaction with the current Medicaid Managed Care system, and relying on anecdotal hearsay in support – particularly in a matter in which the sample selected by Plaintiffs stands to potentially benefit personally from the outcome of this case through increased rates paid to them should Plaintiffs prevail. Thus, the resulting small number of anecdotes (even when reduced to a

declaration) is inherently unreliable, and cannot form the basis for a finding of an ongoing violation of federal law.[2]

And Plaintiffs have produced no evidence that the named Plaintiffs, who are the Court's exemplars of any problems with the Florida Medicaid system, have experienced even the slightest difficulty in accessing care in the Medicaid Program as it presently exists. They present no evidence of any access to care issue, any Medicaid eligibility issue, any switching issue, or any residual "outreach" issue relating to the named Plaintiffs. The named Plaintiffs are in stable plan assignments (including N.G.'s assignment in the Children's Medical Services Network, CMSN, which is a Managed Medical Assistance specialty plan). They are in stable coverage categories, most of which will only change when they turn 19 (or have only changed because they turned 19), and there is no indication that any of them has registered a complaint about their care.

Every aspect of the Florida Medicaid Program has gone through many transformational changes, from the way that Medicaid eligibility determinations are made (in response to changes in federal law), how MMA plan assignments are made, the way outreach is conducted, to the

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[2] / Instead, Plaintiffs would have had to submit evidence of a **pattern or practice** of inappropriate access to care, and not merely isolated instances. *See e.g., Harris v. Thigpen,* 941 F.2d 1495, 1505 (11th Cir. 1991) (requiring a "series of incidents closely related in time" or "repeated examples of delayed or denied medical care" to demonstrate "systemic and gross deficiencies") (emphasis added)*; Society of Good Will to Retarded Children v. Cuomo,* 737 F.2d 1239, 1245 (2d Cir. 1984) (isolated instances of improper medical care or even malpractice are inadequate on a class-wide basis to support a finding of constitutional violations); *Washington v. Brown & Williamson Tobacco Corp.,* 756 F.Supp. 1547, 1551 n. 4 (M.D. Ga. 1991), *aff'd*, 959 F.2d 1566 (11th Cir. 1992) (systemic deficiencies can be shown by evidence of patterns and practices that demonstrate a standard operating procedure). For large systems, more sophisticated analytical methods may be necessary, such as a fully realized research design which includes a statistically adequate random sample and an objective data collection instrument. *L.J. v. Massinga,* 838 F.2d 118 (4th Cir. 1988), *cert. denied,* 488 U.S. 1018 (1989). *See also Wal-Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541, 2556 (2011) (at the class certification phase, in an employment discrimination case, the Court found that Respondents' anecdotal evidence was too weak to raise any inference that all the individual, discretionary personnel decisions are discriminatory).

many changes in the obligations of the MMA plans that are responsible for ensuring access to care for Medicaid enrolled children. And AHCA has made many internal structural changes so that it can better monitor the MMA plans and ensure that they fully comply with their contracts. The operations of the Department of Health's Children's Medical Services (CMS) has also gone through many changes, from the outsourcing of their provider network responsibilities, to improvements on their ability to effectively monitor and measure how they are performing in providing children access to care. Lastly, DCF has not only acquired the Medicaid Eligibility System (MES) which makes eligibility determinations and sets the continuous eligibility periods for eligible children (thereby protecting the children's continuous eligibility), it has also radically modified its operations so that it is capable of accurately making eligibility determinations using new standards and ensuring the accuracy and reliability of those determinations.[3] While Plaintiffs claim that Defendants have done "nothing to . . . make other structural reforms necessary to increase children's access to Medicaid services," D.E. 1318 p. 2, nothing could be further from the truth.[4] It is for this reason that Defendants sought leave to reopen the factual record in this case in the Fall of 2014. D.E.1279 & 1281.

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[3] / The changes in Medicaid eligibility determinations were not driven by this lawsuit, but rather by changes in Medicaid eligibility that were required by the Affordable Care Act, which consists of Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and more particularly changes in income determinations based on the modified adjusted gross income (MAGI) test and the elimination of any assets test in determining Medicaid eligibility. 42 U.S.C. § 1396a(a)(14) (2013).

[4] / It is quite telling that Plaintiffs place "other structural reforms" after their desire for increased reimbursement rates. *Id*. It is very clear that the provider organization Plaintiffs are single mindedly focused on one thing - increasing what they get paid to serve Medicaid children. However, the Supreme Court has put such a claim (and associated remedy) beyond their reach, for the reasons already addressed by Defendants in their Memorandum Of Law Addressing the Impact of *Armstrong v. Exceptional Child Care Center, Inc*. D.E. 1326. Therefore, this Court's focus must be not on what providers are paid, but on the efficacy of the many structural changes that have been made to ensure that enrollees have the ability to access services - if they choose to do so.

