

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No.: 02-20964 Civ-Gold/Simon

Anthony Hernandez, Donna Watson,
Gwendolyn Smiley, Donna Grissom
on behalf of themselves and all
others similarly situated, and
the Florida Transplant Survivors Coalition

Plaintiffs,

-vs-

Dr. Rhonda Medows, in her
official capacity as
Secretary, Agency for Health Care
Administration of the State of Florida,

Defendant.

NOTICE OF FILING SETTLEMENT AGREEMENT

Pursuant to S.D.Fla.L.R.16.2 F. 2. the parties, by and through undersigned counsel, hereby
file notice to this Honorable Court that they have reached a settlement in this case. A copy of the
Settlement Agreement is attached.

Respectfully submitted,

By Miriam Harmatz

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2-24-03
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2-28-03
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S.D. OF FLA. - HIA

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No.: 02-20964 Civ-Gold/Simonton

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on behalf of themselves and all
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Plaintiffs,

-vs-

Dr. Rhonda Medows, in her
official capacity as
Secretary, Agency for Health Care
Administration of the State of Florida,
Defendant.

_____ /

SETTLEMENT AGREEMENT

WHEREAS, the parties have voluntarily and knowingly and for the consideration set forth below, agreed to settle this lawsuit on the terms specified in this Settlement Agreement.

NOW THEREFORE, Plaintiffs and Defendant ("the parties") enter into and do hereby stipulate to a Settlement Agreement ("Agreement") that imposes binding obligations upon the parties and their successors to the extent stated below and constitutes a resolution of the issues in this action.

A. DEFINITIONS

As used throughout this Agreement, the following definitions shall apply:

1. A recipient will be deemed to have made "reasonable efforts" or "reasonable attempts" if one of more of the following two situations occur:

(a) The recipient contacted the Ombudsman, and the recipient performed the

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measures required by Section A(10) of this Agreement.

(b) The recipient performed the measures required by Section A(10) of this Agreement, and the recipient attempted to contact the Ombudsman (e.g., left a voice mail, left a message with a person other than the Ombudsman, sent an email to the Ombudsman's office, or sent a fax to the Ombudsman's office), and during that attempt, the recipient left sufficient information so that the Ombudsman would have been able to either (i) contact the recipient within (3) three business days of the initial attempt by the recipient, or (ii) investigate the claim rejection based on the information provided by the recipient in the initial attempt.

2. The phrase "ongoing or continuing drug therapy" refers to those Medicaid prescriptions for which the Agency for Health Care Administration (AHCA) provided reimbursement in the previous month (excluding 72 hour or other temporary supply).

3. The term "clinical protocol drugs" refers to those drugs, which AHCA has identified as requiring a clinical prior-authorization, pursuant to the requirements and procedures outlined in the Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook.

4. The term "party" or parties" shall refer to Plaintiffs and Defendant. As the term applies to the Defendant, it shall include her agents, employees, and/or successors in office.

5. The term "recipients" refers to present and future Florida Medicaid recipients.

6. The terms "AHCA" or the "Agency" and Defendant are used interchangeably throughout this Agreement for convenience and refer to the Florida Agency for Health Care Administration.

7. The term "notice" is used as a common noun and for the purpose of this Agreement means the conveyance of written information from one party to another. It does not implicate any legal or

statutory definition.

8. The term “emergency” for the purposes of this Settlement Agreement, refers to serious, health-threatening medical situations when claim reimbursement for a recipient's medication has been rejected by AHCA or its fiscal agent or by the recipient’s Medicaid managed care plan or the plan’s fiscal agent or the plan’s pharmacy benefit manager, and any delay in access to the medication could cause the recipient to suffer serious or permanent harm to his or her health, or result in hospitalization or emergency room treatment, or the recipient has a serious contagious disease which, if left untreated, could pose a significant public health threat.

9. “Self-help” means the recipient made a good-faith effort to provide all the relevant and necessary information that the Ombudsman would need in order to resolve the claim rejection(s) in question (e.g., contact the prescriber for prior-authorization; return to the pharmacy on the appropriate date, if the reason for rejection(s) is “early refill” when appropriate; cooperate with the employees of the pharmacy; provide information that is within the control of the recipient).

