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' RESPONSE TO PLAINTIFFS' PROPOSED DECLARATORY JUDGMENT

Defendants, sued in their official capacities as agency heads of the AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA), the DEPARTMENT OF HEALTH (DOH), and the DEPARTMENT OF CHILDREN AND FAMILIES (DCF), submit the following response to Plaintiffs' Proposed Declaratory Judgment [D.E. 1332]. This response is submitted pursuant to the Court's May 6, 2015 Order directing the filing of the response. D.E. 1336.

INTRODUCTION

Plaintiffs propose the entry of a declaratory judgment based on a factual record which closed on February 3, 2012, more than three years ago. While the mere passage of time might not render the record in this case stale, numerous significant changes in the Florida Medicaid Program have done so. Hence, the Court's 2014 Findings of Fact and Conclusions of Law,

predicated on that stale factual record, cannot support a finding that there exists an ongoing violation of federal law.

The existence of an *ongoing violation of federal law* is necessary for this Court to award any relief, pursuant to *Ex parte Young*, 209 U.S. 123 (1908). As the Supreme Court has recognized, an important limitation to the Court's ability to award relief under the *Ex parte Young* doctrine is that the relief be prospective in nature. An important interest which justifies the use of the doctrine is the need to maintain the supremacy of federal law. However, that important interest cannot be present unless there is an ongoing violation of federal law.

The extraordinary changes in the Florida Medicaid Program were not the result of this litigation. Rather, they were dictated by changes in federal and state law, and the ongoing desire of AHCA to improve its delivery of service, through significant changes in the managed care plan contracting process which were the result of a competitive procurement process, and a complete restructuring of AHCA. Also, AHCA has significantly changed its oversight, monitoring, and compliance activities relating to the performance of Managed Medical Assistance (MMA) managed care plans. Defendants have presented many declarations and documents demonstrating these comprehensive changes, D.E. 1265, 1267, 1268, 1280, 1282, 1288, 1327, covering every aspect of the program, from the way that Medicaid eligibility is determined to how services are delivered.

The Court directed the parties to file offers of proof and declarations from any supporting witnesses, to show whether there is an ongoing controversy in the case. D.E. 1311.[1] The parties complied with this requirement. D.E. 1318, 1327, and 1328. At a minimum, those declarations raise disputed issues of material fact requiring an evidentiary hearing on the issue of whether

[1] / The Court stated: "*only such testimony by such witnesses will be considered*." *Id*. (emphasis added).

there exists any ongoing violation of federal law. The Medicaid Program, as it presently exists, bears no resemblance to the program described through testimony during the trial which ended more than three years ago.

Additionally, Plaintiffs' stated basis for ongoing violations relating to 42 U.S.C. § 1396a(a)(8) and (10) rests in large part on two assertions: first, that providers are paid inadequate reimbursement rates and that, as a result, some providers limit the numbers of Medicaid patients they serve or refuse to accept Medicaid at all; and second, that these providers could obtain specialty and dental care for their commercially insured patients faster than they can for their Medicaid patients. These claims are barred as a matter of law. As was required under *Armstrong v. Exceptional Child Center, Inc.*, 135 S.Ct. 1378 (2015), the Court has dismissed the claims brought under 42 U.S.C. § 1396a(a)(30)(A). What the Plaintiffs cannot do directly, the Court should not allow them to do indirectly. This is especially so when permitting these claims to go forward would require the Court to make the types of judgment-laden decisions concerning the adequacy of Medicaid reimbursement rates, particularly in light of the competing interests set forth in § 1396a(30)(A). The Supreme Court has emphatically stated that the federal administrative agency charged with overseeing Medicaid should oversee Medicaid rate setting, and the federal courts should not be engaged in this type of rate setting, for those very reasons. *Armstrong*, 135 S.Ct. at 1385. Before the Court may consider the propriety of declaratory judgment, it must determine whether Plaintiffs may rely on these claims to justify an award of any prospective relief, which, pursuant to *Ex parte Young*, must be designed to terminate an ongoing violation of federal law.

For the reasons set forth below, Plaintiffs' requested declaratory relief may not be issued, because there is no ongoing violation of federal law which justifies the award of prospective as opposed to retroactive declaratory relief.

I. While the Court may have subject matter jurisdiction to consider Plaintiffs' allegations of ongoing violations based on *Ex parte Young*, the Court cannot issue declaratory or injunctive relief in the absence of an ongoing violation of federal law.

Although a party need only allege an ongoing violation of a federal law by a state actor to provide the Court with subject matter jurisdiction over the claims, *Virginia Office of Protection and Advocacy v. Stuart*, 131 S.Ct. 1632 (2011) (*VOPA*), both the Eleventh Amendment to the United States Constitution and limitations that exist on the use of declaratory judgments preclude this Court from awarding any relief that is not prospective in nature and directed to ending the ongoing violation of federal law. "Ongoing" means ongoing as of the time the declaration is enforced, not the time the trial concludes. Thus, the question before this Court is not whether there was an ongoing violation of federal in February 2013, but rather whether there is an ongoing violation of federal law today. The answer to the later question is no.

Ex parte Young, 209 U.S. 123, 150 (1908), provided for an official capacity suit against the Attorney General of the State of Minnesota when he sought to enforce an unconstitutional state law. The Court concluded that when a state officer attempts to enforce an unconstitutional state law, he is stripped of his official or representative character and is subjected in his person to suit for the consequences of his individual conduct. As the Supreme Court later stated, "the theory of *Young* has not been provided an expansive interpretation." *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 102 (1984).

