IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

CARLA FREW, MARIA AYALA, NICOLE CARROLL, CHARLOTTE GARVIN and MARY JANE GARZA, et al., *Plaintiffs,*	§	
	§	Case No. 3:93-CV-65
v.	§	
KYLE L. JANEK, M.D., et al., *Defendants.*	§	

ORDER ON CORRECTIVE ACTION ORDER: ADEQUATE SUPPLY OF HEALTH CARE PROVIDERS (DKT. 637-9) & RELATED CONSENT DECREE PROVISIONS

Pending before the court is Plaintiffs' Renewed Motion to Enforce the Provider Supply Corrective Action Order and Related Decree Provisions (Opposed) (Dkt. 1033), Defendants' Rule 60(b)(5) Motion to Vacate the Corrective Action Order: Adequate Supply of Health Care Providers and Related Decree Provisions; Defendants' Response in Opposition to Plaintiffs' Renewed Motion to Enforce the Provider Supply Corrective Action Order and Related Decree Provisions (Sealed) (Dkt. 1052), Plaintiffs' Reply in Support of Plaintiffs' Renewed Motion to Enforce the Provider Supply CAO and Related Decree Provisions and Response in Opposition to Defendants' Rule 60(b)(5) Motion Regarding Provider Supply (Dkt. 1097), Defendants' Reply in Support of Their Rule 60(b)(5) Motion to Vacate the Corrective Action Order: Adequate Supply of Health Care Providers and Related Decree Provisions; Defendants' Sur-Reply in Opposition to Plaintiffs' Renewed Motion to enforce the Provider Supply Corrective Action Order and Related Decree Provisions (Sealed) (Dkt. 1098), and Plaintiffs' Sur-Reply in Opposition to Defendants' Rule 60(b)95) Motion Regarding Provider Supply (Dkt. 1101). For the reasons set forth herein, Plaintiffs' motion (Dkt. 1033) is **DENIED**, and Defendants' motion (Dkt. 1052) is **GRANTED IN PART**.

I. BACKGROUND

A detailed background of this case can be found in previously issued opinions.[1] A brief summary is included here.

On September 1, 1993, Plaintiffs filed this lawsuit alleging that Defendants (the successive commissioners of the Texas Health and Human Services Commission (HHSC) and the Texas Department of Health (TDH) did not adequately provide Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) services to Texas Medicaid recipients under the age of 21 as required under Title 42, United States Code, Sections 1396a(a)(43); 1396d(r). The EPSDT program is referred to as "Texas Health Steps" (THSteps) and is administered jointly by the federal government and the HHSC. Plaintiffs' class is defined broadly to include all Texas youth eligible to receive Medicaid. Plaintiffs sought injunctive relief to ensure that the state complied with the Medicaid Act. The parties proposed, and the court adopted, a consent decree in 1996. The primary governing documents in this case are the "Consent Decree" (Dkt. 135) and the "Corrective Action Orders" (Dkts. 637, 663).

a. The Consent Decree (Dkt. 135)

In July 1995, after extensive settlement negotiations, the parties proposed a Consent Decree that was approved by the court on February 16, 1995 (Dkt. 135). The Decree is a court-enforced settlement agreement that sets forth a compliance plan for the EPSDT program. The Decree was not intended to resolve all the contested issues between the parties. Rather, it was designed to reduce the nature and scope of the litigation. The Decree discusses in detail the areas

[1] *See Frew v. Gilbert*, 109 F. Supp. 2d 579 (E.D. Tex. 2000); *Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002); *Frew v. Hawkins*, 540 U.S. 431 (2004); *Frew v. Hawkins*, 401 F. Supp. 2d 619 (E.D. Tex. 2005); *Frew v. Seuhs*, 775 F. Supp. 2d 930 (E.D. Tex. 2011); *Frew v. Janek*, Case No. 3:93-cv-65, 2013 WL 6698378 (E.D. Tex. 2013).

in which the EPSDT program was deficient, sets goals and requirements for improvements, and establishes deadlines for the implementation of those improvements.

In July 1998, Plaintiffs moved to enforce the Decree, arguing that Defendants were not complying with several of the Decree's provisions (Dkt. 208). Defendants opposed the motion, arguing that their efforts had been sufficient and that, regardless of their efforts, the Eleventh Amendment barred the court from enforcing the Decree. In 2000, this court held that Defendants had failed to comply with several of the Decree's provisions and that the Eleventh Amendment did not bar enforcement of the Decree. On appeal, the Fifth Circuit Court of Appeals disagreed and held that the Eleventh Amendment barred enforcement of portions of the Decree that were not specifically mandated by the Medicaid Act. The United States Supreme Court reversed the Fifth Circuit Court of Appeals, holding that the Decree was enforceable under the principles of *Ex Parte Young*, 209 U.S. 123 (1908), because the Decree addressed federal interests. The case was remanded to this court for continued oversight.

b. The Corrective Action Orders (Dkts. 637, 663)

In November 2004, Defendants moved to terminate or, alternatively, to modify the Decree under Federal Rule of Civil Procedure 60(b)(5).[2] The basis for Defendants' motion was that even though they had not yet satisfied their obligations under the Decree, their efforts had brought them into compliance with the Medicaid Act. The court denied Defendants' motion, holding that compliance with federal law was not the sole object of the Decree. Defendants' appeals to the Fifth Circuit and the United States Supreme Court were unsuccessful.

Plaintiffs later filed three additional motions relating to enforcement of the Decree.[3] In 2007, the parties reached an agreement on the pending motions that set forth corrective action

[2] Dkt. 406.
[3] Dkts. 428, 429, 607.

plans for eleven areas of the EPSDT program addressed in the Decree. The parties filed their proposed agreement with the court on April 27, 2007.[4] The court orally approved the agreement at a hearing on July 9, 2007, and subsequently entered the agreement as the Corrective Action Order (CAO) or "Remedial Order" on September 5, 2007.[5] On April 17, 2009, the case was transferred by the Honorable William Wayne Justice to the undersigned judge.[6]

The Corrective Action Order contains eleven particularized orders for enforcing specific portions of the Decree.[7] The CAO at issue in these motions is entitled Corrective Action Order: Adequate Supply of Health Care Providers and can be found at Dkt. 637-9. In this order, the court refers to each paragraph of the CAO as "bullet point 1" or "bullet point 2" for clarity. The bullet points in the CAO are not numbered, and the court refers to them in the order they appear in the CAO. Also, to be clear, the court recognizes that there are a number of state departments and agencies that implement Texas's Medicaid program. For simplicity, the court refers to "Defendants" collectively.

II. LEGAL STANDARD

Federal Rule of Civil Procedure 60(b)(5) permits a party to obtain relief from a judgment or order if: (1) the judgment has been satisfied, released or discharged; (2) it is based on an earlier judgment that has been reversed or vacated; or (3) applying it prospectively is no longer equitable. "Rule 60(b)(5) serves a particularly important function in . . . institutional reform litigation" because "injunctions issued in such cases often remain in force for many years, and the passage of time frequently brings about changed circumstances—changes in the nature of the

[4] Dkt. 637.
[5] Dkt. 663.
[6] Dkt. 716.
[7] *See* Dkt. 663 at 13 ("Indeed, each of the eleven sub-proposals addresses important topics that require improvement so class members can receive health care that they need and are entitled to receive.").

underlying problem, changes in governing law or its interpretation by the courts, and new policy insights—that warrant reexamination of the original judgment."[8] Indeed, "institutional reform injunctions often raise sensitive federalism concerns."[9] "Federalism concerns are heightened when, as in these cases, a federal court decree has the effect of dictating state or local budget priorities."[10] Consent decrees often "go well beyond what is required by federal law" and may "'improperly deprive future officials of their designated legislative and executive powers.'"[11] "Where state and local officials inherit overbroad or outdated consent decrees that limit their ability to respond to the priorities and concerns of their constituents, they are constrained in their ability to fulfill their duties as democratically-elected officials."[12] Accordingly, the court must "exercise its equitable powers to ensure that when the objects of the decree have been attained, responsibility for discharging the State's obligations is returned promptly to the State and its officials."[13]

Courts take a "flexible approach" when considering a motion to modify a decree on the basis that its prospective application would be inequitable.[14] Under this approach, a party seeking modification of a decree bears the burden of establishing that a significant change in fact or law warrants revision of the decree; and the court must consider whether the proposed modification is suitably tailored to the changed circumstances.[15] For instance, modification of a decree may be justified by a significant change in fact when (1) "changed factual conditions make compliance with the decree substantially more onerous," (2) "a decree proves to be

[8] *Horne v. Flores*, 557 U.S. 433, 447-48 (2009) (internal quotation marks and citations omitted).
[9] *Id.* at 448.
[10] *Id.*
[11] *Id.* at 448-49 (quoting *Frew v. Hawkins*, 540 U.S. 431, 441 (2004)).
[12] *Id*. at 449-50 (internal quotation marks omitted).
[13] *Frew v. Hawkins*, 540 U.S. 431, 442 (2004).
[14] *Horne*, 557 U.S. at 450.
[15] *Rufo v. Inmates of Suffolk Cnty. Jail*, 502 U.S. 367, 383, 391 (1992).

unworkable because of unforeseen obstacles," or (3) "enforcement of the decree without modification would be detrimental to the public interest."[16] Changed factual conditions may also include when the objects of the decree have been attained and a durable remedy has been implemented.[17] A durable remedy is one that "gives the [c]ourt confidence that defendants will not resume their violations of plaintiffs' constitutional rights once judicial oversight ends."[18] At that point, "continued enforcement of the order is not only unnecessary, but improper" and the court "abuses its discretion when it refuses to modify an injunction or consent decree in light of such changes."[19]

III. ANALYSIS

Plaintiffs move the court to enforce the CAO and related decree provisions, arguing that Defendants failed to comply with its requirements, and even if the court finds that Defendants have complied with the CAO's requirements, their actions have failed to meet the objectives of the Decree, and further action is required. Plaintiffs propose that:

(1) the parties negotiate a comprehensive proposal to:

a. monitor the provider supply by provider type, statewide, by HHS Region and for class member distances to provider;

b. objectively measure the adequacy of the provider supply;

c. study the causes of any shortages (including independent surveys of enrolled and un-enrolled providers;

d. external and independent assessments of the adequacy of reimbursement rates; and

[16] *Id*. at 384-85.
[17] *Evans v. Fenty*, 701 F. Supp. 2d 126, 148 (D.D.C. 2010).
[18] *Id.* at 171.
[19] *Horne v. Flores*, 557 U.S. 433, 447, 450 (2009) (internal quotation marks omitted).