Plaintiffs make much ado of a single CMS 416 report, from 2013 (based on data for the Federal Fiscal Year which ended on September 30, 2012), and suggest that it somehow proves ongoing problems with MMA. However, they fail to acknowledge that the single report has absolutely no data relating to MMA, which was not fully implemented until almost **two years after** that report was issued. Plaintiffs further relegate to a footnote another important fact relating to that report, that there was a methodological change which affects the ability to compare that report to other reports in determining Florida's success in its child health check-up program. And, they present no evidence of a single child who sought but was unable to obtain or was delayed in obtaining a well-child visit. Certainly Plaintiffs do not claim that any named Plaintiff has ongoing issues obtaining any preventative care of any type, including dental services.[5]

Without a doubt, if Plaintiffs' provider witnesses are subjected to even a modicum of appropriate cross examination, they will have to admit that there are many reasons why Medicaid enrollees may not seek preventative care, and that even if providers were paid more money, they cannot ensure that enrollees will seek preventative care. The fact is that Medicaid enrollees and their parents have a number of competing concerns that may outweigh the need for preventative care. Nonetheless, AHCA and its MMA plans take seriously their responsibilities to aggressively reach out to this population to get them in to primary care physician and dental offices for preventative care.

One final introductory note, Plaintiffs are absolutely wrong when they state that they cannot treat patients because of switching. Because of AHCA's new continuity of care contract

[5] / And since they presented no declarations on this issue, they are barred from presenting such proof by the terms of the Court's Order Following Status Conference. D.E. 1311 p. 2 ("Only such testimony by such witnesses will be considered.").

provisions, established providers can provide already scheduled care within that first thirty (30) days after a child is enrolled in an MMA plan, even if they are not a participating provider in the child's new MMA plan, and be reimbursed at the rate they would be paid for the service immediately prior to the transition of the child to the new plan. As is further discussed below, it is not that they cannot treat that child and be paid the rates they were paid before the child was transitioned to the plan. Rather, they may choose not to treat the child despite contractual guarantees that the plans will pay their claims.

SUMMARY OF PLAINTIFFS' CLAIMS

With the ruling in *Armstrong v. Exceptional Child Care Center, Inc.*, 135 S.Ct. 1378, 1385 (2015), Count II of Plaintiffs' Second Amended Complaint must be dismissed, and Plaintiffs concede this fact. D.E. 1325 p. 1. By the Amended Findings of Fact and Conclusions of Law, the Court found that S.M. (the only Plaintiff with standing to proceed against DCF under Count IV) lacked standing to sue DCF because of the expiration of section 409.9122(2)(c), Florida Statutes. D.E. 1314, p. 13. Thus, Count IV must be dismissed as to DCF. Plaintiffs are left with two viable claims, as set forth in Counts I and IV. (Although Defendants maintain that **all claims** were vitiated by the Supreme Court's decision in *Armstrong*. *See* D.E. 1326.)

Notwithstanding Plaintiffs' concession that their claims under 42 U.S.C. § 1396a(a)(30)(A) must be dismissed, from their Offer of Proof and more particularly their declarations, it appears that Plaintiffs believe that nothing has really changed. They still pursue complaints of inadequate reimbursement rates. D.E. 1318 p. 2, 6-7. They still cast their claims in terms of "access" to care, a word that only appears in § 1396a(a)(30)(A). D.E. 1318 p. 6. However, even if the remaining statutes on which Plaintiffs rely created enforceable rights

(which they do not), they certainly do not create an enforceable right to a certain reimbursement rate or to care that is geographically accessible (even though AHCA demands more than the law requires and the MMA plans must provide geographically accessible care, a contractual requirement that is enforced by AHCA).

This case is practically pleading for a prompt ruling by the Court on what claims Plaintiffs may pursue in this action. Absent prompt intervention by the Court, Plaintiffs will continue to try this case as if they have won their claim brought pursuant to § 1396a(a)(30)(A).

Count I alleges that all three official capacity defendant agency heads failed to provide required “medical assistance” with reasonable promptness, pursuant to 42 U.S.C. § 1396a(a)(8), and that the official capacity defendant agency heads of DOH and AHCA have also violated § 1396a(a)(10) for the same reasons.

Plaintiffs allege three principle reasons exist for the purported failure to provide "medical assistance" with reasonable promptness: (1) inadequate reimbursement rates, D.E. 220-2, ¶77; (2) so-called administrative barriers, such as reassignment of a child from one primary care provider to another, and incorrect termination of the child's Medicaid eligibility, D.E. 220-2, ¶78; and (3) the failure of Defendants [Plaintiffs do not specify which Defendants] to adequately monitor Medicaid Health Maintenance Organizations and particularly to monitor the adequacy of their provider panels, D.E. 220-2, ¶81-82.

Even if §§ 1396a(a)(8) and (10) created enforceable rights (which they do not), Plaintiffs' claim that they may sue under these statutes over inadequate reimbursement rates impermissibly expands the reach of these statutes beyond what Congress intended. This issue is covered in

more depth in Defendants' Memorandum of Law Addressing the Impact of *Armstrong v. Exceptional Child Care Center, Inc*. D.E. 1326 pp. 15-16.[6]

Count IV is the "outreach" claim based on § 1396a(a)(43). This claim is pending only against AHCA.

The attached declarations address all of these remaining claims.

LEGAL STANDARD

The parties disagree on the legal standard to be applied in determining whether Plaintiffs are entitled to declaratory and injunctive relief. Plaintiffs claim they need only show whether there is an "actual controversy," or a "continuing controversy," as if this is sufficient to justify an award of declaratory and injunctive relief against Defendants that would otherwise be entitled to Eleventh Amendment immunity. D.E. 1318 p. 4. However, Plaintiffs must demonstrate more than a mere continuing controversy; they must prove continuing violations of federal law at this juncture to justify either prospective declaratory or injunctive relief.

