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, et al.,

Defendants.
_____/

DEFENDANTS' MEMORANDUM OF LAW IN RESPONSE TO COURT'S NOVEMBER 26, 2012 ORDER

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MEMORANDUM OF LAW

The Defendants submit the following memorandum of law to explain whether Section 1202 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §1202, 124 Stat. 1029, 1052-1053 (2010) (Section 1202), as implemented by AHCA, moots or otherwise affects any of the issues raised in this case.[1]

Section 1202 moots Plaintiffs' claims of inadequate reimbursement rates for Medicaid primary care services, provided by specialists and subspecialists in pediatric, general internal medicine and family medicine, since those providers will be paid at Medicare rates for their Medicaid services in accordance with Section 1202. Section 1202 does not render moot Plaintiffs' claims of inadequate reimbursement rates for other physician providers or other types of services provided by physicians beyond those covered by Section 1202 (Counts I & II); dental reimbursement claims (Counts I & II); Plaintiffs' switching claims (Count I); and it does not moot Plaintiffs' outreach claims (Count IV of the Complaint). However, all claims of inadequate reimbursement rates for any other physician providers or services must be dismissed, because, as discussed below, Congress has clearly stated its intention that only certain physician provider types be paid at Medicare rates for certain services. Therefore, Plaintiffs' claims, to the extent that they rely on proof of inadequate physician reimbursement rates must be dismissed.

I. SECTION 1202(A)(2) PROVIDES MEDICARE RATES FOR CERTAIN MEDICARE PHYSICIAN PROVIDERS

A. Relevant changes to 42 U.S.C. §1396a, *et seq.*

Section 1202(a) added subsections 42 U.S.C. §§1396a(a)(13)(C) and (jj), and amended 42 U.S.C. § 1396u-2(f).[2] Section (13)(C) requires that each state's Medicaid Plan provide for

[1] /Declarations have been filed with this Memorandum of Law to inform the Court and Plaintiffs regarding AHCA's implementation of Section 1202.

[2] /§1202(a) (2010); hereafter 42 U.S.C. §1396a(a)(13)(C) is referred to as §(13)(C) or Section (13)(C).

payment at a rate not less than 100 percent of the Medicare Part B physician reimbursement rate (hereafter Medicare rate) for primary care services furnished in calendar years 2013 and 2014, by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.[3] The 2009 Medicare rates shall be used instead of the 2013 or 2014 rates, if the 2009 Medicare rates are higher.

Primary care services are defined as: (1) evaluation and management services (E & M services) which are identified using the E & M codes in the Healthcare Common Procedure Coding System (HCPC), and (2) immunization administration services for vaccines and toxoids. 42 U.S.C. §1396a(jj).

Medicaid contracts with managed health plans (MCPs) must provide that payments made by the MCPs to eligible primary care providers for primary care services are consistent with the payment rates required under Section (13)(C), regardless of the payment methodology (capitation or otherwise) used by the MCPs to reimburse their primary care providers. 42 U.S.C. § 1396u-2(f); §1202(a)(2), P.L. 111-152 (2010).

B. CMS' interpretation of Section 1202's primary care rate requirements

Section 1202 was enacted in 2010; however, the final rules implementing Section 1202 were published by the Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) in the Federal Register on November 6, 2012 (hereafter "final rules").[4] 77 Fed. Reg. 66670-01 (Nov. 6, 2012). The final rules did not resolve all questions about implementation of the primary care reimbursement rate increases (and in fact generated some additional questions). Technical errors in the final rules were addressed by a notice issued on December 14, 2012. 77 Fed. Reg. 74381-02 (Dec. 14, 2012). On December 18, 2012, CMS

[3] /The methodology for payments for Medicare physician services (covered under Medicare Part B) is described in 42 U.S.C. §§1395w-4.

[4] /The proposed rules to implement Section 1202 were published on May 11, 2012. 77 Fed. Reg. 27671-02.

issued "Questions and Answers on the Increased Medicaid Payment for Primary Care, CMS 2370-F;" on December 21, 2012, CMS issued "Questions and Answers on the Increased Medicaid Payment for Primary Care, CMS 2370-F Managed Care;" and on January 8, 2013, CMS issued guidelines applicable to required methodologies and rate-setting for managed care as it relates to the enhanced payments. [Dec. of M. McCullough, Ex. A[5]; M. Brown-Woofter, Ex. V; & S. Lampkin, Ex. S].