(2) jointly develop corrective action plans for the Defendants to implement in order to correct any shortages, including provisions for measurable evaluation of the effectiveness of those corrective actions.[20]

Defendants respond that they have fully complied with the CAO and the corresponding Decree provisions so that the judgment is satisfied. Alternatively, Defendants move the court to modify the Decree because its enforcement is no longer equitable.

First, the court addresses Defendants' position that the court should apply the legal standard for finding a party in civil contempt in considering Plaintiffs' motion for further action. Doing so would require Plaintiffs to provide clear and convincing evidence in support of their motion. The court declines to do so in this instance. Plaintiffs' motion does allege that Defendants' have failed to satisfy the objectives of the Decree and the CAO. However, Plaintiffs do not seek sanctions for that violation. Instead, Plaintiffs ask the court to order that further action be taken to bring Defendants into compliance with that Decree. The agreed-upon CAO, entered after Defendants failed to comply with the Decree, specifically contemplates Plaintiffs' actions in returning to court to resolve the parties' dispute regarding whether further action is required to meet the objectives of the Decree. Indeed, in its Order entering the CAOs, the court specifically noted that "Defendants' lead trial counsel pointed out that Defendants can comply with the Order because they had input into its development."[21] Plaintiffs argue that Defendants have not complied with the CAO, and, even if they had, further action would still be required to meet the Decree's objectives. Defendants' assented to this procedure, and the court sees no reason to hold Plaintiffs' to a higher burden in asserting their argument that further action is required.

[20] Dkt. 1033 at 2-3.
[21] Dkt. 663 at 12.

Second, Plaintiffs have vehemently contended that the "principles of contract law" should guide the court's interpretation of the Decree. More specifically, Plaintiffs argue that no Decree provision should be read in isolation, and all Decree provisions should be interpreted in light of the objectives of the Decree, in accordance with contract law principles. Plaintiffs appear to contend that by addressing each CAO and its related Decree provisions separately the court is somehow not requiring that Defendants meet the Decree's objectives.[22] The language of the CAOs belies this notion. The court explained in adopting the agreed-to CAOs that "[o]nce Defendants comply with the part of the Decree and related section of the Corrective Action Order, then the court may terminate *that part of the Consent Decree and the Corrective Action Order*."[23] The "'assessment conference' process provides a clear potential end point for Defendants' obligations under the Consent Decree."[24] The CAOs unmistakably contemplate that the court will address each one and its related Decree provisions individually as a way of expediting Defendants' compliance with a multifaceted Decree and providing a potential end point for Defendants' obligations to the court.[25] Indeed, Judge Justice explained that "[t]he complexity of this topic is demonstrated by the fact that the parties propose an eleven-part Corrective Action Order, with subparts for each of those eleven parts."[26] There is no evidence or argument put forward by Plaintiffs to show that this agreed procedure fails to give effect to the purpose of the parties or the court when the Decree was entered.

[22] Hr'g Tr. 20:20-25, Dec. 19, 2013, Dkt. 1129 ("The Defendants' argument is largely an attempt to divide the Consent Decree up into pieces, as if they're isolated and unrelated, and present them to the court, I think, out of context and try to get them broken down and, you know, basically vacated. I don't think—we don't think that is the correct way to analyze this.").
[23] Dkt. 663 at 15 (emphasis added).
[24] Dkt. 663 at 15.
[25] Dkt. 663 at 14.
[26] Dkt. 663 at 8.

a. Have Defendants satisfied the CAO and its related Decree provisions?

Defendants contend that they have satisfied the requirements of the provider supply CAO and its related Decree provisions and are therefore entitled to be released from its enforcement under prong 1 of Rule 60(b)(5). Plaintiffs contend that Defendants have failed to satisfy the provider supply CAO by:

(1) refusing to acknowledge and address provider shortages identified by the Provider Supply Assessments;

(2) failing to maintain sufficient payment levels to attract enough providers to serve the class; and

(3) failing to provide accurate information to class members and providers regarding which providers are accepting new patients and their limits on accepting new patients.

Defendants first note that the court has never found them in violation of the Decree provisions related to an adequate provider supply.[27] Nonetheless, the parties agreed to the CAO relating to provider supply in 2007. Defendants contend that the following were specific actions required under the CAO:

- rate increases for medical and dental providers of class members;
- application of $150 Million toward "strategic initiatives" to increase the access of class members to Medicaid services;
- preservation of Defendants' contractual timeliness and distance standards for managed-care organizations (MCOs);
- provision of semi-annual reports on the provider supply for class members enrolled in PCCM and MCO service delivery areas;
- provision of two "major" and two "interim" assessments of the Medicaid Provider Base, alternating between the two reports, spaced over four years; and
- creation of an online provider directory and use of Defendants' "best efforts" to ensure accuracy.

[27] Dkt. 1052 at 5-6.

Defendants maintain that these tasks have been completed "at a cost of well over a billion dollars in all funds."[28] Defendants provided the court with a summary of the actions they took in response to each bullet point of the CAO and the corresponding Decree paragraphs that can be found at Dkt. 1055-3.

The objectives of the "Decree References" in the provider supply CAO (Dkt. 637-9) can be summarized as:[29]

- providing comprehensive, timely, and cost effective health services to children;
- providing recipients, including those served by managed-care organizations, medical and dental check ups on a regular schedule;
- providing recipients all needed follow-up health care services permitted by Medicaid;
- ensuring an adequate corps of capable providers to achieve these goals,
- ensuring that managed-care organizations have an adequate supply of appropriate providers (including specialists) who are located conveniently so that recipients do not face unreasonable 1) delay scheduling appointments, 2) delay waiting for appointments once at the office; and
- maintaining updated lists of providers who serve EPSDT recipients including providers' practice limitations.

To reach these objectives, the provider supply CAO mandated in bullet point 1:

> (1) Care will be provided by an appropriate provider within Defendants' managed care distance standards ("distance standards") unless a provider of the appropriate type is not located that close to the class member's home. . . Within managed care, Defendants will ensure that the supply of primary care providers (PCPs) enrolled in each Managed Care Organization ("MCO") and within Primary Care Case Management ("PCCM") is adequate to allow class members to choose among at least two PCPs appropriate to meet the class members' needs.

Bullet point 2 explains

> (2) This Order relies on the timeliness and distance standards in Defendants' current managed care contracts. Defendants may change these standards only if new standards are more favorable to class members. Defendants will not change these

[28] Dkt. 1052 at 7.
[29] Dkt. 637-9 at 1-2 (citing Dkt. 135 ¶¶ 2, 3, 88, 93, 143, 190, and 197).

> standards so that they require class members to travel longer distances or wait longer for appointments than is now true under Defendants' current contracts. The current standards require that the MCO must ensure that all members have access to an age-appropriate PCP in the provider network with an open panel within 30 miles of the member's residence, that all members have access to an outpatient Behavioral Health Service provider in the network within 75 miles of the member's residence, and that all members have access to a network specialist physician within 75 miles of the member's residence for common medical specialties, which, for child members, shall include orthopedics and otolaryngology.

Paragraph 197 of the Decree stated that "TDH will assure by various means that managed care organizations have an adequate supply of appropriate providers who can serve EPSDT recipients (including specialists) located conveniently so that recipients do not face unreasonable 1) delay scheduling appointments, 2) delay waiting for appointments once at the office or 3) travel times to get to the office as authorized by SB10 and SB 600."

Defendants have represented to the court that 91% of children on Medicaid in Texas are now served by MCOs.[30] This CAO required Defendants to ensure that care was available to class members by an appropriate provider within the managed-care distance standards (where possible), and that MCOs enroll an "adequate" supply of PCPs to allow class members a choice between two providers. It also prohibited Defendants from detrimentally changing the timeliness and distance standards required of MCOs. Defendants declare that the vast majority of class members in managed-care have access to a choice of two primary care providers within 30 miles of their residence and to "common specialists" as required by the Decree and CAO.

To support their claim, Defendants put forth copies of uniform contracts entered with MCOs serving Medicaid and declarations from nineteen MCOs affirming their compliance with the distance standards in the contracts.[31] The Uniform Managed Care Contract for STAR and STAR+PLUS recipients requires MCOs to "ensure that all Members have access to an age-

[30] Hr'g Tr. 104:13-14, Dec. 19, 2013, Dkt. 1129.
[31] *See* Dkt. 1055-3 at 1-2.

appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member's residence."[32] Defendants also put forth evidence regarding dental managed-care contracts and declarations from the state's two dental managed-care providers, DentaQuest and MCNA, affirming their compliance with the state's requirement that members have access to two or more general dental providers with an open practice within thirty miles of the member's residence in urban counties and within 75 miles of the member's residence in rural counties where possible.[33]

Defendants rely on the Declaration of Edli Colberg, Ph.D., a Program Specialist for the HHSC's Strategic Support Division (SDS), to demonstrate Defendants' compliance with the distance standards where possible. [34] Dr. Colberg concludes that "[a]s of February 2013, 99.6% of members under age 21 enrolled in STAR and STAR Health MCOs had access to 2 in-network PCPs within 30 miles of their residence."[35] Dr. Colberg also identifies the percentage of members under age 21 in STAR and STAR Health MCOs within 75 miles of an in-network provider of several types of specialists.[36] For orthopedic surgeons, Dr. Colberg testifies that the statewide percentage of members under age 21 in STAR and STAR Health MCOs within 75 miles of an in-network orthopedic surgeon is 99.9%.[37] For otolaryngologists, the percentage is 99.7%.[38] For in-network psychiatry and neurology and child and adolescent psychiatrists, the percentages are 99.9% and 99.2%, respectively.[39]

[32] Dkt. 1055-4 at 5-6.
[33] Dkt. 1052 at 16, Dkt. 1059-7 ¶¶ 13-14, Dkt. 1064-4 ¶ 4.
[34] Dkt. 1055-2.
[35] Dkt. 1055-2 ¶ 14.
[36] Dkt. 1055-2 ¶¶ 39-49.
[37] Dkt. 1055- 2 ¶ 44.
[38] Dkt. 1055-2 ¶ 45.
[39] Dkt. 1055-2 ¶¶ 45-46.

