UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

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

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

Plaintiffs,

v.

ELIZABETH DUDEK, in her official capacity as the Secretary for the STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION, et al.,

Defendants.
_____/

SETTLEMENT AGREEMENT

The Individual Plaintiffs,[1] as representatives of the certified class, and the Organizational Plaintiffs,[2] (collectively, the "Plaintiffs") and Defendants, ELIZABETH DUDEK, in her official capacity as the Secretary for the State of Florida, Agency for Health Care Administration, ("AHCA"), MIKE CARROLL, in his official capacity as the Secretary for the State of Florida, Department of Children & Family Services ("DCF"), and CELESTE PHILIP, M.D., in her official capacity as the Interim Surgeon General of the State of Florida, Department of Health ("DOH," and collectively, the "Defendants"), have reached an agreement to settle all of the

[1] The individual named plaintiffs are A.D., as the next friend of K.K.; R.G. and L.G. as the next friends of N.G.; E.W., as the next friend of J.W.; K.V., as the next friend of N.V.; S.B., as the next friend of S.M.; K.S., as the next friend of J.S.; and S.C., as the next friend of L.C.

[2] The organizational plaintiffs are the Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics and Florida Academy of Pediatric Dentistry, Inc.

claims pending against the Defendants. The Plaintiffs and the Defendants (collectively, the "Parties") hereby enter into this Settlement Agreement ("Agreement"), following which Plaintiffs will promptly file a motion for approval of the Agreement pursuant to Fed. R. Civ. P. 23(e), which approval is a condition precedent to the Agreement's effectiveness. Upon approval of the Agreement by the Court, all further proceedings in this case will be stayed or abated until no later than September 30, 2022, as set forth below.

I. Definitions

1. "Actuarially Sound Capitation Rates" is defined by the federal Centers for Medicare and Medicaid Services ("Federal CMS") in 42 C.F.R. § 438.6(c)(1)(i) to mean capitation rates that "(A) Have been developed in accordance with generally accepted actuarial principles and practices; (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and (C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board." Generally speaking, Medicaid capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. The Parties agree that actuarial standards for prospective rate setting must take into consideration any material change to MMA Plan contract deliverables that has a material impact on the cost of contract performance. A change in plan network adequacy standards may result in a material impact in the cost of contract performance. *See* Actuarial Standards Board, A.S.O.P. No. 49, March 2015 (pgs. 2, 6 & 7).

2. "AHCA" refers to the State of Florida, Agency for Health Care Administration. However, Defendant, Elizabeth Dudek, is interchangeably referred to herein as "Defendant Dudek" or "AHCA." References to Defendant Dudek, and any obligations of Defendant Dudek under this Agreement, are understood to apply to any successors as Secretary of AHCA in their official capacity.

3. "Assistance in Applying for Medicaid" is defined to mean the assistance available through the ESS call center in applying for Medicaid and in obtaining a redetermination of Medicaid eligibility, as well as assistance made available through ESS centers, on-line or through ESS's community partner network.

4. "Board Certified Pediatricians" is defined to mean primary care physicians that have obtained and continue to maintain board certification in pediatrics and that provide services to Medicaid enrolled children under the age of 21, to the extent services are actually provided to Medicaid enrolled children under the age of 21.

5. "CMS-416 Report" is defined to mean the annual report generated by AHCA in accordance with 42 U.S.C. § 1396a(43)(A) via the Form CMS-416. Measures contained in the CMS-416 Report are reported on a federal fiscal year (October 1 through September 30) basis.

6. "CMSN Managed Care Plan" is defined to mean the Children's Medical Services Network Managed Care Plan, which is expressly excluded from the term "MMA Plan" as that term is used herein.

7. "Contract Year" is defined to mean the year beginning October 1 and ending September 30.

8. "DCF" refers to the State of Florida, Department of Children and Families. However, Defendant, Mike Carroll, is interchangeably referred to herein as "Defendant Carroll"

or "DCF." References to Defendant Carroll, and any obligations of Defendant Carroll under this Agreement, are understood to apply to any successors as Secretary of DCF in their official capacity.

9. "Dental Provider" is defined to mean a dental service provider who provides dental services to children under the age of 21 enrolled in Florida's Medicaid program, to the extent services are actually provided to children under the age of 21 enrolled in Florida's Medicaid program.

10. "DOH" refers to the State of Florida, Department of Health. However, Defendant, Celeste Philip, M.D., is interchangeably referred to herein as "Defendant Philip" or "DOH." References to Defendant Philip, and any obligations of Defendant Philip under this Agreement, are understood to apply to any successors as Florida Surgeon General in their official capacity.

11. "ESS" is defined to mean the DCF Economic Self-Sufficiency (ESS) Program, also known as ACCESS. ESS is a sub-unit of DCF and, accordingly, obligations of ESS outlined in this Agreement are responsibilities of DCF and Carroll coextensively.

12. As used herein, the term "exemplars" refers to the specific information about Medicaid eligibility process problems and deficiencies which Plaintiffs have identified and will bring to the responsible Defendant's attention 30 days prior to the regularly scheduled meetings provided for below. Wherever possible, exemplars shall provide Medicaid enrollee specific information including the Medicaid identification number, full name, date of birth, and social security number for the child at issue (hereafter, all of this identifying information is referred to as "demographic information"), the date of the issue or problem, and a description of the nature of the issue or problem.

13. "HEDIS Measure" is defined to mean a standardized measure that forms a part of the Healthcare Effectiveness Data and Information Set ("HEDIS"), which is developed and tracked by the National Committee for Quality Assurance ("NCQA"). HEDIS Measures are tracked on a calendar year basis.