To determine the 2013-2014 Medicaid rates, one must have the Medicare rates for those periods, and for 2009 as well. The final 2013 Medicare Physician Services Fee rule was not adopted until November 16, 2012. 77 Fed. Reg. 68892-01 (Nov. 16, 2012). The 2013 Medicare physician fee services conversion factor (the dollar figure by which practice cost information is multiplied to derive a reimbursement rate) is now lower than the 2009 rate. As a result, rates calculated using the 2013 conversion factor are lower than they would be using the 2009 rate. Compare 77 Fed. Reg. 68892-01, 69138; and 74 Fed. Reg. 61738-01, 61743 (Nov. 25, 2009). Therefore, the 2009 Medicare conversion factor will be used to determine 2013 Medicaid reimbursement rates. 42 C.F.R. §447.405 (b)(2) (2013).

CMS acknowledged that states did not have the final 2013 Medicare RVUs [relative value units] or the final regulatory requirements for the enhanced primary care payments until late in 2012. 77 Fed. Reg 66670-01, 66679-66680. This left a very short time to implement Section 1202. Therefore, CMS has given states until March 31, 2013 to submit a state plan amendment regarding the primary care increases, which is required by rule. 77 Fed. Reg 66670-01, 66680; 42 C.F.R. §447.410 (2013).

[5] /Rather than filing separate exhibits with each declaration, Defendants have also separately filed the exhibits referenced in all of the declarations (and have used uniform identifiers for those exhibits across all documents).

Significantly, the final rules interpret the enhanced payments required by 42 U.S.C. §1396a(a)(13)(C), to extend to services provided by a broad range of physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine; or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA).[6, 7] 42 C.F.R. § 447.400(a) (2013). A physician is identified as being eligible for the enhanced payments by self-attesting that he or she: (1) is Board certified in a requisite specialty or subspecialty; and/or (2) has furnished E & M services and eligible vaccine administration services that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month. 42 C.F.R. § 447.400(a) (2013); 77 Fed. Reg. 66670-01, 66700.

The E & M services that are "primary care services" under 42 U.S.C. §1396a(jj), are those services which are assigned current procedural technology (CPT) codes in the range of 99201-99499.[8] 42 C.F.R. § 447.400(c)(1) (2013); 77 Fed. Reg. 66670-01, 66700. These E & M services include, but are not limited to, all of the CPT codes included in Dr. Samuel Flint's Medicare-Medicaid rate analyses. PEX 495, pp. 15, 17 & Attachments A1, A2 and A3.

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[6]/The prior Notice of Proposed Rulemaking extended the enhanced rate to subspecialists certified by the American Board of Medical Specialties only. 77 Fed. Reg. 27671-02, 27690, proposed rule 42 C.F.R. §447.400(a).

[7] /The subspecialists eligible for the enhanced rate are Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Hematology; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Transplant Hepatology; Allergy/Immunology; Cardiology; Hematology/Oncology; Oncology; Adolescent and Young Adult Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Neonatology; and Pediatric Allergy/immunology. Dec. of M. McCullough, Exhibit A, numbered pages 2-3.

[8] /CMS recognizes that states may not provide coverage for all services within this CPT range. In fact, states are to report to CMS as part of their required State Plan Amendment (SPA) the CPT codes that will be covered. 42 C.F.R. §447.410(a).

Primary care services also include vaccine administration services. Shortly after Section 1202 became law, there was a change in the CPT codes for vaccinations. Where §(13)(C) makes reference to eight (8) CPT vaccine administration codes, CPT codes 90465, 90466, 90467, 90468 referenced in the statute have been replaced by two codes: 90460 and 90461. 77 Fed. Reg. 27671-02, 27678. Therefore, by rule, CMS has defined primary care services to include: "Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes." 42 C.F.R. § 447.400(c)(2) (2013).