10. The term “business days” refers to Monday through Friday, exclusive of Florida State legal holidays.

11. The term “legal holiday” refers to holidays recognized by the State of Florida.

12. The terms "Managed Care Plan", "Health Maintenance Organization", and "HMO" are used conjunctively or interchangeably throughout this agreement, and for the purposes of this agreement, are deemed to encompass all Medicaid medical provider organizations, of whatever nomenclature, with which the defendant contracts, or will contract, for the provision of care to class members, including, but not limited to Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Prepaid Inpatient Health Plans (PIHPs), Physicians Service

Organizations (PSOs), Health Insuring Organizations (HIOs), Exclusive Provider Organizations (EPOs), and Prepaid Ambulatory Health Plans (PAHPs).

B. NOTICE

The parties recognize the importance of providing recipients with written information explaining why Medicaid reimbursement of a prescription claim has been rejected. The parties recognize that in the vast majority of cases these rejections are due to reasons that can be promptly corrected, and that the recipient needs to know the reason for the rejection and what she or he can do to resolve it. In recognition of the importance of ensuring that recipients receive this written notice, Defendant hereby agrees to the following:

1. The Defendant will require Medicaid pharmacies to post signs advising Medicaid recipients that if reimbursement for their prescription drug(s) is initially rejected, they will be given written information by the pharmacy provider, including a pamphlet, that will tell them the reason their drug claim reimbursement was rejected and what they can do about it.

2. The Defendant will require Medicaid pharmacy providers to provide the notice required under this Agreement to recipients whose claim reimbursement for a prescription drug is rejected by way of either a printed copy of the computer screen stating the reason(s) for rejection or by writing the reasons(s) for claim reimbursement rejection and the date of the rejection on the pamphlet which will be given to the recipient. (*see ¶¶ 5- 9, infra*).

3. For those recipients not physically present in the pharmacy when Medicaid claim reimbursement is rejected for the recipient's claim, such as recipients who have a relative pick up medicines for them, Defendant will require that the pharmacy provider deliver the pamphlet (and copy of computer screen, where appropriate), containing the reason(s) for rejection to the recipient

via the same means by which the prescription medication would have delivered, e.g. mail, personal delivery.

4. The parties agree that Defendant will incorporate the notice requirements described in Section B of this Agreement into the “Prescribed Drug Services Reimbursement, Limitations and Reimbursement Handbook” (the “Handbook”), which is incorporated by reference in Florida Administrative Code Rule 59G-4.250, no later than twelve months after the entry of a Final Order in this case.

5. The Handbook will specify that this written notice can either be provided to the recipient or to a person acting on behalf of a recipient as specified in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and said notice shall be made in accordance with existing law and HIPAA procedures.

6. The parties will draft the informational pamphlet, which the Agency will then print and supply on a continuous basis to pharmacy providers.

7. The parties agree that for those pharmacy providers choosing not to print and provide the recipient with a copy of the rejection computer screen, the pamphlet will be used to provide individual notice to recipients concerning the reason(s) for their particular claim reimbursement rejection (as specified in ¶ 2 *infra*) and will otherwise fulfill the requirements specified in ¶ 2 through ¶ 9.

8. The Defendant will require Medicaid pharmacy providers to provide all recipients whose prescription drug claim reimbursement has been rejected with a copy of the pamphlet.

9. The parties agree that the pamphlet identified in ¶¶ 2 through 8 will include, but not be limited to, an explanation of the following:

(a) the most common reasons for Medicaid prescription drug claim reimbursement rejection;

(b) steps recipients must take to resolve problems themselves when their drug claims have been rejected (*see* definition of “self help,” Section A, ¶10);

(c) how to contact the Ombudsman (*see* Section C *infra*) if the problem is not resolved by “self-help;” including a statement of the reasonable wait time for the Ombudsman both to answer the call and to respond to the recipient’s request for assistance, and an explanation that the recipient has made “reasonable efforts” to contact the Ombudsman. *See* definition, Section A, ¶1.