One of the key restrictions on the application of *Ex parte Young* is that it can only be relied upon to provide prospective declaratory and injunctive relief. *VOPA*, 131 S.Ct. at 1639;

Verizon Maryland Inc. v. Public Serv. Comm'n, 535 U.S. 635, 645 (2002) (*Verizon*). *Ex parte Young* cannot provide the basis for securing a declaration that Defendants violated the law in the past. *Green v. Mansour*, 474 U.S. 64 (1986). Rather, *Ex parte Young* authorizes only prospective relief that is aimed at ending an ongoing or continuing violation of federal law. In the absence of an ongoing violation of federal law, the Court is not empowered to issue a declaratory judgment that state officials have violated the law. *Green v. Mansour*, 474 U.S. at 73.

And there must be a need for a prospective declaration. Simply inserting the phrase "and continue to be" in proposed declaratory statements, as Plaintiffs have done in their Proposed Declaratory Judgment, D.E. 1332 pp. 5-6, ¶¶ 1-5, does not mean that there exists any prospective need for a declaration in this case, particularly given the stale record before the Court. Rather, there must be a need to issue a declaratory judgment about an ongoing violation of law. For example, in *VOPA*, there was an ongoing refusal to provide mortality review records to the state's protection and advocacy agency. *VOPA*, 131 S.Ct. at 1639. In *Verizon*, the Court addressed an action aimed at enjoining enforcement of an order issued in contravention of controlling federal law. *Verizon*, 535 U.S. at 645.

In *Florida Association of Rehabilitation Facilities v. Fla. Dept. of Health and Rehabilitative Services*, 225 F.3d 1208 (11th Cir. 2000) (*FARF*), the Eleventh Circuit addressed the propriety of a final judgment issued about eight (8) years after the commencement of the litigation. The case dealt with the Boren Amendment (also at issue in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990)),[2] which was repealed during the pendency of the case. Florida submitted a state plan amendment in compliance with the new rate setting requirements,

[2] / As this Court will recall, *Wilder* has been repudiated by the Supreme Court. *Armstrong*, 136 S.Ct. at 1387 fn. *.

and then asked the District Court to reconsider its judgment finding it in violation of federal law based on the fact that the claims were moot. The District Court refused to address the issue, finding that it was raised too late. However, the Eleventh Circuit vacated the final judgment in part and also remanded it in part to determine whether the state plan amendment complied with federal requirements, thus mooting Plaintiffs' claims.

The Eleventh Circuit reversed the portion of the District Court's order which required Florida to pay the difference in rates (between what was paid and what was required) back to 1991 (the date of a previously issued temporary injunction). Salient to the restrictions on the use of *Ex parte Young* to obtain prospective relief only, the Eleventh Circuit stated: "*Ex parte Young* has been applied in cases where a violation of federal law by a state official *is ongoing as opposed to cases in which federal law has been violated at one time or over a period of time in the past*." *FARF*, 225 F.3d at 1208 (emphasis added). In discussing the prospective relief requirement associated with *Ex parte Young*, the Eleventh Circuit stated:

> . . . Thus, *Ex parte Young* applies to cases in which the relief against the state official *directly ends the violation of federal law*, as opposed to cases in which that relief is intended indirectly to encourage compliance with federal law through deterrence or simply to compensate the victim. "'*Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law.* But compensatory or deterrence interests are insufficient to overcome the dictates of the Eleventh Amendment.'"

FARF, 225 F.3d 1219-1220 (emphasis added), quoting *Summit Med. Assocs.*, 180 F.3d at 1337 (which in turn quoted *Papasan v. Allain*, 478 U.S. 265, 277–78 (1986)). The Supreme Court has long recognized that the purpose of *Ex parte Young* was to assure the supremacy of federal law. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 102 (1984); *Alden v. Maine*, 527 U.S. 706, 747 (1999) (discussing the purpose of *Ex parte Young* suits, to ensure that the Constitution

would remain the supreme law of the land). The interest in protecting federal law does not exist unless there is a continuing violation of federal law.

As discussed further below, there is no evidence of an ongoing violation of federal law which necessitates the issuance of prospective declaratory relief in order to "directly end the violation." *FARF*, 225 F.3d at 1219-1220. It is Defendants' position that it is Plaintiffs' burden to show that there is an ongoing violation throughout the proceedings, including up to the entry of relief. Therefore, Plaintiffs' request for declaratory relief must be denied.

II. In light of the extremely stale record, there is no evidence on which the Court can conclude that presently there is an ongoing violation to which a declaratory judgment should be directed.

One of the problems with the award of any relief in this case is the extremely stale nature of the factual record. The evidentiary portion of the trial closed on February 3, 2012, more than three (3) years ago. Fact discovery closed, with two minor exceptions, in 2008. Expert discovery closed in 2009. By and large, the case was tried based on evidence from 2008 and earlier. It was extremely out of date then, and that factual record has no relevance now. With all of the changes that have occurred in the interim, Plaintiffs' claims are now moot. While Defendants acknowledge that it is their burden to demonstrate that Plaintiffs' claims are moot, this does not in any way lessen Plaintiffs' burden throughout these proceedings to prove that an ongoing violation of federal law exists, because this is an essential limitation on the Court's authority to award prospective relief under *Ex parte Young*.

If Plaintiffs' claims are not moot, the record is so stale that it cannot support entry of any prospective relief.