The final rule also updates "regional maximum fees" in the Vaccines for Children (VFC) Program,[9] and clarifies what may be paid to VFC providers for immunization administration. 77 Fed. Reg. 66670-01, 66672, 66685-66686. VFC providers are to be paid at the lesser of the applicable Medicare rates or the maximum regional VFC amount (established by CMS). 42 C.F.R. §447.405(b) (2013).[10] The maximum regional fee for Florida is now $24.01. 77 Fed. Reg. 66670-01, 66690. By rule, VFC providers are limited to billing for the cost of administration for the initial vaccine component, and may not bill separately for multiple vaccine components combined in a single immunization. 42 C.F.R. §447.405(b)(2) (2013). This is based on CMS' construction of 42 U.S.C. §1396s(c)(2)(C)(ii) as providing for payment for a qualified pediatric vaccine, and not the individual components of the vaccine. 77 Fed. Reg. 66670-01, 66686. Since "all Medicaid enrollees under age 19 qualify for VFC," providers administering immunizations to these children may claim only the cost of administering the initial vaccine component. 77 Fed. Reg. 66670-01, 66686.[11]

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[9] /In the VFC program, participating providers receive immunization serum free of charge, to use in providing immunizations to eligible children, including Medicaid enrollees under the age of 19.

[10] /The lesser of methodology is required "because the VFC statute prohibits payment above the regional maximum ceiling and because it is consistent with Medicare policy which limits the provider payment to the lesser of the fee schedule amount or provider charges." 77 Fed. Reg. 66670-01, 66685-66686; 42 U.S.C. §1396s(c)(2)(C)(ii).

[11] /This Court may recall that Dr. Tommy Schechtman, a VFC provider, testified at trial that he wished to be paid for additional vaccines for Medicaid children (if there were multiple vaccines combined in a single immunization), as

Only providers who are not VFC providers or who are not administering immunizations to VFC eligible children may bill the cost of subsequent components, using 90461, if the immunization contains multiple components. 77 Fed. Reg. 66670-01, 66685.

Regarding managed care plans, the final rules require the state to secure approval from CMS of two methodologies: (1) the methodology used to determine the amount paid in the managed care entities' capitation rate for primary care services, as of July 1, 2009; and (2) the methodology used to determine the difference between the primary care payments to managed care entities as of July 1, 2009, and the amount needed to comply with the requirement that the plans pay their eligible providers at the enhanced rate for primary care services in 2013 and 2014. 42 C.F.R. §438.804(a)(1) (2013).

After approval of the methodologies by CMS, the states must submit new contract language and certified rates to CMS for approval. 42 C.F.R. §438.6(c)(5)(vi) provides that the contracts must require the managed care plans to: (1) make payments for primary care services to eligible physicians that are at least equal to the applicable Medicare rate; and (2) provide documentation to the state, sufficient to enable the state and CMS to ensure that provider payments actually increase as required. 42 C.F.R. §438.6(c)(5)(vi). CMS will use the approved methodologies described above in the review and approval of the managed care plan contracts. 42 C.F.R. §438.804(a)(3) (2013).

Because of the short implementation time available after issuance of the final rules, CMS extended the deadline for submission of the required methodologies to March 31, 2013. 42 C.F.R. §438.804. Since CMS will use the approved methodologies in the review and approval of

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was the case when he provided immunizations to privately insured patients. Testimony of Dr. Schechtman, pg. 57-58. However, the federal rules (and CMS' interpretation of the statutes it implements) preclude such relief.

managed care contracts and rates, it follows that approval of the contracts and rates will occur sometime after March 31, 2013, or after the methodologies are approved.

II. AHCA'S IMPLEMENTATION OF SECTION 1202

Florida has taken various necessary steps to implement Section 1202. Where it has not completed the implementation steps, it is waiting on information or approvals from CMS. The primary care rate increases (or enhanced payments) will be effective January 1, 2013, when they are fully implemented - both in fee-for-service and managed care. Where necessary, supplemental or retroactive payments will be made to reimburse the fee-for-service providers or MCPs to bring reimbursement rates to the enhanced payment level.

A. Submission of the State Plan Amendment

As noted above, a State Plan Amendment (SPA) was required to implement the enhanced payments for primary care providers. Shortly after adopting the final rule described herein, on November 7, 2012, CMS shared with states a copy of a Medicaid State Plan "pre-print", entitled State Plan Amendment Reimbursement Template for Physician Services for the Increased Primary Care Services (SPA template), to be used to amend each State's Medicaid plan regarding the primary care payment increase. [Dec. of M. McCullough, Ex. B].

On January 2, 2012, via email, AHCA submitted a SPA to implement primary care rate increases.[12] [Dec. of A. Cook and M. McCullough]. CMS has until April 2, 2013 to approve the SPA submitted by AHCA. 42 C.F.R. §447.256(b). Once approved, the SPA will be effective on January 1, 2013. 42 C.F.R. §447.256(c).