(d) a description of the circumstances when a recipient can request a hearing and a description of the circumstances when a recipient cannot request a hearing (*see* Section D *infra*);

(e) how to request a fair hearing if the Ombudsman does not resolve the problem, and a fair hearing is not prohibited pursuant to Section D ¶ 2, including a sample hearing request form and a statement that the recipient may represent him or herself or use legal counsel, a relative, friend, or other spokesman;

(f) the circumstances in which ongoing claim reimbursement will be available pending the outcome of a fair hearing. (*see* Sections E & F *infra*).

C. OMBUDSMAN

The parties recognize that some claim reimbursement rejection problems may not be resolved through self-help by the recipient or the prescriber and that the services of an Ombudsman will be critically important in providing timely resolution of claim reimbursement rejection. In recognition

of the parties' interest in quickly resolving claim reimbursement problems, the Defendant hereby agrees to the following:

1. The Defendant will either staff or contract for an Ombudsman position(s) adequate to investigate and attempt to resolve recipient complaints about prescription drug claim reimbursement rejections where the rejection cannot otherwise be resolved by the recipient or prescriber. The office will be staffed, at a minimum, according to the number of hours in a state government workday. In addition, the Defendant agrees that the Ombudsman's office will be staffed in order to provide access to recipients for at least two hours before and/or after the hours of the standard state government work day. The office phone system will be able to record voice mail messages 24 hours day/ 7 days a week. The office will have a toll free telephone number with adequate voice mail boxes in place to eliminate "busy" or "no answer" responses. The Ombudsman will have two-way fax communication capacity and an e-mail address for recipient use. It will also have computer links with the Defendant's contracted pharmacy benefits manager, Affiliated Computer Systems (ACS), the Department of Children and Family Services, and other necessary computers/data bases which Defendant deems are necessary in order to resolve rejection problems. The Ombudsman will have access to personnel who can communicate with non-English speaking recipients and also have facilities for hearing impaired recipients.

D. FAIR HEARINGS

The parties believe that provision of the written notice and Ombudsman assistance described in Sections B & C will result in the vast majority of prescription claim reimbursement rejections being quickly resolved. The parties also recognize that there will be some instances in which the rejection will still not be resolved and the recipient, after contacting the Ombudsman, believes that

the claim reimbursement rejection is erroneous because there are unresolved disputed facts. The parties further recognize that there are circumstances in which a challenge to the claim reimbursement rejection at a fair hearing would be inappropriate since the recipient would not be entitled to claim reimbursement pursuant to an independent review by a hearing officer of the claim reimbursement rejection. The parties also recognize that there are certain circumstances in which independent review, if requested by the recipient after exhaustion of the Ombudsman procedures, is appropriate. Thus, the parties hereby agree to the following:

1. The parties agree that Medicaid recipients must make “reasonable efforts” to resolve rejection of their drug claim as a prerequisite to obtaining a fair hearing.

2. The parties agree that under this Settlement Agreement, recipients have no right to a fair hearing under the following circumstances:

(a) if the recipient has not made reasonable efforts to resolve rejection of their drug claim;

(b) i. the prescription drug rejection was due to lack of prior authorization and
ii. there is no dispute about whether the drug requires prior authorization and
iii. no evidence included with the hearing request that the prescriber tried to obtain prior authorization;

(c) if the recipient is challenging the legal validity of a restriction set forth in a state or federal Medicaid statute (rather than a factual dispute arising from application of the statute);

(d) if the rejection is for an early refill and there is no dispute of material fact involved;

(e) if the prescription is legally invalid pursuant to any state or federal statute, and only the prescriber (who must be licensed and authorized to do so) can correct the prescription to make it legally valid and refuses to do so; or

(f) if the pharmacy is not a Medicaid provider (or in the case of an HMO member, the pharmacy is not a participating provider) and there is not a factual dispute regarding whether the pharmacy is enrolled as a provider.