MCOs are also obligated to "ensure that their networks are of sufficient size that appointments can be scheduled within specified generally accepted wait times."[40] The timeliness and distance standards are based on regulations issued by the Texas Department of Insurance.[41] Defendants have also put forth evidence of the MCOs' efforts to ensure their provider networks are adequate.[42] To monitor their compliance, all MCOs are contractually required to have a process for plan members to submit complaints.[43] Complaints are logged and reported to HHSC for investigation.[44]

Plaintiffs cite to the Declaration of Glenn Flores, M.D., in which he testifies that physicians still encounter problems serving class members. Plaintiffs generally object to Defendants' arguments and evidence demonstrating their compliance with the the distance standards and contend "that the distance standards are not a meaningful measure of the adequacy of the provider supply, which must be shown to satisfy the obligations of the Decree, particularly at ¶¶ 88 and 197."[45] Plaintiffs argue that proximity to providers does not guarantee that class members can actually access providers. Plaintiffs argue that "[e]ven if applied properly the distance standards are poorly suited to be a sole or even substantial metric for determining the adequacy of provider supply."[46] Plaintiffs' expert, Dr. Steinhauer, testified that "that even these distances probably present a barrier for some children with Medicaid that keeps them from getting a dental care that they need."[47] While Plaintiffs now criticize the distance standards, Plaintiffs agreed to the use of those distance standards in the CAO and cannot now contend that

[40] Dkt. 1052 at 42.
[41] Dkt. 1052 at 43-44.
[42] Dkt. 1052 at 45-46.
[43] Dkt. 1052 at 26.
[44] Dkt. 1052 at 46.
[45] Dkt. 1097 at 34.
[46] Dkt. 1097 at 3.
[47] Dkt. 1034-5 ¶ 22.

they are entirely irrelevant in determining the adequacy of the provider supply. Further, Plaintiffs disagree that Defendants have complied with bullet points 1 and 2 because Defendants relied on data reported by MCOs and not through their own independent data.[48]

The court finds that Defendants have taken action to ensure that care is available to class members by an appropriate provider within the managed-care distance standards articulated in the CAO through contractually requiring MCOs to meet the standards and setting up a process to monitor their compliance through reporting and complaint investigations. The contracts also contractually require the MCOs to enroll enough providers to allow class members a choice between two providers. Finally, Defendants have not detrimentally changed the timeliness and distance standards. The evidence shows that Defendants have fulfilled the requirements of these two paragraphs of the provider supply CAO.

Next, the CAO requires that

> (3) When class members call Defendants or their contractors (including but not limited to the Texas Health Steps ("THSteps") toll free number, MCOs, PCCM) for help finding a doctor, dentist, case manager or other provider of health care services, whenever possible the caller will be given the names of at least two providers of the appropriate type who are accepting new Medicaid patients of the relevant age at the time of the call, within the timeliness and distance standards required by this Order.

Defendants put forth their Exhibit 34,[49] a compilation of Quarterly Monitoring Reports (QMRs), and Exhibits 9-30, declarations from the twenty-one MCOs, to show their compliance with this portion of the CAO. Defendants' evidence highlights their efforts to implement policies and training that requires employees to give callers the names of at least two available providers within the distance standards whenever possible. The April 2013 Quarterly Monitoring Report explains that "Defendants have implemented the practice of providing a choice of at least two

[48] Hr'g Tr. 55:7-8, Dec. 19, 2013, Dkt. 1129.
[49] Dkt. 1070-4

providers (doctor, dentist, case manager, or other provider of healthcare service) upon client request."[50] Plaintiffs contend that Defendants' analysis does not provide a way of knowing "whether the two providers that they referred to are actually accepting new Medicaid patients."[51] Plaintiffs also represent that callers are often given names of providers that are not accepting new patients,[52] but Plaintiffs do not point to any specific evidence on this point.

Defendants have taken steps to ensure that whenever possible, callers will be given the names of at least two providers of the appropriate type who are accepting new Medicaid patients of the relevant age at the time of the call, within the timeliness and distance standards required by the provider-supply CAO.[53]

Next,

> (4) Defendants will comply with federal law concerning the availability of a choice of at least two MCOs in those areas of the state that are served by MCOs. In areas of the state served by PCCM there will be a choice of at least two PCPs. It is understood that federal law allows for short periods in which only one MCO is available in a service delivery area when, for instance, one of the two MCOs in the area is the subject of an enrollment freeze sanction or termination. Similarly, within PCCM, it is understood that in some rural areas of the state there may be only one PCP available. Apart from any pertinent rules pertaining to the Medical Transportation Program, nothing herein will prevent class members or their families from choosing to receive information about or assistance making an appointment with a provider at a greater distance than that specified in the plan.

Defendants have represented to the court that PCCM is no longer utilized in Texas, therefore those statements in the CAO related to PCCM are now obsolete. To prove their compliance with the remainder of this point, Defendants put forth the Declaration of Rudy Villarreal, Director of Health Plan Management ("HPM") at the HHSC, Exhibit 35, Attachment A.[54] Defendants represent that they are in compliance with federal law in all thirteen managed-care service areas

[50] Dkt. 1070-4 at 2.
[51] Hr'g Tr. 56:13-20, Dec. 19, 2013, Dkt. 1129.
[52] Hr'g Tr. 57:10-12, Dec. 19, 2013, Dkt. 1129.
[53] *See* Dkt. 1055-3 at 2-3.
[54] Dkt. 1070-5 at 6.

of the state.[55] Plaintiffs conceded at the hearing that "as far as we know, they're in compliance with [bullet point 4] . . . we're not arguing otherwise today."[56] Accordingly, the court finds that Defendants have satisfied the requirements of bullet point 4 of the provider-supply CAO.

Bullet point 5 states

> (5) Defendants' and their contractors' payment policies for all providers who serve class members will be consistent with currently accepted professional standards and practices. These policies will require coverage of all medically and dentally necessary health care services provided to class members. Payment levels will be sufficient to attract enough providers to serve the class, and comply with the Decree and this Order with respect to all class members, whether or not they are enrolled in managed care. In the 2008-09 biennium, for services provided to class members: a) reimbursement rates for dental providers will be increased to 50% above the SFY2006-07 reimbursement rate levels; and b) reimbursement rates for physicians and other professionals will be increased to 25% above state fiscal years 2006-07 levels. Furthermore, another $50 million will be applied toward additional reimbursement increases for specialists who treat class members. No later than September 1, 2007, Defendants and their contractors will adjust provider payment levels as needed to assure compliance with this Corrective Action Order and with the Decree. An additional $150 million will be applied toward strategic initiatives to improve class members' access to services. By July 23, 2007, the parties will begin to confer to determine if they agree on an approach to the use of the strategic initiative funds. Defendants will report on the status of the strategic initiatives in each quarterly report to the Court including an approximation of the number of class members served. A more detailed report will be provided annually in the July quarterly report.

"[S]ubsequent to the adoption of the CAO, a Physician Payment Advisory Committee was convened and a decision made that rather than increase all dental reimbursement rates by 50%, more good could be accomplished by allocating the same total amount of funds to raising the reimbursement rates of 54 of the most commonly used dental codes by 100%."[57]

Plaintiffs concede that the CAO only required a one-time rate increase, and that the increase was implemented and "is credited with a corresponding increase in the percentage of Texas dentists participating, at least to some extent, in Medicaid . . . [and] statewide, did increase

[55] Dkt. 1052 at 18.
[56] Hr'g Tr. 57:15-17, Dec. 19, 2013, Dkt. 1129.
[57] Dkt. 1052 at 21.

the number of class members being seen by those who have been participating."[58] It is also undisputed that $150 million was applied toward strategic initiatives and reported on in the QMRs as required. Indeed, Defendants contend that thirteen out of twenty-two strategic initiatives continue to be funded.[59] The remaining provisions require Defendants to: (1) implement payment policies consistent with currently accepted professional standards and practices; (2) require coverage of all medically and dentally necessary health care services for class members; and (3) maintain payment levels sufficient to attract enough providers to serve the class. Plaintiffs argue that the 2007 increase was not sufficient to attract enough providers to "keep pace with the growth of the class" and is therefore insufficient.[60]

In support of their allegation, Plaintiffs point to the testimony of Dr. Glenn Flores, reviewing an American Academy of Pediatricians survey which "identifies low provider payment as a very important barrier to pediatrician participation in Texas."[61] Plaintiffs highlight that the State applied a 2% reduction in reimbursement rates (1% in 2010 and 1% in 2011) and argue that Defendants failed to address the corresponding 21% increase in medical care rates as reported by the Consumer Price Index since 2007.[62] Plaintiffs assert that the "[r]educed reimbursements to providers has certainly caused their withdrawal from Medicaid."[63] Plaintiffs, through Dr. Flores's testimony, contend that a shortage of PCPs generally in Texas allows PCPs to be more selective about whom they will accept as patients and that privately insured patients

[58] Dkt. 1033 at 26 n.21.
[59] Dkt. 1052 at 22 n.46 ("Thirteen of the original twenty-two initiatives have been continued and integrated into Medicaid operations and client services through the 2012-13 biennium; on two of thirteen alone, HHSC has spent nearly $38 million for FY 2012.").
[60] Dkt. 1033 at 26 n.21.
[61] Dkt. 1033 at 19.
[62] Dkt. 1097 at 32-33.
[63] Dkt. 1033 at 19, 26.

are more economically attractive than those on Medicaid.[64] Plaintiffs also assert that the evidence shows that Defendants are not in compliance with the CAO and Decree requiring that payment levels be sufficient to attract enough providers to serve the class.[65]

Defendants contend that "payment policies for providers are consistent with currently accepted professional standards and practices, and these policies require coverage of all medically and dentally necessary health care services provided to children under age 21with Medicaid."[66] Defendants criticize Dr. Flores's reliance on the AAP survey.[67] The court is persuaded by Defendants' arguments and does not find the AAP survey to be a reliable assessment of the sufficiency of Medicaid payment rates in Texas.[68] The court does not question the reliability of Dr. Flores's testimony regarding his personal experience in treating Medicaid patients. Defendants concede that they have implemented "two separate, one percent (1%) reductions in Medicaid reimbursement rates."[69] Defendants also respond that the reduction in reimbursement rates was a result of "sizeable shortfalls in the state budget [that] resulted in significant cuts (approaching 10%) to all state agency budgets,"[70] but that these small reductions were "a direct result of HHSC's consistent efforts to maintain provider reimbursement at levels sufficient to assure an adequate supply of health care providers for children under age 21 with Medicaid." [71] Further, the rates paid to providers are dictated by state and federal law and based

[64] Dkt. 1034-6 at 5.
[65] Dkt. 1097 at 34.
[66] Dkt. 1052 at 19-20.
[67] Dkt. 1052 at 79-80.
[68] Dkt. 1052 at 58, 78-9
[69] Dkt. 1052 at 22.
[70] Dkt. 1098 at 17.
[71] Dkt. 1052 at 22.

upon "stakeholder input."[72] Defendants point the court to their Exhibits 2, 5, 8, 31, 36, 37, 38, 39, 40, 43, and the QMRs in support of their contentions.

