UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
NEW ORLEANS DIVISION

CHRISTINA CHISHOLM, a minor, by her next friend, MELANIE CHISHOLM; ERIN ELLISON, a minor, by her next friend, LINDA ELLISON; and JONATHAN TURNER, a minor, by his next friend, WILLIE MAE REAMS, on behalf of themselves and others similarly situated,	*	**CIVIL ACTION NO. 97-3274**
	*	
	*	
	*	
	*	**SECTION J; MAGISTRATE 5**
	*	
	*	
	*	
	*	**JUDGE BARBIER**
PLAINTIFFS	*	
	*	
VS.	*	
	*	**MAGISTRATE CHASEZ**
DAVID HOOD, Secretary of the Louisiana Department of Health and Hospitals	*	
	*	
	*	
DEFENDANT	*	
	*	**CLASS ACTION**

JOINT MOTION, ORDER, AND INCORPORATED MEMORANDUM FOR PRELIMINARY APPROVAL OF STIPULATION AND ORDER OF DISMISSAL

NOW INTO COURT through undersigned counsel come remaining plaintiffs, ERIN ELLISON, a minor, by her next friend, LINDA ELLISON; and JONATHAN TURNER, a minor, by his next friend, WILLIE MAE REAMS, on behalf of themselves and others similarly situated, and DAVID HOOD, Secretary of the Louisiana Department of Health and Hospitals, who submit this joint motion, pursuant to Fed. R. Civ. P. 23, for preliminary approval of the Stipulation and Order of Dismissal ("Stipulation"). In support of this motion, the parties respectfully represent:

1.

The parties have reached a Stipulation with respect to the issue of whether defendant violates Medicaid EPSDT provisions by failing to insure that treatment is provided to class members as a result of EPSDT screens, and the issue of whether defendant's prior approval system violates the EPSDT provisions by refusing requests for EPSDT services without ruling on the medical necessity of requested services, without arranging needed treatment, and without giving notice of appeal rights regarding services not provided. The Stipulation is attached as Exhibit 1. Attached as Exhibit 2 to the Stipulation is the proposed Class Notice. Also attached is a proposed Order Granting Preliminary Approval to the Stipulation.

2.

This proposed Stipulation addresses the only remaining issues in this case, thus bringing it to final resolution, if approved.

3.

The issues contained in this Stipulation previously were briefed for the Court in cross motions for summary judgments filed by the parties. The issues were deferred by Court Order dated August 29, 2000.

4.

The parties believe that the proposed Stipulation is fair, reasonable and adequate to the members of the class, with respect to the issues as set forth in paragraph 1 above, in light of the alleged violations by the Defendant of Medicaid Act, the United States Constitution, and 42 U.S.C. §1983, and in light of Defendant's denials of violations thereof and affirmative defenses.

5.

The Stipulation represents a compromise of disputed claims; it in no way constitutes an admission of liability by Defendant with respect to any of the material allegations in the Complaint, and Defendant specifically denies that his actions constitute a violation of the Medicaid Act, the United States Constitution, and 42 U.S.C. §1983 to any extent whatsoever.

6.

Counsel for Plaintiffs and the Class represent to this Court that counsel is able, experienced and well-qualified to evaluate the fairness of the proposed settlement on behalf of the members of the Class based on their experience in class action litigation, and that counsel is in favor of this Motion.

WHEREFORE, the parties request that this Court grant preliminary approval to the Stipulation and enter the order attached hereto.

Respectfully Submitted:

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Attorney for Plaintiffs

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
NEW ORLEANS DIVISION

CHRISTINA CHISHOLM, a minor, by her next friend, MELANIE CHISHOLM; ERIN ELLISON, a minor, by her next friend, LINDA ELLISON; and JONATHAN TURNER, a minor, by his next friend, WILLIE MAE REAMS, on behalf of themselves and others similarly situated,	*	**CIVIL ACTION NO. 97-3274**
	*	**SECTION J; MAGISTRATE 5**
	*	**JUDGE BARBIER**
PLAINTIFFS	*	
VS.	*	**MAGISTRATE CHASEZ**
DAVID HOOD, Secretary of the Louisiana Department of Health and Hospitals	*	
DEFENDANT	*	**CLASS ACTION**

ORDER GRANTING PRELIMINARY APPROVAL AND FOR HEARING ON PROPOSED SETTLEMENT

CONSIDERING THE ABOVE and foregoing and the Court having made a preliminary review of the proposed partial settlement of this action:

IT IS ORDERED that:

1. The Stipulation dated June 7, 2002, between the plaintiff class and the defendant appears to be within the range of reasonableness, and accordingly, is hereby granted preliminary approval.