14. "Implementation Date" is defined to mean October 1, 2016.

15. "Medicare Fee-for-Service Rate" or "Medicare FFS Rate" is defined to mean (1) the rate of payment for a particular service specified on the fee schedule used by Medicare to pay doctors or other providers on a fee-for-service ("FFS") basis or (2) the calculated fee-for-service rate for services not covered by Medicare, such as well-child check-ups. The Medicare FFS Rate shall be that applicable for a given year to a particular geographical area within the State where the services are being provided, and should be adjusted by sequestration requirements or other legal requirements. The term permits the use of alternative payment methods, including but not limited to, innovative payment arrangements such as bundled payments or sub-capitation payments, if determined by AHCA to be comparable to the Medicare FFS rate in an aggregate amount.

16. "Medicaid Eligibility Process" is defined to include the application used to apply for Medicaid (whether paper or web-based), the ESS assistance in applying for Medicaid or seeking a redetermination of Medicaid eligibility, the redetermination process for Medicaid eligibility, and the process by which ESS creates unborn baby files for Pregnant Mothers.

17. "MMA Plan" or "SMMC MMA Plan" is defined to mean a Managed Medical Assistance Plan for the provision of managed care services to persons enrolled in the Florida Statewide Medicaid Managed Care ("SMMC") Managed Medical Assistance ("MMA") program. The term MMA Plan expressly excludes the CMSN Managed Care Plan.

18. "Ongoing" is defined to mean deficiencies or problems which are continuing and still in progress at the time they are raised by Plaintiffs.

19. "Pediatric Specialists and Sub-specialists" is defined to mean those physician specialty types that are eligible for a 24% increase for services provided to Medicaid enrolled children under the age of 21 according to the Practitioner Fee Schedule, effective January 1, 2016, together with providers providing physical medicine, pediatric surgery, and urological surgery services provided to Medicaid enrolled children under the age of 21.

20. As used herein, the phrase "pregnant mothers" is limited to women who have been determined by ESS to be eligible for Medicaid and for whom ESS is notified of the pregnancy.

21. "Provider" is defined to mean a MMA Plan pediatric service provider who provides medical services to Medicaid enrolled children under the age of 21, to the extent services are actually provided to Medicaid enrolled children under the age of 21.

22. "Program Savings" is defined to mean all of the monies saved through increased efficiencies resulting from implementation and operation of the Florida SMMC MMA program as determined by AHCA in conjunction with its actuaries, other than those amounts the health plans are currently permitted to retain by statute.

23. "Qualified Protective Order" is defined to mean the agreed qualified protective order entered by the Court in this matter on December 7, 2015.

24. "Systemic Issue" is defined to mean a problem or deficiency which is common or widespread in the processes used to apply for and determine Medicaid eligibility in Florida.

25. "Triggering Event" is defined as a material breach by AHCA of the requirements of this Agreement or if the Florida Legislature does not approve action that AHCA is obligated to request pursuant to this Agreement.

26. "Unborn Baby File" is defined to mean a file created by ESS in the case of a Pregnant Mother for her unborn child, so that promptly after birth the "file" can be activated.

27. "Unborn Baby Activation Process" is defined to mean the process administered principally by AHCA of activating newborns after birth. A hospital, pediatrician, or MMA plan may notify AHCA or its designee of the birth of a child for whom an unborn baby file exists, at which point AHCA or its designee is responsible for activating the unborn baby file.

II. Medical Services to Children Under Age 21

A. Implementation of Incentive Program:

1. AHCA will require all MMA Plans to use all Program Savings through at least September 2019 (i.e, for Contract Years 2016, 2017, and 2018) to fund rate increases for MMA Plan network Providers that provide medical services to MMA Plan enrollee children under the age of 21 and Obstetricians, in the following order of priority: (1) Obstetricians, and Providers that are Board Certified Pediatricians; (2) Providers that are primary care physicians, including pediatricians that are not Board Certified Pediatricians; (3) Providers that are general practitioners or family practitioners; (4) Pediatric Specialists and Sub-Specialists. The rate increases will be provided, to the extent allowed by Program Savings, to eligible providers in the form of rate incentives earned when the Provider achieves certain objectively measurable patient

access and patient outcome measures to be established by AHCA pursuant to the Incentive Proposal process set forth below ("Rate Incentives").[3]

2. 2016 Contract Year (October 1, 2016 through September 30, 2017):

A. AHCA is presently surveying MMA Plans to determine the pediatric and pediatric specialist rates currently paid by the MMA Plans. The responses to these surveys will allow AHCA's contracted actuaries to determine for the 2016 Contract Year what rate increases, and for which Providers, may be funded solely through Program Savings while ensuring Actuarially Sound Capitation Rates.

B. On or about April 4, 2016, AHCA will send Information Requests to the MMA Plans which will require the MMA Plans to submit incentive proposals for the outcome and access measures that Providers within their respective networks would need to achieve in order to earn the Medicare FFS Rate ("MMA Plan Incentive Proposals"). At a minimum, the MMA Plan Incentive Proposals must provide a reasonable opportunity for all Providers that are Board Certified Pediatricians and Obstetricians to earn the Medicare FFS Rate for the 2016 Contract Year through Rate Incentives while ensuring Actuarially Sound Capitation Rates.

C. On or about April 11, 2016, AHCA will solicit public comments regarding the Information Requests at a public meeting.

D. AHCA will review and notice approval of approved MMA Plan Incentive Proposals in a timely manner that allows the approved MMA Plan Incentive Proposals to be included in the contracts with the MMA Plans for the 2016 Contract Year.