At the time of the Decree, Plaintiffs contended that "[o]n average, Medicaid reimbursement rates are slightly less than 50% of physician's usual and customary charges."[73] This was considered one of several reasons that providers declined to treat Medicaid recipients. In 2007, "Medicaid reimbursement rates [had] not increased for years. . . ."[74] The rate increases implemented in 2007 were to be based in part on 2007 Medicare relative value units. The court noted at that time that Defendants had implemented RVUs in 1992 but had not updated them "[75] fifteen years later. Now, the process by which Medicaid reimbursement rates are set is detailed and complex. [76] Defendants rely upon the Declaration of Dan Huggins to describe the process by which Medicaid rates are determined by HHSC. Mr. Huggins is the Director of Acute Care Rate Analysis at HHSC.[77] Mr. Huggins testifies that now"[t]here are processes in place at HHSC and CMS to determine the adequacy of Medicaid reimbursement rates on an *ongoing* basis."[78] Further, "Texas Medicaid has a process in place to assure that all rates are reviewed at least once every two years."[79] Michelle Long, HHSC's *Frew* Coordinator, testified that "[a]ccording to the Texas Medicaid fee schedule, as of July 11, 213, Medicaid fee-for-service reimbursement remains well above the rates prior to September 2007, and in some cases, higher than they were before the effective 2% cut in February 2011."[80]

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[72] Dkt. 1052 at 106.
[73] Dkt. 135 ¶ 86.
[74] Dkt. 663 at 18.
[75] Dkt. 663 at 23.
[76] *See* Dkt. 1070-7 ¶¶ 5-11; Dkt. 1052 at 20.
[77] Dkt. 1070-7 ¶ 2.
[78] Dkt. 1070-7 ¶ 12 (emphasis added).
[79] Dkt. 1070-7 ¶ 13.
[80] Dkt. 1052-3 ¶ 50; *see also* Dkt. 1054-3.

It is undisputed that Defendants timely implemented the specific rate increase required by this part of the provider-supply CAO. But in entering the CAO, the court noted that "[t]he settlement, however, specifically 'does not address what reimbursement rates will be needed for future years after the 2008-2009 biennium."[81] This was intended to allow "adjustment of reimbursement rates if further increases are necessary to improve class members' access to necessary health care."[82] Plaintiffs only contend that Defendants have not implemented sufficient payment levels to attract enough providers to serve the class. But Plaintiffs also contend that the provider supply has never kept pace with the growth of the class, even when the 2007 rate increases were implemented. Plaintiffs have put forth no evidence of what they contend rates should be to attract enough providers to serve the class. Further, Plaintiffs have not pointed to any evidence that the small rate decreases in 2011 have decreased the provider supply. There is no evidence that Defendants are not in compliance with federal law with regard to Medicaid reimbursement rates for providers at this point, and the consent decree may exceed appropriate limits if it is "aimed at eliminating a condition that does not violate federal law or does not flow from such a violation."[83] Defendants have created systems to frequently review Medicaid rates and confirm that the rates are appropriate.[84] It is unclear what further action, at this point, is even feasible to increase Texas Medicaid rates. The court finds that Defendants have satisfied their obligations under bullet point 5 of the provider-supply CAO.

Bullet points 6 and 7 require:

> (6) Defendants will make readily available to all providers who serve class members complete, accurate and up to date information about which providers of health care services in each geographic area are accepting new Medicaid-covered patients. The information for each will include: a) type of provider (e.g., general

[81] Dkt. 663 at 29; Dkt. 663 at 4 n.1.
[82] Dkt. 663 at 29-30.
[83] *Horne v. Flores*, 557 U.S. 433, 450 (2009).
[84] Dkt. 1070-7.

dentist, family medicine physician, pediatric neurologist, physical therapist, case manager); b) with which Medicaid managed care organizations the provider has contracted; c) whether the provider participates in fee for service Medicaid; and d) practice limitations such as age range of patients accepted.

(7) By Fall 2007, Defendants will initiate their new web-based Provider Look Up system. Defendants expect that the new system will improve the accuracy of their information about Medicaid-enrolled health care providers of all types, because to be able to use the system, providers will be required to update important information on a regular basis. Defendants will use their best efforts to ensure the accuracy of lists of enrolled health care providers in managed care (HMO and PCCM) and fee for service. "Accurate" means that the lists provide accurate and up to date information about each enrolled health care provider, as follows: a) name, b) address, c) telephone number, d) nature of practice (pediatrician, general dentist, pediatric cardiologist, etc.), e) language(s) spoken other than English, f) whether the provider is accepting new patients and any limits on new patients accepted, such as lengthy waits for a first appointment, and g) practice limitations (only newborns, only teens, etc.). Defendants will be able to provide accurate information by specialty and location (for example, endodontists in the Dallas area; pediatricians in Houston, case managers in Region 1). Defendants will use their best efforts to ensure that only accurate information about enrolled health care providers is provided to class members, whether the information is provided by Defendants or by their contractors. Defendants will also use their best efforts to ensure that only accurate information is available by telephone, in writing and on an easy-to-use-website for the use of health care providers who serve class members.

Paragraph 93 of the Decree also requires Defendants to "maintain updated lists of providers who serve EPSDT recipients. The lists will specify practitioners' practice limitations, if any. Defendants will provide to appropriate NHIC staff information about provider practice limitations and encourage NHIC to use the information."[85] "NHIC", or National Heritage Insurance Company, was replaced by "TMHP" or the Texas Medicaid and Health Partnership in 2004.

It is undisputed that Defendants implemented an Online Provider Lookup ("OPL") system by November 2007. Providers are required to update their information every six

[85] Dkt. 135 ¶ 93.

months.[86] The OPL is also updated daily with data from MCOs.[87] MCOs are required by Defendants to "maintain accurate current online and print version of their respective provider directories, to update their online provider lists twice a month, and to update their hardcopy versions quarterly."[88] HHSC "monitors and confirms the MCOs' efforts to maintain accurate lists and reports a summary of those efforts to the Court in the MCO Activities Reports in each QMR."[89] HHSC also performs periodic random checks of provider directors.[90] An MCO that fails to comply is put on a corrective action plan until improved.[91] Defendants point the court to Exhibits 8, 9-29, 35, 36, 42, 43, and Dkt. 1049-10, the July 2013 QMR, in support of their contentions. Further, Defendants contend that "[s]ince January 2009, TMHP has not received any phone calls or written correspondence regarding complaints from providers or clients about the accuracy of the data displayed in the OPL."[92] Defendants argue that they have complied with the CAO by using their "best efforts" to ensure the accuracy of the timely created OPL and the MCOs' provider directories.[93] Finally, Defendants argue that the isolated complaints highlighted by Plaintiffs are "not persuasive of anything,"[94] particularly because the majority of the complaints received were resolved by Defendants.[95]

Plaintiffs contend that Defendants have failed to satisfy the Decree and CAO by not using their *best efforts* to ensure the accuracy of provider information given to class members or the accuracy of information supplied to providers to make referrals. Plaintiffs point to complaints

[86] Dkt. 1052 at 25.
[87] Dkt. 1052 at 25.
[88] Dkt. 1052 at 26.
[89] Dkt. 1052 at 26.
[90] Dkt. 1052 at 27.
[91] Dkt. 1052 at 27.
[92] Dkt. 1052 at 37.
[93] Dkt. 1052 at 104.
[94] Dkt. 1052 at 58, 107-113.
[95] Dkt. 1084-2.

received by Defendants regarding inaccurate information being provided by their plans.[96] Plaintiffs also, for the first-time in the sur-reply, put forth an affidavit from Jennifer Dailey, the mother of a class member who became eligible for Medicaid in October 2013.[97] Ms. Dailey details her difficulties in attempting to locate a PCP for her daughter based on the provider information she was given from the MCOs and the OPL. Plaintiffs also put forth testimony from Maria Sauceda, Legal Secretary to Plaintiffs' counsel, regarding her attempt to find providers that may be available in her region, despite the fact that she is not currently on Medicaid.[98] Plaintiffs contend that "[t]hese declarations are evidence not only of widespread inaccuracies in Defendants and MCOs' provider lists, but that Defendants and their MCOs are aware of the inaccuracies and do not correct them."[99] Plaintiffs' complain that Defendants' OPL relies on providers to update their own information (even though, the CAO specifically dictates that "*providers* will be required to update important information") and only requires that it be updated every six months.[100] At the same time, Plaintiffs complain about the administrative burden on providers to participate in Medicaid.[101]

The court finds that Defendants have used their best efforts to ensure accuracy of the OPL and contractors' lists including "requiring providers in their Medicaid provider agreement to provide timely notification of any changes to their demographic information, deactivating providers who have not submitted a claim or had managed-care encounter activity for a period of 24 months, running nightly queries of the Encounters Online Data Store to update the online provider lookup (OPL) (utilizing updated data from files submitted by MCOs), and providing

[96] Dkts. 1033-3, 1034-4.
[97] Dkt. 1101-2.
[98] Dkts. 1097-3, 1101-1.
[99] Dkt. 1101 at 4.
[100] Dkt. 1097 at 27-28.
[101] Dkt. 1033 at 19 ("Other noted barriers include the Defendants' burdensome paperwork, complex programs and confusing policies, and unpredictable payment.").

incentives to providers to comply with Defendants' mandate that providers verify their information on the website every six months."[102] Indeed, MCOs are contractually

> required to maintain accurate and current online and print versions of their respective lists, to update their lists twice a month, and to update their hardcopy versions quarterly. All Medicaid MCOs report their processes for updating their lists to HHSC, which monitors and confirms the MCOs' efforts to maintain accurate lists and reports a summary of those efforts to the Court in the MCO Activities Reports in each QMR.[103]

Defendants have satisfied their obligations under bullet points 6 and 7 of the CAO.