2. The proposed Stipulation shall be made available to the class members for their consideration and for a hearing under Fed.R.Civ.P.23(e).

3. A hearing shall be held in Courtroom C-316, United States District Court, Eastern District

of Louisiana, at 9:30 a.m., on July 19, 2002, to consider whether the settlement should be given final approval by the Court.

(a) Objections by interested parties to the proposed settlement will be considered if filed in writing with the clerk on or before July 12, 2002.

(b) At the hearing, interested parties may be heard orally in support of or in opposition to the settlement, provided such persons file with the clerk by July 12, 2002, a written notification of their desire to appear personally, indicating(if in opposition to the settlement) briefly the nature of the objection.

(c) Counsel for the class and for the defendant should be prepared at the hearing to respond to objections filed by class members and to provide other information, as appropriate, bearing on whether or not the settlement should be approved.

4. Within fourteen (14) days of the date of this order, Defendant shall send an individual notice of the hearing to each known member of the class at their last known address.

5. This Stipulation shall not be construed or deemed to be an admission or concession by Defendant of any liability or whatsoever, and actions taken or to be taken by Defendant hereunder are undertaken in the spirit of compromise and based solely upon the preliminary approval of the Stipulation.

6. If the settlement does not become effective in accordance with the Stipulation, or if the Stipulation is not finally approved, or fails to become effective for any reason, this Order shall be rendered null and void and shall be vacated.

7. This Court retains jurisdiction over all matters arising out of the Stipulation.

New Orleans, Louisiana, this 7th day of June, 2002.

JUDGE, UNITED STATES DISTRICT COURT

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
NEW ORLEANS DIVISION

CHRISTINA CHISHOLM, et al., on behalf of themselves and others similarly situated,	*	CIVIL ACTION NO. 97-3274
	*	SECTION J
PLAINTIFFS	*	JUDGE BARBIER
VS.	*	DIVISION 5
DAVID HOOD, Secretary of the Louisiana Department of Health and Hospitals,	*	MAGISTRATE JUDGE CHASEZ
DEFENDANT	*	CLASS ACTION

THIRD STIPULATION AND ORDER OF DISMISSAL

STIPULATION

This Stipulation is made by and between the remaining Plaintiffs, Erin Ellison, and Jonathan Turner, on behalf of themselves and the class they represent in this action, and David Hood, Secretary of the Louisiana Department of Health and Hospitals ("DHH"), Defendant, in his official capacity.

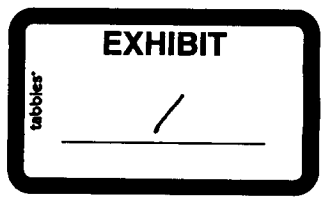
The Plaintiffs filed a civil action in the United States District Court for the Eastern District of Louisiana, styled *Christina Chisholm, et al. v. David Hood*, Civil Action No. 97-3274. Two of the named Plaintiffs, Christina and Meredith Chisholm, have since died.

Plaintiffs' Complaint contains, *inter alia*, allegations that the Louisiana Department of Health and Hospitals is violating the Medicaid Act, the United States Constitution, and 42 U.S.C. §1983, by operating a prior authorization system which fails to authorize requested EPSDT services for reasons other than a finding that the services are not necessary to correct or ameliorate recipients' conditions, or a finding that the services do not fall within 42 U.S.C. §1396d(a); and that further fails to arrange for needed treatment or diagnostic services, or to give notice of appeal rights when such requests are not approved.

Plaintiffs accept the stipulation below in satisfaction of the above-listed claims, provided that the Court enters the accompanying order.

The Court has certified that this action may proceed as a class action under the provisions of Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure. The class is defined as:

> All current and future recipients of Medicaid in the State of Louisiana under age twenty-one who are now or will in the future be placed on the MR/DD waiver waiting list.



In order to settle plaintiffs' remaining claims in this action, the parties agree as follows:

I. DEFINITIONS

1. a. As used throughout this Stipulation, "services that require prior authorization" or "prior authorization services" means all services that are currently reviewed for prior authorization purposes by Unisys, or that are later added to the responsibility of any entity reviewing any of these services for the purpose of prior authorization, including DHH.

b. "PA01 form" or "PA01" means the form used to submit a request for prior authorization, or any successor form.