Proof of an ongoing violation is an essential requirement to evade the Eleventh Amendment immunity available to the State of Florida. Plaintiffs must "seek *prospective* equitable relief to end *continuing* violations of federal law," in order to proceed in an official capacity lawsuit under *Ex Parte Young*, 209 U.S. 123 (1908). *Land v. Central Ala. Community College*, 772 F.3d 1349, 1351 (11th Cir. 2014) (vacating an order dismissing an official capacity claim and remanding the matter for further proceedings), *citing Summit Med. Assocs., P.C. v. Pryor*, 180 F.3d 1326, 1336 (11th Cir. 1999). Otherwise, the relief Plaintiffs seek would be

[6] / The fact that Plaintiffs may claim that § 1396a(a)(43) further defines Defendants' obligation to provide services does not change the fact that this statute and the others on which Plaintiffs rely do not create enforceable rights, but rather describe the provisions of a Medicaid State Plan.

barred by the Eleventh Amendment. *Accord Armstrong*, 135 S.Ct. at 1385 ("The power of federal courts of equity *to enjoin unlawful* executive action is subject to express and implied statutory limitations"), *citing Seminole Tribe of Fla. v. Florida*, 517 U.S. 44, 74, 116 S.Ct. 1114, 134 L.Ed.2d 252 (1996).

Plaintiffs correctly note:

> [T]o obtain a permanent injunction, a party must show: (1) that he has prevailed in establishing the violation of the right asserted in his complaint; (2) there is no adequate remedy at law for the violation of this right; and (3) irreparable harm will result if the court does not order injunctive relief.

Alabama v. U.S. Army Corps of Engineers, 424 F.3d 1117, 1128 (11th Cir. 2005). However, the irreparable harm that must exist must be shown to be the result of the "continuing violation" of federal law by a state actor. *Accord, Armstrong,* 135 S.Ct. at 1385.

This Court's ability to award a remedy is limited to the specific injuries the named Plaintiffs have proven. A named Plaintiff who claims that he was switched from his MMA plan because of issues with DCF's eligibility processes, would not thereby have a basis to seek a remedy relating to the Legislative preference that newborns now be assigned to the plan of the mother on birth, with the ability of the mother to choose a different plan later. Such an approach would not serve the purpose of requiring plaintiffs to prove injury in fact as a predicate to obtaining relief:

> "[t]he actual-injury requirement would hardly serve the purpose ... of preventing courts from undertaking tasks assigned to the political branches[,] if once a plaintiff demonstrated harm from one particular inadequacy in government administration, the court were authorized to remedy *all* inadequacies in that administration."

DaimlerChrysler Corp. v. Cuno, 547 U.S. 332, 353 (2006) (emphasis in original; quoting *Lewis v. Casey*, 518 U.S. 343, 357 (1996)).

Therefore, in analyzing the extent to which the Court may proceed to remedy on a claim, the Court must also determine whether a named Plaintiff has suffered the particular harm at issue. Here, there is no evidence that the named Plaintiffs have sustained any harm (let alone an ongoing violation) as a result of MMA. Absent such evidence, the Court is constrained by the "injury in fact" requirement against awarding relief relating to MMA.[7]

Summary of Testimony

I. AHCA Employees

Defendants offer the testimony of the State Medicaid Director and fifteen (15) other AHCA employees located around the State to describe its organization-wide restructuring that has occurred at AHCA in order to facilitate the close monitoring and management of MMA plans, all with the goal of ensuring that the plans provide the services they are contractually obligated to provide. D.E. 1327-1 through D.E. 1327-3. Whatever historic issues Plaintiffs may cite to, D.E. 1318 p. 2-3, it is clear that AHCA aggressively and closely monitors the performance of the MMA plans to ensure that they provide the medically necessary services that Medicaid enrollees need. D.E. 1327-3, ¶¶ 18-22; D.E. 1327-5, ¶¶ 5-14, 16-20. There is close scrutiny of everything ranging from the reporting on complaints, provider network reporting, to financial reporting that reflects expenditures on services.[8] D.E. 1327-1, ¶ 16; D.E. 1327-2 ¶ 10; D.E. 1327-9, ¶29. AHCA also uses its data-rich complaint database to examine specific issues, again so it may resolve matters swiftly. D.E.1327-13, ¶ 8.

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[7] / While at trial, Plaintiffs presented broad ranging evidence about the "old managed care" system, i.e., managed care as it existed prior to the implementation of MMA, they did not present evidence that the named Plaintiffs suffered harm as a result of anything other than two very narrow issues. In one instance, J.W. had his primary care provider switched. In another, K.K. could not find a single specialty provider, an ENT. These are hardly the broad sweeping changes that would support any remedy related to the "old managed care" system. They certainly are not adequate to show that these named Plaintiffs have ongoing issues with Managed Medical Assistance.

[8] / AHCA has also significantly enhanced and improved both its complaint reporting and tracking capability.