Bullet points 8-11 state that

(8) Every other year Defendants will conduct a "major assessment" of its Medicaid Provider Base. The assessment will include a) all of those provider types that provide services to class members; b) for each provider type, the number and percent of providers who are "available" to class members; c) for each provider type, the number and percent of providers who have provided any service to any class member; and d) for each provider type, the number of providers who are enrolled in Medicaid but have not provided any services to class members. In this assessment, Defendants will review the six months immediately preceding the start date of the assessment. If the major assessment identifies a shortage in any geographic area of any provider type(s) that provide services to class members, Defendants will develop a plan to address the shortage. The first major assessment will be completed no later than May 2008. The second major assessment will be completed within 24 months of the first major assessment.

(9) In the interim years, Defendants will conduct an "interim assessment" of the sufficiency of its "available" Medicaid Provider Base. The assessment will include the PCPs for class members, pediatricians, general dentists for class members, orthodontists, psychiatrists for class members, and psychologists for class members. If the interim assessment identifies a shortage of providers of any of these types in geographic areas of the state, Defendants will develop a plan to address the shortage. The interim assessments will be completed no later than 12 months after completion of the major assessments.

(10) For the purpose of the "major" and "interim" assessments, "available" means a health care provider who has provided at least one service to at least one new class member in the six months immediately preceding the start date of the assessment. Furthermore, for the purpose of these assessments, Defendants will

[102] Dkt. 1098 at 7 n.11; *see also* Dkt. 1071-1 (Declaration of Andrea Daniell, Communication Officer, Government Healthcare Solutions, for Xerox State Healthcare LLC, which is the contractor for TMHP responsible for the OPL).
[103] Dkt. 1098 at 7 n.12.

independently assess whether health care providers are providing services to: a) new class members, and b) any class members. Defendants will not merely accept information on these topics from their contractors.

(11) At their option, Defendants' Research and Evaluation staff may complete the major and interim assessments.

The Assessments were intended to provide the parties with more information regarding the number of providers actually taking new class member patients.[104] The Assessments reveal for each type of provider: the number of enrolled providers, the number of enrolled providers that filed claims, the number of enrolled providers with new patient claims, and the number of eligible class members.[105] A provider is considered "enrolled" in Medicaid if the provider bills Medicaid for a single service within the preceding twenty-four months, but all providers that are "enrolled" in Medicaid may not actually be "available" to see class members. A provider is "available" under the terms of this CAO when he or she has provided at least one service to at least one new class member in the six months immediately preceding the start date of the Assessment. Plaintiffs concede that the definition of "available" "includes many providers who may not be *accessible* to the Plaintiffs."[106]

Defendants originally did not provide the Assessments in six-month increments, but instead provided Assessments of the preceding twelve months of data. In April 2012, this court ordered the Defendants to provide "a report showing the number and type of health care providers 'available' to class members, that is, those health care providers who have treated at least one new class member within the preceding six months, for the six month periods ending

[104] Dkt. 663 at 33.
[105] "Eligibles" is the "[n]umber of Medicaid Eligibles age birth through 20, excluding Women's Health Program, Emergency-only eligible, and Medicare/Medicaid dual eligible not eligible for full Medicaid medical benefits, for the last month of the Assessment. *See, e.g.*, Dkt. 912-1 at 5.
[106] Dkt. 1097 at 13 n.9 (emphasis added).

August 31 of the years 2008, 2009, 2010, and 2011."[107] Defendants complied with that order and submitted correct Assessments.[108] Plaintiffs contend that Defendants' failure to timely produce the Assessments in accordance with the terms of the CAO prevented identification of provider shortages and evaluation of the success of Defendants' efforts to improve the provider supply. Defendants contend that the Assessments do not show any provider shortages that require corrective action.

Defendants did initially fail to comply with the CAO when they unilaterally decided to report the statistics in twelve-month increments instead of complying with the terms of the CAO requiring six-month increments—to which they agreed and affirmed to the court was "'something that works and is efficient . . . .'"[109] Defendants instead opted to report twelve-month increments and to conduct an additional analysis based on the distance standards laid out in the CAO. Defendants contend that this somehow "exceeded the requirements" of the CAO because it included an additional analysis not required by the terms of the order.[110] Defendants' purported reasons for producing the twelve-month Assessments are "that: (1) claims take up to eight months to finalize, meaning that going back only six months data will be missing, and (2) Plaintiffs insisted that HHSC revise its first completed, major assessment, several times, and instead break down the results into 85 provider specialties and subspecialties,"[111] some of which are rarely utilized by class members for various reasons. Defendants also contend that Plaintiffs' argument that they failed to comply with this portion of the CAO is "both moot and specious" because Defendants did ultimately produce the Assessments in six-month increments (in

[107] Dkt. 898.
[108] Dkt. 912.
[109] Dkt. 663 at 12 (quoting Defendants' lead trial counsel from the hearing regarding the implementation of the Corrective Action Orders).
[110] Dkt. 1052 at 61-63.
[111] Dkt. 1025 at 62 n.152.

response to this court's order) and because the delay in the production was attributable to Plaintiffs' "insistence on revising the original major assessment".[112] Defendants maintain that they "timely filed the required assessments, and—based upon Defendants' determination that 12-month increments would provide more useful information—assessments were conducted using data for 12-month increments, as opposed to 6-month increments."[113] Defendants did not *timely* file the *required* Assessments, which were only completed and filed after an additional court order.

The court is concerned about the actions taken by both sides with regard to these Assessments. First, Defendants should have approached Plaintiffs about their concerns that the six-month increments would provide less than useful information and attempted to negotiate an amendment to the CAO instead of unilaterally producing an assessment other than what was agreed upon.[114] There is no evidence put forth by Defendants that any negotiation was attempted with regard to the timeframe of the Assessments. In 2005, the court admonished Defendants that by unilaterally disregarding provisions of the Consent Decree, Defendants faced the possibility of "equitable sanctions for willful violation of Consent Decree provisions."[115] The court reminded Defendants that "[u]nless and until the Court grants a Rule 60(b) motion to modify or dissolve the decree, the obligations contained in the Consent Decree are binding and enforceable, and Defendants may not choose to disregard them after unilaterally determining that a provision is unnecessary or undesirable."[116] Defendants accuse Plaintiffs of delaying the Assessments by

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[112] *Id.*
[113] Dkt. 1098 at 13; *see also* Dkt. 1052 at 28.
[114] Dkt. 1052 at 21. The parties managed to agree to an amendment of the provisions related to the raise in reimbursement rates for dental services required by the CAO after it was initially filed with the court.
[115] *Frew v. Hawkins*, 401 F. Supp. 2d 619, 653-54 (E.D. Tex. 2005) (addressing Defendants' willful failure to comply with portions of the Consent Decree related to Statewideness reports).
[116] *Id*. at 654.

requesting revisions, but it is unclear to the court why the time-period issue was not addressed by the parties during those discussions. The Declaration of Michelle Long explains that Defendants agreed to add additional provider specialties and subspecialties to the Assessments.[117] Ms. Long also testifies that "the statistical staff at HHSC Strategic Decision Support (HHSC SDS) expressed concern that the numbers for some provider types would be too small to draw meaningful conclusions if only six months of data were analyzed; based upon their recommendation, the reporting time frame was expanded to twelve months."[118] Ms. Long's testimony does not show that Defendant made any attempt to confer with Plaintiffs regarding this change. The Declaration of Jane Meier, a Research Specialist for HHSC's Strategic Decision Support Division ("SDS") explains that because Defendants believed that "[r]eporting six-month counts for relatively uncommon subspecialties would have made data patterns more difficult to identify," "Defendants' Strategic Decision Support . . . revised the character of the report to accommodate Plaintiffs' request while providing data in a way that could be meaningfully reviewed."[119] While that may be true, their actions still amounted to a violation of the CAO. Second, Plaintiffs failed to bring this issue to the court's attention until after all of the Assessments had been completed in 2012. At that point, the parties had to brief the issue, the court had to conduct a hearing, and then the court ordered Defendants to go back and re-do the Assessments. Now the parties have re-briefed the issues and the court has held a second hearing and reexamined the issues and the voluminous evidence. This was an expensive and time-consuming process for all involved, which ultimately ended up seriously delaying the conclusion of this CAO. Nonetheless, Defendants have now produced the Assessments as required.

[117] Dkt. 1052-3 ¶ 13.
[118] Dkt. 1052-3 ¶ 13.
[119] Dkt. 1071-5 ¶ 20.