II. CASE MANAGEMENT PROVISIONS

2. DHH shall insure that case managers assist with services that require Medicaid prior authorization as part of class members' comprehensive plans of care ("CPOC's"), and that they follow up to make sure that those services are authorized and provided, unless denied because the service is not necessary to correct or ameliorate a medical condition, or because Medicaid does not cover the service under any circumstances except under a waiver under 42 U.S.C. §1396n(c) ("§1915(c) Waiver"). This shall be implemented as set forth below in paragraphs 3 through 8.

3. The CPOC form that class members' case managers are instructed to use will include a checklist of services that require Medicaid prior authorization, including personal care services, extended home health services, durable medical equipment and supplies, therapy services, mental health rehabilitation, etc. For recipients needing in-home services, the form will guide the case manager in distinguishing whether home health services or personal care services are appropriate for the class member. Case managers shall be required to indicate whether any of these services are needed or will be sought on behalf of the recipient through Medicaid prior authorization and, if so, the nature and the specific amount of the services that will be requested. Case managers shall coordinate the schedules of services in the recipient's home, if more than one in-home service is needed.

4. Class members' case managers shall:

a. See that the case manager's name, address, and phone number are included on the PA01 form submitted by prior authorization providers, and shall obtain a copy of the PA01 for the case management file.

b. Communicate with the defendant's prior authorization liaison, in order to facilitate prior authorization requests.

c. Track the status of their clients' prior authorization requests, to be aware of the status of those requests; inform DHH of the prior authorization providers who are not actively developing the claims; inform the recipient that he/she may choose another provider of the services needing prior authorization; and assist in locating another provider if the recipient chooses to do so.

d. When necessary, provide assistance in assembling documentary support on a request requiring prior authorization. This shall not supplant the prior authorization provider's primary responsibility to assemble documentation for prior authorization requests.

e. Call or otherwise follow-up with class members or their caretakers as needed, and at least monthly until each CPOC has been fully implemented.

f. Maintain a tracking system to insure the case manager remains aware of the status of prior authorization requests, including when the request for prior authorization is made, when it has been submitted to the defendant's prior authorization unit, when decisions have been issued, the development and filing of reconsideration requests, and filing of fair hearing requests.

g. Track the expiration date of the prior authorized services and the deadline for submitting requests for reauthorization in order to maintain eligibility for continued services pending appeal, and take steps necessary to ensure continuity of services.

h. If some or all prior authorization requests are denied based on lack of medical necessity or Medicaid coverage of the service, document that he or she has, after the denial was received, orally explained to the client or client's caretaker the right to appeal and any right to continued benefits pending appeal, shared with the client a Department brochure discussing the right to appeal, and considered making changes to the comprehensive plan of care. If the case manager will not be assisting with the appeal, his or her file shall include the reason why.

i. Go through checklists in their conferences with class member clients, to see whether additional action is needed with respect to prior authorization requests or services. The checklists shall be designed by DHH, in consultation with plaintiffs' counsel.

j. Document in the case record all steps taken by the case manager regarding prior authorization requests.

5. The Department shall, in consultation with plaintiffs' counsel, design the checklists to be used by case managers in seeing that appropriate prior authorization services are included in the comprehensive plan of care, the checklists to be used by the case managers in quarterly face to face meetings with class members, and the brochure explaining fair hearings for class members who have been denied services.

6. Case management agencies shall report to the Department each time a CPOC is entered requiring prior authorization services that are not already in place, and shall report the prior authorization number(s) associated with the request, once a notice has been issued. Beginning six months after entry of this Order, for a period of ten quarters, the Department shall issue to plaintiffs' counsel in each calendar quarter a report as to the numbers of CPOCs under the Targeted or Special Needs case management provided for the class that include prior authorization services, and the numbers that have not received prior authorization decisions within sixty days of development of the CPOC, and the type of prior authorization service at issue.

7. Each case management supervisor shall be required to attend training annually by DHH (with hand-outs) on (a) responsibilities of Case Managers and prior authorization providers, (b) substantive information on EPSDT, (c) substantive training on Medicaid Services Manual provisions regarding services that must be prior authorized (including what needs to be done to maintain continuity of services), (d) the fact that more than 4 hours per day of PCS may be authorized in appropriate cases, (e) how to distinguish whether the recipient needs personal care services, home health services, or both, (f) coordinating services in the recipient's home, for those needing more than one in-home service, (g) the appeals process and what needs to be done to receive continued benefits pending appeal. The format and content of the training shall be developed in consultation with Plaintiffs' counsel, and counsel shall be informed in advance of the dates and locations of the training sessions. A training module on these topics shall be included in any Departmental requirements that case management agencies cover particular modules in their training of case managers.