A. The claims against DCF are moot.

With the implementation of changes to the Affordable Care Act (ACA), which consists of the 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), DCF had to purchase a Medicaid Eligibility System capable of making those determinations.

When it implemented the modifications to Medicaid eligibility determinations required by the ACA, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (federal CMS), also made changes in Medicaid coverage categories. Federal CMS significantly reduced the number and type of Medicaid coverage categories from what it characterized as "many different mandatory and optional eligibility categories for children." Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 FR 51148-01, 51154 (Aug. 17, 2012). Now, for children who have family related Medicaid based on income, changes in those coverage categories basically occur as the child ages. Children under the age of one are in the MM I category, unless they are presumptively eligible newborns in which event they are in the MN category. Children who are at least one year old but less than 19 years of age are in the MM C category. Children between 19 and 21 years of age are in the MO Y category.

At the same time that DCF determined a new Medicaid eligibility computer system would be required, it also obtained the computer functionality to set and protect continuous eligibility periods. With these changes (age-related coverage categories and computer protection of continuous eligibility), the two root causes attributed to DCF by the Court as leading to

switching, D.E. 1314 p. 70-71, have been eliminated. Therefore, the switching claims against DCF are now moot. D.E. 1327-26, ¶ 14; D.E. 1327-32, ¶ 18.

In the declaration of Dr. St. Petery, Plaintiffs acknowledge that "DCF has made real progress in improving the paper Medicaid application since the trial ended." D.E. 1318-27 p. 6. But they fail to acknowledge that customers applying for Medicaid are required to provide the same information, regardless of whether they apply by internet or paper. D.E. 1318-27, p. 7. The internet application has more screens (but not as many as Dr. St. Petery suggests), because information is formatted differently, with less information on a screen. The result is 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. Importantly, federal CMS has approved DCF's application. 42 C.F.R. § 435.907. D.E. 1327-31, ¶ 10; D.E. 1327-26, ¶ 18; D.E. 1327-32, ¶ 6.

Also, DCF made many changes that enable it to focus on providing customer service to persons who want assistance in applying for Medicaid. While there are improved help screens for people applying online, there also are staff and computers available in "storefronts" so that people can obtain assistance in applying for Medicaid via the internet. D.E. 1327-34, ¶¶ 4-6; D.E. 1327-38, ¶ 4; D.E. 1327-36, ¶¶ 3-4. If individuals do not feel comfortable with either of these options, they can also call for assistance. D.E. 1327-28, ¶ 15. DCF call center operations have improved dramatically, so that call centers are able to provide needed assistance. D.E. 1327-28, ¶¶ 8-18, 21; D.E. 1327-33, ¶¶ 6-9.

When DCF last filed its Suggestion of Mootness in October 2014, it had not yet implemented all of the enhancements that are now available. D.E. 1279 p. 3 ("Imminently, DCF will go live with Phase 2 of the MES development"). That is no longer the case. D.E. 1327-26, ¶ 14; D.E. 1327-32, ¶ 18; D.E. 1280-1, p. 6. Now DCF stands fully prepared to meet its burden

of demonstrating that all of the claims about which Plaintiffs claim there exists an ongoing controversy are in fact fully moot. Since the Court is limited under *Ex Parte Young* to prospective declaratory or injunctive relief intended to end an ongoing violation of federal law, the Eleventh Amendment would bar the entry of any relief against DCF.

B. Likewise, Plaintiffs claims are moot against AHCA and CMS.

Since the trial of this case closed more than three (3) years ago, the Florida Medicaid Program has been completely transformed. D.E. 1327-1, ¶ 29. Now, all but a very small number of Medicaid recipients receive their Medicaid services through Managed Medical Assistance (MMA) Plans. D.E. 1327-1, ¶ 5. That this is the current status of affairs is reflected in Plaintiffs' declarations, where complaints about Fee-For-Service Medicaid are absent. . *See generally* D.E. 1318-1 – 1318-27. Instead, Plaintiffs have searched for and found only a very small number of anecdotes which they argue, without evidentiary support, are representative of an ongoing controversy regarding the MMA Program. Nothing could be further from the truth. [3]

One major change is in AHCA's oversight and monitoring of the managed care plans. D.E. 1327-5, ¶ 4-6. There is detailed oversight and monitoring, including a variety of activities intended to ensure that children receive needed preventative and specialty dental and physician services. D.E. 1327-1, ¶ 17; D.E. 1327-5, ¶ 6; D.E. 1327-9. There are detailed provider network standards, which are not merely contractual provisions. D.E. 1327-3, ¶ 7-14. Rather, they are enforced via detailed reporting and verification procedures, as well as secret shopper activities.

[3] / Had Plaintiffs wanted to prove in a scientific and reliable manner what MMA is like today, they could have conducted a random sample of all physician and dental Medicaid providers, with a sufficient sample size that would allow one to reliably extrapolate results to the population as a whole. It would be inappropriate to draw global conclusions about MMA, based on the small non-random anecdotes of Plaintiffs' provider witnesses, who have a vested interest in the outcome of the lawsuit, because they will benefit from being paid more if Plaintiffs prevail. D.E. 1327-8, pp. 8-9.