Further, Defendants admit that they "didn't do anything in response to [Plaintiffs'] Assessments" because Defendants felt the Assessments did not provide any actionable information.[120] Defendants contend that both the six-month and twelve-month Assessments do not reveal any provider "shortages" because the Assessments only show the number of providers that billed for services to a new class member within the previous six months, and it is impossible to draw any conclusions based on that information alone.[121] Yet the CAO requires Defendants to develop a plan to address shortages identified by the Assessments. Defendants' argument that it is actually impossible for the Assessments to identify a shortage is disingenuous given that they agreed to and had input on the process laid out in the CAO. [122]

Plaintiffs concede that "[f]or some provider types, the Assessments show increases in the number of "available" providers."[123] However, Plaintiffs argue that "these small increases are in most cases outdistanced by larger percentage increase in numbers of class members"[124] and are therefore evidence of an ongoing shortage.[125] Plaintiffs contend that a comparison of the provider supply at the time of the CAO "to the provider supply now as compared to the size of

[120] Hr'g Tr. 161:22-162:2, Dec. 19, 2013, Dkt. 1129; Dkt. 1052-3 ¶ 27 ("Data included in the final (2011) interim assessment did not indicate a Medicaid provider shortage in any geographic area."); *see also* Dkt. 1052 at 29.
[121] Dkt. 1098 at 13; Dkt. 1052-3 ¶ 10 ("The major and interim assessments did not provide, and were not required to provide, information regarding the number of children who *needed* a health service, and they did not identify the number of providers available to provide a service if one had been requested."); Dkt. 912 at 2 (" . . . Defendants caution against the making of any broad, qualitative conclusions regarding whether a particular number of providers is the appropriate amount to serve the class based entirely on these assessments.").
[122] Dkt. 663 at 12 ("Defendants' lead trial counsel pointed out that Defendants can comply with the Order because they had input into its development. It requires Defendants to do things that are possible and make sense.").
[123] Dkt. 917-1 at 2.
[124] Dkt. 917-1 at 2-3; Hr'g Tr. 69:3-7, Dec. 19, 2013, Dkt. 1129.
[125] Hr'g Tr. 71:10-15, Dec. 19, 2013, Dkt. 1129. Plaintiffs made a similar argument in seeking further action on the CAO pertaining to lagging counties. Plaintiffs argued that any increase in participation was "minimal" and did not satisfy the objectives of the Decree. Dkt. 1020 at 12-13.

the class . . . represents a significant step backwards."[126] Furthermore, Plaintiffs point out, and Defendants concede, that for some specialties there is a decline in the number of available providers. For instance, the number of available *pediatricians* declined in three regions. Defendants respond that the CAO requires them to make two *PCPs* available to class members and not two *pediatricians*, and that pediatricians are a subset of PCPs, the number of which *increased* in the same regions. Ms. Meier explains that "[p]ediatricians are one of four specialties that can act as primary care providers (PCPs), the first contacts for access to care, and the decreases in available pediatricians were more than offset by increases in available PCPs."[127] Indeed, Plaintiffs' own expert, Dr. Glenn Flores, testified that a shortage of PCPs exists generally in Texas and not just in regard to class members.[128] Plaintiffs remain unsatisfied, however, replying that the CAO requires that Defendants address shortages of *each type* of physician.[129] Plaintiffs' expert, Dr. Flores, mentions especially a delay in referrals for pediatric dermatology, pediatric mental healthcare, developmental/behavioral pediatrics, orthopedists, and dentists.[130] Plaintiffs' Exhibit 6 includes documentation of a call from a referral coordinator of a non-profit agency regarding her difficulty in finding specialists in urology, cardiology, neurology, psychiatry, otolaryngology, pulmonology, allergists, and infectious diseases.[131] Plaintiffs' expert,

[126] Hr'g Tr. 69:15-17, Dec. 19, 2013, Dkt. 1129.
[127] Dkt. 1071-5 ¶ 24.
[128] Dkt. 1034-6 at 5.
[129] Dkt. 1097 at 17; Dkt. 637-9 at 6-7.
[130] Dkt. 1034-6 at 9, 10, 12.
[131] Dkt. 1033 at 21, Pl's. Ex. 6. But Defendants' Exhibit 64 documents that when the MCO spoke with the coordinator, she "confirmed . . . that the referenced shortage of pediatric subspecialists was 'not due to a lack of Superior contracted pediatric subspecialists in the Tyler area,' but was instead 'a community issue' and that '[n]ormal practice patterns for Members/Patients in the Tyler area needing pediatric specialty services is to travel to Dallas for those services." Dkt. 1084-2 at 4. Defendants also noted that the particular patient at issue was granted an out-of-network authorization to see a pediatric urologist. *Id.*

Dr. Steinhauer, testified that there is an inadequate supply of oral surgeons in some regions.[132] Also, for the first time in their reply, Plaintiffs contend that Defendants math artificially inflates the percentages of available providers by relying on percentages of enrolled providers that met the definition of available instead of the percentage of "active" providers that met the definition of "available."[133]

Neither the Decree, CAO, nor federal Medicaid law establish a number or ratio of providers to recipients that would constitute an "adequate" supply and fulfill the requirements of the CAO and objectives of the Decree. The terms of a consent decree "are arrived at through mutual agreement of the parties" after careful negotiation, and "it is the parties' agreement that serves as the source of the court's authority to enter judgment at all."[134] "Courts should not impose their own terms within a consent decree and should read consent decree terms by their plain meaning."[135] A consent decree embodies agreements reached "after careful negotiation has produced agreement on [its] precise terms."[136] "[W]hen a contract is expressed in unambiguous language, its terms will be given their plain meaning and enforced as written."[137]

Accordingly, the court first looks to other provisions of the Decree for guidance in determining what constitutes an "adequate" supply of providers.[138] Paragraph 88 explains that

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[132] Dkt. 1034-5. Defendants criticize Dr. Steinhauer's affidavit as being based on outdated numbers regarding the transition to dental managed-care. During his deposition, Defendants provided Dr. Steinhauer with the most current data on dental managed-care, and Dr. Steinhauer admitted that the numbers "good." Dkt. 1052 at 58, 95.
[133] Dkt. 1097 at 12.
[134] *Local No. 93, Int'l Ass'n of Firefighters, AFL-CIO C.L.C. v. City of Cleveland*, 478 U.S. 501, 519, 522 (1986).
[135] *United States v. Alcoa, Inc.*, 533 F.3d 278, 286 (5th Cir. 2008).
[136] *Local No.* 93, 478 U.S. at 522 (quoting *United States v. Armour & Co.*, 402 U.S. 673, 681-82 (1971)).
[137] *United States v. Chromalloy Am. Corp.*, 158 F.3d 345, 350 (5th Cir. 1998)
[138] *Frew v. Gilbert*, 109 F. Supp. 2d 579, 594-98 (E.D. Tex. 2000) (holding that parties' purpose, as delineated in the Decree, informed the court's interpretation of a Decree provision related to

"[a]n adequate corps of capable providers is necessary to provide recipients with adequate access to needed services."[139] Paragraph 197, relating to managed care, states that "TDH will assure by various means that managed care organizations have an adequate supply of appropriate providers who can serve EPSDT recipients (including specialists) located conveniently so that recipients do not face unreasonable 1) delay scheduling appointments, 2) delay waiting for appointments once at the office or 3) travel times to get to the office as authorized by SB10 and SB 600."[140] Bullet point 1 of the CAO adds that "[w]ithin managed-care, Defendants will ensure that the supply of primary care providers (PCPs) enrolled in each Managed-care Organization ("MCO") . . . is adequate to allow class members to choose among at least two PCPs appropriate to meet the class members' needs."[141] Notably, the court's order adopting the CAOs stated that "[f]ollowing the studies, Defendants will develop plans to remedy shortages of each type of provider in any *geographic* area, if any are found."[142] Other portions of the Decree, not necessarily related to the supply of providers, offer the court some persuasive evidence of the parties' definition of these terms. Paragraph 246 of the Decree, relating to Defendants' provision of toll-free numbers, states that an "'inadequate supply of providers' means that staff cannot satisfy a recipient's request for a needed provider or providers."[143] "Inadequate" is defined in relation to the transportation program in paragraph 228 as meaning "problem(s) exist that Defendants can reasonably be

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whether "'informing' has been done 'effectively,' or an outreach workload handled 'effectively.'")

[139] Dkt. 135 ¶ 88.

[140] Dkt. 135 ¶ 197. The court notes that because 91% of class members are now served by MCOs, this requirement may be the most relevant.

[141] Dkt. 637-9 at 2.

[142] Dkt. 663 at 33 (emphasis added); *see also* Dkt. 637-9 at 6 ("If the major assessment identifies a shortage in any geographic area of any provider type(s) that provide services to class members, Defendants will develop a plan to address the shortage.").

[143] Dkt. 135 ¶ 246.

expected to correct."[144] Taken as a whole, the CAO and Decree appear to require Defendants to retain enough providers to assure recipients adequate access to needed care, which means that recipients do not face unreasonable 1) delay scheduling appointments, 2) delay waiting for appointments once at the office or 3) travel times to get to the office, and allows class members a choice of two PCPs in each geographic area. This comports with the usual and unambiguous meaning of the term "shortage," which is defined as "a state in which there is not enough of something that is needed."[145]

In 2007, the court found that the class had increased from 1.5 million in 1993 to 2.8 million in 2006.[146] The court also stated that "[d]espite this increase in the size of the class, Defendants have not succeeded in increasing—or even maintaining—the number of health care providers who take care of class members."[147] But, at that time, the court also noted that "[e]ven when there is an adequate supply of health care providers for the total population, not enough health care providers take care of class members."[148] Defendants took action to increase the provider supply in areas of the state where providers exist for the total population but are not enrolled as Medicaid providers.

Defendants put forth the Declaration of Michelle Long, which explains that, relying on bullet points 1 and 2 of the CAO, Defendants "considered Medicaid provider shortage areas requiring corrective action to be those in which a provider is practicing, but where children enrolled in Medicaid do not have access to that type of provider within a specified distance from their home."[149] Defendants then targeted their recruitment efforts on those providers.[150]

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[144] Dkt. 135 ¶ 228.
[145] *Shortage Definition*, M-W.COM, http://www.merriam-webster.com/dictionary/shortage.
[146] Dkt. 663 at 17.
[147] Dkt. 663 at 17.
[148] Dkt. 663 at 18.
[149] Dkt. 1052-3 ¶ 12.