In the SPA, AHCA has chosen to reimburse primary care services using all Medicare geographic/locality adjustments, and to reimburse services at the Medicare rate applicable to the

[12] / AHCA was directed by CMS not to submit the SPA before January 2, 2013, even though AHCA was prepared to do so prior to that date.

office setting (non-facility setting), where there are different rates. For some services, there is only a facility based rate. [Dec. of M. McCullough, Ex. C; and e.g., DEX 595]. The SPA provides that the stated reimbursement methodology will apply to services delivered on and after January 1, 2013, and ending on December 31, 2014. [Dec. of M. McCullough, Ex. C].

Once approved, deference should be accorded CMS' approval of Florida's SPA. *See e.g., Douglas v. Independent Living Center of So. Cal., Inc.*, ___ U.S. ___, 132 S.Ct. 1204, 1211 (2012); and *Managed Pharmacy Care v. Sebelius*, No. 12-55067, ___ F.3d ___, 2012 WL 6204214 (Dec. 13, 2012).[13] There is no reason to suppose that the SPA will not ultimately be approved, as it contains the information required by CMS. [Dec. of M. McCullough].

B. Attestation Requirements

As to the attestation requirements explained above, on December 19, 2012, CMS advised AHCA, for the first time, that it would require a separate formal attestation from each eligible physician, and that CMS wanted to work with AHCA on the "form of the attestation." On January 14, 2013, AHCA submitted its proposed attestation to CMS for review and approval.[14] [Dec. of M. McCullough, Ex. J]. Significant programming will be required to implement this separate formal attestation requirement.[15] The fiscal agent has commenced that programming, which is expected to be completed by February 28, 2013. [Dec. of David Powers]. The required programming would have been done sooner, if CMS had indicated sooner that it would require a

[13] /Florida's existing Medicaid State Plan (MSP) has been approved by federal CMS. See PEX 712. Deference should be given to CMS' prior decisions in approving the provisions of the MSP relating to reimbursements contained in Section 4-19-B, starting at pg. FL-Med 8934. Further, it is CMS that Congress has tasked with policing whether MSPs are in compliance with federal law. 42 U.S.C. §1396c.

[14] /Florida did not submit its proposed attestation until January 14, because it was waiting on an approved attestation form which CMS indicated it would provide, but never did. [Dec. of M. McCullough].

[15] /AHCA had planned for a different self-attestation process, which would not require the same extensive programming. [Dec. of M. McCullough]. However, in light of the direction by CMS, AHCA is pursuing the programming necessary to implement the formal attestation requirement through its Provider Web Portal.

formal attestation, rather than some other process (such as through claims submission) by which providers would self-attest to their specialty.

CMS staff has advised AHCA that it may not begin paying the enhanced payment rate for primary care services to eligible physicians until the formal attestations have been completed by eligible physicians, and until the SPA is approved; however, AHCA will make the retroactive payments to providers necessary to ensure they receive the enhanced payment rate for services provided on and after January 1, 2013, but before the completion of the formal attestation (so long as the physician was eligible for such payments prior to completion of the formal attestation) and approval of the SPA. [Dec. M. McCullough].

C. The Fee Schedule

Some of the Medicaid primary care rates are determined using the Medicare rates, others are calculated by CMS. On December 27, 2012, CMS staff advised AHCA staff that CMS would be providing a tool to be used by the states to calculate the enhanced payments for primary care services. The tool was provided to AHCA on January 7, 2013; however, because of difficulties (that have been acknowledged by CMS) with the tool, on January 14, AHCA staff asked CMS to provide Florida with a fee schedule. When received, AHCA will issue a new fee schedule for primary care services, provide notice to providers of those rates, and load the new rates into the fiscal agent's claims processing system, so that, once the attestations are completed and the SPA is approved, providers may be paid at the new rates. [Dec. of M. McCullough and D. Powers].