E. As an alternative, or in addition to the MMA Plan Incentive Proposals, AHCA will create incentive proposals for the outcome and access measures that eligible Providers would need to achieve in order to earn the Medicare FFS Rate ("AHCA Incentive Proposals"). At a minimum, the AHCA Incentive Proposals will provide a reasonable opportunity for (a) all Providers that are Board Certified Pediatricians and (b) all Obstetricians to earn the Medicare FFS Rate for the 2016 Contract Year through Rate Incentives while ensuring Actuarially Sound Capitation Rates. MMA Plans may elect to include the AHCA Incentive Proposals in their contracts with AHCA for the 2016 Contract Year; and the AHCA

[3] The Rate Incentives offered to MMA Plan network Providers shall not affect existing Medicaid FFS rate schedules promulgated by AHCA.

Incentive Proposals will be included in all contracts with MMA Plans that do not submit approved MMA Plan Incentive Proposals.

F. AHCA will meet with Representatives of the Plaintiffs each month from April 2016 through September 2016 to discuss the Information Requests, MMA Plan Incentive Proposals, AHCA Incentive Proposals, and the Rate Incentives to be included in the contracts with the MMA Plans for the 2016 Contract Year. Thereafter, AHCA will meet with Representatives of the Plaintiffs at least quarterly through September 2021 to discuss the success of the Incentive Program and any recommended revisions, recognizing that any collaboration related to amendments to contracts with the MMA Plans must be completed on or before July 1 preceding the respective Contract Year. The meetings provided for in this Agreement shall not be voting or decision-making meetings. Plaintiffs will bear their own expenses of participation in these meetings, including travel expenses. The meetings will be held in Tallahassee, Florida. Participation may be by electronic means to the extent arrangements can be reasonably made for participation by electronic means.

G. AHCA will take necessary action to increase capitation rates if necessary to allow Board Certified Pediatricians and Obstetricians to have a reasonable opportunity to earn the Medicare FFS Rate through Rate Incentives for the 2016 Contract Year, and subsequent years, while ensuring Actuarially Sound Capitation Rates.

3. 2017 and 2018 Contract Years: AHCA will follow the same process set forth above for the 2017 and 2018 Contract Years, and will require all MMA Plans to use all Program Savings to fund rate increases for MMA Plan network Providers and MMA Plan Obstetricians, in the following order of priority: (1) Obstetricians and Providers that are Board Certified Pediatricians; (2) Providers that are primary care physicians, including pediatricians that are not Board Certified Pediatricians; (3) Providers that are general practitioners or family practitioners; (4) Pediatric Specialists and Sub-Specialists.

B. Implementation of Incentive Program:

1. The following metrics shall be used to evaluate the improvements in the Florida SMMC MMA Program relevant to medical services provided to children under the age of 21, to be attained within thirty (30) months of the Implementation Date:

A. meeting a statewide Participation Ratio, as measured on Line 10 of the CMS-416 Reports, at least equivalent to the national mean;

B. meeting a statewide Participation Ratio, associated with Line 10 of the CMS-416 Reports, of at least 75 percent for all aggregate age groups on a weighted average basis below the age of 10;

C. achieving a statewide weighted average of all MMA Plans that is equal to or exceeds the national Medicaid mean for at least eight (8) of the following nine (9) HEDIS Measures:

(1) Adolescent Well Care Visits (AWC);
(2) Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months;
(3) Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years;
(4) Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years;
(5) Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years;
(6) Well Child Visits in the First 15 Months of Life (W15) - 0 Visits (INVERSE);
(7) Well Child Visits in the First 15 months of Life (W15) – 6 or more Visits;
(8) Well Child Visits in third, fourth, fifth and sixth years of Life (W34); and
(9) Lead screening in children (LSC).

D. Performance of the above metrics will be measured against the prior year's results. The CMS-416 Report measures will be evaluated based on the prior federal fiscal year (October 1 through September 30) and the HEDIS Measures will be evaluated based on the prior calendar year.

E. The Parties may retain consultants, at their own expense, to review and opine on the methodology and data gathering related to these metrics. Each party shall make good faith efforts to consider the analysis of consultants retained by the other party, all toward achieving the shared objective of the Florida Medicaid program operating as a top-performing program providing quality EPSDT services to all eligible Florida children.

C. Implementation Measures for All MMA Plans:

For all MMA Plans, AHCA will:

1. monitor and enforce the time and distance access requirements for MMA Plan networks as required under AHCA's contracts with the MMA Plans, and report on network adequacy compliance to Plaintiffs' Representatives; and

2. enforce the contractual obligation of MMA Plans to achieve an 80 percent Participation Ratio through imposition of liquidated damages.

D. Implementation Measures for Non-Performing MMA Plans:

1. AHCA will require all MMA Plans that do not meet the CMS-416 Report measures (as defined in 1.A & B. above) and the HEDIS Measures (as defined in 1.C. above) set forth above for federal fiscal year 2015-16 (for CMS-416 Report measures) or calendar year 2016 (for HEDIS Measures) to take additional steps in connection with the 2017 Contract Year in order to improve performance. AHCA will require all MMA Plans that do not meet the CMS-416 Report measures and HEDIS Measures set forth above for federal fiscal year 2016-17 (for CMS-416 Report measures) or calendar year 2017 (for HEDIS Measures) to take additional steps in connection with the 2018 Contract Year in order to improve performance, and AHCA will continue to require all MMA Plans that do not meet the CMS-416 Report measures and HEDIS Measures set forth above in subsequent years to take additional steps to improve performance in subsequent Contract Years.