AHCA has devoted considerable time and resources to encouraging providers, enrollees, and the people around enrollees to report complaints or issues. D.E. 1327-9; ¶ 22. There is the ability to make an online anonymous complaint if that is what is desired (although complaints can also be made by telephone and email). D.E. 1327-14, ¶¶ 8-9. Yet despite the large number of Medicaid enrollees enrolled in MMA plans, the numbers of complaints regarding provider network adequacy and dental network adequacy are extremely low. D.E. 1327-5, ¶ 13. There are about 3 million people enrolled in MMA plans, yet in a six month period, AHCA received just 42 complaints for both adults and children on dental network adequacy related issues. D.E. 1327-5, ¶12. In a four month period, AHCA received only 189 complaints on network adequacy generally (including dental network adequacy). D.E. 1327-5, ¶ 13. AHCA's data on complaints directly contradicts Plaintiffs' premise that there are systemic issues with network adequacy. And each complaint was investigated and resolved by the respective MMA plan, with oversight by AHCA. D.E. 1327-5, ¶ 13. The MMA plans are required to promptly correct even isolated network issues. Further, the MMA plans are required to approve the use of out-of-network providers if a suitable provider is not otherwise timely available. D.E. 1327-3, ¶ 17.

MMA plans are held accountable by AHCA from the weekly meetings that are conducted with their assigned contract manager, to requirements that they respond in a timely manner regarding complaints or issues that are brought to their attention. D.E. 1327-5, ¶ 16. They are required to comply with detailed reporting requirements covering everything from the timeliness of claims payment, various financial reports, enrollee complaints, grievances and appeals, emergency room visits without a primary care visit schedule, to the performance measure reporting. The reporting that the MMA plans must provide has been improved, and, just as importantly, is reviewed by AHCA employees who have the expertise to evaluate the

information being provided. D.E. 1327-15, ¶ 3. Now service level data can be derived not just from encounter data or a CMS 416 report, but also from required financial reporting. D.E. 1327-15, ¶ 4.

Provider networks must be reported weekly, with an appropriate level of detail about the providers, but, more importantly, the information reported is used to verify the accuracy of the network. D.E. 1327-9, ¶ 30. AHCA has a Provider Network Verification (PNV) system which it uses to analyze the data provided by the MMA plans and match it to different sources (such as licensure sources, sources about providers excluded from Medicare, etc.) all to ensure that the provider network that is being reported is "real" and accurate. D.E. 1327-9, ¶ 31. Additionally, AHCA has the capability now to run detailed reports which measure the adequacy of the provider network using the contractually required provider network standards, including provider to population ratios, as well as measuring the maximum time and distance that enrollees will have to travel for care. D.E. 1327-9, ¶ 31. AHCA has also done "secret shopper activities" to investigate provider network adequacy complaints. D.E. 1327-9, ¶ 32.

AHCA has been very aggressive in imposing liquidated damages and sanctions whenever necessary. D.E. 1327-3, ¶ 22; D.E. 1327-5, ¶ 27. For example, when AHCA determined issues with certain MMA plan's provider networks, it promptly issued notices of intended action. MMA plans were advised that, if they did not correct deficiencies, AHCA would assess $250 per day until all issues were fixed. D.E. 1327-5, ¶ 29. The issue was that the MMA plans' weekly provider network files, once processed through AHCA's system, showed an inadequate number of providers for certain provider types. There are a few reasons this could happen. The issue could be one of a technical nature, such as the MMA plan didn't submit the right Medicaid ID number on the file so AHCA couldn't give them credit for that provider. Another reason could be

that they actually didn't have enough provider contracts to meet AHCA's required provider network ratios or time/distance standards. AHCA treated all reasons the same, in order to send the message that all reasons for noncompliance would be treated the same. MMA plans were told that if they do not meet the network adequacy requirements of the contract, AHCA will assess $250 per day until they fix the issue. *Id.*

As of April 2, 2015, AHCA had imposed final assessments of liquidated damages in the amount of $144,750 for the MMA standard plans. D.E. 1327-5, ¶ 27. There was also one MMA plan that was sanctioned. D.E. 1327-5, ¶ 27. AHCA is using all of its available tools (and there are many) to ensure plan compliance. In fact, with the restructuring of AHCA, two of the Medicaid field offices are devoted to plan management and compliance issues. Those two Medicaid field offices are located in Fort Lauderdale and Tampa. Those offices locations were selected because the physical addresses for the MMA plans respective headquarters are in South Florida and the Tampa Office. D.E. 1327-11, ¶ 4. These Medicaid Field Offices have the capability to (and do) quickly show up at the MMA plan offices when an issue comes up which requires an onsite review. D.E. 1327-11, ¶ 5.

Additionally, AHCA has created a Clinical Quality Review and Compliance Section (CQRC) which takes a multidisciplinary approach (with social workers and registered nurses) to ensuring quality of clinical services. CQRC is tasked with ensuring that the MMA plan's behavioral and medical clinical programs (including dental programs), care coordination, and case management serve patients appropriately and effectively. D.E. 1327-2, ¶ 5. CQRC deals with issues which are identified for a targeted review. D.E. 1327-2, ¶¶ 6, 9. When this occurs, CQRC identifies all provisions of the MMA plan's contractual responsibilities that touch on the issue. D.E. 1327-2, ¶ 9. For example, because access to services is improved with care

coordination, CQRC staff looks not only at the provision of the specific service but also at the MMA plan's care coordination. If a prior authorization is an issue, CQRC will look at that process as well. Staffs take a holistic approach in dealing with issues, looking not just at the service but at the things around the service that impact on access. This is a new approach to monitoring Medicaid plans generally. D.E. 1327-2, ¶ 6.