8. Case managers must return client calls within one work day. Each case management agency must have an emergency number through which a person can be spoken with 24 hours a day, and

each case manager must document that recipients have been notified as to how to contact the case management agency in emergencies.

III. PRIOR AUTHORIZATION PROVISIONS

9. The defendant's prior authorization unit shall eliminate unnecessary bureaucratic barriers to obtaining prior authorization services for class members, as set forth in paragraphs 10 through 25 below.

10. The defendant's prior authorization unit shall communicate with case managers as well as providers regarding requests for prior authorization. The PA01 form shall include space for the name, address, and phone number of the case manager, if any. The defendant's prior authorization unit shall notify prior authorization providers to include this information on the form, when available. However, the failure to include this information shall not delay approval of a request for prior authorization.

11 The defendant's prior authorization unit shall provide notices of approval and denial to case managers listed on the PA01 form, as well as to providers and recipients.

12. a. Except as specified below, the defendant's prior authorization unit shall issue a written decision on all requests for prior authorization of medical appliances, equipment, and supplies within 25 days of a recipient's making a request for prior authorization, and shall issue a written decision on all other requests for prior authorization within 10 days of a recipient's making a request.

b. The defendant shall incorporate the current language of the Durable Medical Equipment section of the Medical Services Manual concerning the availability of emergency approvals into other sections concerning prior authorization services, applying the same standard to those other services, and shall explain this availability in training manuals issued in the future with respect to those other services.

13. When a prior authorization service is denied, all reasons for the denial shall be given at the same time.

14. Whatever the reason for the denial, the notices shall state specifically each reason for denial, in sufficient detail to inform the provider, case manager, and recipient of any further information needed to support the request. In cases where the prior authorization unit disagrees with the treating physician's determination of medical necessity, notices shall spell out specific reasons for the disagreement, in enough detail to allow the physician or other provider to provide further information or explanation in support of the request, if such is available. A statement that 'the service is not considered medically justified based on the documentation submitted," without giving a reason why the conclusion was reached, is not sufficient. This provision, paragraph 14, is effective October 1, 2002.

15. The Department shall simplify the prior authorization notices issued to recipients, and make them more understandable. The Department agrees to provide plaintiffs counsel with draft copies of the notices for review, and agrees to consider any suggestions made by plaintiffs' counsel.

16. Notices that deny the items or services requested shall conspicuously use the words "denial" or "denied." If any part of the request was denied, the notice shall clearly conspicuously state that the request was partially denied and that the recipient may appeal the denial of the requested hours or services.

17. For requests involving hours of services (such as personal care services, home nursing services, or therapy services) that are requested or prescribed in terms of hours per day or per week, notices shall clearly indicate how many hours per day or week were requested, and how many were approved.

18. Notices to members of the class denied any prior authorization services shall notify them conspicuously of the fact that a case manager can assist the recipient in obtaining needed prior authorization services, and how to access one.

19. The Department or its agents shall determine in each case if a prior authorized service can reasonably be expected to be required at the same level in future time periods; and if so services for successive prior authorization periods requests shall be authorized upon receipt of the physician's prescription only. Recipients and their case manager, if any, shall be required to report to DHH any changes in the recipients' condition that reduces the level of services needed;

20. Prior Authorization Liaison: DHH agrees to provide a liaison ("PAL") within the prior authorization unit. The PAL shall for each class member:

a. communicate with case managers, providers, and recipients on prior authorization requests;

b. for all requests which are submitted for a service by a provider that does not provide the service, contact the case manager or recipient informing him/her how to obtain a provider of the services requested;

c. if the provider submits a request with an incorrect prior authorization code, service name, or other technical defect, contact the provider and request the provider send the correct information by FAX;

d. assist with problems on each prior authorization request so that a decision is rendered as to medical necessity, unless the determination is that:

(i) the particular service requested is not a covered service; or

(ii) the prior authorization unit failed to receive notice within 30 days after the Department issued the notice specified in ¶20(e)(ii) (regarding need for additional documentation) that the recipient had scheduled an appointment needed to determine medical necessity, or

(iii) the reported appointment was not kept.

e. (i) If there is insufficient documentation to issue a decision, the PAL shall contact the case manager (if any), provider, and recipient (if there is no case manager) by telephone explaining the documentation needed and the possible sources that could provide it.