3. The parties agree that the circumstances enumerated in ¶¶ 2 & 4 of this section will be transmitted in writing to the state entity responsible for providing Medicaid fair hearings. The parties agree that hearing officers will have, within the confines of the plain language of this Agreement, discretion to determine if the basis of a recipient's hearing request falls within ¶ 2 with or without convening a hearing. The parties further agree that hearing officers will be directed to immediately dismiss the hearing request if the hearing officer determines that the grounds for the hearing request is not permissible pursuant to Section D ¶ 2 of this Agreement. If the Defendant wishes to amend the circumstances listed in Paragraph 2 and Plaintiffs agree with such amendment an agreed motion seeking such amendment will be filed. Otherwise, Defendant may file an opposed motion seeking such relief. In either event, the parties agree to cooperate in seeking prompt judicial action.

4. The parties agree that examples of circumstances in which a recipient is entitled to a fair hearing after complying with the requirements of ¶ 1 of this section include but are not limited to the following:

(a) If the Ombudsman cannot resolve the rejection within three business days from the time the recipient initially contacts the Ombudsman or the recipient asserts that he or she cannot access the Ombudsman after "reasonable efforts", and that the recipient

believes that she or he is eligible for the drug;

(b) if the reason for rejection involves a relevant factual dispute where the recipient asserts that the reason for the rejection is erroneous;

(c) if the reason for rejection is lack of prior authorization and the recipient asserts that the prescriber tried to obtain prior authorization and provides evidence thereof as part of the hearing request;

(d) if the reason for rejection is that the prescription is not "legally sufficient" but the "insufficiency" cannot be cured by the pharmacy, the prescriber, or Medicaid provider.

5. If the recipient is challenging a state claim reimbursement limitation as stated only in the Provider Handbook and which is not included in 42 U.S.C. §§ 1396r-8(d) "Limitations on Coverage of Drugs," the parties agree that such challenge will be raised through a Fla. Stat. Chapter 120 proceeding. Recipients pursuing their rights under a Chapter 120 rule challenge shall have available to them the same provisions for emergency and/or ongoing claim reimbursement as set forth in Sections E and F.

6. When there is a material factual dispute regarding whether prior authorization was requested, the recipient shall have the burden of proving at the hearing that prior authorization was requested.

7. The parties agree that recipients will be required to assert under penalty of perjury on their hearing request form that they have made reasonable efforts to resolve rejection of the prescription drug claim.

8. The parties agree that a recipient can use the sample request form for a fair hearing

contained in the pamphlet to actually request a fair hearing.

E. DISPENSING OF A TEMPORARY SUPPLY UPON REJECTION FOR ANY REASON

1. The Defendant agrees to ensure reimbursement for a temporary supply of medication to a recipient sufficient to cover three business days, i.e. 72 hours plus weekends and holidays in the event a rejection of the medication occurs on or immediately prior to a weekend or holiday (hereafter referred to as “3 business days” or “temporary” supply) as follows:

(a) Where a recipient or his or her representative presents a legally sufficient prescription, to a licensed pharmacy provider, which could otherwise lawfully be filled, but AHCA or its agent rejects claim reimbursement, then the Defendant shall authorize dispensation and reimburse the pharmacy provider (including the Medicaid dispensing fee) for the temporary supply of the drug where:

i. The situation is an emergency in the opinion of the on site pharmacist as defined in Section A of this Agreement, or

ii. The situation is an ongoing therapy as defined herein, except ongoing therapy shall not serve as a reason for dispensing under this agreement where:

a. There are indications, per the rejection code, that the recipient already has the drug, e.g., refill too early, filled at another drug store etc., or the recipient is enrolled in an HMO and needs to go a pharmacy which is in the HMO network, or

b. The rejection is due to an error at the pharmacy that can be corrected

during that visit or,

c. There are clinical issues that must be resolved before the drug can be safely dispensed, e.g., potential drug interactions or need for periodic re-testing; or

d. The rejection reason indicates that the individual is not eligible for Medicaid (*see* Attachment A), unless the individual provides the pharmacy with physical proof of his/her Medicaid eligibility, e.g. statement from recipient's eligibility worker at the Department of Children and Families (DCF), or other evidence from DCF indicating current Medicaid eligibility of the recipient.