Additionally, AHCA has greatly modified its processes both for complaint reporting and analysis, to ensure that issues are addressed before they become problems. D.E. 1327-1, ¶ 12-16; D.E. 1327-3, ¶ 19. Those complaints are analyzed for trends, and regular reporting occurs. D.E. 1327-5, ¶ 10-11. Further, there is follow up with the plans to make sure that complaints are addressed. D.E. 1327-5, ¶ 10-11, 14-16. There was quite a bit of publicity and outreach about the complaint process, and AHCA has encouraged the filing of complaints or issues, so that it could address them and determine whether they reflected problems that needed a more global solution or whether they were merely isolated issues that could be quickly resolved. D.E. 1327-2, ¶ 12-14. AHCA also utilizes the other reporting it receives - including everything from financial reporting to reports on fair hearings - to ensure that medically necessary services are provided to the plans' enrollees. D.E. 1327-5, ¶ 22-24, 30; D.E. 1327-7; D.E. 1327-8; D.E. 1327-9; D.E. 1327-15.

While AHCA will examine the results of HEDIS reporting and other reporting when they become available, D.E. 1327-8, these are not necessary to, and do not determine, the effectiveness of MMA, because of the other rich sources of data available to it (including encounter data reporting). D.E. 1327-5, ¶ 22-26; D.E. 1327-8, ¶ 14-15. And, AHCA is not waiting for HEDIS data to take appropriate compliance actions. *Id.* The Court stated in its findings of fact that there was "virtually no evidence and certainly no systemic evidence in the record that any MCOs were hit with a substantial fine, or expelled from the Medicaid program for failure to provide care to children on Medicaid or meet any contractual requirements relating to the provision of care." D.E. 1314 p. 137. While the evidence provided to the Court was necessarily limited to stale facts (because discovery closed in 2008), this is not presently the case. AHCA has appropriately and consistently utilized liquidated damages to fine the plans for

a variety of issues - all of which can affect the provision of care. D.E. 1327-1, ¶ 28; D.E. 1327-3, ¶ 21-22; D.E. 1327-5, ¶ 27-29. AHCA is closely watching the plans, with each plan having its own assigned manager, to ensure that the plans provide the services which they have contracted to provide. D.E. 1327-5, ¶ 8, 14-16.

Now, to the extent that AHCA staff testify about access to primary or specialty care, D.E. 1314 p. 328, they do so based on rich sources of data which demonstrate the adequacy of robust provider networks. D.E. 1327-5, ¶ 13, 22-26, 34; *see generally* D.E. 1327-7. And in an evidentiary hearing, the Court will also hear from the plans themselves, regarding their work in maintaining provider networks, providing outreach, and resolving any issues that may arise regarding access - regardless of the service. . *See* D.E. 1327-40 – 1327-62.

Additionally, the way that AHCA determines the capitation payments for plans is now different. *See generally* D.E. 1327-4. Base capitation payments were the result of a procurement process, and all of the capitation payments from year one of operation have been determined to be actuarially sound. D.E. 1327-4, ¶ 9, 11-15. Those base capitation rates were included in the plan contracts which were submitted to federal CMS for review and approval as required by 42 C.F.R. § 438.6. D.E. 1327-4, ¶ 11-12. AHCA also uses a risk adjustment process which accounts for the level of acuity of the population that is served by each MMA plan. D.E. 1327-4, ¶ 9, 11-15. Capitation rates are adjusted upward or downward depending on the extent to which the population served by the plan is healthier or sicker. *Id.*

The service delivery system for DOH's Children's Medical Services (CMS) Program is also an MMA plan. CMS operates the Children's Medical Services Network (CMSN), and has contracted with two Integrated Care Systems (ICS) which are responsible for providing administrative services and the provider network for CMSN: 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 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, and operates in 51 counties in the northern and central portions of the state. 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. SFCCN operates in 16 counties in the southern portion of the state. D.E. 1327-23, ¶ 4; D.E. 1327-24, ¶ 4; D.E. 1327-25, ¶ 4.

CMSN still provides care coordination services through its regional offices and its nursing directors, who interact on a daily basis with the families they serve. As a result, the nursing directors are competent to testify that members are receiving services with reasonable promptness. 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.

C. At the very least, the Court may not award declaratory relief because of the extremely stale record, which does not show an ongoing violation of federal law.

Given the extremely stale record, it would be an abuse of discretion to proceed with any remedy on the record from the trial. *See, e.g., Webb v. Missouri Pacific R. Co.*, 98 F.3d 1067 (8th Cir. 1996) (finding it was an abuse of discretion to issue an injunction five years after the close of the fact record, when there was intervening evidence suggesting that there was no continuing violation).

Webb involved challenges of racial discrimination. Procedurally, it is remarkably similar to the instant case, in that the liability phase was conducted over several years and involved

ninety-five days of live testimony. There were major changes in the facts after the close of trial, in that in the Spring of 1985, the Defendant merged with another railroad. Relying exclusively on evidence before the merger, and nearly three and one half years after the trial record was closed, the court found class-wide discrimination and ruled in favor of the employees. Then, after another year and a half elapsed, the Court issued an injunction.

Webb did not involve a state actor, and, therefore did not involve the type of *Ex parte Young* and Eleventh Amendment issues present here. In a case involving a state actor, with a record as stale as the one in the instant case, the arguments are only stronger against any relief until the Court is able to determine whether there is an ongoing violation of federal law.

III. Plaintiffs have not presented any competent evidence of an ongoing controversy with respect to Count IV, the Outreach claim, and therefore, that claim must be dismissed.