Changes have also been made in plan assignment processes. One of those changes Plaintiffs now complain about. By statute, AHCA is required to place the newborn baby in his mom's plan at birth, and that plan is required to provide and pay for the services for that baby. § 409.977(3), Fla. Stat. The logic behind this change is obvious. The healthcare providers surrounding that infant will quickly and easily know who is responsible for supplying the providers and paying for services. Plans can easily be made prior to the child's birth to have the right pediatric oversight in place to provide, for example, a five day jaundice check up. D.E. 1327-1, ¶¶ 23-24. But, this doesn't mean that the infant must stay in that plan. The mother can easily choose another plan, including the plan where the child's siblings may be enrolled (assuming that the mother and children are enrolled in different plans - which may not be the case). *Id.*

There have also been changes to the plan choice process. Although monthly magic still exists, it now occurs on the last Saturday of each month. D.E. 1327-9, ¶ 13. But plan change requests can be processed up to the last day of the month and still take effect on the first day of the next month, meaning that a plan choice change that is registered on April 30th will take effect on May 1. D.E. 1327-9, ¶¶ 13-15. It is no longer the case that implementation of the changes take 45 days or longer.

AHCA's enrollment broker also provides extensive written and oral outreach to parents to encourage voluntary plan choice. In addition to two letters sent in advance of a plan assignment, the broker's staff also makes cold calls to enrollees who have not made a voluntary plan choice before they are due for automatic enrollment. D.E. 1327-9, ¶ 5. AHCA encourages active selection of plans. "Active selection," means that the individual would register a choice to be in a particular plan with the Agency's enrollment broker, Automated Health Systems, Inc. (AHS). "Passive" selection is when an individual, after being advised of his or her choices, does not register a choice but opts to stay in the plan to which he or she is automatically enrolled. The Agency works very hard, through AHS, to encourage active selection by notifying the individual of how to make a choice selection both in writing and by telephone. D.E. 1327-1 ¶10.

Enrollees may register plan choices via telephone or an online enrollment system, 24 hours a day. D.E. 1327-9, ¶ 6. And if someone does not actively select a plan and ends up in a plan they do not want, their continuity of care need not suffer. The MMA plans have an obligation to provide already scheduled services for a sixty day period after the person transitions to the new plan - even if they are scheduled with out-of-network providers. And for the first thirty days, that provider can be reimbursed at the same rate it received immediately before the enrollee was transitioned to the network. D.E. 1327-6, ¶ 11.

In sum, the changes to MMA have been thoughtful and considered with the intention of ensuring that enrollees receive access to medically necessary care in a timely fashion. There are so many other important features which cannot all be addressed here (such as the specifics on the substantially modified provider network requirements that also require that a certain percentage of the MMA plan's providers by provider and specialty type be accepting new patients). D.E. 1327-3, ¶ 10.

One last word about outreach. AHCA is doing its own outreach through the Field Offices. *See, e.g.,* D.E. 1327-13, ¶ 14. It continues to send child health check up letters (which were simplified in 2010), but is revising them to meet the new needs of MMA. D.E. 1327-6, ¶ 22. However, now, AHCA also has the MMA plans performing their own outreach. D.E. 1327-3, ¶ 23. And the MMA plans have substantial incentive to share about Medicaid and their plan - because they may benefit by obtaining additional enrollees. However, their outreach, referred to as "marketing" has strict oversight by AHCA (including a secret shopper program just to evaluate this process). D.E. 1327-11, ¶6.

With the many changes that have been made in MMA, the program is transformed from the program that existed during the trial of this case. For the foregoing reasons, and as shown in AHCA's declarations, Plaintiffs have no evidence of any violation of the Medicaid Act and certainly no basis for any relief.

II. MMA Plans

Most of the MMA plans, as well as their dental subcontractors (to the extent that they subcontract dental services), have taken the extraordinary step to submit declarations regarding their compliance with various MMA requirements. *See, generally,* D.E. 1327-40, D.E. 1327-41, D.E. 1327-43 through D.E. 1327-60, & D.E. 1327-62. Each describes the rigorous efforts they use to ensure that their provider networks are adequate (including dental). *Id.* While they have various payment strategies, it is clear that they are not limited to Medicaid rates. *Id.* For specific provider types, they may pay more in order to secure those providers. *Id.* They do what is necessary to ensure a compliant provider network. *Id.* Some plans may use value based agreements or have provider incentives intended to ensure that providers deliver high quality cost effective care. *Id.*

In addition the plans describe the varying initiatives involving case management, care coordination, examination of Emergency Room (ER) utilization all intended to get members connected to their primary care providers for care, including preventative care. *Id.*

The plans discuss in varying detail the different efforts they make to provide outreach to their members. *Id.* Of course they have traditional outreach about the plan (member handbook, provider directory, information about the plan's Healthy Behavior Plan, contact information for the dental provider). *Id.* The member handbooks have information about dental benefits, the transportation benefit, and the child health check up periodicity schedule. *Id.* But the plans also provide welcome calls to their new members to encourage them to be seen by their primary care provider, and they describe their various initiatives to identify children who haven't had a child health check up for a dental screening according to the periodicity schedule, and their outreach specific to those children and their parents. *Id.* They describe outreach to pregnant women. *Id.* All the plans use a combination of written materials that are easy to understand and telephone calls. *Id.* The plans describe their initiatives to ensure that children get their blood lead screening. *Id.*

The plans also devote significant efforts in outreach to providers, both about gaps in the care of their members (such as missed checkups), and assistance with claims and encounter reporting. *Id.*

The plans describe their own quality efforts both through performance measure reporting, the use of their CMS 416 data, and ongoing medical records review to ensure compliance with child health check up and lead screening requirements. *Id.* They have various Healthy Behaviors Programs, and they incentivize parents to get their child in for preventative care by providing things like a gift card if they comply. *Id.*

The testimony from the MMA plans will show that, while they each have variations in how they do things, they are all committed to ensuring access to care for their enrollees.