E. Additional Statewide Measures

If the Florida SMMC MMA Program statewide does not meet the CMS-416 Report measures (as defined in 1.A. and B. above) and the HEDIS Measures (as defined in 1.C. above) set forth above based on the measures available thirty (30) months after the Implementation Date, AHCA will implement the following, effective as of the 2019 Contract Year:

A. AHCA and Plaintiffs' Representatives will collaborate in good faith to devise a corrective action plan designed to achieve the CMS-416 Report measures

and HEDIS Measures set forth above consistent with the objectives of the Incentive Program. The corrective action plan shall provide for pediatricians and pediatric specialists and subspecialists that are eligible MMA Plan Providers that provide medical services to MMA Plan enrolled children under the age of 21 to earn the Medicare FFS Rate, subject to modifications to MMA Plan-related incentives and disincentives (e.g., increasing percentages of shared savings for compliance or, conversely, liquidated damages for noncompliance, with the CMS-416 Report measures and HEDIS Measures set forth above). AHCA will also amend its contracts with the MMA Plans to prohibit the MMA Plans from relying on the Medicaid fee-for-service rate schedule as a baseline to determine rates to be paid to Providers.

B. AHCA agrees to seek increases in capitation rates, including by legislative action if necessary, that are needed to to ensure Actuarially Sound Capitation Rates to facilitate the measures described in subsection A above, consistent with the Incentive Program.

III. Dental Services to Children Under Age 21

1. AHCA agrees to increase access to and utilization of pediatric dental services through a combination of the following: (1) studies of and enhancements to network adequacy requirements; (2) perpetuation of Florida's state oral health action plan (through which AHCA is attempting to develop in-depth knowledge of the barriers to the receipt of dental care to help target interventions); (3) increased development of performance improvement projects, through which AHCA requires MMA Plans to devote resources to improved utilization of preventive dental services; (4) intensive participation in oral health coalitions; and (5) increased outreach to communicate the availability of dental services to Medicaid children.

2. Within thirty (30) days of execution of this Agreement, AHCA will commence a study of network adequacy standards for all pediatric Dental Provider types to determine enhancements that should be incorporated into the MMA Plan contracts for the 2016 Contract Year. The study of these standards will be robust and broad in scope, and will include, at a minimum, requirements relating to geographic accessibility, travel time, availability to accept new patients, and requirements relating to licensure, specializations, prompt payments, reducing

administrative obstacles and board certification. AHCA will collaborate with the MMA Plans and with Plaintiffs' Representatives, including the Florida Academy of Pediatric Dentists, before finalizing the network adequacy standards for the 2016 Contract Year.

3. AHCA will incorporate the network adequacy enhancements determined appropriate by the study in its MMA Plan contracts for the 2016 Contract Year. AHCA will include in the MMA Plan contracts outcome expectations consistent with the network adequacy enhancements, and consistent with the metrics used to evaluate improvements set forth below, and will impose incentives and contractual penalties (for compliance and noncompliance, respectively) that AHCA deems reasonable and appropriate.

4. AHCA will collaborate in good faith with the MMA Plans and with Plaintiffs' Representatives, including Florida Academy of Pediatric Dentists, to improve outreach for dental services. The outreach efforts will include sending reminder notices to parents and guardians and notification of the availability of transportation.

5. AHCA will continue to review and refine network adequacy standards during the term of this Agreement.

6. The following metrics shall be used to evaluate the improvements in the provision of dental services under the Florida SMMC MMA Program, which shall be achieved on or before September 30, 2021:

A. Meeting or exceeding a statewide weighted average of all MMA Plans that is equal to or exceeds the 2014 national Medicaid mean for the HEDIS Annual Dental Visit measure (HEDIS ADV);

B. Meeting or exceeding the 2014 national average for the child Core Set PDENT measure (CMS-416 Report Line 12b divided by line 1b); and

C. Meeting or exceeding the 2014 national average for the CMS-416 Report Dental Treatment Service measure (CMS-416 Report Line 12c).

7. The following interim benchmarks shall be used to evaluate the progress of the improvements in the provision of dental services under the Florida SMMC MMA Program:

	Year the Measurement is Reported[4]				
	2017	2018	2019	2020	2021
Preventive Dental (CMS 416, Line 12b divided by line 1b; Child Core Set PDENT)	30%	32%	35%	38%	42%
Dental Treatment Services (CMS 416, Line 12c)	14%	16%	18%	20%	22%
Annual Dental Visit (HEDIS ADV)	45%	46%	47%	48%	49%

8. AHCA shall measure the performance of individual MMA Plans that provide dental services to MMA Plan enrolled children under the age of 21 and shall require MMA Plans that do not meet all of the annual interim benchmarks set forth above for the prior year to take appropriate corrective measures effective as of the following Contract Year.

9. If the Florida SMMC MMA Program statewide does not meet all of the interim benchmarks set forth above with respect to the measurements reported in 2017 or 2018, respectively, AHCA will implement the following, effective as of the 2017 or 2018 Contract Year, respectively (e.g. if AHCA has not met the benchmark for 2017, as reported in 2017 based on 2016 data, AHCA will implement the following for the 2017 Contract Year): AHCA and Plaintiffs' Representatives will collaborate in good faith to devise a corrective action plan designed to achieve the interim benchmarks set forth above. The corrective action plan will be consistent with the objectives of the Incentive Program, and may include, but is not limited to, enhanced provider network standards and/or monitoring, additional targeted research into barriers to dental care, additional incentives or penalties for plans that fail to meet these

[4] Measurements are reported in the year after the data is collected, so the measurement identified for one year is based on the data collected from the preceding year (e.g., the 2017 measurement is based on 2016 data).

standards, and additional outreach to inform recipients about the importance of oral health care, the dental benefit, and how to access care.