(b) Notwithstanding any other language in this Agreement, and upon there existing a substantial change in fiscal circumstances, the Defendant, by written notice to counsel for the Plaintiffs and the Court, may withdraw her agreement in ¶ (1) of this section to provide for temporary claim reimbursement of recipients' prescription drugs for rejections in emergency situations or for ongoing therapies for some or all rejection reasons in the event that Defendant determines that such an agreement is cost prohibitive at any time subsequent to 90 days following implementation of the Settlement Agreement by the Defendant pursuant to Section I ¶ 1.

(1) In the event Defendant chooses to exercise said option, Defendant agrees to provide Plaintiffs' counsel, at the time of written notice exercising said option, with baseline data demonstrating the precise nature of the substantial change in fiscal circumstances, and specifying the number of recipients, by

month, for each rejection code (broken into therapeutic class of prescription) whose prescriptions were rejected, the number of recipients who did/did not receive a temporary supply of the rejected prescription at the time of rejection, and the cost of providing temporary claim reimbursement for each rejection code.

(2) In the event Defendant chooses to exercise said option, the parties agree that they will participate in mediation within four weeks of Defendant providing notice. The parties agree that they will attempt to engage a mediator who is willing to waive Plaintiffs' portion of the mediation fee.

(3) In the event that mediation of this single issue is unsuccessful within four weeks of Defendant providing said notice, the parties agree that Plaintiffs can, at their choice, file an unopposed motion to this Court requesting that a status and scheduling conference be set at which time the procedure and attendant deadlines for resolving this issue pursuant to Section J ¶ 6 would be established.

2. Notwithstanding any other language in this Agreement, and upon there existing a substantial change in fiscal circumstances, after ninety days from Defendant's certification that the terms of this Agreement have been implemented, the Defendant, by written notice to counsel for Plaintiffs and the Court, may withdraw her agreement in ¶ 1(a) of this section to pay the dispensing fee for temporary claim reimbursement of rejections in emergency situations or for ongoing therapies. In the event Defendant chooses to exercise said option, Defendant agrees to provide Plaintiffs' counsel, at the time of written notice exercising said option, with baseline data specifying

the number of recipients, by month, for each rejection code (broken into therapeutic class of prescription) whose prescriptions were rejected, the number of recipients who did/did not receive a temporary supply of the rejected prescription at the time of rejection, the number times the dispensing fee for the temporary supply was/was not provided. In the event Defendant chooses to exercise said option, Defendant further agrees to monitor and report to Plaintiffs' counsel subsequent data for at least 6 months after terminating provision of the dispensing fee. This subsequent data would include but not be limited to the same breakdown of information, i.e. the number of recipients, by month, for each rejection code (broken into therapeutic class of prescription) whose prescriptions were rejected, the number of recipients who did/did not receive a temporary supply of the rejected prescription at the time of rejection, and the number times the dispensing fee for the temporary supply was/was not provided.

F. PROVISION OF ONGOING CLAIM REIMBURSEMENT AFTER A HEARING IS REQUESTED

The Defendant agrees that where the Agency rejects claim reimbursement for “ongoing or continuing drug therapy”, the recipient shall be entitled to Medicaid claim reimbursement for continuing therapy in the original dosage from the date of the hearing request until the hearing is decided if all of the following requirements are satisfied:

- (1) the recipient requests assistance from the Ombudsman or asserts that “reasonable efforts” were made;
- (2) the rejection issue is not resolved within 3 business days after contacting the Ombudsman;
- (3) the recipient’s reason for requesting a hearing is not included among the specific

circumstances in which fair hearings are not permitted (as specified in Section D ¶ 2, *supra*); and

(4) the recipient requests a fair hearing and ongoing claim reimbursement of the rejected drug within 10 days of receiving written notice of the rejection. (*See* Section B).