In their Offer of Proof and declaration submissions to the Court, Plaintiffs presented no evidence that there is an ongoing controversy regarding Outreach, which is covered in Count IV of the Second Amended Complaint. No doctor claims that he has patients who are unaware of what services Medicaid provides for children. No doctor claims that he has seen an eligible patient who was unaware of Medicaid. While Dr. St. Petery relies on hearsay statements in a KidCare Coordinating Council report from 2014, regarding a recommendation to "fully fund Florida KidCare outreach to reduce significantly the number of uninsured children in Florida," D.E. 1318-27 p. 4-5, he has presented no non-hearsay evidence that would establish that additional outreach or funding would reduce the number of uninsured children in Florida.[4] This

[4] / Plaintiffs do not establish the admissibility of the KidCare report in Dr. St. Petery's affidavit. Even if it was admissible against a hearsay objection, hearsay statements within the document are not admissible unless Plaintiffs demonstrate that a separate exception to the hearsay rule makes the statements otherwise admissible. *United Technologies Corp. v. Mazer*, 556 F.3d 1260, 1278 (11th Cir. 2009) ("Hearsay within hearsay subject to an

is particularly true in light of the outreach associated with the ACA about the federal Marketplace, which has been implemented by federal CMS. 45 C.F.R. § 155.120.

To the extent that there is a duty of outreach to the uninsured, that duty has been placed by federal CMS with so-called "Navigators." Under the ACA, exchanges have been established either by the state or by HHS. Florida does not operate an exchange, but relies on the federal exchange. 45 C.F.R. § 155.20 defines an exchange, which is responsible for providing Qualified Health Plans (QHPs) available to qualified individuals and/or qualified employers. Basically, individuals may apply for health insurance, including Medicaid, through the federal exchange in Florida. The Navigator Program, established by HHS, is responsible for providing public education activities to raise awareness about the exchange, providing "information and services in a fair, accurate and impartial manner," including providing assistance with submitting eligibility applications, facilitating the selection of a QHP, and making sure that applicants are aware of their function. 45 C.F.R. §155.210(e). To the extent that there exists an obligation to provide health insurance (including Medicaid) information to the uninsured, this is offered through the Navigator Program. 45 C.F.R. § 155.210.

Defendants continue to stress that § 1396a(a)(43)(A) does not address outreach to the uninsured, because it specifically limits the state Medicaid Program's outreach responsibilities to "persons in the State who are under the age of 21 *and who have been determined eligible for medical assistance*." *Id.* (emphasis added). Even if federal CMS imposed a requirement in regulation of outreach to the uninsured (42 C.F.R. § 441.56), that requirement cannot be

---

exception is not admissible."), *citing Joseph v. Kimple*, 343 F.Supp. 2d 1196, 1204 (S.D. Ga. 2004); *Edwards v. National Vision, Inc.*, 946 F.Supp.2d 1153 (N.D. Ala. 2013) ("when a hearsay statement is contained within another level of hearsay, both levels must meet some exception to the hearsay exclusion rule in order to be admissible), *citing U.S. v. Pendas-Martinez*, 845 F.2d 938, 9420943 (11th Cir. 1988). Dr. St. Petery's statements in paragraph 16 of his declaration are likewise inadmissible hearsay.

enforceable if Congress has not created the right in statute (which it has not). As the Supreme Court has stated: *"Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not*." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001) (emphasis added). Because Congress has not created a right of outreach to the uninsured, the state's outreach responsibilities are limited to those who have been determined eligible for medical assistance.

The uninsured individuals who Dr. St. Petery contends would enroll in Medicaid if they had appropriate outreach have not "been determined eligible for medical assistance."[5] Therefore, assuming for argument purposes that the section creates an enforceable right of outreach, that right of outreach does not extend to those individuals who have not been determined eligible for Medicaid. Likewise, in the absence of an ongoing violation of federal law, there is no basis for prospective declaratory relief regarding outreach to the uninsured under § 1396a(a)(43)(A).

IV. Plaintiffs can prove no ongoing violation of either 42 U.S.C. § 1396a(a)(43)(B) or (C), and, therefore, no declaratory relief is warranted on this claim.

Plaintiffs seek a declaration that Defendants have and continue to violate 42 U.S.C. §§ 1396a(a)(43)(B) and (C). D.E. 1332-1, p. 6 ¶ 5. However, declaratory relief is inappropriate where these provisions create no enforceable rights. Even if this Court finds that these statutes create enforceable rights, Plaintiffs have presented no competent evidence of an ongoing violation of § 1396a(a)(43)(B), and therefore no declaratory relief is warranted on this claim.

A. Claims pursuant to §§ 1396a(a)(43)(B) & 1396a(a)(43)(C) are untimely.

Plaintiffs seek a declaratory judgment finding that "that Florida's Medicaid program violates and continues to violate 42 U.S.C. § 1396a(a)(43)(B) and (C), which require that AHCA

[5] / Additionally, Dr. St. Petery has no foundation on which to testify that with more outreach, more parents would enroll their children in Medicaid.

provide or arrange for the provision of EPSDT screening services in all cases where they are requested, and arrange for needed corrective treatment." D.E. 1332-1 p. 6. However, Plaintiffs did not plead a violation of either §§ 1396a(a)(43)(B) and (C) in the operative pleading, the Second Amended Complaint, D.E. 220-2. In fact, the Second Amended Complaint makes no reference to "corrective treatment," let alone a failure to provide it. Plaintiffs also did not allege a single instance of a screening service being requested, but not provided. *Id.* Plaintiffs raised these statutory provisions for the first time in the Joint Pretrial Statement, D.E. 604, and in the Amended Joint Pretrial Statement, D.E. 692, arguing that they were part of Plaintiffs' Count IV, which is labeled as "Denial of Basic Child Healthcare Outreach and Information." See, e.g., D.E. 692 p. 43 n. 17. In each instance, Defendants objected to any consideration of these claims, because they had not been pled. D.E. 604, pp. 4 n. 1 & 44; D.E. 692, pp. 3 n. 3 & 45. While Plaintiffs argued that the "pleadings should be deemed amended to conform with the evidence," D.E. 692 p. 43 n. 17, Defendants have consistently opposed the inclusion of the claims in this case. D.E. 604, pp. 4 n. 1 & 44; D.E. 692, pp. 3 n. 3 & 45. Plaintiffs' requested relief should be denied, because it was not pled. Defendants do not waive their right for this case to be judged within the bounds of the properly pled claims.