(ii) By the end of ten days, if documentation is still lacking, the PAL shall provide written notification to the case manager, provider, and/or recipient, providing a description of the needed information, the suggested type(s) of provider(s) it can be obtained from (identified with enough specificity to enable the recipient to obtain a KIDMED referral to a provider of that type), and an explanation of how it can be submitted, along with the telephone number of the PAL (from whom clarification can be obtained, if necessary). The notice shall prominently state:

"We will deny your prior authorization request unless:

- You notify the PAL in writing within 30 days of the date on this notice, about an appointment you made with a health care provider of the type we specified, and you attend the appointment, OR

- We have received ALL needed documentation within the 30 days.

You should complete and return the enclosed form to notify the PAL about any appointment you make regarding this.

If you need help scheduling an appointment with a health care professional or transportation to the appointment, you can contact your case manager or contact Kidmed at 800-259-4444."

(iii) The notice shall explain how any health professional can contact the PAL at any time to find out what information is needed. The notices shall be clear and understandable. The Department shall provide plaintiffs' counsel with draft copies of form notices referred to in this provision for review prior to adopting them, and shall consider all suggested revisions.

(iv) The notice shall include a form which a recipient or case manager can return to the PAL, notifying the PAL of the date of their appointment and name of the provider they have arranged to see.

(v) After the issuance of such notices, while the prior authorization unit is awaiting additional documentation, any time limits for making a determination on the request are suspended. If the PAL has received neither additional documentation, nor notice that the recipient has made an appointment with a provider to obtain the needed documentation, within 30 days following the issuance of the notice, the request may be denied for lack of documentation under ¶20(d)(ii) above.

(vi) If the PAL receives notice that the recipient has made an appointment with a provider to obtain the needed documentation, within 30 days following the issuance of the notice, yet the necessary documentation has not been received, the PAL shall follow up as necessary to obtain the needed documentation, unless the recipient failed to keep the appointment.

21. a. Beginning six months after entry of relief, the Department shall report to plaintiffs' counsel monthly for one year, then quarterly for the next six quarters, broken down by the Medicaid service at issue, the numbers of class members' prior authorization requests that have been:

(i) received;

(ii) denied;

(iii) partially denied;

(iv) approved;

(v) referred to the PAL under ¶20(e) above (lack of documentation);

(vi) responded to with notice under ¶20(e)(ii) (written notice of documentation problems) within the period reported on;

(vii) denied under provision ¶20(d)(ii) or (iii) above (failing to report or attend an appointment for more documentation);

(viii) pending for over 25 days without a decision, without issuance of a notice under ¶20(e)(ii);

(ix) remaining in suspended status for over 60 days.

b. On the same schedule and for the same time period, the defendant shall also report to plaintiffs' counsel:

(i) the number of notices issued under ¶24(b), below;

(ii) the number of persons that requested a preliminary determination under ¶24(b)(iii) below, and the outcomes of those determinations;

(iii) the numbers of service requests expected to be required at the same level in future time periods, under ¶19;

(iv) the PAL's contacts made monthly pursuant to section ¶20(e) above, and indicating those for which more than one contact has been made;

c. Plaintiffs' counsel may request further information on class members for whom services have been denied or not fully submitted, or whose requests are in suspended status, and DHH shall provide it, subject to necessary confidentiality guarantees.

22. a. For at least the trial period set forth below in subparagraph (c), DHH's notices to class members fully approving a submitted request for prior authorization shall state:

"If you requested a larger amount or a different type of service, you can appeal for that if, with your appeal, you present a doctor's statement that gives the amount or different type of service you need, and says that what was approved is not enough. At the hearing on the appeal, you will need to prove that you need more than the amount or type of service that was approved."

b. DHH shall entertain such appeals.

c. The trial period will extend at least until one of the following has occurred: (i) DHH has decided 20 such appeals; or (ii) six months has elapsed since the beginning of the trial period. The trial period will begin after all notices, education, and informing about this provision have been finalized. DHH will inform and educate providers and case managers about this provision.

d. DHH will continue to operate under provisions of ¶22(a) and (b) above, unless:

(i) DHH first notifies Plaintiffs' counsel, in writing, of its intent to stop doing so. DHH and Plaintiffs' counsel will then meet to review the situation and attempt to reach agreement.

and

(ii) If no agreement is reached, and the trial period has ended, DHH may notify Plaintiffs' counsel, in writing, that it is in fact stopping, and then may do so. At this point, the parties reserve the right to reopen this litigation and litigate the issue of whether class members are entitled to fair hearings when providers fail to submit some, but not all, of the requested services for prior authorization. The provisions in this paragraph 22 shall not waive any claims or defenses of any party, and shall not be construed against any party as a judicial admission.