G. MULTI-SOURCE BRAND NAME DRUGS

The parties recognize the importance of generic drugs in controlling prescription drug costs and further recognize that they are an entirely suitable alternative to their brand name equivalents in most situations. However, the parties also recognize that in some situations the prescribing physician's professional opinion is that the multi-source brand name drug (*see* 42 U.S.C. § 1396r-8(k)(7)(A)(i)) is medically necessary even if there is a therapeutic and bio-equivalent drug (*see* 42 U.S.C. § 1396r-8(k)(7)(C)). Therefore, the Defendant agrees to the following:

1. The Defendant agrees to reimburse Medicaid pharmacy providers for the cost of a multi-source brand drug if the prescriber writes in his or her own handwriting on the valid prescription that the drug is medically necessary (and otherwise complies with Fla. Stat. 465.025) and the prescriber submits a form to AHCA's designated representative. Defendant will draft the form with input from Plaintiffs' counsel. The form will be on AHCA's letterhead or the letterhead of AHCA's designated representative. The form will require the prescriber to confirm in writing that an individual patient has had an adverse reaction to a generic drug or has had, in his or her medical opinion, better medical results when taking the brand name drug.

H. DEFENDANT'S CONTRACT HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

The parties recognize that a large number of recipients receive their Medicaid benefits, including prescription drugs, through managed care organizations (referred to as "HMOs" or "plans") operating under contract with the Defendant. The parties have already stipulated that the certified class in this case includes Medicaid HMO enrollees and that stipulation is hereby incorporated into this Agreement at Attachment B. The parties recognize that the Contract operates on a two-year cycle, and the 2002-2004 Contract is currently in operation and expires June 30, 2004.

The parties recognize the significant logistical difficulty associated with requiring each individual HMO to implement the terms of this Settlement Agreement. Accordingly, the Defendant shall have sufficient flexibility when negotiating an agreement with the HMOs. However, the Defendant, at a minimum, will require the HMOs, via contract, contract amendments, or both, to either (1) provide functionally equivalent procedures and requirements, as specified in Section H ¶ (3), which the Defendant has agreed to provide in this Settlement Agreement or (2) provide a pro rata share of support (financially or otherwise) to ensure that the Medicaid recipients who receive Medicaid services through HMOs will receive the terms specified in Section H ¶ (3) of this Settlement Agreement.

1. Within thirty days of the entry of the Final Order in this case, the Defendant agrees to inform all contract HMOs in writing of this Agreement and to provide them with a copy. The Defendant will inform the HMOs that the 2004 contract will require all HMOs to provide functionally equivalent procedures and requirements set out in Section H ¶ (3) of this Agreement. The Defendant will inform the plans that the Defendant will not enter into any contract with an HMO

that refuses to agree to the terms of this Agreement. The Defendant will further request each plan's written response within thirty days regarding whether the HMO is willing to implement the terms set out in Section H ¶ (3) of the Agreement before the current 2002-2004 Contract term expires.

2. The Defendant agrees that the July 2004 contract will provide that Medicaid recipients are third party beneficiaries for purposes of enforcing provisions of the contract relating to the Settlement Agreement. In the event one or more HMOs choose not to voluntarily enter into a contract amendment, which would implement the terms set out in Section H ¶ (3) of this Agreement, prior to June 30, 2004, or are at any time 12 months or more after the signing of this Agreement otherwise acting in violation of this Agreement, Defendant agrees not to oppose any motion or action before this Court to enforce against an allegedly noncompliant HMO the terms of this Agreement on behalf of class members who are enrolled in the allegedly noncompliant HMO.

3. The due process procedures the Defendant will require HMOs to individually provide or otherwise adhere to will include but not be limited to the following:

(a) the functional equivalent of the notice provisions specified in Section B *supra*, all Medicaid HMOs will provide notice of the reason for a claim reimbursement rejection and how to resolve it as well as how to request a Medicaid fair hearing, the circumstances in which ongoing claim reimbursement will be provided under the same conditions as agreed to by the Defendant and the circumstances on which a multi-source brand name drug will be provided, *see* Sections D, E, F & G *supra*; (HMO pharmacy providers will also have the option of providing recipients with a printout of the computer rejection screen as well as the pamphlet);

(b) HMOs will also provide a toll- free number for the functional equivalent of an “Ombudsman” office and this number shall be published in the pamphlet, along with the number for AHCA’s Ombudsman. (*see* Section C).