10. If the Florida SMMC MMA Program statewide does not meet all of the interim benchmarks set forth above with respect to the measurements reported in 2019, 2020, or 2021, respectively, AHCA will implement the following, effective as of the 2019, 2020, or 2021 Contract Year, respectively (e.g. if AHCA has not met the benchmark for 2019, as reported in 2019 based on 2018 data, AHCA will implement the following for the 2019 Contract Year):

A. AHCA and Plaintiffs' Representatives will collaborate in good faith to devise a corrective action plan designed to achieve the interim benchmarks set forth above. The corrective action plan will be consistent with the objectives of the Incentive Program, and may include, but is not limited to, enhanced provider network standards and/or monitoring, additional targeted research into barriers to dental care, additional incentives or penalties for plans that fail to meet these standards, and additional outreach to inform recipients about the importance of oral health care, the dental benefit, and how to access care.

B. AHCA will afford all eligible MMA Plan network providers that provide dental services to MMA Plan enrollee children under the age of 21 a reasonable opportunity to earn increased payment rates for dental services sufficient to incentivize them to cause the Florida SMMC MMA Program statewide to meet all of the interim benchmarks set forth above for the year 2019, 2020, or 2021, respectively, while ensuring Actuarially Sound Capitation Rates, which increased payment rates shall be in an amount equal to at least the 50th percentile of commercial dental insurance payments for pediatric dental care services furnished in Florida.

C. AHCA agrees to seek increases in capitation rates, including by legislative action if necessary, that are needed to to ensure Actuarially Sound Capitation Rates to facilitate the measures described in subsection B above, consistent with the incentive-based objectives described herein.

IV. Availability of Incentives to CMSN Managed Care Plan Providers

1. AHCA, DOH, and Plaintiffs' Representatives will meet and collaborate in good faith on the best methods of servicing the needs of CMS children. The parties understand that DOH may identify one or more third parties to administer the CMSN Managed Care Plan on an

at-risk capitated basis. If DOH contracts with one or more third party capitated managed care plans to administer the CMSN Plan, the third party plans will be obligated, upon the commencement of the contract with DOH, to comply with the same contractual provisions relating to Rate Incentives for MMA Plan Providers as set forth in the Incentive Program above, including reasonable opportunities to earn the Medicare FFS Rate. AHCA will seek federal approval as necessary to facilitate the changes contemplated by this section.[5]

V. AHCA's Role With Respect to Reassignments/Enrollment of Newborns

1. AHCA and, to the extent needed, DOH, agree to meet with Representatives of the Plaintiffs on at least a quarterly basis and to implement reasonable measures to address the level of MMA Plan changes, or changes in primary care provider assignments, without notice or parental or guardian consent, and timely activation and enrollment of newborn babies with Medicaid coverage from birth.

2. AHCA will continue to make all reasonable efforts to minimize reassignment of children from one MMA Plan to a different MMA Plan without notice or consent of the child's parent or guardian. Additionally, AHCA will continue to make all reasonable efforts to minimize reassignment of children's' primary care providers by MMA Plans without notice or consent of the child's parent or guardian. Plaintiffs recognize that there are circumstances which require the reassignment of children from one MMA Plan to another or the reassignment of children's primary care providers by MMA Plans that are not within AHCA's control. Plaintiffs also acknowledge that parents and guardians are obligated to provide current contact information to AHCA and MMA Plans in order to provide notice of any required reassignments, and that the

[5] Nothing in this agreement shall have any effect on separately pending issues regarding screening of children for eligibility to be admitted into the CMS program.

provision of notice to the address on file with AHCA or the MMA Plans constitutes notice of the reassignment.

3. AHCA will continue to make all reasonable efforts to ensure that presumptively eligible newborns have their Medicaid activated expeditiously after being notified by a pediatrician, hospital, or MMA Plan. Plaintiffs recognize that ESS is responsible for the creation of an Unborn Baby File when a pregnant mother who has been determined eligible for Medicaid notifies ESS of her pregnancy. This Unborn Baby File is then available to be activated by AHCA or its designee following notification.

VI. Outreach

1. AHCA shall either itself or by requirement upon MMA Plans or other contracted vendors, ensure that communications are made through a variety of media and non-media avenues, including by community partners, so as to both inform parents and guardians of enrolled Medicaid children of the availability of EPSDT services, and to inform parents and guardians of eligible but unenrolled children of the availability of the Medicaid program, and how to apply for such benefits. If the number of Medicaid and CHIP eligible but unenrolled children has not reached the 2014 national average, as reflected in the Urban Institute's 2016 report on Children's Medicaid/CHIP participation by September 30, 2018, AHCA will take additional outreach steps either itself or through MMA plans or other contracted vendors and to seek additional funding if required to implement such action.

VII. DCF's Role and the Medicaid Eligibility and Application Process

A. DCF's Goals and Obligations.

Plaintiffs and ESS agree to the obligations set forth in this Agreement so as to advance the objective of improving the Medicaid eligibility process for children in Florida. Goals consistent with this objective include:

1. ESS will continue to make all reasonable efforts to minimize wrongful terminations of Medicaid eligibility for children during the continuous eligibility period. In furtherance of this goal, ESS will, among other things, continue to maintain the current level of improvement, and, each month, ESS will review terminations for children under the age of 18 to determine which terminations are inappropriate. Where inappropriate terminations are identified, ESS will take corrective action.

2. ESS will make all reasonable efforts to ensure that there is an Unborn Baby File associated with each Pregnant Mother who meets the criteria set forth in 42 U.S.C. § 1396a(e)(4) and 42 C.F.R. § 435.117. In furtherance of this goal, ESS will, among other things, conduct a monthly review utilizing a monthly listing of all Pregnant Mothers, and shall provide appropriate training to ESS staff on the Unborn Baby Process.

