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

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

FLORIDA PEDIATRIC SOCIETY/THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS; FLORIDA ACADEMY OF PEDIATRIC DENTISTRY, INC., et al.,

Plaintiffs,

vs.

ELIZABETH DUDEK, et al.,

Defendants.
_____/

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO AMEND OR ALTER FINDINGS OF FACT CONTAINED IN THE COURT'S DECEMBER 30, 2014 FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. INTRODUCTION

In a 153-page order filed on December 30, 2014, this Court carefully considered the parties' factual disputes and legal arguments, and made exhaustive and meticulously detailed findings of fact and conclusions of law following a 90-plus day trial, several days of closing arguments, and 500 pages of post-trial briefing. *See* D.E. 1294. Defendants now raise a panoply of issues in a motion to amend or alter the Court's findings and conclusions, D.E. 1300, including whether the secretaries of the Department of Children and Families ("DCF") and the Department of Health ("DOH") are also liable for violations for which the secretary of the Agency of Health Care Administration is clearly liable. The record shows that the Court's findings and conclusions are well supported and should not be revised, with two exceptions, one of which arose from a legislative change that took effect long after the trial ended.

Plaintiffs agree that Fl. Stat. § 409.9122(2)(c), which imposed outreach obligations on DCF, expired on October 1, 2014, and that as of that date, DCF could no longer be found liable for failing to provide outreach to S.M. or K.K. As to the second matter, L.C., K.K., and J.S. were not enrolled in, or likely to become enrolled in, Children's Medical Services (CMS), which is run by DOH, and so they may not bring Count II, the equal access count against DOH, though the record shows that they have established that AHCA violated their rights under the equal access provision, 42 U.S.C. § 1396a(a)(30)(A) (Count II). However, N.G., whom the Court found could pursue Count I against DOH, has standing to pursue Count II against DOH. Defendants also recycle their misguided contention that to establish causation, Plaintiffs were required to show the impact of low reimbursement rates on specific physicians who treated the named Plaintiffs. The case law, however, shows that causation can be established by showing the relationship between provider reimbursement levels and provider participation, the approach espoused by Plaintiffs and adopted by the Court.

Thus, other than the two items identified above, which in no way alter the Court's essential findings, which are solidly grounded in the law and record, Defendants do not come close to carrying their heavy burden under Fed. R. Civ. P. 52(b) to justify their request for the Court to amend or alter its findings of fact or conclusions of law.

II. STANDARD OF REVIEW

Defendants brought their motion under Fed. R. Civ. P. 52(b), which authorizes revision of a court's findings and conclusions in very narrow circumstances. "The purpose of this rule is to allow the court to correct plain errors of law or fact, or, in limited situations, to allow the parties to present newly discovered evidence, but not to allow the relitigation of old issues, a rehearing on the merits, or the presentation of new theories of the case." *Hannover Ins. Co. v. Dolly Trans Freight, Inc.*, 2007 WL 170788, *2 (M.D. Fla. Jan. 18, 2007). Motions under Rule

52(b) "should be used 'only to correct manifest legal or factual errors or to present newly discovered evidence.'" *Padurjan v. Aventura Limousine & Transp. Serv., Inc.*, 2011 WL 917742, *2 (S.D. Fla. Jan. 24, 2011) (quoting *F.T.C. v. QT. Inc.*, 472 F. Supp. 2d 990, 993 (N.D. III. 2007), *aff'd*, 512 F.3d 858 (7th Cir. 2008)). "A losing party should not use a motion to reconsider to retry its case or rehash arguments it has made previously." *Id.* at *2 (citing *RKI, Inc. v. Grimes*, 200 F. Supp. 2d 916, 921 (N.D. III. 2002)).