4. The Defendant agrees not to contract with any HMO in the future who will not agree to abide by the terms of this Agreement.

5. Defendant will incorporate in its Medicaid HMO monitoring a review of the HMO’s ongoing compliance with the terms and requirements of this Agreement.

I. IMPLEMENTATION AND INTERIM PROCEDURES

1. No later than twelve months after signing this Settlement Agreement, the Defendant shall file written certification with the Court that Defendant has implemented the terms of this Settlement Agreement and will provide Plaintiffs’ counsel with documents substantiating the implementation of the Agreement.

2. Within eight weeks of signing this Agreement, the Defendant will designate a person or persons who will be responsible for investigating and attempting to resolve claim reimbursement rejection complaints by recipients prior to implementation of the Agreement, and Defendant will provide the names and contact information for such person(s) (“contact person(s)”) to Plaintiffs’ counsel. Claim reimbursement rejection complaints from named plaintiffs and class members will only be transmitted to the contact person(s) by Plaintiffs’ counsel.

J. CLASS NOTICE, FAIRNESS HEARING, COURT APPROVAL OF THE SETTLEMENT AGREEMENT AND ENTRY OF FINAL ORDER

1. The parties agree that upon execution of this Agreement they shall file with the Court a Notice of Filing Settlement Agreement with the Agreement attached thereto.

2. Within thirty days after execution of the Agreement the parties shall jointly move the Court to: 1) approve a proposed class notice and a procedure by which notice of the settlement will be given to class members; 2) schedule a fairness hearing if the Court deems necessary; 3) grant preliminary approval of this Agreement.

3. Within fifteen days after completion of Court ordered notice to the class, the parties shall jointly move the Court to enter a Final Order incorporating all terms of the Settlement Agreement; providing that the Court may, through its standard procedures (subject to the notice and mediation requirements set forth herein) enforce the terms and obligations of the Settlement Agreement upon due application by a party; and in consideration of the terms and duties expressed therein, dismissing this case. The parties further agree to file with this Joint Motion an attached Proposed Agreed Final Order of Dismissal, which incorporates the terms of this Agreement.

4. The parties agree that the terms of this Agreement are enforceable in this Court and that the terms of this Agreement will be incorporated in the Final Order of Dismissal and may be enforced following the procedures outlined in section L *infra*.

5. This Agreement is intended by the parties as a final expression of their agreement with respect to the subject matter hereof and is intended as a complete and exclusive statement of the terms and conditions thereof, and this agreement supercedes and replaces all prior negotiations and agreements between the parties hereto, whether written or oral. However, due to the complexity of operating the Medicaid prescription drug program and providing recipients with procedural due process when their prescription claims are rejected, the parties anticipate that they may need to amend or supplement this Agreement in order to facilitate recipient due process protections, manage administrative and financial burdens, or implement any other adjustment deemed necessary or

appropriate by the parties. Should such circumstances arise, the parties agree that they will file a joint motion with attached agreed upon proposed orders describing the need for modification of any portion of this Agreement.

6. This Agreement is not an admission of any wrongdoing or misconduct on the part of Defendant, nor is it an admission by Defendant that Plaintiffs would have prevailed or by Plaintiffs that Defendant would have prevailed in this litigation. Dismissal of this case shall be with prejudice subject to the continued jurisdiction of this Court to enforce the terms of the Agreement as provided herein, to determine the amount of reasonable attorneys' fees should the parties be unable to agree on the reasonable amount, to issue a ruling on any opposed motion to amend Section D ¶ 2, and, should Defendant exercise its option in Section E ¶ 1(b) or ¶ 2, to reinstate and decide, on Plaintiffs' request, Plaintiffs' claims that Defendant's refusal to provide claim reimbursement for a temporary supply of recipients' rejected prescription drugs in certain circumstances violates Plaintiffs' federal statutory and Constitutional rights.