Defendants contend that "the only rational approach to stemming perceived provider shortages is to focus upon recruiting providers who are already located in potential shortage areas but not enrolled in Medicaid,"[151] because the state cannot force doctors to practice in other areas of the state, nor can it force class members to relocate where there are more providers. So, Defendants, "using the same taxonomies used in the major assessment and the list of common medical specialties (as defined by HHSC), HHSC: [c]reated maps and tables comparing providers with an NPI[152] to providers enrolled in Medicaid; [i]dentified areas of the state for which a provider had an NPI but no enrolled Medicaid provider existed; and [d]irected their contractor, TMHP to conduct a targeted recruitment to the providers whose participation in Medicaid would increase access points for children enrolled in Medicaid, meaning a licensed provider existed in the area, but that provider was not enrolled in Medicaid."[153] As a result of these efforts, Defendants "learned that in most cases access in these areas was comparable to what was available to the general population,"[154] and that "children on Medicaid have access to specialists that satisfies the distance standards of children with private insurance"[155] in accordance with federal law.[156] Defendants assert that "there is a general shortage of [] specialty provider types that is not specific to the Medicaid population."[157] For instance, Defendants draw attention to the fact that there are only forty-one developmental pediatricians in the entire state, so any shortage that exists does not exclusively affect Medicaid patients.[158] Similarly, there are only twenty-two

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[150] Dkt. 1052 at 29.
[151] Dkt. 1052 at 64.
[152] An NPI is a National Provider Identifier that health care providers must have to bill insurance companies. Dkt. 1052-3 ¶ 19.
[153] Dkt. 1052-3 ¶ 19.
[154] Dkt. 1052 at 67.
[155] Dkt. 1052 at 30, 77.
[156] Hr'g Tr.157:1-3, Dec. 19, 2013, Dkt. 1129.
[157] Dkt. 1052 at 97.
[158] Dkt. 1052 at 88.

pediatric dermatologists in the state.[159] However, Defendants argue that the transition to managed-care has actually increased availability of specialists because MCOs can authorize out-of-network and out-of-area providers.[160]

Defendants point to their Exhibits 2, 6, 45, 46, and 83 as well as Dkts. 800-1, 838-4 and 950 in support of their contention. Defendants also ask the court to consider their "Provider Access Reports" (PARs) in determining whether further action is required under these provisions.[161] Bullet Point 12 explains

> (12) Defendants receive monthly reports about the status of the supply of providers from their PCCM administrator and each of the MCOs. Defendants also compile semi annual [sic] reports of the adequacy of provider supplies in PCCM and each MCO by service delivery area. Defendants will provide these reports and information about corrective action plans, if any, in their January and July quarterly reports to the Court.

The PARs address MCOs compliance with the distance standards enumerated in the CAO. According to Defendants, the PARs "establish that 97-99% of class members in managed-care have access to providers within the parties' agreed distance standards."[162] Further, Defendants believe the PARs

> consistently show that nearly 100% of children under age 21 with Medicaid served in managed care have access to a choice of primary care providers (PCPs) within 30 miles of his/her home. Access to common medical specialists within 75 miles of home is nearly 100% in urban areas, and ranges from a low of 70% access (in one health plan in one region served by four health plans) up to 100% access to particular types of medical specialists in more rural areas.[163]

[159] Dkt. 1052 at 89.
[160] Dkt. 1052 at 76.
[161] Dkt. 912 at 2.
[162] Dkt. 912 at 2.
[163] Dkt. 1052 at 31-32.

Plaintiffs condemn the "provider access reports" as only showing PCPs with an "open panel"[164] and not disclosing "how recently a PCP has accepted a new patient, or for how long they will accept new patients, or how long a class member may have to wait for an appointment."[165] The same could be said of the Assessments. The fact that a provider billed for one service for one new patient in the preceding six months does not necessarily mean that provider is actually available to take new patients. It also sheds no light on how long the provider will be accepting new patients or how long a class member has to wait for an appointment.

Plaintiffs also disapprove of the "provider access reports" because the reports are "based on self-reported, unverified, information from the Defendants' managed-care contractors, who are contractually obligated to meet the provider-patient distance requirements."[166] Plaintiffs have not put forth any evidence, however, to support their allegation that these reports are unreliable.

Defendants took initiative to address existing problems that Defendants can reasonably be expected to correct. Defendants cannot materialize more providers, nor can the state require providers to practice in a certain area. The state's actions in recruiting and enrolling providers where providers existed but were not serving the class helps achieve the objective of retaining enough providers to assure recipients adequate access to needed care. Plaintiffs have not put forth any evidence of a class member who was denied access to needed care or who faced an unreasonable delay in scheduling appointments, or in waiting at an office, or with respect to travel times. Defendants' actions take steps to enhance recipients' access to health care and

[164] At the hearing on this motion, Defendants characterized having an "open panel" as meaning that a PCP is accepting new Medicaid patients. Hr'g Tr. 134:14-19, Dec. 19, 2013, Dkt. 1129. Plaintiffs criticize this designation because it does not distinguish between providers that may treat patients in an emergency room but are not actually accepting new patients in private practice, and MCOs provide PCPs financial incentives to maintain an "open panel." Hr'g Tr. 52:6-24, Dec. 19, 2013, Dkt. 1129.
[165] Dkt. 1033 at 15-16.
[166] Dkt. 1033 at 16, 28 n.22.

improve the use of health care services by Texas EPSDT recipients. The court finds that the terms of bullet points 8-12 of the CAO have been satisfied.

Finally, bullet point 13 states

> (13) After Defendants complete two major assessments, and two interim assessments, counsel will confer to determine what, if any, further action is required. Counsel will begin to confer no later than 30 days following completion of the second interim study ("completion"). If the parties agree, they will so report to the Court within 120 days of completion. If the parties cannot agree within 90 days, the dispute will be resolved by the Court upon motion to be filed by either party. If the parties cannot agree, either party may file its motion within 30 days of completion of discussions among counsel.

It is undisputed that the parties have conferred about what, if any, further action is required under this CAO and the Decree. However, the parties cannot agree, and they have now filed the instant motions so that the dispute can be resolved by the court.

Defendants also seek an order from the court that they have satisfied the corresponding provisions of the Consent Decree: paragraphs 75-94, 97-103, and 197. Compliance with paragraphs 93 and 197 was discussed in conjunction with the CAO *supra*.

Paragraphs 75-87, 89, 92, and 97 provide background information to the Decree, and while some of that information is outdated or obsolete, no modification is warranted as these paragraphs do not require action on the part of Defendants. To the extent that Defendants are required to report any information in the QMRs related to these paragraphs, the parties are ordered to meet and confer regarding an agreement to remove the outdated or obsolete provisions from the QMR. Any agreements should be filed with the court for the record.

Defendants contend, and Plaintiffs do not dispute,[167] that Defendants have complied with paragraph 90 of the Decree, requiring them to implement use of a simplified form for EPSDT medical check ups in 1995. The court finds this paragraph of the Decree fully satisfied.

[167] Hr'g Tr. 24:10-14, Dec. 19, 2013, Dkt. 1129.

Paragraph 91 reads: "Defendants have created a new billing form for immunizations. It allows the tracking of recipients' progress toward completion of the full series of immunizations. The tracking system will be in place and running by January, 1996. This system will permit providers to promptly request up to date information about patients' immunization status." While the parties touched briefly on this paragraph at the hearing on this matter, it was not briefed in the motions. This paragraph does not necessarily relate to the provider supply, other than being listed as a "see also" provision on page 2 of the CAO. The court declines to modify this paragraph at this time. Should Defendants wish to move for relief under Rule 60(b)(5) on this paragraph separately to allow the parties to fully brief the issue, they may do so.

Paragraph 94 of the Decree states:

> AGENCY RESPONSIVENESS The reorganization of TDH is partly intended to improve responsiveness to providers' needs. Senior management staff in each of the 8 TDH regions will be responsible for provider relations. The number of staff assigned to this task may vary based upon the number of EPSDT recipients in each region. One responsibility of TDH provider relations staff will be to work with providers who serve EPSDT recipients to reduce or eliminate problems that discourage providers from participating in the program.

To the extent that paragraph 94 requires Defendants to take action, "Defendants have routinely provided *Regional Provider Relations Reports*" to the Court detailing the efforts by DSHS staff in reaching out to providers."[168] The court finds that Defendants have complied with this paragraph. However, the court finds no reason to warrant modification of this provision at this time. To the extent that Defendants are required to report any information in the QMRs related to this paragraph, the parties are ordered to meet and confer regarding an agreement to reduce any inefficient reporting in the QMRs. Any agreements should be filed with the court for the record.

Paragraphs 98 and 99 required Defendants to "implement a method to index the reimbursement rate for medical check ups in non-managed-care areas" to annually adjust

[168] Dkt. 1052 at 38.

reimbursement rates to providers for check ups. Defendants complied with the requirements of these paragraphs in 1997. Defendants have explained that

> [t]he current Medicaid reimbursement rate methodology for non-managed-care areas is explained in Ex. 37, Declaration of Dan Huggins. It involves the use of resource-based fees and, when those are not available, access-based fees. TMHP maintains a Pricing and Fiscal Impact Unit, which conducts ongoing reviews of CPT codes and pricing and makes recommendations to HHSC for rate adjustments.[169]

Plaintiffs characterized paragraph 99 as a "relic" at the hearing and did not take a position on its fulfillment.[170] The court finds that Defendants have satisfied these requirements of these paragraphs.

Defendants have satisfied paragraphs 100-102 of the Decree, because "all medical and dental schools in Texas are enrolled as EPSDT (THSteps) providers."[171]

Paragraph 103 requires an increase in new provider relations staff to twenty-eight. It is undisputed that this was completed in 2007. Further, "today there are approximately 72 provider relations staff members employed between TMHP and DSHS."[172] MCOs also employ their own provider relations staff.[173] Plaintiffs agree that this paragraph is "mostly a relic."[174]

Plaintiffs also put forth arguments that the transition to dental managed-care violated Decree paragraph 143 because it resulted in a loss of dental providers and reduced the number of class members receiving dental check ups. While the provider supply CAO does reference paragraph 143 of the Decree, it does not appear to require any additional actions by Defendants with regard to dental services. Defendants have not asked to be released from any obligation relating to paragraph 143. Therefore, the court does not address Decree paragraph 143 here.

[169] Dkt. 1052 at 38.
[170] Hr'g Tr. 42:7-11, Dec. 19, 2013, Dkt. 1129.
[171] Dkt. 1052 at 39.
[172] Dkt. 1052 at 39-40.
[173] Dkt. 1052 at 40.
[174] Hr'g Tr. 43:4, Dec. 19, 2013, Dkt. 1129.

b. Have the objectives of the Decree been satisfied making its prospective enforcement inequitable or is further action required?

Defendants contend that they have fully complied with the provider-supply CAO and the Decree and that even if they had not, prospective enforcement of the Decree would be inequitable. First, Defendants assert that a significant change in fact, the state's transition to the capitated managed-care model for 91% of children on Medicaid in Texas, justifies modification of the Decree. According to Defendants, this makes prospective enforcement of the Decree provisions at issue, agreed to at a time where Medicaid was largely under a fee-for-service model, detrimental to the public interest because of the enormous resources it consumes to administer redundant or obsolete measures. Defendants further argue that the objectives of the Decree have been attained and a durable remedy is in place, so that continued enforcement of the Decree is improper.