23. If a prior authorization request is partially approved, in a recipient's appeal of the partial denial, the amount that can be authorized in the appeal decision may include any larger amount or different type of service that has been prescribed by a doctor, with a doctor's statement that the amount or type of service previously approved is insufficient.

24. a. DHH will provide a mechanism assuring that when providers of services that have to be prior authorized refuse to submit a class member's request for prior authorization of a service for which they are a Medicaid provider, DHH will be notified.

b. (i) DHH shall send a notice to the class member and his/her case manager of what was not submitted, and shall inform them of a phone number that can be used to access another provider if so desired and of the availability of the preliminary determination procedure set out below.

(ii) The notice shall state that if two prior authorization providers have refused to submit the full request, or if there is no other provider from whom to request the service, the recipient can request a review by Medicaid of their possible eligibility for the services not submitted. The notice shall advise where to send the request and that the request must be accompanied by a physician's written statement as to why the services not submitted are necessary, and shall list the recipient's identifying information that should be included.

(iii) If the recipient requests the review and includes a physician's statement, the Department shall review information provided, to determine if the recipient might meet the criteria to obtain prior authorization of the service sought. If the recipient could not, with further development of information, meet the criteria to receive the service, the defendant shall issue a notice denying prior authorization of the service with the right to request a fair hearing regarding the denial. In all other instances, the determination shall be that with further information prior authorization might be granted. If this is the determination, then the Department shall find a provider to submit the request or take other steps to obtain a prior authorization decision as to whether the recipient qualifies for the service.

25. Number of PCS hours: The Department shall remove from its personal care services regulation, manual, and future training materials any reference to a particular number of PCS hours that might be authorized for recipients under age 21.

26. DHH shall create a form to be given to each class member receiving case management services, regarding dissatisfaction with the kind, quantity, and/or quality of services in the CPOC. The form shall have the number of a DHH BCSS Help hotline, and can also be mailed in. When a complaint is received by BCSS, the appropriate region shall investigate the complaint. DHH shall assess the findings and, if necessary, require that the case manager assist the recipient in obtaining a provider to submit for the services. The Department shall also accept and investigate complaints by providers and third parties that case managers are not effectively assisting recipients or performing their responsibilities.

27. DHH shall monitor at least 5% of the case management files per year of class members receiving case management services, to determine the adequacy of the CPOC and its implementation with regard to prior approval services, including files from each region and each case management provider. DHH shall in the course of each monitoring validate whether the steps required by this agreement have been taken, and validate the accuracy of the case management agency's reporting to DHH. This will include determining whether all requests for services on a CPOC were resolved by prior authorization of the service or by a determination that the service was not medically necessary or is not coverable by Medicaid under any circumstances other than under a waiver.

28. DHH shall include in each training of its Personal Care Attendant providers and case managers that more than 28 hours a week of Personal Care Services can be authorized for eligible recipients, depending on their circumstances.

IV. ENFORCEMENT:

29. In the event that class members seek to enforce this stipulation based on the belief that the defendant has failed to discharge any of his obligations under this stipulation, they will give written notice of such failure to defendant's counsel, specifying the grounds that demonstrate such failure, and the defendant will have forty-five days from the receipt of such notice to come into or establish compliance with this stipulation. The sole exception to the obligation of class members to provide the written notice required by this paragraph is a circumstance in which an alleged failure to comply with a term of this stipulation warrants immediate injunctive relief, in which case defendant will receive the appropriate notice required when such relief is sought.

30. If class members believe that the alleged failure has not been cured within the forty-five (45) day period (or that extraordinary relief is required), they may seek in this Court specific performance of this stipulation, together with any sums recoverable under law, but not contempt of court. However, class members may utilize contempt proceedings to enforce any subsequent order entered in a proceeding to enforce this stipulation.

31. This stipulation does not operate as an adjudication on the merits of the litigation. Actions taken or to be taken by the defendant hereunder are not admissions of liability on the part of the defendant but are undertaken in the spirit of compromise, and no provision of this stipulation may be used in support of any claim brought in any proceeding against the defendant except as necessary to enforce the terms of this stipulation. In that event, the sole remedy of the plaintiffs for the alleged failure of defendant to fulfill the terms of this stipulation is to proceed in accordance with paragraphs 29 and 30 above.