3. ESS shall continue to evaluate the application process with the goal of improving the process (subject to Federal CMS requirements) for applicants to submit an application. The Parties acknowledge there can be a variety of reasons why applications are abandoned, some of which are beyond ESS's control. In furtherance of this goal, ESS shall, among other things, evaluate the need for additional training materials for its staff and community partners on the use of the self-service portal, and create such additional materials as indicated. ESS also shall evaluate its current internet based information for customers on the use of the self-service portal, and make improvements to the web based information about the self-service portal as indicated.

B. Meetings and Reporting Obligations

1. In order to achieve the goals set forth in Section VII.A, above, Plaintiffs and ESS have agreed to quarterly meetings with representatives of Plaintiffs and DCF. On agreement of DCF and the Plaintiffs, meetings may be held more frequently than quarterly. The first meeting shall be held within 30 days of the approval of this Agreement by the Court. ESS and Plaintiffs' representatives will bring their expertise to bear on the issues to be addressed at the quarterly meetings. The issues to be addressed in the quarterly meetings are those goals described above and how such goals may be achieved. The meetings provided for in this Agreement shall not be voting or decision-making meetings. These meetings will be held through June 2018.

2. Plaintiffs will bear their own expenses of participation in these meetings, including travel expenses. The quarterly meetings will be held in Tallahassee, Florida, although, where possible, arrangements will be made for participation in the meetings by electronic means.

3. Following the meetings described above, ESS shall consider proposed solutions as well as other measures intended to remedy Systemic Issues, and shall implement appropriate measures to achieve the goals identified above. In the event that DCF determines it lacks the funds needed to implement one or more appropriate measures, DCF will make a good faith effort to secure such funds from other sources, including but not limited to the Legislature, AHCA, and/or grants. ESS shall specifically consider the following measures either before or after the initial meeting, subject to approval if required by Federal CMS:

A. Modifying language on ESS's splash page to better identify the availability of assistance in completing the application on-line or by-phone or in-person;

B. Modifying language on the pop-up warning page that appears when an applicant selects the "finish and submit" option within the online application to better explain that an applicant may finish and submit an application at anytime, and that ESS will follow up with the individual if necessary; and

C. Modifying language surrounding the electronic signature in the Medicaid application to make it clearer that the applicant must both affix an electronic signature and click next in order to submit the application.

4. To facilitate an efficient meeting process, no later than 30 days before each scheduled quarterly meeting, Plaintiffs will provide in writing to ESS Exemplars of problems or deficiencies and other relevant information which Plaintiffs, in good faith, believe show Systemic Issues. To the extent that Plaintiffs' Exemplars involve actual children, Plaintiffs shall, to the extent possible, provide demographic information for the child at issue, the date(s) corresponding to the particular issue, and a description of the problem the child has experienced. Plaintiffs understand that without sufficient demographic information, DCF may not be able to investigate the information provided by Plaintiffs. The Qualified Protective Order currently in place shall be extended to assure that confidentiality obligations under applicable law will be fully complied with in connection with this process.

5. Upon receipt of the written information provided by Plaintiffs, ESS will conduct an investigation to the extent necessary to determine the facts surrounding the Exemplars and information provided by Plaintiffs, including whether the information provided by Plaintiffs is typical of a Systemic Issue. ESS shall share with Plaintiffs at the regularly scheduled quarterly meeting the results of ESS's investigation, and shall discuss appropriate remedial measures.

6. If, on receipt of the information provided by Plaintiffs, ESS determines that there is inadequate time to investigate Plaintiffs' information within the 30 day period prior to the regularly scheduled quarterly meeting, ESS shall notify Plaintiffs of that determination within 7 days of receipt of the information provided by Plaintiffs. Plaintiffs may either agree to reschedule the quarterly meeting to a mutually acceptable date and time, or the scheduled

meeting will go forward with the information that ESS is able to gather in time for the quarterly meeting.

7. Within 30 days after the meeting, ESS will communicate back with Plaintiffs about any decisions it has made regarding issues and suggested measures addressed at the meeting.

8. At the quarterly meetings, ESS will provide the following reports to Plaintiffs, samples of which will be provided to Plaintiffs at time of execution of this Agreement:

A. Reporting on the most recent three months for which ESS has data available on inappropriate terminations of Medicaid, and the steps taken by ESS to remediate any inappropriate terminations;

B. Point in time reporting on Pregnant Mothers with and without an Unborn Baby File created by ESS staff, using the most recent data available;

C. Reporting on the most recent three months for which ESS has data available on ESS call center call volume, abandoned calls, abandonment rate, calls receiving busy signal, busy rate, and average wait time; and

D. Reporting on the most recent three months for which ESS has data available on web applications received and submitted, Medicaid web applications received and submitted, the percentage of Medicaid only applications of all web applications received and submitted, web applications started but not submitted (i.e., no action taken for 60 days), and the percentage of web applications that are started and not submitted within 60 days.

9. Plaintiffs understand that, from time to time, it may be necessary to make changes to ESS's Medicaid eligibility system, policies, and procedures in order to comply with federal constitutional, statutory, regulatory, or legal requirements. This Agreement is not intended to prevent ESS from making changes to its Medicaid eligibility system, policies or procedures, as it deems appropriate.

10. Plaintiffs also understand that the Medicaid application used by DCF has been approved by the Secretary of the ahe Department of Health and Human Services Centers for

Medicare and Medicaid Services (federal CMS), and that further changes to the application may be subject to the approval of Federal CMS and the State's administrative rule-making process.