D. Managed Care Implementation

AHCA had been working with its actuaries to develop the methodologies required by rule for MCPs. On January 8, 2013, AHCA received from CMS a document titled Medicaid Managed

Care Payment for PCP Services in 2013 and 2014 Technical Guidance and Rate Setting Practices (Technical Guidance). [Dec. of S. Lampkin, Ex. S]. It provides guidelines for preparation of the methodologies required by 42 C.F.R. §438.804, and also describes approved payment models, which may be used in structuring the payments needed to implement Section 1202 for MCPs. The Technical Guidance provided, for the first time, the option for a non-risk retrospective payment (hereafter "Model 3"), an option not previously considered by AHCA. *Id.*, Ex. S, pg. 3. After consideration, AHCA has determined that it will seek approval from CMS to use Model 3 to pay MCPs so they may, in turn, pay their providers the enhanced primary care rates. AHCA plans on making the retrospective payments on a quarterly basis. [Dec. of S. Lampkin].

The methodology used to determine the difference between the 2009 capitation payment amount for primary care services and the 2013 payments to MCPs for primary care services required consideration of the model of payment to be used in 2013. Having determined on January 16, 2013, that it will use the Model 3, AHCA is now revising its methodologies accordingly. It expects to submit the required methodologies to federal CMS in advance of the due date of March 31, 2013. [Dec. of S. Lampkin, see also Ex. S, pp. 10-12].

On December 6, 2012, AHCA advised the MCPs of the following amendment that will be made to the managed care contracts:

> Effective January 1, 2013, Attachment II, Core Contract Provisions, Section V, Covered Services, Item H, Coverage Provisions is hereby amended to include sub-item 23, as follows:
>
> 23. Primary Care Services
>
> The Health Plan shall process claims for and, if capitated or are approved by the Agency to subcapitate for certain covered services, pay certain physicians who provide Florida Medicaid-covered eligible primary care services in accordance with the Affordable Care Act and 42 CFR sections 438 and 447, for the period January 1, 2013, through December 31, 2014. Health Plans that are approved by

> the Agency to subcapitate for services shall also pay in accordance with such requirements.

AHCA also advised the MCPs of the enhanced payment requirement, and is currently drafting and routing to the MCPs a Policy Transmittal that gives additional detail on the implementation of the enhanced payment requirement. [Dec. of M. Brown-Woofter].

CMS' approval of the methodologies and contract language is required before AHCA may implement Model 3. However, the effective date for the new rates will be January 1, 2013, and AHCA will make whatever payments are required as soon as the necessary approvals by CMS are in place. [Dec. of M. Brown-Woofter, Ex. A, and S. Lampkin].

By submitting the SPA relating to enhanced payments for primary care services, AHCA has committed itself to a change in policy regarding reimbursement rates for primary care services provided by eligible physicians as required by Section 1202. AHCA is taking all necessary steps to implement those enhanced payments as quickly as possible. It has directed its fiscal agent to implement the programming necessary to comply with the CMS' requirements for payment of the rates. It has sent communications to its providers about its progress in implementation. [Dec. of D. Powers, Ex. L, M, T & U]. It has met with its MCPs about implementation of the enhanced rates. [Dec. of M. Brown-Woofter]. No order of the Court at this point could alter the speed of this process as it requires coordination with and approval by CMS, which is charged with approving SPAs, contracts, the requisite methodologies and rates.

III. PLAINTIFFS' PHYSICIAN REIMBURSEMENT CLAIMS ARE MOOT.

Counts I and II of the Second Amended Complaint (Complaint) are mooted by the above change in policy, to the extent that Plaintiffs sue for increased primary care reimbursement rates provided by specialists or subspecialists in the area of pediatrics, family medicine or general internal medicine. Count I is a claim that Medicaid enrolled children are not furnished with

covered medical assistance with reasonable promptness. Plaintiffs claim that one reason that Medicaid enrolled children do not receive covered services in a timely manner is inadequate reimbursement rates, leading to inadequate numbers of physicians and dentists willing to serve children (see e.g., ¶¶ 53, 70, 72, and 74-76).[16] Count II, the equal access claim brought pursuant to §(30)(A), asserts that AHCA does not pay physicians and dentists high enough reimbursements to ensure that all Medicaid enrolled children have "equal" access to care. [See e.g., D.E. 220-1, ¶96]. At trial, with the exception of switching proof, Plaintiffs tried to prove that the cause of delays, failure to provide care or unequal access to care was inadequate provider reimbursement rates. *See Record.*