III. DOH Employees (CMS)

DOH is responsible for the administration of Children's Medical Services (CMS), which provides services for children who have special health care needs who have applied to CMS and been determined eligible for CMS' services. A portion of the children CMS serves are enrolled in Medicaid, and they are served through the Children's Medical Services Network Plan, which is now an MMA Plan. DOH has entered into a contract with AHCA to provide specialty services through its Children's Medical Services Network (CMSN). DOH has contracted with two Integrated Care Systems ("ICSs") to provide administrative services and a provider network: the University of Florida Board of Trustees ("Ped-I-Care") and South Florida Community Care Network, LLC ("SFCCN"). D.E. 1327-17, ¶ 2. At the same time, DOH contracted with MED3000 Health Solutions Southeast as a third party administrator ("TPA") to perform such functions as the payment of claims, the implementation of an electronic health record, and the generation of a variety of reports. *Id.*; D.E. 1327-21, ¶ 4.

Ped-I-Care is a program operating under the auspices of the University of Florida, College of Medicine's Department of Pediatrics. D.E. 1327-18, ¶ 4; D.E. 1327-19, ¶ 4; D.E. 1327-20, ¶ 4; D.E. 1327-21, ¶ 4; D.E. 1327-22, ¶ 4. It operates in 51 counties, which are generally located in the northern and middle portions of the state. SFCCN, on the other hand, operates in 16 counties in the southern portion of the state, including the populous south Florida counties of Miami-Dade and Broward. D.E. 1327-23, ¶ 4; D.E. 1327-24, ¶ 4; D.E. 1327-25, ¶ 4.

DOH is prepared to show the court that CMSN members are currently receiving services with reasonable promptness. DOH will rebut any claim by Plaintiffs that the operation of the CMSN plan results in an ongoing violation of the Medicaid Act.

CMS has divided its office staff into eight (8) separate regions. Five of the regions work with Ped-I-Care, while the other three work with SFCCN. *See* D.E. 1327-18, ¶ 4; D.E. 1327-19, ¶ 4; D.E. 1327-20, ¶ 4; D.E. 1327-21, ¶ 4; D.E. 1327-22, ¶ 4 (regions contracted with Ped-I-Care); D.E. 1327-23, ¶ 4; D.E. 1327-24, ¶ 4; D.E. 1327-25, ¶ 4 (SFCCN). Each regional office includes care coordinators, nurses, and a nursing director. DOH has filed declarations from the nursing directors of all of CMS' eight regions. These nursing directors do not provide speculative information or information without sufficient foundation, which has previously plagued Plaintiffs' physician testimony. Moreover, this court does not have to wonder whether the CMSN plan is meeting its members' needs. Based on their continuous, daily interaction with CMS staff, members and their families, and providers, the nursing directors have direct knowledge of the status of care for CMSN members in each region. D.E. 1327-18, ¶ 3; D.E. 1327-19, ¶ 3; D.E. 1327-20, ¶ 3; D.E. 1327-21, ¶ 3; D.E. 1327-22, ¶ 3; D.E. 1327-23, ¶ 3; D.E. 1327-24, ¶ 3; D.E. 1327-25, ¶ 3. In their declarations, the nursing directors do not describe the status of care with respect to only certain geographic areas in Florida, or with respect to certain types of care. Instead, the nursing directors provide information regarding the entire State of Florida, and discuss the care to members with respect to primary care, specialty care, and dentistry. In sum, the nursing directors inform the court that CMSN members are receiving reasonably prompt medical services in each of the eight regions. D.E. 1327-18, ¶ 8; D.E. 1327-19, ¶ 8; D.E. 1327-20, ¶ 7; D.E. 1327-21, ¶ 10; D.E. 1327-22, ¶ 7; D.E. 1327-23, ¶ 7; D.E. 1327-24, ¶ 7; D.E. 1327-25, ¶ 7. In doing so, the nursing directors describe each of the regions and

identify whether, and to what extent, that region suffers from an absence or shortage of medical care and any child would have to travel for that care. The nursing directors also specify the types of providers that provide primary, specialty, or dental care to CMSN members.

CMSN continues to provide care coordinators who each have an assigned "case load" of members. As the nursing directors point out, since the care coordinators help to oversee the members' plan of care, and do so by reviewing their medical records and assisting in scheduling members care appointments, they have actual knowledge of any care problems and work to solve them if they exist. D.E. 1327-18, ¶ 14; D.E. 1327-19, ¶ 14; D.E. 1327-20, ¶ 13; D.E. 1327-21, ¶ 14; D.E. 1327-22, ¶ 12; D.E. 1327-23, ¶ 13; D.E. 1327-24, ¶ 12; D.E. 1327-25, ¶ 12. Melissa Vergeson, who is the Chief of CMSN Administration, submitted a supplement to her previous declaration. Ms. Vergeson has pointed out that MMA has enhanced the ability of the care coordinators to do their jobs because they now have access to comprehensive claims data, authorization data, and electronic health records for each member. D.E. 1327-17, ¶ 7. This has allowed the CMSN care coordinators to manage each member's entire spectrum of physical, dental, and mental health care, as well as transportation to and from appointments. *Id.* at ¶ 6.