V. MISCELLANEOUS:

32. All provisions of this Stipulation shall be effective July 1, 2002, except ¶14.

33. The Plaintiffs will dismiss their claims that DHH is violating the Medicaid Act, the United States Constitution and 42 U.S.C. §1983 by operating a prior authorization system which fails authorize requested EPSDT services for reasons other than a finding that the services are not necessary to correct or ameliorate recipients' conditions, or a finding that the services do not fall within 42 U.S.C. §1396d(a); and that further fails to arrange for needed treatment or diagnostic services, or to give notice of appeal rights when such requests are not approved.

34. Any potential claim of a class member that he or she is unable to obtain from Medicaid services which a physician has refused to recommend or that he or she is unable to obtain a fair hearing regarding Medicaid's denial of such services is not within the matters determined in this suit and is expressly reserved without prejudice.

35. Any potential claim of a class member regarding Medicaid services not included in "prior authorization services" as defined herein is not a matter determined in this suit, and it is expressly reserved without prejudice.

36. Plaintiffs reserve the right to seek reasonable attorneys fees, expenses, and costs incurred in obtaining and monitoring this agreement.

37. Plaintiffs' agreement to dismiss their claims that DHH is violating the Medicaid Act, the United States Constitution and 42 U.S.C. §1983 by operating a prior authorization system which fails to authorize requested EPSDT services for reasons other than a finding that the services are not necessary to correct or ameliorate recipients' conditions, or a finding that the services do not fall within 42 U.S.C. §1396d(a); and that further fails to arrange for needed treatment or diagnostic services, or to give notice of appeal rights when such requests are not approved, is expressly conditioned upon the Court's approval of this agreement pursuant to Rule 23(e), Fed. R. Civ. P., and its entering an order requiring the parties to comply with the terms of this agreement. The Court shall retain jurisdiction of this action for the purpose of enforcing this agreement, which is subject to modification on motion of counsel for the plaintiffs or the defendant or the defendant's successors in interest should changes in the governing federal Medicaid statutes or federal regulations necessitate such changes. The Court and the parties are aware that changes may occur in federal law that would alter, amend, or eliminate obligations placed upon the states related to the EPSDT or Medicaid programs.

38. Counsel for the parties shall meet at least once quarterly, through the next two and one-half years, to share perspectives and information about the implementation of this agreement.

SIGNED:

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(318) 237-0486 FAX

by: _____ DATE: 6/7/02
Nell Hahn, T.A., Bar No. 22406

_____ DATE: 6/7/02
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Attorneys for Plaintiffs

by: David W Hood DATE: 6/5/02
David Hood, Secretary of the Louisiana
Department of Health and Hospitals, Defendant

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
NEW ORLEANS DIVISION

CHRISTINA CHISHOLM, et al., on behalf of themselves and others similarly situated,	*	CIVIL ACTION NO. 97-3274
	*	SECTION J
PLAINTIFFS	*	JUDGE BARBIER
VS.	*	DIVISION 5
DAVID HOOD, Secretary of the Louisiana Department of Health and Hospitals,	*	MAGISTRATE JUDGE CHASEZ
DEFENDANT	*	CLASS ACTION

ORDER OF DISMISSAL

Notice of the partial compromise of this action having been given the class as directed by the Court, in accordance with Rule 23(e), Fed. R. Civ. P., this Court hereby approves the Stipulation set forth herein, and enters an order of dismissal in this case, pursuant to Rule 41(a)(2) Fed. R. Civ. P., conditioned upon the parties' compliance with the stipulations and orders entered in this case.

It is hereby ORDERED that the parties to this action shall comply with the terms of the Stipulation, which is set forth and incorporated herein, and that this Court will retain jurisdiction of this action for the purpose of ensuring that the agreements approved by the Court are implemented and enforced, enforcing the Court's orders, and resolving any disputes that may arise in the future regarding the agreements and orders, their terms, or the enforcement thereof, and resolving any claims for attorneys' fees, expenses, and costs.

Pursuant to the parties' stipulation and this Court's approval thereof, Plaintiffs' claims that DHH is violating the Medicaid Act, the United States Constitution, and 42 U.S.C. §1983 by operating a prior authorization system which fails to authorize requested EPSDT services for reasons other than a finding that the services are not necessary to correct or ameliorate recipients' conditions, or a finding that the services do not fall within 42 U.S.C. §1396d(a); and that further fails to arrange for needed treatment or diagnostic services, or to give notice of appeal rights when such requests are not approved, are hereby DISMISSED with prejudice, except as provided herein.

SIGNED at New Orleans, Louisiana, the _____ day of _____, 2002.