The Count I and II reimbursement claims of FPS provider members are now moot, to the extent that FPS has standing to bring these claims. Those provider members, to the extent that they are either board certified in pediatrics (or a subspecialty of pediatrics) or otherwise demonstrate that 60% of their billings are for primary care services, will receive the enhanced payments for primary care services after they complete the required attestation. Likewise the plaintiff class claims (and the named Plaintiff claims) are moot to the extent that they rest on claims that pediatric, family medicine or general internal medicine physicians or subspecialists are paid inadequate reimbursements, and therefore will not care for Medicaid enrolled children.[17]

"A case becomes moot—and therefore no longer a 'case' or 'controversy' for purposes of Article III—'when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome.'" *Already, LLC v. Nike, Inc.*, 11-982, ___ S.Ct. ___, 2013 WL 85300 (Jan. 9, 2013), citing *Murphy v. Hunt*, 455 U.S. 478, 481 (1982) (per curiam) (some

[16] /Plaintiffs otherwise claimed that "switching" resulted in delays or lack of access to care.
[17] /Plaintiffs may argue that eligible physicians' claims are not moot, because higher rates may be needed to ensure access. However, Plaintiffs failed to present scientifically reliable proof that more than Medicare rates would be required to ensure "equal access" or reasonably prompt services. See Record.

internal quotation marks omitted). As is the case here, mootness may affect some claims, while other live claims remain supplying the constitutional requirement of a case or controversy. *Powell v. McCormack*, 395 U.S. 486, 497 (1969), meaning that this Court has a live case or controversy only with respect to the non-moot claims. Dismissal is warranted on mooted issues, even if the entire case is not moot. *See e.g., BankWest, Inc. v. Baker*, 446 F.3d 1358, 1368 (11th Cir. 2006) (addressing what to do when an issue becomes moot on appeal).

A defendant cannot automatically moot a case by ending unlawful conduct (presuming that AHCA's prior reimbursement rates were unlawful). *Id.* However, there is an exception to this general principle "when there is no reasonable expectation that the voluntarily ceased activity will, in fact, actually recur after the termination of the suit." *Troiano v. Supervisor of Elections in Palm Beach County, Fla.*, 382 F.3d 1276, 1283 (11th Cir. 2004). "Moreover, when the defendant is a government actor [as is the case here], there is a rebuttable presumption that the objectionable behavior will not recur." *Id.* In fact, "when government laws or policies have been challenged, the Supreme Court has held almost uniformly that cessation of the challenged behavior moots the suit." *Id.*

While cessation that occurs late in the case may make a court skeptical that voluntary changes have been made, the Eleventh Circuit has stated that "we look for a well-reasoned justification for the cessation as evidence that the ceasing party intends to hold steady in its revised (and presumably unobjectionable) course." *Harrell v. The Florida Bar*, 608 F.3d 1241, 1266 (11th Cir. 2010). Here, Defendant AHCA has long contested whether the provisions of the 42 U.S.C. §1396a relied upon by Plaintiffs, and specifically §(30)(A), created an enforceable right to higher reimbursement rates (or dictated that AHCA raise Medicaid reimbursement rates). Regardless, Congress has changed the law, for the period of 2013-2014, so that eligible

physicians are entitled to enhanced payments for defined primary care services. With that change in the law, AHCA has timely changed its policy and is set on a course to fully comply with 42 U.S.C. §1396a(a)(13)(C).

Plaintiff may argue that because AHCA is only committed to modify its rates for the two year period of 2013-2014, it has not demonstrated that it will hold steady in its revised course. AHCA must report to CMS, in an as yet to be provided format, provider participation 42 C.F.R. §447.400(d). The purpose of this reporting is to provide data that CMS may use to report to Congress, to help it determine whether these rate increases should be extended beyond 2014. 77 F.R. 66670-01, 66673. If Congress chooses to extend the mandatory rate increase beyond December 31, 2014, AHCA will certainly comply with such a mandate, just as it complied with Section 13(C).

Even, if Congress does not extend the expiration of the rate increase, what will happen on January 1, 2015 is too remote to justify this Court's exercise of jurisdiction. "The remote possibility that an event might recur is not enough to overcome mootness, and even a likely recurrence is insufficient if there would be ample opportunity for review at that time." *Al Najjar v. Ashcroft*, 273 F.3d 1330, 1336 (11th Cir. 2001). Should AHCA determine that it will not continue to pay at Medicare rates on and after January 1, 2015, there is adequate opportunity for review of that decision at that time. Further, that change will require an amendment to Florida's Medicaid State Plan.