Numerous other courts agree. *See, e.g., Perez v. State Farm Mut. Auto. Ins. Co.*, 291 F.R.D. 425, 430 (N.D. Cal. 2013) ("[T]he Rule is not intended to serve as a vehicle for a rehearing[.]" (quotation marks and citation omitted)); *French v. Allstate Indem. Co.*, 2009 WL 1668486, *2 (E.D. La. 2009) ("A Rule 52(b) motion is not to be used to introduce evidence that was available at trial but not offered, to relitigate old issues or advance new theories, or to secure a rehearing on the merits."); *Seibert v. Bartow*, 2009 WL 637177, *1 (E.D. Wis. 2009) ("Rule 52(b) is not intended to allow the parties to relitigate old issues, to advance new theories, or to rehear the merits of a case; instead, the recognized grounds for such a motion include manifest error of fact or law by the trial court, newly discovered evidence, or a change in the law.").[1]

III. ARGUMENT

A. A Recent Statutory Change Has Impacted DCF's Outreach Responsibilities.

Defendants contend this Court incorrectly found that several of the named Plaintiffs had standing to sue DCF on Count IV, the outreach claim. *See* D.E. 1300 at 2 (re S.M.); *id.* at 6 (re K.K.). Defendants argue that DCF had no legal obligation to conduct outreach and so any injury

[1] Because this Court has not yet issued a judgment, Defendants' motion can be construed as a motion for reconsideration. However, the standard that would apply would be virtually the same. *See Diaz v. Amerijet Intern., Inc.*, 872 F. Supp. 2d 1365, 1373 (S.D. Fla. 2012) ("In order to succeed, [the movant] would need to raise grounds that would merit reconsideration, such as actually new evidence or potential clear error or manifest injustice." (citing *Instituto de Prevision Militar v. Lehman Bros., Inc.*, 485 F. Supp. 2d 1340, 1342 (S.D. Fla. 2007)).

that Plaintiffs might have suffered was not caused by any act or omission of DCF. *Id.* at 2. As the Court held in its Findings of Fact and Conclusions of Law, "Florida has delegated to DCF, among other agencies, certain outreach and information responsibilities." D.E. 1294 at 150-51 (citing Fl. Stat. § 409.9122(2)(c) as requiring DCF to provide "clear and easily understandable information" about MediPass and Medicaid HMOs); *see also* D.E. 541, Order on Motions For Summary Judgment at 11 (noting same statute imposes outreach obligations on DCF). Accordingly, the record amply supports the Court's finding that S.M. and K.K. had standing to sue DCF on Count IV at the time the case went to trial, and that DCF violated its outreach obligations to them. However, as Defendants note, Fl. Stat. § 409.9122(2)(c) expired on October 1, 2014, even though Defendants did not previously inform the Court of the law's expiration. Thus, it would be appropriate to clarify that at this time Count IV is moot as against DCF.

This is a technical issue that does not affect the Court's conclusion that Florida is out of compliance with the Medicaid Act's "outreach" mandate. In its findings and conclusions, the Court also found that S.M. and K.K had standing to pursue Count IV against AHCA. *See* D.E. 1300 at 18. The expiration of Fl. Stat. § 409.9122(2)(c) had no effect on the Court's findings and conclusions regarding S.M.'s and K.K's standing to bring Count IV against AHCA, and it had no effect on the Court's finding that AHCA violated its outreach obligations, and Defendants do not suggest otherwise.

B. Clarifying The Children With Standing Against AHCA and DOH On Count II.

Defendants ask the Court to amend its findings with respect to the standing of L.C., K.K., and J.S to sue DOH. In its findings of fact and conclusions of law, this Court found four of the named Plaintiffs had standing to pursue counts against DOH. It found that L.C., K.K., and J.S. had standing to pursue Count II, the equal access count, against DOH, and that N.G. had

standing to pursue Count I, the reasonable promptness count, against DOH. *See* D.E. 1300 at 18. To be eligible to receive their Medicaid care through the CMS, children must have special health care needs, such as a chronic medical or psychological condition that has lasted or is expected to last at least 12 months. *See* PX0320 at 6-7. During the time period covered by the testimony at trial and the documents admitted at trial concerning L.C., J.S. and K.K., none of these three children were enrolled in CMS. While it is possible that they may be enrolled in the future in CMS, Plaintiffs do not object to modification of the Court's findings to provide that, for this reason, L.C. J.S., and K.K have standing to assert claims against AHCA, under Count II, rather than DOH. *See* D.E. 1300 at 2-6, 8.[2] As the Court found, these Plaintiffs did not receive equal access to care, *see* D.E. 1294 at 40-46, 50-52. Because they were not enrolled in CMS, it is AHCA, not DOH, which is responsible for their lack of access.[3]