B. Sections 1396a(a)(43)(B) and (C) do not create enforceable rights.

Since Plaintiffs did not reference either § 1396a(a)(43)(B) or § 1396a(a)(43)(C) in their Second Amended Complaint, the Court has not previously determined whether these statutes create enforceable rights. Section 1396a(a)(43)(B) requires that the contents of a state plan provide for arranging for the provision of screening services when they are requested. Section 1396a(a)(43)(C) requires that the contents of a state plan provide for arranging for (directly or

through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.

There are no circuit court cases which address the issue of whether these statutes create enforceable rights. While the Supreme Court discussed the general requirements of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and cited 42 U.S.C. § 1396a(a)(43) and 42 U.S.C. § 1396(d)(r), *see Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 434 (2004), the Court did not and has never been called upon to determine whether these statutes create enforceable rights. *Frew* dealt with the issue of whether the Eleventh Amendment bars enforcement of a federal consent decree entered into by state officials.

Neither statute reflects the necessary intent by Congress to create an unambiguously conferred right, which is the standard to be applied based on *Gonzaga Univ. v. Doe*, 436 U.S. 273, 283 (2002). Comparing the language in §§ 1396a(a)(43)(A) and (B) with the type of language that the Supreme Court has previously found to create enforceable rights in Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972 ("No person . . . shall . . . be subject to discrimination"), the language is "two steps removed" from the kinds of rights creating language endorsed by the Court. *Gonzaga Univ. v. Doe*, 436 U.S. 273, 284 (2002). The statutes are merely part of the necessary contents of a Medicaid State Plan.

Further, Congress has established the method by which the provisions of § 1396a may be enforced in § 1396c. The Secretary, after reasonable notice and an opportunity for hearing, may withhold federal funds if the Secretary finds that, "in the administration of the plan there is a failure to *comply substantially* with any such provision," or "the plan has been so changed that it no longer complies with the provisions of section 1396a." *Id.* Congress only intended that states suffer adverse consequences if they were not in substantial compliance with the requirements of

§1396a, and Congress expressly left the determination of such substantial compliance to the Secretary of HHS, and not the courts. The yardstick of "substantial compliance" suggests an aggregate rather than an individual focus. *Gonzaga*, 536 U.S. at 288; and *Blessing v. Freestone*, 520 U.S. 329, 343-44. *Cf. 31 Foster Children v. Bush*, 329 F.3d 1255, 1272 (11th Cir. 2003).

All of these factors lead to the inescapable conclusion that sections 1396a(43)(B) and (C) do not create enforceable rights. And if they do not create enforceable rights, they are not enforceable using this Court's equity power. *Armstrong*, 135 S.Ct. at 1385. Therefore, they cannot provide the basis for declaratory relief in this case.

C. Declaratory relief is not appropriate because there is no ongoing violation of federal law, let alone an ongoing controversy, regarding § 1396a(a)(43)(B).

The gist of Plaintiffs' offer of proof relating to § 1396a(a)(43)(B) appears to be that children don't get screening services because they are "switched," without their knowledge or notice. Plaintiffs' offer of proof contains no competent, non-hearsay evidence that would establish an ongoing controversy regarding this claim.

First, contrary to what Plaintiffs' provider witnesses state, *see e.g.*, D.E. 1318-1, 1318-3, 1318-4, 1318-8,"switching" neither prevents providers from treating a "switched" patient nor from being compensated for the care, because of contractually required continuity of care provisions contained in the MMA contracts. D.E. 1328 p. 15; D.E. 1327-6, ¶ 11. Basically, for the 30-day period after the patient is assigned to a particular plan, previously scheduled visits may occur and the provider will be paid by the new plan at the same rate he or she received just prior to the transition to the new plan. D.E. 1327-2 pp. 4-5. For the next 30 days (or until a plan of treatment is in place), the provider may be reimbursed at the plan's established rate for services but may still provide the services. *Id.*; D.E. 1268-1 p. 8. So the statements that

providers cannot treat the patients and cannot be compensated for care just aren't true. Further, as Plaintiffs' provider witnesses acknowledge, changing a plan assignment to a different HMO can be resolved the following month. D.E. 1318-1 p. 3. Moreover, as of December 2014, plan choices made even up to the last day of the month will be effective on the first day of the following month (or on the day after the last day of the month). D.E. 1327-9 p. 4.

Additionally, Plaintiffs' provider testimony that patients are switched without their knowledge or notice is predicated on hearsay, and must be stricken. See e.g., D.E. 1318-1 ¶10, 1318-3 ¶17, 1318-4 ¶ 12, 1318-5 ¶ 11 (characterizing switching as involuntary), 1318-6 ¶3, 1318-8 ¶10. Likewise, testimony that the parent requested a change in plans (which was not honored) must be stricken as hearsay. D.E. 1318-4 ¶ 12.