In determining whether this action is moot, this Court must consider whether it may provide Plaintiffs with effective judicial relief relating to reimbursement rates. This is central to the mootness determination. *In re Club Associates*, 956 F.2d 1065, 1069 (11th Cir. 1992). Because of the change in Florida's Medicaid State Plan as it relates to reimbursement rates for

primary care services, this Court could not provide the Plaintiffs with any effective relief pertaining to the adequacy of those rates. Throughout trial, Plaintiffs argued over and over that they should received Medicare rates for their services. This was their stated desired relief. Therefore, this issue is moot. *Atlanta Gas Light Co. v. FERC*, 140 F.3d 1392, 1402 (11th Cir. 1998). AHCA's change in its reimbursement policy (in response to §(13)(C)) renders the evidence presented to this Court regarding adequacy of reimbursement rates stale, precluding entry of injunctive relief. *See e.g., Webb v. Missouri Pacific Railroad Co.*, 98 F.3d 1067 (8th Cir. 1996). Moreover, if this Court were to render an injunction on a policy no longer in force, it would be engaging in a mere academic exercise, which it cannot do. *Jews for Jesus, Inc. v. Hillsborough County Aviation Auth.*, 162 F.3d 627, 629 (11th Cir. 1998).

Given all of these factors, Plaintiffs' reimbursement claims for eligible providers are moot.

IV. CONGRESS' DECISION TO IMPLEMENT RATE INCREASES FOR SOME PHYSICIANS, BUT NOT OTHERS, IN SECTION 1202, DEMONSTRATES ITS INTENT THAT MEDICARE REIMBURSEMENT RATES BE PAID ONLY TO THE PHYSICIANS SPECIFICALLY LISTED, AND ONLY FOR ELIGIBLE SERVICES.

Although Plaintiffs claim that other physician provider types are inadequately reimbursed (K.K. & N.G. - otolaryngology, J.W. - CT Scan, L.C. - psychiatry, J.S. - orthopedic care), neither Congress nor CMS has required that these other physician providers receive enhanced payments, and particularly payments at the Medicare rate (or any other higher payment rate).

Section 13(C) clearly states Congress' intent that **only** those providers with a specialty of pediatric, family or general internal medicine be eligible to be paid for primary care services at Medicare rates. Further, this statute evidences Congress' intent that Medicare rates be the metric used to set those reimbursement rates, and not something else (such as private insurance rates).

Congress has not reflected an intention to require that Medicare rates be paid for other physician providers or for other types of services.

A Court should look beyond the plain language of the statute to ascertain intent only where: (1) the statute is ambiguous; (2) applying the statute would lead to an absurd result; or (3) there is clear evidence of contrary legislative intent. *Iberiabank v. Beneva 41-I, LLC*, 701 F.3d 916, 924 (11th Cir. 2012) (citing *United States v. DBB, Inc.*, 180 F.3d 1277, 1281 (11th Cir.1999)). But where applying a statute's plain meaning would lead to "an unreasonable [result] plainly at variance with the policy of the legislation as a whole," the Eleventh Circuit has stated that it will follow the purpose of the statute, rather than its plain meaning. *Edwards v. Kia Motors of America, Inc.*, 486 F.3d 1229, 1233 (11th Cir. 2007) (quoting *United States v. Second Nat'l Bank*, 502 F.2d 535, 541 (5th Cir.1974)).

Here Section 13(C) is not ambiguous. Moreover, construing the statute to require Medicare rates to be used as the metric for Medicaid reimbursements for only certain primary care services provided by a subset of eligible physicians does not lead to an absurd or unreasonable result. By funding only certain primary care services at a higher rate and not all specialty care services, Congress is obviously focusing on less costly services, with the intent that increased use of those primary care and preventive services minimize the need for specialty services. Further, by not including all primary care services within §(13)(C), Congress is obviously focusing on those services for which it has provider availability concerns. Additionally, for the same reasons, this interpretation is not plainly at variance with the policy of 42 U.S.C. §1396a as a whole. Finally, there is no clear evidence of an intent that physician providers be paid at any higher reimbursement rate than is currently being paid.