Defendants do not dispute this Court's finding that N.G. had standing to bring Count I against DOH. *See* D.E. 1294 at 1. Defendants do not argue otherwise. In fact, N.G. is not even mentioned in Defendants' motion to amend or alter the Court's findings of fact. *See* D.E. 1300. N.G., who received care through CMS, *see* 2/4/2008 Tr. Testimony of Rita Gorenflo at 10:24-11:18, thus has standing to bring both Count I, the reasonable promptness claim against DOH, as

[2] The Court's findings of fact and conclusions of law list only N.V. as having standing to bring Count II against AHCA, even though several children have such standing. Indeed, all of the named plaintiffs actually have standing to pursue counts against AHCA insofar as their status as Medicaid enrolled children puts them in danger of having their rights violated at present and in the future due to the violations of federal law found by the Court.

[3] Defendants argue that there is no evidence in the record regarding what Staywell paid ENT providers in Ft. Meyers or that the capitation amount AHCA paid Staywell was inadequate to ensure network adequacy. D.E. 1300 at 5. The record establishes, however, that Staywell did not have an adequate network of ENTs at the time in question, and the case law is clear that AHCA cannot shirk its responsibility to provide adequate care by delegating responsibility for the provision of care to a Medicaid managed care organization. *See* D.E. 1172, Plaintiffs' Corrected Proposed Findings of Fact and Conclusions of Law at 13 (citing cases).

well as Count II, the equal access claim, against DOH. As the Court found, N.G. did not receive an evaluation from an ENT physician until five days after his mother said he needed an immediate appointment, D.E. 1294 at 48 (citing the record), even though "a patient with the same symptoms and private insurance would have been see by an ENT either the same day or at the latest, the following day[,]" *id.* at 49 (citing record). That disparity is a quintessential violation of the equal access provision.

C. There is No Basis to Amend The Court's Findings Regarding Switching.

Defendants claim there is no record evidence of DCF's liability for the fact that several of the named Plaintiffs' doctors were switched without their parents' knowledge or consent. They are mistaken.

1. The Record Shows DCF Bears Responsibility For K.K.'s Being Switched.

Defendants contend there is no evidence that DCF is responsible for K.K. having been switched and thus claim this Court erroneously found that K.K. had standing to sue DCF on Count I. D.E. 1300 at 6-7. A.D., K.K's mother, testified, and the Court found that the first time K.K. was switched from Medipass to Staywell was at the mother's request. D.E. 1294 at 14, 43. Defendants argue that the second time K.K. was switched was not DCF's fault because K.K.'s termination from Medicaid when his mother obtained a higher-paying job, and his reinstatement to Medicaid when his mother lost that job, were proper. D.E. 7; *see also* D.E. 1294 at 46. Thus, Defendants contend that K.K. does not have standing to sue DCF on Count I because the change in his eligibility status was proper and because it is AHCA, not DCF, that assigned K.K. to Staywell without his mother's consent when K.K. returned to the Medicaid rolls. *Id.*

Regardless of who is at fault for that second switch, Defendants wholly ignore another time K.K. was switched to a Medicaid HMO that K.K's pediatrician did not accept. *See* D.E. 1294 at 46 n.14. That incident alone suffices to provide K.K. with standing to sue DCF under

Count I based on his having been switched, without his mother's consent, to an HMO his pediatrician would not accept. Because Defendants do not even discuss this incident, their motion falls short of carrying their burden under Fed. R. Civ. P. 52(b) to warrant amending the Court's finding on this point.

Defendants do not challenge K.K.'s standing to sue AHCA on Count I.

2. The Record Shows DCF Bears Responsibility For J.W.'s Being Switched.

Defendants also argue that J.W. does not have standing to sue DCF on Count I because there is no evidence that any action or inaction by DCF caused J.W.'s primary physician to be switched, without his grandmother's knowledge or consent, from Dr. Whibbs to Dr. Murray. D.E. 1300 at 9-10. Rather, Defendants argue that the change in J.W.'s primary provider was made by Healthease and that if anyone is at fault for that change, it is Healthease. *See* D.E. 1300 at 10 ("The change in J.W.'s primary care providers was made by his chosen managed care plan, Healthease.").