In the absence of competent non-hearsay evidence that "switching" actually occurs (i.e., that children are switched without their parent's knowledge or notice), or that a parent's request to change plans has not been honored, let alone that either of these phenomena happen other than in isolated or sporadic circumstances, and in light of the contractual continuity of care provisions which allow providers to treat these children even when plan changes occur, Plaintiffs have presented no evidence of an ongoing controversy regarding switching, and no declaratory judgment may be issued on Plaintiffs' claim, brought under § 1396a(a)(43)(B), that children cannot obtain requested screenings because of switching.

V. Plaintiffs' proof of an ongoing violation cannot be predicated on either inadequate reimbursement claims or claims that access to care is different than what would be available to a commercially insured patient, as these claims are barred under *Armstrong*.

While Plaintiffs' proposed declaratory relief makes no reference to rates or "equal access," it is clear from a review of Plaintiffs' Offer of Proof and supporting declarations filed on

April 8, 2015, regarding whether there remains an ongoing controversy, that they believe that these claims remain relevant. While the Court ruled on a *preliminary basis* on the issue of the impact of *Armstrong v. Exceptional Child Center, Inc.*, 135 S.Ct. 1378 (2015), *see* Transcript of April 24, 2015 hearing, p. 65, lines 10-17, it is essential that, before the Court proceeds to declaratory relief, it determine whether it has jurisdiction to adjudicate claims of inadequate reimbursement rates or a lack of equal access under the Medicaid Act. If these issues are no longer justiciable under *Armstrong*, the evidence in the record must be reevaluated to determine whether it justifies declaratory relief.

Plaintiffs' declarations discuss perceived inadequacy of reimbursement rates and compare access to services in the commercial realm. *See, e.g.*, D.E. 1318-1, 1318-2, etc. Inadequate reimbursement rates are featured prominently in their offer of proof regarding the existence of an ongoing controversy. D.E. 1318, pp. 2, 7, 9-11, 14. Notwithstanding the clear statement that § 1396a(a)(30)(A) does not create enforceable rights, *see Armstrong*, 135 S.Ct. at 1385, Plaintiffs appear to believe that they may simply continue to challenge the adequacy of reimbursement rates under §1396a(a)(8) and (10).[6] But that would require this Court to ignore *Armstrong*, and the difficulties of making the judgment-laden determinations about adequacy of provider rates, which even *Doe 1-13* acknowledged was an onerous task. *Doe v. Chiles*, 136 F.3d at 717.

[6] / Likewise, Plaintiffs continue to claim that the access to care for class members is different than that provided to commercially insured patients, although now they cast their claim as one of timeliness - that their commercially insured patients can obtain care sooner than Medicaid patients. However, in § 1396a(a)(30)(A), access is a product of adequate reimbursement rates, which must also be consistent with efficiency and economy. The determination which must be made regarding whether adequate access to care exists is as judgment laden as the determination of the adequacy of reimbursement rates. And the two are inextricably intertwined. In fact, throughout these proceedings, Plaintiffs have claimed that the cure for access issues is adequate reimbursement rates. If federal CMS has been determined to be better equipped to determine the adequacy of reimbursement rates, surely it also must be better equipped than federal courts to determine whether states are providing adequate access to care when measured against the commercially insured population.

Moreover, relying on these statutes to challenge the adequacy of provider payments would "broaden § 1396a(a)(8) far beyond its intended scope." *Oklahoma Chapter of Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1214-15 (10th Cir. 2007).

As Justice Breyer acknowledged in his concurring opinion in *Armstrong*, § 30(A) "underscores the complexity and nonjudicial nature of the rate setting task." *Armstrong*, 135 S.Ct. at 1388. Justice Breyer further stated:

> To find in the law a basis for courts to engage in such direct rate-setting could set a precedent for allowing other similar actions, potentially resulting in rates set by federal judges (of whom there are several hundred) outside the ordinary channel of federal judicial review of agency decisionmaking. The consequence, I fear, would be increased litigation, inconsistent results, and disorderly administration of highly complex federal programs that demand public consultation, administrative guidance and coherence for their success. I do not believe Congress intended to allow a statute-based injunctive action that poses such risks (and that has the other features I mention).

Id. at 1389.

Any argument that Congress intended to allow Plaintiffs to challenge the adequacy of reimbursement rates via statutes which make absolutely no mention of rates is not just highly suspect but fatally flawed, particularly in the context of a Spending Clause statute, which is much in the nature of a contract between the state and the federal government. "The legitimacy of Congress's exercise of the spending power 'thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2602 (2012) (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)).

Likewise, federal CMS is better suited to determine the benchmarks that should be applied in determining timeliness and how to balance the concerns of "equal access with the general population" against efficiency and economy in determining whether services are timely. Congress has not stated its intention that there exists an enforceable right to timeliness measured

against commercial access standards. Nonetheless, AHCA's time standards are included in its contracts (which must be approved by federal CMS whenever changes are made). D.E. 1265-17 p. 80 & D.E. 1327-6 ¶ 7.