While it is obvious that the CMSN plan should not be held to the standard of perfection (any more than any MMA plan would be held to this standard), MMA has allowed DOH to further improve its services to members. A statewide satisfaction survey has been commissioned, and a proactive quality improvement program will be examining some areas that have historically been found to be worthy of examination. D.E. 1327-17, ¶ 9. Furthermore, CMS has been working with each ICS in an effort to recruit and credential more providers. . *Id.* at ¶ 11.

IV. DCF

DCF's sole responsibility vis-à-vis the Florida Medicaid program is to determine and re-determine Medicaid eligibility. *See* § 409.902(1), Fla. Stat. The Offer of Proof and its 26 supporting declarations do not allege any facts which would prove an ongoing issue or controversy (and certainly not an ongoing violation of federal law) with respect to the named Plaintiffs in this case. Specifically, Plaintiffs have presented no proof of any errors in Medicaid determinations pertaining to the named Plaintiffs, even though they previously claimed that various Medicaid errors caused plan assignment issues. *See* Amended Findings, ¶¶ 109, 115-119.

Plaintiffs claim that children are switched from one MMA plan to another, and from one doctor in a plan to another. *See, e.g.,* D.E. 1318-1 p. 3. Under the present MMA plan, no errors by DCF would cause a child to have a plan change. Rather, AHCA's plan assignment processes require that children simply be reinstated to their prior MMA plan if they lose eligibility but regain it within 180 days. D.E. 1327-9, ¶ 35. Regarding claims that children may be moved from one doctor to another, this also would not be due to any error by DCF. DCF staff analyzed their records and they can find no action on their part related to J.W. particularly (or any of the named Plaintiffs) that could have triggered a change in primary care providers in 2005. D.E. 1327-31, ¶ 12. J.W. was determined eligible for Medicaid in the early part of 2005. *Id.* He remained eligible, in the same coverage category with no changes until 2011. *Id.* DCF can identify no action or error it committed which would have caused J.W.'s primary care provider to change in 2005. *Id.* Projecting forward, in similar cases where DCF makes no changes in coverage categories and does not commit any errors in its eligibility determination process, DCF could not "cause" a change in primary care provider assignments. D.E. 1327-31, ¶ 13.

Additional changes to the Medicaid eligibility determination process have been made that eliminate the possibility of the kinds of errors the Court found might cause switching in the Amended Findings, ¶¶ 115-121. Now the coverage period for a child's Medicaid eligibility is set by the computer. D.E. 1327-26, ¶ 14; D.E. 1327-32, ¶ 18. It cannot be closed early without using a limited number of appropriate reason codes. D.E. 1280-1, p. 6. Therefore, children's Medicaid will not be incorrectly terminated early. D.E. 1327-26, ¶ 16.

For children whose Medicaid coverage is based on family income, the need to change their coverage category is dramatically reduced and basically the change only occurs when the child ages. For children up to age 1, they are in one of two coverage categories (if they are a presumptively eligible newborn, they will be in one coverage category for that first year, while if they are not, they will be in another coverage category for that first year). Children who are at least one year old but less than 19 years of age are in the MMC category. Children between 19 and 21 years of age are in the MO Y category. D.E. 1280-1, pp. 2-3, D.E. 1280-3, p. 2.

With the combination of both the setting of the continuous coverage period and the use of these age related coverage categories, the possibility of moving children around to different coverage categories, such as occurred with S.M., just does not exist. Therefore, going forward, DCF would not be responsible for changes in managed care assignments or in primary care physician changes.

In addition to their claims about switching, Plaintiffs also claim that the new online Medicaid application is complicated and Florida still fails to provide adequate application assistance.[9] Regarding Dr. St. Petery's claim that the online application is "unnecessarily

[9] / And Dr. St. Petery, the only declarant on these issues, has not demonstrated that he has the necessary foundation and expertise to opine about the application or what must be included in it. D.E. 1318-27.

complicated," Defendants will prove that the application (both paper and online) has been approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (federal CMS), in compliance with 42 C.F.R. § 435.907. D.E. 1327-31, ¶ 10; D.E. 1327-26, ¶ 18; D.E. 1327-32, ¶ 6. DCF fully complies with the federal requirement to afford applicants the opportunity to apply for Medicaid *via* the Internet. *See* 42 C.F.R. § 435.907(a)(1).

A review of the online application reflects that the information covered in the online application is the same as the information covered in the paper application which Dr. St. Petery says "DCF has made real progress in improving." D.E. 1318-27, p. 7. While Dr. St. Petery overstates the number of screens that an individual must navigate through in the online application, he also fails to note that the different pages exist because less information is contained on each screen (to make the screen more user friendly). These changes have been made so that the online application is easier to understand and use. D.E. 1327-32, ¶¶ 6-7, 9-13; D.E. 1327-30, ¶ 10; D.E. 1327-26, ¶¶ 18-19. And many of the screens that are part of the CMS approved online application provide helpful information and do not request that the applicant input any information. Several screens display just summaries of previously entered information that are provided for verification purposes. D.E. 1327-32, ¶¶ 9-11; D.E.1327-30, ¶¶ 9-10.