The record indicates that DCF *was* responsible for this change in J.W.'s primary provider in the summer of 2005. In fact, the record shows that every time a child was switched, the switch was caused either by the child's termination of eligibility by DCF or a change in the child's eligibility category in DCF's computer, which was erroneously interpreted by AHCA's computer as a termination of eligibility, *see* DX 178 at 2; DX 169a at 2, setting in motion a series of events that culminated in a child being switched to a new primary care provider without the parent's knowledge or consent.

The record shows that Dr. Whibbs, J.W.'s long time primary doctor, treated J.W. until at least June 9, 2005, PX629-000002, but that by August 1, 2005, J.W.'s primary physician had been changed to Dr. Murray, DX8. All the evidence at trial demonstrated that eligibility terminations are the reason switching occurred, *see* D.E. 1294 at 69-71, and that is the only

reasonable explanation for why J.W.'s primary care physician was switched from Dr. Whibbs to Dr. Murray without his grandmother's knowledge or consent. This Court should not alter its finding that DCF was responsible for J.W.'s being switched.

Moreover, this Court found that J.W. was switched a second time from Healthease to "straight Medicaid" in about March of 2007. D.E. 1294 at 57, ¶ 73 (citing record). The Court also found that J.W.'s grandmother did not request that switch and that she had to pay the psychologist herself because the psychologist would not accept "straight Medicaid." *Id.* (citing record). The record supports those findings. The record shows J.W.'s Medicaid eligibility was terminated on February 28, 2007, and restored less than five weeks later on April 1, 2007. DX 5 at 2. When his Medicaid eligibility was restored, he was placed back on straight Medicaid until his grandmother was able to get him back on Healthease. 6/16/2010 E.W. Depo. Desig. at 68:15–69:8. Defendants do not discuss that loss of eligibility and out of pocket expenditure in their motion , *see* D.E. 1300, and cannot show the Court's finding was in error. That incident alone shows J.W. has standing to sue DCF under Count I, and also that DCF was liable under Count I for violating J.W.'s rights.

Regardless of whether J.W. has standing to bring Count I against DCF,[4] and he clearly does, J.W. has standing to pursue Count I against AHCA, including for AHCA's failure to provide him with the care he needed with reasonable promptness. As this Court found, it took J.W. about five weeks to receive the imaging study he needed to determine whether his tumor had spread to his neck, while a child with private insurance whose physician ordered an imaging test in such circumstances would likely receive an imaging study within a day or two, and in no

[4] Defendants do not challenge S.M.'s standing to sue DCF under Count I. As the Court found, S.M.'s Medicaid was improperly terminated on several occasions, leading to a delay in his care, including his 18-month well-child check-up. D.E. 1294 at 37-40.

event would have to wait more than a week. D.E. 1294 at 56, n.23. Defendants argue that Healthease is solely responsible for any delay in J.W.'s care, D.E. 1300 at 10, but AHCA cannot shirk its legal responsibilities under federal law by interposing a third-party agent to provide services to children on Medicaid. *See* D.E. 1172, Plaintiffs' Corrected Proposed Findings Of Fact And Conclusions Of Law at 13 (citing cases). Moreover, as this Court also found, even after Healthease had authorized the imaging study that J.W.'s physician had repeatedly requested, J.W. also experienced a delay in obtaining an infusaport for use in administering the chemotherapeutic agents necessary to treat the tumor that had spread to his neck. D.E. 1294 at 57. That delay, which is not discussed in Defendants' motion, is also a separate and independent basis for his standing to bring Count I against AHCA, and for the Court's conclusion that AHCA violated J.W.'s rights for reasonably prompt access to medical care.

D. Defendants Cannot Establish Any Manifest Error Regarding the Court's Findings on Causation.

Defendants argue that Plaintiffs do not have standing to bring either Count I or Count II, because they failed to show that individual providers refused to care for the named Plaintiffs because of the inadequacy of the Medicaid reimbursement rates. D.E. 1300 at 11.