VIII. Retention of Jurisdiction, Litigation Rights, and Dismissal

1. The Parties have agreed that the Court will retain jurisdiction of this litigation until September 30, 2022, subject to the following litigation rights and other terms:

A. AHCA. AHCA's obligations under this Agreement are specified in Parts II through VI above. The Court will retain jurisdiction of this litigation with respect to AHCA until the earlier of (1) the date on which AHCA attains the Implementation Measures described in Parts II.B (both of the 416 measures and the HEDIS measures) and III.6 (all three measures) or (2) September 30, 2022. If a motion for breach of the Agreement has been filed, the Court shall continue to retain jurisdiction until such motion is finally adjudicated. If Plaintiffs believe a Triggering Event has occurred, Plaintiffs shall provide AHCA with written notice of a Triggering Event, and an opportunity for cure. The parties shall meet to attempt to resolve such issues. If, after 45 days of providing such notice, Plaintiffs believe that a material breach or other Triggering Event has not been remedied, Plaintiffs' exclusive remedy is to file a motion with the District Court and upon establishing such a material breach or other Triggering Event has occurred, Plaintiffs may seek declaratory and injunctive relief to remedy violations of the Medicaid Act, in a manner consistent with the procedural posture of the case as it existed immediately prior to the entry of this Agreement. The process set forth in this paragraph shall be the exclusive means for enforcement of an alleged breach of this Agreement by AHCA. None of the Parties waive any of their respective rights and defenses through the entry of this Agreement or its subsequent implementation.

B. DOH. DOH's obligations under this Agreement are specified in Part IV above. The Court will retain jurisdiction of this litigation with respect to DOH until the date on which the Plaintiffs' claims against AHCA are dismissed. The process set forth above with respect to AHCA shall apply in the event that Plaintiffs believe that a Triggering Event has occurred with respect to the obligations of DOH under this Agreement and shall be, with respect to the obligations of DOH, the exclusive means by which Plaintiffs may seek to enforce an alleged breach of the obligations of this Agreement by DOH.

C. DCF. DCF's obligations under this Agreement are specified in Part VII above. The Court will retain jurisdiction of this litigation with respect to DCF until June 30, 2018. If, prior to June 30, 2018, Plaintiffs establish that DCF has substantially failed, without reasonable justification, to meet the goals identified in Part VII.A, above, by failing to implement available measures to achieve those objectives, the Court will lift the stay and Plaintiffs may proceed to seek declaratory and injunctive relief to remedy violations of the Medicaid Act, in a manner consistent with the procedural posture of the case as it existed immediately prior to the entry of this agreement. The process set forth in this paragraph shall be the exclusive means for enforcement of an alleged breach of this Agreement by DCF.

(1) At least 45 days prior to filing a motion to lift the stay, Plaintiffs agree to give counsel for DCF written notice of their intent to file the motion. The notice shall provide specific reasons why Plaintiffs believe that DCF has breached its duties under the terms of this Agreement, and why declaratory and injunctive relief is warranted.

(2) DCF shall provide a written response to Plaintiffs' notification within 30 days of its receipt. The parties shall then meet and, if the parties are unable to reach agreement on curing the issues identified, Plaintiffs may proceed to seek declaratory and injunctive relief to remedy violations of the Medicaid Act, in a manner consistent with the procedural posture of the case as it existed immediately prior to the entry of this Agreement. If such motion is denied, the obligations of this Agreement are not affected.

(3) The Parties recognize that the Plaintiffs' exclusive remedy in the event of an alleged breach or other triggering event described in this paragraph is to seek declaratory and injunctive relief to remedy violations of the Medicaid Act in a manner consistent with the procedural posture of this case as it existed immediately prior to the entry of this Agreement. None of the Parties waive any of their respective rights and defenses through the entry of this Agreement or its subsequent implementation.

IX. Additional Terms and Conditions

1. This Agreement is the product of lengthy negotiations and compromise among the Parties through a confidential mediation.

2. The parties have entered into this Agreement in order to settle all claims against Defendants, to avoid the uncertain outcome of continued litigation, and to provide improvements in the delivery of Medicaid to all eligible Florida children. Defendants expressly deny that any of the claims brought by the Plaintiffs have any merit and nothing in this Agreement is or shall be construed as an admission of liability by the Defendants. This Agreement cannot be used as an admission by any party in this or any other proceeding; nor should this Agreement be construed as a waiver of any claims that may arise after dismissal of this action. The terms and conditions of this Agreement are not admissions by any party as to a violation of or compliance with any federal or state law; and are not admissible, except for the purpose of establishing a breach of this Agreement. However, nothing in this paragraph restricts the Parties' ability to introduce any standards, metrics, or benchmarks, or data concerning the performance of the Florida Medicaid program in any further proceedings in this case. The Parties agree not to use this Agreement or any of its terms or provisions in any other case or matter to argue that any party has conceded that any particular action must be taken or not taken.

3. The obligations set forth above are independent and specific to AHCA, DOH, and DCF, respectively, as delineated under the above headings. Any alleged failure by one of the

Defendants to satisfy its respective obligations under this Agreement shall not constitute a failure under this Agreement by the other Defendants or entitle the Plaintiffs to exercise any rights or remedies with respect to the Defendants who have satisfied their obligations under this Agreement.