_____
UNITED STATES DISTRICT JUDGE

NOTICE TO CLASS

TO: All persons who are under age 21, Medicaid eligible, and on Louisiana's MR/DD waiver waiting list on or after October 20, 1997:

You are a member of a class of people affected by a lawsuit in the United Sates District Court for the Eastern District of Louisiana entitled *Christina Chisholm, et al. v. David Hood, Secretary of the Louisiana Department of Health and Hospitals*, No. 97-3274-J-5. The lawsuit alleges that the Louisiana Department of Health and Hospitals ("DHH") has failed to provide adequate Medicaid EPSDT services to persons under 21 who are waiting to get on the MR/DD waiver.

The lawsuit seeks to have DHH comply with Medicaid laws. **It does not seek damages or money for any individual or group of individuals.**

Two previous partial settlements have been approved, and other relief has been ordered by this Court in this case.

This is to notify you that the plaintiffs and DHH are proposing to settle the remaining claims in the suit - that the prior authorization system fails to authorize requested Medicaid EPSDT services for reasons other than a finding that covered services are not necessary to correct or ameliorate recipients' conditions, and that DHH fails to arrange for needed treatment or diagnostic services, or to give notice of appeal rights when some requests are not approved.

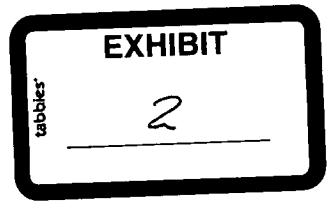
Under the terms of the settlement:

1. Class members' case managers will assist more with services that require Medicaid prior authorization, by receiving additional training and using check lists to be designed by DHH to review if additional services are needed, and following up to make sure the services are authorized and provided, unless the service is not necessary or not covered by Medicaid.

2. The prior authorization process will be streamlined to eliminate bureaucratic barriers by providing for a liaison ("PAL") within Unisys' prior authorization unit to assist class members, case managers and providers with requests for prior authorization services, so that a decision is made as to whether covered services are medically necessary, unless the recipient fails to attend a healthcare visit needed to obtain more information, or fails to notify DHH of the visit, within 30 days after notice.

3. Except when pended to obtain additional medical information, the prior authorization unit shall issue a written decision of all prior authorization requested for medical appliance, equipment, and supplies within 25 day of the request, and shall issue a written decision on all other requests for prior authorization within 10 days of the request.

4. DHH policy shall provide for emergency approvals on other prior approval services as is



currently in place for durable medical equipment.

5. DHH shall simplify the prior authorization notices to make them more understandable. The notices informing the class member of a denial of a request shall clearly state if it is denied, give all reasons for the denial at one time, and inform class members if more information is needed and what kind of information is needed. It shall also inform the class member of his or her right to appeal.

6. For services involving hours per day or hours per week, the notices shall clearly indicate how many hours were requested and how many were approved.

7. For those class members for whom services can be expected to remain the same, DHH will make the request for the services process more simple, by limiting later needed information to the physician's prescription.

8. For at least a trial period, DHH will hear appeals for class members who requested more services than their prior approval provider submitted for. The recipient must submit a doctor's statement that the additional services are necessary to start the appeal, and has the burden of proving that the addition services are necessary. If DHH stops hearing such appeals, the court case can be reopened as to such situations.

9. DHH shall create procedures to help class members find providers to submit prior approval request if two providers have refused (or are not available), and it appears that the recipient could possibly qualify for the services.

10. DHH shall train providers that more than 28 hours a week of PCS can be approved, and remove all references to specific numbers of hours from its regulations, manuals, and training materials.

11. Procedures are set up for DHH to report to Plaintiffs' counsel on the implementation of the settlement.

The complete settlement proposal is 10 pages long, and can be obtained by call calling the Advocacy Center, 800-822-0210, or by writing the Advocacy Center at 515 S. College Rd., Suite 130, Lafayette, LA 70503.

A hearing to determine wether the proposed settlement is fail to the class will be held at ___ a.m. on _____,2002 before United State District Judge Carl Barbier. All members of the class (described above) as well as interested parties may submit written comments concerning the proposed settlement or a written request to testify at the hearing to :

Loretta G. Whyte, Clerk
United States District Court
for the Eastern District of Louisiana
500 Camp St., Room C 151

New Orleans, LA 70130.

To testify against the settlement you must include a brief statement as to why you oppose it. **All written comments, as well as any requests to testify on the fairness of the settlement, must be received not later than 5:00 p.m. on _____.**