7. If the Court does not approve this Agreement or incorporate the terms of this Agreement in the Final Order, or alters or amends any portion of this Agreement, including in the incorporation of this Agreement in the Final Order as provided for in this Agreement, this Agreement is hereby withdrawn, and shall be null and void and all parties shall be placed in the same position as if this Agreement were never agreed to by the parties.

K. ATTORNEYS' FEES AND COSTS

1. Without admitting any liability as to the Plaintiffs' claims in this complaint, the Defendant agrees that Plaintiffs are the prevailing party for the purposes of entitlement to reasonable attorneys' fees and costs only.

2. The parties agree that the Plaintiffs will file a motion for attorneys' fees and costs within 30 days after entry of this Court's Final Order if the parties are unable to reach an agreement on the amount of a reasonable fee award prior to that time.

L. DISPUTE RESOLUTION

1. This Agreement shall be enforceable upon proper application to this Court subject to the terms described in ¶ 2 (a) through (c) *infra*.

2. The parties agree that the following steps must be taken before either party will request any future enforcement by this Court of the Final Order:

(a) The party seeking enforcement will provide written notice to counsel for the opposing party regarding any alleged breach of the terms of the Settlement Agreement;

(b) Said opposing party will have sixty days from the date of written notice in which to cure the alleged breach or otherwise respond to written notice;

(c) Within three weeks following said opposing party's response, the parties agree to participate in mediation and to make reasonable efforts to engage a mediator willing to waive Plaintiffs' portion of the mediator's fee.

3. Plaintiffs agree that they will not seek attorneys' fees for the time or costs incurred during the time period described in paragraph 2(a)-(c) of this Section L.

Respectfully submitted,

Plaintiffs

By: Miriam Harmatz
Miriam Harmatz
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Defendants

By: Rhonda M. Medows
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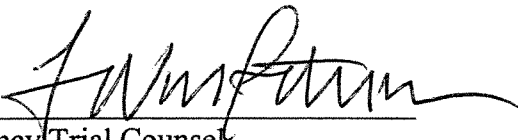
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ATTACHMENT A

The following rejection codes indicate that the individual whose prescription claim was rejected was not eligible for Medicaid at the time the claim was submitted:

- 216: recipient ineligible for date of service-service date on or after date
- 270: recipient ineligible for date of service- denied after pending
- 271: recipient ineligible for date of service-awaiting update will pend
- 274: recipient not eligible fore medicaid but may be eligible for Medicare
- 731: Missing or invalid eligibility

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 02-20964 CIV-GOLD/SIMONTON

Anthony Hernandez, Donna Watson,
Gwendolyn Smiley, Donna Grissom
on behalf of themselves and all
others similarly situated, and
the Florida Transplant Survivors Coalition

Plaintiffs,

-vs-

Dr. Rhonda Medows, in her
official capacity as
Secretary, Agency for Health Care
Administration of the State of Florida,

Defendant.

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D.C.

JOINT NOTICE OF FILING OF STIPULATIONS

In exchange for Plaintiffs' waiving Requests for Production relating to the Defendant's Medicaid Managed Care plans (HMOs), the parties have agreed to the following stipulations. This agreement eliminates the need for this Court's hearing on Defendant's Motion for Enlargement of Time, scheduled for 4:00 p.m. July 26, 2002, prior to oral argument on class certification.

1. As the single state agency, the Agency for Health Care Administration is responsible for ensuring due process required by federal Medicaid law and the U.S. Constitution for all Medicaid recipients regardless of whether they are in a health maintenance organization (HMO), MediPass or fee-for-service.

2. The agency will, by all lawful means, including adding specific notice and hearing requirements to the Medicaid HMO model contract, require their contract HMOs to comply with due process notice and hearing requirements as determined by the U.S. District Court in Hernandez et al. v. Medows after exhaustion of all available appeals.

3. In the event that the Court in Hernandez et al. v. Medows certifies a class, the parties agree that, within the limits of the class definition, the class would include Medicaid HMO enrollees as well as Medicaid recipients in MediPass or fee-for-service.

Respectfully submitted,

Attorneys for Plaintiffs

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Dated: 7-25-02

Dated: 7-23-02