Plaintiffs can make no reasoned argument that any of the remaining statutes afford them an opportunity to challenge the adequacy of reimbursement rates or "access to care similar to that of the commercial population," another vague and undefined standard contained in § 1396a(a)(30)(A). Therefore, these types of claims cannot form the basis for an ongoing violation of federal law, let alone an ongoing controversy, to justify issuance of a declaratory judgment. This is especially so given that Defendants are sued pursuant to *Ex parte Young*, and there are Eleventh Amendment concerns associated with the issuance of unnecessary declaratory relief (i.e., relief that is not directed to ending an ongoing violation of federal law).

VI. Regarding Plaintiffs' requested declaratory relief relating to 42 U.S.C. § 1396a(a)(8), (10), and (43)(C), an evidentiary hearing is required to determine whether an ongoing violation of federal law, let alone an ongoing controversy, exists sufficient to justify the award of declaratory relief.

The Court appears inclined to consider declaratory relief. However, there are disputed issues of material fact which preclude entry of a declaratory judgment without a further hearing. This hearing is necessary to determine whether there is proof of ongoing violation of law, let alone an ongoing controversy, which would justify the entry of declaratory relief. Here the Court is faced with "warring affidavits" and the only way that it may make judgments about witness credibility is with an evidentiary hearing. In fact, a district court cannot decide disputed factual findings or make findings of credibility without an evidentiary hearing. *See, e.g.*, *Bischofff v. Osceola Cnty., Fla.,* 222 F.3d 874, 882 (11th Cir. 2000) (the district court erred by making disputed factual findings and judgments regarding witness credibility that were essential

to its determination of standing); *McDonald's Corp. v. Robertson*, 147 F.3d 1301 (11th Cir. 1998) (an evidentiary hearing should be held where facts are "bitterly contested" and credibility determinations must be made to decide whether injunctive relief should issue); *King v. McCord*, 621 F.2d 205 (5th Cir. 1980) (an evidentiary hearing must be held to facilitate resolution of disputed issues of fact relating to the determination of a reasonable attorney's fee).

VII. Plaintiffs' provider declarations are rife with hearsay and cannot provide competent evidence of an ongoing issue or controversy.

As a general rule, "[h]earsay statements are not permitted because of the concern of their untruthfulness." *Jerome v. Hertz Corp.*, 15 F.Supp.3d 1225 (M.D. Fla. 2014). Plaintiffs' provider witness declarations contain many hearsay statements for which there can be no exception. Alternatively, the declarations do not establish that each witness has the foundation needed to establish the requisite personal knowledge to testify about the matters at issue. In addition to the issues raised previously above in Parts III and IV above, the following are just a sampling of the problems presented by Plaintiffs' provider testimony:

A. Bret Baynham, M.D., testified that children who are on Staywell come to him from outside of Palm Beach County, often from Miami, because they cannot find any orthopedic doctors closer to home who accept Staywell. D.E. 1318-11 ¶ 7. While Dr. Baynham may certainly obtain a patient's address for his records, he has no non-hearsay basis to testify about why patients may come to him for care from another county. Dr. Baynham's testimony does not fall within Federal Rules of Evidence 803(4), because information about why a patient travels to see him from Miami would not be reasonably pertinent to Dr. Baynham providing a medical diagnosis of a particular condition or disease, or treating that condition or disease.

B. Dr. Baynham testified that he treated children who suffered a fracture approximately one week or so ago and they were not able to find an orthopedic doctor who would treat them. While Dr. Baynham could certainly testify that he has treated children who suffered a fracture a week or so ago, as this would be part of the information needed to provide treatment, the reason why the child has not seen earlier would not fall within the exception to hearsay provided in Rule 803(4).

Similar to the situation at trial, Defendants anticipate that there will be multiple hearsay and foundation issues regarding Plaintiffs' provider testimony. Any further findings by the Court (including whether prospective declaratory relief is necessary) should be based on testimony which has the necessary indicia of reliability and trustworthiness as may be found when a witness testifies from an appropriate foundation to matters which do not constitute hearsay.

CONCLUSION

For the reasons described above, no declaratory judgment should issue on the record as it presently exists. The trial record is so stale that it does not show that an ongoing violation of federal law exists as would be necessary to justify a prospective declaratory judgment. There are several legal issues which should be considered before the Court issues a declaratory judgment, such as whether §§ 1396a(a)(43)(B) and (C) create enforceable rights; and whether Plaintiffs' claims of an ongoing controversy may rely on claims of inadequate reimbursements and unequal access as compared to the commercial population. Given the disputes of material fact that are evident from a review of the "warring affidavits" submitted by the parties, should the Court be inclined to proceed forward regarding declaratory relief, an evidentiary hearing must be held to resolve the credibility issues and determine whether an ongoing violation of federal law exists

based on a current record. Further, the Court must determine whether Plaintiffs' claims are now moot.

Respectfully submitted,

PAMELA BONDI
Attorney General

/s/ Stephanie A. Daniel
STEPHANIE A. DANIEL
Chief-Assistant Attorney General
State Programs Litigation
Fla. Bar No. 332305
Stephanie.Daniel@myfloridalegal.com
ALBERT J. BOWDEN, III
Senior Assistant Attorney General
Fla. Bar No. 0802190
Al.Bowden@myfloridalegal.com
CHESTERFIELD SMITH, JR.
Associate Deputy Attorney General
General Civil Litigation
Fla. Bar No. 852820
Chesterfield.Smith@myfloridalegal.com

Office of the Attorney General
PL-01, The Capitol
Tallahassee, Florida 32399-1050
Tel.: (850) 414-3300
Fax: (850) 413-7555

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 May 18, 2015.

/s/ Stephanie A. Daniel
Stephanie A. Daniel