This Court has repeatedly found that the Plaintiffs have adequately established causation as an element of standing and on the merits, and those findings are not in error. Plaintiffs established at trial that reimbursement rates are "by far the most important factor" in "determining whether providers participate in Medicaid." D.E. 1294 at 149. Florida's low reimbursement rates led to (and continue to lead to) inadequate provider participation, thereby causing the Plaintiffs' injuries—in particular, their inability to receive the equal access to care required by statute and also their inability to receive care, including EPSDT care, with reasonable promptness. *Id.* at 11, 144, 147–49.

Although Defendants acknowledge that there was "general causation testimony" establishing this link, they nonetheless complain that "specific causation testimony should have been presented from the actual providers for Plaintiffs." D.E. 1300 at12. In other words, Defendants believe that Article III requires Plaintiffs to interview each doctor who refused to treat the named Plaintiffs in order to establish, on a doctor-by-doctor basis, that low reimbursement rates "were the factor which influenced participation decisions made by the providers who interacted with L.C., K.K., J.S., N.V., and their parents." *Id.*

This novel and remarkable argument has no support in the law of standing. It is misguided because the Named Plaintiffs, like other members of the Plaintiff Class, suffer injury not because of their specific physicians, but because of the general lack of providers providing reasonably prompt, let alone equal, access to medical and dental care to Medicaid children. Moreover, because the law focuses on the imminent danger of such children being denied reasonable or equal access to care at the present time and in the future, the focus is properly on the lack of access generally, not the subjective motivation of a physician who treated a particular Medicaid child in the past.

Article III requires only that plaintiffs demonstrate that their injury is "fairly traceable to the challenged actions of the defendant." *Sicar v. Chertoff*, 541 F.3d 1055, 11059 (11th Cir. 2008). The injury asserted in this case under Count II is that providers are not available to Plaintiffs "at least to the extent that [they] are available to the general population in the geographic area," as required by 42 U.S.C. § 1396a(a)(30)(A). The injury asserted in this case under Count I is the Plaintiffs' inability to access care with "reasonable promptness" and to access EPSDT care, as required by 42 U.S.C. §§ 1396a(a)(8) and (a)(10). The evidence presented was more than sufficient to conclude that the low reimbursement rates caused a

disparity in access; indeed, the fact that so many doctors and dentists do not participate in Medicaid because of the low reimbursement rates is itself evidence of that very disparity. Similarly, the fact that so many providers do not participate in Medicaid because of the woefully inadequate reimbursement rates leads to a failure to provide care with reasonable promptness.

Tellingly, the evidence Plaintiffs presented at trial is precisely the kind of evidence that plaintiffs in this type of cases typically provide and which has been found sufficient. Plaintiffs presented extensive evidence from pediatricians who limited the number of children on Medicaid they will accept because of Medicaid's low reimbursement rates. *See* D.E. 1294 at 89-90. They presented similar testimony from medical specialists, *id.* at 110-111, and from a pediatric dentist, *id.* at 119. *See Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 701 n.5 (5th Cir. 2007) (finding that plaintiffs proved causation, noting that "[s]everal courts have recognized the direct connection between Medicaid recipients' access to medical care and services and low reimbursement rates"); *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 (E.D. Cal. 2003) (finding standing inquiry "straightforward" because low rates lead to reduced provider participation, which would "adversely affect beneficiaries' equal access to medical care"), *rev'd on other grounds*, 140 F. App'x 677 (9th Cir. 2005); *see also Okla. Chapter of Am. Acad. of Pediatrics (OKAAP) v. Fogarty*, 366 F. Supp. 3d 1050, 1075–76 (N.D. Okla. 2005) (low reimbursement rates resulted in Medicaid children having less access to healthcare than children in the general population) *rev'd on other grounds* 472 F.3d 1208 (10th Cir. 2007); *Memisovksi ex rel. Memisovski v. Maram*, 2004 WL 1878332, at *14 (N.D. Ill. Aug. 23, 2004) ("The major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in the decision to participate in the Medicaid program at all, to participate in a limited fashion, or to participate fully. When Medicaid rates are too low, physicians will opt to

treat non-Medicaid children first or exclusively."); *see id.* at *42-46. None of these other cases turned on the testimony of providers who refused to treat the named plaintiffs or refused to treat them sooner and the reasons for their refusal. Defendants can provide no legal support that more is required.