Courts take a "flexible approach" when considering a motion to modify a decree on the basis that its prospective application would be inequitable.[175] Under this approach, a party seeking modification of a decree bears the burden of establishing that a significant change in fact or law warrants revision of the decree; and the court must consider whether the proposed modification is suitably tailored to the changed circumstances.[176] "[A] critical question in this Rule 60(b)(5) inquiry is whether the objective of the [Consent Decree] has been achieved."[177] "If a durable remedy has been implemented, continued enforcement of the order is not only unnecessary, but improper."[178] But a "change in factual circumstances, without more, is [] insufficient to warrant modification of a consent decree in the Fifth Circuit; the moving party must additionally show how the change in factual circumstances warrants modification of the

[175] *Horne v. Flores*, 557 U.S. 433, 450 (2009).
[176] *Rufo v. Inmates of Suffolk Cnty. Jail*, 502 U.S. 367, 383, 391 (1992).
[177] *Horne*, 557 U.S. at 450.
[178] *Id.* (citing *Milliken v. Bradley*, 433 U.S. 267, 282 (1977)).

consent decree by showing that those changes affect compliance with, or the workability or enforcement of, the final judgment."[179]

Generally, the Decree "speaks to the broader goals of enhancing recipients' access to health care and improving the use of health care services by Texas EPSDT recipients."[180] Paragraph 6 of the Decree explains that the Decree was intended "[t]o address the parties' concerns, to enhance recipients' access to health care, and to foster the improved use of health care services by Texas EPSDT recipients."[181] More specifically related to these motions, paragraph 88 states:

> [a]n adequate corps of capable providers is necessary to provide recipients with adequate access to needed services. Assuring an adequate provider pool requires recruiting new providers, retaining current providers, encouraging current providers to increase the number of recipients that they serve and facilitating training so that providers can adequately meet recipients' needs.[182]

Defendants argue that they "have done everything that the law requires them to do, namely act to correct those provider shortages that appear unique to the Medicaid program, *i.e.* where there are insufficient numbers of Medicaid providers to serve children in a geographic location where non Medicaid providers are located."[183] Indeed, "[t]he 'Equal Access' provision of the Medicaid Act requires the state Medicaid program to 'enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[184] Defendants contend that the transition to managed care and the Texas Department of Insurance (TDI) standards "render timeliness and distance standards listed in the CAO and Decree moot, as the CAO and Decree

[179] *Frew v. Hawkins*, 401 F. Supp. 2d 619, 630 (E.D. Tex. 2005) (quoting *Cooper v. Noble*, 33 F.3d 540, 544 (5th Cir. 1994)) (internal quotation marks omitted).
[180] *Frazar v. Ladd*, 457 F.3d 432, 439 (5th Cir. 2006).
[181] Dkt. 135 ¶ 6.
[182] Dkt. 135 ¶ 88.
[183] Dkt. 1052 at 77.
[184] Dkt. 1052 at 8, citing 42 U.S.C. § 1396a(a)(30).

standards are already incorporated into the contractual requirements being imposed upon Medicaid MCOs, and . . . detailed timeliness and distance standards are also required of all HMOs by TDI."[185]

This court has previously held that the switch to the managed-care delivery model warranted modification of the "statewideness" portions of the CAO and the Decree.[186] The "statewideness" portions of the Decree, paragraphs 271-281, and the CAO: Check Up Reports and Plans for Lagging Counties (Dkt. 637-3) required Defendants to create costly reports and action plans to address "lagging" utilization rates by county. In the managed-care model, services are delivered in particular "service areas" instead of per county. The costly statewideness reports had become redundant and unsuitable given Defendants' actions taken to ensure that each managed-care service area's utilizations rates are monitored. Indeed, the Decree contains provisions to address managed care and contemplates its implementation statewide. In relation to the provider supply, the managed-care model also caused a significant change in factual conditions that affects enforcement of the Decree.

Plaintiffs again raise the argument that Defendants cannot rely on this change in circumstances to justify modification of the Decree because the "increasing role of managed-care was certainly not just foreseeable but foreseen when the CAO was adopted." Plaintiffs contend that Defendants cannot rely on change that they initiated to support their argument that prospective enforcement of the Decree has become inequitable. But Plaintiffs cannot feign incredulity at the increased utilization of managed care either. The Decree specifically states that in its 1995 session, the legislature passed bills that require "the Texas Medicaid program to increase the number of recipients who are served by managed-care organizations. Most Texas

[185] Dkt. 1052 at 50-51, Hr'g Tr. 123:7-15, Dec. 19, 2013, Dkt. 1129.
[186] Dkt. 1020.

Medicaid recipients will receive services from managed-care organizations within a few years."[187] The Decree goes on to explain that "[r]egardless of their disagreements about the merits of managed-care, the parties agree that managed-care must be implemented in a manner that benefits EPSDT recipients and does not harm them."[188] Several other provisions of the Decree, and in fact, an entire CAO (Dkt. 637-6) are directed towards improvement of recipients' access through managed care.

While "modification should not be granted when a party bases its request on events that were anticipated when it entered a decree,"[189] a change in factual circumstances does not have to be unforeseen to warrant modification of a Decree.[190] "If it is clear that a party anticipated changing conditions *that would make performance of the decree more onerous* but nevertheless agreed to the decree, that party would have to satisfy a heavy burden to convince a court that it agreed to the decree in good faith, made a reasonable effort to comply with the decree, and should be relieved of the undertaking under Rule 60(b)."[191] There is no evidence that Defendants submitted to the Decree knowing that it would ultimately become fruitless and they could then shirk their agreed responsibilities. Although Defendants were piloting a managed-care delivery model in some counties at the time of the Decree, the fact that the state legislature saw fit to implement managed care statewide over the now *nineteen* years that this Decree has been in place hardly suggests a deceptive purpose. Certainly, Defendants have sought relief from provisions of the Decree for a number of years. But there is no evidence to suggest that Defendants entered the Decree intending to abandon their agreement by transitioning to managed care, particularly because the Decree and CAOs specifically address managed care. At this point,

[187] Dkt. 135 ¶ 188.
[188] Dkt. 135 ¶ 189.
[189] *United States v. City of New Orleans*, 731 F.3d 434, 439 (5th Cir. 2013).
[190] *Rufo v. Inmates of Suffolk Cnty. Jail*, 502 U.S. 367, 385 (1992).
[191] *Id.* (emphasis added).

Defendants have done everything required of them under the provider-supply CAO and related Decree provisions. If the purpose of the Decree is to "enhance recipients' access to health care, and to foster the improved use of health care services by Texas EPSDT recipients,"[192] it appears that Defendants have done so through targeted recruitment efforts where providers exist but were not treating class members, measures to improve the accuracy of provider directories, and increases in rates and procedures to continually assess rates.

Defendants argue that continued enforcement of the provider supply CAO and related Decree provisions has become a waste of valuable state resources.[193] Through its contracts with MCOs, the state, through both HHSC and the Department of Insurance, regularly monitors and enforces the timeliness and distance standards upon which the CAO relies and requires MCOs to maintain updated and accurate information in their provider directories. Provider rates are assessed at a minimum of every other year and are monitored by the federal oversight agency: Centers for Medicare & Medicaid Services (CMS). These safeguards give the court confidence that the problems addressed by the provider supply CAO and related Decree provisions will not resume once judicial oversight ends.

The proposed modification pursued by Defendants is suitably tailored to the changed conditions because it seeks release only from certain parts of the Decree that have been either satisfied or become obsolete, and because the remaining Decree provisions and CAOs will remain in place "thereby preserving Defendants' responsibilities for ensuring adequate provision of EPSDT services to children under age 21 with Medicaid despite the switch to a managed-care model."[194]

[192] Dkt. 135 ¶ 6.
[193] Dkt. 1052 at 51.
[194] Dkt. 1052 at 55.

IV. CONCLUSION

Plaintiffs' Renewed Motion to Enforce the Provider Supply Corrective Action Order and Related Decree Provisions (Opposed) (Dkt. 1033) is **DENIED**, and Defendants' Rule 60(b)(5) Motion to Vacate the Corrective Action Order: Adequate Supply of Health Care Providers and Related Decree Provisions; Defendants' Response in Opposition to Plaintiffs' Renewed Motion to Enforce the Provider Supply Corrective Action Order and Related Decree Provisions (Sealed) (Dkt. 1052) is **GRANTED IN PART**. Defendants have satisfied the requirements of each bullet point of the provider supply CAO (Dkt. 637-9). Defendants have satisfied the requirements of paragraphs 91, 93, 94,[195] 98-99, 100-102, 103, and 197 of the Decree. The court declines to modify paragraphs 90 or143 at this time. Defendants have shown that they have satisfied the objectives of the Decree paragraph 88 by taking realistic and viable measures to enhance recipients' access to care through ensuring an adequate supply of health care providers within the CAO's enumerated timeliness and distance standards through targeted recruitment efforts, increases and monitoring of reimbursement rates, and using their best efforts to maintain updated lists of providers to both recipients and other providers. A durable remedy is in place through Defendants' laws, regulations, policies, and contractual commitments from MCOs to assure future compliance. Defendants are no longer obligated to report on their compliance with paragraphs 91, 93, 98-99, 100-102, 103, and 197of the Decree or CAO 637-9. No modification is warranted with regard to paragraphs 75-87, 89, 82 and 97 of the Decree because those paragraphs mainly contain background information and do not require any action by Defendants. The remaining provisions of the Decree and the CAOs continue in force and are unmodified by

[195] The parties shall negotiate regarding any requirement that any information regarding this paragraph be included in the QMRs and submit their agreement to the court.

this order. Defendants must continue to comply with the remaining terms regardless of whether they believe they are in compliance with underlying federal law.[196]

IT IS SO ORDERED.

SIGNED this the 20th day of January, 2015.

Richard A. Schell

RICHARD A. SCHELL
UNITED STATES DISTRICT JUDGE

[196] *See Horne*, 557 U.S. at 454 ("To determine the merits of this claim, the Court of Appeals needed to ascertain whether ongoing enforcement of the original order was supported by an ongoing violation of federal law . . ."); *Frew v. Hawkins*, 401 F. Supp. 2d 619, 635 (E.D. Tex. 2005) ("While compliance with federal law may be one factor in assessing changed factual circumstances, it is neither the focus of the Court's inquiry nor dispositive of the merits of Defendants' Rule 60(b) Motion.").