Section (30)(A) does not override the express legislative intent in §(13)(C), because it is general and overbroad and does not establish an intent that providers be paid at a particular level. Section (30)(A) does not define what a "sufficient" payment is, or provide standards to be used by states to determine sufficiency. *See e.g., Managed Pharmacy Care v. Sebelius*, ___ F.3d ___, 12 Cal. Daily Op. Serv. 13600 (9th Cir. 2012) ("The statute uses words like 'consistent,' 'sufficient,' 'efficiency,' and 'economy,' without describing any specific steps a State must take in order to meet those standards. The statute's amorphous language 'suggest[s] that [CMS's] expertise is relevant in determining its application.'") (citing *Douglas v. Independent Living Center of So. Cal., Inc.*, __ U.S. ___, 132 S.Ct. 1204, 1210 (2012) (*Douglas*)).

To the extent that §(30)(A) does conflict with §(13)(C), then the more specific statute and the statute passed later in time should be deemed to control as it relates to legislative intent. *Weber v. Finker*, 554 F.3d 1379, 1383 (11th Cir. 2009); *International Union Limited Automobile, Aerospace & Agricultural Implement Workers of America, Local 737 v. Auto Glass Employees Federal Credit Union (IULAAAIW)*, 72 F.3d 1243, 1248 (6th Cir. 1996); *Allen v. Card*, 799 F.Supp. 158, 161 (D.D.C. 1992). Plaintiffs have argued that §(30)(A) requires that all providers of services to pediatric Medicaid patients be paid at Medicare rates (or more than Medicare rates). If Plaintiffs' construction of §(30)(A) is correct (and Defendants contend that it is not for reasons previously asserted), then it conflicts with §(13)(C). In that circumstance, §(13)(C) passed later in time and more specific, in comparison to §(30)(A), "prevails as the most recent expression of the legislature's will." *IULAAAIW*, 72 F.3d 1243, 1248.

Finally, the canon *expressio unius exclusio alterius* ("that the mention of one thing implies the exclusion of another"), *United States v. Castro*, 837 F.2d 441, 442 (11th Cir. 1988), supports the plain meaning of the statute -- that only specified services and eligible providers

shall be reimbursed at the Medicare rate. Congress has provided a list of physician specialty types which are eligible for the enhanced payment. Section (13)(C) reflects Congress' intent to reimburse only those enumerated physician providers at that higher rate.

The Supreme Court has held that the canon *expressio unius est exclusio alterius* does not apply "to every statutory listing or grouping; it has force only when the items expressed are members of an 'associated group or series,' justifying the inference that items not mentioned were excluded by deliberate choice, not inadvertence." *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003). *See also United States v. Castro,* 837 F.2d 441, 442-43 (11th Cir. 1988) (The canon "has its limits and exceptions and cannot apply when the legislative history and context are contrary to such a reading of the statute); and 2A Sutherland Statutory Construction, sec. 47.23, at 194 (Sands 4th ed. 1984 rev.). Here, however, the included and excluded physicians are "members of an associated group" -- Medicaid physician providers. Congress' exclusion of some physicians from the enhanced rate requirements suggests exclusion by deliberate choice, not mere inadvertence. Moreover, there is no legislative history or context to suggest a different intent. Congress could have easily extended the enhanced payments to all Medicaid physicians, or it could have required that a reimbursement rate be paid for physicians that was higher or different than the Medicare rate. It could have required that the enhanced rate be paid for a longer period than calendar years 2013 and 2014. It chose not to do so.

CONCLUSION

For the foregoing reasons, Plaintiffs' claims brought under Counts I and II of the Second Amended Complaint must be dismissed, to the extent that Plaintiffs contend that any lack of access to covered services or timely covered services is because of inadequate reimbursement rates for physicians.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been served by Notice of Electronic Filing on **Stuart H. Singer, Esq., Carl E. Goldfarb, Esq., Damien J. Marshall, Esq.**, and **Sashi Bach Boruchow, Esq.**, Boies, Schiller & Flexner LLP, 401 East Las Olas Blvd.,

Suite 1200, Fort Lauderdale, FL 33301, and by United States Mail on **Thomas K. Gilhool, Esq.** and **James Eiseman, Jr., Esq.**, Public Interest Law Center of Philadelphia, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103; **Louis W. Bullock, Esq.**, Bullock, Bullock, & Blakemore, 110 W. 7th Street, Tulsa, Oklahoma 74112, and Robert D.W. Landon, III, Esquire, Kenny Nachwalter, P.A., 201 South Biscayne Boulevard, 1100 Miami Center, Miami, Florida 33131-4327, on January 21, 2013.

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