Moreover, the Court did make factual findings that establish "specific causation" for named plaintiffs. *See, e.g.*, D.E. 1294 at 13, 41 (L.C.'s therapist would not provide the therapy because she did not accept Medicaid); at 14, 44-45 (K.K. referred to ENT specialist about two hours away from his mother's home; there were not a sufficient amount of ENT specialists on panel in Fort Myers due to failure to set reimbursement rates at required levels); at 15, 49 (N.G. delayed for five days in receiving emergency appointment putting his health at significant risk because of lack of sufficient specialty services); at 16, 50-52 (J.S. had difficulty on three occasions in obtaining orthopedist who would treat her as a Medicaid patient); at 16, 54 (delay in treatment of N.V. due to AHCA's practice of reimbursing doctors at low rates).

The cases that Defendants cite do not support their position. Indeed, in *Elend v. Basham* the Eleventh Circuit found the causation aspect of standing *satisfied* based on a general Secret Service policy, without ever discussing evidence that the challenged policy caused *any particular agent* to violate the plaintiffs' rights. 471 F.3d 1199, 1206 (11th Cir. 2006). The Defendants also rely on *Fullman v. Graddick*, 739 F.2d 553, 563 (11th Cir. 1984), where the court affirmed the dismissal of a § 1983 claim because the "Plaintiff fail[ed] to identify the 'City's policy or custom which deprived him of his constitutional rights,'" as required by *Monell v. Department of Social Services*, 436 U.S. 658, 694 (1978); the decision contained no meaningful discussion of causation, and it has nothing to do with the Defendants' current causation arguments.

Finally, Defendants cite a series of cases standing for the unremarkable and irrelevant principle that expert witnesses are often unable to testify about the motivations and intentions of particular actors. *See, e.g.*, *Linde v. Arab Bank, PLC*, 920 F. Supp. 2d 282, 285 (E.D.N.Y. 2011). That argument misses the mark. As Defendants concede, Plaintiffs never attempted to present expert testimony about the motivation of any one doctor, nor did this Court rely on any such evidence. Rather, this Court found that inadequate reimbursement led to a *general, systematic* unavailability of doctors. As this Court properly concluded, this unavailability directly resulted in the Plaintiffs' injuries—a lack of equal access to care and a lack of access to EPSDT care and to care with reasonable promptness—and therefore Plaintiffs did not need (and never attempted to present) expert testimony about the motivation behind any one doctor's decision not to treat the named plaintiffs.

E. Summary Of Named Plaintiffs With Standing And Who Have Demonstrated Violations Of The Three Operative Counts.

For ease of exposition, Plaintiffs have presented below a chart indicating (1) which of the named Plaintiffs have standing to bring the various claims against particular Defendants and (2) which of the named Plaintiffs have demonstrated at trial that one or more Defendants were liable for violating his or her rights under a given count.

	AHCA	**DOH**	**DCF**
Count I	S.M., K.K., J.W.	N.G.	S.M., K.K, J.W.
Count II	N.V., L.C., K.K., J.S.	N.G.	
Count IV	S.M., K.K.		

There are three changes from the Court's standing summary on page 18 of its December 29, 2014 order. First, S.M. and K.K. have been removed from the box corresponding to Count IV against DCF. Second, L.C., K.K, and J.S. have been moved from the DOH box to the AHCA box on Count II. Third, N.G. has been added to the DOH box on Count II.

IV. CONCLUSION

For the reasons stated above, this Court should amend its Order to find: (1) DCF is no longer liable under Count IV, the outreach claim; (2) L.C., K.K., and J.S. do not have standing to sue DOH on Count II, the equal access count, but do have standing to sue AHCA on that count; and (3) N.G. has standing to sue DOH under Count II. The Court should deny Defendants' motion in all other aspects.

Dated: February 13, 2015

Respectfully Submitted,

By: /s/ Stuart H. Singer

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Florida Pediatric Society/The Florida Chapter of The American Academy of Pediatrics; Florida Academy of Pediatric Dentistry, Inc., et al. v. Liz Dudek in her official capacity as Secretary of the Florida Agency for Health Care Administration, et al.

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United States District Court, Southern District of Florida

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