4. The Defendants agree to pay and the Plaintiffs agree to accept $12,000,000 in full settlement of any entitlement to attorneys' fees and costs incurred by the Plaintiffs and their counsel in relation to this lawsuit from its inception through the date that the last party executes this Agreement ("Settlement Amount"). The Plaintiffs acknowledge that payment of the Settlement Amount is subject to and contingent upon the review and approval of the Florida's Chief Financial Officer, or his authorized delegate (the "CFO"), pursuant to his authority as set forth in the Florida Constitution and section 17.03, Florida Statutes, which provides in pertinent part: "The Chief Financial Officer of this state, using generally accepted auditing procedures for testing or sampling, shall examine, audit, and settle all accounts, claims, and demands, whatsoever, against the state, arising under any law or resolution of the Legislature, and issue a warrant directing the payment out of the State Treasury of such amount as he or she allows thereon." The Plaintiffs further acknowledge that the Defendants' consent to pay the Settlement Amount does not constitute an admission that the Plaintiffs are prevailing parties for purposes of 42 U.S.C. § 1988 and that any entitlement to attorneys' fees and costs incurred subsequent to this Agreement must be proven without reference to this Agreement or any earlier agreements or understandings between the parties relevant to this action. The Defendants acknowledge (1) the parties' intent that payment of the Settlement Amount will be due within 30 days of the latter of (a) approval of this Agreement by the Court or (b) the CFO's determination that the Plaintiffs' counsel have submitted sufficient documentation establishing the incurring of fees and expenses

by the Plaintiffs and their counsel to support the payment of the Settlement Amount to Plaintiffs' counsel, which determination shall occur not later than 30 days after submission of documentation is complete. The Defendants will endeavor in good faith to obtain approval from the CFO and acknowledge that the purpose of CFO review is to confirm that the Plaintiffs' counsel have documented the incurring of fees and expenses to support the payment of the Settlement Amount to Plaintiffs' counsel and is not a process by which the State will seek to reduce that amount by challenging the reasonableness of timekeeper rates or services as might occur in a fee hearing. In the unlikely event the State does not pay the Settlement Amount when due, the Plaintiffs would be entitled to a judgment under Section 1988 for the Settlement Amount. Costs for notice by publication of the hearing on Plaintiff's motion to approve the settlement and any incentive payments to class representatives approved by the Court shall be paid or reimbursed from the Settlement Amount. Payment of the Settlement Amount shall be made by check or wire transfer to the trust account of Boies, Schiller & Flexner, LLP.

5. All Parties and their counsel will use their best efforts to obtain Court approval of this Agreement pursuant to Rule 23(e).

6. Each of the signatories to this Agreement on behalf of Defendants represents that he or she will take all necessary steps to comply with the requirements of Section 45.062, Florida Statutes (2015).

7. The parties agree and acknowledge that: (a) this Agreement constitutes a total and complete integration of the entire understanding and agreement between the Parties with respect to the subject matter of this Agreement; (b) there are no representations, warranties, understandings or agreements between the Parties other than those specifically set forth in writing in this Agreement; (c) in entering into this Agreement, none of the parties has relied on

any representation, warranty, understanding, agreement, promise or condition not specifically set forth in writing in this Agreement; (d) except as expressly provided in this Agreement, all prior and/or contemporaneous discussions, negotiations, agreements and writings have been and are terminated and superseded by this Agreement; and (e) no changes and/or additions to this Agreement shall be valid, enforceable or recognized unless made in a writing and signed by all of the Parties.

8. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Execution of this Agreement by the parties hereto may be evidenced by the transmission of facsimile or electronic pdf copies.

9. This Agreement shall be binding upon the Parties, their predecessors, successors, parents, subsidiaries, affiliates, assigns, agents, directors, officers, employees, and attorneys. Each of the signatories to this Agreement represents and warrants that he or she is authorized to execute this Agreement and to bind the party on whose behalf he or she is signing.

10. This Agreement shall not grant any rights to any third parties other than the successors and assigns of the Parties.

11. This Agreement shall not create a partnership or joint venture between the Parties.

12. If any part or any provision of this Agreement shall be finally determined to be invalid or unenforceable under applicable law by a court of competent jurisdiction, that part or provision shall be ineffective to the extent of such invalidity or unenforceability only, without in any way affecting the remaining parts of said provision or the remaining provisions of this Agreement.

13. The section and paragraph headings in this Agreement are for convenience and reference only, and shall not be deemed to alter or affect the provisions thereof.

14. Where necessary or appropriate to the meaning thereof, the singular and the plural shall be interchangeable and the words of any gender shall include all genders.

15. The Parties cooperated in the drafting of this Agreement, and in the event that it is determined that any provision of the Agreement is ambiguous, that provision shall not be presumptively construed against any party.

16. The Parties acknowledge and represent that they have reviewed and fully understand this Agreement, and that they have entered into this Agreement freely and voluntarily.

17. The Parties further acknowledge and represent that they: (i) have been given an opportunity to retain, and have retained, attorneys of their choice in connection with the execution of this Agreement; (ii) are fully satisfied with the professional services rendered by their respective attorneys; and (iii) have relied on the advice of their respective attorneys and their own informed judgment in executing this Agreement.

18. Each of the Parties agrees to do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, all such further acts and assurances as shall be reasonably requested by the other Party in order to carry out the intent of this Agreement. Without in any manner limiting the specific rights and obligations set forth in this Agreement, the parties hereby declare their intention to cooperate with each other in effecting the terms of this Agreement, and to coordinate the performance of their respective obligations under the terms of this Agreement.

IN WITNESS WHEREOF, the Parties, through their duly authorized representatives, have executed this Settlement Agreement as of the ____ day of April, 2016.

ELIZABETH DUDEK, as Secretary
Agency for Healthcare Administration
2727 Mahan Drive
Tallahassee, FL 32308
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Fax (850) 413-7712

CELESTE PHILIP, M.D., as Interim State Surgeon General and Secretary
The Florida Department of Health
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For Plaintiffs:

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For Mike Carroll, as Secretary of
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