The second part of Dr. St. Petery's claim against DCF is that the agency does not provide adequate assistance to help people complete the application and properly submit it. There are a number of different ways that people can obtain assistance in applying for Medicaid. First, if they apply online, there are help screens that provide information specific to the screen that the applicant is filling out that may be consulted for guidance. D.E. 1327-32, ¶ 13; D.E. 1327-31, ¶ 12. Also, DCF makes staff, as well as computers, available in its "storefronts" so that people

may obtain assistance applying for Medicaid *via* the internet. D.E. 1327-34, ¶¶ 4-6; D.E. 1327-38, ¶ 4; D.E. 1327-36, ¶¶ 3-4. If someone does not feel comfortable with either of these options, they can also call for assistance. D.E. 1327-28, ¶ 15.

Lest Plaintiffs state that calling DCF is not an option, DCF employees will testify that operations at the Statewide Office of Economic Self-Sufficiency (ESS) Call Center have changed dramatically, and the busy signal rate, average wait time, and abandonment rate have significantly declined since the liability trial (to the point where they are within reasonable levels). D.E. 1327-28, ¶¶ 8-18, 21; D.E. 1327-33, ¶¶ 6-9. Liesta Sykes, the Director of ESS's Statewide Call Center, will describe enhancements to the Automated Response Unit and changes in work assignment responsibilities which have afforded Call Center representatives more time to assist with telephone calls. Additional enhancements are being developed (by a vendor) and will be implemented this summer. D.E. 1327-28, ¶¶ 8-19. Liesta Sykes also will testify that the ESS Call Center is a national leader in call center operations. It has been called upon to assist other states to revise and improve their call center operations. D.E. 1327-28, ¶ 20.

DCF employees will testify that the agency strives for excellence in client service and is a national leader in the use of technology in the online application process. D.E. 1327-29, ¶ 15; D.E. 1327-31, ¶ 4. DCF has enacted many policy and technological changes to implement the changes in Medicaid eligibility determinations required by the Affordable Care Act (ACA). These changes make it possible for DCF to manage their responsibilities in determining Medicaid eligibility in a very capable and accurate manner. D.E. 1327-30, ¶¶ 5-21; D.E. 1327-32, ¶¶ 6-19; D.E. 1327-29, ¶¶ 4-15; D.E. 1327-26, ¶¶ 4-17. DCF employees also will testify that there are well-trained ESS staff in all six DCF regions who can answer applicant questions and assist with submitting applications. D.E.1327-31, ¶¶ 4-9; D.E. 1327-29, ¶¶ 7-15; D.E 1327-38,

¶ 4; D.E. 1327-36, ¶¶ 3-4; D.E. 1327-34, ¶ 4. ESS provides its staff substantial and repeated employee training, as well as a detailed communication system that insures that employees are aware of any issues that might affect their work. D.E. 1327-29, ¶¶ 7-15; D.E. 1327-35, ¶¶ 3-15; D.E 1327-37, ¶¶ 4-15; D.E. 1327-34, ¶¶ 8-18; D.E. 1327-36, ¶¶ 3-10; D.E. 1327-38, ¶¶ 6-9, 11; D.E. 1327-39, ¶¶ 4-17. ESS also has a detailed and comprehensive quality management process that ensures that eligibility is determined accurately and in a timely fashion. D.E. 1327-27, ¶¶ 3-21; D.E. 1327-32, ¶ 8; D.E. 1327-34, ¶¶ 16, 18; D.E. 1327-35, ¶¶ 4-15; D.E. 1327-38, ¶¶ 6-9, 12; D.E. 1327-36, ¶¶ 5-12.

For all of the foregoing reasons, Plaintiffs can demonstrate no ongoing violation of federal law relating to DCF, and certainly no basis for any further relief.

CONCLUSION

Defendants present the testimony by declaration of a large number of witnesses to prove that there is no ongoing violation of federal law and certainly no ongoing issue or controversy. Based on the evidence amassed, including the declarations submitted by the MMA plans, it is clear that Plaintiffs can prove no ongoing violation of federal law. Their proof is not adequate or scientifically reliable for this purpose. The expert opinions they provide do not aid the issue and are not based on facts that sufficiently describe MMA and how it is being operated by AHCA and the MMA plans. The Eleventh Amendment and *Armstrong* preclude any relief that would award Plaintiffs any increase in reimbursement rates. Plaintiffs' claims must be dismissed in the absence of their proof of an ongoing violation of federal law.

Should the Court disagree, discovery will be necessary of Plaintiffs' witnesses, including discovery of the foundation for their statements about (1) what they are paid; (2) any purported access issues; and (3) any statements made about switching. The discovery will consist of both

subpoenas to produce records from nonparties, depositions, and requests for production and interrogatories directed to Plaintiffs, their declarants, and others.

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; Robert D.W. Landon, III, Esquire, Kenny Nachwalter, P.A.,

201 South Biscayne Boulevard, 1100 Miami Center, Miami, Florida 33131-4327; and Benjamin D. Geffin, Esq., Public Interest Law Center of Philadelphia, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103; and by United States Mail on Louis W. Bullock, Esq., Bullock, Bullock, & Blakemore, 110 W. 7th Street, Tulsa, Oklahoma 74112, on April 22, 2015.

/s/ Stephanie A. Daniel
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